

Online Supplement 4.1

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Functional Somatic Symptoms in Children and Adolescents: The Stress-System Approach to Assessment and Treatment

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Attachment Strategies

The development of attachment strategies – also known as the self-protective strategies – is described by Patrician Crittenden in her 1999 monograph *Danger and Development*. In the Dynamic Maturational Model of Attachment and Adaptation (DMM), different attachment strategies are characterized by different patterns of information processing. Healthy children (including adolescents) are typically classified into the normative attachment strategies. Children with mental health problems or those who have experienced chronic stress in their attachment relationships are typically classified into the at-risk strategies (Crittenden et al. 2010).

What is important is that attachment strategies, though habitual or characteristic at any particular point in a person's life, are not unchanging. In response to the events (and stress) of life, persons can change their attachment strategies, moving from one strategy to another.

Normative Attachment (Self-Protective) Strategies

The normative attachment strategies include the Types A1-2 (also known as socially facile/inhibited), B1-5 (also known as comfortable or in the broader attachment literature as secure), and C1-2 (also known as threatening/disarming).

The Type B patterns of attachment (B1-5) are characterized by balance between cognitive and affective information across memory systems. The low-subscript Type A patterns (Types A1-2) are characterized by minimal distortion in the information balance between cognitive and affective information across memory systems: cognitive information is prioritized. The low-subscript Type C patterns (Types C1-2) are also characterized by minimal distortion in the information balance between cognitive and affective information across memory systems: affective information is prioritized.

At-Risk Attachment: The Type A+ Strategies

The high-subscript patterns of attachment are characterized by increasingly distorted information processing. In the Type A+ patterns (A3, compulsive caregiving; A4, compulsively compliant; A5, compulsively promiscuous; A6, self-reliant), intolerable affective information is inhibited or omitted.

The children classified into the Type A+ strategies – the Type A strategies with the higher subscripts (A3-6) – are good, compliant children (see Figure 4.1 in Chapter 4). Because their parents have been uncomfortable with expressions of negative affect – fear, anger, and desire for comfort – these children inhibit expressions of distress, and they do what their parents want them to do: they perform, they comply, and they please. By the school-age years, this group of children take on their parents' perspective regarding what they should do, and they blame themselves for any problems. Consequently, this subset of children can be distressed on the inside but nevertheless, on the outside, present themselves smiling and 'just fine'. Crittenden refers to this combination of inhibited negative affect and displayed positive affect as *false-positive affect*.

False-positive affect is part of the higher-subscript, Type A attachment strategies, where a child carefully anticipates parental expectations and learns to mask feelings of anger, fear, or desire for comfort, and to signal (false) positive affect instead. The child does this because the caregiver finds these feelings difficult to tolerate or is demanding and easily displeased. False-positive affect signals that everything is OK; as part of a self-

protective attachment strategy, it enables the child to maintain a closer, more comfortable, and, in the case of potential or actual maltreatment, safer connection with the caregiver. It is possible that Freud's construct of *la belle indifférence* – the idea that patients with functional symptoms showed a lack of emotional distress in response to their symptoms – captured this component of the Type A+ self-protective strategies, though without understanding its self-protective function.

Once this pattern of emotional functioning – the child's attachment strategy (in this case a Type A+ strategy) – becomes habitual, it can be very hard for the child to pick up that her body is signalling distress, to know how she is feeling, and to be aware when she is not OK on the inside. It can also be hard for the parents to tell, from looking at the child, how the child is feeling on the inside. The Type A+ strategies are also, of course, challenging for professionals. Because the child is smiling and saying 'everything is fine', it is not uncommon for a psychological assessment to have a nil finding. The key is to look for discrepancies. Is the child not distressed when she should be distressed? Is she not crying when she should be? Does she not report pain when pain is expected? Is she not seeking comfort when she should be? If not, then something is wrong.

At-Risk Attachment: The Type C+ Strategies

In the Type C+ patterns (C3, aggressive; C4, feigned helplessness; C5, punitive; C6, seductive), affective information is amplified, and cognitive information omitted, leading to split, distorted, or exaggerated negative affect. The odd Type C+ patterns involve overt displays of anger, whereas in the even Type C+ patterns, anger is covert and expressed instead as helplessness or coyness.

The children classified into the Type C+ categories – the Type C strategies with higher subscripts (C3-6) – are the coercive children. Because their parents have been inconsistent in providing attention and support, these children learn to elicit it and thereby secure both more, and more consistent, attention, comfort, and protection. In addition to exaggerating their affect, they also alternate it – for example, by using displays of anger

at one time and disarming behaviour immediately after – to ensure that their parents attend to them but without getting angry at them. These are angry, whiny, difficult children. By the school-age years, they take a ‘me! me! me!’ perspective and blame others for their problems.

It is worth noting that when the coercive, Type C+ children presented with functional neurological disorder or chronic pain, we found that they did not signal anger very much; in their families, anger was not an acceptable mode of expression. Instead, these children signalled distress, pain, ill health, or desire for comfort. Their anger, though expressed in various ways, was hidden. From the perspective of their parents, these children were not, to be sure, perfect and compliant, but the children were perceived as being, overall, just fine. In other words, their parents did not perceive the children to be difficult or angry.

Other Reading

For additional reading pertaining to the application of attachment theory in family systems and in family formulations, see Crittenden and colleagues (2014) and Dallos and colleagues (2019).

References

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