The Connection between Attachment Relationships and the Development of Social Interest

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Abstract

The style of attachment a person develops in the early years as well as one’s level of social interest are important predictors of mental health at all stages of development. When secure attachment does not occur, behavioral, social and emotional problems may become prevalent in childhood and prevail throughout the life span. Early childhood is the critical period in the development of attachment as well as the development of social interest. This paper presented an understanding of attachment theory and of social interest and how the two are linked. The long term outcomes for people that lack secure attachment and in turn lack social interest are discussed. Recommendations for treatment of individuals of all ages experiencing attachment and social interest deficits are included.
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The Connection between Attachment Relationships and the Development of Social Interest

Introduction

Attachment is an early life experience that has a profound effect on the overall mental health of an individual. Attachment is formed between an infant and the primary caregiver. The quality of this attachment depends on the type of emotional bond that develops within this partnership. From this experience the child forms not only the opinion about him or herself but also about others. The infant-caregiver relationship comes before and is the start of the organization of what one considers self. This self-organization, in turn, has significance for ongoing adaptation and experience, including later social behavior. “The self is a social creation, and the self is defined, maintained, and transformed with reference to others. For these reasons social relations are viewed as having such fundamental importance in both normal and pathological development” (Sroufe, 1997, p. 358). Problems can arise early on in a person’s life as well as in later developmental periods if the healthy attachment relationship has not been formed (Muris, Mayer, & Meesters, 2000). Bowlby states that attachment behavior characterizes human beings from cradle to the grave (Bowlby, 1979, p. 129).

Much has been written regarding the effects of attachment but less widely discussed is the idiosyncrasies that go into forming a secure attachment. This paper defines and explains the general attributes of creating a secure attachment: Attunement, mental representation, differentiation process, goodness of fit, the motherhood constellation, internal working model as well as the need for sensitive, responsive caregiving.

The development of the conception of the self is explored. A person’s sense of self is built and maintained with reference to those around him. A discussion about attachment and social interest would not be thorough without the discussion of how one comes to view oneself.
The concept of Social Interest was introduced by Alfred Adler. Adler in his later years came to view social interest as a necessary component of the healthy personality. The core of social interest is a valuing of others rather than self. Social interest holds many facets and will influence a person’s attention, perception, and thinking about others. (Crandall, 1980)

Humans are created in the context of relationships. Brazelton 1981, as cited in Osofsky & Fitzgerald, 2000 showed that as young as three weeks old, infants are able to generate feedback from adults (Osofsky & Fitzgerald, 2000). Throughout life, the social system is represented by transactions between individuals.

Attachment style is a critical piece to a person’s ability to develop a healthy sense of self. A positive sense of self is vital to a person’s ability to develop social interest. Attachment relationship is the first step in an infant’s learning self-regulation. “Disruptions in the regulatory function are associated with pathology in relationships” (Anders, 1989) Essential features for achieving regulation in relationships are reciprocity and mutuality these begin in exchanges between a parent and child.

This paper provides a literature review of studies regarding attachment theory, describes concepts vital to attachment, and explanations regarding styles of attachment. Adlerian theory of social interest is explored as is the correlation between attachment and social interest. Pathologies resulting from varied attachment styles will be discussed. Treatment modalities for children, adolescents and adults dealing with attachment issues will be explored.

Several of the basic tenants of Individual Psychology are also seen in John Bowlby’s Attachment Theory (Shulman & Watts, 1997). The innate need for developed interactions with caregivers is a critical concept in attachment motive and parallel’s Adler’s idea of social interest. Children can only reach their full potential in future relationships according to the degree of attachment and social interest that has been developed within them (Weber, 2003).
Attachment Theory

Attachment Theory was introduced by John Bowlby and other key people such as Mary Ainsworth, Mary Main, Alan Sroufe. The outcome of Bowlby’s research emphasized the importance of interactions within behavioral systems, causing him to discard drive theory and focus on developing the concept of behavioral systems (Ainsworth & Bowlby, 1991). According to Ainsworth and Bowlby (1991), attachment “is an ethological approach to personality development” (p. 333). Bowlby asserted that all species possess a system for protection and that group membership was needed for this protection. Attachment behavior is thought to be a survival instinct because it requires that an infant be proximity seeking of an adult that can provide for the babies needs. According to the Attachment Theory, humans need security, which is provided through love, touch and warmth. Indeed, “attachment theory underscores the central role of relationships in human development from cradle to grave” (Weber, 2003).

Bowlby believed this approach highlights the inner working models of self and the goal-corrected relationship between mother and child. The relationship history determines the working models of self and the attachment figure. These internal working models interpret, regulate, and predict attachment behavior. Constructs developed through repeated experiences guide a child’s perceptions and expectations (Weber, 2003). In addition, this internal working model is believed to direct memory, cognition and attention about relationships (Weber, 2003).

Attachment is considered a social relationship that reflects a set of behaviors and emotions that is observable in infants and is thought to be a unique and exclusive relationship that forms after the sixth month of life (Ainsworth, 1989; Sroufe, 2005). Development of an attachment relationship is the first step in an infant’s learning self-regulation. “Disruptions in the regulatory function are associated with pathology in relationships” (Anders, 1989). Essential
features for achieving regulation in relationships are reciprocity and mutuality that begins in exchanges between a parent and child.

Attachment is often described as the emotional bond between an infant and his primary caregiver. This dyad is viewed by theorists as the foundation for the development of the child. However, Greenspan & Wieder challenge us to take this further by adding that attachment includes an overall pattern of relating between an infant and caregiver, including the depth of pleasure and range of feelings experienced in the relationship. (Greenspan & Wieder, 2006)

According to Attachment Theory an infant needs a committed, caring attachment figure to promote healthy development. The development of infant security is greatly reflected by caregiver behavior (Weber, 2003). Attachment research suggests that there is a basic biologically rooted system of behavior that is universal in human nature despite differences in genetics, culture and individual experiences.

Relationships in general are considered to be critical for the development of emotionality. It is believed an individual’s organization of emotional strategies is rooted in the child’s history of repeated experiences of affective encounters with the caregiver. (Ainsworth M. S., 1989; Konchanska, 2001). From the dyadic relationship the infant develops emotional regulation by forming patterns of adaptation in a coherent, step-by-step process that begins in infancy and carries forth throughout an individual’s development (Carlson, Jacobvitz, & Stroufe, 1995).

Bowlby (1973) explains two key working models for an individual, the first being “whether or not the attachment figure is judged to be the sort of person who in general responds to calls for support and protection.” The second working model is whether or not “the self is judged to be the sort of person towards whom anyone ... is likely to respond in a helpful way” (Bowlby, 1973, p. 204). Three characteristics distinguish attachment from other forms of bonds: proximity seeking, secure base effect, separation protest (Weiss, 1993). Proximity seeking is the
action of a child to remain within protective range of his or her parents. This protective range is reduced in strange or threatening circumstances. Therefore the child seeks proximity to the caregiver. Secure base effect is the effect of the presence of an attachment figure that fosters security in a child’s exploration. This results in inattention to attachment considerations and in confident exploration and play. Separation protest occurs when a child feels a real or perceived threat to the continued accessibility of the caregiver, this in turn gives rise to protest and to active attempts to ward off the separation.

Security theory developed by William Blatz, holds that “learning itself involves security” (Ainsworth & Bowlby, 1991, p. 335). Blatz also believed defense mechanisms were used to provide security to an individual (Weber, 2003). One of Mary Ainsworth’s most famous works is the “strange situation” study, in this study she discovered three types of attachment patterns. These patterns are labeled: secure, anxious-ambivalent, and avoidant. Secure infants, according to Ainsworth, are able to seek comfort and be calmed by their caregiver. Anxious-ambivalent infants engage in numerous proximity seeking behaviors and are unable or resistant to being comforted in distress. Avoidant infants exhibit minimal affect or distress with attachment figures and are avoidant during times that normally produce proximity seeking behaviors (Carlson V. C., 1989). Disorganized is the fourth category of anxious attachment. This pattern was first discovered by Judith Solomon and Mary Main in the mid 1980’s. This pattern was discovered when infants did not fit into any of the original patterns. Attachment disturbances are defined as problems in the child’s use of a discriminated caregiver for comfort, support, protection and nurturance.

In addition to the attachment relationship between an infant and parent, according to Cassidy, parents have their own working models of attachment. Children attempt to regulate their emotions in specific ways in an unconscious effort to “help the parent maintain her own
state of mind in relation to attachment” (Cassidy, 1994, p. 248). These findings regarding adult attachment alter the idea of attachment being formed only within the current dyad of infant and parent and extend to the parents caregiver as well. Data linking mother’s adult attachment representations to specific patterns of infant-mother attachment support the proposition that parents’ working model of attachment contributes to the type of attachment relationship they develop with their infants (Crockenberg & Leerkes, 2005). The motherhood constellation refers to the makeup of attachment that has occurred between a mother and her mother, or other attachment figure.

Adlerian view of attachment

Adlerian theory and attachment theory have many things in common. “The major areas of convergence between the two theories are that both include a coherent and stable view of the self and the world and that both acknowledge the importance of social interaction for the expression of these patterns”. (Peluso, Peluso, White, & Kern, 2004) Relationships that form early on in a person’s life have important implications for future functioning. One of these important implications is the degree that social interest is expressed within the community. Another commonality would be the importance of family life as an influence in psychological development (Weber, 2003).

The concept of interconnection arises from the desire for the feeling of belongingness, which is ascribed by both theories. Both theories also advocated for the relevance and necessity of social behavior toward mental health in which the individual and society are related in the fact that exerting pressure on one influences the other (Weber, 2003). Individual psychology asserts that infants and children are inferior and helpless, and seeking nurturance from others enables them to have their needs fulfilled. A healthy child requires a healthy family and shared responsibility and respect are necessary for long term health.
Another concept that Adler and Bowlby have in common is the concept of goal-directed behavior. Goal-directed behavior begins to show up at a very early age and is more pronounced as a person matures (Ansbacher & Ansbacher, 1956; Weber, 2003). Like Adler, Bowlby believed that goal-directed behaviors are innate and that they have the ability to change with the environment (Weber, 2003). Individual psychology puts forth that by the age of five, a child has adopted a pattern of behavior and style for approaching tasks that reflects their idea of what they can expect from the world. This “private logic” assigns values and rules to the world and includes core convictions about one’s self and the world (Watts & Carlson, 1999).

Safeguarding tendencies is another area in which Bowlby follows Adler. Bowlby believed internal working models could contain distorted information because of the defense distortion which protects an individual from pain, conflict or confusion (Weber, 2003). Individual psychology also views safeguarding tendencies as reactions to feelings of inferiority that protect an individual’s self-esteem and self-worth (Shulman & Watts, 1997; Sperry, 1997). In attachment theory, avoidance is a defense mechanism brought on by the fear of rejection. As a child seeks comfort or reassurance and the caregiver is rejecting or unavailable, the child learns to avoid the needs for reassurance and look inward for comfort. Because of this children form insecure attachments and these children are often seen as angry or avoidant. This is similar to Individual Psychology’s stance that discouragement brings about maladaptive behavior. Discouragement and low social interest are indicative of an individual who does not have the courage or development to meet life’s challenges (Weber, 2003).

According to Adler, as quoted in Weber, “the first evidence of inborn social feeling unfolds in his (the child’s) early search for tenderness, which leads him to seek proximity of adults” (Weber, 2003, p.252). Proximity seeking is a tenant behavior addressed in both theories as necessary for healthy development and long term social interest. Watts and Carlson state that
“social interest is the measure by which a person’s movement through life, and thus the person’s lifestyle, is assessed as either socially useful or socially useless” (1999, p. 3). A person’s level of social interest is indicative of whether they can convey empathy and therefore identification with family, friends and society. Mental health is measured by one’s social interest. A healthy person looks outward instead of inward (Dinkmeyer, Dinkmeyer, & Sperry, 1987).

Innate interactions with caregivers are basic constructs of both Attachment theory and Individual psychology. The mother-child relationship is the first building block for social interest. The attunement between a child and his or her caregiver allows the seeds of cooperation and empathy to begin in a child’s life. The degree to which an individual’s needs are met in early relationships affects their level of social interest and ability to complete life’s tasks (Ansbacher & Ansbacher, 1956; Weber, 2003). The secure attachment style promotes social interest by enabling the child to focus his or her attention away from the caregiver and explore the environment and other people. A child with an insecure attachment becomes self-focused and this self-focus develops because feelings of worth and belongingness are unfulfilled and the child does not feel safe in their environment. This can lead to a preoccupation with the individual’s unmet needs. Attachment theory is congruent with the concept of social interest because both concepts posit that the social environment is an essential nexus for behavior (Weber, 2003). According to Individual psychology, it is not in isolation but through society that an individual is able to achieve security and happiness. Adler believed that social interest is vital to human existence (Ansbacher & Ansbacher, 1956).

The Concept of Self

Webster (1996-2009) describes the definition of self as being the understanding or determination of one’s own nature or basic qualities. At a very early age we determine who we are as defined by our relationship with others. “Young children who have not developed a sense
of self, have a great deal of difficulty making sense of the senseless” (Morrison, 2009, p. 57). Sroufe described “self” as a “social creation”, and stated that “self” is defined, maintained, and transformed with reference to others. According to him, “for these reasons social relations are viewed as having such fundamental importance in both normal and pathological development” (Sroufe, 1997, 358). Our identity is a constancy of self and a consistency of our meaning to others. Without forming an identity we cannot have intimacy. Intimacy is when a person has the ability to enter into deep, close relationships and the capacity to form solid cohesiveness within that relationship (Shahmoon-Shanok, 1999).

According to Bowlby, a child’s working model of self reflects the child’s perspective of his or her worth. As a child interacts with his or her caregiver and is able to make that person smile or meet a need, the child feels a sense of control over the environment. In being acknowledged by another, one has the sense of worthiness in relationship and it fosters a sense of belongingness. A secure attachment allows a child to have a working model of self that is valued and self-reliant.

Adler would call the makeup of self the cognitive schema. Part of the cognitive schema is the self-concept. Self-concept encompasses the individuals perceived weaknesses, strengths, interests, and other attributes that a person defines themselves by. Figuring out one’s own identity implies a constancy of self and a consistency of one’s meaning to others. This is why the self-concept is so essential to a child’s development. After a child forms their self-concept this is used as a springboard for the self-ideal. The self-ideal is what a person strives for and it gives direction regarding movement in life. Without a positive self-ideal a child doesn’t know what he is striving for or begins to strive for the wrong thing.

People tend to act in a manner that is consistent with their self-image. When we see a child that is externalizing in a negative way, we can know that his or her striving for significance
is in the vertical plain in an effort to feel significant. Adler stated that “All of our strivings are directed towards a feeling of security…we want to feel safe and victorious” (Adler, 1992, p. 34). The emergence of a coherent and positive self-concept is undeniably a critical aspect of social and emotional development. Children who come to know and understand themselves acquire an important guide for their behavior and social relationships. As such, children’s early self-perceptions provide a glimpse of personality in the making (Brown, Mangelsdorf, Neff, Schoppe-Sullivan, & Frosch, 2009). Trauma for a child alters the way he or she views self, others and the world thereby creating a tremendous risk for social and emotional difficulties (Morrison, 2009).

**Social Interest**

The core of social interest is a valuing of things other than self. Such value is based on the human capacity to transcend the limits of self and to identify with the needs and concerns of others (Crandall, 1980). Adler viewed this concern for others as supplemental to, not contradictory of self-interest. Social interest manifests itself in cognitive, affective, motivational and behavioral processes. In light of this, a person’s attention, perception and thought given to others are all influenced by their level of social interest. Other areas that are largely influenced by a person’s level of social interest are feelings of empathy and sympathy, as well as behaviors derived from motives such as cooperation, helping, sharing, and contributing. Adler (1992) maintained that all of life’s major problems require social interest and cooperation for their solution. Adler considered that people had three major life tasks: work, love and friendship. Social interest, by involving the capacity and willingness to cooperate with others and reducing the feelings of hostility, threat, and jealousy, should facilitate productive coping with these tasks and minimize unnecessary forms of stress.
Frustrations, failures and losses are inevitable for anyone. Having a level of social interest that entails a lower level of self-centeredness, should help maintain a better perspective and prevent personal misfortunes from taking an exaggerated importance. The feelings of support and belonging that accompany social interest should be of help in these instances.

“Babies are by nature social creatures” (Lieberman, 1997, p. 2). Infants exist and grow in a system of relationships and their functioning needs to be addressed and understood within the systems and framework of their relationships. Interpersonal connections build the earliest foundations for infants in that the baby will feel loved, valued and competent, as opposed to feeling unwanted, burdensome and ineffective (Lieberman, An Infant Mental Health Perspective, 1997). These are the reasons attachment is so vital to social interest in each child. The child needs to first feel loved, valued and competent in order to feel that they can contribute to another. The skills that may be considered part of social interest are: empathy, responsibility, communication, cooperation and contribution. Someone with high social interest would know how to work cooperatively, act responsibly and communicate effectively (Brigman & Molina, 1999).

A core component of Adler’s notion of social interest is that it can and should be developed in one’s upbringing (Ansbacher & Ansbacher, 1956). Adler believed that social interest is innate and that the child-parent relationship is vital to its development. Through this relationship the mother models and develops a sense of caring, closeness, and cooperation in the child. Ansbacher and Ansbacher likened social interest to empathy for others and “the capacity for identification, which alone makes us capable of friendship, love of mankind, sympathy, occupation and love” (Ansbacher & Ansbacher, 1956, p. 156). Cooperation and empathy are both vital parts in a person’s life regarding the ability to impact another’s life and in forming
interpersonal relationships. It is the ability of a person to know who he or she is, and have a positive self-concept that allows a person the capacity to want to know and help others.

Studies reported by Johnson, Smith and Nelson, 2003, have shown that positive perceptions of early childhood family influence demonstrated a significantly higher level of social interest, with positive sibling relationships showing the strongest association of social interest. They also found that social interest was significantly related to one’s perception that family members are helpful and supportive of each other, are open and honest with their behavior and emotions, and do not handle difficulties through conflict and aggression. It was also reported that individuals that scored high on psychological health, including social interest, were more satisfied with their families and perceived better communication between their parents than less psychologically healthy individuals (Johnson, Smith, & Nelson, 2003).

Adler states clearly that social interest means feeling with the whole, sub specie aeternitatis, under the aspect of eternity. It means striving for a form of community which must be thought of as never ending, as if mankind had reached the goal of perfection. It is a normative ideal, a direction giving goal (Adler, Superiority and Social Interest, 1979). This concept of social interest describes the mentally healthy individual as being other or community-oriented and feeling connected to, accepted by, and on an equal footing with all mankind (Nicoll, 1994). Adler puts forth that an individual’s level of social interest is a central barometer of their overall psychological health (Ansbacher & Ansbacher, 1956). Mental health is measured in terms of social interest: one’s willingness to participate in the give and take of life and to cooperate with others (Carlson, Watts, & Maniaci, 2006). Specifically, as social interest develops, feelings of inferiority and isolation will decrease. Conversely lower levels of social interest are thought to lead to discouragement with social interactions, psychological disorders, criminal behavior and generalized dissatisfaction with life (Ansbacher & Ansbacher, 1956).
Using Horney’s (1937) definition of basic anxiety, as cited in Crandall (1980), social interest would help to counteract the feelings of being alone and helpless in a potentially hostile world. Loneliness is stated to be the most common psychological complaint of clients. Loneliness causes feelings of helplessness which in turn accentuates the reactions to stressful situations. One of our most gratifying sources comes from positive interactions with others. Research shows that people who are genuinely concerned for the welfare of others will tend to be more well liked and accepted. Adler argued that the most satisfying and sustaining perceptions of the meaning of life are those that incorporate a sense of community and brotherhood (Crandall, 1980).

Research has generally supported Adler’s view of social interest as being a criterion of mental health. For example, Helle (1991) found that high levels of social interest are associated with high levels of internal control and high self-actualization levels. Mozdzierz and Krauss (1996) found that social interest is related to altruism, prosocial behavior and the need for interpersonal contact. Adler puts forth that the well-adjusted individual behaves in a cooperative manner. This cooperative manner means that the person behaves in accordance with the common sense needs of a particular social situation; his or her goals coalesce with those of the group they are involved with. In contrast, the maladjusted person operates out of a mistaken set of beliefs or convictions that go contrary to common sense and toward “useless” goals which manifest as problems in living (Adler, Superiority and Social Interest, 1979). Social interest became the yardstick by which all movements could be judged in terms of social usefulness or contribution potential. Useless behaviors in contrast were those that did not contribute to society nor contribute to the group, as were such personality traits as selfishness and arrogance which stood in direct opposition to good, responsible and ultimately satisfying social living.
Montagu, as cited in Adler (1979) states that concept of social interest applies to the mother-child relationship, to education, and to an individual’s relatedness in general, in support of his own view that “Life is social and man is born to be social, that is cooperative-an interdependent part of a whole.” (Adler, Superiority and Social Interest, 1979, p. 16). The development of social interest is crucial for mental health and success in living, learning and working. Social interest in its broadest term includes empathy, responsibility, communication, cooperation and contribution. For school age children the training in social skills is one of the keys for developing social interest. It is also one of the keys to school success (Brigman & Molina, 1999).

Deterants in the development of social interest are created when a parent is emotionally or socially detached or if authoritarian parenting is the rule. Similarly Adler postulated that exposure to unhappiness and conflict in the spousal relationship may negatively affect the child’s level of social interest and intimate relationships in later life (Johnson, Smith, & Nelson, 2003). As Adler contended, conflict in family relationships may role-model behavior that is antagonistic to the formation of social interest. Establishing a feeling of connectedness with the community is more difficult for individuals that come from a more conflicted family environment. These individuals may feel threatened or at risk of losing their sense of self or feel they are sacrificing their own needs if they were to reach out to the needs of others (Johnson, Smith, & Nelson, 2003).

Quality attachment and the relationship formed through this, as well as training in social skills are two keys in developing social interest. A growing body of research, according to Brigman and Molina (1999) indicates that children without minimal social skills are at great risk of school failure and of eventually dropping out (Brigman & Molina, 1999).
Attachment Styles

Out of attachment relationships develop internal representational models about self, others and the world. How we come to perceive ourselves, evaluate ourselves in relation to different social roles and our ability to explore and become committed to those roles determines how well our identity is formed (Brown, Montgomery, & Hart, 2003).

Attachment was described by Bowlby (as cited in Greenspan & Wieder, 2006) as the emotional bond between an infant and his primary caregiver. The concept of attachment not only includes using the caregiver as a secure base but also attributes to the infant’s ability to regulate emotions and levels of arousal within the context of the parent-child relationship. This attachment bond works in such a way that when an infant is distressed he signals; a sensitive and responsive caregiver reads the signals and responds by helping him attain a calm and regulated state (Greenspan & Wieder, 2006).

The patterning of the early primary attachment relationship is a prototype for subsequent development operating on numerous levels (Sroufe, 1997). Atypical attachment patterns have a negative impact on children’s emotional, cognitive and interpersonal development (Carew, 1980).

Secure Attachment

If children come to expect that their mothers will be there when needed, and the care provided is responsive and sensitive, they tend to develop secure attachments. (Dozier, Dozier, & Manni, 2002; Sroufe, 1997) Several studies demonstrated that the key element necessary for secure attachment is sensitive and responsive caregiving (DeWolff & van IJzendoorn, 1997).

Responsive caregiving is the ability to read the baby’s signals and respond to them in an appropriate time frame and to do so accurately. For example, if a baby cries the mother gives him a bottle, because she *knows* this is what is needed instead of putting him to bed because she
assumes that if he cries he must be tired. Sensitive caregiving is when a mother holds a child to comfort him, she does this gently and soothingly, not roughly or rigidly. The mother’s actions and words are congruent.

Winnicott’s term “the holding situation” was used to refer to many aspects of the early mother-child relationship. One of the ways a mother holds a child is the actual act of physical holding or body contact with a child. Other ways to hold a child are through vocalization or eye to eye contact, otherwise known as distal modes. However Ainsworth discovered the most desirable forms of maternal behavior is for these to occur in unison. Mothers who were sensitive tended to respond in all modes available to them, when distal modes failed the child was picked up and cuddled with (Hopkins, 1993).

Attunement can be defined as the way in which the parent can know what is going on with their infant or the ability of the infant parent dyad to respond to and reinforce each other contingently. The synchronizing of infant need and parent response is how Gearing, (2009) describes it. Stern (1985), called attention to the affect attunement between mothers and their infants—that is the caregiver’s capacity to intuitively grasp the infant’s internal states (hunger, agitation, contentment, and playfulness) and respond in a way that conveys to the infant. “I got your message, and I can deal with it or help you to deal with it.” During such interactions research shows that physiological measures of mothers and infants paralleled each other (Bleiberg, 2002).

Reflective Functioning is the predisposition to understand behavior in terms of mental states—in normal development as well as when this development is distorted. The developmental roots of this essential function lie in the interaction between mother and infant (Fonagy, Understanding of mental states, mother-infant interaction and the development of self, 2002). Reflective function is an individual’s capacity to go beyond known phenomena and behave in a
manner indicating that he or she has taken account of the mental state of the other to organize his or her own behavior. It is a skill, the intuitive understanding of what others are going through, of their intentions, and of the meaning of actions is an experiential, not an intellectual, formulation. Reflective functioning is incorporated into representations of relationships and its pervasive influence lends shape and coherence to self-organization (Fonagy, Understanding of mental states, mother-infant interaction and the development of self, 2002).

The primary relationship, parent-infant, leads to the development of a most important human function: the ability to understand others and consequently, to be able to relate empathically and reciprocally (Fonagy, Understanding of mental states, mother-infant interaction and the development of self, 2002). *Theory of mind* is a term used to describe a person’s, adult or child, reflective or mentalizing capacity. That is the capacity to attribute mental states - beliefs, intents, desires, pretending, and knowledge – to oneself and others and to understand that others may have beliefs and desires that are different from one’s own. Understanding of others intentions is a precursor to understanding their minds. The theory of mind is important in the establishment of the secure attachment because it allows the baby to know that the mothers’ actions and intentions are in his or her best interest and therefore it allows the child to feel safe and secure.

A child with a secure attachment has the capacity to use the mother for a safe base. The “safe base” is a term used frequently to refer to the behavior of a child seeking out the mother and using the secure attachment relationship as a springboard for exploration. (Gearity, 2009) The child readily seeks out the mother for comfort when scared, concerned, hungry, or sick (Dozier, Dozier, & Manni, 2002). This seeking behavior can be an actual movement towards the mother, looking at the mother or vocalization directed at the mother.
Children with secure attachment are not differentiated from children with insecure attachments based on how long or loud they cry but rather on their ability to use their caregiver to help them settle down (Dozier, Dozier, & Manni, 2002). The two parts to this are that the child has the security to seek out their caregiver and that caregiver is able to help the child soothe.

Longitudinal studies found the securely attached children tend to have better emotional adaptability, social skills, and cognitive functioning (Greenspan & Wieder, 2006). On a behavioral level a child in a secure attachment has been trained into particular patterns of reciprocity and affective sharing, as well as having evolved a sense of curiosity and a skill in exploration. The child has generally positive and trusting attitudes towards others. Along with this the child takes with them a sense of his or her own effectiveness and personal worth. They feel effective in eliciting responsiveness and care from a parent. They take on challenges and expect to master them. They believe in themselves and their power in the world. They value relating and have an internalized template for empathy and reciprocity in relationships (Sroufe, 1997).

To support this behavioral level are patterns of arousal regulation, which allow for the full range of emotional expression with sufficient modulation, such that organized behavior can be maintained (Sroufe, 1997). These children, like all children, can become distressed, however because of past care they have received, they are able to regulate that arousal and return to calm. This is a process that develops over time. The regulation of arousal first happens when a mother for example, gently picks up and soothes a crying child, once this pattern has been well established then the next stage can develop. The next stage in the development of self-soothing is that the caregiver is able to vocalize, across a distance, that the baby is loved and cared for. Again once this pattern is established, then the third stage can begin. The third stage is when a baby is in distress he can look at a distance and just the loving eye to eye contact of the caregiver
can reassure and soothe the child. When these patterns are well established the child has within him or herself the ability to self-soothe and therefore emotions are not frightening and do not overwhelm the child. This allows for the child to have a full range of emotional expression.

This ability to feel a full range of emotions and having developed the theory of mind ability gives rise to other attributes such as empathy. To empathize with others is to understand what the other is feeling, or moreover how one would feel in the same situation. Children who have developed empathy are more likely to do better in school, in social situations and as adults in the workplace. People that demonstrate the greatest amount of empathy are viewed as leaders by their peers.

Adults with secure attachments tend to have high self-esteem, enjoy intimate relationships and seek out social support. These adults also have the ability to express their own feelings and to be able to share in the feelings of others. These adults can express a wide range of feelings about their parents and memories of their childhood (Hernandez Petrulo, 2009). Parents of children with secure attachments are neither caught up in their earlier conflicts, nor do they try to distance themselves from them. They are able to talk coherently about attachment issues. These parents are said to have “autonomous states of mind.” (Dozier, Dozier, & Manni, 2002)

**Insecure-avoidant**

Children that come to expect that their mothers will not be there when needed will develop insecure attachments. Children whose mothers are rejecting of their bids for reassurance tend to develop avoidant attachments. There are a number of ways in which the parents may be rejecting. One such way is the parent not acknowledging the child’s feelings...such as a girl who skips down the side walk and trips and skins her knee and runs to her mother. Rather than a hug the mother may say “Look at the bird in the tree.” Another mother says “You’re a big girl, you
don’t need to cry.” whereas a third mother may say “I told you not to skip”. In all three instances the child has gotten the message that they will not be reassured when hurt. If these responses are characteristic of the parent the child develops the expectation that the mother will not be emotionally available when he is distressed. This child in turn learns to show little emotion and if they do show emotion they do not expect a sensitive response.

Mothers whose babies developed an avoidant attachment all manifested what Ainsworth termed the “the rejection syndrome”. This is characterized by deep aversion to bodily contact which leads them to rebuff their infant’s attempts to initiate physical contact. In addition these mothers were liable to be rough or perceived as threatening to their infants. (Hopkins, 1993)

In the strange situation, the child may first look at the parent and then abruptly turn away or may appear indifferent to the parent’s presence. This pattern is characterized by failing to seek contact with a caregiver even under stressful conditions. These infants have learned to cut off emotional responses especially when tender needs are aroused (Sroufe, 1997). These children appeared independent, competent, and unperturbed during the Baltimore study by Ainsworth, which led observers to believe this to be well adjusted behavior (Karen, 1994).

A parent with the avoidant pattern is dismissing or devaluing of their attachment experiences. When asked to describe their attachment figures they speak of them in idealized terms such as “loving and wonderful”. But they will not be able to instantiate the description with specific examples. Also these parents are unable to recall specific incidences of distress when they were young. In general they are not comfortable talking or thinking about challenging attachment issues or in considering the impact of attachment on current functioning. This inner discomfort makes it difficult for them to deal with their children’s distress. These mothers are said to have “dismissing states of mind” in regard to attachment (Dozier, Dozier, & Manni, 2002). This means that they show disregard or disinterest in their children’s distress. Adults
with this attachment are overly self-reliant and detached seeing little importance for love or connection (Hernandez Petrulo, 2009).

**Insecure-anxious/ambivalent/resistant**

This parent responds inconsistently to their child’s distress. Children are left not knowing whether or not their needs will be met. These children find it necessary to heighten their expression of emotion in an attempt to elicit care from an inconsistently responsive caregiver (Crockenberg & Leerkes, 2005). Because of this the children’s responses are often angry or passive when interacting with their caregiver. The lack of attunement within the relationship causes the infants behavior to be more emotional than that of a securely attached infant. They lack the primary trust in their ability to get their needs met on a consistent basis. These children lack the resources for modulating their behavior so that once they get angry they are not able to calm themselves. The inconsistent attempt from parents to calm the child is ineffective as the child has learned the parent is not to be trusted.

These children behave in fussy and inconsolable ways which makes it difficult for them to form relationships with others. Insecure-ambivalent attachment causes children to have a lower range of pro-social play skills, exhibit more aggression and show impulsive actions (Szewczyk-Sokolowski, Bost, & Wainwright, 2005). They may appear to want contact but then they resist the contact. This child will ask for reassurance frequently because the parent only gives it intermittently (Dozier, Dozier, & Manni, 2002). Due to the inconsistent care patterns it leaves the child hyper-aroused, hyper-vigilant and uncertain regarding caregiver availability and their own effectiveness (Sroufe, 1997).

The parenting style is that care is put forth on the parent’s terms. The care given is insensitive and unpredictable in response. The needs of the child often go unmet leaving the child feeling incompetent and ineffective in communicating his needs to the parent. Parents of
children with resistant attachment are usually caught up in their own attachment issues. They may report things from their past as if they are happening in the present, or they may ramble from one topic to another, without being able to deal with the issue at hand. The state of mind of these parents would be considered to be “preoccupied state of mind” with regard to attachment (Dozier, Dozier, & Manni, 2002).

**Insecure-disorganized**

In the “strange situation” experiments infants with insecure/disorganized patterns, did not respond consistently with pleasure (secure-attached), anger (Insecure-resistant) or avoidance (insecure-avoidant), rather they were disorganized: inconsistent, disoriented, confused, suddenly changing, and jittery with interrupted movements and constricted affect. At times they may display responses representative of all of the other attachment styles.

Parents of disorganized infants are frightening to the child. They act unpredictable and behave in ways that are puzzling to the infant and therefore, frightening. Parents may act with hostility toward the child or the disorganized child may have suffered a loss. The disorganized infant is less likely to seek comfort and is caught in a dilemma. The infant is simultaneously motivated to seek the caregiver for comfort and to avoid the caregiver out of fear of the unknown.

Two types of disruptions in maternal affective communication can occur. The first, “failure of repair,” which is characterized by unresponsiveness to both the content and intentions of the child and demonstrated in communication by hostility, intrusiveness or withdrawal and the second type is called “competing strategies”, this refers to the caregiver behaviors that both elicit and reject infant attachment behaviors and thereby undermine the infants ability to form coherent patterns of attachment strategies. (Crockenberg & Leerkes, 2005)
Parents may be frightening to their child in a variety of ways. They may actually harm or threaten to harm their child. They may threaten to leave their child or play in too threatening a way with them. Responses that fail to soothe the child or create more arousal of the attachment needs are referred to as “failure to repair”. These failure to repair responses include: a lack of response or withdrawal, insensitive response (i.e. affective communication error) these responses can be as fear provoking as behaviors that are directly frightening (Madigan, Bakermans-Kranenburg, van Ijzendoorn, Moran, Pederson, & Benoit, 2006)

These children are likely to show a breakdown in attachment strategies when they are distressed or in the presence of the parent. “According to Mary Mains, these children have an irreconcilable dilemma-they are frightened of the person to whom they look for reassurance (Main & Solomon, 1990)”. During the Strange Situation; these mothers provided infants with contradictory messages and responded inappropriately or not at all to clear communication messages by their infants. These mothers also engaged in more negatively-intrusive behaviors as well as more frightening and other atypical behaviors (Crockenberg & Leerkes, 2005).

Children with insecure-disorganized attachment style can show a range of behaviors such as: entering a trance like state when distressed, moving away from the parent when distressed, or showing an odd combination of behaviors that do not serve a clear goal. Children with disorganized attachment show lapse in orientation, and failures of integration of emotions, cognitions, and behavior result (Sroufe, 1997). “The essence of disorganized attachment is fright without solution.” (Main & Hesse, 1992)

Parents of children with disorganized attachments often have a loss or abuse in their own past that they have not worked through. This previous trauma leads the parent to be frightening or act frightened of the child. These parents can explain their childhood in a variety of ways, but it usually not consistent and can range from idolizing their childhood, similar to avoidant, or be
uncomfortable discussing it or angry and upset when discussing it. These parents are said to have “unresolved state of mind” (Dozier, Dozier, & Manni, 2002). Interestingly enough children of mentally ill mothers maybe at high risk for disorganized attached as will children that are separated from their mothers (Solomon & George, 1999). Studies suggest that there may be multiple identifiable pathways to patterns of disorganization with different etiologies (Solomon & George, 1999).

**Attachment Style and Mental Health**

Much has been studied about the mental state of the mother regarding the attachment organization of her infant. In healthy relationships between an infant and mother one expects the mother to be sensitive and responsive, and generally confident in herself. However the classic systems of depression are quite the opposite. Depression is often characterized by feelings of hopelessness, lack of self worth, low involvement and low energy, disordered personal relationships, episodic emotional dysregulation, and psychological unavailability (Radke-Yarrow, 1993). One of the clear things that has risen from the research is that infants of depressed mothers showed significantly less likelihood for secure attachment and marginally raised likelihood of avoidant and disorganized attachment. Increase in disorganized attachment as compared to secure attachment was from 17% to 28% on average has been consistent across studies (Martins & Gaffan, 2000).

It has been found that preschool children of mothers experiencing depression have a higher level of internalizing and externalizing behavior problems as compared to children whose mothers do not have a history of depression. For internalizing problems this held true for mothers with chronic depression and mothers whose depression has remitted (Dawson, et al., 2003) Frankel et.al found that depression and emotionality were independent of one another and did not interact to predict child empathic responses. The results of their tests suggested that regardless
of depression the child’s optimal outcomes were achieved when mothers are available and
genuine in the expression of emotion (Frankel, Lindahl, & J., 1992).

The best outcome for all children is to have a secure attachment with at least one adult
caregiver. Likewise it is suggested that it is disorganized attachment leads to the highest
incidence of future distressed mental health. “Although some attachment theorists and
researchers may take issue with us, we suggest that it is the disorganized attachment that confers
the most significant risk for later psychopathology.” (Dozier, Dozier, & Manni, 2002, p. 9)

Children with avoidant and resistant attachments have strategies that are well suited to their
caregivers. However such insecurely attached children are at increased risk for anxiety disorders
(Warren, Huston, Egeland, & Sroufe, 1997) and for somewhat less than optimal outcomes with
teachers and peers (Dozier, Dozier, & Manni, 2002). Both the avoidant and disorganized
patterns of attachment were strong predictors especially of dissociation. Disorganized
attachment was particularly associated with internalizing symptoms such as depression and
anxiety as well as externalizing symptoms such as acting out (Dozier, Dozier, & Manni, 2002).

Maladaptive patterns of attachment alone are not viewed as psychopathology per se but
in terms of developmental risk for disturbance. Pathology involves a succession of deviations
away from normal development (Sroufe, 1997). Stroufe goes on to say that change is possible at
any point. Not only is pathology typically not simply an endogenous given, but even when a
maladaptive pathway is enjoined, return to positive functioning often remains possible.

Studies indicated the combination of less than optimal attachment along with other life
situations such as: poverty, divorce, marital discord, homelessness etc increase the chances of
mental health problems in children. Tracing pathways to disturbance is not a clear cut design.
Individuals showing the same symptoms may not be on the same pathway. Adolescence that
exhibit problem behaviors are not on the same pathway as those whose behavior arises in, and
persists from, early childhood. Only those arising in and persisting from early childhood are likely to show criminality in adulthood (Sroufe, 1997).

**The Development of Social Interest**

Adler points out that “the newborn child always finds in life only what the others have contributed to life, to welfare, to security. What we find when we enter our life is always the contribution of our forefathers” (Adler, 1979, p. 35). He goes on to explain that if one contributes nothing to society as a whole than they die and become extinct. It is only through our contribution to society that we can give forth to further generations. Often people will contribute through their children and that is how they contribute to a greater good. Adlerian theory and attachment theory have many things in common. “The major areas of convergence between the two theories are that both include a coherent and stable view of the self and the world and that both acknowledge the importance of social interaction for the expression of these patterns”. (Peluso, Peluso, White, & Kern, 2004) Relationships that form early on in a person’s life have important implications for future functioning. One of these important implications is to the degree that social interest is expressed within the community. Another commonality would be the importance of family life as an influence in psychological development. (Weber, 2003).

When we speak of virtue, we speak of participation in the game of life however when we speak of vice we are referring to the idea that one disturbs cooperation (Adler, 1979). Adler goes on to say that if something signifies failure, it is failure because it disturbs the development of community. This is true whether we are dealing with troubled children, neurotics, criminals or cases of suicide. With each of these situations the contribution to society is lacking (Adler, 1979).

From Adler’s writings Ansbacher developed a three-stage developmental framework for mental health development: First, all individuals have an aptitude that is innate for cooperative,
responsible social living which must be developed through training at home, in school and in the community. Second, the development of this innate aptitude is developed through social skills training with emphasis on these five skills: understanding self and others, empathy, communication, cooperation, and a making a responsible contribution. Third, as these five skills are developed, children’s subjective attitudes emerge, and through these, choices made by self and others are evaluated. The previous a synopsis of information found in Ansbacher and Ansbacher (1956).

According to Nicoll, implementing this three-stage developmental framework would provide school age students with: a preventive program for youth targeted at social-emotional development, a program to target individual social skills, and a program to improve the social climate (Nicoll, 1994).

**Populations at highest risk for attachment disturbance**

Research has shown that insecure attachments are more likely in certain populations. Children of depressed mothers show significantly reduced likelihood of secure attachments and marginally increased likelihood of children with avoidant or disorganized attachment. A depressed mother is 17% to 28% more likely to have a child with disorganized attachment than is a mother that does not have depression (Martins & Gaffan, 2000; Radke-Yarrow, 1993). Research shows that children of parents with major affective disorder are at significant risk for depression and other disorders compared with normal controls. The impairments that presented were neurotic illness, neurotic behavior disturbance, sociopathy, criminal activities, and most particularly, depression. These children were more likely than children of healthy parents to have experienced perinatal complications, cognitive impairments in infancy, school problems and peer problems (Beardslee, Bemporad, Keller, & Klorman, 1983; LaRouche, 1989). Maternal schizophrenia is known to have an adverse affect on the quality of mother-infant interaction and
children of parents with severe mental illness run a higher risk of poor mental health and social outcomes (Duncan & Browning, 2009). Research has shown that both physical and verbal abuse is related to attachment difficulties as well as adverse psychological symptoms (Reinert & Edwards, 2009).

Several studies have been done to determine if premature infants are at higher risk for insecure attachment due to the adverse circumstances in which they are born and due to the fact that for many infants this means long term hospitalization at a critical time for attachment. Despite the extensive studies in the field, the literature remains inconclusive. Most authors have not found higher proportions of insecure attachment patterns among preterm babies compared with full-term infants (Borghini, 2006).

**Identification and referral for problems of attachment**

The beginning of intervention is identifying a need and referring for services. These referrals can come from a variety of sources. The main point of contact for parents and young children is their primary physician. Other support persons that come into contact with families with young children are public health nurses, child care providers, teachers, social workers, mental health workers and clergy. These community members play a crucial role in identifying families at risk for attachment issues and getting proper referrals to mental health services.

Getting proper training to these community members regarding the behavioral manifestations and risk factors associated with attachment and disorders among infants and young children is a crucial piece. Identification of social and emotional issues with young children is a challenge. People in general are either unaware of the issues that can be caused through lack of secure attachment or they feel overwhelmed in the responsibilities already placed upon them. As a society we need to develop systematic ways of identifying and referring families with attachment issues at the earliest possible age. This could begin by having
screenings available at regular well baby checkups, having mandatory home health visits from public health nurses for children under three and training child care workers in milestones for social and emotional development.

The step following identification and referral is having clinicians trained in effective practices in assessing and dealing with attachment issues. This process can begin by requiring colleges to mandate classes in developmental and diagnostics, specific to the birth to three populations. The last step would be requiring clinicians and social workers that work with families with young children to have competencies in this area. Another concern is working with insurance companies to have a reimbursement system that is amiable to the needs of young children. Young children’s mental health needs cannot be adequately met in the same ways as adults. There needs to be an overall shift in mental health services for our youngest children and their families if mental health care is going to be effective in changing outcomes for children and families.

**Prevention**

One cannot discuss therapeutic interventions dealing with attachment until one has discussed prevention. In 1957 the Commission on Chronic Illness as cited in Fonagy, 1998, identified three kinds of prevention: primary, secondary and tertiary. Caplan (1974) adapted these categories to mental disorders. Primary prevention is aimed at reducing the number of new cases of mental disorders. Secondary prevention seeks to lower the rate of established cases of mental disorder by reducing their duration (prevalence) and tertiary prevention aims at decreasing the amount of disability resulting from mental disorders (Fonagy, 1998). Fogany states that “a fundamental truth of our field, is that the preservation of the mental health of infants is the key to the prevention of mental disorder throughout the lifespan” (Fogany, 1998, p. 126).
One of the strongest arguments to preventive/early interventions is recent discoveries concerning “sensitive periods” in the development of the central nervous system. This has now been demonstrated in a number of areas including: emotional reactivity, self organization, motivation, relationships, the irreversible damaging impact of certain types of early sensory experience, more specifically the overwhelming destructive effect of early emotional stress and the sensitization to kindling effects of these experiences (Fonagy, 1998).

The earlier the treatments for attachment problems begin in a child’s life the more optimal the outcome. Just as in the medical field where prevention is paramount, so is it paramount when dealing with issue of mental health. When treatment is initiated early on in a child’s development, the child’s ability to transverse the next development stage appropriately dramatically improves. To give children the best opportunity for optimal functioning it is imperative to address attachment problems when they are first identified.

Some preventive parenting programs available are called The Incredible Years, Six Keys of Social and Emotional Development, and Strengthening Families through Early Education and Care. The promise of preventive interventions is considerable. Early preventative intervention programs have the potential to improve the child’s health and welfare, in the short term. Health and welfare refers to nutrition and feeding problems, fewer visits to hospitals, improved physical health as well as reduced potential for maltreatment. Short term benefits to the parents are, educational and work opportunities, better use of services, improved social support, enhanced self-efficacy as parents and improved relationships between partners and with the child. Long term, children may benefit in critical ways such as behaviorally they are less aggressive, distractible and delinquency is lessened, educationally they exhibit better attitudes and higher achievement, and socially these children show an increase in prosocial behaviors. Parents also benefit long term through employment, education and mental well-being (Fonagy, 1998).
**Therapeutic Interventions for People with Attachment Problems**

The question arises as to the most effective intervention models. There are so many variables in the efficacy of interventions: whether the child or the parent is the center of the intervention, whether intervention starts in pregnancy or at birth, whether the duration of the intervention lasts for the first six months, one year or even up to three years, whether the intervention is best administered through nurses, psychologists, clinicians or by volunteers, whether the intervention is broad-based, focused, educational, behavioral, relationship or psychodynamically oriented.

**Infant-Parent Psychotherapy**

This method was developed by Selma Fraiberg. Selma Fraiberg is most well known because of her article “Ghosts in the Nursery” (Fraiberg et al. 1975). This phrase refers to the child’s engulfment by the unconscious expectations and attributions of the parents or caregivers. The “ghosts” referred to the infant being caught in the parent’s unresolved psychological conflicts. Fraiberg also used this term for shorthand when referring to the transgenerational transmission of attachment problems, as well as mental health problems (Leiberman, 2002).

The belief posed by this therapy is that the baby is an unconscious representation of attachment figures from the parents’ own past. The baby, because of this, may become the target of negative transference through which the parent repeats unacknowledged and unexorcized pain, anger, and disappointment experienced in earlier relationships. In other words the parent’s internal representation of the infant and their experience of the baby’s behavior become distorted by their own past experience. This may manifest itself for example, a baby’s cry is not perceived as a cry for help but rather as an angry accusation that the parent is doing nothing right and is therefore inept. In this case the baby is perceived as a tyrant who probably existed somewhere in
the parents past. Because of these feelings the baby will probably not be attended to in a
responsive, sensitive manner no matter how much others try to persuade the mother to do so.

Infant-parent psychotherapy is meant to increase empathy and continuous pleasure in the
attachment relationship, and as an attempt to correct, soften or modify misperceptions within the
relationship (Leiberman, 2002). The most readily recognized aspect of this therapy is the
process of helping the parents understand their intense and pervasive ambivalence toward the
child that may lead to abuse or neglect of the baby in light of the parents own negative
experience. These memories are often repressed, denied or not remembered at all because
nothing in their childhood is or a parent maybe able to recall the memories intellectually but has
disassociated from the feelings. This component of infant-parent psychotherapy, linking the
present with the past, is to help parents to come to terms with their own childhood instead of
acting it out through the child.

This therapy is usually carried out with the baby present and in the home, when possible.
The therapist works at creating an atmosphere that evokes memories, feelings and images.
Observing natural interactions between the parent and child as you draw out conversation with
the mother is very valuable. The technique of free association is used, except in this instance it is
used not only with words but also in actions, as the mother talks to the therapist, she is also
relating to the baby. The therapist needs to be in tune to the level of behavior as well as the
level of verbalization (Leiberman, 2002). Quite a contrast can occur between what a parent is
saying and what a parent is doing. In a sense, the psychotherapist needs Theodore Reik’s (1948)
proverbial third ear, a hovering attention to capture and sense unspoken themes in the parent’s
narrative (Leiberman, 2002). The therapist also needs to capture the infants experience and
judge how it may or may not fit with the parent’s narrative and behavior. The baby gives us the
whole picture of what actually happens in the home. The therapist as an emotionally involved
participant is able to feel the tension and conflict within the family. For case studies and examples please refer to Infant and Toddler Mental Health, pages 118 – 120 (Leiberman, 2002).

Child-parent psychotherapy is guided by three basic premises. The first being that mental health problems in infancy and early childhood need to be addressed in the context of the child’s primary relationships, because the child’s sense of self unfolds and is sustained by those relationships. The second premise is that mental health risk factors in the first 5 years of life operate in the context of transactions between the child and his or her social environment, including the family, neighborhood, community and larger society (Lieberman, 2004). The third premise is childrearing practices are carried out with deeply held and often unconscious cultural values about who is a worthy human being and which characteristics should be encouraged or discouraged when raising a child. Mental health workers need to be extremely cognizant of this fact. Learning about and incorporating culturally appropriate practices is essential (Lieberman, 2004).

The last fact that the author appreciates about this type of therapy is that the use of concrete assistance is considered a worthy therapeutic modality. When concrete assistance is used appropriately it can open the door to substantial and lasting psychological change. In review, the methods of treatment described by Selma Fraiberg are as follows: insight-oriented interpretations, didactic developmental guidance, crisis intervention, emotional support, and concrete assistance. The common ingredient of all these interventions is the relationship to the therapist.

**Caregiver/Parent-Child Interaction feeding and teaching**

The NCAST Teaching scale is a reliable and valid means of observing and rating caregiver-child interaction for the purpose of assessing whether a dyad has problems in their interaction and communication patterns. The NCAST teaching scale is widely used in research
and clinical practice with families and young children. One premise is that because all
dimensions of a child’s development interact in complex ways, a deficit in one area could have
important implication for overall health and well being of the child. The second premise is that
infants depend on adults to mediate experiences and create learning opportunities for them. A
framework for a child health assessment is depicted as three overlapping circles (Sumner &
Spietz, 1994). Please see appendix C for a chart showing visually how interplay between the
child and their caregiver and the environment happens. This model shows how a caregiver can
mediate the effects of the environment on a child by providing a safe environment and age
appropriate toys. On the other hand a caregiver being overly restrictive can inhibit a child’s
opportunities to grow, explore and master new skills.

The goal of this intervention is to assess the interplay between child, parent, and
environment through the use of video interactions. These interactions are used for the parent to
see themselves interacting with the child in the environment and come to conclusions about how
things may have been done differently. This is enhanced through reading materials designed to
promote positive parenting and thus attachment and social interest. Critical to the success of any
interaction is the ability by the caregiver and child to adapt to one another. Classic research
suggests that initial mother-infant adaptation involves the fitting together of the “active
tendencies” of each partner. For example Condon and Sanders (1974) as cited in Sumner &
Spietz, 1994, documented that limb movements in newborns is synchronized to adult speech
from birth. Caregiver infant synchrony is facilitated by a sense of rythmicity which is propsoed
to be an underlying pattern in the flow of interactive behavior. This would be considered
intunement by Bowlby. When partners in the interaction are passivly involved, the interaction
becomes less adaptive and less positive.
This model set forth by Barnard is based on the assumption that caregivers and infants have certain responsibilities within the relationship. The infant is responsible for giving clear cues and being responsive to the caregiver. The caregiver has the responsibility of reading the cues and responding appropriately, alleviating the infant's distress, and providing opportunities for growth and learning.

Breakdowns in the relationship result from the caregivers' lack of knowledge regarding child behavior, illness, depression, stress or a crisis in the environment. The infant may also give poor cues or respond in a way the caregiver doesn’t receive. Once this lack of intunement happens maladaptive interactions are most likely to occur.

For the infant to have the quality and quantity of stimulation needed for optimal development the interactions must have certain qualities. The first qualities are a repertoire of behaviors such as smiling, talking and body movements so that reciprocity of sequencing can happen. The second is that partners' responses must be contingent on one another, as the child matures the adult must remain consistent and contingent. The third quality is that the interactive content must be rich in terms of positive affect, verbal stimulation and range of play materials available.

**Living, Learning and Working Program**

The purpose and premise of the Living, Learning and Working program, LLW, is to enhance the skills and competencies associated with social interest and school success through the use of service learning. The structure for this intervention is based on The Five Objective Social Skills of Mental Health as put forth by Nicoll. These skills are: understanding self and others, empathy skills development, communication skills, cooperation skills and responsibility skills (Brigman & Molina, 1999). The Brigman and Molina article spells out in detail how this program works and what age groups it is most effective for. For the school age population in a
school setting the LLW program would help build a foundation of social interest for the students and the environment.

The key teaching strategy of the LLW program is what is called “tell-show-do-coach” and is based on Bandura’s social learning model (Brigman & Molina, 1999). According to Brigman and Molina, 1999 the effectiveness of this teaching model has been demonstrated to be an effective means of teaching the skills associated with social interest and school success.

The method of delivery for this intervention uses a group model consisting of 12 sessions. These sessions are divided into three phases: Working together, Learning together, and Living together. The focus during the Working Together stage is to instill hope and universality, the focus during the Learning Together stage is to impart information, create group cohesiveness and foster altruism. The focus of the Living Together stage is the development of socialization, prosocial behavior, and interpersonal learning. Three specific strategies are used to teach skills those strategies are: using stories, teaching story structure, and role playing.

The three cornerstone ideas that come together in this intervention are: the importance of social interest, the connection of social interest to the skills associated with children who are academically and socially successful, the practice of service learning that provides students the opportunity to apply the skills and to contribute to others. For more details about how to implement this intervention program please refer to Brigman & Molina, 1999.

There are several other interventions available to promote positive mental health in infants and young children. Almost all of these interventions happen in the home, on the premise that children and families react best in their own environment. The interventions are relationship based in that they promote the idea of supporting mother’s social relationship so that she in turn will be better able to support her child in a social relationship. Many follow a strict protocol for number of times to visit the family and prerequisite ages of the child at which to visit.
Interventions for teens and adults

This client may also experience issues related directly to their attachment style and the consequences of not having developed a social interest. This assertion is fundamental to Individual Psychologies concept of lifestyle, where the final fictional goal is established by age 5 (Ansbacher & Ansbacher, 1956). The client that has an insecure attachment will likely have grown up storing deep feelings of inferiority and mistaken beliefs about him or herself, others and the world. This individual may be striving on the vertical plan for superiority to overcompensate for the feeling of inferiority.

It is imperative, with this client, for the therapist works to build rapport and provide an atmosphere of trust with the client. Being genuine, showing the client unconditional positive regard, regardless of the client’s behavior and showing empathy will be key to a successful relationship (Carlson, Watts, & Maniacci, 2006). Just as when providing care for the child the adult needs to build a sense of security through interactions that are sensitive and responsive. Adler (1956) says it best “to see with the eyes of another, to hear with the ears of another, and to feel with the heart of another” (p. 135) A client with attachment difficulties may take a long time to warm up to the therapist and may seem disorganized in their ability to relate.

This may be the first time the client has experienced social interest in action. Adler (1929), as cited in Carlson et. al, 2006, states that the individual acting in accordance with developed social interest not only have feelings of self-worth and value and courage and optimism but also treat others in an egalitarian manner. By providing clients with these conditions, therapists model social interest and lay the foundation whereby clients feel safe to grow toward greater mental health and well-being.

This client will need lots of encouragement. They will need to feel heard. This will be accomplished by a therapist that actively listens to and reflects feelings back to the client. A
cornerstone of Individual Psychology is that it is strength based. Looking for and pointing out the strengths and competencies that you find in this client is pertinent. The ability to be curious and let the client know that you realize they are the expert about their own experience is important. Join with the client in a spirit of understanding, using such phrases as “I can understand why you felt you needed to…” The ability to communicate a belief and a hope in the client’s ability to change and that change will indeed occur is essential during this phase of therapy.

An Adlerian therapist will be collaborative in the effort to form therapy goals. It is essential for progress to happen in therapy that the therapist and client have an alignment of goals. The client needs to recognize the therapy goals as important and want to change.

Techniques to be used to get a clear assessment of the client are early recollections and lifestyle. The use of birth order and family constellation may be useful as well. Early Recollections give the therapist an idea of what the client’s interfering attitudes, beliefs and what his assets and strengths are. The entire lifestyle will give the therapist information about what the client thinks of himself and what his goals are.

Once the assessment is done the therapist will lead into the insight phase, asking such questions as “Could it be?” or “do you suppose?” Allow clients the opportunity to come up with answers on their own. A therapist could use metaphors or humor to help client gain insight.

During the final phase which is referred to as reorientation the client is ready to make changes to his lifestyle and way of doing things that may seem very foreign to him or her. The therapist during this phase of treatment may encourage the client to “act as if…” getting the client to try on new behaviors. The therapist will encourage these new behaviors with the reassurance that the therapist will be there to help the client if the actions or behaviors don’t work for him or her.
The Adlerian therapist in this relationship realizes that the client has formed an attachment with him or her that is new and probably fragile. The therapist will leave the door open for any future counseling that the client may need.

**Future Work to be done**

This work of helping society realize the importance of building secure attachments in early childhood and how these attachments lead to social interest. Social interest is the manifestation of a person that is securely attached. We need to impress it upon all that work with small children that “the preservation of the mental health of infants is the key to the prevention of mental disorder throughout the life span” (Fonagy, 1998). Prevention is going to be our answer of the future. Society needs to realize the ramifications if we do not invest heavily in our youngest populations.

The key to prevention is having clinicians that are trained in identification and effective methods of working with very young children and families in a manner that brings about lasting change in relationship. Lasting change in a dyad will have positive ramifications for generation to come.

Researchers also need to look at what qualities of attachment are missing for children that develop conduct order and other pervasive mental health disorders at such early identifiable ages and as a society we need to make concerted efforts to fill in the gaps for these children.

**Conclusion**

The theory of attachment constructed by John Bowlby came about long after Alfred Adler came up the theory of social interest. Both however are pivotal in the development of a person that is known to exhibit positive mental health. Attachment theory posits that humans need security, which is provided through love, touch and warmth. Indeed, “attachment theory underscores the central role of relationships in human development from cradle to grave”
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Weber, 2003). Bowlby believed this approach highlights the inner working models of self and the goal-corrected relationship between mother and child. In addition, this internal working model is believed to direct memory, cognition and attention about relationships (Weber, 2003). Attachment includes an overall pattern of relating between an infant and caregiver, including the depth of pleasure and range of feelings experienced in the relationship. Relationships in general are considered to be critical for the development of emotionality. Emotionality is the ability to have and to feel emotions. It is believed an individual’s organization of emotional strategies is rooted in the child’s history of repeated experiences of affective encounters with the caregiver. (Ainsworth M. S., 1989; Konchanska, 2001).

Adler believed that social interest is innate and that the child-parent relationship is vital to its development. Through this relationship the mother models and develops a sense of caring, closeness, and cooperation in the child. Adler (1992) maintained that all of life’s major problems require social interest and cooperation for their solution. Adler considered that people had three major life tasks: work, love and friendship. Social interest, by involving the capacity and willingness to cooperate with others and reducing the feelings of hostility, threat, and jealousy, should facilitate productive coping with these tasks and minimize unnecessary forms of stress.

There are four different types of attachment that a child can develop. These attachment types are called labeled as secure, insecure-avoidant, insecure-anxious/ambivalent/resistant, and insecure-disorganized. Secure attachments are the most optimal and manifest in a child having an inner working model of self that is confident and competent. The key element necessary for secure attachment is sensitive and responsive caregiving. Securely attached children tend to have better emotional adaptability, social skills, and cognitive functioning. On a behavioral level a child in a secure attachment has been trained into particular patterns of reciprocity and affective
sharing, as well as having evolved a sense of curiosity and a skill in exploration. The child has generally positive and trusting attitudes towards others. Along with this the child takes with them a sense of his or her own effectiveness and personal worth. A child having a secure attachment feels effective in eliciting responsiveness and care from a parent. They take on challenges and expect to master them. A person with secure attachment believes in him or herself and their power in the world. They value relating and have an internalized template for empathy and reciprocity in relationships.

All of the attributes found in children with a secure attachment are also found in people that have a high level of social interest. A person’s level of social interest is said to effect feelings of empathy and sympathy, as well as behaviors derived from motives such as cooperation, helping, sharing, and contributing. Attachment and social interest intersect at this juncture of manifesting in persons who value not only themselves, but society at large and they feel confident of their place and contribution to society.

Insecure-avoidant children are those that first look at the parent and then abruptly turn away or may appear indifferent to the parent’s presence. This pattern is characterized by failing to seek contact with a caregiver even under stressful conditions. These infants have learned to cut off emotional responses especially when tender needs are aroused. These children are at heightened risk for developing anxiety disorders as well as the tendency towards dissociation. These children have not learned a positive sense of worthiness in a relationship. Because of this they find it threatening to give towards others and therefore lack a necessary level of social interest.

Several of these same qualities follow a child with an insecure-anxious child. Their outlook for positive mental health is similar to that of a child with an avoidant attachment. The difference here is that these children are generally angry and more negative emotionality is
present. Because of this it makes it difficult for this child to maintain relationships and find work and school environments difficult.

The insecure-disorganized child has the hardest time in life regarding not only feeling comfortable with themselves but also relating to others. These children have grown up in an atmosphere that is frightening, the parent may have been overtly hostile to the child or the adult was frightened of the child. Either situation causes a child to be on edge and not comfortable with him or herself. Children with insecure-disorganized attachment style can show a range of behaviors such as: entering a trance like state when distressed, moving away from the parent when distressed, or showing an odd combination of behaviors that do not serve a clear goal. Because of this these children grow up without social interest because others are frightening and they need to protect themselves. It is the child with a insecure-disorganized attachment pattern that is at most risk for future psychopathology.

There are many benefits to persons having a secure attachment relationship and in turn a high level of social interest. Persons that feel good about themselves, have a positive self-concept have within them the capacity to reach out to others and think about the welfare of the larger group. This in turn manifests itself in relationships that are satisfying and bring a sense of fulfillment. People with high levels of social interest that developed secure early attachments are shown to have fewer problems with both internalizing and externalizing behaviors.

Attachment is the foundation upon which social interest can develop. Attachment and social interest parallel each other in very obvious ways. Attachment and social interest both contribute to a positive self concept and therefore a desire to help others. Both concepts lead to more positive mental health and less pathology in later life, this is due to the fact that people with secure attachment and high social interest make good friends and have the ability to get
along in the work place and other social settings. People with a secure attachment style are confident in themselves and therefore do not feel it risky to reach out to others.

Adler stated that when we speak of virtue, we speak of participation in the game of life however when we speak of vice we are referring to the idea that one disturbs cooperation. He referred to this lack of cooperation as a person that is troubled, neurotic and criminal in their actions. Cooperation is a key component here. A mother and child need to cooperate in the very first of relationships for the child to be able to move on from that relationship and build cooperative relationships with others in society.

There are several interventions that work well to either build or repair attachment systems. It is essential to look at the individual dyad, as it concerns parents and children, to determine which intervention will work most ideally. The interventions of Individual Psychology work well with people where attachment patterns have already been determined. This type of therapy can get to the root of a person’s attachment issues and help that person to build a new “private logic”. This new private logic will then be the foundation for creating a level of social interest.
Bibliography


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Definitions

Attunement – The ability of the infant parent dyad to respond to and reinforce each other contingently.

Mental Representation – the attribution of meaning given to an event, feeling or action.

Motherhood constellation – The mother’s relationship with her own mother during the mother’s attachment period.

Intersubjectivity – emphasizes that shared cognition and consensus is essential in the shaping of our ideas and relations. This is the bedrock of the intimate connection between attachment and self-regulation. Beginning in the 7 – 9 month range infants can begin to understand that their own thoughts and feelings can be shared and that they understand the thoughts and feelings of others.

Social biofeedback – empathic emotion wherein the mother’s emotional state is yoked the infant’s emotional state. This in turn helps the infant learn and recognize their own emotions.

Goodness of fit – the interplay between the mother’s temperament and the child’s temperament.

Proximity seeking – the child will attempt to remain within protective range of his parents. This protective range is reduced in strange or threatening circumstances.

Secure base effect – the presence of an attachment figure fosters security in a child. This results in inattention to attachment considerations and in confident exploration and play.

Separation protest-Threat to the continued accessibility of the caregiver gives rise to protest and to active attempts to ward off the separation.