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ATTACHMENT AND BONDING

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TO ACCESS THE QUIZ:
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ATTACHMENT AND BONDING

INTRODUCTION

Attachment is the reciprocal affectionate relationship that binds two people deeply together, or, more simply, loves. Attachment is also the process by which infants internalize emotional connections to others – that is, learn to love. Attachment influences all aspects of child development and becomes the basis by which the child relates to the world, learns, and forms relationships throughout life.

Bonding and attachment refers to the mutual affectionate connection that is cemented between a child and a parent, whether the child is a birth child or an adopted child. The process of establishing this connection includes a growing feeling of entitlement to family life, love, responsibility and a variety of other emotions normally experienced by a parent and child. "Bonding" is the process and "attachment" is the result.[1]

The life experiences of most internationally adopted children prior to placement conspire to interfere with the attachment process. Although no statistics are available, disordered attachment undoubtedly occurs more frequently among international adoptees, who are virtually all placed after 6 months of age, than among adoptees placed as newborns. Disordered attachment profoundly affects the well-being of the child and family. Through the publicizing of several cases of international adoptees with severe attachment disorder in the popular media, awareness of attachment issues for internationally adopted children has greatly increased.

ATTACHMENT: WHAT IS IT?

Attachment is the reciprocal, affectionate enduring emotional bond between individuals. The child's first attachment to his or her primary caregiver is the model for all later attachments in life.

The early psychiatric literature about attachment was based on observations of children left without parental care in institutions or hospitals. Lessons learned from children with obvious and severe attachment disorders have been applied to children who have experienced abuse, neglect, multiple foster care placements, or other disruptions in normal family life (including day care).

Attachment is the basis for many human relationships, including spouses, siblings, and extended family. The attachment of child to parent, however, is the most primal form of attachment, and the type of most importance in adoption.

Cross-cultural research in Africa, China, Japan, Israel, Puerto Rico, and the United States demonstrates that each society has different standards for attachment. The person or persons to whom the infant is expected to attach and the behaviors that express attachment vary greatly. Sleep patterns, age of weaning, and demonstration of independence are very culture-specific. Each culture's attachment process prepares the child for adulthood in that culture, and regardless of differences, most children become securely attached to their caregivers.

DEVELOPMENT OF ATTACHMENT

The normal experiences of an infant in a loving family naturally promote attachment. The child feels a "need," such as hunger, thirst, discomfort, or fear. He fusses, cries, vocalizes, or in some way expresses this need, and becomes progressively more 'aroused'. The parents respond with attention and attempt to satisfy the need (feeding, changing diaper, rocking, touching, making eye contact, vocal soothing). The infant's gratification results in trust that his needs will be fulfilled, that his parents will protect and care for him, and that he will be loved and nurtured.

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This process has been described as "attunement", as the parent and child synchronize their emotions. Some physiologic processes, such as heart rate, also become attuned. In normal family life, this cycle is repeated countless times during infancy and childhood. Through these patterns, the child learns what kind of person he is and what kind of responses to expect from people around him; these internal models are carried into adulthood. The child learns to accept a range of emotions and behaviors in his parents and in himself.

Early social responses develop in concert with the normal stages of attachment. Children exhibit a nonspecific smiling response at approximately 3 months, followed by specific social smiling that differentiates among individuals. Reactions to strangers (carefully examines, frowns, cries at unknown face) evolve; by 6-12 months separation and stranger anxiety emerge. Children begin to protest a caregiver's departure, eagerly greet the caregiver on return, cling when frightened, and follow the caregiver when able. By 8-10 months of age, a preferred relationship with one (or a few) caregiver(s) has been established; this relationship solidifies by 18 months of age.

BONDING AND ATTACHMENT IN RELATION TO THE CHILD'S AGE [1]

Most adoptive parents and experts in adoption are concerned about the time of bonding in relation to the age of the child who is adopted. In general, children adopted as infants or young children have a more rapid rate of attachment than older children.

The first meeting with an adoptive child is very dramatic for most parents. Parents adopting an older child will usually have seen photographs or a videotape of the child as well as received information about the child. Many adoptive parents have reported that they felt bonded to the child before the first meeting, based on the photograph or videotape alone. This is especially true when the decision to adopt was based solely on the photo, videotape and/or sketchy information they received. If such an adoption falls through for some reason, even though the child was never theirs, the adoptive parents experience a grieving process. In their minds, the child was theirs.

If the child to be adopted is an infant, the adoptive parents will have virtually no idea what the child will look like until they first see the child. They may know the child's racial and ethnic background and have general information about the birthparent's appearance and may have met the birthparents.

The time when the adoptive parents first view their baby or older child is very important and unforgettable. Both adopting parents should be present at the first meeting along with other members of the family who reside together in the same household. To avoid overwhelming the child, in general it is best for extended family members to meet the child later on.

DISORDERED ATTACHMENT

Abnormal attachment may occur if these normal cycles are disrupted, disordered, or never established. For example, the child born into a neglectful or abusive environment learns very different lessons compared with the situation in a loving home. For these children, "need" stimulates "arousal," but when the "need" is not met, "arousal" escalates to "high arousal." If still not gratified, the infant becomes exhausted or may develop self-gratification techniques (for example, rocking or head banging). The infant thus learns self-reliance and suspicion of the ability of others to meet her needs.

In an abusive environment, "high arousal" may be met with injury or physical silencing, which after a time may be experienced as a pathologic form of gratification. The parent's strong emotion creates an intense but unsatisfying connection. The child does not learn to trust and also loses the sense of logical consequences. These experiences, if repeated, become ingrained into the child's most fundamental behaviors and psyche.

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The first two years of life are the most vulnerable period for the development of attachment problems. Formation of attachment by institutionalized children may be impaired by many factors.

These factors include
- Sudden or traumatic separation from primary caretaker (through death, illness, hospitalization of caretaker or removal of child)
- Physical, emotional or sexual abuse
- Neglect (of physical or emotional needs)
- Illness or pain which cannot be or is not alleviated by caretaker
- Frequent moves and/or placements
- Inconsistent or inadequate care (holding, talking, nurturing, as well as meeting basic physical needs)
- Chronic depression of primary caretakers
- Neurological problem in child which interferes with perception of or ability to receive nurturing (i.e. babies exposed to crack cocaine in utero).

Children removed from loving caretakers display a predictable succession of symptoms if not permitted to form new attachments. Most children exhibit weepiness, demanding attitude, loss of appetite and weight, regression, withdrawal, and insomnia. If the loved one does not reappear, children display decreased movement, susceptibility to infection, facial rigidity and atypical finger movements. Children suffering from these symptoms show increased morbidity.

One researcher describes the predictable responses of a secure 15 to 30 month old child removed from his mother. The infant first exhibits “protest,” which may last hours to a week or more. The child “appears acutely distressed, cries loudly, shakes his cot, and throws himself about, looks eagerly towards any sight or sound which might prove to be his missing mother”. This stage is followed by “despair”, in which the behavior suggests increasing hopelessness. The infant’s active physical movements diminish, crying is monotonous or intermittent, and the child becomes withdrawn, inactive, makes no demands on people, and appears to be in deep mourning. This stage is followed by “detachment”, commonly misconstrued as a sign of recovery. The child accepts his caregivers, may even smile and be sociable. However, if his mother visits, he is listless and apathetic, and seems to have lost all interest in her. He begins to act as if neither mothering nor contact with humans has much significance for him.

CHARACTERISTICS OF ATTACHMENT DISORDER

Although some children may recover from a single loss of this magnitude, others unfortunately suffer recurrent psychic losses. Some children gradually commit themselves less and less to succeeding parent figures and eventually no longer attach to anyone. Such children may appear cheerful, easy-going, and unafraid, and may be described as affectionate and charming. However, this sociability is superficial and closer inspection reveals a child who is indiscriminately friendly. Such behaviors mask inner feelings of insecurity and self-hate. Deep down, the child no longer cares for anyone.

Children with attachment issues have little or no understanding of family bonds, the depth of parental commitment, or the desires a parent has in acting for the child’s best interests. The unattached child determines what is best for himself; it does not occur to him that adults would try to understand what is best for him and to help him. The child has little desire for relationships with adults except as a means to fulfill wishes. There is little empathy or concern for parents or the rest of the family. These children have difficulties with reciprocal relationships, accepting responsibilities and developing a conscience. A variety of behavioral problems are common among children with disordered attachment (see list below).

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CHARACTERISTICS OF ATTACHMENT DISORDER

- Superficially engaging and “charming” behaviors
- Indiscriminate affection toward strangers
- Lack of affection with parents on their terms (not cuddly)
- Little eye contact with parents
- Persistent nonsense questions and incessant chatter
- Inappropriate demanding and clingy behavior
- Lying about the obvious
- Stealing
- Low self-esteem
- Destructive behavior to self, to others, and to material things (“accident prone”)
- Abnormal eating patterns
- Poor peer relationships
- Lack of cause-and-effect thinking, difficulty learning from mistakes
- Lack of a conscience
- Cruelty to animals
- Preoccupation with fire, blood, gore

REACTIVE ATTACHMENT DISORDER

Attachment disorders comprise a spectrum. The most severe form is reactive attachment disorder (RAD). These children have severe, life-long problems if not treated. Wikipedia (http://en.wikipedia.org/wiki/Reactive_attachment_disorder) defines RAD as follows: “RAD arises from a failure to form normal attachments to primary care giving figures in early childhood. Such a failure would result from unusual early experiences of neglect, abuse, abrupt separation from caregivers after about age 6 months but before about age 3 years, frequent change of caregivers, or lack of caregiver responsiveness to child communicative efforts. It is characterized by markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before the age of 5 years.”

At the milder end of the spectrum are children with attachment issues who do not fulfill diagnostic criteria for RAD. This includes many international adoptees, who may have signs of disordered attachment, usually of the insecure or anxious type. This may also result in social, behavioral, cognitive, and emotional problems. Common findings are lack of awareness of social boundaries, social cues, and differentiation in responses to adults. Some children readily go off with a stranger, fail to check back with the parents, and develop distress without coming to the parent for comfort.

The spectrum of attachment issues is illustrated in the following table:

SECURELY ATTACHED	INSECURELY ATTACHED	POORLY ATTACHED
Confident, high functioning	Gives up when frustrated	Lacks empathy
Strong sense of self-worth	Collapses when stressed	Lacks conscience
Highly developed empathy	Over control of emotions, aggressive	Unable to relate to others except as objects to meet their needs
Able to engage in healthy, mutually enhancing relationships in and out of the family	Doesn’t seek comfort when distressed	Dissociates

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ATTACHMENT AND INSTITUTIONALIZATION

The early life experiences of many internationally adopted children greatly increase the likelihood of attachment problems. Prenatal exposure to stress may influence the hormonal regulation of attachment. After birth, few children, with the exception of most Korean and some Guatemalan children, go directly from the maternity hospital to loving, consistent foster care until adoption. Most children experience institutionalization for months or years. The orphanage experience may be one of impersonal, inattentive care with few caregivers, so that the children experience deprivation and neglect. (This was the situation in Romania, about which much of the recent research on attachment after adoption is based.)

Other orphanage environments may have adequate numbers of staff, but the structure and staffing arrangements expose the children to inconsistent caregivers. Caregivers work rotating shifts, and children must adjust to various personal styles or care giving at different hours and different days. Staff turnover may be high. Children are often moved to new groups as they age, leaving beloved caregivers (and peers) behind. The lack of a consistent caregiver is the most common experience in the institution. In one study, it was estimated that by the age of 2 years, the child in a well-staffed orphanage has encountered 20 different caregivers; by 4 years, 40 caregivers and by 8 years, 80 different caregivers.

Although many children attach to their caregivers, these attachments are frequently disrupted and do not have the same depth or quality as attachments developed in a loving family. Thus it is not surprising that after adoption some post-institutionalized children display behaviors characteristic of attachment disorder. These behaviors overlap with many other entities common in post-institutionalized children. (Grief, adjustment reaction, post-traumatic stress disorder, sensory integration disorder, language delay, developmental delay, learning disabilities). Such behaviors are expected in the first days and weeks after adoption. In most cases, they do not indicate permanent attachment problems but reflect the extraordinary psychological adjustments to adoption. Conversely, many behaviors seen after adoption may be rooted in insecure attachment.

ATTACHMENT AFTER ADOPTION

Although considerable research has addressed the effects of institutionalization on attachment, relatively little has been reported about the effects of adoption after institutionalization. Early research suggested that children were incapable of developing a first attachment after infancy. More recently, others have found no relationship to age at placement and attachment security, although differences in attachment quality among children adopted after 6-10 months of age or those adopted interracially have been cited. In one study of 13-18 month old infants adopted between 3 and 10 months of age, no relationship was found between the infant's developmental quotient, number of foster homes, and age at adoption and the quality of mother-infant attachment. However, clinginess, attention seeking, difficulties establishing deep social attachments, and indiscriminate friendliness may persist for years after adoption as "minor" signs of disturbed attachment. The experience of the child during the transition to the new adoptive family also affects attachment.

THE BONDING PROCESS [1]

Most adoptive parents bond more rapidly to infants than older children. That is because part of bonding is physical touch and infants require more touching in the course of their care. When siblings are adopted, some research suggests that parents bond more quickly with the younger child, probably because the younger child needs more care.

Parents bond to older children by performing parent/child activities such as teaching them how to cook and taking them shopping. Adopting parents need to learn to "go slow" until an older child is ready to accept love especially if the child does not respond to affection at first. If an older child had been abused, they may shrink from hugs and kisses.

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Studies indicate that parents seem to bond more quickly and with the most lasting bond when they perceive that the adopted child is similar to them in physical appearance, intelligence, temperament, or some other aspect. Adoptive parents tend to respond with embarrassment, confusion, pride or a mix of all of these emotions when strangers point out apparent similarities between the parent and child. The parents may feel compelled to tell them that the child is adopted. This is unnecessary. Strangers often make pleasant conversation and do not need details about the adoption.

Bonding is not always instantaneous when the child is a newborn baby, nor is bonding always instantaneous between a biological mother and her child. Bonding rarely occurs immediately when the child is older. The bonding process is often a slow evolution of a myriad of tiny events in the course of days, weeks or months.

Many parents of children who were adopted when they were older report that the first time they really knew they were parents was when they felt that their child was threatened by someone who spoke harshly to their child or pushed them. The rush of parental anger and protectiveness is a genuine sign that the parent has bonded to their child.

Important in the bonding process is the support from extended family members. However this may not be possible because of distance or negative feelings about the adoption, which can cause anxiety and may affect the bonding process. New adoptive parents should join an adoption parent support group whose members can help them with their need for a feeling of importance and belonging.

One factor that can seriously impair the bonding process is if the adopted child is very different from the type of child the parent had dreamed of. For example, a child's behavioral problems far exceed what the parent is ready to cope with.

INDISCRIMINATE FRIENDLINESS

Indiscriminate friendliness is common among post-institutionalized children. Indiscriminate friendliness must be differentiated from sociability or gregariousness, also common in post-institutionalized children. Indiscriminately friendly children respond to any adult as long as their needs and wishes are met: one person can easily replace another. For children living in institutional care, indiscriminate friendliness has adaptive advantages. Indiscriminate friendliness may occur regardless of whether the child has a preferred attachment figure. After adoption, it is problematic. Evaluation of 14 institutionalized children who entered foster care at age 18 to 24 months found that these children initially displayed fear at separation from their foster parents, but several months later they displayed indiscriminate friendliness to all adults. In a longer follow-up study of children adopted from institutions at age 2 years, indiscriminate friendliness continued for several years, but was gone by age 8 years in most children.

ATTACHMENT AND INTERNATIONAL ADOPTION

The incidence of attachment issues among internationally adopted children is unknown, as is the outcome of children with these problems. Attachment research on international adoptees to date has focused on a specific group of children: those adopted from Romania in the late 1980s to early 1990s. These children came from institutions where they suffered extreme neglect and deprivation. These studies on attachment address the ability of children to develop a first attachment after infancy.

In a comparison of Canadian-born children with Romanian children adopted to Canada after either greater than 8 or less than 4 months of institutionalization, several important findings emerged. Not surprisingly, the longer-institutionalized children had lower attachment security and more indiscriminate friendliness, but there was no relation between these two behaviors.

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Some of the characteristics that differentiated each group are shown in the following table:

DIFFERENCES IN ATTACHMENT SECURITY
More Typical of Longer-institutionalized Children ▪ Wants to be put down, then fusses and wants to be picked right back up ▪ Is demanding and impatient ▪ Easily becomes angry at parent ▪ When upset tends to stay where he or she is and cries ▪ Plays roughly with parent: bumps, scratches, or bites ▪ Is quick to greet parent when parent enters a room
More Typical of Non-adopted Controls When picked up puts arms around parent
More Typical of Shorter-institutionalized Children ▪ Shows a pattern of using parents as a secure base from which to explore ▪ Follows parent when asked to do so ▪ Recovers quickly from crying if held

When the same children were reevaluated 3 years later, attachment had improved, and the longer-institutionalized children did not differ in attachment security compared to the other two groups. However, more of the longer-institutionalized children had insecure or atypical attachment patterns. Those with insecure attachment were more likely to have lower IQs, behavior problems, and more stressed parents. These families also had lower socioeconomic status than those of children with more secure attachments.

Indiscriminate friendliness was also reevaluated at the 3-year follow-up. The longer-institutionalized children still displayed more signs of indiscriminate friendliness, even some of those with secure attachments. Seventy-one percent of parents of longer-institutionalized children described them as overly friendly; 90% reported little or no improvement in this behavior with time. It is possible that this behavior may have been reinforced by both parents and strangers early after the adoption. Children with more signs of indiscriminate friendliness were more likely to have been favorites in the orphanage, which suggests the adaptive nature of this behavior. Only the extreme measures of indiscriminate friendliness differentiated children with secure and insecure attachment. Indiscriminate friendliness was not a sign of Reactive Attachment Disorder.

The conclusion of these investigations (and others) is that most post-institutionalized children are capable of forming attachments to their parents. This includes even those children exposed to extreme institutional conditions. However, compared to children raised in families, these children have less secure attachments.

ATTACHMENT: PRACTICAL ASPECTS

Research supports the clinical impression that most internationally adopted children form attachment to their parents. However, it is apparent that many children have attachment issues.

After adoption, some post-institutionalized children fail to exhibit normal pre-attachment behaviors, such as eye contact, smiling, and making their needs known. Some children do not signal their parents when they waken, do not show that they are in pain, or come to their parents when distressed.

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These are behaviors that a child normally uses to foster attachment, but they were never learned or reinforced during institutional life. These uncommunicative behaviors of the child make it more difficult for their parents to recognize their child's need for attachment and to respond in ways to promote attachment.

If the child does display attachment-seeking behaviors, the parents may perceive these as "immature" rather than appropriate – for example, clingy, not cuddly, or demanding, not needy. Likewise, indiscriminate friendliness is usually not perceived as a particular problem by most parents shortly after adoption. Over time, however, many parents become alarmed about their child's safety and disappointed that their own relationship with the child has not grown deeper over time.

Sleep behaviors are also an important area related to attachment. Parents who expect newly adopted infants to sleep through the night in their own rooms may be misguided. In her book, Toddler Adoption: The Weaver's Craft, Mary Hopkins-Best states: "Always assume that a request for parental contact and comforting represents a need for a toddler struggling to develop attachment. Meet that need on demand, day or night. Parents need to reframe their thoughts about getting up at night with a new toddler as a wonderful opportunity to build attachment, rather than a dreaded chore. Do NOT leave an adopted toddler or infant alone crying at night as often recommended by many parent discipline specialists. The techniques of temporary segregation and isolation are for children who are securely attached, not for toddlers and infants learning to trust that their parents will meet their needs in a loving and responsive manner."

Little scholarly work has addressed the parent's attachment to the child. Clearly, the parent's own emotional makeup, along with his or her expectations about the child, is crucial to this vital process.

TECHNIQUES TO PROMOTE ATTACHMENT

Information, preparation, and support before and after adoption assist parents to deepen their emotional bonds to the child. Understanding the barriers to attachment experienced by their child may help parents make decisions about child care, returning to work, and other practical matters. The parent's *direct* involvement in caregiving is the *critical* foundation for building attachment. Extraneous caregivers, day care providers, and well-meaning assistants should be minimized as much as is practical, especially in the early months after adoption.

TREATMENT OF ATTACHMENT DISORDER

The treatment of RAD is arduous and complex. Treatment of less severe attachment problems is also difficult and challenging. The goal is to increase empathy and attunement. Although traditional therapy presupposes that the child had the readiness and ability to form a therapeutic relationship that may be used to resolve past trauma, children with attachment problems are not likely to enter into a relationship with a therapist.

Most theories of treatment attempt to replicate normal attachment sequences at some level. In the "developmental attachment" model, children must develop a relationship with their primary caregivers who then provide a secure base from which to resolve their earlier trauma. This is promoted by "playful, engaging interactions that provide the attunement essential to forming a relationship and help the child come to terms with experiences that have left him feeling shame and isolation". "Theraplay" is attachment-based play that purports to help with anger, aggression, depression, attentional difficulties, and developmental delays.

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SEVERE ATTACHMENT DISORDER

Attachment disorder and international adoption have been linked in the news on several tragic occasions over the past 10 years. At least two Russian adoptees said to have RAD have been killed. In both cases, the adoptive parents were accused and/or convicted of the crimes. The defense claimed that the children had severe RAD and that their injuries were self-inflicted.

In addition to these two tragedies, many more children with severe behavioral disturbances have been adopted by American families. Many have been removed from the adoptive homes and placed in specialized foster care, juvenile detention facilities, or psychiatric facilities. No statistics are kept that reveal the scope of this problem. However, between 1994 and 2001, one agency that arranges adoptions of special-needs youngsters placed 105 Eastern European children who were unable to remain with their original adopting families, often due to RAD. Some children had to be placed with three or even four different families. Many of the children had been neglected and sexually abused in Russia; after adoption some displayed severely aggressive behaviors, molesting others and even attempting murder. The tragedy for these children and their parents is enormous.

KEY POINTS FOR INTERNATIONALLY ADOPTED CHILDREN

- Orphanage life conspires to produce disordered attachment.
- There is a spectrum of disordered attachment.
- Many internationally adopted children have some disordered attachment behaviors.
- Most international adoptees develop good attachment to their families.
- A small minority have severe reactive attachment disorder.
- Treatment of reactive attachment disorder is complex and arduous.

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ACTIVITIES TO PROMOTE HEALTHY ATTACHMENT

1. Wear infant in chest carrier, all day if possible.

2. Mom should initially be the only person meeting her needs. Baby needs to build a bond with one person first, then she can branch out to others.

3. Bathe together, to promote skin-to-skin contact. Baby and Mom wear the same lotion; baby associates scent with Mom.

4. When child gets a shot, Mom shouldn't be the person to hold her. Ask nurse to hold her, and then have Mom be the one to comfort her.

5. Laminate loving family pictures of you together and put around her crib and other places.

6. Outline her body, as well as your own, on huge sheets of newsprint. Color them. Tape the "portraits" to her ceiling.

7. When feeding her something she particularly likes, tell her you are a good mommy or daddy. Telling her with words that you are a good mommy is important – otherwise, how would she know?

8. If you use cologne (or if you don't, use your shampoo), place a tiny bit on her arm so she has your smell with her at all times.

9. Play with dolls to act out how parents always return after the child goes to day care, babysitter, bed, etc.

10. Limit choices. At first, parents should make all decisions, including foods, toys, and clothes. This helps the child feel safe. Then as the child becomes accustomed to the new family, limited choices can be offered.

ACTIVITIES TO PROMOTE ATTACHMENTS IN TODDLERS

1. Bottle feed your toddler, no matter what the age. Encourage eye contact by gently touching her cheek. DO NOT let her hold the bottle. Nourishment has to come from parent(s); be sure to hold her when feeding.

2. If she turns away (avoiding eye contact) try placing a large mirror across from you. That way, when she turns away, she will see herself in your embrace.

3. Continue to hold her in your gaze. It may take a long time for her to glance at you. When she finally does, be ready with a warm, loving, approving smile. This sounds little but is really big and pays big rewards.

4. Encourage eye contact by gently tapping the bridge of her nose and yours as a hand signal to look at you.

5. Play peek-a-boo.

6. Have the baby pull a sticker off your nose – and put it back.

7. Hold the baby in your arms and dance with her – a very synchronous activity.

8. Swim together.

9. Paint each other's faces with paint, powder or just pretend.

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10. Play musical nose – sing a song and let your child pinch your nose so you sound very silly. You stop singing if she breaks eye contact.

11. Play musical swing – put child in a baby swing. Face her as you push. Encourage eye contact by singing a song and stop if she looks away.

12. Fill your cheeks with air. Have child "pop" them.

13. Put lotion on each other.

14. Ask her to feed you. This works great with raisins, Cheerios, or popcorn.

15. Give Eskimo kisses – rub noses and stare into each other's eyes.

16. Play in front of a mirror. Make faces, painting Mommy's face, trace each other's faces on the mirror with washable marker, finger paint, shaving cream. Let your child be your puppet and make her dance. Make dolls dance. Any kind of game that gets your child to relax and meet your eyes in the mirror will likely get her relaxed enough to meet your eyes directly.

17. Instead of using an actual mirror, take turns being each other's mirror. Sit face to face, and have your child imitate every facial movement you make, and vice versa. Then try it with your whole body, mirroring each other's movements.

18. For an older child, try lip-reading with each other. While you're not really getting eye contact, you're at least looking at each other's faces.

19. Play a memory game with a more personal touch. Have your child look you over carefully. Then leave the room and return after you've changed something about yourself. See if she can figure out what is different. It could be something really obvious for younger kids, like taking off a sweater, but for older kids you could do something more challenging like buttoning one more button on the sweater.

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[1] Adamec, Christine, and Laurie C. Miller, MD, *The Encyclopedia of Adoption, Third Edition*, New York, Facts On File, Inc., 2007

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