It’s Never Too Late to Have a Happy Childhood

Attachment and Alzheimer’s: An Adlerian Perspective

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Abstract

A happy, secure attachment to a happy, secure caregiver in childhood may help the person with Alzheimer’s disease navigate the unfamiliar territory that is their everyday reality. As people age and their children become adults, there is often a reversal of roles, where the parent becomes the child, and the child becomes the parent. And though these caregiving roles are exchanged, there are similarities that stand out and parallel each other, even if one of the caregivers has dementia.

In this paper I will look at the model of attachment and how it may serve in caring for and understanding the subjective reality of a person with Alzheimer’s disease. Within the Adlerian framework there are many concepts that are compatible with attachment theory. Both Adlerian and attachment constructs can guide caregivers to a better understanding of this terrifying, yet common disease. Likewise, the person with Alzheimer’s disease may experience their reality as less frightening and more secure with a caregiver that is informed from both of these theories.
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Attachment and Dementia: An Adlerian Perspective

The most common cause of dementia, which accounts for an estimated 60% to 80% of cases, involves Alzheimer’s pathology. This slowly progressing brain disease has characteristics such as apathy, depression, and difficulty remembering recent names, events, or conversations in the early stages. These symptoms may begin well before the later symptoms emerge. Behavior changes, disorientation, confusion, poor judgment, and impaired communication, are all common in the later stages of this disease. The synapses in the brain that connect neurons to other neurons, creating the circuit that provides the cellular base of memories, begin to fail and the number of synapses decline; neurons eventually die and cause widespread debris in the brain. The devastation within the brain’s cortex robs a person of thinking, planning, and memory; nerve cell damage and tissue loss spreads throughout the brain and affects nearly all of its functions. The mean duration of survival after diagnosis is approximately 10 years, although some individuals can live with the disease for as long as 20 years. Ultimately the person with Alzheimer’s disease commonly die forgetting how to swallow and how to breathe.

As the US population age 65 and older continues to increase, the number of people with Alzheimer’s disease will escalate. At this time, one in nine people age 65 and older have this devastating disorder. A total of 5.3 million Americans are part of the social, economic and caregiving burden that continues to grow with each wave of aging Baby Boomers. People with Alzheimer’s need complete supervision, protection, and care. Given the severity of this disease, it is incumbent on caregivers to find ways that best alleviate the Alzheimer’s sufferer’s most distressing symptoms (Alzheimer’s Association, 2015).
Cognitive Domains

According to the DSM-V (American Psychiatric Association, 2013), the core features of this neurocognitive disorder include an insidious onset and gradual progression of cognitive and behavioral symptoms.

The typical presentation is amnestic, with impairment of memory and learning, sometimes accompanied by deficits in executive functioning. Social cognitive or social functioning tends to be preserved until late in the course of the disease as well as procedural memory such as playing a musical instrument. (p. 442)

The following list is a collection of six cognitive domains that illuminate the deficits so apparent with this disease as well as explanations of each. They include:

- Complex attention
- Executive function
- Learning and memory
- Expressive and receptive language
- Preceptual motor
- Social cognition

Within the Table of Neurocognitive Domains, the domain of complex attention would be apparent when the person diagnosed has difficulty holding new information in mind and is unable to attend to an environment with multiple stimuli unless input is restricted and simplified. All cognition takes longer than what is usual for a premorbid condition, and components to the process must be simplified to one or a few thinking activities. In addition, the person is unable to perform mental calculations.
Executive function, which includes planning, decision-making, working memory, response to feedback, inhibition, and mental flexibility would be seen as a person abandoning complex projects, and the need to rely on others to plan activities of daily living, to make decisions.

The domain of learning and memory, including immediate memory, recent memory, cued recall, and recognition memory, is observed in the person with an Alzheimer’s diagnoses as a tendency to repeat parts of a conversation, often within the span of the same ongoing conversation. The diagnosed person needs frequent reminders to orient to a task at hand. Recent memory is the process of encoding new information. The DSM-5 notes that semantic, autobiographical, and implicit memory are relatively preserved, compared with recent memory, except in the severe last stages of the disease (DSM-5, American Psychiatric Association, 2013).

The paucity of language used, in both its expressive and receptive aspects, is another indicator in the neurocognitive domain of Alzheimer’s symptoms. Idiosyncratic word usage, grammatical errors, spontaneity of output and economy of utterances commonly occur. The person with this disease prefers general pronouns rather than names, and may not remember the names even of close friends and family.

The domain of pre-ceptual-motor includes abilities subsumed under the umbrella of visual perception, visual-constructional, pre-ceptual-motor, praxis, and gnosis. The diagnosed person has significant difficulties with previously familiar activities. These often include navigating unfamiliar environments, as well as environments where shadows and lower levels of light may change perceptions.

Social cognition, which may include a person’s recognition of emotions and their “Theory of Mind,” (an inability to reflect upon the contents of their own mind), shows behavior
that is clearly out of the acceptable social range, including decision-making, (without regard to safety), and their behavioral intentions, (without regard to the effect upon family and friends). Typically the diagnosed person has little insight into how they have changed. Behavior and attitude changes, such as having less ability to recognize social cues or read facial expressions are common, as well as having decreased empathy, increased extroversion or introversion, decreased inhibition, subtle or episodic apathy and restlessness (American Psychiatric Association, 2013, p. 444).

The person with Alzheimer’s disease has deficits in domains that encompass every aspect of life; these deficits seem as frightening as they are extensive. There are many approaches identifying the most successful way to care for a person with this type of dementia. Because this disease slowly impairs and erodes memory, (which is often viewed as the immense stored library of information about an individual’s learning, experiences, and totality of past), there are beneficial ways to help with the loss of memory function. A relevant theory to help us to understand the emotional meanings behind the behavior of a person with Alzheimer’s disease was developed while studying the behavior of infants and their caregivers.

**Attachment Theory**

John Bowlby, the originator of attachment theory, posited that a central aspect of normal development is the bond between infants and caregivers. The bond of attachment’s principal role, he discovered, is to provide security and protection. The attachment figure is the adult who functions as a secure base from which the child can explore the world, as well as retreat into in times of distress (Bowlby, 1969, 1979). Once the infant has developed an attachment to a caregiver, which usually happens within the first nine months of life, the infant then develops a pattern of behaviors that ensure the caregiver stays within a close proximity to the infant.
Because the infant’s survival is compromised by complete helplessness, as well as the imminent danger from the environment, Bowlby theorized that through the infant’s innate behavioral control systems, the goal of attachment is survival. The system of behaviors that is coordinated to achieve that goal is the foundation of attachment theory. Bowlby maintained that internal cues, external cues, or stimuli associated with situations that the infant perceives as frightening, dangerous, or stressful, will activate the attachment system. Therefore the infant expresses patterns of behavior for securing the caregiver’s attention and availability. According to Simpson (1999), the main reason that attachment theory is so prominent in contemporary and behavioral sciences, is because of its ties to the principles of evolution.

The evolutionary stages Bowlby recognized may be organized into three categories. The first is behaviors that occur immediately after separation of the infant and the caregiver, when infants often feel most vulnerable, and commonly include protests, crying, screaming and throwing tantrums. This stage is a successful strategy to promote survival, as infants may be vulnerable to injury or predation if left unattended. Loud protestations alert the caregiver to return. The second stage is despair, which happens when the protests fail to retrieve the caregiver. This strategy of despair also promotes survival; if protests fail, excessive noise or movement might result in an accident or injury, or draw predators to the infant. The third and final stage is detachment, where the infant resumes normal activity in the absence of the caregiver. This function, Bowlby hypothesized, is also a way to relinquish a caregiver’s attachment and form new attachments with other caregivers who might better provide safety and security. Bowlby believed that the attachment system is profoundly ingrained in human nature. Because our ancestors lived in a hostile environment, they needed to solve the problem of surviving through infancy. The stages that characterize attachment are the cognitive, emotional,
and behavioral reactions that increase the chances of survival. These evolutionary stages were adapted to insure survival of humankind (Simpson, 1999).

Bowlby also recognized that emotions play an exceedingly important organizing role in secure base relationships; although the actual goal of the behavior can vary according to context and age, emotions remain the same across the lifespan (Bowlby, 1969, 1988). According to Hinde (1982), “Rather than being indicative of regression, Bowlby’s systems are set to perform natural, healthy functions, even in adult life” (p. 61). Therefore, along with evolutionary, biological and developmental functions, attachment also becomes the foundation for warm and close relationships.

Research has become more prevalent during the last two decades. Although attachment theory has much empirical evidence, it has focused mostly on infants and children (Cassidy & Shaver, 2008). Bowlby contended that attachment is a process that continues “from the cradle to the grave” (1988, p. 209). Studies on attachment that focus on adult romantic relationships suggest that these relationships function in ways that are similar to the infant-caregiver relationship (Fraley & Shaver, 2000). Attachment researchers might imply that stability in attachment style may be the rule rather than exception, but Fraley found two models of continuity that make different predictions about long-term continuity, even though they were derived from the same theoretical principles. One model assumes that the differences in attachment are shaped by variation in experiences with caregivers in early childhood and that these early representation shape the quality of the individuals subsequent attachment experiences (Bretherton, 1992). These can be characterized as prototypes. However, according to Bretherton, some models assume that existing representations are “updated and revised in light of new experiences ways that overwrite the older representations” (p. 759).
Bowlby suggested that change is possible in adult life. He hypothesized that children construct a model of the world through ongoing and repeated interactions with their caregivers. This model of the world can be seen as a guide to behavior as well as an appraisal system. The development of formal operational thought along with the development of the child’s powerful relationship with the caregiver, can initiate change. The development of mental representations provide a method through which the child’s subjective view and experience (rather than the objective features of experience), influence development and behavior, allowing the child to interpret and reflect on past and present experiences (Crowell & Treboux, 1995). When infants - whom Bowlby saw as competent, curious, and fully engaged with the environment – utilize their control systems, they construct mental representations of their own secure base of attachment. He then proposed that “the infant gradually develops internal representations of whether the self is worthy of care and attention (or not), and whether others are trustworthy and available (or not), based on caregiving experiences” (Connors, 2011, p. 352). This working model is directly built on the early caregiver experience of the child. As children grow, (in addition to their cognitive growth), the model includes how relationships are formed, kept, or dismantled. Both consistency and change are seen in attachment style over time, but data suggesting that attachment security promotes relational competence are especially strong (Connors, 2011).

**The Strange Situation**

The nature of relationships is understood as a key part of attachment, (as well as survival and protection). Mary Ainsworth, John Bowlby’s colleague and a key figure in the development of attachment theory, was interested in the concept of a secure base, and how it can impact the emotional, intellectual, social development of an individual. She created the “Strange Situation”
study in 1963. The study provides an understanding of the processes of infants in response to both stressful and unfamiliar situations, as well as separation from their primary caregivers (Ainsworth, Blehar, Waters, & Wall, 1978). Infants were observed playing in a play room while both their caregivers and strangers entered and left the room. The infant’s reaction to the departure and return of their caregivers, as well as the degree of exploration and play, were studied.

The behavior patterns of infants with a secure base of attachment, (Ainsworth’s first category), showed them to be visibly upset when their caregiver left, but they were also able to explore and engage with strangers until their own caregiver returned. The infant-caregiver reunion was consistently observed to be a joyful and delightful experience. Sensitivity, acceptance and availability are all traits of caregivers that lead to a secure attachment for children. Broadly speaking, securely attached children, who have grown into adulthood, do not worry about being abandoned or mistrust others (Ainsworth et al., 1978).

Ainsworth found that infants in her second category, “Insecure-Avoidant” attachment, independently explored when their caregivers were present, but refused to use their caregivers as a secure base to return to. They did not seek proximity to their caregiver and when offered a choice, showed no preference between their caregiver and a complete stranger. The caregiver in this case was insensitive and rejecting, with an aversion to warmth. Insecure-avoidant children as adults are typically detached and mistrustful.

Infants in her third category of attachment, called “Insecure-Ambivalent,” responded with either anger or passivity to their caregivers. They were afraid of both exploration, and of strangers, and were ambivalent when the caregivers returned. The caregivers of these children had chaotic, inconsistent, and unpredictable behavior. As adults, insecure-ambivalently attached
individuals dreaded abandonment. Furthermore, they were observed to be unable to see their own part in relationship difficulties with others (Ainsworth, 1989).

These three categories of attachment are instrumental in understanding and treating individuals with problematic relationships. We can see that people with insecure-avoidant and the insecure-ambivalent attachment styles have problematic models for effectively interacting with others. Ainsworth (1989) suggested that the function of the attachment behavior system in an adult facilitated competence outside of the relationship. The individual with a secure attachment is able to move off the secure base, provided by a partner, and engage in activities with confidence. Although the behaviors of infants may be easily measured through observation, how might adult attachment be measured?

The Adult Attachment Interview (AAI), (George, Kaplan, & Main, 1996) is often used as a tool to capture a general representation of attachment. Scoring is based on descriptions of childhood experiences, the language used in the interview and the ability to give a believable account of those experiences. Scoring was developed using interviews of parents and research provided from the strange situation (Ainsworth et al., 1978). Scoring also utilizes access to memory as part of the scoring system. Individuals may be classified as “Secure/Autonomous,” “Insecure/Dismissing,” or “Insecure/Preoccupied.” Stability has been demonstrated in a number of studies and discriminant validity of the AAI has been demonstrated with respect to intelligence, memory, cognitive complexity, social desirability and overall social adjustment (Bakermans-Kranenburg & van IJzendoorn, 1993).

The adult attachment styles parallel the infant attachment styles with some exceptions in terminology. Secure infants are referred to as secure or autonomous adults. Secure adults were cohesive and succinct and their answers on the AAI. Insecure/disorganized (or ambivalent)
infants are referred to as insecure/disorganized. Unresolved adults, (those with insecure/disorganized attachment) had interviews that showed confusion and preoccupation with attachment figures (Hesse, 1999). Anxious/avoidant infants are referred to as insecure-dismissing adults. Those adults minimize attachment related experiences and their responses are often contradictory (Shilkret, 2005).

Another observational assessment method that measures attachment was developed by Peter Fonagy and Mary Target in 1997. Their assessment, using the AAI questions, is analyzed from the perspective of the reflective function, which involves assessing the adults’ ability to reflect on their own inner experience, and at the same time reflect on the mind of others (Fonagy & Target, 1997). As noted previously, theory of mind is the capacity to reflect upon mental states in oneself, as well as in others. It is included as a key determinant of self-organization in the domain of social cognition (DSM-V, American Psychiatric Association, 2013).

Attachment can be measured and observed from the perspective of an infant or of an adult. Research demonstrates significant intergenerational transmission with a high correlation between attachment patterns of parents and their children, independent of the temperament of the infant (Main, 1995). Therefore we see how caregivers, such as adult children, typically have the same attachment pattern as their older parent. Additionally, caregivers that were not related to the recipients of care will typically have the same attachment pattern as their own parents. This is important because the attachment style of unrelated caregivers will be providing care from the template of their own innate attachment style as they provide care for persons with Alzheimer’s disease. The activation of the caregiver’s attachment model acts in a reciprocal manner, as both the caregiver and the infant, (or the person cared for), rely on cues from each other:

Korbak and Madsen (2008), proposed that if the internal or external cues associated with
situations that a child perceives as dangerous, frightening, or stressful activate their attachment system, it would follow that internal or external cues associated with situations that a caregiver perceives as dangerous, frightening, or stressful for their child, activate the caregiving system as well. Since the emotional availability of the caregiver makes the secure bond of attachment possible, a securely attached child will explore, express, and trust their environment and others.

Bowlby assumed that the caregiving system is reciprocal within the attachment system, in that the infant and the caregiver interact with each other. The infant’s attachment system functions to survive; the caregiver’s attachment system functions to protect. Once the caregiver’s attachment system is activated, the repertoire of behaviors they can call upon include following, signaling the child to follow, calling, looking, maintaining proximity, caring, and retrieval. The child’s attachment system is deactivated by the proximity and/or psychological or physical contact with the attachment figure when the caregiver response to the child’s need sufficiently. The caregivers system should be deactivated by psychological or physical proximity and signs that the child was comforted or satisfied. Bowlby suggested that just as attachment is linked with and regulated by strong feelings such as joy or anger in response to whether or not the caregiver is within proximity of the child, caregiving also is associated with an regulated by strong emotions (Solomon & George, 1999).

According to Howe (2011), the caregiver must evaluate the child’s behavior, their proximity, and also the environment, to be able to assess the child’s need for safety and protection. The caregiver’s behavior must also “organize the environment to establish neural controls that monitor a wide range of internal and external information in order organize their behavior into purposeful patterns” (p. 7). And although physical nearness is significant, Stroufe
and Waters (1977) also suggest that the “goal of attachment seeking is “felt security” and the maintenance of the attachment figure’s accessibility and responsiveness” (p. 1190).

Bowlby viewed the attachment system as a lasting psychological connectedness between human beings. He also considered the interaction between the caregiver and the infant as a two-way process (1969). Through Bowlby’s and Ainsworth’s discoveries, we have a better picture of caregiver attachment styles and how they can shift from the caregiver’s perspective to the perspective of the person in need of care, as well as how these processes may be measured.

**Adult Children and Aging Parents**

According to Krause and Haverkamp (1996), relationships between children and parents continue to be important throughout life. Although advances in modern medicine increase the lifespan of older people, new stressors to parent-child relationships are created when change affects the lives of parents. Illness, widowhood, divorce or financial worries of the parent may affect the adult child in adverse ways. Adults who care for elderly parents commonly report stress-related symptoms such as depression, anxiety, and feelings of fatigue (Alzheimer’s Association, 2015).

The adult child and the older parent will be influenced by the life stages experienced by each, and each are experiencing different tasks and transitions, developmentally (Erikson, 1950). Erikson describes the middle-aged psychosocial crisis as one of intimacy versus isolation, (establishing intimate relationships with family and friends versus living in isolation from intimate contact), and generativity versus stagnation, (leaving value to the next generation versus becoming preoccupied with self and personal goals). For older parents this stage of crisis is one of integrity versus despair, concentrating on one’s inner life and past accomplishments versus emphasis on past failures and fear of death (Erikson, 1950). As the older parent is experiencing
changes in health, decreased physical strength and declining functional capacity, the adult child generally is experiencing the first biological signs of aging, as well as their own financial, household and family obligations. Bowlby emphasized that attachment behavior is especially evident in times of ill health (Bowlby, 1969, 1979). These sets of circumstances become more likely and more frequent with aging (Browne & Schlosberg, 2006).

The protective function of attachment during these times can serve both caregiver and the care recipient. Seeing the adult child and aging parent dyad through the attachment lens is enlightening, because the parent-child relationship is one that denotes a high degree of bonding across the entire lifestyle (Hagestad, 1984). The concept of internal working models, as demonstrated through Ainsworth’s strange situation, illustrates beliefs and expectations about whether the caregiver is trustworthy, or the recipient of caregiving’s self is worthy of care (Ainsworth, 1989). As previously noted, this model was developed in infancy. Parents who continue to provide a secure base for the child, well into that child’s adult life, may expect their adult child caregiver to help them, based on the child reciprocally protecting and caring for the parent (Cicirelli, 1983).

The degree of continuity between early experiences of the adult child and the current state of the adult child-aging parent relationship is supported by the perspective of attachment theory (Krause & Haverkamp, 1996). According to Main (1995), securely attached adults report their parents were warm and not rejecting. Adults with anxious-attachment styles report their parents were inconsistent and individuals with avoidant-attachment styles report that their parents were disinterested and rejecting during times of stress. Attachment styles seem to become more visible when historical roles of caregiving are reversed. Therefore, knowledge of attachment theory may be helpful to both adult children and aging parents in times of increased
stress. Adult children and aging parent dyads with secure attachments can expect support from each other, even as they experience the frustrations of navigating their individual life stages. Aging parents with insecure working models may experience more uncertainty, and expect less support from their adult children, as insecure models activate attachment behaviors that rely on the patterns that they have come to expect from close relationships.

Like a parent protecting their child, caregiver behavior is informed by attachment theory, through the assumption that the attached figure needs protection. Reasons for helping elderly parents are more likely based on protecting the parents rather than on feelings of duty (Cicirelli, 1991).

Attachment bonds later in life may act as a protective function. Cicirelli (1991) posited: A mechanism of symbolic attachment emerges later in life in order to help maintain attachment with parents under conditions of separation and over long periods of time. In symbolic attachment the older individual creates a representation of the attachment figure, which enables them to feel feelings of psychological closeness and security. (Cicirelli, p. 30)

Antonucci (1994), furthers the idea of adult attachment by stating, “The increasing number of attachment relationships acquired by adults over time constitutes a convoy that accompanies each person throughout life, offering the protection and security needed to confront life’s challenges” (p. 260). The well-being and sense of self in an individual are contingent upon the attachment bond throughout a lifetime of relationships. The salience of a parental secure base for adult children can be noted even when parents are no longer living. “Attachment processes are manifested in overt behavior: they reflect the operation of internalized representations of self and other that are both reality reflecting and reality creating” (Bretherton
& Munholland, 1999, p. 107). When a person is diagnosed with Alzheimer’s disease, the reality that they reflect and the reality that they create can seem significantly different than the reality that is reflected and created by the caregiver. These vast differences occur due to the deterioration of the stored library of the past, both, internal and external, of the diagnosed person. An individual needs their stored library to retrieve memories of protection and security to serve them in life’s challenging events. What happens to attachment bonds when memory disappears?

**Attachment and Alzheimer’s**

Current scientific evidence suggests that in preclinical Alzheimer’s disease, key biological changes are already underway in the body, but the disease has not yet caused any noticeable clinical symptoms. Research suggests that brain changes caused by this disease may begin years or even decades before symptoms such as memory loss and confusion occur. As Alzheimer’s advances through the brain, it leads to increasingly severe symptoms (Alzheimer’s Association, 2015). The three stage Alzheimer’s disease model includes: Stage 1-Mild/Early (lasting 2-4 years), Stage 2-Moderate/Middle (lasting 2-10 years), and Stage 3-Severe/Late (lasting 1-3 years). The symptoms in Stage 1 include:

- Frequent occurrences of short term memory loss
- Repeating questions
- Problems expressing and understanding language
- Difficulties with physical coordination
- Apathy, mood swings and depression
- Difficulty with driving
- Difficulty performing daily activities.
Stage 2 has symptoms that include:

- Pervasive and persistent memory loss
- Inability to recognize friends and family
- Rambling speech
- Unusual reasoning
- Confusion about current events, time, and place
- Becoming physically lost in familiar settings
- Sleep disturbances
- Changes in mood and behavior, which and can be aggravated by stress and change
- Delusions, aggression, and uninhibited behavior
- Mobility and coordination affected by slowness, rigidity, and tremors
- Assistance with the activities of daily living is required

In Stage 3, (the most severe), symptoms are:

- Confusion about past and present
- Loss of ability to remember, communicate, or process information
- General incapacitation with severe to total loss of verbal skills
- Inability to care for self
- Problems with the mobility, swallowing, incontinence and illness
- Extreme problems with mood, behavior, hallucinations, and delirium (Alzheimer’s Association, 2015)

When reading this list of symptoms, it is not hard to believe that studies show that the fear of getting Alzheimer’s disease has now surpassed the fear of getting cancer, and is now the number one fear Americans over 55 years of age (Alzheimer’s Association Care Resource
Center, 2015). The most fearful theme running through all of the symptoms seems to be the loss of memory, and with it, the loss of the self. For many, this may be even more terrifying than “death anxiety” - the dying person’s apprehension generated by death awareness (Abdel-Khalek, 2005). The dying person’s cognition may not be impacted and therefore they have access to their memories of themselves, and can comprehend the self that is leaving.

According to Kitwood (1997a), attachment theory is a person-centric model that addresses the subjective experience of the person diagnosed with Alzheimer’s. Implications for understanding the subjective experience of Alzheimer’s disease are enormous. Through attachment theory, (which is rooted in evolution), we understand that the emotions behind the behavior communicate and explain the diagnosed person’s reality.

We have previously seen how attachment behavior is activated under times of stress and in unfamiliar situations. The themes central to attachment theory are the separation from attachment figures, the experience of loss, and the feeling of insecurity. These themes are also central to the processes in the person with Alzheimer’s disease (Browne and Schlosberg, 2005).

In 1993, Bere Miesen conducted a study in an attempt to explore attachment behavior and the level of cognitive functioning. In particular, Miesen was interested in a phenomenon called “Parent Fixation” which is the fervent belief that one or both parents are alive, when in fact they may have been dead for some time (Browne & Schlosberg, 2005). This fixation frequently occurs with many diagnosed people. They search for their parents, talk to them, call out for them, and beg to be allowed to return to their parents or to their parent’s home. Miesen wanted to find out whether or not this phenomenon was an expression of their need to feel safe and secure. The study was conducted in the Netherlands, in a psychogeriatric nursing home, which was an unfamiliar setting for most of the study participants. Initially, Meissen had 40 diagnosed persons
at the nursing home assessed according to their level of cognitive functioning. He then assessed their attachment behavior by using the Ward Attachment Observation Questionnaire (WAOQ) and the Standard Visiting Procedure (SVP). The WAOQ, a questionnaire that consists of 60 items on a three point scale, was completed by two staff caregivers in this facility, independently of each other. The SVP, created by Miesen, can be considered a parallel experiment to Ainsworth’s strange situation study (Ainsworth et al., 1978). The SVP manipulates a potential threat and activates feelings of insecurity by placing the diagnosed individual within five distinctive stages.

In stage one, the patient is together with a stranger, which means that the patient must habituate to a strange person and also to a new environment. This situation is comparable with the daily experiences in a ward of a psychogeriatric nursing facility. In stage two, the family member meets the patient. It is an unexpected visit for the patient. Families mostly pay unannounced visits so this is a frequent occurrence on the ward. In this stage, the family member possibly represents the familiar person in the midst of a relatively strange, more or less threatening environment. The second stage is referred to as the ‘sudden arrival’ of the family member. Stage three is a critical one. After the patient and the family member have been together, the family member indicates, by talking or gesturing, that she or he must leave, and suddenly ends the visit. This moment can be a potentially threatening moment for the patient. On the psychogeriatric ward, many families or family members end visits in this way. This third stage is referred to as the sudden departure of the family member. In the fourth stage, the patient is again together with the stranger of stage one, but now it is immediately after the potentially stressful event in the preceding stage. Stage five is the same as stage two. But the potential
emotional upheaval caused by the family member’s sudden departure precedes the second meeting of the patient with the family member (Miesen, 1993).

Miesen found that the following attachment behaviors of patients with dementia are measured in the second and third stages of the SVP by the patient expressing the following behaviors:

- crying
- touching himself or herself
- turning to stranger
- looking after
- running after
- calling after

Based on the clinical observation of families and their loved ones, the SVP manipulated potential threats and activated insecurity. It also advanced the exploration of possible attachment behavior under different conditions.

Miesen (1993) asserts that the WROQ scores obtained by facility caregivers showed that attachment behavior during family visits and at bedtime is paired with less parent fixation. Patients who had a high level of cognitive functioning showed more attachment behavior during family visits and at bedtime than patients who had lower levels of cognitive functioning. Miesen’s results indicate that parent fixation occurs in two-thirds of patients with Alzheimer’s disease and that this phenomenon is strongly related to their levels of cognitive functioning. His study’s results also indicate a strong correlation between the level of cognitive functioning and attachment behavior during family visits. These results are based mainly on statistically significant differences between the groups. An important feature disappears in an analysis of this
type, namely the individual differences within the groups. Individual data showed that parent fixation indeed occurs in diagnosed patients with a ‘high’ level of cognitive functioning (Miesen, 1993).

People with higher levels of cognitive functioning were found to have more overt attachment behavior, (such as ‘touching’, which depends on whether family members are arriving or leaving), than people with lower levels of cognitive functioning. In contrast, parent fixation occurred more frequently in people with lower levels of cognitive functioning than those with higher cognitive functioning. In the early stages of dementia, overt behaviors such as calling out for a parent can be used to seek reassurance. But as orientation to the outside world decreases, overt behaviors may become less useful in finding safety or security in a strange and unfamiliar environment; because of lower cognitive functioning, the ability to self-initiate these behaviors may be diminished (Miesen, 1993). Miesen thus theorized that the “experience of dementia erodes the feeling of safety and security and activates attachment behaviors” (p. 151).

Additionally, Miesen concluded that Alzheimer’s disease can, in itself, be considered a strange situation which activates attachment behavior. The parent fixation was found to have different meanings according to the different stages of this disease, and also can be explained as a form of attachment behavior. He connected the idea that the parents or caregivers in Bowlby’s attachment theory are viewed as one and the same and understood as attachment figures for patients with Alzheimer’s disease; He suggested that if the link with the outside world disappears, especially through memory dysfunction, the patient will search for a kind of anchorage in this dangerous situation. Memory dysfunction erodes the feeling of safety because durable affective bonds are not possible. The patient with Alzheimer’s disease is caught in a set
of circumstances that can be compared to a bereavement process; this bereavement process, however, can never be resolved, and a vicious cycle begins.

The patient’s needs for safety that have arisen from this loss can never be fulfilled. According to Miesen, in the later stages of Alzheimer’s disease, the ‘strange situation’ becomes permanent. “Parent fixation in itself has now become attachment behaviour which reciprocates the need for safety from within the person himself” (1993, p. 151).

Miesen and Jones (1997) acknowledge that memory and attachment are both central to behavior found in diagnosed persons. They found that re-stimulated past memories of an attachment figure from early life becomes an important part of the lives of people with dementia, and that thinking about parents may help the person hold onto a sense of safety and emotional security.

Does the attachment style of a person with Alzheimer’s disease have any effect on their parent fixation? Researchers Browne and Schlosberg (2005) sought to further Miesen’s work on attachment and parent fixation by replicating his study using updated measures with a larger sample of participants. And since Miesen did not address whether attachment behavior and parent fixation were influenced by a pre-morbid attachment style, Browne and Schlosberg examined both pre-morbid attachment styles and cognitive functioning in their study’s participants (2005).

A sample of 53 participants, living in 21 different residential nursing homes, was used. After measuring cognitive impairment, Browne and Schlosberg (2005) used the “Attachment Style Questionnaire” (ASQ), a single term measurement numbers that was designed by translating established infant attachment styles into terms that were appropriate to adult attachment bonds. Through its previous use, this questionnaire, developed by Hazen and Shaver
in 1990, has validated the use of caregiver reports of premorbid assessments as well as the validity of informant evaluations of attachment style (Banai, Weller, & Mikulciner, 1998). A third measurement, previously described, was the WAOQ (Miesen, 1993), and finally, an updated version Miesen’s original test in 1993, which rated parent fixation, mother fixation and father fixation as being present, absent or fluctuating, depending upon the participant’s responses in the interview. Participants were asked questions such as, ‘Please tell me something about your parents’, ‘Do you think about your mother/father often?’, and ’Do I understand correctly that your parents are deceased?’

From this group of participants, Browne and Schlosberg (2005) discovered that 72% had a secure attachment style and 26% had an avoidant attachment style. Only one participant rated an anxious-ambivalent attachment style, and that participant’s data was dismissed for this study. 54% of the participants consistently exhibited parent fixation. 42% were consistently aware that their parents had died. 4% had a fluctuating fixation; further analyses for the 4% were dropped. Browne and Schlosberg noted the presence of mother fixation (54%) was more common than father fixation (44%) among the participants. This study indicated that fixation occurred significantly more often among participants with severe levels of cognitive impairment than in those with less severe levels of cognitive impairment. This is consistent with the result of Miesen’s 1993 study. Browne and Schlosberg found that higher levels of cognitive functioning were significantly associated with increased attachment behavior at bedtime. Conversely, lower levels of cognitive functioning were significantly associated with increased attachment behavior at mealtime. They found no significant associations between cognitive functioning and attachment behavior during visiting, morning routine, or in general. Participants with a pre-morbid avoidant attachment style were just as likely as patients with a secure attachment style to
show parent fixation. Patients with a premorbid avoidant attachment style, however, had more attachment behavior in general than patients with secure attachment style (Browne & Schlosberg, 2005).

This study determined that more than half of the participants showed a consistent belief that one or both of their parents were still alive, and, as in Miesen’s study, parent fixation was more prevalent among participants with lower cognitive functioning. The study showed more mother fixation than father fixation. Attachment theory suggests that attachments to parents or other caregivers remain consistent throughout adult life (Ainsworth & Bowlby, 1991). And since it is likely that the mother would have been the primary caretaker for most of the participants in this study, believing she was alive and appealing to her presence may provide more emotional security than that gained by a father attachment figure. According to Browne and Schlosberg (2005), the higher prevalence of mother fixation offers indirect support to Miesen’s hypothesis that “thinking about parents as if they were still alive serves the function of providing feelings of emotional security” (p. 8).

Browne and Schlosberg (2005) hypothesized that participants with an avoidant attachment style would have significantly less overt behavior than participants with a secure attachment style, due to the reluctance of individuals with an avoidant style to display attachment feelings or needs. And, due to their tendency to remain emotionally distant, these participants might also find that invoking the presence of their parents would not be comforting. Although the avoidant-attached participants in their study were just as likely to believe their parents were alive as the securely-attached participants, the avoidant attached participants actually manifested more overt attachment behavior styles in general then securely-attached participants.

According to Brown and Schlosberg, the increased attachment behavior of the avoidant
participants was a reflection of the wider insecure-secure distinction between the two groups. Since individuals with avoidant-attachment style tend to have more fears about abandonment and rejection than securely-attached individuals, they may defend against their insecurities by adopting a strategy of self-reliance. Perhaps the presence of cognitive impairment makes it gradually more difficult for avoidant-attached individuals to defend against their emotional needs by means of self-reliance, thus resulting in the frequent occurrence of attachment behavior (Browne & Schlosberg 2005).

Browne and Schlosberg (2005) acknowledge that the attachment style of informants could possibly have influenced the rating of the participants. The ideal replication of their study would be to use a longitudinal approach and collect self-reported attachment style information at regular intervals throughout participants’ adult lives until Alzheimer’s disease developed into a subsample. Their study, although limited, tentatively suggested that premorbid attachment style is connected to subsequent attachment behavior among individuals with dementia.

The implications of this study highlight the need for responding to attachment needs among people with Alzheimer’s disease who are living in nursing homes and residential homes. Feeling safe and secure is paramount to a person with this diagnosis. Responding with awareness to parent fixation is key to high quality caregiving. Caregivers must understand that emotional communication, rather than factual communication, is what is truly needed in order to attend to the person receiving care most sensitively.

Researchers Magai and Cohen, (1998) found that when caregivers identified the attachment typology personality style of the person with Alzheimer’s disease, that person’s future behavioral disturbances became relatively predictable. In addition to their findings, we find another insightful study of attachment behavior, of both caregivers and care recipients, in the
research of Steele, Phibbs and Woods (2004). In methodology paralleling Ainsworth’s observations of caregivers and infants in her strange situation experiment (Ainsworth, et al., 1978), Steele, Phibbs and Woods observed mothers with Alzheimer’s disease and their caregiver daughters during a separation and reunion experiment. They hypothesized that the same caregiver characteristics associated with attachment security in children, namely the ability to provide a clear and coherent account of a person’s attachment history, would be linked to evidence of secure attachment relationships between mothers with Alzheimer’s disease and their adult daughter caregivers. This clear and coherent account provides an assessment of the extent to which an adult caregiver is coherent, emotionally balanced, and valuing of the relationship whether or not the caregiving figure behaved responsibly and sensitively during childhood. An adult caregiver with a dismissive style may lack emotional investment in the topic of attachment and have blocks regarding attachment related memories. An insecure style in an adult caregiver may show a high level of current anger toward a parent as well as an elevated awareness of adversities in childhood (van IJzendoorn, 1995).

The adult daughters in this study were interviewed using the adult attachment interview (George, Kaplan, & Main, 1985), which showed to what extent an adult is coherent, emotionally balanced, and valuing of relationships whether or not caregiver figures have behaved and responsibly and sensitively during childhood. Broadly speaking, and as previously noted, there are three categories of caregivers and their response to attachment theory varies as follows:

1. The secure and autonomous adult caregiver is not mistrustful, and has no fear of abandonment
2. The insecure and dismissive adult caregiver, however, has little interest and emotional investment in learning how attachment theory might help with their own relationship with their recipient.

3. The insecure and preoccupied adult caregiver has an elevated awareness of childhood adversities that translate into a turbulent and inconsistent way of relating to the recipient of their care.

The authors of this study looked at the correlations between the greater evidence of coherence in daughters’ AAI and the greater evidence of joyfulness in their mothers upon reunion.

Reunion behavior was filmed following a separation lasting 45 minutes. During the separation the daughter was administered the AAI. The mother met with a female researcher who engaged her in conversation about family relationships. The administration of the AAI, and the conservation with the mother, was intentionally done to activate both the mother and the daughter’s attachment system upon reunion. Because of the small sample, and the paucity of autonomous-secure classifications, attention was given to the rating of the daughter’s current state of mind regarding attachment in terms of four scales that were most relevant to the study, which, according to Steele, Phibbs, and Woods (2004) were:

1. Coherence of mind
2. Reflective functioning
3. Coherence of transcript
4. Unresolved mourning concerning past losses and past trauma

The mothers reunion behavior consisted of a coding scale consisted of five positive dimensions, which were:

1. Facial expression
2. Proximity seeking

3. Contact maintaining

4. Overall responsiveness

5. Overall attunement

Positive facial expressions indicate that a mother is happy to see her daughter. She is enthused by the reunion and this is evident on the mother’s face by observing the mother smiling and appearing bright eyed. In the proximity-seeking response category, mothers make efforts to gain physical contact with their daughters, either by looking toward, reaching, or actually moving toward the daughters, in an obvious wish to achieve contact. Contact-maintaining behavior shows mothers making one or more obvious attempts to maintain contact, and once again, hold on. Responsiveness indicates that a mother’s body language shows interest and attention towards their daughters. This may take the form of leaning towards, following the gaze of, or intensely listening to their daughter. The overall emotional attunement between a mother and a daughter is shown by the extent of sheer emotional expression, the evidence of ability to anticipate communication, the evidence of mirroring, the frequency of eye contact and the overall affectionate involvement with each other. Each of these five dimensions is rated on a four-point scale (Steele, Phibbs & Woods, 2004).

Results of the study showed that a significant level of overlap occurred between a daughter’s levels of coherence, when talking about their own attachment history with their mother, and their mother’s behavior upon reunion. High coherence in the daughter’s AAI was linked with the mother scoring highly on a cumulative index of joy in relatedness upon reunion. Whether or not the mother’s dementia was in the early or the later, more severe stages appeared
to be unrelated to whether they were joyful or not upon reunion. A daughter with unresolved mourning and relatedness upon reunion by the mother suggests a negative correlation and that unresolved mourning in the daughter makes it much less likely that a mother with dementia will respond positively upon reunion. A daughter’s AAI that was more organized, believable, and emotionally balanced with respect to childhood experiences—regardless of whether the interview was judged insecure over all—had mothers who responded toward them with greater joy and success (Steele, Phibbs & Woods, 2004).

According to Steele, Phibbs and Woods (2004) this research suggests that applications of research tools such as the strange situation and the AAI extend to a new domain consisting of the needs of people with dementia and their family caregivers. In particular, daughters with a paucity of coherence, or heightened levels of unresolved mourning, had mothers who were less joyful and able to connect upon reunion. This intergenerational association, however, was unrelated to the severity of Alzheimer’s disease of the mother.

The severity of a mother’s dementia in the above study was not found to be associated with their joyful facial expressions, proximity seeking, contact maintaining, overall responsiveness, and overall attunement with a daughter. In other words, mothers who were very advanced in the disease process were nonetheless responsive to their daughters in their reunion behavior. Steele, Phibbs and Woods (2004) state their findings in this study as follows:

This highlights the need to appreciate how a core sense of self, capable of responding socially and emotionally to a preferred other, survives into the very late stages of the disease, if not until the end itself. This observation is consistent with neurobiological evidence and speculation on areas of preservation within the brain function of the person with dementia. It may be that what survives longest are certain core features of what was
encoded and stored earliest, namely one’s earliest internal model of attachment arguably established in the right orbital frontal cortex. (p. 447)

Their study also showed that daughters, who were more resolved regarding past loss or trauma, demonstrated higher evidence of reflective functioning and contributed positively to the likelihood of their mother showing trusting, animated interest, as well as joy upon reunion. In this light, mothers who have access to greater joy in relatedness may be positively influencing their daughters, and helping them to achieve greater coherence of mind, in the same reciprocal manner that we have seen in previous studies. And as also reflected in previous studies, the reunion behavior that follows a separation from a loved one on whom one feels dependent has significance throughout a person’s lifetime.

Miesen (1997, 1999) maintained that a heightened context of awareness is what influences how a person with Alzheimer’s disease experiences chronic trauma related to separation, a loss, powerlessness, displacement and homelessness. Understanding losses of security in a diagnosed person, and acquiring knowledge of attachment theory, could help caregivers interpret and respond to attachment behaviors such as parent fixation. According to de Vries and McChrystal (2010) when viewed from an attachment perspective, responding to the need for security, rather than of overt behaviors, could reduce stress in the diagnosed person more effectively. Caregivers of persons with dementia could benefit by being taught to recognize attachment behavior in people deprived of their cognitive capability and their ability to communicate verbally. Identifying patterns of attachment in those they care for, and reflecting on their own patterns of attachment and how their own pattern may impact on the quality of care they provide for others may greatly facilitate positive communication and interaction (de Vries & McChrystal, 2010).
The emphasis on person-centered care (Kitwood, 1997b) recognized the importance of relationships and the potential for well-being. A supportive and constructive social and interactional contact can help to maintain functioning and maximize well-being, while negative or malignant social contact can undermine functioning and result in excess disability. Researchers Nelis, Claire and Whitaker (2012), found that the importance of “felt security” in a diagnosed person is related to a more positive self-concept and lower levels of anxiety and that a positive working model of attachment does appear to enhance an individual’s quality of life (2012).

How might the implications of all of the studies cited in this paper help persons diagnosed with Alzheimer’s disease? Interventions that provide “felt security” have been instrumental in promoting a better quality of life for these diagnosed individuals. Three efficacious interventions are Simulated Presence (Woods & Ashley, 1995), Doll Therapy (Bryant & Foster, 2002), and Validation Therapy (Feil, 1963). Each of those therapeutic interventions can foster security and belonging for the person diagnosed.

In the Simulated Presence Therapy (SPT) of Woods and Ashley (1995), caregivers comfort patients by altering their environment. The goal is to create an environment for the patient that includes “the people and experiences best-loved by the patient over the course of a lifetime…. such an environment decreases maladaptive behaviors” (Woods & Ashley, 1995, p.10). In SPT, a family member is instructed to complete an assessment inventory that identifies the patient’s most cherished memories and experiences. These selected memories are then audiotaped and played for the diagnosed person. Since the diagnosed person’s remote memories are more likely to be retained than their recent memories, SPT “may be used repeatedly because the deficit in recent memory may allow the audiotape to be perceived by the person as a new
experience each time” (p. 14). This intervention draws upon and enhances the bonds between the person diagnosed and their family (Woods & Ashley, 1995).

In the memory loss unit of my late parents’ nursing home, SPT was used in a variety of ways. One environmental intervention that home utilized was the way in which each resident’s room was personalized from the hallway. Along the side of each doorway to a resident’s room, a display case was filled with treasured items of that resident, which often included pictures from that resident’s childhood, early adulthood pictures and family pictures. This shrine to past memories also functioned as a visual cue, which helped residents locate their rooms. Several times a week there were “reminiscence groups” that focused on the culture, the food, the music, and the news events of the past. This writer witnessed the leader of the reminiscence group feature remembrance objects from long ago. On one occasion she brought in a milking chair, which deeply connected with those residents that had lived on farms and may have milked cows by hand with their own parents. There were regularly scheduled music interventions consisting of live performances of “Old Time” music as well as music originating from the countries of the parents of their residents, such as Swedish, German and Norwegian music. Cooking interventions included baking bread, buns and cakes with the residents. Hearing the music of their youth, and smelling the aroma of freshly baked bread that they had made and served to their fellow residents, was a common sight in this nursing home. Individuals also identified memories of gardening, prompted by the facility’s outdoor gardens, or memories of taking care of fish or birds, through viewing the indoor aviaries and fish tanks and the facility’s outdoor duck pond. Therapy dogs and cats visited the residents on a daily basis, which resulted in rekindling recollections of resident’s own fond memories of their own past pets, as well as giving them joy through connecting with a live pet in present time.
Another effective intervention for persons with Alzheimer’s disease is “Doll Therapy.”

The origins of doll therapy go back to Winnicott (1953), and his use of transitional objects. Winnicott introduced the concept of a transitional object in reference to a particular developmental stage. Because infants initially see themselves and their caregivers as one and the same, as they begin to separate from their parents, they experience frustration and anxiety from realizing that they are independent. The use of a transitional object can help represent the components of “mothering.” Research of Winnicott’s theory by Passman, (1987) suggests that security objects are appropriately named and can help individuals adapt to new situations.

According to authors McKinsey, Wood-Mitchell and James (2007), the identified outcomes for doll therapy for people with dementia are:

- To initiate and encourage interaction and communication
- To fulfill attachment in nurturing needs
- To act as a transitional object
- To provide sensory stimulation through activity

This therapy can be used as a way to allow persons with dementia to stimulate memories of a life role, particularly that role of parents. Dolls can be touched and held as a way of remaining in contact with the environment, as well as providing physical contact for the person diagnosed. Individuals with Alzheimer’s disease may rekindle positive emotions of the parent-child attachment bond and those emotions may generalize a positive attachment to staff, family, and other residents (Bryant & Foster, 2002).

Doll therapy played a significant part in the life of this writer’s mother, during the last four years of her life while living in her nursing home’s memory unit. She selected a doll, (out of several), that she called “Baby Danny.” Daniel was also the name of my older brother, so it
seems logical that she believed this was her baby boy. There were many times when she would hand baby Danny to me so that I could take care of him and I did, knowing that I was taking care of the representation of my older brother in doll form. During a time when she was quite agitated, she let the staff people of the nursing home know that baby Danny had not been baptized. The staff then arranged for the chaplain to come into her room and have a baptismal ceremony for baby Danny; the chaplain arrived in his religious robes and used a med cup for the holy water. This writer’s mother became completely calm and content once this important need was met. A deeper need regarding her anxiety over her baby’s baptism may have been that she wanted to give her infant child admission to belong to the larger Christian family, or community, as her spiritual orientation recommended. According to James (2011), doll therapy is a simple way of engaging older people with dementia by allowing them a way to deal with ongoing inner psychological stress in an adaptive way. Additionally Moore states that dementia is not all about “confusion, forgetfulness and inevitable decline but can transform an individual’s own experience and involve the awakening of the ability for playfulness, love and affection” (Moore, 2011, p. 23).

Developed by Feil in 1982, Validation Therapy is another person-centered intervention. Its basic principles propose:

- All people are unique and must be treated as individuals
- All people are valuable, no matter how disoriented they are
- There is a reason behind the behavior of disoriented old-old people
- Behavior in all old-old age is not merely a function of anatomic changes in the brain, but reflects a combination of physical, social and psychological changes that take place over their lifespan
- Old-old people cannot be forced to change their behaviors. Behaviors can be changed only if the person wants to change them.
- Old-old people must be accepted non-judgmentally.
- Particular life tasks are associated with each stage of life and the failure to complete a task at the appropriate stage of life may lead to a psychological problem (Feil, 1999).

When more recent memory fails, older adults try to restore balance in their lives by retrieving earlier memories. When eyesight fails, they use the mind’s eye to see. When hearing fails, they commonly listen to sounds from the past. Painful feelings that are expressed, acknowledged, and have been validated by a trusted person will diminish. On the other hand, painful feelings that are ignored or suppressed will gain strength.

Empathy builds trust, reduces anxiety, and restores dignity (Feil, 1993). The staff of the memory unit where this writer’s parents lived was trained in validation therapy; for this writer, this intervention seemed to be successful in gracefully maintaining their environment and allowing residents to express themselves without being contradicted or shamed.

Research on the effectiveness of validation therapy is mixed, with some stating that it is effective, and others stating that it is no more helpful than a placebo. But this therapeutic approach, which uses empathy and understanding to help resolve issues that drive the behaviors and emotions of a person with Alzheimer’s, has much anecdotal representation. The techniques of reminiscing with the person, asking about their emotions, matching and expressing the emotions (joining in with the person) and rephrasing the feelings, all decrease anxiety in the person with dementia. Because the person diagnosed hears the caregiver expressing exactly what the person is feeling, the validation is profound (Feil, 1993). The person is allowed to feel and to feel human.
It is important to realize that a person with Alzheimer’s disease is so much more than their cognitive disabilities and neurobiological deficits. My parents struggled with the emotional problems that come with loss of memory, but due to the caring interventions of the staff, this writer does not believe that they lost their sense of self. Researchers Tappen, Williams, Fishman, and Touhy (1999) maintain that although the theme of diminishing self is quite common in the literature about the progressing decline in the stages of a person with Alzheimer’s life, there is an alternative perspective. Their observations indicate that persons with the late stages of the disease do retain a sense of themselves. The results of their 1999 study showed that participants diagnosed with Alzheimer’s disease who had taken the Mini -Mental Scoring Examination created by Folstein, Folstein and McHughes (1975), expressed awareness of the change in cognition that was occurring, as well as indications that they continued to monitor themselves and to respond to perceive changes. They initiated specific talk about themselves, and used the first person pronoun in these conversations.

The awareness and persistence of the self indicates that the essence of humanness is not lost in a person with Alzheimer’s disease. One only needs to consider the meaning behind the emotion and what it serves to express. Caregiver attitudes and knowledge about the subjective experiences of persons diagnosed can only result in a better understanding and appreciation of the experience of this disease.

**An Adlerian Framework**

What constitutes a happy childhood and why is it never too late to have one? Research suggests that adults who have happy memories about childhood are happy in adulthood. Components of a happy childhood may include parents or a caregiver expressing love and care
for the child, time that is free from abuse or trauma, a feeling of safety and security, and a sense of belonging to a family.

The bond of affection and care that characterizes this close relationship is the basis for attachment theory and it is rich with Adlerian concepts. Adler’s theory of Individual Psychology (Ansbacher & Ansbacher, 1956) looks to memory to find clues about happiness, function and dysfunction. As both integrated memories, (ones that focus on concerns that theoretically foster social cognitive development), and intrinsic memories, (ones that focus on concerns that theoretically lead to well-being), correlate with well-being in adulthood (Bauer & McAdams, 2005). Looking at early memories in the form of Adler’s early recollections is intrinsic to the Adlerian framework. Bauer and McAdams (2005) maintained that happy memories emphasize intrinsic memories, which are humanistic concerns. They discovered that feelings of comfort, reassurance and trust may be more important than either events or achievements. Thus, awareness that each person has a range of characteristics in a lifetime of experiences that can influence the behavior of each, speaks directly to Adlerian concepts.

In his book, *Understanding Human Nature*, Alfred Adler asserts that the “most important determinants of the structure of the soul life are generated in the earliest days of childhood…. when we hear the most vivid recollections of a patient’s childhood, and know how to interpret these recollections correctly, we can reconstruct with great accuracy the pattern of his present character” (Alfred Adler, 1927, 1946, p. 6). According to Adler, we can compare the attitudes and experiences of our earliest recollections with the attitudes and experiences of our mature lives in order to see how patterns were formed.

The conclusions that children make about the interactions that they have with others in childhood represent their own subjective reality. This representation is called the “schema of
apperception,” which is the sum of the conclusions that children make about their relationship with others (Ansbacher & Ansbacher, 1956). The schema of apperception is the arbitrary training children receive through their life experiences that provide them with a worldview. Combined with the law of movement, (which is a decisive factor for individuality), schema is the opinion that the children, (and later adults), have about themselves and the world. These opinions or statements that children believe about themselves, others, and their own world are necessary for them to feel secure in their journey toward adulthood and throughout life.

Adler believed that behavior stems from this opinion of ourselves, which is completely subjective and private. This subjective and private reality from childhood holds a person’s “Private Logic,” which is the interpretation of the perspective of the world within a person’s “Style of Life.” This is the “Lifestyle” pattern and the internal organizer of an individual’s behavior. This logic drives the individual and marks the line of direction for all actions and movements (Ansbacher & Ansbacher, 1956). Behavior is therefore purposeful and it strives for significance and belonging; its pattern permeates all aspects of action and of perception.

Adler also believed that humans are hardwired to belong with other humans. In other words, a person would be vulnerable to dangers from the environment if left to survive completely alone. People need to belong with other people to survive. This need to belong permeates a person’s patterns or lifestyle convictions. “Social Interest,” which is the intrinsic concern for others, ensures this sense of ‘belongingness’ as well as our physical and psychological survival. Adler believed that social interest is an individual’s ability to empathize with others: “to see with the eyes of another, to hear with the ears of another, to feel with the heart of another” (Ansbacher & Ansbacher, 1956, p. 42), and that empathy is central to the development of positive mental health. Social interest as a barometer of mental health is one of
Adler’s key concepts. To be of use to one’s community is enacting a useful style of life; the loss of social functioning, the useless and self-absorbed style of life, results in subjective mental suffering.

These basic tenets of Alfred Adler’s Individual Psychology are germane to what individuals’ create from, and out of, the influences and experiences of their lives. Adler maintains that the recollections of an individual’s experiences along with the earliest memories of childhood, transform an objective operating system into a subjectively active schema. It becomes the schema’s mission to bring about connections with the environment that function to enhance self-esteem and to give direction to actions and thoughts. Memory works with the schema to influence a person’s perception of the world. He states, “Our conscious and unconscious memory and its individual structure function in accordance with the personality ideals and its standards” (Ansbacher & Ansbacher, 1956, p. 214).

Adler purported that all problems in life are social problems and that it is vital to be prepared for social behavior. He believed that by understanding early recollections, we evoke the power of empathy and compassion and it is this power that allows us to identify with the child in his or her childhood situation (Adler, 1929). Adlerian theory, like attachment theory, looks to the past to determine how individuals use behavior to belong and to feel secure. How else might Adler’s Individual Psychology and attachment theory inform what we have learned about the experience of Alzheimer’s disease?

Attachment, Alzheimer’s and Adler

First, and foremost, the idea that an individual’s subjective reality can be looked at, validated and appreciated for all that it does for the individual is a central belief that resides in both Adlerian and attachment theories. The reason for behavior is locked in the memory of
persons with Alzheimer’s much like the reasons for the mistaken beliefs of childhood are locked in the memory of everyone else. Behavior works in a purposeful manner: infants need to survive and to be secure so their behavior, (such as crying), draws the mother close, for protection, care and love. In an analogous way that infants need security, children need to belong, so that their behavior draws a blanket of belonging around them and their experience of others. Both sets of behaviors are predicated on the need of the individual to survive and the attunement and the sensitivity of the response given by the caregivers. The subjective experiences of infants and children as they are cared for, determines how they will behave with others throughout their lifetime. Their interactions with others and their levels of social interest are also informed by these experiences. Both attachment and Adlerian constructs use early memory to examine early vulnerability in order to interpret present actions.

The memory of the caregiver never really leaves. In persons with Alzheimer’s, the longing for the parent to come back and help them feel secure again seems to be an almost universal longing; we are social beings and we belong to and with each other. The sense of identity in the world that individuals develop during infancy, (mistaken though it may be), is also what continues throughout a lifetime – as Bowlby understood, from the cradle to the grave (Bowlby, 1969). We have seen that individuals with Alzheimer’s disease do not lose their sense of self, along with their loss of memory, and their loss of security. It is this abiding self that caregivers must reach towards and connect with. The ability to enter the subjective experience of a person diagnosed takes empathy, and: “to see with the eyes of another, to hear with the ears of another, and to feel with a heart of another” is an essential quality for an effective caregiver.

To enter the subjective experience of a person diagnosed with Alzheimer’s disease is to honor the soul of the person that is radiating an outward communication that may not make sense
to us. But we must examine the underlying feelings of the behavior to understand that in fact, their communication make perfect sense. When we care for others, and embrace this way of communicating, we are acting heuristically, compassionately and courageously. Belonging is a profound need with a simple solution.

During the last months of my mother’s life, it was hard for her to move or to talk. She loved to hear my husband play his saxophone and bassoon for her as he did in the many years before she was diagnosed. One day, after he stopped playing and was putting away the instrument, she looked at me and whispered, “He is our possession.” Her love for him, and her feeling of belonging and security was evident. She expressed her contentment that he belonged here, and that he wouldn’t suddenly depart. He did not depart; along with this writer, he stayed with her until her death. It is this writer’s belief that in the last years of her life, she had a happy childhood; the self she was as a child did not disappear with the self she appeared to be with dementia. It simply continued, moving in a singular, and often, surreal way.

**Conclusion**

We have seen how this disease moves through the neurocognitive domains on a relentless journey that seemingly obliterates the self. At each stage, more cognition is lost until the person seems unrecognizable, trapped alone and drifting unmoored within their own perplexing universe. It would appear that there is no way to enter into that subjective experience that commonly includes fear and confusion. But in examining attachment theory, we find that the connection between an infant and a caregiver is similar to a person diagnosed with Alzheimer’s and their caregiver or family member.

Bowlby’s theory, along with Ainsworth’s strange situation experiment, provides insight into the evolutionary concept of vulnerability and survival, as well as the deep emotional bond
between caregivers and persons cared for. It is this bond, and the memory of this bond, that illuminates and deciphers the sometimes inexplicable behavior of a person diagnosed. An understanding of attachment theory gives us the key to a different kind of connection. As cognitive ability declines, so too, do the domains of learning and memory, personal agency and theory of mind. In contrast, attachment research shows us how a core sense of self, one that is capable of responding socially and emotionally to a preferred caregiver, survives into the very late stages of the disease, if not until the end of life itself (Steele, Phibbs & Woods, 2004).

We have previously learned that this observation is consistent with neurobiological evidence on areas of preservation within the brain function of the person with Alzheimer’s disease. Accordingly, what survives the longest in a person with Alzheimer’s disease are certain core features, including what was encoded and stored first, expressly the earliest internal models of attachment (Steele, Phibbs & Woods, 2004). Models of attachment are established in the right orbital frontal cortex, the part of the brain that allows an individual to anticipate and decide courses of action that will bring about either positive or negative emotions and adapt their behavior in response to rewards or adversities. This area of the brain also houses theory of mind and the ability to socialize effectively (Bechara, 2004).

Additionally, the orbital frontal cortex facilitates empathy, the ability of a person to experience emotions that another might feel. As we learned from Adlerian theory, empathy is an essential component in social interest. When this area is impaired by Alzheimer’s disease, an individual’s behavior may be inappropriate to the social setting, as their ability to “see with the eyes of another” is compromised. Yet this is also the part of the brain that stores the earliest encoded memory of survival, security and belonging. It permits the individual to express a social and emotional response to a preferred caregiver.
It is unfortunate that the very behavior that is utilized by a person with Alzheimer’s disease to connect to others on their most vulnerable, human level is sometimes perceived by those around them as disturbing, thus rendering them unreachable. As previously stated, one in nine Americans over the age of 65 are presently living with this disease. The research reviewed in this paper has shown that diagnosed individuals retain their earliest memories, even in the last stages of dementia. It is incumbent on us, as caregivers and family members, to understand that the person with Alzheimer’s disease is attempting to connect and communicate through the subjective reality of their experience, and that their behavior is a telling indicator of how much they need us. The loss of cognition, memory and even self-awareness of diagnosed persons should not become a rationale to fear or avoid them. Caregivers and family members who recognize the human needs of diagnosed persons to feel secure, and to belong, can reunite with them. Joining in their emotional reality can alleviate their anxiety and longings.

In conclusion, we have seen how attachment theory, along with Adlerian concepts such as empathy and social interest appear congruent in understanding the significance of communicating and connecting with a person with Alzheimer’s disease. Interventions such as validation, and doll therapy, provide effective tools that caregivers and family members can use to enter diagnosed persons’ subjective reality, engage with them, and assist them in feeling secure, and a sense of belonging, as they navigate this traumatic disease’s solitary terrain. By providing love and care, safety and security, and a sense of belonging to a family, caregivers and family members can recreate a happy childhood in a person diagnosed with Alzheimer’s disease.
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References


Bryant, J., & Foster, S. (2002). Can the use of dolls and soft toys really make a difference in
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European perspectives on therapeutic work with older people (pp. 142–154). London, UK: Jessica Kingsley.


