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Sleep and attachment disorders in children

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INTRODUCTION

An infant's quiet night of sleep is a source of happiness and empowerment for parents. In prenatal classes, many parents worry that their baby might develop a sleep disorder and that night-time could become an intense scene of crying and responses. Indeed, quite a percentage of infants and children develop sleep disorders, and nocturnal wakings and bed sharing are quite common during early childhood. During infancy, the frequency of night-wakings increases with maturation of locomotion.¹ Nocturnal awakenings have been reported in 20–30% of 1- to 3-year-olds.^{2,3} These findings appear despite the fact that methodologic problems exist in assessing sleep problems in infants, and it is well documented that maternal reports do not objectively reflect the sleep pattern of their infants.⁴ Although a sleep disorder does not necessarily lead to an attachment disorder, an infant's crying through the night can be the start of a disturbed parent–infant relationship that may conclude with this result. Conversely, attachment disorders in children are also associated with a range of psychosomatic problems, one of which is sleep problems. If a sleep disorder and an attachment disorder are a baby's predominant symptoms, then the parent–infant and, later, parent–child relationship will be stressful and in the worst case can progress to a vicious circle of crying and physical abuse. Therefore, it is necessary to understand more about the association of sleep and attachment and

their disorders in children, and to strategize prevention measures that can help parents and infants establish sleep patterns and regulate sleep rhythms from the beginning.^{5–12}

ATTACHMENT THEORY AND DISORDERS

Attachment is a fundamental human motivation that helps the infant to survive. During the first year, an infant develops a specific, exclusive attachment relationship to an attachment figure that serves as a secure base for the infant and provides protection. Once the baby's attachment system starts to develop, which can be observed from 12 weeks onward, the infant reacts on separation with attachment behavior, such as crying to protest separation from the attachment figure followed by seeking physical contact and reunion.¹³ We can distinguish three different patterns of attachment quality. A securely attached infant will protest after separation from his or her attachment figure and will calm down quickly after reunion. An insecurely avoidant attached infant will appear not to be stressed by separation and will not actively seek physical contact with the attachment figure after reunion, whereas an insecurely anxious–ambivalent attached infant will react with extreme arousal and will take a long time to settle down after his or her attachment figure has returned. It is typical that the attachment system of the infant, once activated, can be preferentially calmed by physical

contact with the attachment figure. Only if the primary attachment figure, for example the mother, is not present, does the infant allow a secondary attachment figure, such as the father, to soothe him or her.¹⁴⁻¹⁸

Attachment disorders are caused by an infant's early experiences of repeated separation and multiple traumas. Such disorders commonly evolve from traumatic events such as physical, sexual, or emotional violence and severe deprivation, often perpetrated by attachment figures. In addition, if an attachment figure is sometimes a source of emotional availability and protection for the child and at other times a source of violence and anxiety, it will be difficult for the child to organize these disparate experiences into a coherent internal working model of attachment.^{18,19}

On a behavioral level, attachment disorders may emerge as strange patterns. Two forms of attachment disorders are included in the International Classification of Diseases (ICD-10)²⁰ and the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).²¹ One pattern involves non-selective, undifferentiated attachment behavior. Children possessing this pattern exhibit promiscuous attachments, rapidly and seemingly randomly seeking physical contact with strangers. They are indiscriminately friendly toward strangers, who by definition can never be real attachment figures. Other children display a type of disorder characterized by inhibited attachment behavior: these children, although anxious, do not show their attachment behavior, instead suppressing their attachment activities, which results in a continuous state of high arousal. Additional types of attachment disorders have been classified, including attachment disorders with psychosomatic symptoms (e.g., sleep problems).¹⁸ Further types of attachment disorders (such as non-attachment behavior in attachment-relevant situation, aggressive behavior, role reversal, aggressive symptoms, and a hyperactivation of attachment behavior) also show pathologic behavior patterns in attachment-relevant situations.²²

Separation at night for sleep is one of the attachment-related situations leading to activation

of the attachment system. Children with different types of attachment disorders may have disturbed sleep patterns or even sleep disorders. For example, some attachment-disordered children cannot calm down easily at night or wake up often and suffer from nightmares and night walking. These disorders may manifest through hyperactivity of their attachment system, or the children may have difficulty separating before sleep. Other children may suffer from an inhibited attachment disorder and will anxiously lie in bed, and not cry at night to seek the attachment figure. Caregivers of these latter children may thus think the infants are easily cared for, whereas the babies are instead lying in bed in a state of hyperarousal. Their hyperarousal and inhibition of showing attachment may cause them to complain of stomach aches or headaches, vomit, or develop an elevated temperature. If attachment figures do not understand these signals and prefer children who do not cry at night, children may develop chronic psychosomatic symptoms. Still other children may suffer from undifferentiated attachment disorders (as most foster infants do) and will be happy when anyone picks them up from bed. They might calm down for a short while, but will again cry until another person comes along. No secure attachment representation results from this undifferentiated attachment behavior, so that while the children may receive physical contact from various people, there is no decrease in the level of arousal.

Infants or children with hyperactivation of their attachment system normally cannot separate until they fall asleep in close physical contact with their parents in the children's or the parents' bed. It is important to note that many parents also have attachment problems and have difficulty separating, and sometimes it is not clear who is clinging to whom. Some parents, especially those with prior trauma experiences, also have their own sleep problems. Attachment anxiety has been associated with self-reported sleep difficulties in men and women; even with depressed affect been included as a control variable, the effect of attachment anxiety remained significant.²³ If a mother has an

attachment disorder with role reversal, she may carry her infant into her bed and take the infant as a secure base to help herself fall asleep. Mothers with panic disorders, when describing parenting behaviors concerning infant sleep, reported less sensitivity toward their infants, who showed more ambivalent/resistant attachment, higher salivary cortisol levels, and more sleep problems.²⁴ Mothers with high symptoms of depression and anxiety more likely had ambivalent attached infants and used high levels of active physical comforting, and their infants developed high initial levels of sleep problems that continued in infant sleep disturbances over time.²⁵ Benoit et al²⁶ have shown that a mother's own insecure status of attachment is strongly correlated with attachment and sleep disturbances in her infant: every insecurely attached mother in their study had a child or children with sleep disturbances. Therefore, at the start of treatment, it is vital that the therapist learn something about the parents' own histories of attachment and their experiences of unresolved loss and separation, so that treatment can also address their needs – or the therapy of the sleep-disordered child will not be successful. The importance of focusing on parents' status of attachment when treating their infant's sleep problem cannot be overstated.

Finally, sleep disturbances and sleep disorders of infants caused by traumatizing experiences with insensitive care by attachment figures can lead to attachment disorders, but if a child is securely attached during the day, then inconsistent caregiving or unresponsiveness to attachment signals at night will not necessarily lead to a complete attachment disorder but perhaps only to subtle irritations in the attachment system. It may be that infants with insensitive night-time care become more clingy or ambivalent in their daytime attachments, which makes separation for sleep more difficult and may result in long-lasting behavioral problems.^{27,28}

The presence of parents when an infant separates for sleep and sleeps during the night may support him or her in developing a secure attachment representation. Children from kibbutzim who

were home sleepers with their parents developed a secure attachment relationship with their parents, while infants who slept in the group setting without their parents available at night developed attachment relationships with their metapelet (caregiver in the kibbutzim).^{29–32}

ATTACHMENT, SEPARATION, AND SLEEP

Looking at attachment behavior from an evolutionary point of view, most infants around the world have slept and continue to sleep in close physical contact with their parents for the first year of life and possibly longer, so these infants do not experience separation at sleeping hours.³³ Thus, a crying baby at night is not a question in most countries. Only in Western countries and especially in Europe and North America do parents expect an infant to separate at night and sleep in his or her own bed or own room. This form of separation between infants and attachment figures during the night is not consistent with evolutionary development. In former times, when human beings were nomads, survival required that an infant remain in close contact with the attachment figure, usually the biologic mother, during the daytime and even more so during night-time. Since an infant is dependent on the attachment figure for all of his or her physical, social, and emotional needs, close physical contact was a great advantage for survival. It is likely that the attachment system in humans developed within the context of evolution, as those infants who showed attachment behavior when separated from the attachment figure and when experiencing anxiety had a higher survival rate than those who did not. This might explain why many children in Western countries do not stay in their beds at night, especially when they experience anxiety and initiate co-sleeping in the parents' bedroom once they can walk.³ Through the lens of attachment, it is not surprising that once arrived and snuggling up to their parents, the children can fall asleep within seconds.

Considered in the context of evolution, then, it is quite natural that an infant react to nightly separation from his or her attachment figure with alarm, crying, and signalling a desire to be picked up. If the attachment figure does not arrive to soothe the infant, the attachment arousal can escalate to hyperarousal in the autonomous nervous system, leading to an increase in bowel movements, as with colicky infants, or to vomiting when the gastrointestinal tract reacts. Therefore, night-time crying, seeking physical contact with the attachment figure, and protesting against separation from the attachment figure are correct evolutionarily based behavior.^{34–36}

Nonetheless, an infant can learn to sleep through the night without his or her attachment figure. If Western cultural standards indicate that it is proper for parents and children to sleep apart, parents must train children to tolerate this type of separation, even though it is contrary to evolution. Parents must listen for sounds from the baby after separating and leaving the room and be ready to provide the child with a positive, attachment-oriented experience. Whenever the infant starts crying energetically and increasingly loudly, the parent should return to the room and try to console the infant. The child will sometimes need physical contact to calm down, especially if he or she has become hyperaroused. Returning rapidly to the room when the child starts to cry intensely is key to not having the child's arousal escalate to hyperarousal. Parents may have to enter the room repeatedly during the first nights, but this frequency will decrease. If parents respond promptly to an infant's crying at night, the baby will cry less during the next few weeks. In contrast, if parents delay in answering the cry signal and consoling the child by physical contact – perhaps because of their philosophy not to spoil the baby – the child will cry for longer periods in the future.³⁶ It has been found that each time the parents come in and respond, the infant learns that he or she is not lost, separate, and alone, but that the attachment figure is available and sensitive to his or her signalling. When parents consistently and reliably respond in

this way, an infant will make an important discovery: even while separated at night when it is dark and anxiety can become intense, attachment figures are present and emotionally and physically available. This comes to signify an important attachment representation within the context of sleep and night-time separation, implying security and safety despite separation from the parents.³⁷

THERAPY OF ATTACHMENT-RELATED SLEEP DISORDERS

Sleep problems in babies can be subtle indicators of difficulties in parent–infant relationships. If a baby cries for several hours day after day, it is important to seek help with a specially trained psychotherapist, who can quickly treat the dyad with an eye toward assessing the attachment and trauma experiences of the mother and father in addition to the interactional irritability of the infant.^{18,38,39} The aim of attachment-related therapy for sleep disorders in infants is to enable these children to separate from the attachment figures in the evening, fall asleep, and remain in their own bed overnight without nightmares, anxiety, or panic attacks.

As mentioned earlier, attachment and separation concerns are present for parents as well as infants and children, and thus treatment must involve both parties. As in any attachment-related therapy, the therapist must become a therapeutic bonding figure; i.e., he or she must become a safe place for the parents as well as for the infant or child. In the same way that parents' 'sensitive behavior' is required for the positive development of a baby's secure attachments,⁴⁰ a therapist must become a secure base for parents – a framework for trust and a springboard for change.^{14,18} Highly interactive therapeutic sensitivity – in which the therapist comes to recognize family signals (especially the parents'), interprets these signals correctly, and reacts conscientiously and promptly – will lead to the development of such a therapeutic bond, which will become a mirror for the parent–child relationship. The therapist fosters the

development of a secure therapeutic bonding with the parents, and, as a result, parents can become a safe haven for their infants.⁴¹

The therapist can then help the parents to understand the night-time needs of their infants, be sensitive about a child's anxiety, and react appropriately by going into the infant's bedroom and trying to soothe him or her. If the baby is in an elevated state of arousal, the parents should take the child out of bed and provide physical contact. Most hyperaroused children will quickly relax with physical contact. Securely attached infants will need more and longer periods of physical contact to calm down than insecurely avoidant attached infants, but securely attached infants will have longer sleep durations than avoidant attached infants.³⁴ Some parents may allow a child to sleep briefly with them to calm down, after which the child can be placed back in his or her bed.

CASE STUDY

A mother, T., was referred by her pediatrician and telephoned that she urgently needed help to deal with the night-time needs of her 6-week-old infant. Every night, Baby S. had awakened for a feeding session. After being fed and put back to bed, the infant started to whine and cry, whereupon the mother would go into S.'s bedroom, lift her out of bed, cuddle and soothe her, rock her, and lay her back down in bed. Despite these ministrations, the baby continued to cry. This interaction went on several times each night, with the mother walking around and rocking S. for hours until the two fell asleep on the sofa during the morning hours. The whole family, especially the mother, was exhausted and did not know 'how to survive'. The partnership was in danger, as the husband threatened to leave the family. The couple's first child, now 6 years old, had also cried at night for 2 years, but the parents had decided to have another child despite their first 'catastrophic' experience. For these parents, the first years of having a child were equated with regular nightmares and

sleepless nights. As a result, the whole family was in an acute alarm state, and the children were at risk of harm from their parents. This is the moment when parents might start shaking babies. Things were worst at night, but similar difficult sleeping interactions took place during Baby S.'s morning and afternoon sleep. Several pediatric examinations had established a normal developmental pattern for her, with no indications of somatic disease to explain the symptom of sleep disturbance. Therefore, the sleep problem seemed to be a psychosomatic sleep disturbance.

A video diagnostic session of the mother changing diapers and playing with the infant as she would have done at home revealed an interesting interactional pattern. At first, the mother interacted sensitively, with eye contact, fine vocal attunement, and touch, responding to cues from the infant and engaging in a very nice dialogue of rhythmic interaction. But in between were switches in behavior and affect attunement: suddenly the mother would stop, avert her gaze, and anxiously and sadly examine the child's feet. Her affect became simultaneously shut down, depressed, and highly aroused. This lasted about 20 seconds, after which she again attended to the infant, interacting vocally and visually, then switching back and examining the child's feet, saying that the feet were too cold. In 2 minutes of videotaping, there were several switches back and forth between mother and child. When the mother shut down eye contact with S. and became preoccupied with the infant's feet, the child's gaze also shifted.

When we watched the video recording with T. and tried to understand what we saw and how to interpret this, she told us she was not aware of these switches but remarked that she was checking the child's feet for signs of disability. T. related that, because of her age, she had undergone amniocentesis to check for possible fetal abnormalities. The first result of amniocentesis indicated an abnormal set of chromosomes and a handicapped child. T. and her husband were deeply shocked, and the gynecologist took another blood sample that revealed a normal set of chromosomes and a normal child.

Of course, this double diagnosis of contrary results led to extreme arousal and stress for the parents. The mother was highly ambivalent about attaching prenatally to the child or holding back in case the baby was born disabled. After birth, externally and physically S. appeared normal, so the mother declined a third, postnatal, chromosome test. Nevertheless, she began constantly to check the child for signs of abnormality, such as the special foot or hand folds found in children with Down syndrome, which she had learned about on the Internet and in books about disabled children. Although she did not find any such signs, the absence of abnormalities did not calm her, and she compulsively checked her child over and over. She had also read that disabled children sometimes exhibit a particular type of crying and wondered whether S.'s crying at night was the special kind of whimpering and crying called the cri-du-chat syndrome. On top of the erroneous prenatal diagnosis, S.'s crying was a trigger for anxiety and bonding ambivalence on the part of T., alarming the mother and leading her to worry that the symptom was part of a disability as yet undiagnosed.

During the process of diagnostics, we routinely perform an Adult Attachment Interview (AAI)⁴² or an Adult Attachment Projective test (AAP),⁴³ as well as a Caregiving Interview (CGI)⁴⁴ for any mother presenting an infant with early interactional problems. These three interviews give us a lot of information about parents' own attachment representations and perhaps unresolved trauma experiences. During the AAI, T. was asked when she was first separated from her own parents. She remembered quite vividly that at the age of 3 year, she was admitted to a hospital for a tonsillectomy. Her mother sent both T. and her 8-year-old brother for tonsillectomies, with the idea that the brother might calm her down when feelings of being lost and separated at night-time would come up. T. felt very lonely at night in her unfamiliar bed in the hospital, and experienced a tremendous, sick feeling in her stomach, which she did not interpret as anxiety and arousal. At this point in the AAI, I realized that the mother had previously

told me that she felt sick to her stomach when little S. cried at night, and she took the baby out of her bed and started walking about the apartment. T. had also experienced a second separation shortly after her discharge from the hospital, when her mother gave birth to another child and all the children left home to stay with a grandmother. Again, she felt lonely and separated from her mother and had the same gastrointestinal symptoms. From that point onward, she could never tolerate separation and stay elsewhere overnight. Any attempt at an overnight separation such as in kindergarten or during school excursions failed because she became sick and her parents had to pick her up during the night.

Attachment dynamics of the sleeping disorder

Within the context of attachment-oriented psychodynamic theory, the mother's history and Baby S.'s sleep problem become more understandable. When T. and her husband were confronted with the possibility of expecting a disabled child, triggers of anxiety and preoccupation emerged. T. was highly ambivalent about bonding with her infant, and became preoccupied with searching for signs of disability after birth. Thus, the mother was in a permanent status of arousal, which did not help to bring the child into a relaxed state and help her fall asleep. Baby S. might have sensed T.'s ambivalence – clinging to her infant on the one hand and being preoccupied and emotionally distant on the other – which might have led S. to cry louder and search for physical contact with the mother, as the child experienced emotional separation and detachment from T. Furthermore, the AAI revealed that the mother retained her own separation problems from childhood and had a high psychosomatic arousal and trigger when she had to separate from her infant: The 3-year-old within the mother's own representational world needed an attachment figure. Because of her own experiences, T. could not be a secure attachment base for her own infant. S.'s crying at night had triggered T.'s own separation

experience from the past and brought the mother into a helpless state. Parents who become triggered by their infant's night-time crying and whose own traumatic experiences are reactivated have a high probability of acting out at night or becoming hyperaroused and needing their own attachment figure, thus not being emotionally available to their infants.

Treatment

Using an attachment-oriented approach, the following treatment procedure was arranged. During the daytime just before putting little S. to sleep, T. telephoned me, and we talked about her feelings of anxiety and feeling lost. This therapeutic phone contact helped her to feel reassured and secure and to separate more easily from the child. During the night-time, there was still a great sleep disturbance, so we explained the attachment problem to the husband and asked him to get up at night with his wife. This led to the following situation. When T. had nursed the infant at night and put her to bed, the infant was still awake, whining a bit but not crying. The husband took T.'s hand and helped her separate from the infant, providing a secure base and becoming an attachment figure for her. While the mother became calmer, little S. was already sound asleep.

Baby S.'s sleep problem disappeared rapidly, and it became quite clear that the infant's sleep problem was an entangled reenactment of acute insecurity because of the prenatal diagnosis and the early unresolved trauma of the mother. After the acute situation with Baby S. eased, T. came for further therapeutic sessions to work on her unresolved trauma. The result was quite remarkable, and the mother made an astonishing recovery. For the first time in her life, she could drive away for holidays and sleep in an unfamiliar bed. Furthermore, she was able, without hyperarousal and anxiety,

to cross bridges and drive through tunnels, locations previously to be avoided. After termination of the treatment, she phoned me only once, after her son's first day of school. The morning after the first day, her son told her he wanted to go to school with his friends and without her, and he separated quite easily with a quick goodbye. Standing at the window and watching him walk along the road, she experienced the same sick feeling and remembered that it was related to her experience of early separation. At that moment, she decided to phone me, and we talked about how the situation came about and how it was triggered. She was aware of it, and did not need to reenact that situation by holding back or accompanying her son, hindering his autonomy and individuation.

DISCUSSION

Sleep problems of infants and even older children can be highly related to attachment problems. Children and adults with attachment disorders may have problems at night falling asleep, staying in their bed in darkness, or going back to sleep after waking from anxiety or nightmares. Depending on the attachment disorder, they long for physical contact, or, in contrast, may not want physical contact and instead stay in bed in a hyperaroused state, suppressing their attachment needs and developing psychosomatic symptoms.*

Children who have experienced early trauma such as deprivation or violence are likely to develop attachment disorders. Typically, those children do not have an inner representation of security, and if they have to separate and sleep in the dark apart from any person, anxiety arises and activates the attachment system. Depending on the type of attachment disorder, they will start crying, shouting, fighting, or entering dissociative states and not showing signs of attachment behavior.

*In addition to gastrointestinal symptoms, respiratory symptoms, (e.g., asthmatic symptoms with coughing and wheezing) are quite common and should be considered outside diagnoses of allergies. A convincing study has shown how asthma attacks and separation problems are associated.⁴⁵

Since a baby cannot crawl or walk to search for the attachment figure, the only way to signal an attachment need is to cry through the night. If an infant is to form a secure attachment during the night, the parents must help the child to calm down by walking into the room and soothing the child, going away to help him or her to tolerate a short period of separation, and returning if the child is aroused again. This helps the baby to learn a form of separation training in which the attachment figure is available and will consistently arrive to soothe him or her when anxiety becomes intolerable and the crying escalates to a panic state. This training requires more time, emotional and physical availability, and sensitivity in a consistent and reliable way than leaving the child to cry through the night and get used to sleeping on his or her own.

Ultimately, if the child cannot calm down, a temporary period of having the child sleep with the parents may be wise, provided that there is no contraindication for co-sleeping such as drug addiction, alcoholism, smoking, elevated temperature in the parents' room, or a very soft mattress. Most children who bed in between the mother and father fall asleep fairly soon at night or after waking from nightmares, as the space between their attachment figures seems to provide the most security and reassurance.

PREVENTION

Many parents in Western countries themselves did not have the stressful experience of initially sleeping apart from their own parents, and so started co-sleeping with their infants, as most parents and children throughout the world still do.⁴⁶ Insufficient research is currently available that examines

how parental status of attachment, correlated with co-sleeping and bedding-in, influences the emotional development of infants. Studies on sleep patterns in earlier days, which did not include attachment concerns in the research, showed that co-sleeping mothers and infants had the same sleep pattern in terms of depth and alertness. When the child became uneasy and irritable, the mother awoke and fed it, and both fell asleep again. Co-sleeping mothers were in tune with their babies and did not feel irritated during the night. In contrast, if the infant slept in a bed next to the mother's, their sleep rhythms were not as well tuned together, and if the child slept in a different room, the sleep rhythms of mother and infant were completely uncoordinated. Those mothers were the most exhausted in the morning.⁴⁶⁻⁴⁸

Children who can reestablish close physical contact with their parents at bedtime or even sleep together in the same room may form more secure relationships than those who are separated from their parents at night (parenthetically, this is one reason why admittance of parents with their infants in children's hospitals should be the norm). If parents do not want to co-sleep or room-in with their infant, they must consider attachment theory and attachment needs and realize that they are subjecting the child to a behavior that is contrary to evolution. If parents want children to sleep on their own, then the separation in the evening hours and calming down at night have to be done delicately and with the awareness that the evening and night separations are the most sensitive phases for attachment needs. Parents have to reassure children again and again that they are physically and emotionally available and help make the separation tolerable. Here, significant teaching and training are necessary for parents. In our parent groups,

*Coincidentally, bedding-in during the weeks after delivery seems to protect against postpartum depression, as the incidence of postpartum depression is much lower in Asian countries, where bedding-in is the traditional form of caring. Some researchers recommend that bedding-in after delivery should be practiced everywhere as a preventive method against maternal postpartum depression.^{49,50} In addition, we hypothesize that if mothers and children do not co-sleep or bed-in, then perhaps mothers become depressed because they cannot see their infants and worry about whether the children are still breathing and alive. Co-sleeping promotes breastfeeding, and might (consciously or unconsciously) reassure a mother during the night that her baby is breathing, side by side with her in physical contact, and so she might relax and sleep more quietly. In addition, the child would feel secure about the mother's closeness.^{51,52}

one of the biggest fears is that if the child is brought to the parents' bed as a co-sleeper, he or she might stay for 25 years. Of course, this will not happen, and most parents find places and times for sexual activity outside of the parental bed at night, so that, among other things, co-sleeping need not be an obstruction to parental sexuality.

All these subjects are part of our new prevention program SAFE[®] (Secure Attachment Formation for Educators). Parents participate in this preventive program of four prenatal and six postnatal full-day workshops from the 20th week of gestation until the end of the child's first year. In addition to receiving many instructions and having personal experiences, all parents are given the AAI. Parents with unresolved traumas receive supportive psychotherapy before birth and trauma-centered therapy after birth. The goals of this prevention program are to uncover parental unresolved traumas that could be risk factors leading to a reenactment with the infant and to treat these problems before and after birth so that harm to the infant is prevented.

CONCLUSIONS

Sleep problems in infants and children can be difficult psychological problems that always need early attention and treatment. Diagnosis should focus on the whole family – i.e., psychosocial and partnership problems, individual attachment problems and traumatic experiences of the mother and father, and the infant's own experiences of attachment or trauma. Children with attachment disorders are high-risk candidates for sleep problems, because separation and sleeping at night are important markers of the attachment relationship with the attachment figure. On the other hand, sleeping through the night does not mean that no attachment problems exist. The infant may have learned that no-one is available at night, no matter how loud he or she might cry.

In addition to markedly helping individual families, education about attachment theory, attachment

figures, and attachment relationships holds the potential to effect dramatic social change. Such information can be obviously and directly useful to parents of infants with sleep disorders, as we have seen in this chapter. Moreover, many powerful societal benefits could also accrue if knowledge about the concrete ramifications of attachment theory were disseminated more widely, to adult clients, clinics, schools, and society at large.

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I am most grateful to the parents who allowed me to learn about their attachment problems and to increasingly understand the psychodynamics within families with infants who cry at night. Through these case histories and treatment experiences, I learned about the attachment-related problems of sleep disturbances in children with normal family backgrounds and those with attachment disorders and trauma-related experiences. Without these experiences, this chapter would not have been possible.

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