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DISTURBED BONDS – CONSEQUENCES FOR MENTAL HEALTH OF A CHILD

The article is a theoretical analysis of consequences arising from shaping disturbed bonds for the mental health of a child. It describes a typology of attachment disorders and indicates their consequences for the psychosocial development of a child and an adolescent in terms of psychosocial development, regulation of emotions, motivation, and cognitive skills. This knowledge may be an important element in the prevention of disturbances in the emotional development of children and their possible treatment. Bonds are a relatively permanent construct, significantly affecting a child's mental health, however, they may change as a result of a change in their relationship with the primary caregiver and a better adjustment between them, appropriate responses to the child's needs, or worsening of these relationships. Particular attention in prevention of mental health disorders in children should be paid to the abilities and limitations of cooperation among professionals of different fields: judges, experts, advisors, mediators and therapists.

Keywords: disturbed bonds, child's mental health, psychosocial development, a typology of attachment disorders.

1. INTRODUCTION

From the early stage of life, a child develops its emotionality, motivational system, social relationships, and cognitive curiosity in response to and on the basis of bonds built with the closest caregiver. Creating around the child an atmosphere based on the feeling of security, showing them acceptance, and responding adequately to the child's needs are the foundation for their optimal development in all spheres and for maintaining mental health. Properly shaped bonds, defined as safe, also at subsequent stages of life affect people's trust in the surrounding, experiencing peace and the belief that they have sufficient resources for their activities.

Lack of emotional bonds with their closest caregivers or shaping them in a disturbed manner results in a loss of trust in the immediate surrounding which is necessary for the proper mental development of a child. Such relationships are connected with improper care provided by caregivers manifested by the abuse of power: use of physical or mental violence, but also by neglecting the child, up to abandoning the child in extreme situations. The development of health and mental disorders is often associated with relational trauma experienced in childhood or adolescence, in particular its influence on the formation of

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internal operating models of bonds. There is a belief that these models significantly determine the development of certain mechanisms which regulate emotions and motivation (Grzegorzewska, Cierpiałkowska, 2020). Relational traumas are most often of repetitive nature, and when they significantly extend over time, they largely affect the development and maturation of various aspects of personality, presenting different levels of generalization.

2. DEVELOPING BONDS

The first months and years of a child's life are essential for developing a safe bond between the child and the caregiver, which in turn translates into the ability of a person in adolescence and adulthood to develop healthy relationships with their surrounding, to present proper social, emotional, and motivational functioning and, consequently, proper cognitive functioning. Availability of the caregiver for the child, as well as predictability and responsiveness of the caregiver, which is an active and adequate response to needs, build the feeling of security. Noticing that the closest caregiver responds to the signalised needs, especially when calming down and comfort are needed, the child learns to trust and satisfy the feeling of security. All behaviours related to understanding signals sent by the child contribute to the improvement in the quality of the caregiver-child relationship, which is crucial for development. Stability, repeatability of reactions and tension-reducing behaviour become the foundation for shaping a safe style of attachment, which is also connected with the so-called synchrony, a harmonious interaction between the child and the caregiver, which is their mutual adjustment of reactions in response to behaviour and feelings of the other person in the relationship.

Early experiences of a child in contact with the caregiver constitute the foundation not only for the development of personality, but also become dynamic operational models that are used to regulate, interpret, and predict behaviours, thoughts and feelings both towards others and towards oneself. They highly determine behaviour of the child which the child will use to achieve closeness with others. They shape self-esteem, beliefs about oneself and the way a person regulates emotional states. Thus, they contribute to the formation of mechanisms of regulation in difficult situations and coping with agitation. Maternal sensitivity is a key factor in the development of a safe attachment style, and the term covers a set of cognitive, emotional, and social characteristics which are part of the caregiver's competences. Mother, characterised by a high level of activity, creates a safe style of attachment with her children – the representation of a caregiver who is a source of comfort and safety is the basis for coping with developmental challenges during later stages of life.

2.1. The theory of attachment

Disturbed bonds with the closest caregiver and improperly formed attachment style in the early childhood period were analysed by John Bowlby (2007). The author noticed the consequences of these problems manifested in various aspects of adult life (Cierpiałkowska, Górska, 2017). He considered attachment in two dimensions, i.e. interpersonal and intrapsychic. He considered the first one as a motivational and behavioural system, the aim of which is to maintain closeness with the caregiver in a threatening situation, and later on also between two adults. On the other hand, he considered the second one as shaping mental representation of attachment in the form of the so-called internal operating model concerning the figure of attachment, self and the relationship between them.

Bowlby believes (Bolby, 2007; Bee, 2004) that in the period of mental development, the physical umbilical cord is replaced by the mental need for closeness with the caregiver – most often with the mother. A child is born equipped with instinctive behaviours – crying, smiling, making eye contact, which provoke others to take care of the child. On the other hand, parents, in particular mothers, have an instinctive ability to respond to the signals sent by the child. These patterns initiate a complex chain of stimulus-reaction relationships, which in turn lead to the development of specific attachment patterns based, among others, on meeting the need for security. This way, synchrony is created, i.e. an adjustment between the child and the caregiver. The ontogenesis of the attachment process develops in three phases. Initially, during the first three months of life, these are unspecified reactions of a child who learns to signal its needs to the surrounding. In the next stage (between 3 and 6 months), the child establishes a relationship with its caregivers smiling at them, and then, between 6 and 8 months of age, the child refers to other people guided by their facial expressions and searching for confirmation of its own emotions. At around 6 months of age, the child shows fear of strangers, and starting at around 10 months of age, the child is afraid of separation, which increases until the age of 16 months. According to Bolwby (2007; Bee, 2004), as early as 6 months of age, a sincere attachment develops between the child and the caregiver, which is also called a secure base. The author believes that achieving mental health requires that an infant and a young child experience a warm, intimate, and safe relationship with their mother or another caregiver. The types of attachment distinguished by Bowlby (Cierpiałkowska, 2013) are considered to be a significant risk or protective factor for the development of disorders. Erikson (Brzezińska, 2000) also emphasised that the basic trust in the caregiver which develops in infancy is a key resource for further proper development. People who stay with a child for a long period and who bring strong feelings in the child (significant people) become objects of identification and a point of reference in the process of socialisation. With properly shaped relationships between parents and children, the strength of their influence decreases with the age of the child. According to Cholewa, Krzywicka and Jadczak-Szumiło (2008), functions of attachment can be applied to five main spheres of human life, i.e., biological, emotional, cognitive, social, and spiritual. In the biological sphere, attachment fulfils the function of protecting against danger, satisfying biological needs (food, etc.), and ensuring survival. In emotional sphere, its function is reduced to modification of physiological agitation and regulation of an affect in the sense of obtaining the ability to self-calm down. In relation to cognitive area, attachment translates into a person's ability to learn about themselves, others, and the world, as well as to freely explore the surrounding. On the other hand, in social aspect, thanks to attachment, it is possible to acquire social and interpersonal competencies and to build relationships with others. As far as the last, spiritual sphere is considered, attachment refers to shaping a basic attitude – trust vs. distrust, hope.

Bowlby (2007) assumes that behavioural attachment system is one of the systems that enable a child to gain elementary knowledge about the world and others, to learn to trust another human being. By the end of the first year of life, when attachment becomes a fact, the affective, cognitive, and behavioural systems create mental representations of interactions with the caregiver, when, where, and how the caregiver becomes available. Based on this process, a self-regulatory system is developed. This process transforms slowly from sensorimotor into symbolic, and these representations become the basis for seeing oneself and others, and for anticipating the future and one's place in relations with others

(Oatley, Jenkins, 2003). The attachment system related to the indicated areas of life shapes the later functioning of a person in various areas.

2.2. Types of bonds and attachment

The key to the attachment relationship is the responsiveness of caregivers, which has already been mentioned. It is the ability to notice signals sent by the child, but also the ability to properly interpret them and to respond adequately. Depending on the relationship between the child and the caregiver, patterns of attachment are formed which can already be seen in the first year of life. They can be secure or insecure styles, i.e., avoidant, anxious-ambivalent, or disorganised.

Referring to the already mentioned Bowlby's theory and observing the behaviour of children aged 12–18 months in laboratory conditions, Ainsworth (Bee, 2004; Cierpiałkowska, 2013; Cierpiałkowska, Górska, 2017) has developed the concept of attachment. She distinguished 3 types of bonds connected with responsive behaviours of mothers and satisfying by them the feeling of security of their children. The first type of bond she distinguished – the so-called B, or secure attachment, was characteristic for children who were able to cope with separation from their caregiver and quickly engaged in exploring their surroundings. Feeling threatened, they looked for contact, it was easy to calm them down in the absence of their mother, and after her return they showed joy and did not resist contact. If the relationship between the child and the closest caregiver has been formed properly, the feeling of trust and safe bonds have been developed, thus the absence of the caregiver does not cause strong anxiety in the child, as the child realizes that the parent will return. Moreover, when the caregiver is present, the child is not focused on watching him/her as not to be abandoned, and freely explores the surroundings. This is because the child experiences security when the caregiver behaves predictably and shows sensitivity to information sent by the child as well as adequately responds to such information. Such behaviour was observed in 60% of children.

The second type of attachment: A – was defined by Ainsworth (Bee, 2004; Cierpiałkowska, Górska, 2017) as an insecure type shaped on the principle: disconnection/ avoidance. It characterised 15% of children and was associated with experiencing repeated rejection by the closest caregivers. As a result of such experiences, children avoided contact with their caregiver, in particular after the caregiver's absence. They did not prefer relationships with the caregiver over other people, and when the caregiver made contact, they did not resist but did not initiate it either. Due to repeated abandonment, the child does not trust the caregiver and does not know if the caregiver responds with help when the child needs it – the child rather expects rejection. Due to the lack of helpful responses from the caregiver, the child makes an effort to cope without any support and builds a coping strategy based on emotional self-sufficiency. It also learns to suppress negative feelings or to show false positive feelings. The formed bonds are of anxious and avoidant type.

Another type of insecure attachment – C, refers to the resistance/ambivalence relationship, and it was observed in 10% of respondents (Bee, 2004; Cierpiałkowska, Górska, 2017). Children characterised by this type of attachment showed little interest in their surroundings and were distrustful of strangers. They became worried when the caregiver left the room, did not allow themselves to be comforted in the absence of the caregiver, and after the caregiver returned, they still did not calm down or even showed anger towards the caregiver. Such behaviour of children was explained by the unpredictable attitude of caregivers, who sometimes were available and helpful and sometimes were not

or used separation and threats of abandonment as a form of control of the child. Children experienced uncertainty as to whether the caregiver would be available, would respond, and would be helpful when needed, and due to lack of trust and unsatisfied need for security, they exhibited separation anxiety, showed the tendency of being clingy, activated exaggerated attachment behaviour, and abandoned activities connected with exploring the surrounding. Through intensive control of the surroundings and the compulsion to be close to the caregiver, the children tried to create a substitute for the feeling of security.

Ainsworth's research was continued by Main (Cierpiałkowska, Górska, 2017), distinguishing one additional type of insecure attachment – disorganization/disorientation (type D). It was observed in children who experienced violence, neglect, or various types of abuse. These children reacted to the absence of the caregiver with bewilderment and confusion, and in the company of the caregiver they engaged in disorganised behaviour, such as rocking, covering the face, etc. When the caregiver took them in their arms, they turned their heads away. Characteristic for this type of attachment is the lack of a consistent strategy for coping with stress in the child. The child exhibits various behaviours, often contradictory and bizarre, as they simultaneously experience fear and attachment, and the inability to solve this conflict. This pattern has been observed in abused children and children of mothers suffering from depression. The caregiver is often a threat to the child.

Literature indicates the significance of the four of the above-mentioned styles of the child's attachment to the caregiver: trusting, ambivalent, avoiding and disorganised in the emergence of separation anxiety in children, as well as in the further development of personality disorders or depression (Cierpiałkowska, 2013; Cierpiałkowska, Górska, 2017). Referring to the Bowlby's theory, procedures and techniques based on internal representations of attachment are created. They take into account the impact of internal attachment models on the course of the disorder, the type of relationship created, but also the effectiveness of specific therapeutic strategies and interventions (Rajewska-Rynkowska, 2005).

3. TYPES AND CONSEQUENCES OF DISTURBED BONDS

Disorders of bonds resulting in a lack of a proper sense of security in a child are nowadays perceived as a significant cause of disorders, e.g., anxiety (Cierpiałkowska, 2013), as well as in a broader aspect – the cause of personality disorders (Cierpiałkowska, Górska, 2017). Attachment disorder syndrome was first mentioned in the standard classifications of psychological disorders in DSM-III, in 1980, after collecting evidence on children raised in orphanages (http://www.teczaserc.pl). Criteria included the requirement for the disorder to appear before the age of 8 months and they were compared to abnormal development. Both features were rejected in DSM-III-R in 1987. Instead, the disorder onset period was changed to the first 5 years of life, and the disorder itself was divided into two subcategories: inhibited and disinhibited. These changes resulted from further research on abused children and children from orphanages and remained in the current version, DSM-IV, dated 1994, and its 2000 text version, DSM-IV-TR, as well as the ICD-10 dated 1992. Both classifications focus on small children who are not only in the group of an increased risk of developing further disorders but already exhibit clinical disorders.

3.1. Reactive attachment disorders – the rad syndrome

In situations of specific emotional problems emerging in childhood, it happens that the explanation is incorrectly formed bonds and the failure to satisfy the feeling of security in the early years, and the observed irregularities are a consequence of them. The RAD syndrome (Pużyński, Wciórka, 2007) develops in children up to 5 years of age in response to the failure to satisfy the need for security and in response to improperly formed relationships with caregivers. Improper care typically involves mental and physical neglect or abuse of the child, constant lack of responses to child-initiated contact, and severe punishments. Symptoms are often observed by adoptive families who, by putting a lot of effort into creating a safe and accepting surrounding for their child, have the impression that the strength of their feelings was "tested" by children, who in turn react with rejection and even aggression to the attempts of showing them love and affection.

In addition, the disappearance of the closest caregivers from the child's life – that is, the inability to form normal bonds with them early in life may cause permanent emotional problems of the child and the development of the RAD disorder, which is abnormal reactions of the child in response to an attempt to build a close relationship with the child. This syndrome is characterised by clearly disturbed and inappropriate in terms of development ways of establishing social bonds, in particular a lack of emotional responses, withdrawal (e.g., curling up on the floor), or aggression towards malaise in oneself and others, as well as by excessive fearful alertness. The child may show strong contradictory and ambivalent social reactions in various situations and does not react to the attempts of its surrounding to comfort it, nor it looks for support in difficult moments. A certain ability of social reciprocation and reactivity in interactions with adults is observed, but it is quite typical to limit social interactions with peers. In children diagnosed with RAD, aggression towards oneself and others and the sense of unhappiness are often observed, and in some cases, there may even be disturbances of growth and physical development.

Children with RAD have severely disturbed internal patterns of behaviour in relationships with other people, which can lead to social and behavioural disorders later in life. Research on children raised in institutions suggests that they are not very attentive and hyperactive, no matter the quality of the care they receive. Children aged 3 to 6, diagnosed with the RAD disorder, are characterised by much lower empathy than their peers with proper bonds with their caregiver, and they experience difficulties with accurate self-assessment and adaptation to the environment. They often judge their personality traits too positively and at the same time show far more behavioural issues than children without such problems. Hence, the importance of the closeness and safe bond between children and their caregivers cannot be overestimated for their proper emotional and social development.

It should be emphasised that children with reactive attachment disorders present normal ability for social interaction and social response, hence disturbed patterns of social interaction largely subside if they are placed in an educational environment that provides them with continuous and responsible care. The cognitive development of children suffering from RAD is normal and they do not have permanent deficits, nor they experience limited, repetitive stereotypical patterns of activity and interests.

Although the main reason for the appearance of the RAD syndrome in the child's functioning is the failure to satisfy the need for security on the part of the closest caregivers, due to the chronic and broad nature, including also neglecting the child's other needs, the consequence is impaired social functioning, which suggests a greater severity of the

problem than only resulting from the loss of the feeling of security. While a child does not feel safe with one caregiver, they can establish a safe relationship with another one, and as a result, social relationships are not disturbed (Namysłowska, 2015).

Bonds disorder in the form of RAD is often referred to as the "inhibited form" – as opposed to DAD – "disinhibited form". An important criterion for the diagnosis of RAD and DAD is the fact that they are reactive disorders, i.e. they are the result of specific negative relationships with people, without originally physiological basis, associated with the unsatisfied feeling of security, belonging, and love in early childhood.

3.2. Disinhibited attachment disorder – the dad disorder

Another disorder resulting from the failure to develop safe bonds with caregivers in childhood is the DAD syndrome (Pużyński, Wcióra, 2007), i.e., the lack of bonds selectivity. It develops in the first 5 years of a child's life (same as RAD) and is often observed in children placed in various types of institutions. Children who have such problems try to establish close relationships with all the adults they meet, excessively shortening the distance from them and perceiving each of them as the possibility of satisfying the need for security and belonging, which may be associated with uncritical sociability, in the form of excessive intimacy with strangers, the so-called "disinhibited form". These children look for comfort and support in their surroundings, however, the person they turn to is irrelevant to them. Social interactions with strangers are poorly modulated by children suffering from DAD, and depending on their age, they have a specific character: during infancy "clingy" behaviours are dominant, whilst in the early childhood and preschool periods, they are characterised by intense attention-seeking and overly friendly behaviour towards all people from their surroundings. Children have difficulties in establishing close relationships with their peers, which may also be accompanied by behavioural and emotional disorders (Pużyński, Wciórka, 2007; Namysłowska, 2015).

The DAD disorder develops as a result of the coexistence of early lack of selective bonds, the persistence of weak social interactions, combined with a lack of their specificity concerning the situation. Children seek in all adults the satisfaction of the need for security and belonging without making a selection or preference for such relationships.

The consequence of early problems related to functioning in important relationships and creating lasting relationships are problems in establishing friendships, close relationships with peers and the opposite sex in later life. Early, effective therapeutic intervention reduces the severity of symptoms and may lead to their disappearance. The first principle of treating childhood bonds disorders is to ensure security to the child. Establishing contact with extended family and engaging them to cooperate in creating a safe place can be very effective. Due to the lack of other options to ensure security to the child, placement in an institution should be considered, although, as mentioned above, frequent changes of caregivers may also harm the emotional development of children (Namysłowska, 2015). A commonly practised solution nowadays is cooperation with small, professional foster families.

3.4 Induced bonds discturbances – parental alienation syndrome

Gardner's syndrome, known in Polish literature also as parental alienation syndrome (Namysłowska, Heitzman, Siewierska, 2009; Czerederecka 2010; Czerederecka, 2010; Zielona-Jenek, 2012), was described by an American psychiatrist, who was the first to

notice the symptoms emerging in children in a situation of prolonged divorce cases and the context of the ongoing fight between the spouses for custody of their children, or motivated by the desire to harass the partner after splitting. The doctor noticed a specific disorder of children's bond with the so-called secondary parent when the caregiver who exercises direct custody strives to obtain a favourable judgement at the expense of deteriorating the relationship of the child with the other parent as a result of specific actions taken by the first parent.

Important symptoms of the PAS syndrome (Grzegorzewska, Pisula, Borkowska, 2016; Zielona-Jenek, 2012), i.e. parental alienation, is engaging the child by the parent who has custody in deprecating and criticizing the other parent, unjustified or/and exaggerated, poorly argued criticism, and showing clear hostile attitude towards the so-called secondary parent. The strong influence of the main caregiver, e.g., by hindering contact, or presenting the other parent in a less favourable light, as well as subtle ones, e.g., showing disrespect or disapproval for maintaining relationships with the other caregiver, showing distance, use of specific (hostile or disrespectful) intonation in statements about the other parent contributes to the development of disorders in children. The belief of the child that it expresses its own judgement is necessary to diagnose parental alienation syndrome. A symptom of PAS is also the presence of the so-called borrowed scenarios in relationships of the child – that is, quoting the same arguments, situations, and even the same words as the main caregiver and spreading animosity towards the other parent to the parent's friends and extended family.

PAS is closely related to the destruction and distortion of the child's relationship with the parent who does not have direct custody of the child. On the other hand, a close bond with the primary parent is pathologically used to destroy the child's sense of security in contact with the other parent. Gardner (Zielona-Jenek, 2012) states that involving a child in a conflict with the other parent and setting the child against the other parent, consequently leading to alienation is a form of psychological abuse by the primary parent and as such may cause irreversible destruction of the relationship with the other parent, together with all its consequences for the functioning of the child. Parents striving for parental alienation are unable to see the emotional needs of their children or the consequences of their deprivation in the long term. They do not predict psychological consequences of their actions.

Potential consequences of PAS in children include self-destructive behaviour, blocking one's individuality, ease of becoming addicted, lowered self-esteem, anger, aggression, depression, anxiety, and even suicidal tendencies. In addition, the consequences of parental alienation syndrome include difficulties in building intimate relationships, problems with identity throughout life, mental illness, emotional problems and sexual disorders in adulthood. PAS may also be accompanied by hyperactivity and anxiety, and in its advanced stage - neurotic and psychosomatic problems such as headaches, stomach-ache, asthma, problems with metabolism, and difficulty falling asleep, and the child may be bound with the primary caregiver even by paranoid fantasies about the secondary caregiver (parent).

Parental alienation syndrome (PAS) is criticised (Namysłowska, Heitzman, and Siewierska, 2009 Czerederecka 2010; Zielona-Jenek, 2012) as insufficiently proven by scientific research and therefore it is not included in the classification of diseases and disorders. However, it should be emphasised that the criticism of the PAS syndrome mainly concerns the imprecision and common language in the diagnosis and the lack of nosological status of the syndrome, whilst the problem of alienation itself is not questioned (Grzegorzewska, Pisula, Borkowska, 2017). There is no doubt, however, that the child's

involvement in the fight of parents for the so-called primary custody and elimination of the second parent from it entails high emotional costs for children and is a significant disturbance of their bond with their parent. Conflicts between parents or just a lack of understanding between them increases the child's feeling of danger (the child ceases to feel that the parent will ensure security to them) and generates the so-called conflict of loyalty (the child feels that it has to hide from his parent information about its relationship with the other parent). It is not uncommon for children to take over the role of the guardian of one of the parents who they consider to be the aggrieved or weaker – the phenomenon of parentification. They are often uncertain about which information and feelings they can and cannot share with each parent. Such uncertainty can lead to hiding difficult feelings, problems, and thoughts that need to be discussed with the adult. However, the child does not reach for the parent's help, because it is not certain if this can and will not lead to another conflict. The child tries to cope by itself, which it often cannot do. The likely consequences of parental alienation syndrome are difficulties in building intimate relationships, life-long identity problems, mental illness, emotional problems, and sexual disorders in adulthood.

4. Consequences of disturbed bonds for mental health and functioning

Based on the analysis of the attachment styles developed during childhood, Bartholomew and Horowitz (Cierpiałkowska, 2013; Cierpiałkowska, Górska, 2017) have noticed that during adolescence, and later in adulthood - one can notice specific personality traits as a consequence of specific relationships with parents in the early years of life. Creating a bond based on the feeling of trust and security, or in the absence of them, has led to distinguishing four patterns of attachment, described on two dimensions: dependence/avoidance and positive/negative, which in turn lead to the emergence of specific personality traits. They identified the following patterns:

- trusting – associated with a positive image of oneself and others, as well as with a low level of dependence and avoidance;
- preoccupied – characteristic to people with a negative self-image and a positive image of others, showing high dependence and a low level of avoidance;
- rejecting – observed in people with a positive self-image, and negative in others, with a low level of dependence and high avoidance;
- anxious – associated with a negative image of oneself and others, a high intensity of dependence with a high level of avoidance at the same time (Cierpiałkowska, 2013).

Disturbed patterns of attachment occurring in childhood can be preserved in the form of internal operational models, which in adulthood will become a source of the feeling of threat, anger, anxiety, and fear (Cierpiałkowska, 2013). The readiness to experience them is in turn conducive to the development of many mental disorders – especially personality disorders and anxiety disorders. Bearing in mind the above findings regarding the concept of attachment models in adulthood, Lydon and Sherry (Cierpiałkowska, Górska, 2017) have identified the sources of development of individual types of personality disorders in terms of intrapsychic, insecure attachment models.

In-depth research conducted by Lydon and Sherry (Cierpiałkowska, Górska, 2017) has shown, however, that some types of personality disorders coexist with more than one attachment pattern, e.g., borderline type turned out to be associated not only with a disorganised attachment style but also with anxiety-absorbed style. Apart from these additional and significant factors for the development of personality disorders, which

changed dependencies indicated in tab. 4 were, for example, addictions. Undoubtedly, however, the lack of a secure bond during childhood significantly influences the development of disturbed features of functioning and feeling.

The concept of attachment is also an attempt to explain depressive disorders in adults (in dynamic terms). According to Thompson (Cierpiałkowska, 2013), the anxiety style of attachment characterised by the fear of loneliness and helplessness in difficult situations gives predispositions to the occurrence of affective disorders. The author showed that shame, low self-esteem, and a tendency to worry and self-blame occur in people with an anxious and avoiding attachment style (Sęk, 2016). Other psychoanalytical concepts also explain depression and manic-depressive disorders with the circumstances of object loss in ego development disorders in the course of object relations in the early stages of development.

5. SUMMARY

The type of bond built up in early childhood is relatively stable over time but may change as the child's relationship with the primary caregiver becomes more closely aligned with or mismatched with his needs. The formed attachment style, which is an internal operational model of bonds, affects the psychosocial development of the child and adolescent, their ability to regulate emotions, the ability to get to know themselves and explore the world, as well as the ability to maintain interpersonal relationships and deal with difficult situations.

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