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CASE REPORT

Importance of Attachment: Two Cases, Attached to Different Parents and Given to Their Biological Parents at the Age of Four

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ABSTRACT
Attachment between mother and the baby is important regarding the healthy development of the child. Importance of attachment was aimed to be investigated. Two male children, who were given to other families after birth and given back to their biological families at the age of four by court order, were observed with their families and evaluated regarding their attachment, coherence in their new families, and other problems. The follow-up continued by clinical evaluations. Denver II, Maternal Attachment Inventory, Adult Attachment Style Scale, Child Behavior Checklist (CBCL), Parental Attitude Research Instrument (PARI) were used. Informed consents were taken from the families for research purposes. As a result, children who were raised by other parents then their biological parents, were determined to attach to the parents who raised them. It was established that there were problems regarding separation from the families who were the children attached to and reattachment to the biological parents were risen in the process. The importance of attachment between mother and children, regarding the psychiatric development of children was discussed. The problems which were caused by the separation from parents who the children were attached to and the difficulty of re-attachment after four years were reviewed.
Keywords: Attachment, ambiguous loss, adult attachment style scale, maternal attachment scale, separation and loss

INTRODUCTION

Attachment is known as an emotional bond which a person establishes with another. For the attachment to be provided, the child needs an accessible, uninterrupted caregiver who gives the child consistent reactions (1). Attachment is an effective bond, which is seen as the source of security in stressful situations. It has 3 main functions: be a safe haven when the child is exploring the world, to provide physical needs of the child, evolve a sense of security in life (2). The nature of the caregiver-child relationship should provide a psychological environment in which a child can regulate behavior and emotions especially when under stress. So attachment should serve a stress reduction function that allows a child to feel secure when under pressure.

The child's attachment relationship with their primary caregiver leads to the development of an internal working model (3). This internal working model is a cognitive framework comprising mental representations for understanding the world, self, and others. A person's interaction with others is guided by memories and expectations from their internal model which influence and help evaluate their contact with others (4). Around the age of three, these seem to become part of a child's

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personality and thus affects their understanding of the world and future interactions with others (5). According to Bowlby (3), the primary caregiver acts as a prototype for future relationships via the internal working model. There are three main features of the internal working model: (1) a model of others as being trustworthy, (2) a model of the self as valuable, and (3) a model of the self as effective when interacting with others. It is this mental representation that guides future social and emotional behavior as the child's internal working model guides their responsiveness to others in general.

Seperation and Loss

Theoretically, the separation of children from their parents is a risk factor associated with poor mental health (6). Bowlby, argued that children who suffered a loss of additional figures would be distressed even if the attachment was replaced by a capable caretaker (3). Whether the attachment is secure or insecure, separation will likely be distressing and anxiety-provoking (7). This distress can manifest in problematic behaviors, such as aggression, delinquency, and depression (8). Children who have suffered traumatic separations from their parents may also display low self-esteem, a general distrust of others, mood disorders (including depression and anxiety), socio-moral immaturity, and inadequate social skills. Regressive behavior, such as bedwetting, is a common response to separation. Cognitive and language delays are also highly correlated with early traumatic separation (9).

Ambiguous Loss

Ambiguous loss is most devastating of all losses experienced in personal relationships because it is unclear, unrecognized, indeterminate and distressing. Ambiguous loss is difficult to find closure for since there is usually no official recognition of the loss. There are 2 kinds of ambiguous loss: Physical Absence with Psychological Presence and Physical Presence with Psychological Absence. As Boss suggests, "the greater the ambiguity surrounding one's loss, the more difficult it is to master and the greater one's depression, anxiety, and family conflict" (10).

Ambiguous loss is a frequently cited term to explain the situation in which children are taken from their biological families and given to foster families. According to Boss (11), ambiguous loss often results in boundary ambiguity. Conceptually, boundary ambiguity is a lack of clarity regarding who is in and who is out of the family system, and what role each member plays (12). Boss, argues that the higher the boundary ambiguity in the family after a loss, the greater the likelihood of dysfunction. The child's removal from the home does not necessarily represent a clear-cut and final exit from the family, possibly resulting in a high degree of boundary ambiguity (13-15). Jones and Kruk, found many children reported they do not feel like they are part of any family (16). This ambiguity can lead to feelings such as hopelessness and depression (11).

This case report relates to a 13-month clinical follow-up of two families and two children who had to return to their biological families after living with their caregivers until 4 years of age. In this case report, mother-child attachment, mother's loss and grief processes, ambiguous loss of children were studied. It was aimed to be one of the first contributions to the literature related to this specific situation.

CASE PRESENTATION

Patient A and Patient B were born in 31st of May, 2013, in City 3 in a private hospital. After they were born, due to a mix up at the hospital, they were given to each other's biological parents rather than their own. Biological parents of Patient A, who got Patient B from the hospital, were living in City 1 and biological parents of Patient B, who got Patient A from the hospital, were living in City 2. After they got out of the hospital, both families went to their own cities. After 4 years, there were problems between Father A and Mother A, who were raising Patient B, regarding their marital relationship. Father A asked for a DNA test because he claimed that Patient B looked nothing like him and Mother A must have cheated on him. After the DNA test, it was obvious that Patient B was not Father A's son. So the mother also asked for a DNA test,

claiming that she never cheated on him and there must have been something else going on. So another test was administered. The results showed that Patient B was also not Mother A's son. They approached the hospital to solve this situation. The hospital checked its records and there was another birth on the same day. It got apparent that the hospital mixed two patients after birth. The legal process to determine the children's condition lasted for 18 months. 18 months after it was certain that the children were mixed up, the court decided the children should be delivered to their own biological parents. Even though the mothers were not willing, they took their biological sons back and gave the other mother the son they have raised. After the change of the children, the families got back to different cities. Even though it was proven that Mother A did not cheat on Father A, they still got a divorce. Father A did not want to see the son he has raised or his biological son till date.

Patient A and Patient B were first examined at the 31st of May. It had been 10 days since the children started living with their biological parents. They were 4 years old at the time of the examination. Both of the children could not understand the incident due to their developmental stage at the time being. They both thought that this situation was temporary. They both called the parent who raised them, "Mother" and could not yet establish a bond with the other family. When they came to the clinic for evaluation, both children were really happy to see the mother who raised them did not want to get separated from them. Denver II, Maternal Attachment Inventory, Child Behavior Checklist (CBCL), Parental Attitude Research Instrument (PARI) were administered at the day of the first examination. It was clear that the children have established a healthy attachment with the parents who raised them rather than their biological parents. Also; the parents were also attached to the children whom they have raised rather than their biological children.

Because of the problems the families were suffering from, the family in City 1 (Mother A and Patient A) was recommended to move to City 2. After the move, the families reported moving affected both the families and the children in a positive way. The children and the families started getting counseling at City 2 in June, 2017. The mega-family order was created in which children lived with their biological parents and could also meet with attachment objects. Families were met at regular intervals.

Patient A-Family A

Patient A was born in 31st of May, 2013 with C Section. He was breastfed for 3 months. He started walking when he was 1 years old. He started talking when he was 1.5 years old. He completed his toilet training when he was 3 years old.

During the sessions in City 2, which have started at June, 2017, it was seen that Patient A had problems with the new environment, regarding boundaries. Patient A grew in a more relaxed environment in the past. Because there were more rules and boundaries in his biological parent's house, he suffered getting used to the new system. Patient A's parents were divorced, so not only he lost the mother and the father who raised him, he also did not meet his biological father at all, because Father A was not interested in being involved in the family anymore. So he did not have a male figure in the house. Also he had problems understanding the situation. His biological mother was asked to get information about his son from the mother who raised him. Also to support him socially, Patient A started kindergarten. He had no problems adapting to school and he attended the activities regularly. Another problem was with the sibling. Patient A has an older sister who is 6 years old. She also had difficulties getting used to another brother. Patient A and his sister had a problematic relationship. Main problems regarding Patient A were found to be the boundaries in the new family, expressing emotions, getting used to the new family, missing the parents who raised him and the problematic relationship with the sister.

At the end of the first month, anxiety-depression scores, behavior problems and aggression scores were found to be high in the CBCL scores (Table 1. Patient A CBCL Scores). Compared to Patient B, it was observed that Patient A was more extroverted, more easily adapted to the environment, and could relax more easily in

Table 1: Patient A CBCL scores

Patient A	After 1 Month	After 6 Months
Introversion	4/18	1/18
Somatic complaint	1/18	0/18
Anxiety-Depression	8/28	4/28
Social problems	3/16	1/16
Thought problems	2/14	0/14
Attention	9/22	5/22
Behaviour problems	9/26	0/26
Aggression	16/40	8/40

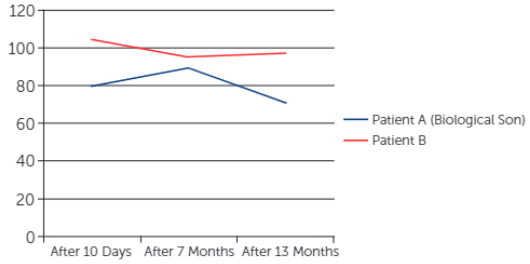

Figure 1: Mother A-Maternal attachment scale.

stressful conditions. Shortly after starting school, he managed to adapt. His biological mother was coping with a serious sense of loss, his biological father had never been in his life. He had an advantage. The presence of grandfather and grandmother became a stable base for him. While the family B was in a serious process of chaos and dissolution, the A family drew a stable structure with the support of grandparents. Although they could not be agreed in the early period the presence of the sister became a catalyst for bounding his home over time (Table 3, Scale of Family Functions).

At the end of the sixth month, it was observed that, the Patient A was used to his new home greatly. Anxiety-depression scores and behavioral problem scores were minimized. The aggression scores decreased but were still high (Table 1. Patient A CBCL Scores). He continued to meet regularly with his parents. It was observed that he did not overreact to leave them and returned to the biological mother easily. In his drawings, he found biological mother, grandfather and grandmother next to him. It was seen that she named the mother who raised him as "nursing mother" and positioned her in an important place in her mind.

Mother A's mind was full with the Patient B. She thought that Mother B would not take good care of him, thinking about her son throughout the day. During the meeting days, Patient B resisted the separation from Mother A. In time, a serious competition between mothers began. This competition negatively affected her mental state. Mother A had difficulty in showing sensitivity to Patient A. She was unable to tolerate loss due to attachment style and had difficulty in linking with her biological son. In time, she began to think that returning to homeland would be better for their children and families. She began to experience rage attacks and conversive syncopal attacks. The binding scores with his biological son followed a fluctuating course. Currently, the attachment score with Patient A is above the binding score with his biological son (Figure 1. Mother A Maternal Attachment Scale).

Patient B-Family B

Patient B was born in 31st of May, 2013 with C Section. He was breastfed for 1.5 years. He started walking when he was 10 months old. He started talking when he was 1 years old. He completed his toilet training when he was 3 years old.

Patient B's sessions in City 2 have also started at June, 2017. Patient B had different problems. He had setbacks regarding his development after the incident. He started to not do the things he used to do, such as, toilet training, wearing his own clothes. He also started crying out of no reason. During the follow-up examinations it was clear that Patient B was in need of the mother who raised him. His biological mother wasn't very fond of this situation. Also, there was a tense relationship between the parents and the parents had different approaches regarding the children. The parents of Patient B weren't spending much time with the children. Also, Patient B had a younger sibling, who was 1 years old and he was consuming most of the mother's time. Because of these issues, Patient B had a hard time adapting to the new family. Because Patient B had a really close relationship with the mother who raised him (Mother A), his biological mother (Mother B) had problems and started to be harsh on Patient B and threatened him with not letting him see the mother who raised him. Patient B continued his education in

kindergarten. A rule list was made, regarding his play time, sleep time and eating times, because there weren't any obvious rules in the house and it was affecting Patient B's development.

After several sessions with Patient B, he started to get attached to his biological parent too. When parting with the mother who raised him, he became less agitated compared to the times the sessions have started. Although it has been a year since Patient B had support, it still seems that Patient B has problems with feeling accepted emotionally in his family. (Table 2, Patient B CBCL Scores).

There were also problems regarding the mothers. In the first session, which was done on the 5th of June, 2017, Mother B was upset because Patient B wanted to get on mother A's lap. She compared herself to Mother A and she feels that she's an incompetent mother. Mother A also thought that Mother B was not paying enough attention to Patient A or Patient B. She thought that Mother B should be informed on raising children. She was also scared that Mother B would make Patient B stop seeing her. There was a tense relationship between the mothers.

Patient B he had a serious disadvantage about the family. The family B was in a serious crisis recently and the issue of divorce was on the agenda. Mother B was in jealousy and in thoughts of losing her husband. She was thinking about Patient A. all the day. She was comparing Patient A. with the Patient B. She was waiting from Patient B to behave as Patient A. Unlike the Patient A., the Patient B had an inward looking, fragile, sensitive nature. After leaving his mother, he had serious aggression, was not obeying the rules, hurting his brother. Patient B was exposed to violence by Mother B because he did not behave as she wished. In family B, the roles were not well distributed and the boundaries were not clear. The patient was unable to allocate enough time due to his younger brother.

Table 2: Patient B CBCL scores

Patient B	After 1 Month	After 6 Months
Introversion	12/18	6/18
Somatic complaint	3/18	0/18
Anxiety-Depression	11/28	6/28
Social problems	6/16	4/16
Thought problems	4/14	3/14
Attention	11/22	9/22
Behaviour problems	6/22	2/26
Aggression	24/40	16/40

Table 3: Scale of Family Functions

Scale of family functions	Family A	Family B
Solving problem	1.5	2.1
Communication	1.2	1.6
Family roles	1.5	2.5
Emotional response	1.1	2.8
Showing interest	1.9	3
Behaviour control	1.9	2.1
General functions	1.1	2.1

Considered positive as it is closer to 1, negative as it is closer to 4

During the meeting days, Patient B did not want to leave Mother A. and was crying for hours. Mother B interpreted this as her failure and began to charge her. The patient threatened not to meet with Mother A. Mother B suffered clinical depression in time. The attachment was damaged due to lack of her precision. After family interviews and medication, jealousy crisis began to decrease. The problems between spouses decreased. She began to accept his son's differences and to mirror his needs more appropriately. The attachment process has begun to progress favorably (Figure 2. Mother B, Maternal Attachment Scale).

When the Adult Attachment Style Scales were evaluated, it was seen that Mother A was in the anxious/ambivalent attachment style group. Her point for the avoidant attachment was also very high. Mother B, was also in the anxious/ambivalent attachment style group. But she, on the other hand, had a very high point for the secure attachment style. (Figure 3, Adult Attachment Style Scale)

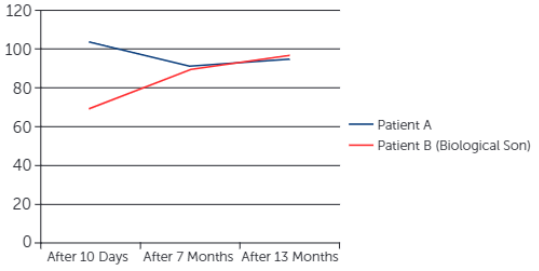

Figure 2: Mother B-Maternal attachment scale.

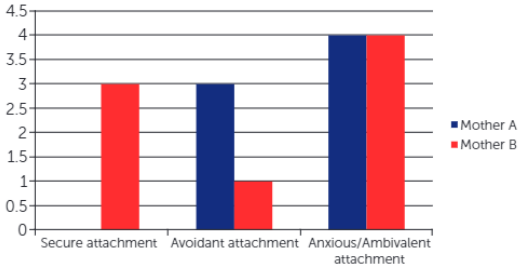

Figure 3: Adult attachment style scale.

Because personal reasons, on June, 2018, Mother A took Patient A and moved back to City 1. After they moved back, Mother B seemed to enter a mourning phase. Her relationship with Patient B was impacted negatively in the process. Patient B seemed to have tolerated the move of Mother A. Only, he started to act a little indifferent in the house. It was decided that Mother B should be monitored closely.

DISCUSSION

In this extraordinary case, the court's decision may bring discussions. The separation of caregivers from the 4-year-olds can induce traumas on both themselves and their mothers. Children do experience a sense of loss and emotional pain when permanently separated from an attachment figure.

The loss of children is considered as ambiguous loss. They were suddenly separated from the parents they knew existed and they started to live with someone they did not know? Why did they leave your family? Was the separation temporary? Inaccuracy and uncertainty led to serious instability in children's inner worlds. Considering the role of attachment in coping with stress, this has caused serious stress. Children were pushed to a depressive-anxious position because of corrupted self-regulation system. Their aggression increased because they could not express their experiences. Considering his developmental characteristics, he probably felt guilty because of his magical thoughts and filled them with feelings of guilt.

A transition process was designed as the first intervention. Families were scheduled to be in the same city and meet frequently. It is suggested that continuing contact with birth parents after a separation, may well help the child come to terms with the separation, and could play a crucial role in preparing the child to accept a new caregiver (17).

The truth were announced, identifed and re-framed to children. Mothers who raised themselves were conceptualized as "nurture mothers". To help them expressing painful feelings, demonstrating play, pictures and stories are used. In order to combat the feelings of internal uncertainty and instability, daily routines were tried to be created (10).

As stated in the literature, positive attachments develop when caregivers respond to situations of distress with warmth and sensitivity. A child with a disturbed attachment history needs to develop trust that the caregiver will provide predictable, sensitive and effective care during times of emotional need (18).

Mothers were encouraged to demonstrate an empathic, mirroring approach to children's needs. In the first months this was hardly possible. Mothers were busy with their losses and their own agendas. They wanted to see the children they raised in their biological son. They constantly compared and criticized them internally. This made it difficult for them to be empathic. Both families had advantages and disadvantages. The friction between the spouses in Family B and their 1-year-old baby from the house made it difficult to give the patient adequate support. After the psychiatric follow-up, the Mother B's mental state was better. Her attachment style showed strong secure attachment characteristics.This characteristics accelerated the attachment process with her biological son.

The absence of the father in the family, the insecure attachment style of the mother A., the intrinsic endless relationship between the Mother A and Patient B were negative for Patient A. However, his mother had strong social support, numerous attachment objects at home, and relationship with an older sibling. Another advantage that makes the patient more advantageous is that there is probably a safer attachment with the care giver in the early period compared to the Patient B. Patient B's early development of coping skills may be better.

Mothers were monitored with attachment scales and attachment styles. Awareness was made about biological children. Children's own temperament and developmental differences were tried to be respected.

Maternal Attachment Scale is an important component in this case study. The first time both mothers filled out the scale for both children, it had been 10 days since they have given the children they have raised to their biological families. It was seen that they both had healthy attachments with the children they have raised. Their points regarding the scale were much higher for the children whom they have raised.

When Mother A's Maternal Attachment Scale scores were evaluated, (Figure 1. Mother A - Maternal Attachment Scale), it was seen that in the first scale which the mothers have filled out at the 5th of June, 2017, she was much more attached to the son she's raised (Patient B). She had been living with her biological son (Patient A) for 10 days. Second time she filled out the scale for both patients at the 2nd of February, 2018, it was seen that her attachment to her biological son increased, whereas her attachment points regarding the son she's raised decreased. At that time, she had been living with her biological son for 7 months. The last time she's filled out the attachment scales at the 4th of July, 2018, when she had been living with her biological son for 13 months, it was seen that her attachment scores were higher for the son she's raised, whereas the scores regarding the biological son decreased.

When Mother B's Maternal Attachment Scale scores were compared, (Figure 2. Mother B - Maternal Attachment Scale), it was seen that in the first scale which the mothers have filled out at the 5th of June, 2017, she was much more attached to the son whom she have raised (Patient A). She had been living with her biological son (Patient B) for 10 days. The second time she filled out the scale at the 2nd of February, 2018 for both patients, there was a decrease in her attachment score to Patient A, whereas her attachment score to Patient B increased. At that time, she had been living with her biological son for 7 months. The last time she filled out the scales, at the 30th of June, 2018, when she had been living with her biological son for 13 months, her attachment score to Patient A increased, whereas her attachment score to Patient B also increased. Eventually her attachment score to Patient B was 1 point higher than her attachment score to Patient A.

Even though the relationships of the children with their biological parents have evolved with time, it still seems that their primary attachment figures are the mothers who raised them. The mothers still have difficulties with getting attached to their biological sons and the new environment in their houses. There are also siblings involved in this situation which makes the children get used to their new houses even harder. According to the Maternal Attachment Scales they fill out in intervals, it is shown that Mother A is still more attached to the children whom she's raised after living for 13 months with him. Mother B, on the other hand, seems to be attached more to her biological son according to the scale, after living for 13 months with him.

When the Adult Attachment Style Scale was evaluated, (Figure 3. Adult Attachment Style Scale), it was seen that Mother A was in the anxious/ambivalent attachment style group, but had high scores for both anxious/ambivalent attachment and avoidant attachment, but she did not have any points for the secure attachment statements in the scale. Mother B was also in the anxious/ambivalent attachment style group, but she had high scores for the secure attachment statements. Her avoidant attachment points were really low. This might explain Mother B's healthy attachment relationship with her biological son, according to the Maternal Attachment Scale she filled out throughout time, which evolved in time. Mother A, on the other hand, did not have any points for the secure attachment style statements, which means she could not have a secure attachment relationship with her own mother. This might explain her not being able to establish a healthy attachment, according to the Maternal Attachment Scale she filled out throughout time, with her biological son.

Limitations

Our findings may be affected by shared method variance, reporting and recall bias, and regression to the mean. Despite those limitations they underline the fact that attachment is also based on daily experiences and expectations as well as genetics and biology.

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Ethics Committee Approval: This article is in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of in 2000.

Patient Informed Consent: Consent was taken from the families for research purposes.

Conflict of Interest: The authors declare that there is no conflict of interest regarding the publication of this article.

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