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**Chapter 9: The prevention of attachment disorders**

By Karl Heinz Brisch



**9.1 The emotional effects of attachment disorders**

The prevention of emotional disorders by means of secure attachment to a specific attachment figure provides a major foundation for the healthy motor, cognitive, and emotional development of children. It is therefore crucial to foster secure development in children, and to prevent early attachment disorders because such disorders are associated with developmental lags, including serious disorders in motor and cognitive skills, and with a lack of empathy in children. Children with attachment disorders show serious deficits in their ability to enter into and structure attachment relationships. Such children often behave aggressively in conflicts, and have a hard time empathizing with the emotional needs, thoughts, and intentions of others. This can lead to considerable misunderstandings and problems in day-to-day interactions, which may manifest in difficulties in personal relationships during adolescence and adulthood (Becker-Stoll, 2002; Zimmermann et al., 1997). Attachment disorders demonstrate a certain persistence and cannot be resolved without fresh experiences of secure emotional attachment or therapeutic intervention. Rather, they tend become reinforced and, clinical experience indicates that parents may transmit their own poor attachment patterns to their children (Brisch, 2002; Brisch 1999; Brisch, 2003).

Primary prevention of attachment disorders is therefore essential to promoting emotional stability.

**9.2. Primary prevention of attachment disorders by means of the SAFE® program "Safe Attachment Formation for Educators"**

A primary goal of prevention should be to foster psychological health in parents and children. The development of a secure attachment pattern is a fundamental goal that is associated with considerable advantages for the development of the child. Children who have a secure attachment pattern are better able to solicit help in emergency situations and have more and better friendly relationships. They also used more nuanced coping strategies in that they have available a greater palette of approaches involving emotional availability to others. Children with a secure attachment are more creative, persistent, and nuanced in their cognitive functions. Their memories are better, as is their ability to learn. They resolve conflicts more constructively and

cooperatively, and show less aggressive behavior in conflict situations. Speech develops more smoothly in small children and with fewer problems (Dieter et al., 2005; Klann-Delius, 2002). All of these positive effects are delayed or problematic in children with attachment disorders; in fact such children are considerably more subject to psychopathological problems in all of these developmental areas (Brisch, 1999; Brisch, in press; Minde, 2003; Zeanah & Emde, 1994). The goal of any prevention program should therefore consist in sensitizing parents to the emotional needs and signals of their children. Sensitive parents who are emotionally open to their children's signals foster the development of secure attachment in their children. However, parents who themselves suffer from attachment disorders are less able to recognize their children's needs and signals, frequently interpret these signals incorrectly, and end up promoting insecure attachment in their children. If in addition the parents traumatize their children by using physical, emotional, or sexual violence, a variety of disordered attachment patterns may result (Brisch, 1999). Prevention program should therefore help parents to practice sensitive interaction behavior, while at the same time sensitizing them to their children's signals by using video feedback. Videotaped parent-child interactions have been shown to be a particularly effective instrument for enabling parents to become more sensitive to these signals, and to interpret them better (Grossmann et al., 1985; Kindler & Grossmann, 1997).

Clinical experience has shown that parents who have not yet worked through their own traumatic experiences tend to use their children as a projective screen when prior trauma is triggered by their child's behavior. In such situations, parents may reenact their own traumatic experiences with their children, thereby recruiting them as unwitting actors in an old play. These are precisely the classical situations in which parents reexperience sometimes violent affects as a result of the reactivation of old trauma and then -- unconsciously -- make their children the victims of physical, emotional, or sexual abuse. And these are precisely the behaviors that lead to attachment disorders in children. The result is a vicious cycle of traumatic experiences that are transmitted from the parents to their children; we can, in fact, diagnose attachment disorders resulting from trauma across generations. One might be tempted to assume that such transmission of developmental disorders is genetic; however, family histories show that the "family story" has generally been marked by generations of violence and insensitive behavior on the part of parents toward their children (Brisch, 2003; Brisch, 2003; Brisch, 2003; Brisch, 2003; Brisch, 2004).

### 9.2.1 Target group for preventing attachment disorders

Fathers and mothers are the target group for preventing emotional developmental disorders. Parents-to-be, both first-timers and more experienced couples, should be encouraged to participate in primary prevention programs so that they may be guided from the outset to be more sensitive to the needs of their child, both emotionally and cognitively. All the parents need to bring to these sessions is receptiveness to the emotional development of their child and the motivation to take advantage of a the support offered by a preventive program. Clinical experience indicates that during a pregnancy parents tend to be particularly involved with traumatic experiences from their own childhood. Positive attachment experiences as well as traumatic ones in their relationship with their own parents are reactivated from memory, and affective memories of happiness, anger, rage, and disappointment often bubble close to the surface during pregnancy. As they turn over in their minds the sorts of roles they hope to assume in their infant's life, they often consider whether they want to be like their own parents -- or not. Pregnancy is a time when the dynamics of their own childhood make parents especially motivated and receptive to dealing again with their own experiences. Once the infant is on the scene, the parents are busy with the dynamics taking place in the present such as feeding, diapering, and the baby's sleep patterns, so that these positive and/or painful experiences from the past again retreat into the background or vanish completely from consciousness. During the postnatal phase and the first year, parents often need additional help because of the many questions that arise only when they are confronted with the concrete reality of their infant. In our psychosomatic outpatient service, we frequently see parents only after difficulties with feeding, sleeping, and relation building have already taken hold and become somewhat chronic. This may manifest in a baby that cries many hours a day over several weeks and cannot be soothed. Often, the parents come to us only after they can no longer cope psychologically. In order to stave off such outcomes early all in, and to

offer assistance to parents as soon as they experience their first coping difficulties, a prevention program should ideally be in able to support parents and their infant during the first year of life in the postnatal adaptation phase.

**9.2.2. Contents covered in the SAFE® program**

The SAFE® program "Safe Attachment Formation for Educators" was developed specifically to foster the development of secure attachment patterns between parents and children, and to prevent attachment disorders, particularly the transmission of traumatic patterns across generations. This is why the program came to be called SAFE®, a word that implies that development should be safe for both parents and children. Parents are informed of and solicited into new SAFE® groups by flyers placed in pharmacies, doctors' offices (gynecologists, pediatricians), family education and counseling centers, pregnancy counseling centers, and by press reports. There are a number of different financing models, depending on the location of the SAFE® group, and who the organizers are. In part, SAFE® groups are organized and sponsored by family education and pregnancy counseling centers, but may also be financed by contributions so that the parents themselves only pay a small portion of the actual cost. Sometimes the groups are organized by established midwives or psychotherapists who receive fees directly from the parents. In general, the groups are led by a facilitator and co-facilitator over the entire period from pregnancy to the end of the first year of life.

The SAFE® program consists of four modules:

Table 1: The 4 modules of the SAFE prevention program

1. Prenatal module (20th to 32nd week of pregnancy)
2. Postnatal module (1st to 12th month after birth)
3. Individual trauma psychotherapy (for traumatized parents)
4. Hotline (for crisis intervention)

Parents meet in parent groups in both the prenatal and postnatal modules. Groups with parents who are in similar phases of pregnancy provide an important framework for the entire program over time. Group cohesion develops over the duration of the course, from the 20th week of pregnancy to the end of the first year of life. Parents make use of individual trauma therapy and the hotline as needed. This means that SAFE® combines group therapy and individual therapy in a single prevention program.

**SAFE® -- prenatal module**

In the prenatal module, the parent groups meet on 4 Sundays during the pregnancy, beginning on about the 20th week of pregnancy, and continuing on the 24th, 28th, and 32nd week of pregnancy. The program begins at a very early stage, at a time during which ultrasound diagnosis of malformations has been performed, and the viability of the pregnancy is no longer in question. Sundays have generally been found to be excellent days for the course because the parents tend to be relaxed, and the father in particular is more motivated to join in. In the prenatal module facilitators convey certain necessary information information, and the parents and facilitators exchange experiences among themselves. Subjects discussed may include the competencies of the infant and the parents, parental expectations of the "ideal" baby, the ideal mother, the ideal father, parental fantasies and fears, the prenatal development of attachment, and parent-infant interaction. These are illustrated using videotaped examples, and the parents are trained in how to perceive and correctly interpret a baby's signals. This training enables parents to get their first experience -- in videotaped form -- with specific tasks such as feeding, nursing, diapering, playing, and dialoguing between parent and child, and to attune themselves emotionally to their infant's signals. In the process, parental competencies and the ability of the infant to respond can be illustrated by short video sequences. The parents also learn stabilization and relaxation techniques from the very beginning of the course so that they may better handle stressful situations during the pregnancy and after the birth. Research has shown that fears and stress during pregnancy can have a negative effect on the mother-to-be in terms of her ability to become attached to her infant, and on the infant himself and his irritability and tolerance for stress. The

parents can use the stabilization and relaxation techniques that they learned prenatally after the birth when they encounter stressful situations with their infant, which occur sooner or later in all parent-child relationships. However, as long as the baby is still being nourished in the mother's womb, the parents have more time and emotional space to learn such relaxation techniques. Once the baby is there and making demands on them day and night, they often lack the inner peace to do so.

**SAFE® -- postnatal module**

After the birth, the parent groups continue with six full-day Sunday seminars held on the 1st, 2nd, 3rd, 6th, 9th, and 12th month. This means that the parents are supported during this difficult phase of postnatal child development and adaptation, and get help in reorganizing their relationship to take into account this new third person. The cohesion of the group is particularly beneficial during the postnatal phase because all of the parents are undergoing a similar developmental process. Individual parents may meet outside of group sessions to exchange experiences, and to do things together. This leads to the formation of parent peer groups, which even before the birth has been shown to have a stabilizing effect on the parents. This positive effect continues to grow after the birth. The postnatal groups deal largely with working through the birth experience, which is not always associated with positive feelings. In some cases the baby had to be delivered prematurely or by cesarean section; in either case, more intensive psychotherapy within the group or individually may be necessary so that the parent-child relationship does not develop in an atmosphere of anxiety and fear. Unprocessed birthing experiences can have a negative effect on parent-child interactions and attachment. Postnatal depression, which, according to longitudinal studies, afflicts 12-15% of all mothers, could perhaps be prevented as well by timely group psychotherapy.

Further key contents covered after the birth include parental competencies; triangulation between the mother, father, and child; interactional difficulties with feeding, nursing, sleeping; and the building of an emotional relationship. The parents bring their babies to the meetings so that the attachment behavior of the parents and infant and the baby's exploratory behavior may be observed directly in the group. All of the parents learn a great deal from these interactions.

During this time, the parents and their infant are videotaped in interactions involving diapering, feeding, nursing, and play. These video sequences are then discussed with both the mother and the father in individual feedback training sessions. The goal is to enable the parents, based on actual experience, to learn to recognize their baby's individual signals, to interpret them correctly, and to respond to them appropriately and promptly. Irritation and the parents' emotional difficulties and misinterpretations and projections from their own childhood can be recognized in a timely manner at this stage. They can then be discussed and dealt with. If the parents consent, their individual videotaped interactions with their baby may be used in the group as feedback training for all participants. The parents are generally highly motivated to share their interactions with the group so that everyone can learn from their own positive experiences, and so that others in the group can give them tips for dealing with difficulties in fine attunement or "misunderstandings" in the interaction. Given that relationships based on trust have developed among group members over time, parents have little difficulty openly discussing their anxieties, fears, and interactional difficulties.

**Individual trauma therapy**

An Adult Attachment Interview (AAI) is conducted with all parents. The specific purpose of this interview is to determine what attachment resources the parents-to-be have, and what traumatic experiences that they have perhaps not yet resolved may intrude into their relationship with their children. Experience has shown that approximately 30% of parents have such unresolved traumatic experiences that require individual psychotherapy. These *unresolved* traumatic experiences are particularly important because clinical experience indicates that children can -- completely unintentionally -- by their behavior reawaken old traumatic experiences and associated affects in their parents. These are like "ghosts in the nursery" (Fraiberg et al., 1975) that come completely unbidden. For example, a child's crying, desire for tenderness, tantrums, or even demands for closeness and contact may bring unresolved traumatic experiences bubbling to the surface. If this occurs unchecked and unconsciously, a parent may suddenly find him- or

herself in a full-pitched battle on an imaginary stage. In the worst case scenario, the child may become both an actor and victim in an old traumatic script, assigned a role that she never sought. The child may then become a target and projective surface for violent fantasies which at worst can result in real repetition of violent experiences in that the mother or father unintentionally shakes the child. Such often brief traumatic reenactments can have fatal consequences or leave the child handicapped or damaged as a result of bleeding in the brain or eye from shaking trauma. If the attachment interview shows that the parents are bringing such unprocessed traumatic experiences into the present, they are informed that these experiences represent a certain risk factor to the extent that they have not yet been worked through. They need to know that events will likely occur in which they may well repeat their own traumatic experiences in their relationship with their child, thereby setting in motion a vicious cycle in which the violence they themselves experienced is transmitted to the next generation. One specific goal of the SAFE® program is to break this vicious cycle. If the parents can be motivated and are ready, we offer them separate individual trauma therapy sessions during the pregnancy to help stabilize them. After the birth, the parents may be helped to work through their traumatic experiences in individual trauma-centered psychotherapy using modern techniques such as EMDR. This part of the SAFE® program in particular aims at preventing parents from repeating with their own children the trauma they themselves experienced.

**Hotline**

Another intervention module is the "hotline." After birth in particular, all adaptation processes such as going to sleep are typically subject to difficulties so that parents may for the first time get into trouble when they cannot put their baby to sleep or when he cries for hours on end without their being able to soothe him, or to figure out what the problem is (Brisch, in press). Clinical experience has shown that parents often seek out help much too late when they find themselves in such stressful situations. At worst, they come into the clinic only after they have responded violently to their crying infant. The hotline provides parents with the ability to call the SAFE® group facilitator, and to get advice and support immediately. It is an enormous advantage here if the parents already know the person answering the hotline from prenatal group meetings in which a relationship of trust has developed (Brisch, 2000). The frequency of hotline use by particular couples and couples overall varies considerably and fluctuates, depending on the particular crisis and stress situations, which are difficult to predict. Specific interventions can now be targeted with precision because the group facilitator knows the parents' individual histories and resources as well as their particular risk factors and problems from previous group meetings and the AAI. In general, the parents' ability to perceive and interpret their baby's signals were recognized and increased prior to birth with the use of video training. This means that the parents' competencies and resources are well known from their diapering and feeding video recordings so that they can be rapidly referred for appropriate intervention and counseling when they call the hotline. If the parents are projecting their own unconscious fears and expectations onto their infant, and these projections are the cause of the interactional disorder, this can be recognized early on and treated in parent-infant therapy (Bakermans-Kranenburg et al., 1998; Beebe, 2000; Bodeewes, 2002; Brisch, 1995; Brisch & Lehmkuhl, 2003;Kühle et al., 2001, Papoušek, 2000; Schmücker et al., 2005; Zelenko & Benham, 2000).

The goal of the SAFE® program overall is to ensure that as many children of parents who participated in the SAFE® group show evidence of secure attachment patterns after the first year of life, and that the parents' traumatic experiences are not repeated with their infants.

### 9.2.3. SAFE® mentor training

Persons who wish to facilitate a SAFE® group may be trained as SAFE® mentors at the Dr. von Hauner Children's Hospital in Munich (for further information, see http://hauner.klinikum.uni-muenchen.de/dt_psy.htm). Regional training centers are planned for the future. All professionals who work with pregnant women, parents, and their infants may apply for SAFE® mentor training. These include pregnancy counselors, midwives and nursing counselors, nurses, obstetricians, psychologists, pediatricians, pediatric and adolescent psychotherapists, speech trainers and therapists, and others. What is crucial for work in SAFE® groups is the ability to engage with pregnant women, parents, and parents with infants, and to bring "hands-on" experience to the

group from daily professional practice. SAFE® mentor training is conducted in 3 full-day seminars and additional practice days that may vary in length and intensiveness, depending on prior practical experience. The mentors then organize SAFE® groups in their localities under their specific working conditions. The work is preferably done by a pair of mentors or co-facilitators. This leadership model makes it possible for one mentor to convey content, while the other monitors group dynamics and leads the group.

### 9.2.4. Evaluation and research on the SAFE® program

The SAFE® program and the contents it covers were successfully modeled in the pilot phase. A prospective, randomized, longitudinal study is currently underway, in which SAFE® group intervention is compared to conventional pregnancy and birth counseling and assistance with nursing. The control group meets for the same amount of time and at the same frequency as the SAFE® group so that the differences between the intervention models can be studied. The control group also contains parents who meet for full-day seminars on Sundays during the same time period up to the end of the first year of life. Mother-child and father-child interactions are evaluated in both the SAFE® group and the control group using video recordings of diapering, feeding, and playing, and the quality of infant attachment is studied and evaluated at the end of the first year of life.

In addition, questionnaires are used to obtain prenatal and postnatal data, and all parents are given an AAI. Physiological stress parameters in both the mothers and fathers are determined by means of saliva cortisol tests before and after the interviews, and in the infants before and after attachment quality testing.

### 9.2.5. Summary

The primary preventive goal of the SAFE® program is to support and help as many parents as possible build secure attachment with their infants in that the assistance parents find in the SAFE® program can help them to perceive and respond more sensitively to their children's signals in spite of their own painful or traumatic experiences.

The SAFE® program begins during pregnancy and continues through the end of the first year of life. It makes use of both group therapy as well as individual psychotherapeutic counseling and trauma-centered psychotherapy. This approach combines the strengths of group and individual counseling and therapy. Parents can break the vicious cycles of the trauma and even violence that they themselves experienced by taking part in individual trauma-centered psychotherapy. The hotline offers parents a day-to-day safety valve for interactional difficulties and enables them to contact competent mentors quickly when emergencies arise. Optimally, these mentors are in a position to respond more quickly to parental calls for help because they are already familiar with their histories. The SAFE® program is open to all parents, both mothers and fathers, and to single parents. It is not offered only to so-called "at-risk parents" with known psychosocial risk factors, because clinical experience has shown that traumatized parents are found in all socioeconomic strata. Parents from the middle and upper classes often find it particularly difficult to talk about traumatic experiences, or to trust another person. However, these parents run the same risk of reenacting and transmitting their own traumatic experiences to their children. This fundamental openness to all classes of parents on the part of the SAFE® program makes it possible to reach out to many social groups with different psychological problems and structures. Holding the parent seminars on Sunday makes it possible for fathers to participate in the SAFE® groups as well. Addressing the needs of parents early on during pregnancy, when all of them are dealing individually with their new roles as mothers, fathers, and parents, and the actual difficulties of caring for a real-life baby are not yet front and center seems to motivate them to participate in a SAFE® group. Involving the parents in a 1½-year individual *and* group therapeutic process increases the reliability of their engagement.

The SAFE® program should prove acceptable to many types of parents because no parent groups are stigmatized. If the mentors succeed in spreading the SAFE® model, it should be possible in the future to help a large number of children build secure emotional attachment to their parents, creating a significant foundation for their later social, emotional, and cognitive development.

### 9.3. Secondary prevention of emotional disorders through the BASE® program "Babywatching Against Aggression and Anxiety for Sensitivity and Empathy"

The goal of this prevention program is the secondary prevention of aggressive and fearful behavior disorders in 3- to 6-year-old children by improving their sensitivity and empathy. Children whose ability to empathize is lacking or rudimentary tend to behave more aggressively toward their peers, and more frequently have an insecure attachment pattern (Parens, 1989; Parens, 1993; Parens, 1993; Parens & Kramer, 1993; Parens et al., 1995; Suess et al. 1992). Children who developed an attachment disorder after suffering early trauma have a very hard time imagining the feelings and thoughts of others (Fonagy, 1998; Fonagy (1998); Fonagy, 2003; Fonagy, 2003).

The capacity to empathize and the development of self reflection prevent children from responding hostilely or fearfully to others because they better understand their intentions and feelings. Children can learn to behave more cooperatively in preschool groups, be more pro-social and overall more creative and attentive; when this occurs, behavior disorders such as aggressiveness, inattention, hyperactivity, and oppositional behavior melt into the background.

#### 9.3.1. Contents covered in the BASE® program

In this program, which is based on the work of Henri Parens (Parens & Kramer, 1993), 3- to 6-year-old children observe a mother with her infant over a period of about one year. For many single children, this is the first and often only chance to observe milestones in a baby's development over the entire first year of life. The infant is only a few weeks old when the mother visits the children's group for the first time to be observed by preschoolers sitting in a circle. This type of participatory interactional observation can begin shortly after birth and continue to approximately the end of the first year of life or the beginning of the second year. It ends when the infant has begun to walk about and verbalize. Generally, the mother and her infant visit the preschoolers once a week, and each observation session lasts between 20 and 30 minutes. The children are guided in how to observe the mother and child and their interactions. A teacher generally leads the group, and another teacher guides the observation. A record is kept of the sessions. The teacher focuses on several levels of observation: Under the guidance of the teacher, the children describe what the mother actually does with her infant -- the action level --, what the infant does during the same time period, and how they affect each other in the process of interaction. The children then discuss possible motivations for the actions of the mother and infant. A third level of observation is the emotional level: The children are asked to empathize with the mother's and baby's emotions, and they answer questions about what might be going on emotionally with the mother and her baby in this or that particular interaction. The final stage of babywatching is the empathy stage. Here, the children answer questions about how they would feel, what they themselves would experience emotionally when, as a thought experiment, they fantasize themselves into the position of the mother or the baby.

#### 9.3.2. Results of a pilot study

The behavioral problems of preschool children (n = 50) were analyzed before and one year after babywatching in a prospective, randomized design with a control group. Both the teachers and the parents filled out a number of different questionnaires, including the Child Behavior Checklist (CBCL) (Achenbach, 1991), which measures behavioral problems.

The results before the beginning and at the end of the intervention after one year of babywatching were compared with each other. The study showed significant differences between the control group and the intervention group after babywatching. Overall, positive effects were found in boys and girls in the intervention group in comparison with the control group. The positive changes related both to externalizing and internalizing disorders. In the opinion of the teachers and the parents, both the boys and the girls behaved less aggressively and showed greater attentiveness and less oppositional behavior after one year. In addition, positive changes were found for internalizing disorders, because both the boys and the girls were less fearful and depressed, were less apt to withdraw, and were more emotionally responsive in conflict situations. The girls (but not the boys) in the intervention group seemed, according to the teachers, had fewer physical complaints, and according to their parents they also had fewer sleep

disorders. The parents and the teachers each assessed the changes positively. These changes were not found in the control group.

### 9.3.3. Summary

Babywatching was a positive emotional experience for all participants. We found that the children generalized the empathy gained from observing mothers and their infants to their play interactions and their interpretation of the behaviors of their playmates. This may explain the changes in observed behavior after one year.

Babywatching is a cost-neutral, secondary preventive interaction with positive results for boys and girls, both in terms of externalizing and internalizing behavior disorders. These results are preliminary and will be tested in other evaluation studies with a randomized, prospective design. In particular, babywatching programs will be initiated in socially more labile settings in which a high proportion of preschool children have behavioral problems. In the future, babywatching will also be tested with different age groups, and introduced and studied as a pilot project in elementary school classes.


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