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EASTERN EUROPEAN ADOPTION: A THEORETICAL STUDY OF
ATTACHMENT DISORDER THROUGH A SELF PSYCHOLOGY LENS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2007

ACKNOWLEDGEMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

I wish to thank my research advisor Anita Glicken for her patience and encouragement throughout the year. Marilyn Folwer the Boulder Mental Health Center librarian for the time and interest she displayed over the year and for her help searching out literature on the study question. Finally, I would like to thank all my friends especially Bindu Pomeroy who supported and inspired me in the writing process.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
ABSTRACT.....	iv
CHAPTER	
I. INTRODUCTION.....	1
II. METHODOLOGY.....	4
III. PHENOMENON.....	9
IV. ATTACHMENT THEORY.....	24
V. SELF PSYCHOLOGY.....	42
VI. DISCUSSION AND CONCLUSIONS.....	60
REFERENCES.....	75

Andrea Leadbetter Larkin
Eastern European Adoption:
A Theoretical Study of
Attachment Disorder through
a Self Psychology lens

ABSTRACT

This theoretical research paper focuses on both attachment theory and self psychology to examine the consequences institutions have on infant mental health. The research specifically addresses Eastern European institution infants that develop reactive attachment disorder. The research discusses the current treatment solutions for reactive attachment disorder using the two aforementioned theoretical lenses. Institution infants are an important target for research because the pathogenic care provided by institutions inherently disrupts the infants early attachment needs.

The findings of this study were as follows: 1) It would benefit potential adoptive parent to participate in educational training about reactive attachment disorder. 2) Adoptees that develop reactive attachment disorder need to be treated with empathy despite the symptoms. 3) The adoptive parents need to take responsibility for getting the adoptee the mental health care that is appropriate.

CHAPTER I

INTRODUCTION

In recent years potential adoptive parents from the United States have increasingly turned to Eastern European countries for white babies to adopt. Due to the shortage of healthy white babies within the U.S. and the long waiting lists, adopting children from Eastern Europe is one of the quickest ways to become an adoptive parent. According to the Child Welfare Information Gateway in 2003, the United States government recorded 21,616 visas issued to children adopted internationally. Just two years later in 2005 a total of 22,728 visas were issued to international orphans.

As the adoptees await their final destination during the adoption process, most of the orphans are housed by the country of origin in large, understaffed institutions where they receive little to no healthcare or personal attention. The U.S. Department of State warns potential adoptive parents that it may take six to twelve months before the parents can remove the child from the provided institutional care and the country of origin. The child can experience emotional and developmental delays during the lengthy adoption process and become traumatized before arriving in the United States. Effectively treating the attachment disorders the majority of Eastern European adoptees incur while residing in institutions is an emerging concern for clinicians.

This study will examine how understanding attachment disorder through a self psychology lens could help reduce the potential life long effects of attachment disorder and promote healthy development in Eastern European adoptees. Current research has found that Eastern European adoptees are more likely to struggle with attachment disorders than children raised by birth parents (Fries et al, 2004). The intention of this study is to help inform clinical social workers and researchers of a possible theory-based intervention for treating attachment disorder in Eastern European adoptees.

Theoretical research is specifically needed to help clinicians understand how to more effectively promote the healthy development of institution infants. As Carla Leone argues “a solid theoretical framework for understanding how and why problems develop” in Eastern European adoptees “can help guide the clinician through the maze of possible treatment options to those that are likely to target most directly the causes of the problems and be most effective in addressing them” (Leone, 2001, p. 275). Lisa Serbin agrees with Leone and notes that there is a “lack of awareness in the research community regarding the theoretical relevance” of research in the area of Eastern European adoption which needs to be addressed (Serbin, 1997, p. 87). Serbin argues that theoretical research is imperative because it is necessary for the elucidation of developmental issues (Serbin, 1997, p. 87). Thus, the purpose of this study is to further examine how an understanding of attachment

disorder through a self psychology lens will help reduce the potential lifelong effects of attachment disorder and promote healthy development in Eastern European adoptees and their adoptive families.

CHAPTER II

METHODOLOGY

Introduction

Eastern European adoption is a popular solution among white couples in the United States searching for white infants to adopt. This research paper will use both attachment theory and self psychology to examine the consequences institutions have on infant mental health. The research specifically addresses those institution infants that develop reactive attachment disorder. The research will then discuss the treatment solutions for reactive attachment disorder using the two aforementioned theoretical lenses. Importantly, children that have not been institutionalized can develop attachment disorders. However, institution infants are an important target for research because the pathogenic care provided by institutions inherently disrupts the infants early attachment needs. Thus, institution infants are at a far higher risk for developing reactive attachment disorder.

Research Design

The theoretical research design will allow this paper to investigate empirical and observational studies which provide insight into both the institution infant's experience with and reactions to unmet attachment needs throughout life. By studying John Bowlby's attachment theory this paper will recognize how important it is to identify and then treat reactive attachment disorder. It is noteworthy however,

that attachment therapy, the current treatment for the emotional and social turbulence the institutional infant experiences in life, does not always reduce the symptoms of reactive attachment disorder. It is important to continue to conduct empirical and theoretical research to find more effective treatments for attachment disorder. This paper will consider self psychology as a theoretical perspective which could inform Bowlby's work and reveal a more operational model for the clinical treatment of attachment disorder.

Before it is possible to determine if self psychology can inform Bowlby's work, the research must look at and understand attachment theory and self psychology separately. The paper will identify and discuss not only each theoretical perspective of human development but also, each theory's definition of mental health. Conclusions can be drawn about if and how self psychology can inform clinical interventions with the patient with attachment disorder after the analysis of both theories is complete. Once it is determined whether self psychology is useful in the treatment of attachment disorders clinicians will be more able to adapt current and apply new treatments. It is one conjecture of this project that without further research, institution infants will suffer grave emotional consequences for the duration of their lives.

Research Question

The specific research question for this paper is: how will understanding attachment disorder through a self psychology lens help reduce the potential lifelong effects of attachment disorder and promote healthy development in Eastern European adoptees and their adoptive families? This question will be addressed by identifying and analyzing each theory's fundamental principle. The principle will then be used to consider the common experience of institution infants. Therefore, the research will not be grounded in an individual case study but, rather in the collective experience of most institution infants.

Sequence of Chapters

The third chapter of this study will establish the need for research to be conducted regarding the research phenomenon, reactive attachment disorder. The chapter will both define and present empirical research on reactive attachment disorder. This section will show that reactive attachment disorder is prevalent among institution infants and that the mental health of institution infants is dependent on consistent and quality long term treatment. Therefore, it is important to continue research for improving clinical methods with attachment disorder.

The fourth chapter will provide a comprehensive review of attachment theory and the empirical evidence which validates the theory. The review addresses how children develop in an institution and why the children develop attachment disorders.

This chapter will show that there are many different attachment styles depending on the level of care provided. The empirical evidence will consider how attachment disorders effects children over a lifespan. The research on attachment theory will also show that treatment is ineffective in some cases and needs to be refined.

The fifth chapter will examine Heinz Kohut's self psychology as a possible theory to inform attachment theory and refine the current treatment model for attachment disorder. A review of the literature on self psychology will be presented along with the observational data collected by Heinz Kohut and his colleagues. Importantly, unlike attachment theory, self psychology is not empirically researched. However, this study will show that the fundamental principals of both self psychology and attachment theory are closely linked.

Based on the previous chapters, the final chapter in the study will offer the findings and conclusions of this theoretical study. The fundamental underpinnings of each theory will be reviewed and synthesized to create a deeper understanding of the phenomenon and provide an answer to the research question.

Methodological Biases

Personal biases will be present from the onset of this theoretical research project. First, the researcher has personal experience with reactive attachment disorder and how devastating its long lasting symptoms can be to a child. This experience lends the researcher to believe the more pessimistic research results are

more accurate. Second, the researcher's personal experience may make it difficult to remain objective throughout the project and present each side with consistent levels of skepticism. Finally, it will be difficult not to get overly excited about finding a more effective treatment model. Thus, these personal biases will be necessary to keep in mind as the reader progresses through the following chapters.

Conclusion

The following chapters use a theoretical approach to investigate the situation of institutional infants that develop reactive attachment disorder. The paper uses those findings to consider the theoretical possibility for more effective treatment. This study is needed because more families are looking to Eastern Europe for white babies to adopt. However, once the infants arrive in the United States, both the families and the clinicians are failing to relieve the symptoms of attachment disorder.

CHAPTER III
EASTERN EUROPEAN ADOPTION
&
REACTIVE ATTACHMENT DISORDER (RAD)

A Brief History of Eastern European Adoption

When media coverage exposed numerous images of orphaned children during the early years of the Cold War, interest in Eastern European adoption increased among the American public (Herman, 2005). The media images of these destitute children inspired American families and religious charities to rescue the orphans (Herman, 2005). In 1953, Congress passed The Refugee Relief Act, which allowed four thousand visas to be issued to orphans over a three year span (Adamec et al, 1991). In the late 1950's, however, the proxy adoption became the easiest way for sympathetic American families and religious sects to adopt Eastern European orphans (Herman, 2005). Proxy adoptions were unregulated, and allowed Americans to adopt an unlimited number of children without visiting either the country or the adoptee. The government did little to respond to the increasing adoptions or to regulate adoption from Eastern European nations. Therefore, the statistics on Eastern European adoption in the 1950's are unreliable.

Research recorded by the *Encyclopedia of Adoption* found that in the 1990's regulations on international adoption became more stringently enforced by both the

United States and the Eastern European countries (2006). At The Hague Convention, the United States and Eastern European governments developed a new international treaty on adoption. The treaty allowed more reciprocity between countries. Prior to the treaty, citizens of the U.S. were able to adopt from foreign countries, but the U.S. prohibited the adoption of U.S. born children by non-U.S. citizens living abroad (Adamec et al, 1991). Further, in the late 1990's, a new motivation for U.S. citizens to adopt internationally emerged. The demand for healthy white babies in the United States was rising. However, greater acceptance of contraception and abortion decreased the available number of domestic white babies (Encyclopedia of Adoption, 2006). Therefore, U.S. citizens turned to Eastern European orphanages to find white children to adopt (Encyclopedia of Adoption, 2006).

Though Eastern Europe supplied the U.S. with white babies to adopt, little was known about the toll institutionalization had on the adoptees. However, as the institutionalized children began to exhibit extreme signs of delayed social and physical development (withdrawn and/or socially aggressive behaviors and stunted growth) scholars began to study and categorize the adoptees (Groark et al, 2005). Research has found that the most common diseases Eastern European adoptees can arrive to the United States with are Tuberculosis, intestinal parasites and Hepatitis B. As a result, before the adoptees travel to the U.S. the United States Department of State now requires the adoptees receive a medical examination and that infectious

diseases are treated. In Christina Groark's study *Improvements in early care in Russian orphanages and their relationship to observed behaviors*, she describes the physical and emotional affects of institutionalization on children:

Research indicates dire consequences to children who are raised in depressed institutional environments...such children may be malnourished, have intestinal disorders and skin diseases, be of smaller stature and weight, display marked developmental delays, eat voraciously, fail to eat solids, lie quietly in bed without calling or trying to get up, exhibit stereotyped behaviors, withdraw from other children, shift from early passivity to later aggressive behavior, are overactive and distractible, are unable to form deep or genuine attachments, are indiscriminately friendly, and have difficulty establishing peer relationships (Goark et al, 2005, p. 100).

In 1980, the American Psychiatric Association released the DSM-III-TR which equated the adoptees abnormal social behaviors and physical growth with "failure to thrive" children (Zeanah, 1996, p. 43). However, it was specified that children must be eight months or younger to be diagnosed with failure to thrive. Therefore, in 1994 the America Psychiatric Association created a new classification for children five years and younger who exhibited delayed social development. In the DSM-IV-TR the diagnosis is referred to as reactive attachment disorder (RAD).

Though the behaviors which constitute reactive attachment disorder must appear before the age of five, the age a child is adopted is associated with the success of their psychosocial development and their integration into family life (Howe, 2001). For instance, David Howe found in his study *Age at placement, adoption experience and adult adoption people's contact with their adoptive and birth*

mothers: an attachment perspective, that children adopted during infancy display an increased risk for poor peer relationships, behavior problems at home (Howe, 2001). The study also showed adoptees are also more likely to be referred to therapists for treatment and medications consultations (Howe, 2001). Further, Howe noted in his study that the longer a child remains institutionalized the more profound the developmental impairments (Howe, 2001). Howe's study explains that the reason the older adoptees have a more pronounced risk for developmental impairments is not simply their age but, their long "histories of adversity, deprivation, neglect, rejection and abuse" (Howe, 2001, p. 223). Finally, Howe's study proved that, reactive attachment disorder is definitely associated with how long a child is exposed to pathogenic care (Howe, 2001). Therefore, an adoptees successful assimilation into family life post-institution is dependent on the duration of the child's institutionalization.

Introduction

Government-run institutions have cared for orphaned children for centuries. However, scholars have recently questioned the effects that institutions and sustained deprivation have on orphans. Due to the increase in number of Eastern European adoptions academics have directed research toward examining the consequences of both the short-term and the long-term effects of institutionalization on children. According to the results of the empirical research conducted on institutionalization,

the majority of Eastern European adoptees arrive in the United States with reactive attachment disorder (RAD) (Hesse & Main, 2000).

Eighty percent of the Eastern European adoptees that arrive in the United States meet the criteria for reactive attachment disorder (Hesse & Main, 2000). Most Eastern European adoptees present with RAD symptoms because they are deprived of and are unable to attach to a warm, attentive, and loving caregiver. Forming healthy attachment relationships from zero to twenty-six months is crucial for physical and emotional development (Reactive Attachment Disorder, 2006, slide 5). Roy Lubit's study, "Child Abuse & Neglect: Reactive Attachment Disorder," shows "the long standing absence of emotional warmth took an enormous toll on the children, primarily on their emotional development but also on their physical growth" (Lubit, 2006, p. 1). The early attachment relationships are the foundation for and predictors of the child's intellectual abilities, logical thinking process, and the child's development of a conscience (Reactive Attachment Disorder, 2006, slide 5).

Empirical studies show the early deprivation of institution infants places them at a higher risk for developing RAD (O'Connor & Rutter, 2000). Children diagnosed with RAD engage superficially with adults, are destructive toward others, animals, and the self. They will not make eye contact, and have poor peer relationships; they also lack a conscience, and have poor impulse control. If RAD is not effectively treated by clinicians, the family may be scrutinized by the community

and be frustrated and exhausted by the child's behavior (Reactive Attachment Disorder, 2006, slide 14).

Reactive Attachment Disorder

A child who presents with RAD has difficulty forming loving and permanent relationships and displays an inability to be sincerely affectionate with others. As a result of their rearing environment, children diagnosed with RAD usually have not developed a conscience and do not trust adults (Reactive Attachment Disorder, 2006, slide 2). It is important to note that RAD can manifest itself in two different ways. The DSM-IV-TR classifies the two types of RAD as either inhibited or disinhibited. First, a child with the inhibited type persistently fails engage in social activities and withdraws from others (DSM-IV-TR, 2000). Roy Lubit found that the reason Eastern European institution infants develop the inhibited form of RAD is because they:

Are exposed to multiple caregivers simultaneously or sequentially [and] do not experience the sense of security associated with unique and exclusive long-standing relationships. No opportunity exists to trust one person because past relationships were interrupted, disrupted, or consistently unreliable (2006, p. 7).

A child with the inhibited form of RAD is not socialable; however, a child with the disinhibited type presents as socially promiscuous (DSM-IV-TR, 2000). Lubit's study results found that children diagnosed with the disinhibited form of

RAD are less likely to have been placed in institutions but rather, in multiple foster homes or different relatives (Lubit, 2006). Therefore, there is no consistent caregiver in their lives (Lubit, 2006). Children that present with the disinhibited form of RAD are not wary of strangers and do not chose attachment figures with caution. Therefore, both types of RAD correlate a child's inability to relate socially with the absence of an adequate caregiver.

DSM-IV-TR Diagnostic Criteria for RAD

In 2000 the DSM-IV-TR introduced RAD as an official diagnosis. The specific clinical criterion for RAD consists of the following:

- A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before the age of 5 years, as evidenced by either (1) or (2):
 - (1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)
 - (2) diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g. excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)
- B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet criterion for Pervasive Developmental Disorder.
- C. Pathogenic care as evidenced by at least one of the following:
 - (1) persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection
 - (2) persistent disregard of the child's basic physical needs

- (3) repeated changes of primary caregiver that prevents formation of stable attachments (e.g., frequent changes in foster care).
- D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specific type:

Inhibited Type: If Criterion A1 predominated in the clinical presentation

Disinhibited Type: If Criterion A2 predominates in the clinical presentation

Literature on RAD

To diagnose a child with RAD is controversial because of the potential stigma placed on the child. However, Jerry Wiener argues in his essay *Concepts of Diagnostic Classification*, it is imperative to treatment and to research that those children with RAD are diagnosed. Wiener argues, “establishing a diagnosis is not an academic exercise; it is done in the interest of the patient, and it helps the clinician to determine the best treatment and to predict outcome” (Wiener, 1997, p. 25). It is important to identify a child with RAD so clinicians can implement the most recent and the most effective therapeutic treatment. Further, to conduct accurate research a series of patients with similar biopsychosocial histories must be followed, without diagnostic criteria it would be difficult to recruit participants for studies (Wiener, 1997). Therefore, the benefits to diagnosing children with RAD are twofold: treatment can be tailored specifically to RAD and research can work to develop more effective treatments for RAD.

Currently, it is difficult to treat RAD. There are no pharmaceutical remedies and the therapeutic interventions can take years to be effective. The research tends to conclude that the early mother-infant bond lays the foundation for a person's relationship patterns for the duration of his or her life (Lubit, 2006). For instance, Bowlby notes:

In the life of an individual, it is the 'patterns of behavior' perceptible in infancy that 'must be the original endowment form which the purely mental states develop; and that what is later regarded as inner, be it an emotion, an affect, or a fantasy, is 'a residue' that remains when all forms of associated behavior are reduced to vanishing point (1969, Vol. 1, p. 6)

More recently, in Arthur Green's study of abused children, the results concur, with Bowlby's; showing that peers regarded abused children as antisocial. The peers noted such antisocial behaviors as aggressiveness and disruptiveness and cited the abused children's difficulty with sharing and leadership (Green, 1997). The negative effects of RAD on a child's life make it paramount that theorists and researchers alike work to develop new and effective treatments for children who develop RAD.

Research on RAD also indicates that neglected children develop RAD in response to various early life experiences. William Kronenberger presents four life situations that place children at high risk to develop RAD: 1) hospitalization 2) institutionalization 3) abusive and neglectful homes 4) children who fail to develop normally because of maladaptive parent-child interactions and relationships such as conflict (Kronenberger et al, 1996). The Eastern European adoptees

diagnosed with RAD have experienced severe emotional and physical neglect and pathogenic care in the institutions where they are placed after birth. As a result of their chronic neglect Eastern European adoptees have significant difficulty comprehending the comfort and safety of a secure attachment relationship (Hughes, 1999). Thus, Eastern European adoptees are at high risk for developing RAD.

At birth, Eastern European adoptees experience what Daniel Hughes terms “the trauma of absence” (Hughes, 1999, p. 559). Instead of experiencing a secure attachment to a caregiver, the adoptees are traumatized by the absence of a permanent and warm caregiver. Hughes postulates that the trauma the child endures at its separation from the mother can stunt the child’s emotional development (Hughes, 1999). Sue Chapman agrees with Hughes’ argument that the child is traumatized when it is separated from the mother-figure. In the *British Journal of Special Education*, Chapman asserts that when a child is born it does not understand itself as separate from the mother. As a result, the child fears annihilation when it is taken from the mother during early infancy. Therefore, an infant who is taken from its mother and placed in an institution becomes preoccupied with survival: “the child remains focused on meeting his primary needs and surviving. Without healthy bonding and attachment to a parent, the child is not free to focus his attention on things other than survival” (Chapman, 2002, p. 92). In the situation Chapman presents, the child’s fear of annihilation is so great that the child is unable to learn

how to form healthy attachments. Chapman and Hughes conclude that without any healthy attachment the child is likely to develop RAD and experience great developmental difficulty as an adoptee and throughout life.

In comparison to Chapman and Hughes' conclusions, Neil Boris' essay on RAD offers a more optimistic understanding of the disorder. Boris predicts that though early attachment deprivation can cause significant attachment difficulties later in life, children can learn to form healthy attachments. In the *Journal of the American Academy of Child and Adolescent Psychiatry*, Boris notes that if the child is placed into a nurturing home, the RAD symptoms will be reduced despite the early fears an infant experiences at separation from its mother (Boris, 2005). Note, even if the child's relationship to the caregivers is compromised as the symptoms of RAD dissipate the child may no longer meet the DSM-IV-TR criteria for RAD (Boris, 2005). Boris argues, that research has not yet shown there is a critical time during development when a person learns to form healthy attachments. Rather he states, that healthy attachment relationships can be developed at any stage in life (Boris, 2005). Thus, Boris agrees with Chapman and Hughes that early deprivation greatly disrupts a child's ability to attach to a caregiver. However, Boris argues that children are resilient, and disagrees that the impacts of neglect and of the RAD symptoms permanently prohibit achieving healthy attachment.

David Howe's study, *Age at Placement, Adoption experience and adult adopted people's contact with their adoptive and birth mothers: An Attachment Perspective*, found that the combination of early institutional life and an attachment disorder "increases the risk of adoptive parents and older children becoming emotionally distant and disengaged" (Howe, 2001, p. 234). However, like Boris, Howe argues that adoptive parents and their adopted children can avoid developing a distant relationship. Howe's study showed that empathetic adoptive parents are better able to understand the adoptees behavior and are more likely to be compassionate and available to the adoptee (Howe, 2001). At the same time as understanding attachment styles teaches adoptive parents how to relate to their Eastern European adoptees, it teaches the adoptee that they can rely on their caregivers for consistent treatment (Howe, 2001).

Daniel Hughes agrees with Howe and contends that the caregiver's presence in therapy is essential so they begin to build a healthy attachment relationship with their adoptee. Parents can build this relationship by providing consistent emotional reinforcement, attunement experiences, and a sense of safety during the stresses of treatment (Hughes, 1999). Furthermore, the caregiver's presence during therapy helps the child to separate the adoptive parent from their previous pathogenic caregivers (Hughes, 1999). Therefore, the family's commitment to the therapeutic

process is one crucial component to treating children who have developed RAD so they can experience life long healthy attachments with caregivers.

Attachment Therapy

Attachment therapy is rooted in attachment theory and is currently the most effective treatment modality for children diagnosed with RAD (Kelly, 2003). In Victoria Kelly's article *Theoretical Rationale for the Treatment of Disorders of Attachment*, she notes that "the important contributions from academic attachment research promote and inform an ever broadening continuum of interventions for attachment-related difficulties" which is "grounded in attachment theory" (Kelly, 2003, p. 4). Research has shown that attachment therapy is one of the successful interventions for insecurely attached children (Kelly, 2003). First, attachment therapy develops mental models of security. Second, the feeling of security allows the child the space to learn how to modulate emotion. Third, as the child learns to modulate emotion, the child will experience more positive interactions with his/her environment. Finally, the child will begin to expect positive reactions to his/her actions in the future from the environment.

To promote positive feedback from the child's environment attachment therapists create a safe space for the child to develop emotionally. Attachment therapists create this safe environment by establishing more effective communication; greater attunement and shared interactions that amplify the positive

affective states and reduce the negative (Kelly, 2003). Establishing such an intimate relationship with an insecurely attached child is difficult. In his essay *An Attachment-based treatment of maltreated children and young people*, Dan Hughes notes that therapists must directly address disruption in the safe setting and then repair the relationship before progressing in treatment (Hughes, 2004). Further, it is important that adoptive parents understand and replicate the same safe environment at home that the therapist creates in the office (Hughes, 1999). Therefore, attachment therapy can be a successful treatment when it allows insecurely attached children to confront and resolve attachment fears without consequence to the therapeutic or parental relationships.

Conclusion

This chapter presents a brief history of Eastern European adoption and discusses the previous studies and research completed on reactive attachment disorder (RAD) and its clinical treatment. The studies all note that the majority of Eastern European institutional infants experience difficulty achieving developmental milestones. As a result, the research shows that when eighty percent of these institutional infants are adopted they meet the criteria for, and are diagnosed with, RAD (Hesse & Main, 2000).

It is necessary to understand RAD not only as a phenomenon, but also as a disorder which has effective treatment models clinicians can use to work with

Eastern European adoptees that have developed RAD. As Daniel Hughes writes in his text Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioral Change in Foster and Adopted Children:

Too often we have saved these children from abuse, but we have failed to encourage their healing. We have failed to show the child how to respond positively to a relationship with a parent...with these children, our primary responsibility is to provide them with the opportunity for an attachment to a caring and capable parent and then focus all our energies on successfully facilitating this attachment. Within this context, the child has the means of developing a sense of self that is both positive and competent (1997, p. 2).

Here, Hughes not only notes the need for more research on Eastern European adoptees but also, emphasizes the importance of attachment to caregivers and the development of a cohesive self. Clinicians then must have an extensive knowledge of attachment theory to understand the effect of chronic neglect on infants and children. Thus, to facilitate treatment, research must be performed in order to identify and investigate the most effective theoretical lens through which to work with the adoptees that present with RAD symptoms and their families.

CHAPTER IV

ATTACHMENT THEORY

Introduction

Before 1950, attachment theory and the concept of a healthy attachment had not been developed, and the impact of institutionalization on children was not documented. As a result, it was common practice to institutionalize orphaned children. However, in 1950, the World Health Organization became interested in the mental health of homeless children (Bowlby, 1969, xi). In 1956, John Bowlby agreed to study neglected children and the consequences of that neglect on development. From his research, Bowlby developed attachment theory. In the first of three volumes that articulate the premise of attachment theory, Attachment and Loss, Bowlby states the theory's fundamental idea: "What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment" (Bowlby, 1969, xii). Since the release of Bowlby's tri-volume publication many scholars and researchers including Rene Spitz (1965) have pursued and extended his ideas with both theoretical and empirical evidence. Attachment theory is now accepted as a way to explain how crucial an infant's early attachment to a caregiver is to successful development.

Bowlby's Attachment Theory

Attachment theory states that to rear a healthy infant requires an infant's confidence in a caregiver's ability to provide a secure base for development. The caregiver becomes a secure base by being consistently accessible and responsive to the infant's emotional and physical needs. First, an infant that judges a caregiver accessible and responsive whenever the infant desires or needs attention, "...will be much less prone to either intense or chronic fear than will an individual who for any reason has no such confidence" (Bowlby, 1973, p. 202). Research suggests Eastern European institution infants often do not experience consistent care from a warm or permanent attachment figure (Bowlby, 1969). The chronic neglect and fear the institution infants feel as a result leads many to develop symptoms indicative of reactive attachment disorder (Crittenden & Ainsworth, 1989).

Second, Bowlby notes that it is not just during infancy that an individual can develop healthy attachments. Attachment theory proposes there is a sensitive period when confidence in an attachment figure slowly develops. Bowlby argues, "confidence in the availability of attachment figures, or lack of it, is built up...during the years of immaturity – infancy, childhood, and adolescence" (Bowlby, 1973, p. 202). These are crucial years for healthy development because the expectations an individual develops in these years usually endure unchanged for a lifespan (Bowlby, 1973). Finally, Attachment theory postulates that how accessible and responsive an

individual is to others reflects how accessible and responsive attachment figures were to them during their years of immaturity (Bowlby, 1973). Therefore, Bowlby presents an optimistic theory which states that Eastern European adoptees placed into homes with accessible and responsive caregivers during the years of immaturity will have the potential to develop healthy attachment behaviors.

Before institution infants are placed in nurturing homes, the inconsistent and negligent care prevents institution infants from experiencing mutual satisfaction or enjoyment from any care they receive. For instance, Bowlby noticed in one of his studies that infants raised in institutions first smiled a couple of weeks after most family infants begin to smile (Bowlby, 1969). This deviation can be accounted for because Eastern Europe's institution infants lack the attention family babies receive and thus, are less likely to know how to respond to stimuli (Fries, 2004). Therefore, most institution infants will experience great difficulty navigating Bowlby's developmental phases of attachment.

The Four Phases of Attachment Theory

Bowlby's attachment theory presents four phases of attachment necessary for an infant's healthy development. First, the infant is oriented toward and signals without discrimination to adults. Throughout this attachment phase an infant can signal toward people, but the ability to differentiate between people is nonexistent or very limited. This phase lasts from birth to not less than eight weeks of age, and

more usually to about twelve weeks. However, it may continue much longer in the presence of pathogenic care (Bowlby, 1969). It is important to note that theoretically Eastern European adoptees with disinhibited reactive attachment disorder have not negotiated this phase of attachment (Hughes, 1997).

Second, the infant is oriented to and signals directly to one (or more) discriminated figure(s) (Bowlby, 1969). This phase lasts until about six months of age, or later if the infant experiences neglect. If this phase is navigated successfully, “an infant continues to behave towards people in the same friendly way as in phase one, but does so in a more marked fashion towards his mother-figure than towards others” (Bowlby, 1969, p. 266). An Eastern European institutional infant may experience developmental arrest during this phase because they do not have consistent physical and emotional contact with a permanent caregiver (Fries, 2004). During the first two phases of attachment, an infant learns how to respond to stimuli in a mutually enjoyable way and develops a preference for the mother-figure.

Attachment theory’s final two phases of development the infant not only learns how to attract and maintain the attention of the primary caregiver, but also forms a goal-driven partnership with that caregiver. The third phase of attachment theory usually begins at six months, but can be delayed until after the one year is an infant has little contact with a permanent attachment figure (Bowlby, 1969). At this time, the child is able to follow a departing caregiver, greet the caregiver on return,

and use the caregiver as a base to explore surroundings (Bowlby, 1969). The infant also begins to be more apprehensive of strangers and will become alarmed if left for long without the primary caregiver's attention (Bowlby, 1969). Eastern European institution infants are usually unable to form a primary attachment and, thus, are less likely to protest the attention and stimuli strangers may provide. Thus, the institution infants are unable to negotiate this phase of attachment development and explore the world from a secure base or with a primary attachment figure.

After the infant develops a secure attachment to the mother-figure, the child's understanding of the world becomes more sophisticated. In the fourth phase of attachment, the infant begins to realize the mother-figure has personal goals and plans for achieving those goals. From this point forward, the infant's behavior becomes more flexible and "once that is so, the groundwork is laid for the pair to develop a much more complex relationship with each other...a partnership" (Bowlby, 1969, p. 267). Without a consistent and predictable caregiver, Eastern European orphans often struggle to develop a partnership with adults (Zeanah, 1996).

Atypical Attachment Organization

In his second volume, Attachment and Loss: Separation, Bowlby extends his theory beyond the four phases of attachment. In his sequel, Bowlby recognizes that healthy attachments are not only formed in infancy but also, in the second and the third years of life (Bowlby, 1973). Bowlby notes when each of the four early phases

of attachment are successfully achieved, after twelve months infants are able to have an organized fear response. This response is characterized by an infant's ability to move away from threatening objects and toward perceived protective objects (Bowlby, 1973). Thus, if a caregiver is accessible to and responsive to an infant's emotional and physical needs the infant will develop confidence in the caregiver and seek that adults company in distressing situations.

However, Bowlby also addresses how neglect can prevent organized fear behavior from developing and lead to the development of maladaptive attachment behaviors. First, Bowlby asserts,

The behavioral systems develop within an individual through...the environment in which the individual is reared; the further the rearing environment departs from that of evolutionary adaptiveness the more likely are that individual's behavioral systems to develop atypically (Bowlby, 1973, p. 82).

Bowlby used institution infants as an example of atypical development because an institution infant is immersed in an unpredictable environment in which one caregiver does not consistently respond to the infant's basic needs (Bowlby, 1973). Instead, many caregivers come and go to respond to the infant's basic needs as part of an impersonal routine. Institution infants, then, are unable to move away from perceived danger and toward a pre-selected and consistent protective figure. They are "frightened not only by the presence, or expected presence, of situations of certain sorts, but by the absence or expected absence, of situations of other sorts"

(Bowlby, 1973, p. 78). Without the ability to seek protection, institution infants are caught in a constant paradoxical cycle of fear and anxiety.

This paradox explains how institutional infants develop atypical attachments such as the inhibited or disinhibited form of reactive attachment disorder in response to their environment. Attachment disorder not only causes institution infants to either shrink from the world or to do battle with it but also allows them to engage in superficial attachments. As Bowlby writes,

It holds that the main cause of such deviations is that during childhood, an individual's attachment behavior was responded to in an inadequate or inappropriate way, with the result that throughout life he bases his forecasts about attachment figures on the premise that they are unlikely to be available (1973, p. 210).

Here, Bowlby is emphasizing that if an infant is unable to establish healthy attachment patterns in the immature years, it is likely to fear attachment because it has been comfortless, unpredictable, and therefore dangerous (Bowlby, 1973).

These fear-provoking feelings “shake a person's confidence that his attachment figures will be available to him when desired” (Bowlby, 1973, p. 213). Thus, to defend against the anxiety, despair and detachment of losing an attachment figure, institutional infants as children and adolescents avoid forming attachment relationships as they grow up.

Literature on Attachment Theory

Empirical research indicates that Bowlby's theory is especially accurate regarding the extreme states of anxiety all infants experience when they are separated from the mother. In Roger Kobak's study, *The emotional dynamics of disruptions in attachment relationships*, Kobak outlines the three observable phases infants navigate in order to regain proximity to the mother-figure (Kobak, 1999). First, the infant protests the mother's absence. The infant signals its protest by "crying loudly, showing anger...or shaking his or her cot" (Kobak, 1999, p. 24). Bowlby postulates in Attachment and Loss: Separation, that this anger response in the protest phase is an expression of frustration at separation (Bowlby, 1973). Kobak agrees with Bowlby and concludes in his study that the fear-induced actions taken by the infants upon separation express the child's assessment of the threat of separation from the primary attachment figure. Further, the anger is the child's effort to restore the contact with the attachment figure (Kobak, 1999). Kobak notes that this initial reaction to the infant's separation from the mother can last from a few hours to a week or more (Kobak, 1999).

After the infant protests the separation from its mother and fails to regain proximity to her, it enters the phase of despair (Kobak, 1999). An infant's despair is "marked by behavior that suggest[s] increased hopelessness about the mother's return" (Kobak, 1999, p. 24). Bowlby believes that the phase of despair is

synonymous with an infant's frustration and longing which results in an overwhelming sense of sadness (Bowlby, 1980). Like Bowlby, Kobak notes in his work that in this phase the infant grieves the loss of an attachment figure. During this phase, physical manifestations of deep grief and depression are notable in the infant's intermittent crying, decreased physical activity, and decreased amount of engagement with people in the environment (Kobak, 1999). In the final phase, detachment, a child will not reject alternative caregivers, but rather will begin to begin to be more social with others (Kobak, 1999). Kobak noted that detachment can occur when an infant is separated from its mother for twelve to twenty-one days. Thus, Kobak reaffirms Bowlby's attachment theory by using empirical research to describe the three phases an infant passes through in an attempt to regain closeness with the mother.

Whether and when the attachment figure returns during the infant's progression through each of the three phases of protest, despair and detachment is a crucial predictor for the infant's attachment style throughout life. As Alicia Lieberman's study found, "young children's ability to recover from the damaging impact of traumatic events [such as institutionalization] is deeply influenced by the quality of the child's attachments" (Lieberman, 2004, p. 338). In Mary Ainsworth's study *Attachment and Exploratory Behavior of One-year-olds in a Strange Situation*, Ainsworth used a laboratory setting to study a "child's use of his mother as a secure

base from which to explore the world, his response to his mother's leaving the room, and to her return" and finally "his response to a stranger" (Ainsworth, 1978, p. 111). At the conclusion of her study, Ainsworth classifies infant attachment in three ways: *secure, insecure-avoidant, and insecure-ambivalent/resistant* (Ainsworth, 1978). Twelve years later, Mary Main and Judith Solomon replicated Ainsworth's study and added a fourth attachment classification, *insecure-disorganized/disoriented* (Main & Solomon, 1990).

Ainsworth's study classifies and identifies the characteristics of three attachment patterns. First, infants that develop secure attachment patterns show confidence in the attachment relationship. For example, the secure infants moved closer to the mother when distressed and were easily soothed by the mother's attention. Importantly, even though the securely attached infants showed varied distress responses to separation, the infants all greeted the mother positively when she returned. As Ainsworth notes, if the infants were alone with their mothers, they explored the room and displayed few attachment behaviors. However, most of the infants were upset and explored little when separated from their mothers. All the infants greeted the mother when she returned and most preferred to have bodily contact with the mother (Ainsworth, 1982). Thus, securely attached infants have confidence in their attachment figure's ability to respond to their needs during

distressing situations and rely on the mother to help them regulate their emotions (Main & Hesse, 1990).

In comparison to the securely attached infants, the infants that developed insecure-avoidant attachment patterns exhibited minimal attachment behaviors throughout Ainsworth's entire experiment. The avoidant infants smiled at and were responsive to the stranger. However, infants played independently, and did not act distressed when the mother left (Ainsworth, 1965). Further, when the mother returned, the avoidant infants actively ignored her when she tried to make contact (Ainsworth, 1965). Unlike the securely attached infants who value attachment, the insecure-avoidant infants seem to value self-reliance and give the impression that attachment is not important. Douglas Davies speculated further than Ainsworth in his book, Child Development, and argues that insecure-avoidant infants do understand the importance of attachment. Davies notes, "the defensive strategy of avoidance is the baby's way of staying close to the parent while protecting herself from overt rejection" (Davies, 2004, p. 14). Insecure-avoidant infants are more likely to develop aggressive behaviors and be viewed in a negative way by peers, teachers and parents. More current research has shown that, as young children, these avoidant infants are "subject to more discipline by their teachers, thus reinforcing and confirming the child's untrusting assumptions about attachment" (Davies, 2004, p. 14). Therefore, infants that develop insecure-avoidant attachment patterns learn to

be self-reliant. The avoidant infants learn to be self-reliant because their attachment figures fail to regulate the infants' emotions or even to respond positively during stressful situations.

In contrast to the two previous attachment types, the third attachment type Ainsworth identified was found in infants who expressed a strong need for attachment, but lacked the confidence in its' availability. Ainsworth classified these infants as insecure-ambivalent/resistant. Ambivalent/resistant infants reacted extremely to separation from the mother, could not be soothed by the stranger and even in the mother's presence they were not soothed or interested in exploring the environment (Ainsworth, 1965). As Ainsworth later wrote, insecure-ambivalent/resistant,

Children were anxious even in the pre-separation episodes. All were very upset by separation. In the reunion episodes they wanted close bodily contact with their mothers, but they also resisted contact and interaction with her, whereas Group B [securely attached infants] babies have shown little or no resistance of this sort (Ainsworth, 1982, p. 16).

Ainsworth's study also found that the mothers of ambivalent/resistant infants were not consistently responsive to the baby's attachment signals. As a result, the infants' angry behaviors reflect their "anxious uncertainty about how their parents will respond" (Davies, 2004, p. 16). Therefore, ambivalent infants are not only unlike the avoidant babies because they express a desperate desire for attachment, but they are

also unlike the secure infants because they do not have confidence in the attachment figure's ability to consistently meet their attachment needs.

Fifteen years after Ainsworth published her findings and new classifications for infant attachment patterns; Main and Solomon examined Ainsworth's data and realized some infants in the sample did not fit into the three categories. Main and Solomon recognized the need for a fourth classification which categorized the infants that exhibited attachment behaviors not falling within Ainsworth's three attachment types. In their study, *Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation*, Main and Solomon indicate insecure-disorganized/disoriented as a fourth type of attachment pattern. This classification compartmentalizes the infants that did not fit into Ainsworth's three types.

In comparison to the other insecure patterns, the insecure-disorganized/disoriented infants lack a coherent approach to the attachment relationship (Main & Solomon, 1990). For instance, Main and Solomon observed that one of the most prominent behaviors of disorganized/disoriented infants is contradictory.

Rather than avoiding the parent upon reunion for a few seconds, and then gradually initiating interaction or contact, some infants give the parent a full greeting with raised arms and active bids for contact, then suddenly succeed this search for contact with avoidance (Main & Solomon, 1990, p. 135).

Here, the disorganized/disoriented infant's attachment behaviors are evoked as seen by the infant's attempts to regain proximity to the mother during her absence (Main & Solomon, 1990). However, when the mother approaches the infant to help alleviate the distress the infant backs away and its affect appears flat (Main & Solomon, 1990). As a result of the infant's confusion, the disorganized/disoriented infant does not effectively use the attachment figure to help it regulate its emotions (Davies, 2004). Without an attachment figure to help the infant regulate affect, s/he remains in a hyper-aroused state. The aroused state "contributes to [its] internal sense of disorder and has an ongoing negative impact on [its] ability to self-regulate...the essence of disorganized attachment is fright without solution" (Davies, 2004, p.17). Therefore, the disorganized/disoriented infant does exhibit secure attachment behaviors, but is insecure because s/he is fearful of actualizing the attachment relationship.

The attachment pattern an infant develops in response to the attachment figure is an accurate predictor of the child's ability to cope with distressing situations later in life (Kronenberger, 1996). For instance, Irene Chatoor found in her study, *Feeding and eating disorders of infancy and early childhood*, that during the first months an infant uses the caregiver to learn to regulate emotions and to provide structure and predictability over time (Chatoor, 1997). However, if an infant does not develop healthy ways to manage emotions early it can affect attachment behavior

later in life (Davies, 2004). As Karlen Lyons-Ruth and Deborah Jacobvitz explain in their study *Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies*; children with insecure attachment patterns will exhibit increased controlling behaviors toward parents and aggression toward peers in both preschool and school-age children (Lyons-Ruth & Jacobvitz, 1999). It is worth noting here that in comparison to Bowlby, Lyons-Ruth and Jacobvitz study presents a much more pessimistic view of attachment disorders. Further, only after an insecure child “develops a way to interact with the caregiver may the child be able to develop a consistent behavioral style, even though often not an optimal one, for interaction with peers (Lyons-Ruth & Jacobvitz, 1999, 538). Therefore, the purpose of the attachment system is to not only draw the attachment figure to the infant during stressful situations, but also for the attachment figure to model appropriate affect management.

Implications for Eastern European Adoptees

In the phenomenon chapter of this study, it was noted that eighty percent of institutionalized Eastern European adoptees arrive in the U.S. with reactive attachment disorder (Hesse & Main, 2000). Infants with early insecure attachment styles often develop reactive attachment disorder (Howe, 2001). The maltreatment Eastern European adoptees often experience while they are institutionalized places them at a high risk for developing insecure attachments in infancy (Aber, Allen,

Carlson, & Cicchetti, 1989). The Eastern European adoptees that do develop insecure attachment styles are less likely to make a smooth transition to a family lifestyle (Aber, Allen, Carlson, & Cicchetti, 1989). For instance, Aber et al found that for maltreated children such as institution infants, “low levels of secure readiness to learn are related to total reported behavioral symptomatology and to syndromes of aggressive, depressed, and socially withdrawn behavior” (Aber, Allen, Carlson, & Cicchetti, 1989, p. 602). As a result of their aggression, adoptees deter attachment and are less likely to engage in new and healthy attachment relationships (Aber, Allen, Carlson, & Cicchetti, 1989, p. 586). It is harmful to the adoptees long-term mental health if the negative attachment behaviors are not addressed and the children maintain their maladaptive style throughout immaturity and into maturity.

The long-term effects of maladaptive attachment patterns are well documented by empirical research. For instance, Daniel Hughes postulates in his study *Adopting children with attachment problems* that attachment plays “a central role in future relationships and psychopathology because the original parent-child bond is believed to provide the working model for all subsequent meaningful relationships” (Hughes, 1999, p. 547). Further, Victor Groza’s 2003 study, *Institutionalization, Behavior and International Adoption: Predictors of Behavior Problems*, confirms Hughes’ hypothesis. Groza’s study concludes that most institution infants struggle or fail to develop a partnership when placed in homes

with permanent and consistent caregivers (Groza et al, 2003). Hughes and Groza note that it could be that the difficulty Eastern European adoptees experience while trying to establish healthy attachments is the result of never having a responsive maternal figure.

Conclusion

Most Eastern European institution infants have never experienced a warm, loving and responsive caregiver. It is difficult to navigate attachment theory's four phases of development without the presence of a responsive primary attachment figure. Many infants develop maladaptive attachment styles if it is not possible for them to experience a healthy attachment relationship. Ainsworth, and later Main and Solomon, classified atypical attachments that infants develop in response to inadequate attachment figures. Importantly, Bowlby argues that institution infants that developed maladaptive attachments early in life could later develop healthy attachments if they were exposed to a consistent and responsive caregiver. However, the most recent empirical research is more pessimistic and shows that institution infants "struggle or fail to develop a partnership when placed in homes with permanent and consistent caregivers" (Groza et al, 2003, p. 7). The pathogenic care institution infants receive before being placed in nurturing homes can cause most to develop insecure attachments which persist over time. Therefore, after Eastern European adoptees are rescued from institutional neglect, it is the responsibility of

adoptive families and clinicians to facilitate the healing process, so the adoptees can begin to develop new attachment skills.

In the phenomenon chapter and in this chapter attachment theory has been the dominant theoretical lens through which to view attachment disorder and also the foundation for the treatment of attachment disorder. However, in the next chapter a new approach to viewing attachment disorder is presented. In combination with a new theoretical framework, a new treatment model is also proposed. Instead of viewing Eastern European infants as insecurely attached through the eyes of Bowlby, Ainsworth, Main and Solomon, attachment disorder is considered in the context of Heinz Kohut's self psychology.

CHAPTER V

SELF PSYCHOLOGY

Introduction

In the 1960's and 1970s, Heinz Kohut used his observations of clinical sessions to develop self psychology. Kohut continued to record and publish this observational research until he died in 1981. At the time of his death, Kohut had not entirely completed his theory and after his death Kohut's colleagues continued to investigate and further develop self psychology. In contrast to the classic psychoanalytic theories (drive theory, ego psychology, and object relations) Kohut's theory suggests that it is more productive for a clinician to view mental illness as a person's search for psychological balance throughout life (Ornstein, 1980).

Analogous to Bowlby's theory, self psychology focuses on increasing a child's capacity for affect regulation. Kohut and Bowlby agree that a child's ability to regulate inner tensions stems from the parents acceptance of significant ambitions and values, and the important process of integrating these parts of self which provide the child with an experience of cohesiveness and constancy early in life (Cohler, 1980). Importantly, unlike attachment theory, Kohut's theory specifies therapeutic techniques clinicians potentially can use to facilitate the recovery of an institutionalized child that develops attachment disorders. However, to understand better if Kohut's theory would be useful in the treatment of Eastern European

adoptees, it is necessary to evaluate both the limitations and the advantages of viewing attachment disorders through a self psychology lens.

Empathy

Kohut observed in his clinical practice that the two essential components for healthy development are empathy and selfobjects. To Kohut, empathy was “the projection of one’s own personality into the personality of another in order to understand him better: intellectual identification of oneself with another” (Berzoff et al, 2002, p. 179). In Kohut’s theory, empathy is a readiness to understand others by being immersed in the full experience of another person. Based on Kohut’s notion of empathy, his colleagues understood the purpose and importance of the therapist’s empathic immersion as threefold. First, Crayton Rowe and David Isaac argued in 1989 that Kohut “was aware that his empathic immersion into the patient’s experience provided him with a different understanding of the patient’s mental life” (1989, p. 29). Here, rather than attributing the patient’s maladaptive functioning to a textbook diagnosis, self psychology challenges clinicians to find a deep empathic understanding of a patient’s life. Theoretically, this understanding will allow clinicians to focus on the subjective experience of the patient and to pinpoint the origins of the patient’s symptoms (Rowe and Isaac, 1989). The emphasis the theory places on maintaining an empathic stance could be beneficial. It could be constructive because it permits the clinician to be a part of and not separate from the

patient's experiences. Second, Kohut realized both the importance of and challenge of knowing when to exchange the subjective for the objective. As Rowe and Isaac note from Kohut's observations "whenever [Kohut] moved away from his empathic treatment stance, using interventions removed from his patient's experience, the patient reacted with disappointment, disillusionment, and rage" (1989, p. 29). Here, Rowe and Isaac explain that in his years of observational research Kohut found that due to a patient's defensive structures, treatment was mostly ineffective or futile if empathy was not integrated into the initial phases of analysis.

Finally, Kohut's observations note that if a clinician misinterprets a patient's subjective experience and strays from an empathic stance during sessions, they can correct the empathic failure and return to empathy later. Clinicians can do this by relating to the experience of being misunderstood. Connecting to the patient in this way may help the patient manage the empathic failure and potentially will reestablish a sense of safety and support within the therapeutic relationship (Rowe & Isaac, 1989). Thus, the relief the patient experiences from an empathic response may allow defensive structures to dissipate and therapy to continue successfully instead of ending in an impasse (Lee & Martin, 1991).

Importantly, the patient will experience and react to over stimulation throughout treatment. It is the clinician's task to use an empathic stance to recognize and help manage the patient's over stimulation as it arises (Lee & Martin, 1991).

Accordingly, whether or not a clinician skillfully uses empathy it is not the therapist's goal to create and maintain a perfect relationship. This point is essential because the healthy growth of a child depends entirely on the empathic matrix a caregiver creates and how attuned the caregiver is with the shifting needs of the child (Lee & Martin, 1991). If a caregiver does not fulfill a child's needs, but continues to try, the child learns to manage slight empathic failures. For example, a caregiver may fail to be empathic if a child is crying and the caregiver attempts to change a diaper. They will quickly realize it is not a changed diaper but food the child wants and the child's needs are met. Here, the child realizes that its needs will be met despite the initial empathic failure.

As shown in the previous chapter by Bowlby's empirical research, Eastern European adoptees often do not experience an empathic caretaker (1969). Therefore, self psychology may be useful in working with Eastern European adoptees because the theory's empathic premise would allow institution children to slowly replace defensive structures with experiences of healthy attachment figures or selfobjects that provide empathic attunement as well as managed empathic failure.

However, it is a challenge for clinicians to use empathy effectively. For instance, a patient may become suspicious of the clinician if they interpret the empathic attunement as superficial or too much (Kohut, 1971). Further, the clinician's immersion in the patient's experience potentially clouds the clinician's

objectivity and thus hinders their ability to help provide accurate interpretations which facilitate the patient's healing. Therefore, on the one hand, empathy is an important tool clinicians can use to gain a more intimate understanding of the patient's life. On the other hand, clinician's must be careful not to lose the objectivity which is integral to the patient's healing process.

Selfobjects

It is important to define what Kohut meant when he coined the term selfobject. Kohut understood selfobjects as similar to Bowlby's attachment figures. Kohut defined selfobjects in the most ideal empathic form as "able to function as a more or less self-propelling, self-directed, and self sustaining unit" for a person "which provides a central purpose to his personality and gives a sense of meaning to his life" (Kohut, 1977, p. 139). Though this definition explains healthy selfobject relationships which help to thrust children through each developmental pole, not all selfobjects respond to and confirm a child's innate sense of vigor, greatness, and perfection.

In fact, negative selfobject experiences fragment the self and discourage the healthy development of an individual (Kohut, 1978). As Howard and Margaret Baker's observational study revealed, "early pervasive selfobject failures produce the most severe developmental arrests, greater reliance on archaic selfobject relationships, and a predisposition to more severe psychopathology" (1987, p. 3).

Thus, Kohut originated the term selfobject to explain and define how individuals' experiences (good and bad) integrate into a part of the self during the process of developing self cohesion or fragmentation (Lee & Martin, 1991).

Kohut believed the negative selfobject experiences occur early in life because an infant's caretaker is unavailable, the infant is separated from, experiences the loss of, and/or the rejection of the primary caregiver (Ellis, 1998, p. 443). Institutional life is not a conducive environment for children to acquire and retain healthy selfobjects. The Eastern European institution infants are unlikely to find suitable selfobjects because of separation, instability, under-stimulation, rejection, and loss. As a result, the institution infants are more likely to develop a fragmented self. For instance, Gerald Stechler concluded from his clinical observations of infants in 1983 that Kohut was accurate to attribute the development of the fragmented self in children to a caretaker's persistent failure to respond empathically to an infant (1983). Further, Stechler observed that a fragmented self, instead of a cohesive self, emerges when a child does not experience empathic attunement (1983). The lack of an empathic caretaker in an institution infant's life greatly increases the risk that the self will fragment.

As discussed in the previous chapter, Bowlby's empirical research also concluded that infants without responsive and caring attachment figures would experience emotional difficulty throughout life. Like Bowlby's empirical studies,

Stechler's earlier observations (1983) and later Baker & Baker's (1987) observations expose the detrimental affects of negative selfobjects. Bowlby, Baker & Baker and Stechler's conclusions concur and show through both empirical and observational studies the long term danger of not promoting healthy and reciprocal relationships as soon as possible in a child's life. This promotion is essential because it is potentially the emergence of the fragmented self which allows different insecure attachment styles to present in Eastern European institution infants and is eventually what leads to a RAD diagnosis.

It is significant, however, that selfobject experiences are not limited only to childhood but are needed throughout life to develop and maintain a cohesive self (Kohut, 1983). It is also important to remember selfobjects are influences outside the self, experienced as a part of the self which either propel or stunt development. This concept does provide hope for children diagnosed early in life with attachment disorders. It potentially promises that with long term help and the acquisition of constructive selfobjects, a child may build a cohesive self. When considering clinical interventions for attachment disorders this developmental perspective is beneficial precisely because the cohesive self can emerge at any age in the presence of healthy and empathic selfobjects (Rowe & Isaac, 1989).

The clinician working with individuals who have developed attachment disorders will know if selfobjects are internalized adequately because the object will

perform a self sustaining function of the self's relationship to objects that help maintain the experience of self cohesion (Fosshage, 1992). Simply said, when treatment is successful, the patient will be able to manage empathic failure and experience the elation of success. Thus, self psychology states, on the one hand, that the empathic attunement selfobjects provide is necessary for the healthy development of a cohesive self. On the other hand, if interactions with selfobjects result in chronic empathic failures, the individual's development of a cohesive self is disturbed and obstructed, resulting in what Kohut called a fragmented self.

Kohut's Cohesive Self

Kohut's theory proposes that for healthy development, an individual must be surrounded by selfobjects that provide not only empathy but also manageable empathic failure (Berzoff et al, 2002). Kohut argues that when an individual develops within an adequate empathic matrix the self becomes cohesive (Kohut, 1985). Kohut's cohesive self, then, has ambition and confidence, even in the face of adversity (Susske, 2000). After Kohut's death, Rowe and Isaac observed that an individual who develops a cohesive self:

Will experience himself as a cohesive harmonious firm unit in time and space, connected with his past and pointing meaningfully into a creative-productive future, [but] only as long as, at each stage in his life, he experiences certain representatives of his human surroundings as joyfully responding to him, as available to him as sources of idealized strength and calmness, as being silently present but in essence like him (1989, p. 30).

From this statement, the cohesive self is what allows an individual to feel confident and happy, and experience success throughout life. Here, the theory is potentially limited when considering the issue of attachment disorders. The notion of a cohesive self as defined implies one must experience joy in human surroundings. The empirical research presented in the previous chapter strongly suggests institution infants that develop attachment disorders may never be capable of experiencing such joy or cohesion. Further, after Kohut's death, his colleague Ernest Wolf predicted that the development of a cohesive self occurs on or before the second year of life (1980). This theoretical stance does not bode well for institution infants adopted later in life. Therefore, the importance Kohut placed on each person experiencing and maintaining self cohesion at an early age may limit the effectiveness of his therapeutic interventions and interpretations if applied to attachment disorders.

Kohut's Fragmented Self

However, limited Kohut's notion of a cohesive self may be, Kohut's understanding of the fragmented self is potentially beneficial to consider when treating attachment disorders. First, unlike the cohesive self, the fragmented self engages in a "vicious cycle of mutual deprivation, disappointment, and psychological illness" (Wolf, 1980, p. 122). Here, the theoretical presentation of the fragmented self accurately describes the cycle Bowlby's empirical research shows most adoptees experience after institutional neglect (1969). Further, Amy Eldridge

and Mary Finnican published an observational study from a self psychology vantage point which shows that during clinical sessions a child who has developed a fragmented self is unable to trust caregivers to provide the necessary “admiration, care, protection, or soothing”(1985, p. 55). As seen here, like attachment theory, self psychology does consider the essential ingredients for a child’s development. Thus, the theory’s awareness of how detrimental the deprivation of these ingredients is provides an advantageous platform from which to begin considering the treatment of the fragmented self and attachment disorders.

The Tripolar Self

The cohesive or fragmented development of Kohut’s tripolar self is motivated or thwarted by the degree to which an individual perceives how empathically attuned selfobjects are to his or her experiences (Lee & Martin, 1991). Before his death in 1981, Kohut conceived of the self as developing throughout life on three poles: the grandiose self, the idealized parent imago and twinship. Kohut described the first pole of the self as the grandiose self. The goal of the grandiose self is to build identity and individuality (Berzoff et al, 2002). If it develops within an empathic matrix, the purpose of the grandiose self is to support healthy self confidence and motivation (Ornstein, 1980). To successfully develop, the grandiose self needs to feel special. During this stage, the self chooses mirroring selfobjects. Mirroring selfobjects reflect and identify individuals’ “unique capacities, talents, and

characteristics” (Berzoff et al, 2002, p. 182). Therefore, by reflecting the unique and special qualities of the self, the mirroring selfobjects build an individual’s confidence.

In 1991 Kohut’s colleagues also noted that if an individual gets stuck in this stage of development the grandiose self never stops seeking mirroring selfobjects that reflect its greatness. As Lee and Martin observed in clinical sessions,

For the grandiose self, successes achieved are never enough; because, imbued with perfectionism, the grandiose self is never satisfied. It will brook no limits; its greed knows no bounds. Its ideas are perfect; its control, absolute. It acts dangerously to prove its omnipotence. Lying and name dropping are attempts to live up to its expectations (1991, p. 134).

Here, Lee and Martin observed that the grandiose self is maladaptive if it lacks confidence and does not have the appropriate mirroring selfobjects to place limits upon it. An individual stuck in the primitive form of the grandiose self that seeks mirroring selfobjects, needs to believe that the selfobjects that are present are invincible (Eldridge & Finnican, 1985). During the therapeutic process, this type of mirror transference may be problematic. For instance, it may cause the patient fear or discomfort when the clinician fails to express perfect empathic attunement. Kohut suggests that if an impasse occurs during this phase of treatment the clinician should help the patient understand the misinterpretation. By assisting the patient in this process the analyst assures the patient they are competent enough to provide

treatment hopefully reducing the patient's anxiety and diminishing resistance (Kohut, 1971).

Eastern European institution infants are likely to experience developmental arrest at the grandiose self. According to the empirical research presented in the previous chapter, without empathic attunement, most institution infants rarely, if ever, will experience a caretaker who reflects and identifies the infant's unique capabilities and talents. So, a clinician who is working with an Eastern European adoptee has the task of promoting the growth and the purpose of a healthy grandiose self which develops inside an empathic matrix. Thus, a clinician treating an Eastern European adoptee with a maladaptive grandiose self would provide empathic attunement, appropriate mirroring and positive countertransference.

Once an individual is confident in his or her own unique and great qualities that person can begin to see and reflect the praiseworthy traits in others. Kohut described this developmental stage in his second pole of the self as the idealized parent imago. Kohut used the word imago to capture an "internal, sometimes unconscious, object representation of an idealized other" (Berzoff et al, 2002, p.185). In contrast to the grandiose self, the idealized parent imago is motivated by the need to find admirable qualities in others (Berzoff et al, 2002). The healthy development of the idealized parent imago requires access to a strong and calm selfobject "to idealize and merge with in order to feel safe and complete within the self" (Berzoff

et al, 2002, p.185). In contrast to the grandiose self, Paul Ornstein observed in 1980, that the mature development of the idealized parent imago promotes both the capacities for an individual to regulate anxiety, and internalize core values and ideals (1980). However, Rowe and Isaac observed in their practices that a child who does not develop a healthy idealized parent imago and are unable to idealize a parent or selfobject, will search throughout life for the embodiment of a perfect selfobject (1989).

During this phase of treatment the clinician's challenge is not to interfere with the development of such idealizing transference (Kohut, 1971). Rather, the clinician must slowly express to the patient an understanding of how difficult it is to constantly have their perfectionist expectations disappointed; and how difficult it is not to be able to manage experiencing the world as fallible (Kohut, 1971). The length of this therapeutic process is also challenging to patients and parents of patients who expect to see signs of developmental gains (Kohut, 1971).

Theoretically, to treat patients, such as Eastern European adoptees, who may not have had the opportunity to successfully navigate the idealization phase; it is the clinician's task to become a selfobject worthy of the patients' idealization. Thus, by merging with the idealized traits of the selfobject, those qualities can potentially be integrated into the adoptees' sense of self.

At the point when an individual has confidence in their uniqueness and is able to idealize other people's good qualities, that individual can begin to understand that there are others like them in the world. Kohut described this process in the third pole of the self as twinship. During this phase of development the self "needs to feel that there are others in the world who are similar to the self" (Berzoff et al, 2002, p. 187). Twinship is the pole where both the mirroring and idealized selfobjects are important to the development of a cohesive self. Twinship selfobjects are others who are similar to the self: "this mutual recognition, this finding of sameness in a pal or a soulmate, provides another kind of universal sustenance from selfobjects" (Berzoff et al, 2002, p. 187). Therefore, the twinship pole is the final phase in developing a vigorous and cohesive self because it fulfills the need to have both the mirroring and the idealized selfobjects present at once in the self.

It can devastate a patient if they realize too soon in the therapeutic process that the clinician is not in fact an object of twinship. How the clinician handles the twinship transference, then, is challenging and of particular importance. Before the clinician begins to investigate the twinship transference with the patient, the patient must already have developed other selfobjects which fulfill the need for twinship. If other structures are in place to buoy the patient the clinician decreases the risk of an impasse (Kohut, 1971). This process may be difficult when a clinician is working with attachment disorders because there is not only a potential for the child to regress

and resort to feeling not only that adults are untrustworthy but also, that it is impossible to develop earnest relationships without the threat of abandonment. Thus, the phase of twinship requires special attention from the clinician so the patient can successfully develop the capacity to establish healthy relationships with persons who resemble the self.

Kohut designated the twinship pole as separate from the grandiose pole and idealizing pole near the end of his life. As a result, Kohut did not entirely research or develop the adverse effects of twinship not being adequately developed within an individual. However, Kohut did argue that “the greatest fears in people are not associated with biological death per se, but with the destruction of the self through the withdrawal of selfobject support” (Kohut, 1983, p. 399). Here, Kohut argues that it is the psychological death of the cohesive self that people most fear. For that reason, it can be hypothesized that the danger of not experiencing sufficient twinship may cause a patient to fear isolation from the world and create extreme anxiety. The anxiety comes from the patient believing there is no one that can fulfill the need for twinship (Berzoff et al, 2002). As a consequence to the feeling of isolation from the world, the patient may believe there is no psychological space for them to live in the world. Accordingly, the patient may feel in essence a psychological death. Therefore, in the case of a patient who needs to feel twinship, the empathic therapist must try to help the patient understand how others in the world resemble the patient.

Treatment Limitations

According to the theoretical perspective of self psychology analysts attachment disorders are the result of children who have contact with inadequate selfobjects and who therefore develop a fragmented self. For instance, Anna Ornstein observed in her sessions that “symptom formation begins when the cohesive self is threatened by the danger of psychological depletion, enfeeblement, and loss of vitality” (1981, p. 442). This observation offers a theoretical explanation for the origin of the fragmented self and possibly attachment disorders. Self psychology analysts have the advantage of using theory to hypothesize about how to decrease the psychological depletion of the child.

Treatment from a self psychology stance focuses on the individual’s ongoing interactions with and attachments to selfobjects that can theoretically heal the fragmented self. Self psychologists believe that by responding empathically to the child and focusing on reconstructing the child’s original experiences with empathic failure, the clinician would eventually facilitate the healthy development of a cohesive self. However, this would only happen if the theory is correct in its assumptions (Cohler, 1980). As a result it is impossible to definitely prove that self psychology can inform clinical practice with adoptees who receive the consistently inadequate care provided by many Eastern European institutions. Therefore,

viewing attachment disorders through a self psychology lens is limited by the absence of empirical research.

Conclusion

From the perspective of self psychology, the individual must develop and experience a cohesive self to have a self propelled and creative life. For the self to develop and progress through each of the three poles there must be an empathic matrix present at some point in an individual's lifespan. Kohut argues that it is better to experience an empathic matrix as early in life as possible, but recognizes that that is often unable to occur. Theoretically, when a child such as an Eastern European adoptee is treated by a clinician well versed in self psychology, the clinician will attempt to create an empathic matrix during each session that can be maintained throughout treatment.

Both empirical and observational research show it is difficult to reverse the effects of early selfobject failures (Bowlby, Eldridge et al, Lee et al, Kohut, Rowe et al, Wolf). Despite how difficult treatment can be, Kohut and his colleagues have observed over the years that during therapeutic session it is clear that a therapist with empathy who creates a healthy selfobject relationship will allow a patient to remain in treatment longer (Basch, 1983). The result of such empathic treatment was found to end in the development of a "reasonable and functioning self; that is, to acquire those abilities that will stand him in good stead in good times and bad, when alone

and with others, when successful and when disappointed” (Basch, 1983, p. 235).

Therefore, in the theoretical treatment model self psychology proposes the clinician must be able to construct an empathic matrix (Cohler, 1980).

To construct an empathic matrix, the clinician first must be able to be a mirroring selfobject which reflects the unique talents and greatness of the patient to fulfill the grandiose self. Once the grandiose self is stable and cohesive, the therapist must be empathically attuned to realize when to morph into an idealized selfobject and lead the patient through the idealized parent imago pole of development. And finally, the therapist must use empathy to join with the patient in a selfobject relationship which reflects twinship to dissipate the fear of isolation in the world. Therefore, self psychology promotes a theory based treatment model which is limited, but can be potentially beneficial to Eastern European adoptive families.

The theory is promising precisely because it focuses on healing the adoptees’ fragmented selves and then progresses to deal with the establishment of healthy relationships (parental and otherwise) during the twinship phase. In the absence of empirical research, it can only be speculated how successful the proposed treatment model is in treating children with attachment disorders.

CHAPTER VI

DISCUSSION

Introduction

The intent of this theoretical project is to investigate attachment disorder through a self psychology lens. The initial conjecture was that viewing attachment disorder through a new theoretical lens could make current clinical practice more operational. However, instead of extending the theory base, the investigation of self psychology revealed that its' application reinforces the fundamental tenet of attachment theory. Self psychology validates the empirical work and clinical recommendations attachment theory derived from for the treatment of attachment disorders.

Strengths of a Theoretical Thesis

Theoretical research is useful and necessary for a variety of reasons. First, it allows the researcher to delve into specific theories which relate directly to the phenomenon, in this case attachment theory and self psychology. The possibility of a new theoretical prospect expands what empirical researchers can investigate. Second, theory is more accessible to a greater population. This is the case because theory provides a more illustrated and personal picture of whatever population is studied and what may be useful to clinicians working with the population. Third, theoretical research allows a researcher more freedom in methodology and provides

the chance to make a study more personal. Therefore, though theoretical and empirical research projects are co-dependent in many ways, the theoretical project is an asset for its creative potential, its accessibility and its personal perspective.

Limitations of a Theoretical Thesis

Theoretical research has many advantages; however it also has some disadvantages. First, this particular theoretical study is limited because it only examines two psychodynamic theories (attachment theory and self psychology) in relation to reactive attachment disorder. Second, this project was inspired by the researcher's personal experience with an Eastern European adoptee that developed reactive attachment disorder while institutionalized. The personal experience with such a case made it difficult to remain objective throughout the research process. For instance, it was difficult to believe any institution infant could avoid developing RAD and escape the tumultuous aftermath. Finally, for any theoretical hypothesis to be truly legitimate, empirical research must be conducted and show the conjecture to be valid. Therefore, due to these limitations, theoretical research projects are dependent on future empirical studies to be substantiated.

Synthesis

In light of the strengths and the limitations of a theoretical research project, it is important and necessary to synthesis this project's theoretical base and findings. At the outset, attachment theory states it is necessary for healthy development that a

child must experience a secure bond to one or more attachment figure (s) that are responsive to the individual's shifting emotional and physical needs (Bowlby, 1973).

Bowlby states how vital this is in Attachment and Loss: Separation:

Confidence in the availability of attachment figures, or lack of it, is built up...during the years of immaturity – infancy, childhood, and adolescences...whatever expectations are developed during those years tend to persist relatively unchanged throughout the rest of life (1973, p. 202).

Here, Bowlby argues that there is a window of opportunity where children's attachment expectations are formed and solidified. It is also important to note here that empirical studies concur with Bowlby and foreshadow a bleak future for infants, children and/or adolescents that experience uncorrected attachment disruptions (Ainsworth, 1964, Aber, 1989, Allen, 1989, Carlson, 1989, Cicchetti, 1989, Groza, 2003, Hesse, 2000, Jacobvitz, 1999, Kronenberger, 1996, Lyons-Ruth, 1999, Main, 1990). For example, Victor Groza's study on institutionalized children concludes:

Any institutionalization resulted in more behavior difficulties, but children were particularly sensitive to the negative effects of institutionalization during the 2nd through 6th months of life. Finally, the longer the child was institutionalized, the more postadoptive behavioral health problems were evident (2003, p. 5).

Significantly, such behavioral problems often repel attachment and place institution infants at a high risk for not establishing or maintain healthy attachment relationships.

Barbara Novak illustrates the persistent emotional struggle Bowlby and Groza reference above in her study. Novak notes that the consequence of early attachment disruption is that the child's "inner world [is] chaotic, overwhelmed" and often filled with "rage, sadness, fear, envy, guilt and longing for closeness that [is] always frustrated by the dangers it arouse[s]" (2004, p. 76). Here, Novak explains the dilemma that children who develop attachment disorder face: Craving close relationships at the same time that they fear and act out against those relationships. With these references, Bowlby, Groza and Novak describe the harmful lifelong effects institutions have on infants even when there is an early intervention. Therefore, when children that are reared in institutions are adopted it is important for the adoptee to develop healthy attachment relationships as soon as possible.

The empirical research conducted to date demonstrates that attachment theory's predictions are accurate regarding the handicapping developmental consequences children will experience if they are unable to form a bond with an attachment figure (Boris, 2005, Bowlby, 1969, 1973, 1980, Chapman, 2002, Fries, 2004, Hesse, 2000, Howe, 2001, Hughes, 1999, 2004, Kelly, 2003, Lubit, 2006, Main, 1990, O'Connor, 2000, Zeanah, 1996). Bowlby and his colleagues understand the developmental consequences children encounter if they develop atypical attachment styles (secure, insecure-avoidant, insecure-ambivalent/resistant or insecure-disorganized/disoriented) or attachment disorder. Scholars such as Victor

Groza and Barbara Novak also understand that the behaviors which constitute attachment disorder perpetually repel healthy attachment and reinforce the child's atypical attachment style (2003, 2004). David Howe further argues in his study about institution infants that develop attachment disorder, *Age at placement, adoption experience and adult adopted people's contact with their adoptive and birth mothers: an attachment perspective*, that if adoptive parents are educated about insecure attachment styles they are more capable of giving consistent and appropriate care to the adoptees (2001). Howe also states that adoptees rely on the consistent care adoptive parents provide to separate them from and counteract their past caregiver's abuse and negligence. Thus, attachment theory asserts that institutionalized children who develop atypical attachments early in life need a corrective, empathic and long term attachment bond to catalyze healthy development.

The goal of creating a corrective experience for the institutionalized children with atypical attachment styles is to eventually have the children develop the following: (1) secure mental models (2) emotion regulation (3) the expectation of positive and non-threatening responses from the environment. Attachment theory in combination with the aforementioned goals led clinicians to develop attachment therapy. Attachment therapy works collaboratively with adoptive families to create an environment during therapeutic sessions and at home which promotes positive

feedback. The positive feedback comes from the environment and allows space for the child to develop emotionally. This family oriented therapeutic intervention is effective in reducing the symptoms of attachment disorder.

To support an environment that provides more positive and less negative feedback to the children, the therapists and the adoptive parents must learn to be attuned to the child's emotional and physical needs. Attachment therapy recognizes that it is impossible to be attuned to the child at all times. The therapists and adoptive parents will experience disruptions and setbacks throughout the treatment of children who have developed atypical attachment styles. These impasses, however, can be beneficial to the relationship and the child's healing process. The disruption is valuable only if the therapist and/or the parent work to repair the relationship, regain attunement with the child's needs and by doing so, eventually resolve the child's attachment fears.

Like attachment therapists, self psychologists postulate that an individual must encounter empathic selfobjects (or attachment figures) at some point during his or her lifespan to experience self cohesion (or resolved attachment fears). Despite the lack of empirical evidence to support self psychology's theoretical tenets, self psychology uses a new vocabulary to reflect the tenet of attachment theory. For instance, self psychologists argue that to move through developmental stages a child must be exposed to at least one selfobject relationship which reflects and is

responsive to the child's need to experience the self as vigorous, great and perfect.

Kohut argues that it is through the healthy and attuned selfobject bond that the child learns how to regulate emotion and find meaning in life. Here, Kohut's term selfobject has the same purpose and function as Bowlby's attachment figures.

Also similar to attachment theory, self psychology surmises that when a child does not encounter a healthy selfobject relationship the self will fragment; likewise, in Bowlby's theory the child will develop an insecure attachment style. If the child develops a fragmented self, self psychology asserts that the child's life will be fraught with an inability to both regulate emotion and maintain meaningful relationships. Note that the symptoms of a fragmented self mirror the established and well-researched criteria for reactive attachment disorder.

Importantly, both theories cite the same environmental factors as causes resulting in both a child's development of a fragmented self and attachment disorder. Analogous to Bowlby's claim that developmental arrest occurs when an attachment figure is inaccessible and unresponsive to a child, Kohut believed that a fragmented self developed as the result of negative selfobject experiences. Such negative selfobject experiences include an unavailable selfobject, traumatic separation from the selfobject and rejection of the infant by the selfobject. Though both theories have different terms for the disrupted development of children, the theories' arguments are similar: children who experience pathogenic care will be unable to

progress through age-appropriate developmental stages. They will not experience secure mental models, emotion regulation or expect positive and non-threatening responses from the environment. Therefore, both theories agree that children who experience a negligent caregiver will face great emotional and interpersonal challenges throughout life.

Attachment theory and self psychology concur that pathogenic care is one reason children develop atypically. However, attachment theory claims that it is imperative for a child to receive constant and adequate care from a primary attachment figure throughout infancy and early childhood. In contrast, self psychology alleges that a child chooses selfobjects that will fulfill their developmental needs from their surrounding environment in the absence of a constant and adequate caregiver. Note that though selfobjects perform the same function as attachment figures, selfobjects are not limited in the same way. Though it is preferable for selfobjects to be caregivers, they can be any entity in a child's life which develops personality, individuality and thus, attaches meaning to life.

To illustrate this notion of a selfobject consider a hypothetical situation. For instance, if a child experiences neglect and abuse at home or in an institution, the child may choose a peer or teacher at school or even an inanimate object to use as a selfobject (Kohut, 1977). The concept of the selfobject and the child's ability to choose implies that the child is innately motivated to seek out healthy relationships

and has the potential for some control over his or her own development from very early in life. This postulation suggests that children do not necessarily need human contact to meet their basic attachment needs. Rather, some children may use the consistent presence of an inanimate object such as a blanket or a toy to develop personality, individuality and attach meaning to life (Kohut, 1977). The implication of this is: if a child is able to experience an entity as a healthy and responsive selfobject the child will negate some of the developmental challenges inherent in the institutional setting.

Significant to the point, however, is that Kohut never showed through empirical research that children do have this volition. Without more empirical research the notion that a child can maintain control over early development in this way is not a valid claim. In contrast to Kohut, however, Bowlby not only demonstrated with empirical research that children exhibit behaviors which illicit attachment relationships; but also showed that in the presence of pathogenic care, young children are unable to develop healthy attachment relationships.

The treatment model that self psychology follows is based on a situation in which a child is unable to experience adequate selfobject relationships and subsequently develops a fragmented self. Like attachment therapists, self psychologists hope to build secure mental models, refine emotion regulation and create the expectation of positive and non-threatening responses from the

environment in the patients psyche. However, self psychologists and attachment therapists use a different vocabulary to refer to the phases of treating a fragmented self or attachment disorders. First, self psychologists focus on developing the cohesive self. To do so, the self psychologist will concentrate on the maturation of each of the three poles of the self (the grandiose self, the idealized parent imago and twinship). In an effort to guide development, the self psychologist uses transference and countertransference to meet each individual child's developmental needs and strengthen the cohesion of the tripolar self.

Attachment therapists also use transference and countertransference to remain empathically attuned to a child's needs. However, attachment therapists do not use the model of the tripolar self to explain the child's developmental progress or regression. Though attachment therapists do not use the same vocabulary as self psychologists, the concept is the same. Attachment therapists and self psychologists alike emphasize the importance of consistency along with the increase of positive affective states and the decrease of negative ones (Kelly, 2003). Thus, both theories use a different diction to promote emotional stability, self regulation and a positive experience with one's environment.

Similar in another vein, attachment therapy and self psychology both note that effective clinicians will allow the child to experience manageable empathic failure. In fact, a knowledgeable clinician will use empathic attunement and

repairable empathic failure as the foundation for treating attachment disorder or the fragmented self. Both empirical and observational research shows that by experiencing repairable empathic failure, the child will learn to independently maintain secure mental models, positive affective states and experience an empathic failure as non-threatening (Ainsworth, 1964, Bowlby, 1969, 1973, 1980, Hesse, 2000, Kohut, 1985, Main, 1990, MacIsaac, 1989, Ornstein, 1981, Rowe, 1989, Ruth-Lyons, 1999, Wolf, 1980). Thus, the empirical research shows that attachment therapy is an effective way to treat children that develop attachment disorder. Whereas, years of clinical observation demonstrate that with more empirical research self psychology potentially will affirm and reinforce the validity of attachment therapy and self psychology as two effective treatment strategies for attachment disorder.

Implications for Policy and Practice

It would greatly benefit adoptive parents to seek educational training before, during and after the adoption process. If potential adoptive parents are more informed of not only the possible psychological challenges adoptees face but also, the vastly different cultures the adoptees are emerging from, they may be better prepared to make a decision about whether or not to adopt (Cox & Lieberthal, 2005). Likewise, the research strongly recommends that adoptive parents would benefit significantly if they began therapy with the adoptees. If adoptive parents do seek

professional help they will have the benefit of starting to heal attachment fears and the fragmented self from the start (Howe, 2001). As the research shows, parents that understand the symptoms of and reasons for a child developing RAD are able to respond to the child with more empathy and with less frustration (Howe, 2001). Here, the role of the therapist is to help facilitate a healthy attachment relationship between the family and the child and work as a catalyst for the healing process. As the Handbook for Treatment of Attachment – Trauma Problems in Children, reported adoptive parents in therapy are more likely to feel supported and more optimistic that the situation may become more manageable in the future (James, 1994).

Once the adoptive family is in therapy, it is the therapists' responsibility not only to provide the child with a corrective emotional experience, but it is also their job to teach adoptive parents how to offer the same corrective experience at home (Hughes, 1999). The corrective experience occurs when the therapist or the adoptive parent is momentarily not attuned to the adoptees needs but, is quick to become attuned and thus, repair the empathic failure. The therapist and adoptive parents can do this by relating to how it feels for the child to be misunderstood; validating and encouraging the positive aspects of the experience for the child (Kelly, 2003, Rowe & Isaac, 1989). Note, here it is essential to resolve the misunderstanding and the feelings of frustration the adoptee might have in order for them to experience the positive environmental feedback (Kelly, 2003, Rowe & Isaac, 1989). If the

misunderstanding results in an impasse the early attachment fears are reinforced by the negative environmental feedback (Kelly, 2003, Rowe & Isaac, 1989). This theoretical paper would suggest that clinicians could effectively facilitate this process with the adoptive parents and provide the adoptees an empathic attachment experience by using attachment therapy and/or self psychology.

It is important to consider policy as well as practice when the population of international adoptees is rising and more adoptive families are seeking professionals to help alleviate the symptoms of RAD. For the reasons stated above it may be proposed that a policy requiring adoptive parents to participate in educational training before, during and post adoption could promote a more healthy development of the adoptive family unit. It may also be proposed here that the educational training outline the benefits of participating in therapy. For instance, David Howe's study notes the importance of therapeutic interventions because it helps "adoptive parents increase their understanding of their children's behavior and distress" and this "is likely to increase parental sensitivity and availability" (2001, p. 235). Neil Boris agrees with Howe and points out in his study that if a child is placed into a nurturing and empathic home the child may begin to resolve his or her attachment fears more quickly (2005, p. 1210). The need for a policy such as this is also clearly stated by one mother who volunteered a written comment regarding the importance of parent education and training:

I think adoptive parents should be required to have more training...I was under the mistaken idea that if you could adopt a child, give it lots of love and it would make everything all right for them. This is not always true. Some things you can never make right for them (Groze, 1996, p.119).

Here, a mother attests to the need for and benefits of receiving educational training and therapeutic assistance throughout the adoption process. Therefore, it is recommended a policy should be in place which requires educational training which emphasizes the importance of therapy to the adoption process. If such a policy were in place, the unhealthy patterns adoptive parents and adoptees develop could be replaced by empathic understanding early in the new relationship.

Conclusions and Recommendations for Future Research

This theoretical project proposes three conclusions. The conclusions are based on how understanding attachment disorder through a self psychology lens will help to reduce the potential lifelong effects of attachment disorder and promote healthy development in Eastern European adoptees and their adoptive families. First, adoptees need to be treated with empathy despite any RAD symptoms. Second, to create a more empathic environment for the adoptee, adoptive parents should be required to be educated about RAD and encouraged to learn as much as possible about the adoptees specific biopsychosocial history before the child arrives in the United States. The psycho-educational component will help parents empathize with the adoptees situation of possible neglect and isolation. Third, the adoptive

parents need to take responsibility for the mental health care the adoptees need. For instance, it would be beneficial to seek therapeutic treatment for the child and family.

Finally, future research needs to focus on using empirical evidence to substantiate self psychology as an informative base for clinicians to use when working with children that have developed RAD. This empirical research potentially would assist clinicians and adoptive parents to establish different therapeutic modalities for treating RAD. Finally, it may also provide more insight into the real needs of the adoptees and promote the use of empathy as a focus for the adoptees development. In turn, the therapists and/or the adoptive parents empathy has the potential to create a healthy relationship which may eventually reduce the adverse effects of RAD.

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