

Origins of attachment parenting



By Dr David Roberts, Paediatrician, Joondalup

Prescriptions on how to raise children have a long history; from the Pentateuch and Plato, through Locke and Rousseau, to the 20th century. The most recent popular movement is Attachment Parenting. Examples of this are known as positive, non-aversive, ethical, nurture or 'helicopter' parenting, as well as concerted cultivation, emotional coaching, and the circle of security.

Some background

Attachment Theory, upon which Attachment Parenting is based, was first proposed by British psychiatrist John Bowlby post WWII. Like Erikson's theory, it proposes that psychosocial development in humans occurs in stages. Bowlby sought to explain the origins of significant mental and behavioural problems in adolescence and adulthood, as the result of a disordered early childhood infant-mother relationship.

He proposed that the child's first stage is to bond to the caregiver, usually mother, not merely with affection, but attachment. The caregiver, in being reliable and responsive to needs, instils a sense of safety and security, an expectation of always being readily accessible, and confidence in secure attachment. Otherwise, healthy psychosocial development is at risk.

American psychologist Mary Ainsworth extended Bowlby's concepts, devising a method of categorising security of attachment in infants, 'The Strange Situation'. Its validity and reliability is not universally accepted. Using The Strange Situation, she and others found disordered attachment not only in mothers and babies presenting clinically with problems, but also in mother-infant 'dyads' randomly drawn from the population, and with unexpected frequency. Bowlby's idea that attachment disorders were a cause of mental ill health was then generalised; attachment disorders were seen as the major cause.

Not so simple

The many studies supporting this view have been criticised. This is for methodological flaws related to poor study design and flaws inherent in the paradigm of psychology research, which examines psychological constructs rather than observable reality (behaviourism excepted). Attachment theorists counter that their critics have the good fortune to work in more objective fields.

The evidence gap between Attachment Theory and clinical practice (i.e. Attachment Parenting) is also wide. For psychologists, the theory suggests most causes of child behavioural problems are attachment related. Therefore parents should work with therapists to restructure their parenting style and practice, their internal working models of parenting. This is a variation of cognitive behavioural therapy. Parents are instructed to be 'supportive', and risk harming their child if they say, "No". Parents are often upset, but comply.

A second consequence is drawn from the modern fashion of advocacy. Attachment Theory supports preventative mental health programs on the care of children such as The Circle of Security and the Positive Parenting Programme. Locally, the Disability Services Commission's Code for the Elimination of Restrictive Practices is another example. Unfortunately, like breast-feeding advocates, zealotry is the rule rather than the exception. ●

Author competing interests: no relevant disclosures. Questions? Please contact the author 9300 3002



Hear the best you can!

Progressive and Late-Onset Hearing Loss In Children...



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Timely management of hearing loss leads to better speech, language and learning outcomes for children. The current WA Newborn Hearing Screening Program covers all public and private maternity services across the state.

While such programs identify hearing loss in newborns, many children remain at risk of a permanent hearing loss developing in infancy and early childhood. Knowledge of the risk factors for late onset and progressive hearing loss is vital, along with continued vigilance in screening, monitoring and referrals.



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Rates of permanent hearing loss increase during childhood, meaning that some auditory dysfunctions develop (or worsen) only after routine newborn hearing screening is passed. Hereditary factors, infection, trauma and teratogens are among the leading causes.

An audiological evaluation is needed if any of the following risk factors are identified:

- Caregiver concern regarding hearing, speech, language or developmental delay
- Family history of permanent childhood hearing loss
- NICU stay more than 5 days
- Ototoxic medications
- Hyperbilirubinemia requiring exchange transfusion
- In utero infections (e.g. CMV, Herpes, Rubella, Syphilis, Toxoplasmosis)
- Craniofacial anomalies (involvement of pinna, ear canals, ear tags and pits)
- Temporal bone anomalies
- Physical findings associated with a syndrome Meningitis
- Head trauma requiring hospitalisation
- Neuro-degenerative disorders

In young children, detecting hearing losses through observation is problematic, especially if the problem is mild or fluctuating. Immediate referral for comprehensive audiological testing are needed if any problems are suspected. Audiologists use a combination of electrophysiological and developmentally-appropriate behavioural tests to test hearing at any age and developmental level. Strict monitoring protocols may be required.

It is important to remember that conductive hearing associated with otitis media remains the most common childhood hearing problem and can cause social, developmental and learning delays comparable to those observed through permanent hearing loss.

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