At least since Freud we have recognized that the infant-mother relationship is pivotal to the child’s emerging personality. Freud (1940) said that for the baby, his mother is “unique, without parallel, laid down unalterably for a whole lifetime, as the first and strongest love object and as the prototype of all later love relations for both sexes.” More recently, Greenspan (1997), Schore (1994), and Siegel (1999) have written convincingly about the ways that the early caregiving relationship influences the child’s developing cognitive ability, shapes her capacity to modulate affect, teaches her to empathize with the feelings of others, and even determines the shape and functioning of her brain. The attachment and caregiving systems are at the heart of that crucial first relationship.

John Bowlby (1969/1982; 1973; 1980) described the attachment and caregiving systems in biological and evolutionary terms stating that, across species, the attachment system was as important to species survival as were feeding and reproduction. At the heart of the attachment and caregiving systems is the protection of a younger, weaker member of the species by a stronger one. The infant’s repertoire of attachment behaviors are matched by a reciprocal set of caregiving behaviors in the mother. As the mother responds to the infant’s bids for protection and security, a strong affectional bond develops between the two that forms the template for the baby’s subsequent relationships.

Attachment behaviors change as the child develops. A young baby who is tired, frightened, hungry, or lonely will show signaling and proximity seeking behaviors designed to bring his caregiver to him and keep her close. The baby may cry, reach out, or cling to his mother. Later when he is more mobile, he may actively approach her, follow her, or climb into her lap. A toddler may use his mother as a secure base, leaving her briefly to explore his world, and then reestablishing a sense of security by making contact with her by catching her eye, calling out to her and hearing her voice, or physically returning to her (Lieberman, 1993). By the time a child is four years old, she is typically less distressed by lack of proximity from her mother, particularly if they have negotiated or agreed upon a shared plan regarding the separation and reunion before the mother leaves (Marvin & Greenberg, 1982). These older children have less need for physical proximity with their mothers, and are better able to maintain a sense of felt security by relying upon their mental image of their mothers and upon the comforting presence of friends and other adults.

Bowlby (1969/1982) referred to attachment bonds as a specific type of a larger class of bonds that he and Ainsworth (1989) described as “affectional” bonds. Ainsworth (1989) established five criteria for affectional bonds between individuals, and a sixth criteria for attachment bonds. First, an affectional bond is persistent, not transitory. Second, it involves a particular person who is not interchangeable with anyone else. Third, it involves a relationship that is emotionally significant. Fourth, an individual wishes to maintain proximity or contact with the person with
whom he or she has an affectional tie. Fifth, he feels sadness or distress at involuntary separation from the person. A true attachment bond, however, has an additional criterion: the person seeks security and comfort in the relationship.

It is important to note that an infant does not have only one attachment relationship. Bowlby (1969/1982) posited that babies routinely form multiple attachment relationships, arranged hierarchically, although they most likely have a single preferred attachment figure to whom they will turn in times of distress if she is available. As the baby develops, however, he will form multiple attachment bonds and an even greater number of affectional bonds. And the need for attachment bonds does not end with infancy. Across the lifespan, we all experience times when we feel weak, ill, or vulnerable and turn to a loved person for support and comfort. This turning, we will see, is the echo of our infant attachments, and our expectations of what will happen when we turn to another are also built in infancy.

**Patterns of Attachment**

The quality of the child’s attachment to his mother is determined by the way the mother responds to her child’s bids for attention, help, and protection. As Ainsworth (1989) pointed out, the defining characteristic of an attachment bond is that it is marked by one person seeking a sense of security from the other. If the seeker is successful, and a sense of security is attained, the attachment bond will be a secure one. If the seeker does not achieve a sense of security in the relationship, then the bond is insecure.

Ainsworth and her colleagues (1978) established the most widely used research method for assessing quality of attachment: a laboratory procedure known as the Strange Situation which involves two brief separations from mother in which the baby is left with a stranger. The baby’s behavior on reunion following these separations forms the basis for classifying her quality of attachment. Ainsworth (1978) described three basic patterns of attachment: securely attached, avoidant, and resistant.

Babies described as **securely attached** actively seek out contact with their mothers. They may or may not protest when she leaves the laboratory, but when she returns they approach her and maintain contact. If distressed, they are more easily comforted by their mothers than by the stranger, demonstrating a clear preference for their mothers. They show very little tendency to resist contact with their mothers and may, on reunion, resist being released by her.

Babies who are classified as **avoidant** in the Strange Situation demonstrate a clear avoidance of contact with the mother. They may turn away from her or refuse eye contact with her. They may ignore her when she returns after the separation. Some avoidant babies seem to prefer the stranger and appear to be more readily comforted by the stranger when they are distressed.

The third group, **resistant** babies, may initially seek contact with their mothers on reunion, but then push her away or turn away from her. They demonstrate no particular preference for the stranger, but on the contrary appear angry toward both their mother and the stranger.

Later, Main and Solomon (1990) described a fourth pattern of attachment behavior: **disorganized/disoriented behavior**. These babies seem to have no clear strategy for responding to their caregivers. They may at times avoid or resist her approaches to them. They may also seem confused or frightened by her, or freeze or still their movements when she approaches them. Main and Hesse (1990) have hypothesized that disorganized infant attachment behavior arises when the baby regards the attachment figure herself as frightening. Studies have demonstrated a higher incidence of disorganized/disoriented attachment patterns in infants whose mothers report high levels of intimate partner violence (Steiner, Zeana, Stuber, Ash, & Angell, 1994) and in infants who were maltreated (Lyons-Ruth, Connell, Zoll, & Stahl, J., 1987). The babies of mothers who abuse alcohol have also been shown to have higher incidence of disorganized/disoriented attachment behavior (Lyons-Ruth & Jacobvitz, 1999).

**Example of disorganized/disoriented attachment behavior**

Jill was 30 months old when she was removed from her parents’ home because of their pervasive neglect of her. Both of her parents were heavy drinkers. They fought with each other, sometimes with knives as weapons, and they had been observed to punish Jill for small infractions by biting her. Jill did not see her parents for the first ten days that she was in foster care, and then was reunited with them for a visit in our clinic playroom. When they came into the room, Jill did not respond to them and seemed not to see them or anyone. She sat frozen in her chair. She did not explore the room or play with any of the toys. When her mother offered her a toy or food, Jill sometimes seemed to be looking at her without seeing her, and sometimes turned away. When either of her parents spoke, Jill startled visibly, pulled at her hair, and shouted, “What?” in an alarmed tone. Other than that she spoke no words during the two-hour visit. When the therapist said that it was time to leave, however, she fell screaming to the floor, refused to put on her coat, grabbed for her mother and clung to her as she tried to walk away. She remained inconsolable for nearly 20 minutes after her parents left the visiting room.

**Internal Working Models and the Role of Attachment in Normative Development**

Bowlby (1969/1982) believed that as the baby or child experienced his caregiver’s responses to his bids for help and protection, he developed mental/emotional templates—called internal working models—of himself and what he could expect in his relationships with other people. A baby whose mother responds quickly and sensitively to his cries comes to see himself as worthy of attention and help. He comes to anticipate that other people in his life will
respond to him positively when he needs something. He gains a sense of efficacy and agency: a belief that he can make things happen. On the other hand, a baby whose mother does not respond to his bids constructs an internal working model of himself as unworthy and other people as unresponsive or, perhaps, as dangerous. The avoidant, resistant, and disorganized styles of attachment described above are in response to inconsistent or insensitive caregiver responses to the baby’s bids.

The literature suggests that the internal working models of attachment that are formed in infancy and early childhood form the templates for a variety of relationships, not only attachment relationships. Preschool children with secure attachment histories have been shown to be more self-confident and less dependent with their teachers than insecurely attached children (Sroufe, 1983). The same children, at age ten, were less dependent on summer-camp counselors than were children with insecure attachment histories (Urban, Carlson, Egeland, & Sroufe, 1991). Wartner and his colleagues (1994) also found that securely attached six year olds were more competent in play and conflict resolution with peers than were insecurely attached children. Other researchers have found that these increased competencies extended into later childhood (Grossmann & Grossmann, 1991) and adolescence (Weinfield, Sroufe, Egeland, & Carlson, 1999).

Further, insecurely attached babies have grown into children with problems in some areas of functioning. Cohn (1990) and Turner (1991) found that insecurely attached boys were more aggressive than securely attached ones at four and six years of age, respectively; and Turner (1991) found that insecurely attached girls were more dependent and less assertive than securely attached girls. Although other findings of increased aggression, particularly among avoidantly attached children, have been reported, many studies have failed to replicate them, and one must be cautious in suggesting that insecure infant attachment leads to any particular psychopathology. Recent studies have also noted that other factors besides inconsistent or insensitive mater-}

nal caregiving contribute to attachment insecurity. Some authors now suggest that an interaction of child characteristics (such as a difficult or “slow to warm” temperament), insensitive caregiving (including factors such as child maltreatment, maternal depression and maternal substance abuse), and high levels of family adversity and stress interact to result in insecure attachment (Greenberg, 1999).

Disorders of Attachment

Even though some studies indicate that insecure attachment styles can lead to emotional and behavioral difficulties, it is important to keep in mind that insecure attachment styles are not mental disorders. They are strategies for protection seeking that occur in the normative population. Lieberman and Zeanah (1995) propose three separate categories of attachment disorders: (1) disorders of non-attachment, (2) disordered attachments, and (3) disrupted attachment disorder: bereavement/grief reaction. This article will discuss only the first two categories.

Disorders of Non-Attachment

The disorders of non-attachment closely parallel the description of reactive attachment disorder that appears in the DSM-IV (APA, 1994). These disorders most frequently appear in children who have not had the opportunity to attach to a single caregiver, and they are of two major types, the first involving emotional withdrawal and the second, emotional promiscuity or indiscriminate behavior.

Example of non-attachment with emotional withdrawal

Ivan was born to a young mother overwhelmed by the demands of poverty. Ivan’s active 19-month-old brother, and her violent relationship with her children’s father, who lived with her sporadically when he was not in jail. Ivan’s mother, who reported a lonely childhood in which she sat alone in her apartment many hours each day waiting for her mother to return from work, coped with her negative feelings by drinking heavily. She was ambivalent about her pregnancy with Ivan and abused alcohol throughout. Ivan was born several weeks premature and small for gestational age. He lagged behind in his development and from time to time during his first year of life slipped from his growth curve. He spent the year moving between the homes of his mother, his maternal grandmother, and a maternal aunt. When he was first seen in the clinic he was 17 months old. He could sit and crawl but could not walk and he had no language. He did not respond when his mother spoke or approached him; nor did he respond when the therapist approached him. He would sit quietly for up to an hour on a sofa without toys or anything else to entertain him.

Ivan appeared withdrawn from contact not only with his mother but also from the world. He did not seek stimulation from people or objects in his environment, and he seemed to have given up on asking for anything. It took extraordinary effort, over several weeks, for the therapist to begin to engage him so that he would make consistent eye contact, accept a toy from her or respond by vocalizing and smiling to her emotional expressiveness. Even then, his mother remained ambivalent about Ivan’s development. She wanted him to walk so that she would not have to carry him everywhere, but she dreaded the loss of her “easy” baby, who placed so few demands on her. It was difficult for her to understand the importance of talking to Ivan or playing with him, and she seemed unable to follow the therapist’s lead in trying to engage her son.

Example of non-attachment with indiscriminate behavior

Susan was 15 months old when she came to live with her paternal aunt and grandmother. Until then, she had been in the care of her crack-cocaine addicted mother and had lived with her in a variety of crack houses and, sometimes, on the street. Her mother also had left Susan sporadically with relatives, sometimes telling them that she would be back in several hours and then not returning to
Infant massage is neither a new nor an innovative parenting practice. Most cultures throughout the world possess some tradition of systematic, purposeful physical interaction between parents and their infants. For most, this interaction features variations in holding, skin to skin contact, and gentle, affectionate stroking of the limbs and torso all within the context of supportive verbal and nonverbal communication (Heller, 1997; Montague, 1986; Schneider, 1982). Although Western culture has only recently been exposed to this ancient parenting custom, research over the past two decades suggests that tactile stimulation and infant massage provide numerous benefits for infants as well as their parents. 

**Physiological Advantages of Infant Massage**

Current research primarily documents the effects of infant massage on physiology. Premature infants who have been massaged, for instance, demonstrate a 20-47% weight increase over non-massaged controls (Kuhn et al., 1991; Scafidi et al., 1990; Field et al., 1986). These infants also demonstrate improved performance on the Brazelton Neonatal Behavior Assessment Scale as well as the Bayley Scales of Development (both the mental and motor scales) compared to controls (Field, Scafidi, & Schanberg, 1987). Moreover, these advantages persist through the first year of life (Field, 1999).

Massage research has also identified various benefits for full-term infants. Compared to a rocked control group, massaged babies gained more weight, cried less, were more alert, were more sociable and soothable, engaged in face to face interactions longer and demonstrated improved sleep/wake cycles (Field, Grizzle, Scafidi, Abrams, & Richardson, 1996).

Infant massage research has also substantiated advantages for parents. Beyond the consequent effect resulting from the positive infant temperament and behavior outcomes, both parents and infants exhibit a decrease in urinary stress hormones (i.e., norepinephrine, epinephrine, cortisol) upon completion of an infant massage episode (Field, Hernandez-Reif, Quintino, Wheeden, Schanberg, & Kuhn, 1997; Field, Grizzle, Scafidi, Abrams, & Richardson, 1996; Field, Grizzle, Scafidi, & Schanberg, 1996). Additionally, depressed teenage mothers, as well as their infants, manifested increased levels of serotonin as a result of an infant massage interaction (Field, Grizzle, Scafidi, Abrams, & Richardson, 1996; Field, Grizzle, Scafidi, & Schanberg, 1996).

Each of these physiological effects is significant and justifies the use of infant massage as a parenting strategy for most families. But, what effect might infant massage have on the psychosocial and emotional development of an infant or a new parent? Does infant massage affect parent-infant attachment? To date, subjective reports suggest that it has a positive impact in both these areas. The staff of Aurora House (described below), for instance, noted that mothers and babies who participated in infant massage instruction demonstrated more effective interaction behaviors. Although this relational aspect seems to resonate powerfully in the reflections of parents and observers of infant massage, research in this area is notably absent.

In order to validate these observations, Aurora House staff developed a research protocol designed to explore, beyond the physiological aspects, the effects of touch—particularly infant massage—on the interactions and attachment behaviors elicited between mothers and their infants. At the time of publication, the study had not been applied for one year.

**The Program**

Aurora House is a non-profit transitional housing facility for homeless women and their children. Aurora offers safe, secure housing, a supportive communal setting, and a service enriched environment that allows women to work through the issues that led to their homelessness while learning skills that will lead them toward self-sufficiency. One of the major issues most of the women face is chemical dependency.

Aurora uses a client driven approach to progressing through various program requirements. Coordinated case plans are developed in conjunction with substance abuse treatment programs, Children Services, Mental Health, and the criminal justice system. Case plans are designed to empower each woman with the necessary tools to begin and maintain sobriety.

Aurora’s in-house programming includes Life Skills, Life Enrichment, Relapse Prevention, Self Esteem and Relationship Building, Parenting, Financial Management, GED Preparation, Job Readiness Training, and After Care. Additionally, Aurora operates a licensed child development center to support the women through...
the completion of their goals. One of the keys to Aurora’s success is that families may reside at Aurora for up to 24 months. The Parent Education Program at Aurora began developmental testing in 1997. Testing revealed that developmental delays were present in every child of every woman entering the program. The most prominent areas of delay included socialization and communication. It was hypothesized that these delays reflected a lack of bonding and attachment with the primary caregiver during infancy. With this in mind, Aurora began searching for programs that would foster the growth of these basic skills as well as enhance the interactions between mother and child. The Aurora staff was hopeful that the Infant Massage Instruction program might help to accomplish this goal.

The Study

Inherent in literature regarding the interactions of mothers in treatment with their infants was the assumption that these mother/infant dyads were at-risk for a compromised attachment relationship (Weatherston & Tableman, 1989; Howard, Beckwith, Rodning, Kropenske, 1989; Miller, G., 1989; Tittle & St. Claire, 1989; Weston, Ivins, Zuckerman, Jones, & Lopez, 1989; Chasnoff, I. J., 1988). Based on this assumption, the conceived research question queried: Does Infant Massage instruction affect (1) social/emotional outcomes for mothers in treatment and (2) social/emotional outcomes for the infants whose mothers are in treatment? The question produced two hypotheses: (1) Among mothers in treatment, infant massage instruction increases maternal responsiveness to infant interaction; and (2) Among infants whose mothers are in treatment, infant massage instruction increases infant responsiveness to maternal interaction.

Research Method

Subjects in this study included mothers involved in a transitional housing facility for homeless women dealing with substance abuse issues (the Aurora House) and their infants (birth through 12 months of age). Dyads were assessed via three social/emotional and parent-infant interaction tools: (1) the Nursing Child Assessment Teaching Scale-NCATS (Barnard, 1980); (2) the Borgess Interaction Assessment-BIA (Borgess, 1989); and (3) the Nursing Child Assessment Feeding Scale-NCAFS (Barnard, 1980).

The NCATS was used to assess the interaction skills of the mother and infant via observation during a contrived teaching episode determined by the child’s developmental age. Parent-infant interactions were ranked on a simple yes/no scale. The parent items included sensitivity to cues, response to child’s distress, social-emotional growth fostering, and cognitive growth fostering. The infant items included clarity of cues and responsiveness to parent.

The BIA was used to examine factors that could potentially interfere with the attachment relationship in terms of mother-infant interaction skills. The first section of this assessment considered demographic information and birth history. The second section addressed observational data rated on a 3-point Likert scale focused on interactions of the infant and the mother. The BIA has demonstrated an internal consistency and reliability of .95 for postpartum observations (Weatherston & Tableman, 1989).

The NCAFS was used to analyze the interaction skills of the mother and infant via observation during a feeding episode. Parent-infant interactions were ranked on a simple yes/no scale. The parent items included sensitivity to cues, response to child’s distress, social-emotional growth fostering, and cognitive growth fostering. The infant items included clarity of cues and responsiveness to parent.

Procedure

Informed consent was obtained for participation in the study, the use of multiple assessment tools, and the use of videotaping as a method of data collection. Informed consent obliged the staff at
Aurora the opportunity to assign the mother/infant pair an identification number and random placement into either the control or experimental group.

The assessment tools served as pre and post measures for analyzing the impact of the experimental treatment of infant massage instruction. Prior to the intervention, each mother/infant dyad participated in two videotaped episodes (one feeding episode and one teaching episode) and was assessed by Aurora staff via the BIA. A Certified Infant Massage Instructor taught infant massage to the participating dyads in the experimental group. The massage techniques taught followed the curriculum endorsed by the National Center for Analysis of Therapeutic Effectiveness (NCATE), which included a combination of strokes from the traditions of Indian massage, Swedish massage, Chinese reflexology, and the conditioned-response technique developed by V. Schneider, Touch Relaxation (McClure, 1988; Schneider, 1982).

Following infant massage instruction (or the passage of four weeks for the control group), each mother/infant dyad again participated in two videotaped episodes (one feeding episode and one teaching episode), and was assessed via the BIA. All pre and post videotapes and pre and post BIA assessments (control as well as intervention, each mother/infant dyad) were then forwarded to a certified NCATE examiner.

**Results**

Although results are not yet available, the following plan is in place. The collected data will be compared for pre and posttest deviations for each dyad. Control vs. experimental group identity will remain unknown to the examiner until the sample size reaches a total of ten mother/infant dyads. At that time, group assignments will be compared across test deviations to determine the impact of the treatment, if any, on the interaction behaviors of the mothers and their infants. If the hypotheses are proven with this small sample size, grant monies will be solicited to expand the project, re-assess its design and replicate its findings within a multisite framework.

**Conclusion**

Infant massage is a family-centered, developmentally appropriate strategy for meeting numerous physiological needs. Should the hypotheses for its impact on improving interaction capacities be proven, infant massage instruction could become one more element in the options available to agencies working with families affected by substance abuse. Infant massage instruction may be one more approach for social service agencies to employ to enhance nurturing and parenting skills among women in treatment with their babies. Imagine the possibilities for psychosocial competence and communicative capacity if a direct correlation exists between infant massage and the attachment relationship.

— Mary Margaret Crombez, M.Ed., Infant Mental Health Specialist, Certified Infant Massage Instructor (CIMI); Robin Charney, CIMI; Kyle Grefe, Executive Director of Aurora House; Patricia Schmidt, BA, Client Services Manager/Parent Educator for Aurora House

**REFERENCES**


For further information, or if your agency is interested in participating in the study or replicating the study, please contact Mary Crombez at 734-522-2967.
In the eyes of my children I see love, unconditional love. 
Love that I have the privilege of having from them.
In the eyes of my children I see fear, that I once remember having myself, and sometimes I still do . . .
In the eyes of my children I see laughter, laughter that comes from having the freedom to be a child . . .
In the eyes of my children, I see sobriety, sobriety that I have to have in order to look in my children’s eyes again and see all the beauty they hold.
— Nea, mother of two

The Mother’s Journal Project is a therapeutic writing intervention designed to help recovering women build stronger relationships with their children. It was originally based on the belief that a mother’s reflective writing about her children would lead to improvements in parenting. For some mothers, this approach worked. However, requiring a client to write about her children before she was comfortable yielded little gain in mother-child relationships. When given a choice, many women opted to write about themselves. This initial focus on self was understandable in light of Fraiberg’s finding that mothers cannot address the emotional needs of their children until their own pasts are acknowledged (Fraiberg, Adelson & Shapiro, 1987). These reflections often became an essential bridge to examining relationships with children.

Background

Many addicted women are survivors of sexual, physical and emotional trauma (Marcenko, Spence & Rohweder, 1994; Root, 1989). Few have the opportunity to address past abuse. If a mother lacks understanding of her own issues, she may not respond to her child with empathy (Fraiberg, Adelson & Shapiro, 1987). When a mother can remember the affective experience of her childhood sufferings, she can then say, “I would never want that to happen to my child.”

Remembering feelings and experiences proves essential in mending relationships and promoting psychological healing. Telling stories of trauma transforms wordless, unspeakable memories into tangible confrontations of the past (Herman, 1993). It puts memories in a place where they can be felt, processed, and integrated into present life, enabling the survivor to “become more open to new forms of engagement with children.”

Themes of Writing

Women entering drug treatment often feel that they are “voiceless,” especially those with histories of abuse. Journal writing is a way to concretely voice feelings, desires and pain. Moreover, the

The Mother’s Journal Group

The Mother’s Journal Group is a weekly writing group facilitated by parenting staff. Music, poetry, literature and suggested topics for writing are used to encourage reflections on family and relationships. How each client approaches writing about self and child is as unique as the stories she has to tell. Although many clients exhibit limited grammar and spelling skills, literacy issues do not deter the process. The few clients unable to read and write dictate their stories which are transcribed verbatim, preserving the woman’s tone and grammar. Staff provides individual conferencing and written feedback to help women process some of the issues that arise in their writing.

Please see page 8 . . .
Mother’s Journal gives a client the opportunity to take control of her life and examine how her past contributes to her current situation. This process includes claiming a private space, documenting past events, working through long-ignored feelings, examining personal relationships and planning for the future.

After fifteen years of heroin abuse, Angie entered treatment. Raised in an emotionally abusive home, Angie had not spoken with her mother or father during the past five years although her eldest daughter lived with them. As she began writing, Angie addressed her father from a “sober” standpoint.

Your only daughter is all grown up now and she is rather sick . . . I’m addicted to drugs. Today I’m able to admit that I have a problem, just a few 24 hours ago you couldn’t get me to express these feelings. Hell I had no feelings. You see now that I’ve been clean these few days I’m starting to have feelings and my mind is starting to remember some very old memories that I buried during my addiction.

For many women, revisiting the past by “going home” in their writing is the first step in understanding their addiction and their relationship with their children. Whether a place, a relationship or a memory, home can be a source of strength or a territory of unresolved pain. Mother’s Journal provides an arena where clients are free to feel pain, be angry, wonder why, or question God.

Louise, a twenty-seven year old mother of six, used her journal to write to her mother about ongoing sexual abuse by her father. After showing her writing to a staff member, Louise said, “This is the first time I have ever been able to really talk about it.”

He was angry and he slapped me and I fell. Then he kicked me in my head with those shoes. And I tried to run. No one was there . . . He just pushed me down and started to grind on me. I just layed there. I was very afraid and did not know what to do. All I was thinking was I got to tell Mama . . . But I guess you did not believe me. I was very hurt Mama. I love you so much. I would never lie to you about something like that. Mama can we put this behind us forever and you not hate me because of what happened. Mama I was an addict in life.

Many women write about past relationships with family members, suggesting that emotional injuries obtained early in life or within drug abuse must be tackled before they can focus on their children. Nikkie, a nineteen-year old mother of three, wrote about her relationship with her deceased mother. After her mother fell ill with AIDS, fifteen-year old Nikkie became the caregiver her mother never was. Nikkie remembered, “When it was near the end, and it was just like taking care of a baby, I did it.”

Are you coming back? What?!?! I don’t have to answer you, I’m your momma…

Can I go out and play? What?!?! No, Why? Because I said so.
Oh! No! Here they come, fists of fury.

Tables Turn!

Will you stay with me? Of course!
Mommie I love you…

When I leave will you miss me? What?!?! Of course!!! You are and will always be my mother.

Main (1987) found that women who remembered what it felt like to be a child empathized more with their children. Through this process, mothers make connections between their earlier relationships with caregivers and their current parenting attitudes and practices. Twenty-two year old Nina exhibited a strong and loving bond with her children. Having already processed issues from her own childhood, she related her understanding of her painful upbringing to her current need to be a present and strong mother.

As a child I went from house to house, people to people . . . I didn’t have a steady household, but the one I established for you . . . But I am going to try to be a better mom for you, than the way I was raised. I have to break the cycle that my family has had for so many years, because I thought that is not the way I want my kids to live and feel. It took me a long time to break and get enough knowledge to accomplish that goal. I just want you to be a lot happier than I was.

As a mother develops a greater sense of self through her journaling, she becomes less self-focused. She often attempts to connect with her children by apologizing for past behavior and planning for an improved relationship. When a mother can voice her regret and guilt, she may write with increasing awareness of the unique qualities and needs of her child.

Toni, a thirty-two year old woman with multiple sclerosis, entered treatment due to recurrent drug abuse (often used to self-medicate the pain of MS) with her infant, Junior. The following piece marked a turning point in the mother-infant relationship:
I’m writing this letter to you to tell you that I am sorry for all the pain I caused you while you were growing up inside. The only thing I can say is that I shared your pain. I know by saying I shared your pain doesn’t make up for the pain I caused . . . I have no excuses . . . I was sick with a disease called drug addiction and Mommy didn’t know that she was sick at all. Today all I know is that the love I have for you is the fairest star in the sky. I’ll never give that up again. Please forgive me. P.S. It’s time to live.

Love Mommy

As Toni expressed her guilt, her attention to Junior became more pronounced.

Junior shows his Mother love by smiling when she talks to him. He shows his appreciation by kicking his legs out when I bathe him. He stops crying with relief when I change his diaper. He gives a good burp with a smile when I feed him.

Awaken the artist! Teach women to see themselves as creators – “artists of the everyday” (Breathnach, 1987). Women feel connected and inspired to see their own work as valuable art when they discover that people share similar feelings but express them in different forms.

Conclusion

Writing is a powerful parenting tool in a drug treatment program. By writing about family, a client re-creates her relationships in a tangible form on the page. A client can reflect on, share and revisit these words. They have a visibility that beckons and calls for accountability. If a mother cannot find words to describe her infant, she knows something is missing. If she previously did not care about her child but now wants to care, she knows that words need to be found and emotions need to be displayed. This understanding is the beginning of healing; it is a stepping stone to empathy and good caregiving. When a treatment program cultivates writing within a supportive, caring atmosphere, reflection occurs without condemnation, words spill on the page, insight is gained, and parent-child relationships can improve.

— Kelley Evans, Yuri Iwaoka, Deirdre Graziano, M.Ed., The Women’s Treatment Center, Chicago, IL

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Role of Staff

The Mother’s Journal process differs for each facilitator as it does for each woman. However, staff is guided by a number of principles:

Create a safe place for exploration and reflection. Foster a supportive group environment through attentive listening, sensitivity to cultural issues, and validation of a woman’s strengths.

Respect the individual. Start where the client is; avoid confrontation that causes the client to retreat. Connect with clients’ pain without trying to provide solutions. Avoid overwhelming her or abandoning her to her feelings.

Reflect and communicate. Share suggestions; provide support through letters or personal conversations and follow-up on issues of concern with other staff.
Project Care is a medically based demonstration project designed to enhance the developmental outcomes, and decrease the abandonment, of children born to women who abuse illegal drugs or are HIV positive. Located at the Regional Medical Center in Memphis, Tennessee, it is administered through the Newborn Center at the University of Tennessee Memphis Health Sciences Center. The project has been funded since 1996 by an Abandoned Infants Assistance grant through the U.S. Department of Health and Human Services’ Children’s Bureau.

The Program

Women who deliver at the Regional Medical Center are enrolled in Project Care soon after delivery and followed for 24 months. The project provides comprehensive evaluation and intervention services delivered through a multidisciplinary team, interagency collaboration and coordination of services, center-based group participation programs, and interventions specifically designed to promote maternal-infant attachment.

Social workers provide intensive case management throughout the 24 months of involvement with the program. Mothers attend support groups conducted by a certified alcohol and drug abuse counselor. A parenting specialist teaches parenting classes. The babies are seen in the UT Newborn Center Developmental Clinic at ages one month, four months, eight months, twelve months, eighteen months, and twenty-four months. At each visit, they receive a physical examination conducted by nurse clinicians and psychological and developmental assessments conducted by developmental psychologists. Additionally, the social workers complete extensive interviews with the mothers.

Assessing for Infant Attachment

Essential to all of the services is an assessment of maternal-infant attachment. In an extensive psychological evaluation of the infants, the developmental psychologists use the Maternal Feeding Interaction and the Face-to-Face Interaction tests to assess the infants’ interaction with their mothers. The social workers assess the mothers’ attachment to, and interaction with, their infants through tools such as: the Parenting Stress Inventory, the Beck Depression Inventory, the Brief Symptoms Index, the Child Abuse Potential Inventory, the Infant Behavior Questionnaire, the Conflict Tactics Scale, and the Caretaker Inventory of Substance Abuse. The multi-disciplinary intervention team then works with the mother and infant together to help foster their mutual attachment by addressing difficult issues (e.g., substance abuse, sexual and physical abuse) and teaching appropriate parenting skills.

Additionally, in order to establish a healthy maternal-infant attachment, an infant must have a consistent primary caregiver. Therefore, promoting consistency of caregiver and establishing permanency are primary goals of Project Care. To this end, of the first 100 infants who completed twelve months of the program, 64 remain in the care of their mothers. The remainder are cared for by non-custodial relatives (13), in formal kinship care (10), in foster care (5), in adoptive homes (2), in the care of a non-relative who does not have custody (1), expired (1), or their caregiver status is unknown (6). Further, during the first 12 months in the program, only ten infants experienced a change in status of caregiver. One was returned to his mother (from a non-custodial relative); six were removed from their mothers’ care; two were moved out of foster care (one placed for adoption and one to a formal kinship care); and one was moved from a non-relative to formal kinship care.

Case Example

In 1996, when Denise became pregnant with David, she had seven children in foster care, three children that had been placed for adoption after parental rights were terminated, and one child in the custody of paternal relatives. As with the past two pregnancies, Department of Children’s Services (DCS) had notified the hospital of the pending delivery and had
requested that the baby not be released to Denise. She was not surprised when she delivered David to receive a visit from a Newborn Center Social Worker. However, things were different this time. Rather than being hostile and unresponsive as in the past, Denise was receptive and communicative. She had been clean and sober for over eight months.

Nevertheless, DCS took custody of David at the age of two days due to his mother’s extensive history with the department, her past inability to provide a stable and safe home, and her past inconsistency in cooperating with them. She would be required to complete an alcohol and drug counseling program, have negative random drug screens, complete parenting classes, maintain regular visits with David, provide legitimate proof of income through legitimate employment, maintain a safe and stable home, and report any changes of circumstances to the department. Denise was determined to complete the tasks assigned to her in order to be able to parent David and, ultimately, regain custody of some of her other children. The social worker’s offer to enroll Denise in Project Care gave her the resources she was looking for to achieve her goals.

Denise immediately became involved in Project Care and recently celebrated her two-year anniversary of sobriety with the recovery support group. She was able to apply things she was learning in Project Care’s parenting classes in the two-hour visits she had with David bi-weekly, and David’s attachment to his mother was obvious. The worker reported that he was always anxious to visit with his mother. “When we pull up in front of her apartment, he always starts to scream her name. When it is time for me to pick him up and take him back to the foster mother’s house, I am always met with tears, as he does not want to leave.” As Denise progressed in her treatment, her visitation with David was extended to overnight, unsupervised weekends and, several months later, David was returned to her home.

Denise says, “Project Care brought me through it this time. Everybody showed me nothing but love, and it came from the heart. It was sincere. I had never had any support before, even when I was trying, but now I have three years of sobriety. And, from day one, David knew I was his mother. Even from the first day of visitation at two weeks, he knew who I was. At all the places he had been and all he’s been through, he never lost that.”

**Conclusion**

Project Care offered Denise support in her efforts to continue her sobriety and become the mother she wanted to be. The project provided the resources and taught her the skills she needed to meet the requirement of DCS. Through Denise’s tremendous efforts and cooperation and the documentation provided by Project Care, she was able to overcome the departmental preconceptions of her attitude and abilities based on her past history and performance. Most importantly, although her son experienced foster care, his mother was present and involved with him from birth. This provided an opportunity for mother and son to form a mutual attachment, which gave David a better chance at healthy development and provided ongoing incentive for Denise to improve her situation.

— *Charlotte Bursi, Coordinator, Project Care*
Establishment of an attachment relationship with a primary caregiver is a critical milestone in the emotional development of young children (Ainsworth, 1973; Bowlby, 1969). In order to develop healthy attachment relationships with caregivers, infants need continuity of care as well as sensitive and responsive care. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), either repeated changes in primary caregiver or lack of adequate care can lead to Reactive Attachment Disorder of Infancy or Early Childhood (American Psychiatric Association, 1994).

Additionally, care that provides for the infant’s basic physical needs but is relatively insensitive or unresponsive to the infant’s attachment signals and emotional needs can lead to an insecure infant-caregiver attachment (Ainsworth, Blehar, Waters, & Wall, 1978; De Wolff & van Ijzendoorn, 1997). Although early insecure attachment relationships are not pathological, they place children at risk for subsequent emotional and interpersonal difficulties (Carlson, 1998; Erickson, Sroufe, & Egeland, 1985; Lyons-Ruth, Alpern, & Repacholi, 1993; Lyons-Ruth, Easterbrooks, & Cicchetti, 1997).

The attachment needs of infants are of particular concern given the fact that infants are more likely than older children to be placed in foster care (Goerge & Wulczyn, 1999). Between 1988 and 1994, 25% of first placements in foster care were infants (Goerge & Wulczyn, 1999). A number of these infants were placed in out-of-home care as a result of prenatal exposure to maternal substance abuse (e.g., 29% of Illinois infants in substitute care in 1992) (Goerge & Wulczyn, 1999).

This article discusses why infants in out-of-home placements are at increased risk of having experienced attachment disruptions that interfere with their emotional development. It also describes some of the barriers that prevent babies in out-of-home care from developing secure attachment relationships. Finally, the article suggests interventions and policies to facilitate healthy attachments in this at-risk population.

**Risk for attachment disruptions**

Out-of-home placement is typically associated with numerous disruptions in attachment relationships. These losses and lack of permanence undermine a child’s attempt to form a secure attachment with a primary caregiver. A number of the infants in substitute care are placed soon after birth and the median length of time infants spend in foster care ranges from almost a year in Texas to three and a half years in New York (Goerge & Wulczyn, 1999). In the life of a young child, this spans a critical portion of the child’s psychological and emotional development during a developmental period when forming a secure attachment is of paramount importance. It is during these early years that children determine who they will view as their caregiver. Thus, infants placed in out-of-home care for several months will come to view the caregiver who provides for their daily emotional and physical needs as their attachment figure. When working with infants in out-of-home placements, it is important to keep in mind that, unless the out-of-home placement is very brief, reunification or placement in an adoptive home constitutes an attachment disruption.

The rights of infants to the adequate, consistent care needed for healthy emotional development sometimes appear to be over-shadowed by the constitutionally protected rights of biological parents. According to Supreme Court interpretations of the Fourteenth Amendment of the Constitution, parents have a fundamental liberty interest in the control, care, and custody of their biological children (Miller, 1994; Swingle, 1995; Crawford, 1994). In light of this interpretation, the custodial rights of a biological parent must prevail even over the best interest of the child, absent what the courts call a “compelling interest” to the contrary. Thus far, courts have been reluctant to find a compelling interest in a child’s welfare in any but the most extreme circumstances (e.g., where there is a direct threat to the physical safety of the child). Thus, in cases where it is not safe to return infants to the care of biological parents but there is not sufficient reason to terminate parental rights, infants may experience extended stays in foster care, increasing their risk for attachment disruption.

**Risk of unresponsive care**

Research on the interactions of substance abusing mothers with their infants suggests significant difficulties in the mother-child relationship. In a study of infants placed with substance-abusing mothers following birth, seven percent died prior to one month of age and four percent were reported for abuse or neglect prior to six months of age (Tyler, Howard, Espinosa, & Doakes, 1997). Observations of cocaine-using mothers found they spent significantly more time disengaged from
their 12 to 48 hour old newborns than a comparison group (Gottwald & Thurman, 1994). When compared to a control group, polydrug using mothers are observed to be less attentive to their infants; mother-infant pairs engage in fewer dyadic interactions regardless of the child’s willingness to interact (Mayes, et al., 1997).

Very few substance abusing women are free from some type of economic disadvantage, mental illness, abuse, or poor social skills (Jeremy & Bernstein, 1984). Thus, it is not possible to determine whether the deficits in mother-infant interactions are due to maternal substance abuse or other maternal characteristics. This has important implications for treatment of mother-infant attachment difficulties as it indicates sobriety may not be sufficient to ensure sensitive, responsive maternal care.

At the same time, maternal separation from infants may compound preexisting mother-infant interaction problems. Mothers who are separated from their infants are less likely to be familiar with the child’s attachment signals. Thus, when reunification occurs interaction difficulties are further compounded by the infant’s grief over loss of an attachment figure and the mother’s lack of familiarity with the infant’s needs. Mothers separated from their infants may have less tolerance for their infant’s individual needs which may inadvertently lead to an increased risk of child maltreatment (Wobie, Eyler, Conlan, Clarke, & Behnke, 1997).

According to attachment theory, the quality of care provided in the kinship or foster placement will determine the type of attachment relationship the child and caregiver develop. Although there is little empirical data available on the quality of care provided in kinship and foster placements and the establishment of healthy attachment relationships with substitute caregivers, kinship placement has been found to be safer for infants than placement with an actively substance-abusing mother (Tyler et al., 1997). There is, however, a range of care provided in kinship placements with some kinship placements failing to provide the sensitive, responsive care needed for the development of a secure attachment (Tyler et al., 1997).

Among infants placed in foster care at less than a year of age, the nature of the infant-foster mother relationship is a reflection of the foster mother’s attachment style (Dozier & Stovall, 1999). Conversely, with toddler placements, the infant-foster mother relationship reflects the child’s previous attachment experiences (Dozier & Stovall, 1999). Thus, toddlers placed in out-of-home care after experiencing neglect or unresponsive care may actually need more responsive care than typical toddlers.

The type of out-of-home placement most likely to interfere with the development of healthy attachment in infants and toddlers is placement in a group care setting. During the 1930s and 1940s, there were detailed observations of the deleterious effects of group care on the physical and emotional health of young children (Freud & Burlingham, 1944; Spitz, 1945). Although the events of the 1980s and 1990s have been less dramatic than the events leading to the out-of-home placement of children in the 1930s and 1940s, the number of “displaced” children has again led to the placement of young children in group care settings. Thirteen to eighteen percent of children placed in group settings in California from 1988 to 1995 were under age six (Berrick et al., 1998). The minimum staffing ratio for infants in California group care is one adult to ten infants and there is a high staff turnover rate (Berrick et al., 1998). Thus, it seems highly unlikely that babies placed in group care will receive consistent, responsive care in these settings and make good attachments.

Reducing attachment disruptions

Residential treatment for substance abuse typically requires women to place their children in out-of-home care. Yet, women are more likely to complete treatment if they are not separated from their children (Wobie et al., 1997). A significant concern of women in treatment without their children is that they will lose permanent custody of their children during the treatment stay. Therefore, many mothers may terminate treatment prematurely to decrease that possibility.

Women whose children are allowed to stay with them during residential treatment experience the advantage of learning parenting skills from trained personnel at the facility, observing effective parenting skills used by other mothers, and receiving feedback on their parenting styles from others. Furthermore, they may learn strategies for handling the stress of parenting (Wobie et al., 1997). If they encounter this stress without support, their risk of relapse may increase.

In an attempt to expedite placements in a permanent setting to support healthy emotional development, concurrent planning has been promoted as a useful tool. Development of concurrent plans, when a child is in foster care, allows efforts to reunify children with their biological parents to take place simultaneously with efforts to achieve an alternative plan. Concurrent planning is one feature of the Adoption and Safe Families Act (ASFA) which was passed in 1997. An additional feature of ASFA is that the length of time for the biological parents to make significant progress on the goals outlined by the reunification plan is limited to twelve months, though judges can make exceptions. Both policies have the potential to reduce the attachment disruptions experienced by young children in out-of-home placements.

Concurrent planning specifically targets issues created by numerous disruptions in attachment relationships faced by infants placed in substitute care. By placing the child in the home of a foster family or family member who could become the child’s adoptive family if the biological parent fails to regain custody, further disruption of attachment relationships is prevented if the child is unable to be reunified with biological parents. Concurrent planning does not eliminate the stress that attachment disruptions cause babies and toddlers. However, it may limit the extent of the disruption by reducing the number of disruptions the child experiences.

According to ASFA guidelines, if biological parents have failed to make...
significant progress toward reunification at the end of twelve months, a petition to terminate parental rights can be filed. This time limit serves the ultimate goal to reunify child and biological parents within a timely manner. If the biological family is unable to make the changes needed to provide adequate care by this deadline, then the child may obtain permanency by remaining with his current caregiver for the purpose of adoption. This time limit is more congruent with a child’s sense of time and a child’s need for a stable, continuous relationship with a caregiver.

There are a number of issues with the application of concurrent planning that have not been resolved. For the attachment needs of infants, concurrent planning is clearly superior to the current system as it has the potential to reduce the number of attachment disruptions experienced by the child. For caregivers, however, the loyalty conflicts inherent in the plan have the potential to create friction between substitute caregivers and the biological parents. Although time limits are responsive to the child’s sense of time, this deadline creates additional stress for adults seeking treatment for substance abuse and the providers working with them as it decreases the amount of time available for recovery.

It is unclear what impact concurrent planning and the new time limits will have on quality of care. It is possible that concurrent planning may indirectly affect quality of care both in the out-of-home placement and in the home. The possibility that foster parents may adopt the child may increase their emotional investment in the child while in their home. However, there is also the possibility that reduced time lines in ASFA may cause social workers to return infants to parents before the quality of care is adequate in order to avoid termination of parental rights.

Improving quality of care

Regardless of the placement option used for at-risk infants, there should be an emphasis on the quality of daily care the infant receives. For infants who remain with a substance-abusing mother, residential treatment or extremely close supervision to ensure the infant’s safety is obviously critical. The reunification of young children with a mother who has completed treatment for substance abuse is also likely to be a particularly important time for intervention for the mother-infant dyad. It is necessary for clinicians to assess all relevant social factors that affect the quality of care provided when identifying interventions for the dyad. Although perinatal abstinence is one key aspect of facilitating positive mother-infant interactions (Blackwell, Kirkhart, Schmitt, & Kaiser, 1998), it may not be sufficient. Regardless of current status of sobriety, mothers with substance abuse histories often continue to lack positive parenting skills (Blackwell et al., 1998). Therefore, it is essential that ongoing parent-child interventions be emphasized in this population.

It also is important that quality of care be considered when placing an infant in a kinship placement. Family members of at-risk infants may face some of the same challenges to effective parenting as the infant’s biological parents. Thus, it is important to determine the level of support family members will need in order to provide sensitive, responsive care. Interventions may include concrete support services such as transportation to appointments, help with child care or other responsibilities, and therapeutic services. In addition, family members often need assistance in negotiating the changes that can occur in their relationships with the child’s biological parents following placement. Also, when a young child’s previous experiences in relationships make it difficult for him to communicate his needs to a caregiver, it may also be necessary to work directly with the children.

Foster parents may also need guidance in how to effectively respond to the attachment needs of sick or vulnerable infants. Again, both concrete support (e.g., day care) that helps foster parents have the energy to respond to young at-risk children and consultation about the infant’s attachment needs may be necessary.

When infants are placed in group care, the care should simulate, as much as possible, the type of care infants receive in a family setting. Caregivers should be assigned to particular infants rather than to particular tasks. The group care should be organized such that caregivers have the time and flexibility to learn the infant’s attachment needs and communications and respond to them.

Conclusions

When addressing the attachment needs of babies in out-of-home placements, it is important to recognize the critical importance of current caregiver relationships on young children. We need to consider both the baby’s need for continuity of relationships and his need for sensitive, responsive care. In some cases, it may be necessary for the baby to experience a disruption in an attachment relationship in order to have sensitive, responsive care with an alternative caregiver. In other cases, it may be possible to increase the current caregiver’s responsiveness and prevent the disruption of the attachment relationship. Both factors must be given equal consideration.

— Beth Troutman, PhD, Assistant Professor of Clinical Psychiatry, and Michelle Cardi, MA, Research Assistant, University of Iowa Hospitals and Clinics; Susan Ryan, MA, Doctoral Candidate, School Psychology Program, University of Iowa

REFERENCES


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**SAVE THE DATE!**

**— AUGUST 3-4, 2000 —**

**Healing Havens for Families Affected by Substance Abuse**

This national conference will highlight Shared Family Care and other innovative strategies for supporting and strengthening whole families affected by alcohol and other drugs. It will provide information on developing and implementing these time-limited residential programs, which assist families with young children in obtaining the skills and resources they need for independent, sober living. Designed for administrators, policy makers and direct line staff from public and community-based organizations in the fields of child and family welfare and substance abuse, the conference will provide training on both administrative and service issues. The conference will be held in the San Francisco Bay area.

For more information or to receive registration information or the call for papers, contact Amy Price, AIA Resource Center, 1950 Addison St., Suite 104, Berkeley, CA 94704-1182. (510) 643-8383.

E-mail: amyprice@uclink4.berkeley.edu.

http://socrates.berkeley.edu/aiarc.
child may appear to be extremely inhibited, may engage in self-endangering behavior, or may reverse roles and offer emotional relief to the attachment figure to whom she would more appropriately turn for comfort and safety herself.

Treatment of Attachment Disorders

There are several models for treating attachment disorders. Some of them have sprung up in response to an increase in numbers of children in foster care and children adopted from institutions in the Eastern European block countries. Children from these backgrounds often present as non-attached to any particular caregiver. Keck and Kupecy (1995) use therapeutic holding in their work with poorly attached children and adolescents. Therapeutic holding is a technique in which the child is physically held on the laps of two therapists and/or parents. The holding is intended to provide physical containment, which can be reassuring if frightening feelings are aroused. The therapist maintains eye contact with the child throughout the holding, even turning the child’s head toward her physically if that becomes necessary. Holding is thought to heighten emotional contact between the therapist and the child and to increase the child’s capacity to attach. Proponents of holding maintain that the child’s increased capacity for attachment is transferrable from the therapist to the parent. Hughes (1997) describes a treatment method for working with non-attached children that encourages the caregiver to treat the child in a severely regressed manner, keeping the child under the constant close supervision of the caregiver and perhaps even permitting the use of diapers and a bottle by older children. Hughes’ method also makes use of therapeutic holding as part of the treatment modality. These methods are based on the premise that, because attachments grow from the whole history of interactions between an infant and her parents, children who have not formed attachments must be encouraged to regress to an infantile psychological state so that attachment growth can be fostered.

Disordered Attachment

Lieberman and Zeanah (1995) make the important point that a child does not have to be non-attached to have disorders of attachment. This is a major step forward that they have made in diagnosing relational problems in infancy that put a baby at developmental risk. As they point out, the principal difference between a disorder of non-attachment and a disordered attachment is that in the latter, the child does express a preference for a particular attachment figure. The preference, however, is unlike normative attachment patterns (even insecure ones) in that it is characterized by intense conflict that pervades the relationship because of intense negative feelings such as anger, fear or anxiety. The child does not express these emotions directly, but masks them with defenses that interfere with the heart of his attachment relationship. Such a...
Example of infant-parent psychotherapy used with a drug-addicted mother

Karen was separated from her daughter, Lily, at birth because Karen had sought no prenatal care, and she and Lily both tested positive for several substances (including heroin and methadone), and she had no stable home. Lily was placed in a group home where she was cared for by nurses and aides, including one nurse who was assigned to be her particular caregiver. Karen engaged in a day treatment program and visited Lily several times a week. Karen and her frequent comings and goings were confusing to Lily. The staff at the home noted that Lily cried frantically whenever Karen left her, but that when Karen was with her Lily was sometimes clingy and sometimes pushed her away or ignored her overtures.

When Lily was ten months old, Karen was admitted to a clean and sober house for mothers and young children, and Lily was transitioned to her care. The referral for infant-parent psychotherapy was made to facilitate the transition and to support Karen in undertaking the fulltime care of her daughter. Karen was thrilled that her daughter, Lily, at birth because Karen used with a drug-addicted mother

Summary

Attachment, an affectional relationship between mother and baby and, later, between other caregivers and baby, is central to the personality development of every infant. Secure attachment can be derailed in many ways. Economic and social stresses, mental illness, substance abuse, and the constitutional vulnerabilities of the child can all act to place difficulties in the path of the relationship between a baby and her mother. These relationships can, however, be healed, and the baby returned to a hopeful developmental path.

— Patricia Van Horn, PhD, Assistant Clinical Professor of Psychiatry, University of California at San Francisco, and Research Coordinator, Child Trauma Research Project, San Francisco, CA

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