Above all, the contributors enjoy teenagers, and they are not afraid to say so. They recognise, as Camila Batmanghelidj says (p.191), that -

> It is a privilege to work with traumatised teenagers. They have visited spaces of the soul which afford them extraordinary insight. Their courage and dignity is always deeply inspiring. Their honesty creates so much wonderful energy - and they will keep you young!

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Attachment and adolescence

The influence of attachment patterns on teenage behaviour

Karl Heinz Brisch MD

Attachment develops in the infant over the course of the first year of life, and stabilises in subsequent years as an 'inner working model' of how to relate to others. This model determines how we enter into attachment relationships for the rest of our lives. Adolescence poses particular challenges for the development of attachment. It is a time when young people separate from their *primary attachment figures* - usually their parents - and seek out new attachments with peers and sexual partners. This separation or detachment is not without anxiety for the adolescent, which he or she will resolve in a variety of ways in new individual and group attachments, depending on his or her internalised working model of attachment.

In this chapter, I will first discuss the basis of the development of attachment and its significance for adolescence, as well as the various ways in which attachment may become disordered. I will then go on to describe the effects of such difficulties and disorders on the adolescent's attachment relationships, on her group attachments, and on her behaviour in the family and at school, in order to set the scene for the practical interventions described in subsequent chapters.

THE FUNDAMENTALS OF ATTACHMENT DEVELOPMENT

ATTACHMENT THEORY

Attachment Theory was developed in the 1950's by the English psychiatrist and psychoanalyst John Bowlby (1958). It states that infants develop a strong emotional

attachment to a primary attachment figure over the course of the first year of their lives, based on a biologically rooted pattern of behaviour. If the infant or small child experiences fear (such as occurs when separated from the primary attachment figure), or pain, or external or internal threat, the child's 'attachment system' is activated in the form of an inner behavioural disposition. Depending on the infant's particular attachment pattern, he will exhibit different attachment behaviours in such a situation, such as clinging or protesting when separated. If the primary attachment figure is not available, *secondary attachment figures* such as the father, grandmother, or nanny may be sought out as a replacement. This ability to seek out a protective attachment figure is of lifesaving significance for the dependent human newborn and infant (Bowlby, 1975). No unlimited exploration is possible without secure emotional attachment (Ainsworth & Bell, 1970), which has clear implications for learning. For teens, exploration could be an excursion, or exploring feelings, ideas and thoughts about oneself or others, or expressing interest and curiosity in studying new topics at school (*and see below*, p.125).

If the need for attachment or the desire to explore are not satisfied, are ignored, or are acted on in a particularly unreliable or unpredictable manner, this may lead to ambivalent feelings toward the attachment figure, and also to anger, disappointment, and aggressive behaviours (cf. also Parens, 1993).

According to Ainsworth (1977), sensitive care-giving by the attachment figure, in other words, prompt, appropriate responsiveness to the needs of the infant, is crucial for the development of *secure emotional attachment* (Attachment type B). Mothers who themselves had a positive experience of attachment when they were children are generally better at this than are mothers who exhibit a more adverse attachment pattern, resulting from childhood neglect or trauma. A *secure attachment pattern* functions as a protective factor of resilience during later childhood development (Werner, 2000), and enables the child to better deal with emotional stress such as may occur when parents divorce. The development of *insecure attachment*, by

contrast, functions as a risk factor, so that these children more frequently develop psychological problems when stressed or are less able to resolve conflicts in a socially competent manner (*and see* Chapter 6).

If the caregiver tends to reject the child's attachment needs, the child is more apt to develop an *insecure-avoidant* attachment pattern (Attachment type A). After separation, this child will be more likely to avoid the attachment figure or be less open to expressing his attachment needs. In extremely threatening or fear-provoking situations, these children will give up their attachment avoidance and turn to their attachment figure for help and protection, and she will then protect her infants.

If the infant's signals are sometimes responded to reliably and sensitively, but rejected or rebuffed at other times, an *insecure-ambivalent* attachment pattern may develop (Attachment type C). These children begin to cry loudly on separation and cling desperately to their attachment figure. They may also behave aggressively, for example by kicking their mother while seeking proximity at the same time. And they take a long time to calm down again.

Deterioration of organised attachment

A *disorganised attachment pattern* (Attachment type D) (Main & Hesse, 1990) is characterised by stereotypic and contradictory behaviour. After separation, the child may, for example, run toward his mother, freeze halfway, turn around suddenly, and run away again. Disorganised children tend to stop their movements, or 'freeze' for several seconds. These trance-like states are reminiscent of dissociative phenomena. When approaching their mother, these children can show clear signs of fear and agitation. It is apparent that their mother represents not only an emotional safe haven, but also occasionally a source of fear and threat, either because she responds aggressively to her child in attachment situations, thereby engendering fear, or because she herself responds fearfully (Main & Hesse, 1992). We see such behaviour patterns in mothers - but also in fathers - who have previously experienced

trauma that they have not yet worked through. If one conducts an 'Adult Attachment Interview' (George, Kaplan, & Main, 1985) with such parents, they frequently report 'unprocessed' separation, loss or traumatic violence in their own childhoods.

The definition and classification of attachment disorders

At the far end of the spectrum of attachment difficulties, we see a variety of *attachment disorders* that can be traced back to more deep-seated changes and deformations in the development of attachment. These can be found in clinical samples of patients (Brisch, 2002). Before looking at how attachment difficulties appear in teenage behaviour in groups (*see below*, p.16), within families, and at school (p.19), it is important that these more extreme patterns are highlighted if adolescents in our schools are to be properly understood and helped appropriately.

What all attachment disorders have in common is an inadequate, contradictory or violent response from the care-giver to the child's early need for closeness and protection in threatening situations, or to the extreme activation of attachment behaviour in fear situations. This may occur, for example, when the infant experiences many sudden separations, or various forms of violence, resulting from parental overload or mental illness (Brisch & Hellbrügge, 2003; Brisch & Hellbrügge, 2006).

In situations that induce attachment behaviour, the disorders are so pronounced that they must be diagnosed as pathological. Two extreme forms of reactive attachment disorders can be classified and diagnosed in accordance with ICD 10* (Dilling, Mombour, & Schmidt, 1991 World Health Organisation), one form with *inhibition* (F 94.1), and one with *disinhibition* (F 94.2) of attachment behaviour.

**ICD-10: International Statistical Classification of Diseases and related health problems, 10th Revision 2007, World Health Organisation*

Diagnostic classification of attachment disorders in childhood according to ICD 10

REACTIVE ATTACHMENT DISORDERS WITH INHIBITION OF ATTACHMENT BEHAVIOUR (F 94.1)	REACTIVE ATTACHMENT DISORDERS WITH DISINHIBITION OF ATTACHMENT BEHAVIOUR (F 94.2)
The capacity of these children to attach with adults is described as very inhibited. They react with ambivalence and fear to the attachment figure They exhibit an emotional disorder with withdrawal, over-caution, and an impairment in their capacity for social play.	Children show a diffuse, non-selectively focused attachment behaviour: attention-seeking and indiscriminately friendly behaviour: poorly modulated peer interactions; depending on circumstances, there may also be associated emotional or behavioural disturbance. Children with a disinhibited propensity seek contact without boundaries with the most varied caregivers.

Chapter 5, paragraphs F01-F99, Mental & Behavioural Disorders

Several other types of attachment disorders can be distinguished following and supplementing the forms of attachment disorders that have thus far been included in the international classification systems (Brisch, 2002). Clinically, these manifest as the children exhibiting *little or no overt attachment* (type I) and no protest on separation, even in extremely threatening or life-threatening situations. *Undifferentiated* - also called *promiscuous-attachment behaviour* (type IIa) - comparable to the diagnosis of F94.2 - is characterised by a lack of preference for a particular attachment figure.

Other children have a pronounced tendency toward *risky behaviour* (type IIb): they seek out dangerous situations and force their parents, other caregivers or medical staff into care-giving behaviour.

A further form of attachment disorder manifests as *excessive clinging* (type III). Such pre-school or school-age children require absolute and often very physical

closeness to their caregiver or attachment figure to achieve peace and contentment, and are very hesitant to explore their surroundings playfully. They often attend neither pre-school nor school, and have few or even no contacts outside the family. In this type of attachment disorder, the children's fear of separation and loss of the attachment figure has become generalised and resembles generalised panic attacks, with a constant need for closeness and physical contact ('clinging'), even in older children. Their fear is thus more comprehensive and the need for closeness more pronounced than, for example, in children diagnosed with 'separation anxiety' (ICD 10 F93.0), as seen, say, in children with 'school phobia', which is a separation anxiety problem. Children showing excessive clinging cannot separate from their attachment figure even at home.

Being an attachment-separation issue, the term 'school phobia' is misleading, as it is not a classic phobia. It is similar only in the sense that the anxiety is projected by the child onto the school which is then anxiously avoided, as patients with phobias project anxiety onto an object or situation. Whereas children with an attachment disorder with excessive clinging seek out direct contact with their attachment figure to calm themselves, even in the home - a calm which they rarely find, in spite of closeness - children diagnosed with 'separation anxiety' exhibit a fear of imagined or actually imminent separation, but are able to function without anxiety in familiar surroundings.

The attachment disorder with *inhibited attachment behaviour* (type IV) (comparable to diagnosis F94.1 in ICD 10) manifests in over-conforming behaviour vis-à-vis attachment figures, frequently as a result of domestic violence. In the care of outsiders, such children are frequently less fearful and are able to explore their surroundings better. An attachment disorder with an *aggressive form of attachment behaviour* (type V) is an attempt to make contact with the preferred attachment figure. Unfortunately, she frequently responds with rejection, because she fails to recognise the child's concealed desire for attachment. As a result, the aggression-rejection pattern of behaviour tends to escalate on both sides.

Role reversal (type VI) can also be a form of attachment disorder. In such instances, children serve as a secure emotional base for their parents who may, for example, suffer from a chronic physical disease, addiction, chronic severe depression with suicidal ideation, or chronic anxiety disorder. The children themselves get little or no useful help in threatening situations, nor do they expect it from their dependent caregivers, from whom they then have difficulty separating.

Psychosomatic disorders with crying, sleeping, and eating problems sometimes develop in infancy in the context of attachment disorders. Pronounced psychosomatic reactions in childhood and adolescence are observed with attachment disorders, so that diagnosis and exploration of the inner working model of attachment is recommended where psychosomatic disorders are present, because attachment disorders may turn out to be the underlying condition (type VII). The diagnosis could then read: *Attachment disorder with psychosomatic symptoms such as eating disorder, bedwetting, sleep disorder.* The psychosomatic symptoms can also be coded as an additional disease that goes together with the attachment disorder.

The relationship between disorganised attachment and attachment disorders

Research indicates that there is a connection between disorganised attachment patterns in children and unresolved trauma in their parents (Lyons-Ruth & Jacobvitz, 1999). The child's behaviour, such as crying, may triggers the parent's memories of traumas they themselves experienced, because it reminds them of their own crying and their own pain. This, in turn, can trigger dissociative or trauma-specific behaviours in the mother or father, which, in turn, induces fear in the child (Brisch & Hellbrügge, 2003; Liotti, 1992; Lyons-Ruth, Bronfman, & Parsons, 1999). Similar interactions and psychodynamics may occur between teachers with unresolved traumas and their students. If 'pathogenic factors' such as deprivation, abuse, or severe disorders in the parent-child interaction occur either transiently or in phases, they may

frequently be associated with disorganised attachment behaviour (attachment type D).

If, on the other hand, a pattern of neglect and violence, inflicted by the child's attachment figures beginning in the first year of life, are the predominant pattern of interaction, and if these pathogenic experiences extend over several years, attachment disorders are likely to result. These may continue even after a change in milieu in the case of adoption, with a better emotional environment, and are frequently an ongoing source of stress in the relationship between adoptive parents and child (Beckett et al, 2003; Steele, 2006). Attachment disorders often generate extreme distortions in behaviour that conceal children's real attachment needs beyond recognition and may, in the worst-case scenario, solidify into serious personality disorders, psychopathologies that may already be observable in adolescence (Brisch & Hellbrügge, 2003).

Attachment and groups

In addition to the dyad of child-parent attachment, children, particularly teenagers, also develop attachments to various groups that confer an important sense of security during adolescence, a phase of life in which separation is the challenge at hand.

Detachment or separation from the family is made possible by groups of adolescents that present themselves as a new and accepting 'emotional safe haven', in place of the security of the dyadic attachment (that is, pair-bond) represented by the primary attachment figure. Groups enable the adolescent to explore the world: enter, for the first time, into intimate relationships with others, and embark on other adventures, without necessarily gaining the consent of parental attachment figures. The young person's peers provide crucial support and encouragement. The feeling of safety in the adolescent group has a similar fear-reducing effect as did the sense of emotional security with the early attachment figure.

In *secure group attachment*, the group as a whole represents a *secure base* for the individual, which she can use in fear-provoking situations and as a basis for exploratory behaviour, either with the entire group or as an individual exploring the big wide world

around her. She comes to feel that she can return to the group for support and security at any time, and that she will find acceptance there, which helps to defuse whatever fear she may experience. *Insecure-avoidant group attachment* occurs when the adolescent allows herself/himself to use the group for shared activities and exploration, but is fearfully reluctant to engage in emotional relationships within the group. *Insecure-ambivalent group attachment* is characterised by intense fluctuation between group activities and individual activities. When the individual leaves the group, she tends to feel insecure and then returns to the closeness of the group, resulting in ambivalent behaviour that vacillates between closeness to and avoidance of the group.

Psychopathology of group attachment

In *disorganised group attachment*, the group generates a lot of fear for the young person, while at the same time being experienced as less threatening than the dyadic attachment relationship. The group provides the individual with more potential for dissipating fear, but also more room in which to act, which is important for and used by adolescents developing a borderline personality disorder (all behavioural pathologies exhibited by borderline personality disorder patients may be seen in this context, including the potential for relationships with other group members or with the entire group to be broken off suddenly). Sexual relationships within the group and intense, even hostile, aggressive feelings and responses may be observed, in addition to the idealisation of the group as a protective, safe, and all-powerful place (Brisch, 2009; Brisch & Hellbrügge, 2009).

The seven types of attachment disorders described earlier may manifest in *disordered group attachment* in adolescents with, say, an attachment disorder with *inhibited* attachment behaviour: these teenagers not only avoid dyadic attachments and cannot use them for security purposes in fear-provoking situations, but they avoid groups in the same way. They fear them and withdraw from group activities, or never take part in the first place. The opposite is an attachment disorder with *disinhibited*

(also called promiscuous or indifferent) attachment behaviour. Here, adolescents join numerous groups without apparent fear or difficulty, and switch allegiance frequently after only brief involvement. However, they fail to develop any sense of ongoing group attachment with a specific group. These adolescents are perceived by their peers in each of the groups they are in touch with as not actually belonging to any group. No group actually views them as members, nor do they themselves feel a specific attachment to any of the groups.

An adolescent with an *attachment disorder with risky behaviour* may become noticeable in a group in that the adolescent continually provokes accidents - either alone or with other group members - in order to gain more emotional support from other group members, who care for her as an accident victim. Young people with an *attachment disorder* involving *excessively active attachment* behaviour do not join groups in the first place, because they have a pathological attachment to a dyadic attachment relationship, often to their primary attachment figure, their mother. *Attachment disorders with aggressive attachment behaviour* are very widespread. Adolescents with this disorder tend, when afraid, to use the protection of the group to project their fear outwards, provoking people and picking fights, hoping to gain backing and support from the group (*see below*).

In *role reversal attachment disorder*, an adolescent - often a girl - 'mothers' an entire group and lovingly cares for individual group members, but is unable to accept help from the group when she is in trouble herself (*and see* p.24). This is a crucial difference between disordered and secure attachment behaviour; in the latter case, the adolescent provides protection and support to others in the group, but also allows group members to help her when the need arises.

Psychosomatic symptoms are frequent in adolescents with attachment disorders. To defend against anxiety, several adolescents in the group may develop eating disorders such as anorexia, obesity, or bulimia. Here, the anxiety of the individual adolescents is not contained by the emotional support of the group, but rather the group is held

together by the symptom (for example, anorexia) and concern for the individual group member. All the members care for and worry about the anorexic in the group, and the adolescent experiences caring, protection, and support. So the symptom becomes persistent and no therapy can occur, because it would have to be sought outside the group. Rather, the notion becomes rampant that the group could actually cure the anorexic member. Group members collectively look for and fight those outside the group they deem to be responsible for the anorexia, such as the anorexic's parents or family of origin (*and see* p.25).

We will now look at how attachment difficulties and disorders affect the way in which adolescents manage the central task of adolescence - that of separation, within the family and at school.

Attachment, adolescents, family, and school

The attachment pattern developed during childhood determines the way in which an adolescent separates from her family during puberty and adolescence, and how she enters into relationships outside the family, including first friendships, intimate relationships, and group relationships with peers.

Securely attached adolescents initiate detachment/separation, and the discovery of new relationships and group identity during puberty, with relaxed curiosity, knowing that their relationships with their attachment figures are secure. Such adolescents develop stable new attachments outside the family system. They will be able to oscillate between familial and extra-familial attachments. They will enter into their first stable intimate relationships characterised by sensitivity and emotional availability for the needs of the other. They will be able to support classmates when they have academic or personal problems. In general, they will find success in school commensurate with their particular intellectual gifts and efforts, and they will enter into relationships with teachers and classmates that are characterised by mutual respect and cooperation. They tend to take responsibility in the groups to which they belong, including in

school; are creative and flexible in their ideas for shaping the group; and find pro-social solutions in conflict situations that maintain the integrity and quality of the group. They are also apt to volunteer to speak for the group when necessary, without 'hogging the stage'. They place the goals of the group as a whole above their own narrow interests. They are respected and loved as well by their group mates as by their teachers, and can be very successful in life in personal and in academic achievements.

Adolescents with an *insecure-avoidant* attachment pattern tend to direct themselves outward and leave their family prematurely, either because they find it threatening or because they don't get the emotional support they need. They have learned to withdraw when in trouble, or to fall back on their own resources; in conflict situations they tend to respond aggressively with little thought about the social consequences. They do not prefer groups, and when they do join, their membership is shallow and lacking in emotional commitment because they expect little assistance from the group. They use their membership instrumentally to achieve personal or joint goals, but not for emotional support for the process of detaching from their families. If intellectually gifted, they are often academically successful, but they have trouble in relationships with people who have a secure attachment pattern. Problems may arise in early intimate relationships, when their partners express the need for closeness and support in moments of uncertainty.

Adolescents with an *insecure-ambivalent* attachment pattern oscillate between the desire for security in the family and the need to detach, needs they may have difficulty reconciling. They often accuse their family of trying to 'hold onto' them. But the truth is that their own confusion about whether to remain embedded in the family or stand on their own two feet is very great. Time and again, they try to gain entry to a peer group, but because of their ambivalence about their relationship with their family their peers often make fun of them for their 'dependency'. And so they only take part in the activities of the group half-heartedly, since they also want to spend time with their family. These two desires are often in conflict, and

they accuse their family or their peers of attempting to stymie their development.

These young people may be quite successful in school, but they often fail to live up to their intellectual potential because they are still dependent on the emotional presence and support of their family and individual classmates. They frequently fear failure, and their self-esteem is easily upended. They look forward to school outings and being away from their family, but these occasions are often associated with anxiety and agitation. The adolescent fails to make a 'best friend' to help them endure the anxiety associated with the outing, as would be appropriate at this age (*see* Chapter 3 *for more on how both these patterns manifest in the classroom*).

Adolescents with an *insecure-disorganised* attachment pattern often show early signs of borderline personality disorders, much as they are seen in adulthood. Family members, friends, and group members find their behaviours and emotions hard to understand when the desire for closeness and help is at issue. Their reactions can fluctuate very quickly between seeking closeness and feeling stifled, resulting in belligerent accusations and even violence toward the group. The support they expect isn't enough, and they may suddenly withdraw, break off a relationship, express rage, or cry and whine like a small child. Occasionally, completely out of touch with reality or any actual incident, they may threaten suicide in desperation.

Because they continually 'make a scene', their friends come to see them as unpredictable (*and see* Chapter 8). Some of their peers may become intensely involved, but others may reject or ostracize them, express rage, or act out in other ways. Sometimes these adolescents actually manage to split groups. Splitting is a well-known means of dealing with anxiety in which, for example, group members may be split into 'good' and 'bad' friends. It often doesn't take long for the group to be split into members who sympathise ('the good ones') and those who reject the young person ('the bad ones'). In addition to shouting matches, actual fights are not uncommon. Similar scenes may play out in class with classmates and teachers. Academic performance fluctuates widely between good grades and bad - even if the

student is gifted. Friends must constantly prove their allegiance, and the energy poured into shoring up the adolescent's attachment system leaves little over for intellectual exploration of academic material. The question that such adolescents ask each morning when stepping into class is not, *"What can I learn today?"* but *"Who loves me and will stick by me?"* Or conversely, *"Who do I have to fear; who is going to reject me?"* and *"Who do I have to I beat up before they get to me?"*

It is not uncommon for adolescents with attachment disorders to leave their families prematurely because they are subjected to violence, or to be removed from their families early by child protection services. They may grow up in foster homes or in institutions. Caregivers change frequently, as do the settings in which they are cared for. Relationships are frequently broken off, and their attachment system is constantly more or less activated. This means that they are actually seeking a secure attachment figure, but they are often unsuccessful in this endeavor because of the bizarre behaviour that results from their attachment disorder.

Adolescents with an *attachment disorder characterised by disinhibition* and promiscuous-indifferent behaviour will turn to almost anyone for help in fear-provoking situations. They seek out closeness without any sense of boundaries, including physical - and even sexual - closeness with complete strangers. They tend to leave their caregivers prematurely, and enter into relationships promiscuously. Often their caregivers are not their family of origin. They often trade sex for emotional attachment, security, and protection, with frequently-changing partners. They quickly enter into short-term relationships with other adolescents, groups, or much older adults - only to break off these relationships as quickly as they were formed. Other adolescents might describe them as not capable of relationships, or as 'superficial'.

Adolescents with an *attachment disorder with inhibition* in their attachment behaviour will often have been subjected to violence. This is why they tend to be very careful before turning to someone for help when they are afraid or anxious. They are unable to accept even well-meaning offers from teachers or foster parents

and take a long time to develop trust, or to seek help in anxiety-provoking situations. They would be very hesitant to turn to a group of friends when they get into trouble. They tend to be distrustful of teachers and expect only criticism and belittling. They are often viewed as 'shy' or 'withdrawn' loners. In one extreme form of attachment disorder, adolescents completely avoid contact or closeness with others because their lives have been so traumatic. They also avoid groups, and live like 'lone wolves', in that they would rather hide and run away than seek help when they get into trouble. Contact with others triggers panic and flight.

Aggressive behaviour disorders are frequent in adolescence, leading to the question whether the need for attachment may not be behind the aggression. Such adolescents never simply go up to others and say *"I'm in trouble. Can you help me?"* Rather, they pick fights, both verbal and physical. Because of their own fears, they tend to use the group as back-up rather than accosting others on their own. Sometimes they are able to mobilise their entire peer group against an 'enemy' group, and even start brawls. When several adolescents with this pattern of attachment disorder with aggressive behaviour band together, they frequently form gangs that serve the purpose of protection so that each individual gang member experiences less anxiety - all of which is turned outward. Group loyalty is enforced absolutely, and this is the price paid for group protection. The result is pathological attachment to the group.

Any attempt to detach from the group activates fear in the other group members, so that the group will resort to almost anything, including violence, to enforce allegiance and prevent drop-outs. The real motive behind the aggression, however, is massive fear and an activated need for attachment to secure protection and help. Of course, this is desperately denied and defended against. The attacks on others are a displacement. Intimate relationships also induce anxiety. As a result, they are not even attempted, and gangs frequently develop into all-male or all-female gangs. Group alcohol and drug binges also serve to blunt anxiety. Sexual activity is not uncommon during binges, but it rarely results in intimate relationships, which would

threaten gang cohesion. Only in therapy may adolescents come to recognize that their 'hard armoring' conceals a child's need for attachment, safety, and closeness. Only then can they open up for the first time about the violence they experienced in the home (Allen, 2002; Allen, Hauser, & Borman-Spurrell, 1996; Allen & Land, 1999). Often, these adolescents drop out of school and never finish (*and see* Chapter 7 *for more on adolescent gang formation*).

Adolescents with an *attachment disorder with role reversal* are often well loved. They cared for their nominal care-givers, typically alcohol- or drug-dependent parents, and functioned as their parents' secure base. In adolescence, they are prepared to take care of group members and intimates who are in trouble. They may also cook for everyone and make sure that the atmosphere in the group is conducive, thereby becoming the 'mother or father' of the group. They enjoy a particular status and get recognition, but never as much as they feel they should. As a result, they often suffer from feelings of guilt at not having done enough for the group. They then continue to sacrifice for others, with no regard for their own capabilities or their own needs. They find it hard to express their own need for protection and security, even in emergencies, and their friends are often left to 'guess' what they really need. They are equally well regarded in school, and often academically successful. However, their schoolwork may suffer under the internal pressure to care for others. They would rather help others complete their schoolwork successfully than ensure their own success. In their intimate relationships, they tend toward limitless care-giving, not infrequently ending up with alcoholic partners. This allows them to persist in their familiar pattern.

Occasionally, they are removed from their families in childhood by Child Protection services, because their own development is imperiled by their addicted parents. But more often than not they are left in these pathological family structures because Child Protection services understand that if the young person is removed, the family may deteriorate. This may constitute a form of child abuse on the part of the services, and in no way serves the needs of the adolescent. If they remain in the

family, or even if they are taken in by foster parents, unless they receive psychotherapy, they will continue to feel responsible for their parents, siblings, or relatives, and they will feel guilty when they are unable to give them the assistance the family demands. They will make one attempt after another to return to their family of origin and stabilise it. It is not easy for them to enter into an intimate relationship as part of the process of separation, or to integrate into a group, because they constantly vacillate between caring for their family of origin, or their partner, or their own family, or the group. They frequently 'burn out' under this burden and become depressed, with exhaustion and physical symptoms (Yap, Allen, & Ladouceur, 2008, Yap et al, 2008).

All forms of eating disorders may be linked to attachment disorders and result from traumatic experiences in the past. This includes anorexia, which may result from long-term sexual abuse by an attachment figure. Such abuse often begins before puberty. Anorexia may be the only way that an adolescent - generally a girl - feels able to extricate herself from a pathological attachment - even if her self-induced starvation lands her in intensive care. The desire to separate and detach from a violently abusive attachment figure, but not necessarily from the family as a whole, generates a tremendous amount of ambivalence, which may be reflected in fluctuating weight losses and gains.

These adolescents generally do not join groups, but rather withdraw and spend many hours trying to control their weight. This strategy suppresses the anxiety that results from the violence experienced in the context of attachment. This form of control is often generalised to other areas in that the same compulsion may be used in the service of academic performance. Even if the student is not particularly gifted, she may get very good grades, but it will cost her hours of tireless, compulsive learning. Classmates frequently reject or tease such students as 'grinds'. But no-one senses the distress behind her starvation and her obsessive learning. As a result, she may become increasingly isolated in class, lonely and depressed, and sometimes even suicidal.

Prevention - an example of specific interventions

In Munich, our prevention programme, 'SAFE® - Safe Attachment Formation for Educators' (www.safe-programm.de), follows parents from Week 20 of pregnancy to the end of their child's first year of life. The goal is to teach parents in day-long seminars how to foster secure attachment in their infants. Parents who experienced trauma that they have not yet worked through receive individual trauma psychotherapy during the pregnancy, which begins with emotional stabilisation. After the birth of their infant, old traumatic experiences are specifically targeted for psychotherapy. The goal here is to ensure that these old traumas are not reactivated by the infant's behaviour, and that the parents are not tempted to respond violently to their infant. Our experience to date has shown that the programme can break the vicious cycle of violence transmission from generation to generation. SAFE® mentors have now been trained in many countries (Germany, Austria, Switzerland, Australia, New Zealand) and offer SAFE® courses for parents. If this programme becomes standard practice in the preparation of parents-to-be in Germany and indeed, further afield, we believe that more children will experience secure attachment with their parents, and thereby receive a stable foundation for the development of their personalities.

There are all kinds of overlaps between the different types of attachment difficulties and disorders, and patterns can be complex. An understanding of the importance of attachment issues may give us a starting place for recognising what young people's behaviour maybe communicating, for planning effective interventions, and providing adolescents with appropriate support.

More detailed descriptions of therapy for attachment disorders are found in Brisch (2002).

In summary

- Early attachment experiences have a crucial effect on later attachment behaviour in adolescence, both with peers in groups and intimate relationships, and in school with teachers and classmates
- The development of pathological attachment patterns, such as disorganised attachment and attachment disorders, could be recognised and treated in early childhood. Once they have become chronic in adolescence, they are much more difficult to treat
- The experience of new secure attachments however, can change the inner working model of attachment, even in adolescents
- Adolescence in particular is characterised by an increasing drive to find other and new secure attachment figures outside the family who may exhibit sensitivity towards anxiety and the need for emotional security
- All adults who work with adolescents, regardless of context, need to know about this opportunity
- Experiencing secure attachment in groups that are moderated by adults, and dyadic attachment with sensitive adults and/or adolescent intimates, may be sufficient to begin to steer the inner working model of attachment of an adolescent with attachment difficulties onto a new, more secure track - perhaps for the first time

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Survival of the 'fittest'…

Teenagers finding their way through the labyrinth of transitions in schools

Louise Michelle Bombèr

The longer I work within education, the more aware I am of how crucial it is for us to reflect upon the journey that a young person with attachment difficulties makes throughout their life within the school system. From an emotional perspective, there is an increased potential for things to go wrong at secondary level: against a backdrop of trauma and loss, the mix of transitions and hormones can be disastrous. In the primary phase, any gaps between a child's emotional and chronological age can be managed fairly readily. However, in secondary, the gaps tend to widen, leaving young people with attachment difficulties more vulnerable to ending up on the sidelines. The secondary phase can then become a matter of survival. Who survives?

It seems that the fittest do. The 'fittest' seem to be the young people who have had 'good enough' early experiences (Winnicott 1964) and who have developed the emotional and social capacity and resources to manage the challenges of the secondary phase. But secondary schools are a minefield of transitions; between staff, peer groups, rooms and subjects. For a young person with an already fragmented sense of self - a consequence of relational trauma and loss - multiple transitions can be a recipe for disaster. Such young people can easily be left behind, misunderstood, and, at worst, excluded.

> Nationally, children in care are eight times more likely to be permanently excluded than their peers. Ofsted 2008, p.6