SPECIAL EDUCATION AND REHABILITATION - SCIENCE AND/OR PRACTICE

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Sombor, 2010

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ATTACHMENT THEORY OF THE CHILDREN WITH AUTISM AND DOWN SYNDROME

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Summary

The general aim of this study was to explore the emotional ties between child with disability and its attachment figure (mother) and pathology that can occur in this emotional bond. For this propose we study two children with disability (child with autism and child with Down syndrome) and to access the results we used version 3 of the Q-sort test, which consists of 90 items. Here we presented characteristics of a "secure attachment" with the primer care giver, also characteristics of "unsecure attachment", classifications, causes of insecure attachment and methods that can help us to recover emotional ties. We gave special explanation of disorganization / disorientation, as most frequent insecure attachment of the child with disabilities. Throughout analysis, we determined that both examined children have insecure attachment. According to the results of the Person coefficient of correlation child with Down syndrome has 0.23 ratios of attachment, and child with autism has coefficient of – 0.35. The results from the analysis were compared with standardized coefficients that are considered as a characteristic of the safest child – criterion sort.

KEY WORDS: attachment theory, insecure attachment, emotional ties, Down Syndrome, autism.

I. OVERVIEW OF THE ATTACHMENT THEORY

Attachment theory was first conceptualized in the 1950's by John Bowlby. It was first a clinical theory based upon the observation that the delinquent boys he was working with all suffered severe traumatic losses. His inquiry led him to explore the effects of early separation, evolutionary biology, ethology, cognitive neuroscience and information processing theory.

An attachment may be defined as an affection tie that one person or animal forms between himself and another specific one – a tie that binds them together in space and endures over time. (Vaughn et al, 1992)

The emphasis on attachment to the mother has shifted to an emphasis on the primary caregiver (which may not be the mother) and it is now recognized that children can form multiple attachments. An important development in challenging the assumption that mothers needed to be at home full-time was the discovery that quality was more important than quantity in forming secure attachments between caregivers and their children. Both the primary caregiver and the infant are active participants in this process. The key factor for the caregiver is sensitive responsiveness – the ability to attune to the child and respond to their signals. The child's responsiveness is also an important contributor to the process. When the parent and the child are in sync with each other, then the child develops a *secure attachment*. The child feels safe, knowing that mom or dad will be there when needed.

The success or failure of the parent-children attachment bond has a life-long effect on the way your child feels about him or herself and about others. Individuals who experience confusing, frightening, or broken emotional communications during their infancy often grow into adults who have difficulty understanding their own emotions and the feelings of others. This limits their ability to build or maintain successful relationships.

Secure attachment helps the child: (Fahlberg et al., 1988)

- attain full intellectual potential;

- sort out what he or she perceives;
- think logically;
- develop a conscience;
- become self-reliant;
- cope with stress and frustration;
- handle fear and worry;
- develop future relationships;
- reduce jealousy.

With secure attachment there is a fertile environment for the capacity for five kinds of love: maternal love, paternal love, peer love, sexual love, and parental love. Early affective ties have a big influence in social activities of the child, accomplishing higher degree of socialization, confident and good about themselves and enjoying being with others.

1.1. Attachment and psychopathology

Infants are helpless from birth, and need consistent, loving responses to their needs for food, sleep and comfort. As the infant grows, so does the bond of trust with the primary caregiver. Secure attachment has a lifelong effect on growth, development, trust and relationships. If a child is not provided this consistent, loving care, he will develop an *insecure* attachments form. Children with insecure attachments have learned that the world is not a safe place. They don't have the experiences they need to feel confident in themselves and trust in others. Because attachment is a fundamental part of children's development that affects the growing brain, insecure attachment shows itself in many different ways.

Signs of attachment problems: (Fletcher, 2008)

- Inappropriately clinging and demanding;
- Little exploration of environment;
- Reckless self-endangerment (failure to use secure base in times of risk);
- Role reversal – excessive concern for attachment figure;
- Hyper vigilance leading to withdrawal and ambivalence;
- Indiscriminate friendliness;
- Superficially engaging and charming behavior;

- Avoidance of eye contact;
- Extreme independence;
- Lack of affection on carer's terms;
- Destructiveness to self, others, and material things;
- Difficulty using others for emotional comfort;
- Learning delays -more than expected for intellectual abilities;
- Extreme sensitivity to change or rejection;
- Abnormal eating patterns;
- Poor peer relationships;
- Persistent questioning or chatter;
- Sleep disturbances, in particular not being able to sleep alone.

In this list we can see that signs, symptoms for attachment problems can be manifested as an emotional, physical, social problems and problems in educational process. Different patterns of attachment have been identified by Ainsworth using the 'Strange Situation'. This was a laboratory experiment in which the interaction between mothers and infants was observed prior to, during and after a brief separation. Three categories have been identified by Ainsworth: (Ainsworth, 1978)

Secure attachment – child protested when mother left, sought her out while she was gone, greeted her with delight when she returned, explored more when mother present (Category B).

Secure children explore freely in the presence of their caregiver, check on him or her periodically, and restrict exploration during the caregiver's absence. Children who are securely attached show varying levels of distress in the absence of their caregiver but respond positively to the caregiver's return. They will seek contact with their parent when distressed and will settle down once contact is made and comfort is provided.

Anxious attachment – distressed when mother left, little relief when reunited, highly anxious before, during and after separation, loathe to explore even when mother present (Category C). In addition, they find little comfort in contact and are often angered if mother tries to comfort them with a toy. They are sometimes termed "ambivalent" in reference to the fact that they mix weak contact maintaining with strong protest if

mother puts them on the floor. Exploratory behavior rarely recovers to preseparation levels during the reunion episodes. (Solomon, 1999)

Avoidant attachment – relatively indifferent to mother, rarely cried when she left, little positive response on return, curiosity unaffected by mother's presence (Category A). Avoidant children seem not to care whether a parent is present or absent. In the presence of the caregiver, avoidant children will explore their environment without interest in the parent's whereabouts. Upon departure avoidant children are minimally distressed. At reunion avoidant children do not move toward the parent or try to initiate contact. In fact, they often ignore or avoid the parent. Despite this apparent lack of concern, infants with an avoidant attachment style show as much, if not more, physiological arousal than other infants, suggesting that they have learned to contain their distress.

There is a group of children who do not fit into Ainsworth's original three-category scheme. Mary Main, another influential attachment researcher, added a fourth category to include these children.

Disorganized attachment – children either lack an organized pattern to their behavior or have strategies that repeatedly break down. When stressed, in the presence of their caregiver, these children appear disorganized or disoriented displaying unusual behaviors such as approaching the caregiver with their head averted, trance-like freezing, or strange postures. These behaviors have been interpreted as evidence of fear or confusion with respect to the caregiver. Disorganization is considered an extreme form of insecurity. (Main, 1981).

Causes of Insecure Attachment and Attachment Disorders

- **The caregiver is unable to provide for the child.** Sometimes, parents may love and intend the best for their children, but not know themselves how to provide the care the children need. They may have a history of abuse, depression, trauma or be overwhelmed by work and childcare responsibilities. A medical emergency may have occurred in the parent, making care very difficult. A death or trauma in the family can also have enormous impact.

- **Abuse and neglect.** If the primary caregiver is a source of pain and terror, as in physical or emotional abuse, a secure attachment cannot form. Parents who abuse alcohol and drugs may have a lowered threshold for violence and are at increased risk for neglecting their children.
- **Constantly changing caregivers.** Insecure attachment can also occur if the child has very little interaction with a primary caregiver, but instead has a succession of childcare providers that are not attuned to the child and do not stay in the child's life.
- **Children in institutional care.** Children in institutional care have not only lost their primary caregiver but may have lived in conditions where they cannot form a secure bond. Children in a succession of foster or group homes, or children adopted from overseas who have lived in orphanages, are at risk.
- **Child illness or disability.** Infants with long hospital stays, where they have been isolated and alone, are also at risk. Parents may also feel overwhelmed with an infant's needs if the infant is constantly sick and in pain, withdrawing or lashing out at the child because they don't know what to do. (Kemp et al., 2009)

If we look at the previous division, we can see that people with disabilities have a higher risk to develop insecure attachment. But often in our country as in many others, these people are unnecessarily exposed to other factors, and we make even higher risk for insecure attachment. One of those factors was institutional care that we provide for children with disabilities. One of the first measures for primary prevention is the prevention against separation of child from the mother during the first year of life. The risk exists until the 4th or 5th year of the child's life. For mentally retarded children, when the case is child's separation from the mother, we should be lead by the mental age and not the calendar age of the youngster.

Assessment of emotional connection between mother and child can estimate by using the test called "Strange situation" and "Q-sort" methods.

The **"strange situation"** is a laboratory procedure used to assess infant attachment style. The procedure consists of the following eight episodes: (Connell & Goldsmith, 1982)

1. Parent and infant are introduced to the experimental room.
2. Parent and infant are alone. Parent does not participate while infant explores.
3. Stranger enters, converses with parent, then approaches infant. Parent leaves inconspicuously.
4. First separation episode: Stranger's behavior is geared to that of infant.
5. First reunion episode: Parent greets and comforts infant, then leaves again.
6. Second separation episode: Infant is alone.
7. Continuation of second separation episode: Stranger enters and gears behavior to that of infant.
8. Second reunion episode: Parent enters, greets infant, and picks up infant; stranger leaves inconspicuously.

The **Attachment Q-Set** was developed for three reasons:

- to provide an economical methodology for further examining relations between secure base behavior at home and Strange Situation classifications,
- to better define (via a Q-set) the behavioral referents of the secure base concept, and
- to stimulate interesting normative secure base behavior and individual differences in attachment security beyond infancy.

In our research we used Q-set methods, version 3.0. It was written in 1987 and consists 90 items.

This illustrates a method that can be used to test the validity of Strange Situation classifications across age, across cultures, and in clinical populations. (Waters, 1987)

1.2 Neurological aspects of the disorganized / disoriented attachment

When a child has developmental delays, the emotional tie between parent and child may not be as easy to achieve. For example, a prema-

ture infant who has developmental delays may not smile at the typical four to six weeks, she may not be able to coo, clap her hands, or even sit on the floor and play with mom and dad as other child can. She may not give clear messages as to when she is hungry, tired, or over-stimulated. If the parent has a difficult time understanding the baby's cues, or the baby does not respond as expected, the "emotional play" is interrupted and the synchrony between them can be broken. Also, when a child is dependent on her mother for needs beyond the routine feeding, holding, playing each day, the dynamics of love between them can change. The mom may have to switch back and forth between the roles of being a nurse and mother, which can confuse both her and the child.

There were a number of studies designed to answer whether a behavior that is considered to disorganize and disorient may be associated with neurological abnormalities. Studies have shown that the percentage of children with disoriented / disorientated attachment was significantly higher in those who had neurological abnormalities, compared to the children who don't have abnormalities. The percentage of D attachment was increased in children with autism and Down syndrome (35%), among children born prematurely (24%) and children whose mother was an alcoholic or drug addict (43%). (Main, 1990).

Main and Solomon described several specific behaviors in children with D attachment to the mother. They gave seven key behaviors that can define this attachment:

1. Periodically access contradictory behavior of parents.
2. Ex. When a parent would seek to embrace the child (to spread hands) it moves towards the wall or standing in the middle of the room with the frozen, silly expression on his face.
3. Simultaneous display of contradictory behavior of parents.
4. Ex. The child sits in the lap of parents, but it is stiff or child's smile towards the parent has elements of fear.
5. Wrong, incomplete movements or expressions,
6. Ex. When a child is frightened, it doesn't goes to his parents to seek comfort.
7. Stereotyped, unsymmetrical movements and improper posture.
8. Ex. Swaying, pulling his ear, bending the hair and other rhythmic repetitions of certain movements.

9. Cold, static and slow movements and expressions.
10. Direct display of misunderstanding by the parent.
11. Immediate indicators, indicators of D attachment

A number of syndromes, diseases and health disorders may be accompanied by neurological disorders, such as autism, cerebral palsy, Down syndrome, epilepsy, Tay – Sachs disease and many others. It is important to emphasize that the behaviors points to the D attachment are very rare in the general population, which is not the case when it comes to children with disabilities. Main and Solomon described specific behaviors of the child, but when observed, we should not look exactly for these behaviors, but behaviors that are similar or close to them and who has shown the presence of D attachment between parent and child.

Children with Down syndrome in Strange Situation

Bowlby used the term "secure attachment" as a system of child's behavior, when the child uses his/her mother as a secure base to explore the environment and after each survey returns to her to receive the necessary physical and emotional contact.

He establishes two types of mad behavior, i.e.:

- Secure behavior, which serves the child to call her mother. Such behaviors are: crying, laughing and gesture like the spread of arms.
- Accessible behavior: when the child goes to the mother or located in its vicinity. These include walking and running.

This research examines these behaviors in children with Down syndrome. Behaviors such as their reaction when they are alone only in the presence of the mother, only in the presence of unknown or in the presence of both, actually the behavior in Strange Situation.

This research examined 12 children with Down syndrome and 12 children without disabilities (a control group). The experimental and the control group were homogeneous in terms of sex, age and social status. (Bowlby, 1983)

1.1. Emotional ties – children with autism and Down syndrome

Parents and families who have child with disabilities are in the front of the big test. However, in contrary the child suffers from the repercussions of the unfulfilled parental expectations.

Parents go through several stages: (Kopachev, 2008)

- Stage of shock – crying, irrational behavior and helplessness;
- Stage of negation – followed by the words: "This is not possible" or "This is not happening to us";
- Stage of anger – often to the child with disabilities, anxiety etc;
- Stage of reorganization – parents accept the reality and begin to act constructively.

Mother suffers from depression and sorrow for a long time. For that period the child grows aside a mother that resembles "dead mother" and she is unable to serve as a reflection of her image of life and existence to the child. Relations with objects that are very important for the development of the child will be affected across all the life stages.

Children with autism show difficulties not only in the creation of emotional ties, but in expressing their emotions. When they were compared to mentally healthy children, they showed greater lack of emotion and a lot less need for sharing emotions and interactions with other people.

Autism has been found to disrupt mother-child interaction generally and specifically maternal responsibility. (van IJzendoorn et al, 2007).

During free play, children with autism compared to other children from the same age-group, played with a fewer toys and were less focused on entering the game and rarely interacted with their peers. When the game was more structural, children with autism had more contact with their teammates and they were not distinguishable from their peers. Based on this fact, we can conclude that children with autism do not miss the ability to express their emotions, but have reduced social skills that affect their opportunity for emotional expression.

The aim of one survey was to make a comparison of the emotional statements of children with autism and children with Down syndrome.

Children with autism showed greater capacity for emotional expression than is expected of them, in terms of their mental abilities.

Children with autism showed less positive emotions toward their mothers during the game than children with Down syndrome. These children showed negative effects in their feedback of emotional requests by their mother and existence of hostility and fast irritability. The biggest difference between these two groups was in the field of self-regulation (self-control). Self-control includes the emotional reactions during the game, the attention of the child, the child exploring experience, focusing on toys, this includes the possibility of the child to solve a problem and to determine the function of toys.

II CASE STUDY

In the further section of the text, we will present two case studies. With Q-set we analyzed two children with disabilities, in order to determine whether they have secure or insecure attachment. In the same time we will make comparison between emotional ties which those children had develop with their mothers. These girls were at the age of five. One of them has Down syndrome (DS), and the other has autism with intellectual disability.

The results of the child with DS showed that she has developed insecure attachment, and according to the results of the Person coefficient of correlation she had 0.23 ratios of attachment. Through analysis we determined that the child with autism has extremely insecure attachment, with a coefficient of – 0.35. The results from the analysis were compared against standardized coefficients that are considered as a characteristic of the safest child – criterion sort.

In the study we used version 3.0 of the Q-sort test consisting 90 items. Below are presented the results of some of the items that are especially important for determining the emotional ties between child and his/her mother – care giver. Items are grouped in several groups: affective sharing, secure base, enjoyment of physical contacts, compliance and fussy/difficult.

Table 1. *Scores in items for affective sharing and differences between scores of the child with DS and the child with autism*

Affective sharing	Autism	Down Syndrome	secure child – criterion sort	differences between secure child and autism child	differences between secure child and DS child
1. When child finds something new to play with, he carries it to mother or shows it to her from across the room.	1	1	7.6	6.6	6.6
2. Child quickly greets his mother with a big smile when she enters the room. (Shows her a toy, gestures, or says "Hi, Mommy").	7	9	8.6	1.6	0.4
3. Child tries to get mother to imitate him, or quickly notices and enjoys it when mom imitates him on her own.	1	9	7.2	6.2	1.8

From this table we can see that the child with autism and the child with Down syndrome achieved lower scores on the items related to affective sharing. We observed big differences in the first item (6.6), from which we can see that these children do not feel their mother as a secure base for research. The child with autism had the lowest score for 3 items, so we can conclude that she cannot recognize the signs which her mother sends to her, like it is imitation.

Table 2. *Scores in secure base items and differences between scores of the child with DS and the child with autism.*

Secure base items	Autism	Down Syndrome	secure child	defenses between secure child and autism child	defenses between secure child and DS child
1. When he is upset or injured, child will accept comforting from adults other than mother.	6	6	5.5	0.5	0.5
2. Child is willing to talk to new people, show them toys, or show them what he can do, if mother asks him to.	3	5	6.6	3.6	1.6
3. Child keeps track of mother's location when he plays around the house.	4	1	5.6	1.6	4.6
4. Child is easy for mother to lose track of when he is playing out of her sight.	6	6	2.9	3.1	3.1
5. Child sometimes signals mother (or gives the impression) that he wants to be put down, and then fusses or wants to be picked right back up.	4	6	2	2	4
6. When child is upset about mother leaving him, he sits right where he is and cries. Doesn't go after her.	8	6	1.4	6.6	4.6
7. Child clearly shows a pattern of using mother as a base from which to explore.	3	3	8.9	5.9	5.9
8. Child will accept and enjoy loud sounds or being bounced around in play, if mother smiles and shows that it is supposed to be fun.	6	9	5.4	0.6	3.6
9. If mother reassures him by saying "It's OK' or "It won't hurt you", child will approach or play with things that initially made him cautious or afraid.	6	5	8.9	2.9	3.9
10. If held in mother's arms, child stops crying and quickly recovers after being frightened or upset.	2	9	9	7	0
11. At home, child gets upset or cries when mother walks out of the room. (May or may not follow her.)	3	4	1.8	1.2	2.2
12. Child uses mother's facial expressions as good source of information when something looks risky or threatening.	1	2	8.8	7.8	6.8

This table gives us very important information about the emotional ties between the mother and the child. Bout children do not feel their mother as a secure object for making emotional connection. There is no adequate emotional sheering, the mother did not sufficiently recognize the signs from her child. On the other hand, the child cannot understand what is required from him/her and how he/she can respond to those requests because of the intellectual difficulties. We can notice this in the items with particular low scores, actually with big differences compared to the scores of a "secure child", in the items number 7, 10 and 12.

Table 3. *Scores in secure base items and differences between scores of the child with DS and the child with autism.*

Enjoyment of physical contact	Autism	Down Syndrome	Secure child	differences between secure child and autism child	differences between secure child and DS child
1. Child often hugs or cuddles against mother, without her asking or inviting him to do so.	5	3	7.4	2.4	4.4
2. Child enjoys relaxing in mother's lap.	3	9	7.4	4.4	1.6
3. Child asks for and enjoys having mother hold, hug, and cuddle him.	5	8	8.3	3.3	0.3
4. Child puts his arms around mother or puts his hand on her shoulder when she picks him up.	4	4	7.8	3.8	3.8
5. Child enjoys climbing all over mother when they play.	5	3	6.6	1.6	3.6

It's necessary to have a physical contact, so you can build adequate emotional connection with somebody. Yet again, the scores of these items are different to the scores of the so-called "secure child". The autistic child has significant differences in the second item, compared to the criterion sort. This is an aspect of secure based behavior. A child who enjoys close physical contact is expected to find such a comforting

contact if distressed. During our observation we noticed that the child is confused and stiff when she sits in her mother's lap.

Table 4. *Scores for compliance items and differences between scores of the child with DS and the child with autism.*

Compliance	Autism	Down Syndrome	secure child	differences between secure child and autism child	differences between secure child and DS child
1. Child readily shares with mother or lets her hold things if she asks to.	6	7	8.3	2.3	1.3
2. Child follows mother's suggestions readily, even when they are clearly suggestions rather than orders.	4	7	6.7	2.7	1.7
3. When mother tells child to bring or give her something, he obeys.	2	7	7	5	0
4. When mother says "No" or punishes him, child stops misbehaving (at least at that time). Doesn't have to be told twice.	2	4	6.1	4.1	2.1
5. When mother says to follow her, child does so.	1	8	6.8	5.8	1.2
6. Child is easily upset when mother makes him change from one activity to another.	7	1	2.7	4.3	1.7

In these items we can see significant differences between the child with autism and the child with Down syndrome. According to this, autistic child has lower compliance with her mother. She does not react on verbal instructions from her mother and in the most cases the child didn't understand those instructions.

The biggest score differences is in the item 5. This item says more about mother's intuitive understanding of good behavior modification principles than with any trait of the child. There is also a significant difference in item 3. This behavior reflects both the mother's implicit understanding of behavior modification principles and the child's history of harmonious or interfering interaction with her.

There are no significant differences between the children with Down syndrome and criterion sort.

Table 4 *Scores for fussy/difficult items and differences between scores of the child with DS and the child with autism.*

Fussy/difficult	Autism	Down Syndrome	secure child	differences between secure child and autism child	differences between secure child and DS child
1. When child returns to mother after playing, he is sometimes fussy for no clear reason.	2	6	3.1	1.1	2.9
2. When child cries, he cries hard.	8	3	4.1	3.9	1.1
3. Child is lighthearted and playful most of the time.	3	7	6.2	3.2	1.2
4. Child often cries or resists when mother takes him to bed for naps or at night.	4	5	2.5	1.5	2.5
5. When the child is upset by mother's leaving, he continues to cry or even gets angry after she is gone.	7	6	2.4	5.4	4.4
6. Child ignores most bumps, falls, or startles.	9	8	3.3	6.3	5.3
7. Child cries when mother leaves him at home with babysitter, father, or grandparent.	2	5	3.5	1.5	1.5
8. Child easily becomes angry with toys.	8	2	2.3	6.3	0.3
9. Child is demanding and impatient with mother. Fusses and persists unless she does what he wants right away.	9	2	1.8	8.8	0.2
10. Plays roughly with mother. Bumps, scratches, or bites during active play.	6	6	2	4	4
11. When child is in a happy mood, he is likely to stay that way all day.	1	8	5.7	4.7	2.3
12. When mother doesn't do what child wants right away, child behaves as if mom were not going to do it at all.	9	8	1.7	8.7	7.7

Yet again, the scores of the autistic child have bigger differences from criterion sort, compared to the DS child. We have significant dif-

ferences in a several items, especially items number 8 and 9. Those items are about frustration, tolerance or low threshold of tolerance.

I. The children have higher scores on item 12. This item is for sensibility and includes a low threshold for detecting infant signals, co-operation (vs. interference) with the infant's ongoing behavior, physical and psychological availability and acceptance of the infant's needs and demands.

III REPAIRING INSECURE ATTACHMENTS AND ATTACHMENT DISORDERS

Insecure attachment can be a vicious cycle. Due to problems with social relationships, insecurely attached children may become even more isolated and withdrawn from their primary caregivers, family and friends. Children with disabilities already have a lot of problems making appropriate and quality social contacts with the environment. These processes of socialization of those children will be more difficult if they have insecure attachment with their primer caregiver. However, it is never too late to work on forming secure attachments. While the brain is most pliable in infancy and early childhood, it is responsive to changes all of our lives. Relationships with relatives, teachers and childcare providers can also supply an important source of connection and strength for a child's developing mind.

Secure attachment doesn't happen overnight. It is an ongoing process between the parent and baby. Early intervention has the greatest chance of success. Appropriate models of intervention with mother-infant dyads are available. The availability of support services to new mothers is essential.

Intervention with toddlers and older children is also possible. To understand how to do this we need to look at the way in which secure attachment develops between caregiver and infant. While we cannot recreate this situation it is important to remember that the basic needs of the baby are still unmet in the child who is not securely attached.

Holding and eye contact are very important. Children with attachment difficulties often resist this. This is especially characteristic of children with autism, they cannot make eye-contact with other person.

In the treatment of the child we can use holding therapy, so we can improve eye-contact, but from the other hand we will have big influence in improvement the emotional ties between child and his primer caregiver. In the past it was believed that autism occurs as a result of emotional lack of the mother – "cold mothers", today we know that inability to establish adequate emotional contacts between the child with autism and his mother is not a cause of autism as a condition, but its consequence.

Holding therapy has been demonstrated to be effective in a wide range of situations. This technique is based on the physical holding of children, even while they protest. Clearly there are problems implementing this with older children and children have suffered abuse. However, holding can be achieved in other ways – sitting with children, tucking them into bed and staying with them etc. (Welch 1988).

Building a secure attachment requires all your nonverbal communication skills, not just eye– contact, but also gentle handling, playful movements at times, rhythmic movement, a soft soothing voice (child maybe can't understand what we are saying, but he or she can enjoy just listening of our voice).

For making secure attachment we must also:

- **Provide support for the primary caregiver.** The primary caregiver needs to be emotionally healthy, have adequate time, and the right skills to be attuned and responsive to the child's needs.
- **Help the child express his or her needs.** Children with attachment problems will need extra help in learning to express their needs. They may have learned not to cry if in pain or frightened, for example, or not associate touch with being soothed. They may revert to developmentally inappropriate behaviors if stressed or scared. It might take extra creativity and diligence on the caregiver's part to help the child express needs safely and appropriately.
- **Time, consistency and predictability is key.** Problems in attachment result from problems with trust. By this very definition, repairing an attachment disruption takes time, consistency and patience. It will take time for a child to realize that they can trust and rely on their primary caregiver and other important people in their lives.

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