Second edition

Attachment, Trauma and Healing

Understanding and Treating Attachment Disorder in Children, Families and Adults

Terry M. Levy and Michael Orlans

Foreword by Sumiko Tanaka Hennessy

Attachment, Trauma, and Healing

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Dedication

To my wife, Suzanne, whose love and support provides, the “secure base” I need; to my children, Mia, Eliah, and Matthew; to my grandchildren, Anika, Mariah, and Jordana; and my parents, Donald and Renee, who have taught me a lot about commitment, attachment, and love.

T.M.L.

To my parents, Rachel and Samuel Orlans, who taught me to value family above all else and showed me how to live life with heart, strength, passion, and integrity. To my wife, Jeri, who continually encourages me and challenges me to grow and heal. To my children and their families: Adam, Julie, Rhyan, and Taylor; Ushi, Jon, Skyler, and Noah; Raina, Craig, Sienna, and Reese; and Jesse and Nicole, for their unconditional love, support, and wisdom.

M.O.

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Foreword

Sumiko Tanaka Hennessy

It was May, 2004 that I first met Dr. Terry Levy and Mr. Michael Orlans of the Evergreen Psychotherapy Center/Attachment Treatment and Training Institute (ATTI), of Evergreen, Colorado. They were teaching a preconference workshop on Corrective Attachment Therapy at the National Foster Parent Association Conference in Orlando, Florida. I participated in their workshop while waiting for the arrival of a group of Japanese foster parents who were attending this conference. I had just come back to the United States from my four-year stay in Japan, where I helped to open a college of social work. During my stay in Japan, I realized the mounting problems of child abuse and neglect, and made it my mission to get to know Japanese foster parents who cared for these children. Before going to Japan, I was the executive director of the Asian mental health clinic in Denver, where we worked with refugees and immigrants with posttraumatic stress disorder (PTSD) and Asian adopted children with attachment disorders. Attachment and healing of trauma had been my lifelong interest.

Although I was very familiar with the attachment therapy offered by the Attachment Center in Evergreen, Colorado, I had never met Dr. Levy or Mr. Orlans, who also practiced in Evergreen. I immediately realized that the work of Dr. Levy and Mr. Orlans was quite different from what I had observed at the Attachment Center. First, Dr. Levy and Michael Orlans were family therapists, and based on systems theory, believed that the child needed to be healed within the family system. The Attachment Center separated the child from his/her adoptive or foster parents, and placed the child into a therapeutic foster home. Second, the Attachment Center used a holding technique which was controlling and coercive. I always felt that this approach was too severe and worried about damaging the child further. The therapeutic process used by Dr. Levy and Mr. Orlans, referred to as the

Limbic Activation Process (LAP), was done with the child's permission, and was nurturing, supportive, and safe. They stressed the cues of attachment, including eye contact, gentle touch, and mutual smiles. The DVD they used to illustrate their therapy process touched me so deeply that I requested there and then to become a student of their approach.

Immediately after returning to Colorado, I participated in a two-week training session at their Center, and witnessed how the entire family changed for the better within the designated 30 hours of therapy (three hours a day for ten days). Every year since 2005, I have brought a group of Japanese mental health workers and foster parents to ATTI, where Dr. Levy and Mr. Orlans gave a week-long workshop on attachment theory, childhood trauma, and the healing process. These workshop participants always report extremely positive results of their training.

Another fortuitous event in 2004 was a week spent with Dr. Bessel van der Kolk at the Cape Cod Institute in Easton, MA. Since our Asian clinic dealt mainly with refugees from Viet Nam, Cambodia, and Laos, we had studied the work of Dr. van der Kolk, the president of the International Society of Traumatic Stress Studies (ISTSS). He is the Chief of Psychiatry at Boston University, the founder and medical director of the Boston Trauma Center, and is a leading researcher and clinician regarding psychological trauma. Dr. van der Kolk presented new approaches to healing trauma based on recent findings from brain research. He first clarified that psychotropic medications could not heal trauma, but only reduced the symptoms. The use of selective serotonin re-uptake inhibitor (SSRI) medication and counseling might reduce the severity of PTSD symptoms for a while, but if the patient subsequently experienced a similar occurrence, his/her PTSD symptoms would reappear. This I knew very well from treating refugees, as they returned to our clinic for more therapy after they watched refugee incidents in Europe or Africa on television. The second point Dr. van der Kolk stressed was that when trauma occurred, the functioning of our new brain (frontal lobe) diminishes, and the old brain function (limbic system and brain stem) takes over for survival. Therefore, it is not effective to counsel a person by targeting the frontal lobe area. Neither our limbic system nor brain stem is aware of time, therefore flashbacks can occur at any time. As there is no connection from the frontal lobe area to the limbic system, using words to heal trauma, which he called "a top-down approach," does not work. What we needed to do, he suggested, was to focus our therapy directly on the overactive, impaired limbic system (symptoms such as arousal, flashbacks, rage, fearfulness, avoidance). By healing the limbic system and brain stem, we can then heal the cortex. He called this approach "a bottom-up approach to

healing psychological trauma." He emphasized the importance of utilizing psychodrama to help people come to terms with trauma memory.

After attending Dr. van der Kolk's lecture series, I became further convinced that Dr. Levy and Mr. Orlans were on the right track. Their therapy model, described in detail in their book, has three stages: *revisit*, *revise*, *revitalize*. The *revisit* process helps the client recollect traumatic memories. The client, who was convinced that he or she was bad and unlovable, learns that the maltreatment was not his or her fault. Using a teddy bear to represent the wounded inner-child, the client goes through a *revision* process, facilitating self-protection and healing. Dr. Levy and Mr. Orlans utilize psychodramatic reenactment; these dramatizations rescript the client's narrative and rewire the limbic brain. This is consistent with Dr. van der Kolk's findings that the limbic system and brain stem must be healed before before addressing the frontal lobe of the traumatized clients. The *revitalize* stage involves forgiveness and closure. During this stage loyalty conflicts are mitigated, letting go of resentments and fears is encouraged, and attachment bonds are strengthened. Although I have observed this therapy countless times, I am always deeply moved to tears as I witness the positive changes in family members.

It is said that therapy is both a science (based on proven theories) and art (creative use of therapist's self). Dr. Levy and Mr. Orlans' newly revised book talks a great deal about the underlying theories to their therapy, based on new brain research. Making these theories come alive, however, and using them effectively to treat those suffering families is art!

Please enjoy this second edition of Attachment, Trauma, and Healing. This book provides numerous clinical examples of healing interventions with children, parents, adults, and couples. It is written in a clear and practical way, and offers hope to all professionals and parents striving to help wounded individuals and families.

Sumiko Tanaka Hennessy, Ph.D., LCSW

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I express my appreciation to my colleagues, friends, and family, who have been supportive and encouraging during the preparation of this second edition of *Attachment, Trauma, and Healing*. I want to thank Ruth McCue for being extremely conscientious and meticulous during the arduous process of typing, organizing, and editing this manuscript. I am grateful for the contributions of numerous researchers, clinicians, educators, and child welfare professionals, who have helped me to understand the children, adults, and families who are in need of our services. Finally, I extend my heartfelt appreciation to the many children, adults, and families who have participated in our treatment programs over the years, and have inspired me with their courage, resilience, and perseverance toward growth.

Terry M. Levy, Ph.D.

Science is generally believed to be the attainment of systematic knowledge based on a series of dramatic results, breakthroughs, or advances. However, science is first and foremost a process you begin on one path and then find yourself going down a different road. If you do not make mistakes you are doing something wrong. If you do not modify these misconceptions you are really amiss. Provincial, narrow, or limited, truth is the best truth available at the moment and is continually modified as new information emerges. This book is dedicated to the researchers who offer us new insights and the health care professionals and clinicians who have the courage and vision to challenge conventional beliefs in an effort to better the human condition. I would like to give special recognition to the adults who are suffering with attachment issues and the families who have bared their hearts and souls to help their wounded children.

Michael Orlans, M.A.

Confidentiality

We have used case vignettes throughout this book to illustrate clinical and treatment issues. These vignettes are based on actual children, adults and families, who have participated in our treatment program, although names and circumstances have been changed to protect confidentiality.

1

Introduction

Over 25 years ago, we (Terry M. Levy and Michael Orlans) rarely received a referral of a child with a diagnosis of attachment-related disorder. The focus was usually on the symptoms (e.g., anger, aggression, anxiety, depression, emotionally distant from parents), but the core issue—disrupted attachment caused by maltreatment and interpersonal trauma—was overlooked. It is now common knowledge in the mental health and social science fields that lack of safe, secure, and attuned caregiver–child attachment in the early stages of life can lead to many problems in childhood and, in fact, throughout life.

Many children are failing to develop secure attachment to loving, protective caregivers—the most important foundation for healthy development. They are flooding mental health, child welfare, and school systems with an overwhelming array of problems (emotional, behavioral, social, cognitive, developmental, physical, and moral) and growing up to perpetuate the cycle with their own children. Some social service and mental health professionals believe that attachment disorder is rare: the evidence indicates otherwise. Research has shown that up to 80 percent of high-risk families (poverty, substance abuse, abuse and neglect, domestic violence, history of maltreatment in parents' childhood, depression, and other psychological disorders in parents) create disorganized/disoriented attachment patterns in their children. Since there are one million substantiated cases of serious abuse and neglect in the United States each year, the statistics indicate that there are 800,000 children with severe attachment disorder coming to the attention of the child welfare system each year (Lyons-Ruth 1996; Pynoos *et al.* 2008). This does not include the thousands of children with interpersonal trauma who are adopted from other countries.

Attachment

Attachment is the deep and enduring connection established between a child and caregiver in the first several years of life. It profoundly influences every aspect of the human condition—mind, body, emotions, relationships, and morality. Attachment is not something that parents do *to* their children; rather, it is something that children and parents create *together*, in an ongoing, reciprocal relationship. Attachment to a protective and loving caregiver who provides security and support is a basic human need, rooted in millions of years of evolution. We have an instinct to attach: babies instinctively reach out for the safety of the "secure base" with caregivers; parents instinctively protect and nurture their offspring. Attachment is a physiological, emotional, cognitive, and social phenomenon. Instinctual attachment behaviors in the baby are activated by cues or signals from the caregiver. Thus, the attachment process is defined as a "mutual regulatory system," in which the baby and the caregiver influence one another over time.

The principal developmental task of the first year of life is the establishment of a secure attachment between infant and primary caregiver. In order for this bond of emotional communication to develop the caregiver must be psychologically and biologically attuned to the needs, emotions, and mental state of the child. Beyond the basic function of secure attachment—providing safety and protection for the vulnerable young through closeness to a caregiver—there are several other important functions for children:

- to learn basic trust and reciprocity that serve as a template for all future emotional relationships
- to explore the environment with feelings of safety and security ("secure base"), which leads to healthy cognitive and social development
- to develop the ability to self-regulate, which results in effective management of impulses and emotions
- to create a foundation for the formation of an identity that includes a sense of competency, self-worth, and a balance between dependence and autonomy
- to establish a prosocial moral framework that involves empathy, compassion, and conscience
- to generate a core belief system that comprises cognitive appraisals of self, caregivers, others, and life in general
- to provide a defense against stress and trauma, which incorporates resourcefulness and resilience.

Secure attachment can only be established in the context of a relationship that includes nurturing touch, eye contact, smile, positive affect, need fulfillment, and attunement:

- *Touch:* For millions of years, mothers have held their babies "in arms," providing nurturing touch and safe containment. The communication transmitted through touch is the most powerful way to establish a human relationship (Montagu 1986). Secure attachment involves loving and caring touch, as well as sensitive and appropriate limits and boundaries. Without touch children can die; with abusive touch and/or little loving and nurturing touch, children develop severe biopsychosocial problems and an aversion to the very touch and closeness they desperately need.
- *Eye contact:* A newborn can focus his or her eyes on objects 7 to 12 inches away, the exact distance needed to make eye contact in arms. The caregiver–infant gaze is a primary releaser for the development of secure attachment and is synonymous with closeness and intimacy. Securely attached children are able to communicate and connect through eye contact. Children with disrupted attachment typically use their gaze to manipulate, control, or threaten.
- *Smile and positive effect:* The baby's smile is an instinctive response that attracts the attention of the caregiver and encourages an ongoing positive caregiver response. The caregiver's smile and positive affect help the baby feel safe and secure. The relationship between caregiver and a securely attached child is characterized by warmth, joy, and love. Children who experience interpersonal trauma feel rejection, pain, fear, and anger.
- *Need fulfilment:* Successful completion of the first-year-of-life attachment cycle leads to the development of secure attachment. The sensitive caregiver gratifies basic needs, which alleviates the child's stress and discomfort. Securely attached children learn to trust caregivers and believe that their own needs are valid. Children with compromised attachment mistrust caregivers and develop negative self-perceptions ("I am bad, defective, unlovable").
- *Attunement:* The infant's brain is an "open loop system"; it relies on attuned and nurturing input from attachment figures for healthy development. Sensitive and attuned caregivers down-regulate stress, facilitate safety and trust, and encourage optimal neural wiring.

Children who begin their lives with the essential foundation of secure attachment fare better in all aspects of functioning as they develop. Numerous

longitudinal studies have demonstrated that securely attached infants and toddlers do better over time in the following areas:

- self-esteem
- independence and autonomy
- resilience in the face of adversity
- ability to manage impulses and feelings
- long-term friendships
- relationships with parents, caregivers, and other authority figures
- prosocial coping skills
- trust, intimacy, and affection
- positive and hopeful belief systems about self, family, and society
- empathy, compassion, and conscience
- behavioral performance and academic success in school
- promoting secure attachment with adult partners and with their own children when they become adults. (Sroufe *et al.* 2005).

Disrupted Attachment

Children who begin their lives with compromised and disrupted attachment (associated with prenatal drug and alcohol exposure, neglect of physical and emotional needs, abuse, violence, multiple caregivers) are at risk of serious problems as development unfolds, including:

- low self-esteem
- being needy, clingy, or psuedoindependent
- decompensating when faced with stress and adversity
- lacking self-control; being biologically and behaviorally dysregulated
- inability to develop and maintain friendships
- alienation from and opposition to parents, caregivers, and other authority figures
- antisocial attitudes and behaviors
- aggression and violence
- difficulty with genuine trust, intimacy, and affection

- negative, hopeless, and pessimistic view of self, family, and society
- lacking empathy, compassion, remorse, and prosocial morality
- behavior and academic problems at school
- perpetuating the cycle of maltreatment and attachment disorder in their own children when they reach adulthood
- being incapable of securing adult-to-adult attachment relationships.

Disrupted and anxious attachment not only leads to emotional and social problems, but also results in biochemical consequences in the developing brain. Infants raised without loving touch and security have abnormally high levels of stress hormones, which can impair the growth and development of their brains and bodies (Perry 1994; van der Kolk 2003). The neurobiological consequences of emotional neglect can leave children behaviorally disordered, depressed, apathetic, slow to learn, and prone to chronic illness. Compared to securely attached children, children with attachment disorder are significantly more likely to be aggressive, disruptive, and antisocial. Teenage boys, for example, who have experienced attachment difficulties early in life are three times more likely to commit violent crimes (Raine 1993). Disruption of attachment during the crucial first three years can lead to what has been called "affectionless psychopathy;" the inability to form meaningful emotional relationships, coupled with chronic anger, poor impulse control, and a lack of remorse. These disturbing psychosocial qualities have contributed to a more violent and "heartless" character to the crimes being committed by today's youth. The vast majority of these children had histories of abuse and neglect, lived in single-parent homes, had young mothers, and/or a parent with mental illness and a criminal record.

Attachment disorder is transmitted intergenerationally. Children lacking secure attachments with caregivers commonly grow up to be parents who are incapable of establishing this crucial foundation with their own children. Instead of following the instinct to protect, nurture, and love their children, they abuse, neglect, and abandon. There is a "pyramid effect;" with each generation, there is a multifold increase in the number of children with attachment disorder.

Compromised attachment early in life not only leads to aggression and antisocial acting out, but also has contributed to the current disorganized and overwhelmed state of our foster care system. Over the past generation, the number of children with severe attachment disorder in out-of-home placements has increased, while the number of foster parents had decreased. Child protective services removes many children from violent, substance-abusing, and maltreating birth parents, and places them in foster homes.

However, due to the lack of proper diagnosis, effective treatment, and inadequate training and support of foster parents, large numbers of children with attachment disorder are moved aimlessly through the system, their problems increasing in severity with each move.

Many of these children are eventually adopted by well-meaning parents who are intellectually and emotionally ill-prepared to handle the children's severe emotional and behavioral problems. Such children are unable to give and receive love and affection, constantly defy parental rules and authority, are physically and emotionally abusive to caregivers and siblings, and create ongoing stress and turmoil in the family. As a result of insufficient preplacement services (education, training, support, matching) and postplacement services (individual and family therapy, parent education, support), family members and marriages suffer. Traumatized parents may relinquish, shifting the child and his or her problems back to the child welfare system. Others place their children in long-term institutions that drain financial resources and often fail to address the child's attachment difficulties. Many parents choose to maintain the child in their family, which results in years of ongoing stress, neglect of the needs of their other children, and prolonging parenting responsibilities well into their child's adult years.

Many parents choose to adopt children internationally; over 216,000 children were adopted from outside the United States from 1998 to 2008 (U.S. Department of State 2013). Many of these children experienced early interpersonal trauma, in additional to being institutionalized (i.e., in orphanages), and display impairments in attachment, self-regulation, neurobiology, behavior, cognitive functioning, and morality. In our treatment programs we observe the devastating effects of ongoing stress and conflict—the *traumatized adoptive family*. The family systems are characterized by: an emotional climate of anger, frustration, and despair; secondary traumatic stress in parents and siblings; parents feeling isolated, misunderstood, and blamed; chronic power and control battles between parents and child; triangulation—child playing one parent against the other; marital and coparenting conflicts; severe sibling discord.

In the following chapters we will describe our *Corrective Attachment Therapy* and *Corrective Attachment Parenting* programs. These programs focus on treatment for trauma and compromised attachment for children and adults, parent training, adult and coparenting relationships, and family therapy.

A significant family and societal issue regarding the attachment of young children is substitute child care. Currently, 75 percent of all women in the United States with young children work full time outside the home. About 8.2 million children—40 percent of all children under 5 years of age—spend

at least part of their week in day care (Cohen 2013). Child care services are well regulated in many countries, but not in the United States. The maternity and nursing benefits given to working mothers in the United States are the least generous in the industrialized world. Although there is ongoing debate regarding the benefits of staying home with your child versus placing the child in day care, the need for substitute child care is a reality. Research has revealed the ingredients of quality substitute child care: proper staff education and training, small staff–child ratios, adequate financial incentives for staff, consistency of one child care provider who remains with a child through developmental stages, staff–parent collaboration, cooperation, and communication. Despite this knowledge, most child care facilities do not meet these requirements. One survey found that *every* state in the United States failed to meet the requirements for quality day care (Young, Marsland, and Zigler 1997).

Basic Principles

Our treatment program (*Corrective Attachment Therapy*) and parenting program (*Corrective Attachment Parenting*) are grounded in a foundation of basic theories, principles, and research. The following are the key elements of our philosophy, which inform our work with children, adults, couples, and families:

- *Family Systems:* The child, parents, and other family members must be understood in the context of the systems that influence their lives. The focus is on prior and current family systems, and external systems such as social services, extended family, social networks, and community resources. The systems model concentrates on the behavior of family members as they interact in ongoing and reciprocal relationships, and on the family as it interacts with external social influences.
- *Neurobiology:* In utero and early attachment experiences significantly affect the wiring of the brain, because the young child's brain grows more than at any other time in life, and relationships shape the developing brain. Lack of secure attachment and traumatic stress triggers an alarm reaction, altering the neurobiology of the brain and central nervous system. Traumatized children and adults often have impaired wiring in the brain's limbic system and altered levels of stress hormones, resulting in anxiety, depression, and self-regulation problems. Effective treatment and parenting rewires the limbic system and reduces the biochemistry of stress.

- *Attachment theory:* Early attachment relationships set the foundation for the rest of our lives. Attachment is at the core of our beliefs, emotions, behaviors, relationships, and morality. Effective assessment, treatment, and parenting hinges on understanding healthy and disrupted attachment. Facilitating secure attachment with children and adults involves the establishment of healing relationships, which include trust, empathy, safety, dependability, appropriate boundaries, and limbic resonance.
- *Trauma therapy:* Abuse, neglect, and compromised attachment are traumatic experiences that cause psychological, social, behavioral, and biological distress. Trauma results in anxiety, depression, dissociation, shame, the stress response (flight, flight, freeze), and long-term health problems. Effective treatment depends on understanding developmental trauma and posttraumatic stress disorder (PTSD), in order to ameliorate the effects of trauma on self-concept, attachment styles, self-regulation, core beliefs, and depression.
- *Developmental perspective:* Child development consists of a series of stage-relevant tasks that are essential to learn, which lead to the mastery of subsequent developmental tasks over time. The most important task of the first year of life is the establishment of secure attachment, resulting in trust, self-confidence, positive relationships, optimistic attitude, resilience, and success. The emotional and cognitive stage of a child at the time of interpersonal trauma determines the reaction and consequences. The developmental stage of the child at the time of treatment dictates the type of interventions utilized. Further, treatment is sequential and developmental: creating a therapeutic foundation, setting and achieving goals, mastering skills, and integrating healing experiences.
- *Integrative and holistic:* Assessment and intervention occur on all relevant levels of the human experience—emotional, cognitive, social, physical, behavioral, moral, and spiritual. This orientation assumes that all of these dimensions are interconnected. Behavioral change leads to alteration in meaning and beliefs; cognitive changes produce alterations in actions and choices; relationship change brings about rewiring of the brain and reduces stress; emotional security fosters academic achievement. Mind affects body and body affects mind. Interventions are didactic, experiential, skill based, systemic, biological, and community oriented.
- *Experiential change:* Recovering from trauma, rewiring the brain, developing secure attachments, learning constructive coping skills, and

changing core beliefs are best achieved via positive experiences with significant others—therapists, parents, spouses, and siblings. Effective treatment employs mental, emotional, and interpersonal experiences, in a safe, sensitive, and supportive manner. Healing parents realize that the *experience* of a positive relationship with their children is the primary vehicle for change.

- *Positive psychology:* Therapy is competency based. All family members have resources and strengths that must be identified and encouraged. It is helpful to focus on "what is right" and build upon that, not only on "what is wrong." Therapists and parents must be aware of becoming frustrated, overwhelmed, and pessimistic. It is crucial to remain calm, positive, use a language of hope, and communicate an expectation of success. Positive psychology teaches that resilience, recovery, and posttraumatic growth following trauma is associated with several factors: hope, sense of meaning and purpose, positive emotions, social support, acts of kindness, and internal locus of control ("I can create change").
- *Theory and research based:* Treatment is based on a variety of theories and research findings. The underpinnings of our model are trauma theory (PTSD, neurobiology of stress and trauma); family systems theory (dynamic, structural, strategic approaches); attachment theory and research (internal working model, developmental research, disorganized–disoriented attachment, parent–infant bonding); experiential therapy (affective expression, process orientation); cognitive–behavioral treatment (cognitive rescripting, developing coping skills); psychoanalytical theory (object relations); and positive psychology (signature strengths, resilience). Research findings are incorporated into the treatment methods to bring about safe and effective outcomes.
- *Solution focused:* The primary goal of treatment is positive change—new choices, perspectives, options, behaviors, coping skills, and relationships. It is essential to have a conceptual framework that defines the process of change. Our theoretical framework is *revisit*, *revise*, and *revitalize*. This framework provides a structure for determining therapeutic goals and methods during the course of treatment. A four-step model guides treatment interventions: *assess* → *set goals* → *intervene (method)* → *reassess*.
- *Culturally sensitive:* Behavior, as well as the personal meaning of events, varies depending on cultural background and tradition. The therapist must be aware of the cultural orientation of the child and family, and be careful not to project his or her own cultural biases, perceptions, or

beliefs on those individuals. Therapists and parents must understand and respect the diversity of beliefs and practices of different ethnic, racial, and cultural groups, and understand the way in which children are affected.

Attachment, Trauma, and Healing: Second Edition

Attachment, Trauma, and Healing was originally published in 1998. Since then there have been advances in the fields of child and family psychology, psychotherapy, and the evolution of our work with traumatized children, adults, and family systems. The second edition of this book includes an additional focus on interpersonal neurobiology, adult and couple treatment, positive psychology, and the evolution of *Corrective Attachment Therapy* and *Corrective Attachment Parenting*.

Interpersonal Neurobiology

The study of interpersonal neurobiology focuses on the relationship between early attachment experiences and the "wiring" of the brain (Siegel 2007; Schore 2012). Understanding neurobiology has resulted in a deeper appreciation of how the earliest relationships shape child development and have an influence later in life. Brain development in infancy is "experience dependent"; the baby's brain, specifically the limbic system, relies on sensitive and attuned care from attachment figures for healthy growth and functioning. Early relationship experiences play an essential role in shaping the architecture of the brain and building connections between parts of the brain. Chronic stress associated with lack of safe and secure attachment can impair the formation of brain circuits and alter levels of stress hormones, resulting in emotional and biological dysregulation, anxiety, and depression.

Combining our understanding of attachment, trauma, child development, family systems, and neurobiology enables us to provide a comprehensive approach to treatment and parent training that links mind, body, and relationships. Psychotherapy with children and adults who have experienced interpersonal trauma focuses on changing brain structure and function—rewiring the limbic brain—in addition to mental, emotional, and social changes.

Adult Attachment

In recent years there has been significant interest in adult attachment styles and how these patterns of attachment influence adult intimate and romantic relationships (Johnson 2008; Levine and Heller 2010). Attachment styles

learned in childhood tend to endure throughout life. Thus, each of the four childhood attachment styles has a corresponding adult version. Securely attached children become *autonomous* adults, who are comfortable in warm, loving, and emotionally close relationships. Avoidantly attached children become *dismissive* adults, who are distant and rejecting in their intimate relationships. Anxiously attached children develop into *preoccupied* adults, chronically insecure, needy, and worried about abandonment. Children with disorganized attachment, a result of severe maltreatment, turn into *unresolved* adults, who display PTSD symptoms, cannot tolerate emotional closeness, and have serious psychosocial problems.

The quality of adult attachment relationships affects emotional and physical health. Just as a secure attachment in childhood is associated with overall well-being, attachment security in adulthood is a primary factor linked to a healthy and meaningful life. In addition to a treatment program for children, parents, and families, we provide therapy for adults and couples who have a history of maltreatment, unresolved loss, and interpersonal trauma.

Positive Psychology

Until recently, the field of mental health focused primarily on psychopathology and mental illness. Positive psychology, conversely, is the study of positive emotions, psychological strengths, and paths to a meaningful and fulfilling life. Additionally, lessons learned from research on positive psychology have shed light on resilience, recovery, and posttraumatic growth following trauma. The study of posttraumatic growth (PTG) shows that many people increase personal strength, appreciation of life, positive relationships, and spirituality, following traumatic experiences. The factors associated with resilience and PTG are hope, positive emotions, social support, sense of meaning and purpose, acts of kindness, and internal locus of control (belief in one's ability to change).

While our treatment and parenting programs concentrate on alleviating the psychological, social, behavioral, and biological effects of interpersonal trauma, there is an equal emphasis on capitalizing on strengths and resources and fostering resilience—from "victim to survivor." Individual and family therapy must facilitate a future-oriented approach, in which the goal is to help children and adults create meaningful and fulfilling lives.

Evolution of Our Therapy

Since publication of the first edition of *Attachment, Therapy, and Healing*, we have worked with thousands of children, adults, couples, and families in our treatment programs, as well as thousands of mental health, social

service, school system, and allied professionals in training programs. We constantly strive to make treatment and training programs more effective and compatible with the latest research findings and advances in the field.

Years ago we combined our knowledge of trauma and compromised attachment with a family systems approach. Therapy in the 1970s and 1980s was more child focused, rather than identifying and modifying the psychosocial context of the child—the family dynamics and structure. Next, we emphasized adult attachment patterns from the perspective of adult intimate, romantic relationships (e.g., marriage), and parent's attachment histories. We incorporated the *Life Script*, an assessment tool to identify and understand prior relationship experiences that affect current perceptions and patterns of behavior. For example, helping parents to identify their emotional "triggers" enabled them to utilize parenting skills and solutions more effectively.

Attachment Communication Training (ACT) became an essential aspect of our treatment and parenting program. Teaching children, parents, and adult couples the skills of constructive communication, problem-solving, and conflict management facilitates positive change in destructive and dysfunctional relationships. As previously noted, the recent research on the brain and human relationships—interpersonal neurobiology—has helped us understand the biological basis of developmental trauma and disrupted attachment. Therapeutically, understanding neurobiology has enabled us to design experiential interventions which bring about rewiring of the limbic brain and mitigate the biochemistry of stress and trauma.

The original model of attachment and trauma therapy was coercive and intrusive ("rage-reduction"). Our model focuses less on the child's anger and more on the deeper emotions, i.e., fear, sadness, loss, grief, shame. The goal of our therapy is to create connections between parents and children, not to control their behavior. It is a supportive, nurturing, and compassionate approach. In 1989, we cofounded the Association for the Treatment and Training in the Attachment of Children (ATTACh). This is an international organization concentrating on research, therapy, and education regarding attachment and trauma. ATTACh advocates for evidence-based and ethical approaches to helping children and families.

Attachment Therapy Controversy

Over a decade ago a therapist in Evergreen, Colorado used what she referred to as a "rebirthing" intervention with tragic consequences. The child was wrapped in a blanket to simulate the birth experience; the child suffocated and died. Unfortunately, this therapist had a prior reputation as an "attachment specialist," and there were negative associations to the field of attachment

therapy, and to Evergreen, Colorado. This therapist had been trained in the "rage reduction" model, emphasizing control of the child, focusing on the child's anger, ignoring the contextual factors (e.g., family system), and misunderstanding basic attachment needs (safety, attunement, empathy, creating a secure base, supporting emotional and physiological regulation, building trust, reducing shame, and dealing with the fear, anxiety, and pain under anger and controlling behavior).

To clarify, our treatment and parenting programs never use coercive, intrusive, controlling, unethical, or fear-provoking interventions. We believe children must be respected in order for them to learn to trust and respect adults; children must be understood within the context of their social systems (i.e., family, school, community); change occurs in positive, safe, supportive, and compassionate relationships with parents, teachers, and therapists; parents must be willing to "look in the mirror" in order to be a healing (i.e. therapeutic) presence in their children's lives.

This second edition of *Attachment, Trauma, and Healing* reflects not only the evolution of our ideas and methodologies, but also the evolution of the field in general. Many researchers, child welfare specialists, and clinicians who treat child, adult, and family trauma have expanded their understanding of resilience and the healing process. This book hopefully describes this learning and growth – our and theirs.

Solutions

What are the solutions to the vast problems of attachment disorder in families, the child welfare system, and society? The solutions can be found in four areas: attachment-focused assessment and diagnosis, specialized training and education for caregivers (*Corrective Attachment Parenting*), treatment for children and caregivers that facilitates secure attachment (*Corrective Attachment Therapy*), and early intervention and prevention programs for high-risk families.

- *Assessment and diagnosis:* Attachment disorder is one of the most easily diagnosed and yet commonly misunderstood parent–child disorders. Diagnosis rests on three pillars: 1) developmental history; 2) symptoms and diagnosis; and 3) attachment history of parents/caregivers. Many social service and mental health professionals who are adept at assessing behavioral and emotional disorders are not trained in the use of an "attachment frame." Chapter 6 provides a comprehensive overview of assessment and diagnosis of attachment disorder in children, adults, and families.

- *Training for caregivers:* Parents and other caregivers assume the responsibility of childrearing accompanied by the challenges of children with attachment disorder, often without the information, training, and support they need. These individuals need specialized parenting skills to be successful in their parenting role. Adoptive and foster parents commonly feel frustrated, angry at the child and the "system," demoralized, disillusioned, and burned out. Chapter 12 will cover the basic concepts and skills of *Corrective Attachment Parenting*.
- *Treatment:* For more than 25 years, Evergreen Psychotherapy Center in Evergreen, Colorado, has been developing and refining approaches for the treatment of children, adults, couples, and families. We have found that effective treatment involves creating secure attachment patterns; systemic, holistic, and integrative interventions; and utilizing a developmental structure (Revisit, Revise, Revitalize).
    - *Creating secure attachment patterns:* The primary therapeutic goal is to facilitate secure attachment in the parent–child relationship. To achieve this goal we must recreate the elements of secure attachment that were unavailable in the child's early developmental stages. Children are provided with structure, attunement, empathy, positive affect, support, reciprocity, and curative relationship experiences.
    - *Systemic interventions:* Attachment develops in the context of overlapping relationship systems, including parent–child, marital, family, extended kin, and community. For example, the quality of the mother–infant relationship is influenced by the behaviors and attitudes of the father. Thus, effective treatment must address the various social systems in the life of the child and family.
    - *Holistic and integrative interventions:* Treatment focuses on mind, body, behaviors, emotions, relationships, and morality. Therapeutic interventions and strategies are varied: experiential, psychoeducational, cognitive, and skill based. The holistic approach is based on the concept that many factors interact to create both health and dysfunction.
    - *Revisit, Revise, Revitalize:* Treatment is developmental, requiring the successful completion of each stage, which in turn builds upon the next. Attachment trauma is first revisited to address core issues. Next, the therapist facilitates revisions in belief systems, choices, relationship patterns, and coping skills. Last, revitalization includes celebrating achievements, cementing positive changes, and enhancing hope for the future.

- *Early intervention and prevention:* Even with the availability of effective therapeutic interventions, it is impossible to reach all the children and families that need help. A significant amount of evidence accumulated over the past 40 years indicates that early intervention and prevention programs are effective for at-risk children and families (Guralnick 1997; Ramey and Ramey 1998; Bromberg *et al.* 2010). For example, high-risk mothers (young, single, poor) who received prenatal and postnatal home visits by a public health nurse had significantly fewer instances (4%) of child abuse and neglect than mothers who did not receive these services (19%) (Barnett 1997). Early intervention and prevention programs have been shown to enhance parent–child attachment and children's cognitive and social development (see Chapter 13).

Traditional psychotherapeutic approaches have not been effective with children with severe attachment disorder, who cannot trust or form a working alliance basic to success in therapy. Lack of secure attachment in the early years results in a need to control, a fear of closeness, and a lack of reciprocity. The therapeutic challenge is to take charge in a firm, yet caring way and gradually form a working relationship with the child. Mental health professionals are taught to be empathic, caring, and to allow the child to take the lead. This nondirective client-centered approach is appropriate for many children, but it is not effective with children who rarely admit they need help and are not motivated to improve. The same characteristics that make it difficult to help those with antisocial personality (no empathy or remorse, angry, defiant, dishonest, self-centered) are present in many of these children. The therapeutic challenge is to instill the basics—trust, empathy, cooperation, and conscience—qualities essential for successful living in a family and community.

Attachment during infancy is a physiological, emotional, and social experience. Instinctual attachment behaviors, rooted in biology and evolution, are activated by caregivers' cues (social releasers). The therapeutic challenge is to elicit these primitive, internal attachment feelings, behaviors, and patterns in children and parents. Activating the portion of the brain that monitors and controls attachment behavior (the limbic system) is necessary (see Chapter 8).

Many parents of children with severe attachment disorder have been "through the mill" of mental health and social service programs. Parents are commonly blamed for their child's problems, denied access to their child's social service records, and thoroughly frustrated in their attempts to get help. They are angry with their child, feel guilty and inadequate, and are demoralized. The therapeutic challenge is to increase motivation, enhance positive emotion, instill faith and hope, and encourage a more effective framework for conceptualizing their parenting role and understanding their child.

About This Book

This book addresses the entire scope of attachment from the perspective of the child, family, community, and society. We have three major purposes for writing this book. First, our hope is to increase awareness and understanding of attachment as a critical factor in childhood and family psychosocial functioning and dysfunction. Second, our goal is to provide a specific and effective framework for assessment and treatment of interpersonal trauma. Last, we will offer answers to commonly asked questions regarding attachment-related problems and solutions. The following questions will be considered and answered throughout the text:

- Is attachment instinctual (prewired) or environmental (learned from caregivers)?
- What do an infant and toddler need in order to feel secure, worthwhile, and lovable?
- What are the advantages of secure attachment for the child, family, and society?
- How do attachment experiences during the first three years of life lead to autonomy, confidence, and resilience in the face of adversity?
- Is the need for secure attachment during infancy as important as other basic needs?
- Is attachment a universal phenomenon, or does it vary from culture to culture?
- What role do fathers play in the attachment process?
- Can fathers or other nonmaternal caregivers facilitate secure attachment as effectively as mothers?
- What traits, symptoms, and relationship patterns can be observed at various developmental stages in order to accurately assess attachment disorder?
- What are the similarities and differences between attachment disorder and other childhood psychosocial disorders (e.g., attention deficit/hyperactive disorder, PTSD, oppositional defiant disorder, conduct disorder, bipolar disorder)?
- In what way does disrupted and disordered attachment contribute to the development of antisocial personality (lack of empathy and conscience, dishonesty, hostility, aggression, exploitation)?

- What high-risk factors in families are most often correlated with the development of severe attachment disorder?
- Why do some children develop major psychosocial problems as a result of early compromised attachment, while other children with similar backgrounds develop normally?
- What are the similarities between the neurobiology of trauma and attachment disorder?
- What are the family system issues in the understanding and treatment of attachment disorder?
- Why do many child welfare caseworkers, mental health professionals, and parents fail to produce positive changes in children with attachment disorder?
- What are the most effective therapeutic interventions for children, adults, couples, and families who are dealing with interpersonal trauma?
- What are the effects of day care on attachment patterns in children and families?
- What are the best out-of-home placements for maltreated children with attachment disorders?
- When should sibling groups be placed together in foster and adoptive homes, and when is it best to separate them?
- How does the foster care system exacerbate the problems of children with attachment disorder, and what are the best solutions for overwhelmed child welfare systems?
- Do all adopted children have attachment-related challenges and problems?
- How do you emotionally and intellectually prepare foster parents and preadoptive parents to address and manage the special needs of children with attachment disorder?
- What are the changes in public policy that must take place in order to foster secure attachment and prevent attachment disorder in children and families in our society?
- What skills and solutions do parents need to be "healing parents?"
- How do you treat adults/couples with early unresolved interpersonal trauma?

2

Historical Perspective

Early Theory and Research

Not long ago, the standard approach to treating infants and children totally ignored any basic understanding of attachment. This was true in Europe and the United States as recently as the 1950s, and some of these ideas still influence policy today. Hospitals had strict rules against parents visiting their children, or the visits were to be brief and infrequent. Parents were considered a nuisance and were thought to contaminate the children with germs. Similarly, staff were warned against contact with the children. It is not surprising that failure to thrive was the leading cause of death among hospitalized babies. "Experts" in behaviorism who viewed children as "blank slates" to be shaped by the environment provided childrearing advice to parents. They warned parents against picking up a crying baby, as that only resulted in creating a demanding and needy child. "Never hug and kiss them, never let them sit on your lap. If you must, kiss them once on the forehead when they say goodnight. Shake hands with them in the morning," advised John Watson in his book on childrearing (Watson 1928; cited in Karen 1994, p.3).

The prevailing attitude in the foster care system was to prevent children from becoming attached to caregivers by moving them from home to home—it was wrong, they believed, for a child to attach to someone who would never be his or her permanent parent. Prospective adoptive parents were discouraged from adopting early, as it was better to allow the child to develop so that defects could be detected (Karen 1994).

Fortunately, there was a new trend developing among social scientists by the middle of the 1900s. John Bowlby, considered to be the founder of attachment theory, was a pioneer in these new "child-friendly" concepts. Bowlby, one of the first British psychiatrists to work at a child guidance clinic, believed that the infant–mother relationship was crucial for healthy psychological and social development. He studied antisocial children and

adolescents and found prolonged early mother–child separations to be common. Bowlby concluded that these "affectionless children" developed behavioral disorders and criminal characters as a result of early emotional deprivation, resulting in traumatic loss and depression. Upon assessing the parents, he found that they consistently displayed disturbed attitudes and parenting styles (Bowlby 1944).

Bowlby's report to the World Health Organization in 1951 began a powerful movement toward understanding attachment. He studied homeless children from various cultures and found that significant early deprivation resulted in a variety of severe problems as the children developed: lack of empathy, conduct disorders, inability to give and receive affection, and attentional deficits (Bowlby 1951). He then went a step further, suggesting that these problems become intergenerational when the children grow to become abusive and neglectful parents. Although these notions seem obvious or even trite today, they created quite a stir in the early 1950s.

Bowlby developed many of his ideas about attachment from studying the research of ethologists, such as Konrad Lorenz and Niko Tinbergen. The ethologists studied imprinting, the bond that develops quickly between adults and offspring in birds and mammals, which is not related to feeding. Lorenz (1971) and Tinbergen (1951) found that bonding behavior is instinctive, but that the young only respond when certain cues or signals from their caregivers are available ("special-specific behavior"). For example, the young herring gull opens its mouth to eat only when it sees a red spot on the beak of the adult gull. Certain birds only develop a song when they hear the song of an adult of their species. Bowlby, and others to follow, applied this idea of the interplay between instinct and environment to the mother–infant relationship. This concept suggests that infants are "prewired" for attachment, but this process only unfolds when activated by certain cues or conditions from primary caregivers. This was the beginning of a long journey involving numerous researchers and clinicians in an effort to explore the mother–child relationship.

Bowlby's work with children and families led him to formulate a number of important conclusions (Bowlby 1988b):

- Infants possess instinctual behaviors (sucking, clinging, following, crying, smiling, and gazing) that serve to keep the mother close.
- The smile is a "social releaser" for both mother and infant. The baby's smile elicits maternal care, while the mother's smile promotes feelings of security in the baby.
- Anxiety, fear, illness, and fatigue cause increases in attachment behaviors, a need for more closeness and contact.

- Maternal deprivation and separation are traumatic, because they prevent the fulfillment of a biological need.
- The loss of an attachment figure causes pathological mourning, resulting in disturbed development, emotional detachment, inability to love and trust, and depression.

Other researchers and clinicians were coming to similar conclusions regarding the nature of the mother–child bond. David Levy studied children who lacked early maternal care, had several out-of-home placements, and later would not attach to adoptive parents. He found these children to be conduct disordered (lying, stealing, aggression), full of rage, indiscriminately affectionate, demanding, and incapable of genuine affection. They suffered from "primary affect hunger," he suggested, an emotional starvation resulting from maternal deprivation. Loretta Bender studied children who had numerous foster home placements and found them to be delayed in speech and social behavior, indiscriminately affectionate, abusive toward peers, clingy, and displaying attentional deficits and frequent temper tantrums. She diagnosed these children with psychopathic personalities, a result of early emotional deprivation. Harry Bakwin studied babies with failure to thrive syndrome in institutions. He found that they improved when nurses took more of an interest and when they were placed in nurturing homes. Harold Skeels noticed that deprived, institutionalized children had language and cognitive deficits. When he provided these children with older affectionate caregivers, their IQs increased an average of 30 points within one and a half years. Rene Spitz filmed children after they were left in hospitals and institutions by their parents, showing their emotional and physical deterioration. He found that most recovered if the mother returned within three months. After then, they became apathetic and unresponsive (Levy 1937; Bender and Yarnell 1941; Bakwin 1942; Spitz 1947; cited in Karen 1994, pp.15–24).

James Robertson observed children in British hospitals who were separated from their parents for long periods of time. He made dramatic films depicting their deterioration and described three stages of emotional reaction to separation and loss:

- *Protest:* Child is frightened, confused, screaming, and anxiously looking for mother.
- *Despair:* Child is losing hope of being reunited, becomes depressed and disinterested in surroundings and food.
- *Detachment:* Child is indifferent to maternal care, does not connect with mother during visits nor seems to care when she leaves. Child appears

to have adapted to institutionalized life. Feelings for the parents "died" due to repeated disappointment (Robertson and Robertson 1989).

The famous experiments of Harry Harlow validated the importance of a basic attachment need for contact. He found that infant rhesus monkeys preferred a "surrogate mother" covered with cotton terry cloth to a wire mesh "mother" that provided a bottle of milk. These infants spent most of their time clinging to the cloth mother, using her as a secure base from which to explore. These experiments demonstrated the importance of contact comfort and instinctual attachment needs, as separate from the issues of feeding (Harlow 1958). Subsequent studies showed that monkeys reared without their mothers developed disturbed behaviors, including aggression and violence, self-mutilation and self-stimulation (e.g., head banging, prolonged rocking), eating disorders, learning disabilities, abnormal social and sexual behavior, and rejecting and attacking their own offspring (Suomi 1991).

Mary Ainsworth was most influential in moving Bowlby's original ideas and observations to the next level. She began observing mother–infant relationships in Uganda in 1954, in an effort to learn how attachment develops. Through these observations Ainsworth coined the phrase "secure base," using the attachment figure as a base from which to explore the environment without anxiety—a phrase that even today is widely associated with healthy attachment (Ainsworth 1967). Ainsworth described five phases of attachment:

- *Undiscriminating:* No specific social responses; baby responds to anyone.
- *Differential responsiveness:* Baby knows and prefers mother.
- *Separation anxiety:* Baby cries when mother leaves and is calmed when she returns.
- *Active initiation:* Baby protests when separated from mother and actively pursues her by approaching, following, and greeting upon reunion.
- *Stranger anxiety:* Between 6 and 8 months, baby is uncomfortable with strangers.

In the early 1960s, Ainsworth began a longitudinal study of mother–child relationships in the United States to determine if attachment patterns were universal (cross-cultural) and to compare parenting styles and subsequent attachment. She developed the "Strange Situation," a laboratory assessment procedure designed to study separation and reunion under conditions of low and high stress, which would be utilized by numerous researchers for years to come. In the "Strange Situation," the baby is initially in the playroom with

the mother only, then a stranger enters; mother next leaves the room, then returns; the stranger next leaves the room, and mother then leaves with the baby now alone; then mother returns. The child's reactions to separation and reunion are observed through a one-way mirror and recorded on film for further analysis. The Strange Situation provokes separation anxiety in the child, which activates the inborn attachment system. The child's response to reunion determines the attachment classification.

Similar to the Uganda findings, the babies explored more with mothers present (secure base behavior). Three distinct attachment patterns were discovered, one secure and two insecure/anxious patterns, in 12- to 18-month-olds. *Securely* attached babies actively sought out mother when distressed, maintained contact on reunion, and were easily comforted by mother. *Ambivalently* attached babies were extremely distressed by the separation, but were difficult to soothe on reunion and resisted their mother's comfort. *Avoidantly* attached babies seemed disinterested in their mothers and, in fact, rejected them on reunion (Ainsworth and Wittig 1969).

Why did these babies respond with different attachment patterns? Did it have to do with inborn temperament or environmental factors? Ainsworth was able to answer these questions because she had a team of observers who made numerous home visits during the infants' first year of life. Vast differences in parenting style were found on scales of acceptance, cooperation, sensitivity, and availability. Mothers of securely attached babies were rated higher on all four scales; they were more responsive to baby's needs and signals and showed more pleasure in their reactions. Mothers of anxiously attached babies were less likely to respond to their baby's needs in sensitive, attuned, and consistent ways, and were inconsistent and unpredictable. Mothers of avoidant babies were rejecting.

These studies provided concrete evidence about ways in which parenting style affected individual differences in children. Securely attached babies had mothers who were affectionate, fed them on demand, and picked them up quickly when they cried during the early months. These babies cried less than anxiously attached babies by the end of their first year, indicating that responsive parenting did not create "spoiled," dependent children, but instead, led to healthy autonomy. The mothers of anxiously attached babies were inconsistent and themselves very anxious and tentative. Avoidantly attached babies had mothers who were much less affectionate, angry, and irritable, displayed gruff physical interactions, and often had an aversion to physical warmth and contact. No wonder these babies rejected their mothers on reunion—they were doing to their mothers (rejection) what had been done to them, and showing indifference to disguise their hurt and anger.

The Strange Situation provided an assessment of the mother–child attachment relationship, reflecting the child's prior experience with that caregiver. Securely attached children had learned that their caregivers were reliable, safe, sensitive, and emotionally available—a "secure base." Their mothers were attuned, able to perceive, understand, and respond in a timely and appropriate way to their baby's signals and needs. Thus, these young children learned to trust their mothers, and actively initiate engagement upon reunion. Conversely, the children with insecure attachments lacked basic trust, and either failed to be comforted by their caregivers upon reunion or actively avoided them.

Developmental Studies

Mary Main and colleagues at the University of California at Berkeley began a longitudinal study of middle-class families in the 1970s. Attachment patterns were assessed at 12 and 18 months of age, and aspects of psychosocial development were evaluated. A fourth attachment pattern was discovered—*disorganized/disoriented attachment*—where some children displayed both avoidant and anxious styles, and sought closeness to their mothers in strange and bizarre ways (Main and Weston 1982). Many of these disorganized children were found to have been abused (Crittenden 1988) and to have mothers who had experienced trauma and loss in their own early family life, which they never successfully resolved or mourned (Main and Solomon 1990). Fear and anxiety were verbally and nonverbally communicated to the baby (see Chapter 5 for more information on disorganized attachment).

Further studies provided new insights into the emotional, cognitive, and relationship aspects of attachment. The child's early attachment pattern creates an *internal working model*, a mental and emotional reflection of early attachment relationships that determines perception of self, others, and the world (Bowlby 1982). Relationship experiences of the baby and young child are encoded in the brain's limbic system. Repeated encoded experiences become internal working models, or core beliefs, about self, self in relation to others, and life in general. These core beliefs become the lens through which children and adults view themselves and others, especially attachment figures. Core beliefs operate outside of conscious awareness and influence one's interpretation of events and social interaction.

The internal working model was found to influence not only behavior and emotion, but also attention, memory, and language. When 6-year-olds were asked to react to photographs showing children separated from parents, the differences were profound. Securely attached children talked about their feelings associated with separation, had ideas about coping, and

were serious but not distressed. Anxiously attached children responded in a contradictory way similar to the responses that they demonstrated at 1 year of age—anger mixed with seeking closeness. Avoidantly attached children became distressed and were not able to suggest ways to cope. Children with disorganized attachment patterns deteriorated; they were extremely frightened, gave aggressive and confusing responses, and expressed fears of annihilation. The researchers were able to accurately guess the children's original attachment classifications by merely observing their reactions to the photos (Main, Kaplan, and Cassidy 1985).

Researchers were also able to accurately assess attachment patterns by observing parent–child interactions. Securely attached children had relationships with their parents that were relaxed, friendly, with a warmth and intimacy that was "natural" but not clingy. Children in the anxious category had a relationship that mixed closeness with hostility and often seemed artificial or contrived. The avoidantly attached children distanced and rejected their parents, avoiding intimacy and connection in many ways. Disorganized children would either reject their parents or become parental with them, but either way their basic stance was to control or dominate (Main and Cassidy 1988).

The researchers hypothesized that the insecurely/anxiously attached children had developed unconscious strategies to deal with their mothers' neglect, rejection, or inconsistency. Their internal working models (belief systems) and ways of relating showed that these children had learned their lessons well; they were now perpetuating rejection and hostility. Anxious children long for a connection, but alienate others by clinging and neediness. They act helpless in order to elicit care, try desperately to get their mother's attention, and are chronically anxious about how mother will respond. Avoidant children are angry about the rejection, but not able to be honest and direct, otherwise this may lead to more rejection. They are "shut down" and avoid interactions that involve attachment needs, resulting in a detached, "I don't care" attitude. They typically act out their anger toward others in passive–aggressive ways.

Further research, much of it from Alan Sroufe and colleagues at the Institute of Child Development, University of Minnesota, focused on attachment and self-esteem, moral development, social relationships, and school achievement. The Minnesota Longitudinal Study of Risk and Adaptation (MLSRA), involving many studies over the past 35 years, has demonstrated the importance of attachment security with a primary caregiver. In general, children with secure histories had a greater sense of self-efficacy, higher self-esteem, better relationships, and were better emotionally regulated than those with compromised attachment. Attachment patterns

were found to be consistent over time, regardless of developmental changes. Babies were assessed at 12 and 18 months, and more than 95 percent fell into the same attachment category on both occasions (Waters 1978). In another study, securely attached 18-month olds were found to share more positive feelings with mother, smile more during play, and share toys, compared to anxiously attached children. By 3½, these secure children were more likely to be sought out by other children, be more empathic, and demonstrate better leadership skills (Waters, Wippman, and Sroufe, 1979).

One large-scale research program was initiated that focused on a high-risk population (low-income, young, single mothers, with few resources or support systems). These mothers and their children were followed for 20 years. This study provided a valuable contrast to the results of the Berkeley studies involving middle-class families. The initial finding was both interesting and controversial; mothers who were depressed and had low interest in their babies during pregnancy were more likely to have anxiously attached children at 1 year (Sroufe 1983). By ages 4 and 5, the securely attached children scored higher on every measure: social skills, friendships, leadership, empathy, self-esteem, self-reliance, and resilience. Avoidant children made the worst friends: they took pleasure in other's distress, were devious and manipulative, and had trouble sharing. Anxious children were dependent, socially incompetent, and concerned mostly with their own needs (Troy and Sroufe 1987). These findings were consistent with others who found securely attached children to have better social skills and to be generally more liked by peers (Pastor 1981; Jacobson and Wille 1986).

Similar patterns were found at age 10, but now problems with power and control were more apparent for the anxiously attached children. Avoidant boys were most aggressive and conduct disordered (lie, bully, destructive, angry, defiant). Avoidant girls were also angry, but more likely to internalize and become depressed. Again, secure preadolescents were more competent socially and emotionally (Elicker, Englund, and Sroufe 1992). These patterns continued throughout adolescence (Sroufe, Carlson, and Shulman 1993).

Research also focused on the relationship between attachment and resilience, the ability to effectively deal with the stresses and adversities of life. Studies have shown that children with histories of secure attachment are less vulnerable to stress and better able to manage and grow from difficult times (Yates, Egeland, and Sroufe 2003).

Sroufe and his colleagues summarized the findings of their long-term study of children and families. First, they found that the key factor regarding attachment is parental sensitivity. Sensitive, responsive, and communicative parents tended to have securely attached children, even with irritable, colicky, and difficult-to-soothe babies. They could even overcome genetic

disadvantages. Second, attachment patterns remained consistent over time, supporting the predictive power of early experience. Third, attachment patterns correlated with school performance. Attachment security ratings were related to reading and math scores throughout the school years. Children with insecure attachments were more likely to display behavior and academic problems in school. Fourth, attachment patterns in early childhood predict the quality of romantic relationships later in life. Last, children tend to replicate their parents' behavior when they grow up and have children. Forty percent of the parents who experienced abuse while young went on to abuse their own children (Sroufe *et al.* 2005).

In summary, the studies on attachment patterns, development, and psychosocial functioning consistently show that children classified as securely attached in infancy do better in every important area of life as they develop: they make better friends, feel better about themselves, are more competent problem solvers, receive more positive feedback from others, and are more resilient and independent. The anxiously attached children and adolescents are always more dependent, emotionally troubled, and socially incompetent.

Temperament

The previous section focused on the importance of early parenting influences on the development of attachment patterns. It is also of importance, however, to emphasize the role of genetics, temperament, and other biological factors. The nature–nurture debate has been a controversial issue in the social sciences for many years: to what extent are behavior and personality traits genetic, biological, or a function of inborn temperament? To what extent do early life experiences shape and influence the developing individual? Some theorists and researchers emphasize the biological factor, others point to psychosocial influences, while another group focuses on the interaction between nature and nurture as most relevant.

Jerome Kagan (Kagan and Moss 1962; Kagan 1984, 1989, 1994) has been a leading proponent of the importance of inborn temperament. He began a longitudinal study of children in 1957 and followed them into adulthood. Kagan and colleagues found that the children labeled "fearful" during their first three years of life became adults who were introverted, cautious, and psychologically dependent on their spouses (Kagan and Moss 1962). They concluded that temperament predicted adult behavior more than early family influences. Further studies revealed two temperamental types of children: *inhibited* and *uninhibited*. According to Kagan, inhibited children are more shy with unfamiliar children and adults, smile less with unfamiliar people, take longer to relax in new situations, have more impaired memory

recall following stress, take fewer risks, have more fears and phobias, and have higher muscle tension (Kagan 1994). Kagan also notes physiological differences: "temperamentally inhibited children have a more reactive circuit from the limbic area to the sympathetic nervous system than do uninhibited children" (Kagan 1994, p.140).

Karen (1994) reviewed studies that give credence to constitutional and genetic factors. One study of 120 pairs of identical twins reared apart found many traits that were genetic in origin (e.g., imagination, leadership, sociability, stress reactions) (Bouchard *et al.* 1990). The Colorado Adoption Project compared adopted children to their biologically unrelated siblings. They found children temperamentally different despite similar family influences (Dunn and Plomin 1990). Neubauer and Neubauer (1990) reviewed research on the genetic origins of personality traits and listed a variety of traits that appear to have an inherited basis: aggressiveness, alcoholism, depression, empathy, excitability, temper, shyness, and vulnerability to stress.

The New York Longitudinal Study also focused on inborn temperament (Chess, Thomas, and Birch 1959; cited in Karen 1994, pp.274–288). Researchers followed both middle-class and low socioeconomic status infants into adulthood. They assessed infants' temperamental characteristics using nine variables: activity level, rhythmicity, approach or withdrawal, adaptability, intensity of reaction, threshold of responsiveness, quality of mood, distractibility, and attention span and persistence. The babies were found to fit into four different categories:

- *Difficult* babies (10%) displayed negative mood, were slow to adapt, withdrew in novel situations, and were irregular in biological functioning.
- *Slow-to-warm-up* babies (15%) were similar to the difficult babies, but reacted with less activity and intensity.
- *Easy* babies (40%) showed positive mood, regular body functions, adapted well, and approached rather than withdrew from new situations.
- The last group, *mixed* (35%), displayed combinations of these traits.

Evaluations revealed that children born with difficult temperaments developed the most emotional and behavioral problems over time; 70 percent developed serious symptoms in adulthood. Researchers did not conclude, however, that temperament alone produced these problems. Rather, they pointed to an interaction of nature and nurture (temperament and environment); i.e., children with difficult temperaments were much more likely to experience negative responses from others as they developed. For

example, these children were more likely to "trigger" their parents, causing negative parental attitudes and reactions, and provoking old, unfinished issues to surface (Thomas, Chess, and Birch 1969). Only parents who were patient, consistent, firm, and emotionally resolved could manage these children well. Additional evaluations showed that a "poor fit" between child's and parents' temperaments often accounted for difficulties (e.g., high-activity child and low-activity parent) (Chess and Thomas 1987). Again, the conclusion was that temperament is influential, but that environmental factors play a critical role. The reaction of parents and others (e.g., teachers) could amplify or diminish any inborn traits and qualities.

There is no doubt that babies with difficult temperaments are more challenging to parents and caregivers than those who are easier and more relaxed. However, family and environmental factors cannot be underestimated, and many studies validate this notion. Mother's personality, assessed prior to the birth of her baby, was found to be a more reliable predictor of later attachment than temperament. Mothers who were more empathic, emotionally mature, and stable, were more likely to have securely attached children (Belsky and Isabella 1988). Another study of 100 infants irritable after birth found that many more babies (68%) were securely attached at 1 year when their mothers received parenting training to increase sensitivity than babies without parent training (28%) (van den Boom 1988). Social support does make a difference in families. Mothers of irritable infants who received external support (extended kin, social program) were found to provide parenting that led to secure attachment significantly more than mothers of irritable infants who lacked such support (Crockenberg 1981).

Thus, it appears that temperament and environment interact in an ongoing manner over the course of development to determine emotional, behavioral, and social traits and outcomes. This is hopeful news for children who are born with difficult temperaments or who receive inadequate or damaging care in the early phases of life. It indicates that outside forces, such as effective parenting programs and therapeutic interventions, can go a long way toward attenuating early difficulties.

3

Roots of Attachment

Biology and Evolution: The Basis of Attachment

Attachment between the human infant and caregiver is rooted in biology and evolution. During the course of evolution, certain behaviors became incorporated into the biological equipment of our species. These universal adaptations are found in almost all human cultures and include the development of complex language, mating, the care of babies and the very young, and attachment between the young and their parents. These instinctive behaviors have an evolutionary nature with the goal of survival of the offspring and of the species (Bowlby 1969).

Humans are genetically programmed for attachment behavior and family life. The nuclear family evolved over the course of 150 million years as the social environment best suited to provide the necessary ingredients for the survival and development of the young. Mammalian evolution is characterized by helpless and dependent young who require considerable care for survival. Human babies need the longest period of protection and nurturance of any mammal, and parental burden and responsibility are also the greatest. Prolonged dependency of the young on the mother, father, and family unit, and the concomitant attachment behaviors, are necessary to maximize proximity, adaptability, and survival (MacLean 1982; cited in Donley 1993).

Sociobiologists, ethologists, and others who study naturally occurring behaviors have concluded that infant–mother attachment is primarily due to the biological nature of the bond. However, other influences must be considered and understood. For example, the infant attaches to the entire family system, with each family member playing a unique, valuable, and highly specialized role. Temperament, psychological, and cultural influences also affect attachment and are superimposed over the biological and evolutionary forces.

Development and Function of Family Roles

Patterns in human life emerged over the course of evolution, which led to distinctive gender roles. Humans evolved from isolated gatherers to cooperative hunter–gatherers. Limited food supplies, combined with the demands and dangers of the hunt, created a situation in which females would have difficulty protecting and nurturing their young while traveling far afield to gather food. Additionally, limiting female exposure to the risks of the hunt was based on the greater survival value of females for subsequent generations. For example, assume in a population of an equal number of males and females, all but one of the females died. Only one female would be available for procreation, and the survival of the group would be in jeopardy. If all but one male died, however, the surviving male could impregnate a number of females. Thus, males were the more expendable sex, while females were more valuable for the survival and perpetuation of the species (Morris 1994; Ornstein 1995).

Evolutionary psychologists believe that men and women differ in those realms in which they confronted different adaptive challenges over the course of evolution (Buss 1995). Initially, food gathering accounted for most of the diet. As humans developed skills in hunting large animals, they began to develop a level of cooperation, communication, and problem-solving not needed previously. An increasingly differentiated set of roles and responsibilities evolved as males became more efficient hunters and females became more effective at gathering food and caring for the young. Males developed more upper body strength, stamina, speed, and other attributes specialized for the chase. Hunting required that they become more courageous, less selfish, and concentrate on long-term goals. The higher protein diet led to increased intelligence in all family members. Females still provided the bulk of the food source in gathering, but also perfected their abilities regarding the care of the young. A monogamous pair, each with specialized roles and functions, provided the best opportunity to perpetuate the species. This led to the "breadwinner" and "homemaker" distinction between men and women, which, of course, is less relevant in our modern society. Although not politically correct in the modern era, these stereotypical gender distinctions appear to be based on adaptation and evolution.

All animals have two basic strategies for procreation, both aimed at passing on genes and ensuring the continuation of the species. The first is to produce and disseminate as many young as possible. The male mates with many successive females, provides little or no protection of and interest in offspring, and relies on quantity for perpetuation of their genes. The second approach is to produce only a few young with one mate, providing quality care and higher levels of protection, involvement, and nurturance. This strategy

of increased participation by doubling parental care greatly improved the chances of offspring survival and fostered the establishment of the nuclear family (Morris 1994).

Emotional evolution accompanied the development of gender roles and functions. For example, for the male to leave the family to hunt while the female remained behind unprotected from the advances of other males, required the development of pair-bonds. This social arrangement (rare among primates) required a sense of loyalty, commitment to mutual goals, and affectional attachments. The females remained bonded to their mates, staying faithful while they were away. Because fertilization occurs internally within women, men have faced the uncertainty that their putative children were genetically their own. The development of emotional ties increased the senses of security for both the male and female. The declaration of an exclusive pair-bond inhibited sexual rivalries among males, reducing disharmony and enhancing cooperation among the group. The committed pair-bond greatly benefited the offspring by providing maximum protection and nurturance. The females were assured of their mate's support, allowing devotion to maternal functions. The development of the family unit was instrumental in the crucial task of rearing the slowly developing offspring (Morris 1967).

Family as a Natural System

Systems theory is a way of thinking that goes beyond the reductionist approach in Western culture to understand events by breaking them down to their smallest parts. Reductionist models focus on how individuals function, while systems theory focuses on their interpersonal environment—family dynamics and larger systems (schools, mental health, social services, health care, criminal justice, culture). Central to this concept is the emphasis on understanding and changing relationships and interactions in order to effectively treat human problems (Doherty and McDaniel 2010).

All natural systems operate according to basic principles and processes that are rooted in evolution and occur across cultures and species. The human family is a naturally occurring system and is regulated by the same forces that influence all other living systems. The concept of an emotional system describes how families operate within this natural-systems framework. The emotional system allows the organism to receive information (from self and environment), to integrate that information, and to respond on the basis of that information. It includes responses that range from instinctual to learned, such as obtaining food, reproducing, fight or flight when threatened, rearing young, and other aspects of social relationships (Kerr and Bowen 1988).

The emotional system is guided by two counterbalancing life forces that govern behavior: *individuality* and *togetherness*. Family members sometimes respond on the basis of self-interest and other times based on the interests of the group. Individuality is a biologically based life force that motivates one to follow inner directives, to be separate and distinct. Togetherness propels an individual to follow the directives of others, to be connected and interdependent. The interplay of individuality and togetherness affects the level of stability, cohesiveness, and cooperation in the family. It is critical for understanding how family members function and how attachment occurs. There is need, for instance, for a child to develop into a separate individual, able to think, feel, and act for him or herself. Simultaneously, however, there is a need for the child to remain connected to the family: to think, feel, and act as a part of the unit. The process of attachment occurs within this dynamic family setting.

There are a number of additional concepts that describe the functioning of family systems (Kerr and Bowen 1988; Doherty and McDaniel 2010).

- *Reciprocity:* Family members occupy different roles and interact in reciprocal relationships to one another. The mother's familiar smile soothes and calms the infant, while the infant's reciprocal smile brings joy and a sense of warm emotion to the mother. The younger child shapes the behavior of an older sibling as much as the older child shapes the younger. Adult partners in an intimate and romantic relationship develop ongoing reciprocal patterns that can be constructive or destructive—the "dance" of relationships. A reciprocal relationship also exists between the individual and the larger system. A child's behavior does not exist in a vacuum, but is part of the larger emotional system of the nuclear and extended family. For example, a symptom (e.g., anxiety, depression) is not viewed as existing inside a child, but rather exists both inside and between the child and the system.
- *Differentiation of self:* There is an instinctively rooted need toward differentiation: to develop emotional separateness and to think, feel, and behave as an individual. A symbiotic, interdependent relationship is a normal state for mother and infant. This profound level of connection and togetherness promotes secure attachment, and allows the child to develop into an autonomous, distinct individual as development unfolds. The higher the level of differentiation, the greater the developing child's ability to direct his or her own functioning. The lower the level of differentiation, the less individuality emerges. A poorly differentiated person (young or old) has virtually no capacity for autonomous functioning. Emotional maturity is associated with

the degree of separateness achieved from one's family of origin, while still in emotional contact with the group.

- *Anxiety:* All living things experience some form of anxiety, which is a natural response to real or imagined threat. Anxiety is associated with differentiation of self in the family system. The lower an individual's differentiation, the less he or she is able to adapt to stress, and the higher their level of chronic anxiety. For example, a securely attached child has lower levels of anxiety when exploring the environment than a child anxiously attached, knowing the parent serves as a "secure base." Acute anxiety develops into chronic anxiety over time, as the anxiously attached child strives to function independently.
- *Triangles:* The triangle is the basic foundation of an emotional (family) system. Attachment occurs within the context of many interlocking triangles (e.g. mother–father–child; mother–grandparent–child; parent–social service agent–child). Family triangles are influenced by the level of anxiety present. When anxiety increases between two people, a third person becomes involved in the tension, creating a triangle. For example, tension between a mother and child will draw the father into the conflict; conflict between a husband and wife can be avoided by focusing on a "problem child" (scapegoating). The involvement of a third person decreases anxiety in the twosome by spreading it among three.
- *Boundaries:* Every living organism has boundaries separating it from its environment, and internal boundaries separating subsystems. Boundaries in a family system are "rules" determining who will participate and how they will participate. Enmeshed boundaries indicate lack of appropriate autonomy. Disengaged boundaries reflect lack of necessary communication and contact between family members or subsystem (i.e., parental, marital, sibling subsystems). Boundaries must be clear so that family members can relate to one another and the world in a healthy way (Minuchin 1974).
- *Adaptability:* Successful organisms continually adapt to their environment. This means the ability of a family to change its beliefs and patterns of relating in the face of developmental changes and other challenges. Families that maintain flexibility and connectedness when coping with challenges (e.g., divorce, illness) achieve better adjustment and psychosocial functioning.

According to evolution and biology, the mother–infant bond is primary and strongest. However, as will be emphasized throughout this book, many other

forces in the family system affect mother–child attachment and the child's process of attachment in general. Attachment occurs in the context of the family network, including the extended family. The larger social context in which mother–child attachment occurs exerts more influence on attachment than the specific characteristics of the mother or child (Donley 1993).

Triune Brain

Paul MacLean (1978), while director of the Laboratory of Brain Evolution and Behavior, National Institute of Health, developed the triune brain concept. MacLean described the human brain as actually a hierarchy of three brains in one, each significantly different in structure, function, and chemistry. Although the brain has evolved in size and complexity, it still contains the basic components and functions of its reptilian and mammalian past. Thus, all human beings carry in their brains this legacy of millions of years of evolution.

The *brain stem* (reptilian brain), located at the base of the skull, represents the first stage of brain evolution and is shared by all vertebrates, from reptiles to mammals. It controls primitive sexual, territorial, and survival instincts, such as reproduction, circulation, digestion, and muscle contraction in reaction to external stimulation. It regulates automatic behaviors like sleeping, breathing, blood pressure, heart rate, blinking, and swallowing. The brain stem also governs imitative behavior, tendency toward routine and ritual, stress-provoked responses, and tropistic behavior (ability to adapt to environmental changes). Distributed along its length is a network of cells, called the reticular formation, that governs the state of alertness and serves as a gateway to channel information to the higher brain structures.

The *paleomammalian brain* (limbic system), wrapped around the reptilian brain, developed as evolution proceeded to provide mammals with enhanced survival skills and the ability to interact with the environment. This second phase of brain evolution gave humans the capacity to experience and express emotions and also maintains the immune system, the body's capacity for self-healing. The limbic system governs the general adaptation syndrome, the fight-or-flight response necessary for self-preservation. There are three subdivisions of the limbic system:

- The *amygdala* controls emotion and aggression.
- Procreation, affectionate, and sexual behaviors are incorporated into the *sextal* area.
- The *mammillary* portion manages maternal functions, such as nursing and other attachment-related behaviors.

The limbic system is the seat of all relationship bonds. The brain stem and the limbic system together are referred to as the "old brain," primarily concerned with automatic reactions and self-preservation.

The *neomammalian brain* (cerebral cortex), the third layer of the brain to evolve, is most highly developed in humans. It is five times larger than its two lower neighbors combined, contains more than 8 billion cells (70% of the nervous system), and is what makes us uniquely human. The prefrontal cortex allows for planning, creative thinking, capacity to observe internal emotional states, and to have choice regarding those internal subjective states. The cerebral cortex, called the "new brain," governs production of symbolic language, decision making, and information processing, and is believed to regulate the "higher emotions" of empathy, compassion, and love (Pearce 1992).

There is an ongoing relationship between the three parts of the brain as they continually exchange and interpret information. The reticular activating system (RAS), which begins in the brain stem and is attached to the cerebral cortex, serves as a switching device between the old and new brain. When we become threatened or emotionally aroused, the RAS enables the limbic system to take over and facilitate automatic, instinctual responses (fight or flight). When we are relaxed, not perceiving threat, the cortex is switched back on, allowing logic and reasoning to return. The old brain determines our basic survival reactions, while the new brain allows us to make choices about those reactions and enables us to consider alternative actions.

The work of MacLean and other researchers demonstrates how much of the social behavior of animals is controlled by the old brain. An experiment on rats, for instance, showed they were able to mate, breed, and rear their young with the removal of their neocortex. MacLean also found that, when neocortical development was prevented in hamsters, they were still able to display every behavior pattern found in normal hamsters. Other research showed that monkeys lost the capacity for typical social behavior when their neocortex was left intact, but the reptilian and limbic connection were destroyed (MacLean 1982; cited in Kerr and Bowen 1988, p.36). The neocortex is crucial for higher-level mental functioning, like speech and language, but the operation of the old brain governs basic instinctual and social functions. Much of attachment behavior is governed by the old brain, and so is rooted in biology and evolution.

Contrary to previous thought, human infants are not born a *tabula rasa* (blank slate), but enter the world equipped with a repertoire of basic survival mechanisms and behaviors. For example, babies are born *without* a fear of water (and instinctively hold their breath when submerged), and *with* an inborn fear of falling and an ability to reach out for support (the

Muro reflex); they instinctively orient toward the breast (rooting reflex), and demonstrate a head-turning reflex to prevent smothering. These reflexes disappear after three or four months, suggesting that we possess biologically rooted capabilities until we are able to learn and adapt to our environment.

The triune brain reflects a pattern of evolutionary progression in which nature builds newer and more complex structures on the foundation of previous structures. Each component of the triune brain has its own specialized capabilities and behaviors that emerge sequentially over the course of development. The successive unfolding and maturation of the triune brain corresponds to the evolution of human behavior and parallels the stages of child development. The old brain (brain stem and limbic system) must be appropriately stimulated and nourished during the early years of life. If this foundational brain system is understimulated, the higher brain (neocortex) does not develop to its full potential (Pearce 1992). Sensitive and protective caregiving stimulates the natural evolution of the old brain during infancy, the critical phase of prolonged helplessness. When appropriate care is not provided (e.g., abuse, neglect, multiple separations and losses), intellectual, emotional, and social maturation does not occur normally and naturally (MacLean 1978).

Genesis of Attachment

Fifty years ago "experts" believed that the human fetus was a blank slate, devoid of sensitivity, feeling, and any interactional capability. Over the last 30 years, a wealth of knowledge has been acquired about the fetus, its prenatal environment, and events surrounding the birth experience (perinatal). Pre- and perinatal psychologists, using such modern clinical tools as electronic fetal monitors and ultrasound, have proven that the unborn baby has well-developed senses and reacts to stimuli from mother and the environment. We now have an increased understanding of the physical, emotional, and social influences on the unborn baby. Communication, both physiological and emotional, between parents (particularly the mother) and the fetus can have a significant impact on future health and development.

Over the past 20 years, the new field of "fetal programming" or "fetal origins" has been studying how in utero experiences exert lasting effects on us from infancy into adulthood. A woman's experiences and lifestyle can change the development of her unborn baby and beyond. The nutrition in the womb, the drugs, infections, and pollutants the fetus is exposed to, the mother's health, stress level, and state of mind during pregnancy, all affect the fetus and the person later in life. The experience in the womb has been linked to physical and mental health problems later in life, including heart

disease, diabetes, cancer, hypertension, allergies, obesity, anxiety, depression, schizophrenia, and autism (Paul 2010).

Pregnancy is a dynamic, interpersonal process. The fetus is attuned to its mother in many ways. It learns about the day–night cycle from the mother's rhythm of activity and sleep. It knows her voice. It knows her tastes in food by swallowing amniotic fluid tinged with the flavors of the culture. The fetus's nervous system is shaped by its mother's emotional states. If a pregnant woman has chronic anxiety due to marital problems, financial difficulties, or other stressors, high levels of the stress hormone cortisol enters the fetus's brain and body. High cortisol levels can result in anxiety, depression, and emotional dysregulation in childhood and later life. In a British study of thousands of women, those who were highly anxious during pregnancy had children with double the rate of behavioral and emotional problems at 10 years old (Monk, Fitelson, and Werner 2011). Research examined the effects of national grief and trauma. Throughout the United States, a woman's chance of miscarrying was higher in September 2001 (i.e., the time of the World Trade Center attack) than in the months before and after (Bruckner 2010). Pregnant women with elevated stress hormones are unknowingly preparing their unborn babies for a harsh world, programming their brains and nervous systems to be on high alert for potential threats (Laber-Warren 2009).

Not eating a healthy diet in the first days after conception increases the likelihood of cardiovascular diseases and depression in adulthood. Conversely, women who gain too much weight during pregnancy have children who are 48 percent more likely to be overweight by age 7. Pregnant women who eat a diet low in iron have children who are shyer, fussier, and less sociable. When the mother fails to provide essential nutrients, the fetus is being programmed to adjust its metabolism for deprivation. If a woman gets the 'flu during her first trimester, her child is seven times more likely to develop schizophrenia. The effects of air pollution on the fetus have been studied for many years, and have been found to lead to a host of adverse outcomes: premature delivery, low birth weight, heart problems, increased cancer risk, cognitive delays, and lower IQ scores. It is well known that consuming alcohol during pregnancy is particularly toxic, damaging the prefrontal cortex in the fetal brain, the region responsible for decision making and impulse control. Fetal alcohol syndrome and fetal alcohol effects cause physical, cognitive, and emotional damage throughout life (Paul 2010).

Despite these negative results of stress and trauma during fetal development, a healthy postnatal environment can be healing. Secure attachment, nurturing, and mental stimulation can reverse the effects of a compromised pregnancy. Research shows that when mothers were attuned to their babies, the cortisol levels of these infants returned to normal. Sensitive,

responsive, and loving parenting can prevent the development of learning, emotional, physical, and behavioral disorders. Proper exercise and eating habits can halt diabetes and obesity in children and later in life (Laber-Warren 2009).

Prenatal psychologists believe that the core of personality forms in the womb, rather than during the first few years of life. Research and observation have demonstrated the significance of the in utero experience (Verny and Kelly 1981):

- Maternal emotional, as well as physical, messages are transmitted to the fetus.
- Severe maternal stress during pregnancy is associated with prematurity, low birth weight, and infants who are irritable, hyperaroused, and colicky.
- Women who want their babies have easier pregnancies and healthier infants than women who have unwanted pregnancies.
- The 5-month-old fetus can recognize mother's voice and communicate auditorily with the father.
- Synchrony and bonding occur during pregnancy; mother and unborn baby develop reciprocal sleep–activity cycles and styles of reactivity.
- Every sensory system of the baby is capable of functioning prior to birth.

The time of pregnancy offers parents-to-be an opportunity for both physical and psychological preparation. This period of time is truly the dawn of attachment, the time in which mother, father, and baby-to-be begin the process of uniting and connecting. We continue this discussion by examining the physical development of the fetus and the psychological tasks and reactions of the parents that accompany pregnancy.

First Trimester

The first trimester is divided into three separate stages of in utero development: germinal, embryonic, and fetal (Ornstein 1995). The *germinal* stage begins at the moment of conception, when a sperm fertilizes the egg (only one sperm in a million reaches the egg). It ends two weeks later after the fertilized egg, repeatedly dividing, implants itself on the uterus wall. A few days after fertilization, a small cluster of cells forms that is the beginning of the human heart (Pearce 1992). This is, in essence, the first "attachment" between mother and offspring.

The *embryonic* stage lasts from implantation of the fertilized egg in the uterine cavity until about the eighth week. Embryologists refer to the baby as an embryo until all of its systems are formed by the end of the second month. This is the time of greatest differentiation, when organs are undergoing their most rapid and extensive changes. New organs and systems are created almost daily. By the end of the third week the embryo is 2 millimeters long and has a working heart and rapidly developing nervous, skeletal, and digestive systems. Between the fourth and eighth weeks, the embryo goes from a primitive shape to one that begins to resemble a human form. By the eighth week, it has a human face with eyes, ears, nose, lips, tongue, and even milk-teeth buds. The brain is sending out impulses that coordinate the functioning of organs; all major organs and structures are beginning to develop. The earliest sense to develop in the human embryo is touch. As early as six weeks, the fetus will bend its head away from the site of stimulation when the face is touched lightly near the mouth (Montagu 1986). The first smooth, circular movements of the body occur at this time. The life of an embryo is quite tenuous. Due to the rapid growth and development of organs, this is the time when teratogens—agents that cause birth defects—are most likely to harm the embryo (Samuels and Samuels 1986).

The third development period of the first trimester is the *fetal* stage, from the ninth week of pregnancy until birth. The ninth week represents a turning point; only the reproductive system undergoes new formation, while all other organs simply undergo fine differentiation and rapid cell growth. By the end of the third month the fetus can kick legs, turn feet, curl toes, make a fist, move its thumb, turn its head, squint, frown, open mouth, swallow, and breathe. The vocal cords are completed, digestive glands are working, and vital functions of breathing, eating, and motion are rehearsed. The baby shows distinct individuality in behavior, and facial expressions are already similar to those of the parents.

During the first trimester, as the fetus is physically developing, the "work" of pregnancy truly begins for the parents. The mother must prepare herself for the monumental changes that will occur in her anatomy and physiology. Her uterus grows from 500 to 1000 times its normal size. Her cervix softens, breasts grow, blood volume increases up to 2½ quarts, and she will experience significant weight gain. She will store more protein and water, and go through significant hormonal changes. Psychological and emotional issues, both conscious and unconscious, begin to emerge as pregnancy unfolds.

As discussed previously, the "old brain" controls biologically rooted instincts to procreate and attach. The "new brain" (neocortex), however, is responsible for the complex psychological and social factors involved in reproducing and caring for the young. A woman's desire for a baby is

prompted by a variety of motives and needs that may include identification, fulfillment of narcissistic needs, and desire to heal old relationships through the baby. Many of these same wishes and desires are true for fathers-to-be, such as narcissistic needs, the desire to heal past relationships, and the drive to provide a link to past generations. Additionally, the wish to reproduce one's own sex is stronger for men than women, which may reflect the need to enhance the masculine identity (Brazelton and Cramer 1990).

The process of attachment begins in this early phase of pregnancy. This is a time of excitement, anxiety, ambivalence, and other emotions. The first task involves accepting and adjusting to the reality of the pregnancy. There is often an initial feeling of euphoria, followed by doubts and worries: Can I handle the responsibility? Will I receive the support I need? Will the child be healthy? Am I emotionally prepared to take care of a baby? Family-of-origin issues begin to surface, including memories and unresolved feelings. The woman thinks about her own mother, wondering if she will be better or worse in the nurturing role. Men often consider their early family relationships, with similar concerns and questions regarding their own capabilities. These issues may be conscious, but more often remain out of awareness until later stages of pregnancy (if at all).

The woman may feel ambivalent or anxious about becoming increasingly dependent on her partner, especially if there is marital or relationship conflict. Support from the partner is extremely important at this time and influences maternal adjustment. The nature of the marital relationship during the first trimester—support, trust, security—has a direct bearing on the mother's adjustment before and after birth (Grossman, Eichler, and Winnickoff 1980). Since there is typically less access to, and therefore less support from, extended family in our modern society, the supportive role of the man becomes even more urgent. The distant, unsupportive, or absent father has a strong negative impact on attachment, even in the initial stages of pregnancy. By not supplying the necessary support and emotional engagement, the mother-to-be develops more pressure, responsibility, and anxiety, which may affect her perceptions and feelings about the life growing inside of her. The man's self-identity, self-esteem, and own childhood experiences will affect his ability to provide love and support to his mate and face the prospects of fatherhood (Brazelton and Cramer 1990).

Second Trimester

The fetus now responds to light, taste, and sound. He or she is capable of learning, intentional behavior, and has a rudimentary memory. By the fourth month the fetus can frown, squint, and grimace. The first embryonic cells are sound sensitive and by four and a half months in utero, the auditory

system is virtually complete. By six to seven months, the fetus responds with a precise muscular movement to each of the phonemes (smallest unit of sound of which words are formed) of the mother and moves his or her body rhythm to mother's speech. The unborn baby also practices the fine neuromuscular movements of the vocal tract that are used later in crying and vocalizing (Pearce 1992). The fetus shows preferences for certain kinds of music: it becomes calm and relaxed when listening to gentle music such as Vivaldi and Mozart, or becomes agitated and kicks violently when exposed to Brahms, Beethoven, or loud rock music (Verny and Kelly 1981).

In the second trimester, the mother experiences "quickening" as she begins to feel the baby's movement. This heightens the mother's awareness of focusing on the baby. The movements soon turn to kicks, and mothers instinctively place their hands gently on their abdomens when this occurs. Mothers calmly talk to their babies. Some believe that this soft, soothing talk makes the fetus feel loved and wanted (Brazelton and Cramer 1990).

Often, as a woman's belly grows, so do her doubts about her sexual attractiveness and anxiety about her husband's attention. As the realities of the impending birth increase, she may wonder if he will ignore her, be totally engrossed in the baby, or ignore her and the baby. The pregnant mother requires a great deal of emotional support and understanding. Couple communication becomes crucial. If the father is feeling resentment, apathy, jealousy, or other conflicts, the mother can easily become anxious, depressed, ambivalent, or angry. Studies indicate that the way a man feels about his wife and unborn child is one of the single most important factors in determining the success of the pregnancy (Truman 1991).

Having no partner present can be devastating for a single mother. Lack of financial and emotional support can leave her chronically stressed and worried about her future and the baby's. Maternal depression, ambivalence, or rejection of the fetus can leave a deep scar on the unborn child. The fetus can sense and react to love and hate, as well as ambivalence and ambiguity. Studies demonstrate that accepting mothers, who looked forward to having a family, had children who were healthier emotionally and physically at birth and afterward, than offspring of rejecting mothers. Another study showed that "negative attitude mothers" had the highest rate of premature, low-birth weight, and emotionally disturbed infants. Ambivalent mothers bore children with a large number of behavioral and gastrointestinal problems. The situation can be further complicated by a family environment of chronic stress and/or violence. In a study of 1300 children and families, it was found that women in high-conflict marriages ran a 237 percent greater risk of bearing psychologically and physically damaged children (Verny and Kelly 1981).

Third Trimester

There is a great acceleration in growth toward the end of in utero gestation. The fetus is showing its greatest weight gain, moving more, and taking on a "personality" of its own. It is demonstrating preference of activity in day or night, is more receptive to communication from the outside world, and is capable of conditioned learning. All the sensory systems are functioning, i.e., responding to visual, auditory, and kinesthetic stimulation. The unborn baby is affected by touch, noise, and stress and is particularly vulnerable to the ingestion of drugs, alcohol, and tobacco. Babies exposed to drugs in utero are often born with low birth weight, extremely agitated, tactilely defensive, and may exhibit developmental, emotional, and intellectual impairments. The effects of fetal alcohol syndrome and fetal alcohol effect have long-term implications for the child's ability to learn and integrate experience (Besharov 1994). Smoking also has serious effects on the fetus. In addition to injecting the neonate with numerous noxious chemicals (arsenic, cyanide, formaldehyde, carbon monoxide), smoking decreases the oxygen supply to the fetus, carried by maternal blood passing through the placenta. Studies show that an unborn fetus becomes agitated (measured by significantly increased heart rate) each time mother even thinks about having a cigarette (Sontag 1970).

During the last few months of pregnancy, the increased activity level of the fetus falls into certain cycles and patterns. A receptive mother interacts with her fetus in response to these patterns and knows if it is in deep sleep, light sleep, or actively awake and alert. Synchrony is developing: the baby responds to the mother's rest activity level, and the mother responds to the baby's. The fetus and mother are preconditioned to each other's rhythms, preparing for the mother to respond to the cries, needs, and other signals after birth.

Our brains are like pharmacies, compounding a wide range of chemicals that affect our moods and biological systems. The fetus decodes maternal feelings through a neurohormonal dialogue (Borysenko and Borysenko 1994). Fear and anxiety, for example, are biochemically induced by a group of chemicals called catecholamines. When a pregnant woman becomes frightened, the hypothalamus orders the autonomic nervous system (ANS) to increase heart rate, pupils dilate, palms sweat, blood pressure rises, and the endocrine system increases neurohormone production. This floods into the blood stream, altering both the mother's and fetus's body chemistry. When a mother thinks joyful thoughts, the limbic system releases neuropeptides into her blood stream, which fit into receptor cells throughout her body (and fetus). When she feels joy and acceptance, every cell in her body responds to that emotion. Depression, anxiety, and ambivalence are also broadcast

throughout her entire body/mind system and to that of the unborn child. Almost anything that upsets the mother also upsets the fetus. (Infrequent or isolated incidents will not cause serious harm; it is the ongoing stressors that produce damaging effects.)

The Birth Experience

Immediately prior to birth, the infant's body releases adrenal hormones that initiate a chain of reciprocal events within the mother. First, the hormones alert the infant's body to mobilize for the challenges of birth. Second, these hormones are transmitted through the umbilical cord to signal to the mother's body, which begins its own set of programmed responses. The pregnancy-maintaining hormone progesterone begins to decrease in the mother's bloodstream, initiating the birth process. The mother also begins to secrete oxytocin, which induces uterine contractions and signals the start of lactation (Pearce 1992).

There is a variety of factors that influence the degree of difficulty of labor and delivery. The birth experience is affected by mother's medication, diet, level of stress, and general physical and emotional health. The mother's anxiety level before and during birth can be increased by lack of knowledge about or fear of the birth process, apprehension about motherhood, and a lack of emotional support (especially from the child's father). All mammals seek a safe and secure environment to deliver their young, due to their high level of vulnerability. Humans continue to require this ancient need for birth protection. Stress and anxiety send a danger signal to the mother, flooding her body with biochemicals that slow down the birth process. The more anxious the mother, the longer she takes to give birth. Delaying the birth can lead to an increased risk of complications, use of drugs to induce labor, and a higher incidence of cesarean section. Thus, attention to the mother's emotional state and available support are critical factors during the birth experience (Morris 1994).

Our concept of the newborn infant has changed dramatically. The neonate is considerably more sensitive, aware of, and responsive to the environment than previously imagined. The birth experience radically changes the neonate's environment from wet to dry, muffled sounds to loud noises, head down to head up or flat, and these changes have an impact on the sensitive baby. In many instances, the newborn is separated from mother at a time of importance for closeness and connection, designed by nature to reduce the stress of birth. For example, one-third of the infant's blood and oxygen remains in the placenta for five to ten minutes after birth, allowing time for the infant's internal systems to function independently.

The environment in which the birth occurs is also a critical factor. A relaxing, safe, and supportive atmosphere leads to a more positive birth experience for the mother, father, and baby. The birthing environment has come full circle: the place of birth has shifted from the home, to the hospital, and back again to a family focus. Initially, advances in medicine led to a dramatic increase in the survival rate among high-risk infants and mother. What was previously a family-oriented organic event became a medically oriented technical event, and the psychological aspects of the birth experience suffered. The birth experience became more clinical and sterile, consisting of bright lights, loud noises, electronic devices, and cold instruments. Hospital births required women to lie down as if a "sick patient." Our ancestors knew that squatting was the natural position for childbirth, taking advantage of gravity, and allowing for an easier and more natural birth. Recently, hospital birthing environments have been designed to be more "family friendly" and conducive to a natural experience. For example, family birthing suites offer dim lights, soft music, and a reassuring and comfortable atmosphere. Home births with midwives have also reemerged as a viable alternative in low-risk situations (Brazelton and Cramer 1990).

Prematurity

Premature birth has been found to affect not only the physiology of the infant, but also early interactions and attachment with caregivers. Preterm infants show a variety of characteristics: less well-defined sleep cycles; less alertness and responsiveness at birth; poor motor coordination; greater percentage of time fussing and crying; and are more difficult to feed and soothe, compared to full-term infants (Frodi and Thompson 1985). Full-term babies have an instinctual protective response, "habituation," that prevents the nervous system from being overstimulated. Premature babies, however, generally lack this protective response, and are easily overstimulated.

Prematurity also affects the biological and psychological reactions of parents. After nine months of pregnancy, parents typically feel a sense of completion and readiness for the birth of their infant. When this process is cut short, parents may feel unprepared and anxious. A mother may blame herself, perceiving the premature birth as her own personal failure. Disrupting the instinctual and biological schedule increases parental anxiety and reduces confidence, which can have detrimental effects on the parent–infant relationship. Some studies have shown that parents of premature babies initiate less body contact, less face-to-face contact, smile and talk less, and play less with their infants (Brazelton and Cramer 1990). "On the whole, interactions with prematures are more taxing for parents, testing their

capacities to attune to a less responsive, less well put together infant. This is also true for 'professional infant handlers'" (Brazelton and Cramer 1990, p.199). Other studies of middle-class samples, however, have found mothers of premature babies to be more sensitive to cues for contact, more responsive in early face-to-face interactions, and more affectionate and gentle (Field 1987). Parents who become hypervigilant and overprotective toward their vulnerable infants may inhibit the development of age-appropriate autonomy and independence.

The premature baby is physically and emotionally isolated at a time when he or she requires a great deal of contact. The name of the incubator ("isolette") aptly describes this predicament. Corrective touching and caressing of the infant can minimize detrimental effects. Massaging premature babies for example, has enabled these infants to be more alert, active, responsive, sleep better, gain weight faster, and leave hospital sooner than untouched babies (Field 1987). Premature birth alone does not necessarily cause attachment problems. It does place the infant at risk for anxious attachment, however, when combined with other risk factors, such as chronic illness and negative parental responses (Colin 1996).

Birth to 3 Years

Bonding is the biological, genetic, and emotional connection between mother and baby during pregnancy and at birth. All babies have a bond with their birth mother. Attachment, however, is learned after birth through interactions between caregivers and child during the first three years. "Attachment is an affective bond characterized by a tendency to seek and maintain proximity to a specific figure, particularly while under stress" (Bowlby 1970, p.12).

Human babies are born earlier in the growth cycle than other mammals. The fetus must be born when its head has reached the maximum size compatible with passage through the birth canal. The female pelvis is relatively small to support an erect posture. The baby must be born after 266 days of gestation in order to pass through the birth canal, due to the rapid growth of the brain during the last trimester. The baby is born well before complete maturation. Extrogestation lasts, on average, the same amount of time as in utero gestation (266 days). Thus, significant brain development occurs outside the womb, when the baby is exposed to a variety of social and environmental influences (Verny and Kelly 1981; Montagu 1986).

The infant's brain, especially the limbic region, is an "open loop system," because it relies on attuned and nurturing input from attachment figures for healthy growth and development. Relationship experiences in the early

stages of life are most important in shaping the development of brain and behavior (Lewis, Amini, and Lannon 2000).

Attachment: Four Stages

Developing an attachment to a principal caregiver (e.g., mother, father, other consistent caregiver) occurs during four developmental stages. During the first stage, from birth to about 10 weeks, the infant's behavior is mostly reflexive. Newborns seek contact with and can be comforted by different people. In stage two, from 10 weeks to 6 months, infants develop social and cognitive abilities and can discriminate caregiver's physical attributes. They also gain more control over their gross motor skills and can direct attachment behaviors (e.g., crying, clinging) toward consistent caregivers.

At approximately 6 to 7 months of age babies reach stage three, in which a strong attachment to a specific caregiver is fully formed. Babies can crawl and soon walk, enabling them to seek out and maintain contact with their attachment figures when upset or in need of protection or comfort. Thus, they can communicate attachment behaviors more actively, receive need-fulfilling responses from their caregivers, and create a strong, consistent, and reciprocal attachment relationship. This is a critical developmental milestone; these bonds are essential to subsequent key areas of development and will persist over the course of the lifespan. The fourth stage of attachment development begins around 30 months. Young children have achieved more advanced social and cognitive capacities, and are learning to cope with separations and reunions in everyday life. For instance, they now understand that their caregiver will return after a few hours away, and do not experience the distress of an infant earlier in development. Young children feel more security at this time, and therefore, reduce contact- and proximity-seeking behavior (Marvin and Britner 2008).

Birth to Eight Months

The newborn infant's nervous system is not well organized, and it is through the interactions between baby and caregiver during the first year that organization occurs. The attachment relationship is critical for the infant's developing nervous and hormonal systems; lack of healthy attachment can result in deficiencies in cognitive and physical development (Fahlberg 1991). Studies have demonstrated the importance of early mother–infant interaction. Infants are born with the ability to distinguish their mother's voice and express a preference for the voice of their birth mother (DeCasper and Fifer 1980). Newborns turn preferentially toward their mother's breast, instead of toward the breast of another lactating woman (MacFarlane 1975). Brazelton's

pioneering study on mother–infant relationships demonstrated that they form a "mutually regulated partnership." The relationship is reciprocal, with the mother and infant moving in synchrony through positive and negative experiences (Brazelton, Koslowski, and Main 1974). The mother's behavior can actually regulate the infant's body and brain: the mother's body warmth affects the infant's endocrine systems, maternal touch stimulates growth hormones, and maternal milk changes the baby's heart rate. Conversely, the infant also affects the mother's mood and behavior. By 3 months of age, more than 50 percent of the mother's behaviors and almost 40 percent of the infant's behaviors were found to be influenced by their partner (Tronick and Weinberg 1997). These ongoing interactive routines between caregiver and infant serve as a meaning system; the infant senses consistency and predictability, which lead to a feeling of security (Bruner 1995).

Mutual regulation is dependent upon three factors: the infant's ability to organize and control physiological states and behavior, the infant's ability to communicate messages to the caregiver, and the caregiver's capacity to read those signals accurately and respond appropriately. Unlike other species, in which the offspring imprints on the mother, the human mother becomes imprinted on the baby. Human infants are born too helpless to follow and too weak to cling to caregivers for protection. The infant's only means of getting his or her needs met are to signal distress and then hope that assistance is forthcoming. It is critical for survival to have a responsive caregiver who is perceptive of the infant's signals and attentive to his or her needs. This imprinting impulse allows the mother to override her own hunger, fatigue, or self-interest in order to meet the infant's needs and numerous demands (Montagu 1986). Nature has provided a means to entice the attention and assistance of caregivers. There is a strong instinctual reaction to what is called "kinderschema," the qualities of the infant's face that are strongly appealing (large round eyes, large domed forehead, chubby cheeks, flattened face, snub nose, and smooth, soft skin). These physical characteristics induce the caregiver to stay close, cuddle, caress, smile, gaze at, and talk to their babies (Morris 1994).

Brazelton and Als (1979) have described four stages in early mother–infant interaction. These stages highlight the progression of achievements of the infant and the development of reciprocity and synchrony in the relationship. The stages, outlined in Table 3.1, include homeostatic control, prolonging of attention and interaction, testing limits, and the emergence of autonomy. Although these original concepts were applied to the mother–infant relationship, it seems that a close father–infant relationship also follows similar development. Developmental changes in the child and caregiver–child relationship from birth to 3 years of age are outlined in Tables 3.2–3.4 (adapted from Zero to Three 1997).

First-Year Attachment Cycle

Many reciprocal interactions are infant-initiated during the first year of life within the context of the ongoing attachment cycle. This cycle begins with the infant's needs and the expression of arousal or displeasure and is completed by the caregiver's response. The infant develops trust and secure attachment through successful gratification of these basic needs and by alleviation of arousal and discomfort (see Figure 3.1; Orlans and Levy 2006).

Table 3.1 Stages in Early Infant–Caregiver Interaction

1. Homeostatic control (7–10 days)
• Achieves control over input and output systems; receives and shuts out stimuli, controls motor activity, state of consciousness, and autonomic responses. • Caregiver must have deep sense of empathy to be in synch with infant's needs.
2. Prolonging of attention and interaction (1–8 weeks)
• Prolongs interaction with caregiver; pays attention longer, utilizes cues from caregiver to maintain alertness. • Uses own capacities (e.g., smile, vocalizing, facial expressions) to signal receptivity. • Adapts to give and take of a synchronized relationship. • Caregiver needs support (e.g., from spouse, kin, nurse) and must be highly sensitive to infant's cues.
3. Testing limits (3–4 months)
• Parents and infant test and stretch infant's limits; responds to information, withdraws and recovers in mutual relationship. • Prolonged state of attunement between infant and caregiver; learns more about self and other. • Infant experiences mastery; ability to sequence controls and produce signals. • Mother feels control over baby's responses and ability to be available and nurturing.
4. Emergence of autonomy (4–5 months)
• Baby begins to search for and respond to environmental or social cues; imitates, reaches for and plays with objects. • Increasing sense of autonomy; increased voluntary control over environment and sense of competence. • Enhanced cognitive awareness; aware of every sight, sound, texture, presence, and absence of parents; will cry for attention. • Object permanence begins; baby looks at spot for object after it disappears. • Attachment feelings increase; caregivers become more important to baby. • Parent must be able to tolerate both the attachment needs and the need for autonomy. • Stranger awareness and anxiety begins.

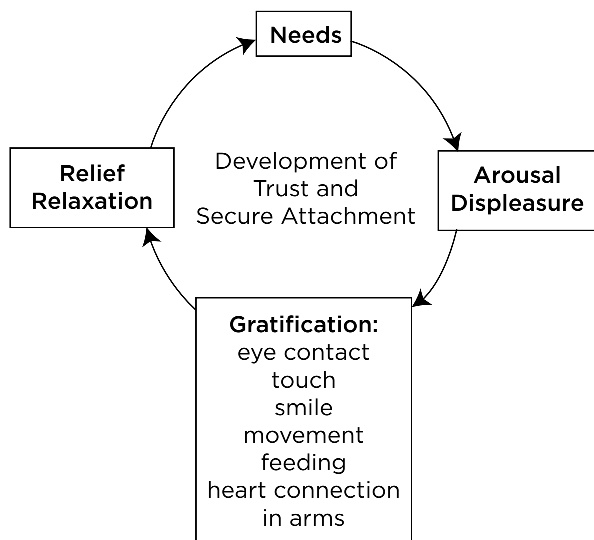


Figure 3.1 First-Year Attachment Cycle

The following infant and caregiver behaviors are crucial ingredients the successful completion of this cycle and the development of secure attachment.

Crying

One primary function of crying is to communicate discomfort to the caregiver. Wolff (1969) described four types of infant crying: hunger, pain, danger, and neurological impairment. Maternal stress level during pregnancy has been found to correlate highly with infant crying. In one study, almost half of the mothers whose infant cried extensively reported chronic and severe stress during pregnancy (Kitzinger 1985; cited in Solter 1995, p.21). Caregivers who respond promptly, sensitively, and consistently to their infant's cries have babies who cry less in frequency and duration as they grow older. Crying is the baby's way of signaling to the caregiver that he or she has a need. When the baby's need is met, he or she learns that the caregiver is dependable. This is the basis of trust and secure attachment. Crying also serves the purpose of releasing stress-related hormones that reduce tension and arousal. Crying is an inborn stress management and healing mechanism (Solter 1995).

Eye Contact

The caregiver–infant gaze is a primary social releaser and communication method for the development of attachment. A newborn can focus his or her eyes 7–12 inches, the exact distance needed to make eye contact in arms. Soon after birth, the infant can follow a slowly moving light and the movement of curved objects that have qualities of the mother's face. Face-to-face proximity

and eye contact are synonymous with closeness and intimacy. Spitz (1965) found that infants responded with pleasure when shown a mask of a human face. When the lower part of the mask was covered, their response did not change. Covering the upper part, however, (even one eye) caused displeasure and loss of interest. He concluded that the infant's response to eye contact is instinctual. Our autonomic nervous system directs the pupils to expand slightly when viewing something positive or pleasurable. Conversely, the pupils shrink when seeing something unpleasant. The pupils cannot lie. The infant gazes into his or her mother's eyes and receives potent messages about her emotional state and level of involvement (Morris 1994).

Table 3.2 Birth to 8 Months

1. Development of self
• Explores and manipulates body. • Trusts caregivers (can depend on caregivers to meet needs, provide a secure base for exploration, feel secure with holding and smile). • Comforts self (self-soothing). • Impacts environment (shakes a rattle, kicks a mobile, reciprocal smile).
2. Emotional development
• Expresses a range of emotions (pleasure, excitement, joy, fear, anger, and sadness). • Needs caregivers to understand feelings and respond with comfort and protection.
3. Discrimination skills
• Preference for attachment figures (recognizes parent's voice, feels relaxed with familiar caregivers). • Stranger anxiety begins. • Learns to interact with the world (visually explores surroundings, plays with parents).
4. Physical development
• Body moves automatically (instinctive movements). • Dexterity develops (places objects in mouth, holds objects). • Purposeful movement (holds head up, rolls over, sits, crawls).
5. Communication and social development
• Communicates needs by crying, facial expressions, and body movements. • New forms of communication develop within a few months (different sounds, laughs, gestures to get attention, imitates sounds). • Reciprocal cues and signals (reaches out to be picked up, diverts gaze to signal overstimulation).

Eye contact and observing facial expressions are a main source of information about others' feelings. A toddler uses the parent's facial expressions to guide behavior. This is called social referencing: "Is it safe to explore? Am I safe with this stranger? Is my behavior acceptable?" The child visually communicates with caregivers, which influences his or her actions and emotions.

Touch

All warm-blooded animals are born with an innate need to be touched and stroked affectionately. Research has confirmed that the handling or gentling of mammals early in life results in increased weight gain, activity, and resilience under stress (Simon 1976). The mammalian mother's behavior of licking her young serves the purpose of cleaning and also stimulates internal systems (gastrointestinal, circulatory, immunological).

Touch for the human baby serves both physical and emotional functions. Somatic stimulation begins in labor when uterine contractions activate principal organ systems of the fetus. Human babies actually die from lack of touch. In the nineteenth century, most institutionalized infants in the United States died of marasmus ("wasting away"). Institutions surveyed in 1915 reported that a majority of infants under the age of 2 had died due to failure to thrive, related to the lack of touch and affection (Chapin 1915; cited in Montagu 1986, p.97). Prescott (1971) found that deprivation of touch and movement contributed to later emotional problems. He also found that cultures in which physical affection toward infants was high had low levels of adult aggression, but cultures where affectionate touch was low had high adult aggression. More recent research on contact comfort between mother and infant revealed interesting but not surprising findings. Low socioeconomic-status mothers were given either a soft baby carrier or a plastic infant seat to use on a daily basis. At 3½ months of age, the soft carrier infants looked more frequently at their mothers and cried less; these mothers were more responsive to their babies' vocalizations. At 13 months, these infants were more likely to be securely attached (83%) compared with the infant seat group (30 percent) (Anisfield *et al.* 1990).

Table 3.3 Eight to 18 Months

1. Development of self
• Reciprocity and internalization (self-esteem results from positive and empathic message; feelings of competency and pride develop). • Initial stages of autonomy (says "No," expresses individuality). • Language development (knows own name; labeling objects and events with words).
2. Emotional development
• Experiences and expresses intense feelings (shrieks with joy, hits, pushes when angry or frustrated). • Deepening attachment feelings (increased autonomy and attachment needs, shows affection and need for "secure base," frightened when attachment figure disappears). • Time and predictability (understands that caregiver will return after separation; feels safe with consistency).
3. Discrimination skills
• Learning about choice (choosing toys, food, clothes). • Play and social skill development (enacts simple scenes with other children; beginning to learn cooperation and sharing via adult supervision). • Modeling and imitation (emulates caregivers' behavior; initial stages of internalization). • Interacts with environment (interested in how things work; increased control over objects and events).
4. Physical development
• Increased manual dexterity (uses crayons, stacks blocks, feeds self, drinks from a cup). • Control over body and movements (sits, pulls up, walks, climbs stairs, runs).
5. Communication and social development
• Communicates through expression and actions (deliberate eye contact to get attention and express feelings; points to express desires; needs help from caregiver to learn to express feelings in acceptable ways). • Increased verbal skills (can use up to ten words; employs a variety of sounds to get help). • Receptive to signals and cues (understands verbal and nonverbal behavior; sensitive to caregivers' tone of voice and body tension).

Touch is an essential means of communication between baby and caregiver, affecting emotional, social, cognitive, and physical development (Anderson 2008). A mother's touch reduces pain when infants are given a blood test, and massage helps premature babies sleep better, grow faster, be less irritable,

and leave the hospital sooner. Warm and caring touch lowers stress hormones (e.g., cortisol), and stimulates the release of oxytocin, the "love hormone," which enhances security, trust, and secure attachment (Field 2010).

Humans are prewired to be able to interpret the touch of others. Studies have shown that people have an innate ability to decode emotions with touch alone. Hundreds of participants, between the ages of 18 and 36, were able to communicate eight distinct emotions via touch—anger, fear, happiness, sadness, disgust, love, gratitude, and sympathy—with accuracy rates as high as 78 percent (Hertenstein *et al.* 2009). Touch seems to be a more nuanced and effective means of communicating emotions than even facial expressions or tone of voice. Touch definitely promotes more positive interactions and a deeper sense of connection with others. Recent studies have found that people buy more if they are gently touched by a store greeter, strangers are more likely to provide help if touch accompanies the request, and waitresses receive bigger tips when they briefly touch customers. Most of the people in these studies did not remember being touched, but when asked they reported that they liked the person and felt some positive connection (Guerrero *et al.* 2007). Touch-oriented doctors, teachers, and managers consistently receive higher ratings. They communicate warmth, caring, and support (Anderson 2008). Of course, context matters; society has rules about whom we can touch, where, and when. Touch can be appropriate and safe, or inappropriate and unsafe. Different people as well as cultures have varying comfort levels and standards regarding touch. There are significant cultural variations in comfort with touch. Some cultures are more liberal about touching (e.g., Greek, Puerto Rican), and others less so (e.g., German, British).

Therapeutic touch can be reassuring, comforting, supportive, and down-regulate anxiety and arousal. We incorporate therapeutic touch in our treatment and parenting programs. Dyads (e.g., couples, parent–child, siblings) are encouraged to hold hands at opportune times during Attachment Communication Training to enhance caring, support, and attachment. Physical contact from parent to child (e.g., gentle touch of the arm) is encouraged during the Limbic Activation Process (LAP) to communicate nurturance, empathy, and love (the LAP will be described in more detail in Chapters 7,8,9, and 10). Parents are taught to touch their children gently and sensitively on the hands, arms, or shoulders during conversation to foster caring and connection. The best way to provide comfort is via touch, especially when someone needs consoling. The language of touch can deeply communicate our feelings and inspire connection.

Table 3.4 Eighteen Months to 3 Years

1. Development of self
• Seeks increased independence, but still requires clear and consistent limits from caregivers. • Self-identity forming through exploration and limits. • Develops a sense of belonging (connected with family; child care setting should reflect cultural background). • Internal working model solidifies (caregiver messages and emotional reactions help shape child's self-esteem). • Normal ambivalence regarding independence/autonomy. • Developing increased self-control with a framework provided by caregiver (provides a few simple and clear rules for child to follow with ongoing support; child displays sporadic impulse control).
2. Emotional development
• Intense emotional reactions (pride about accomplishments; frustration and anger may be expressed through physical aggression; fears emerge – dark, monsters, people in costumes). • Increased control over feelings (expresses feelings via words and play). • Modeling and identification (learns how to treat others by the way caregivers treat child and others). • Tuning into caregiver's feelings (responds to caregiver emotional state).
3. Discrimination skills
• More aware of other children (age, sex, physical differences, presence or absence from group). • Increased social play (moves from parallel play to interactional play). • Increased awareness of other children's rights (learning to share, cooperate, delay gratification, and be sensitive to the feelings of others). • Aware of caregiver's responses to own actions (knows when caregiver is pleased or upset). • Aware of and can classify similar and different objects (e.g., puts toys in groups).
4. Physical development
• Increased manual dexterity (turns pages of a book, draws shapes, learning to use scissors). • Enhanced movement (kicks and throws ball, walks on tiptoes, walks upstairs). • Increased physical competencies (eats with utensils, dresses self).

cont.

Table 3.4 Eighteen Months to 3 Years continued

5. Communication and social development
• Language and communication (increased vocabulary, creates sentences, can talk about yesterday and tomorrow).
• Becomes frustrated when having trouble expressing self; benefits from caregiver assistance in identifying ideas and feelings.
• Enjoys reciprocal story telling (listens as caregiver reads, participates in story telling).
• Plays with words and concepts (enjoys songs and word games, uses objects to represent something else, acts out scenes with others).

Smile

Smiling is a universal human greeting that signals friendliness and nonaggression. By the eighth week, the infant begins to smile in response to seeing the primary attachment figure. The baby's smile is an instinctive response that attracts the attention of the caregiver. The smile on the face of the mother provokes feelings of safety and security in the baby. The baby's smile is a powerful signal that rewards and motivates an ongoing positive parental response. This reciprocal smile promotes secure attachment. Observing a smile on the caregiver's face triggers a biochemical reaction in the baby. Neurotransmitters (e.g., dopamine and endorphins) are released, which promote brain growth and a relaxed, happy feeling (Schore 1994).

Movement

Movement is another basic instinctual need for healthy development and attachment. The vestibular–cerebellar system (associated with balance and movement) is the dominant sensory system during fetal brain development. Studies on infant monkeys reared in isolation demonstrated that a mother surrogate that moved (on a swinging device) prevented the development of social and affectional maladjustment (Mason and Berkson 1975). In humans, every time the mother moves, the fetus moves, naturally rocking to the rhythms and motions of the mother's body. After birth, vestibular stimulation through activities such as bouncing and rocking plays a crucial role in the infant's development. Rocking slows the heart rate, promotes effective respiratory and gastrointestinal functioning, and decreases congestion. When a baby is hungry, feeding most effectively terminates crying; at all other times, rocking is the most effective soothing and calming intervention (Bowlby 1982).

Neal (1968; cited in Montagu 1986, p.161) studied the effects of rocking on premature infants. He found that when incubators were kept in motion the

infants functioned better than unrocked infants in visual tracking, auditory development, weight gain, and bodily control. Healthy parents naturally rock, bounce, and rhythmically sway their babies, which promotes reciprocity and secure attachment. Our ancestors instinctively knew this; they traveled, worked, played and slept in constant interaction with their offspring. They held their infants close to their bodies, which provided continual stimulation, motion, and contact (Liedloff 1975).

Feeding

In infancy, satisfaction of needs involves food and nourishment. The psychosocial experiences associated with feeding are part of the infant's emotional and relational development. The infant begins to associate food and feeding with warm skin-to-skin contact, eye contact, and soothing voice and smile. Breastfeeding can become part of attachment behavior, as it is another way of clinging to the mother that is both intimate and soothing. Breast milk contains important nutrients and antibodies that nourish the newborn and strengthen his or her immune system. Colostrum in the mother's milk acts as a laxative, effectively cleaning the meconium in the newborn's gastrointestinal tract, and is rich in antibodies needed to provide immunities until the infant acquires his or her own at 6 months. As the newborn suckles on the mother's breast, the hormone oxytocin is secreted in the mother, which helps shrink the uterus, reduces postdelivery bleeding, and produces pleasurable and loving feelings.

The infant's brain consumes twice the energy of the adult's, and must be provided with nutrients on a regular basis, due to limited storage capacity of energy (glucose). The regularity and consistency of the feeding ritual, the quality of the food, and the care with which the food is provided, greatly influence security, attachment, and later attitudes and behaviors regarding food. Research showed that children who had pleasurable mealtime experiences displayed better impulse control, concentration, ability to solve problems, and greater anticipated pleasure from others (Arnstein 1975).

The Heart Connection

The heart is not merely a blood-pumping station; it also plays a major role in social and emotional functioning. The sound and steady movements of the mother's heartbeat are an ongoing component of fetal development. After birth, proximity to the mother's heartbeat provides familiar reassurance and stress reduction for the newborn. The heart contains neurotransmitters that directly affect the functioning of the brain. For example, the heart produces a hormone (ANF) that affects the limbic systems, the part of the brain that

regulates emotion. ANF also plays a key role in regulating immune system response, memory, and learning.

Research in the 1940s reported that the mother's heartbeat affected the infant in utero (Bernard and Sontag 1947; cited in Pearce 1992, p.103). Years later, researchers piped an audiotape of a human heartbeat into a newborn nursery. The babies hearing the heartbeat had increased appetite, weight gain, sleep and respiration, and cried 50 percent less than the babies not exposed to the heartbeat (Salk 1960; cited in Verny and Kelly 1981, p.28). Pearce (1992) notes that if a heart cell is isolated, it loses synchronous rhythm and fibrillates until it dies. If two heart cells are placed in proximity to one another, however, they will not only survive, but will also synchronize and beat in unison. This even occurs across a spatial barrier. Infants who are placed in close heart-to-heart proximity with a primary caregiver maintain a mutual heart synchrony.

In Arms

Being held in a caregiver's loving arms is essential to creating a secure attachment. All cues of attachment—eye contact, smile, touch, movement, feeding, and the heart connection—occur within the context of the in arms position. Babies have thrived close to their mothers in arms throughout human history. This milieu provides the physical, emotional, and interpersonal foundation for security, trust, and love. Children who have experienced neglect, abuse, and multiple moves, have typically lacked the safety and security of in arms attachment. Healing the negative effects of this early trauma, for both children and adults, is facilitated by utilizing the in arms position therapeutically—the Limbic Activation Process (LAP).

Development of Attachment (8 months to 4 years)

The first year of life involves the development of basic trust and security through sensitive, consistent, appropriate, and reliable fulfillment of the infant's needs. The second year of life focuses on both needs and "wants," and the development of autonomy and self-identity (see Figure 3.2, adapted from Cline 1992). (Infants and toddlers develop at differing rates; the first- and second-year attachment cycle designations are merely reference points.) During this developmental stage, the infant moves toward toddlerhood, and becomes aware of self as separate. Self-identity forms on the basis of the balance between parental limits and the child's search for independence. At 7 to 8 months of age, the infant begins to show active "goal-corrected" maintenance of closeness to a preferred caregiver. For example, the baby will both cry for and follow the attachment figure to maintain closeness.

Attachment behaviors include crying, smiling, reaching, following, approaching, clinging, and protesting separation. At this same time, babies search for objects hidden from view, which Piaget (1952) referred to as "object constancy," the ability to understand that an object still exists even when out of sight or reach. This cognitive development allows the baby to use flexible behaviors to achieve the goal of proximity with the attachment figure.

Crawling also develops around 6 to 8 months; the baby will wander off but soon return to the safety of the attachment figure. Securely attached infants use their attachment figures as a secure base from which to explore. Erikson (1950) described this as the development of basic trust, a primary developmental task of the first year of life. Another sign of attachment is stranger anxiety, which occurs when the infant shows fear of unfamiliar people and places and protests separation.

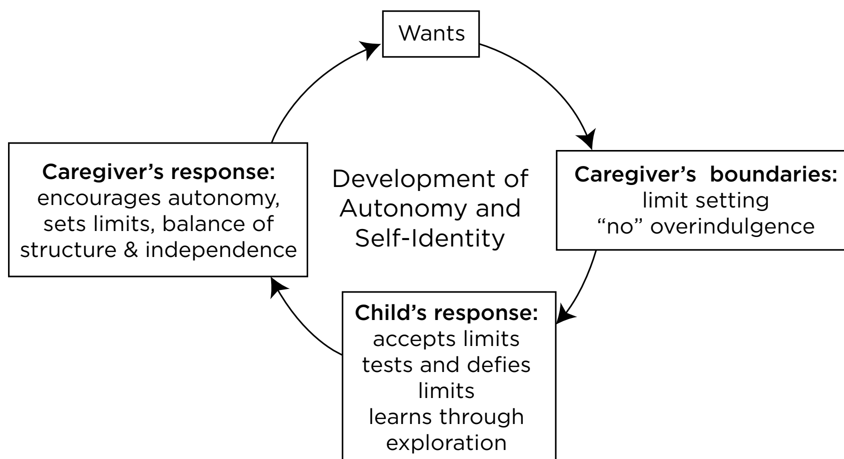


Figure 3.2 Second-Year Attachment Cycle

The sequence of responses to separation emerges at this same time: protest, detachment, and despair. Prior to this stage, babies can often adapt to new environments and caregivers without severe disturbance. After this time, however, the baby signals extreme protest when separated from the primary attachment figure, and prolonged disruption has serious consequences for the vulnerable infant.

As the child becomes more mobile, consistent limits and discipline become a part of effective parenting. Between the ages of 8 and 17 months, toddlers have limited self-control; the parent's limit setting and discipline fosters the process of learning compliance and respect. For example, a normal part of a toddler's exploration includes biting, pulling hair, and hitting. Effective parents respond firmly and calmly, providing limits and "rules" for the child.

As toddlers grow and develop, they become more independent and autonomous, and the need for continuous closeness gives way to a need to investigate the world. By 18 months, they turn to caregivers for guidance in unfamiliar situations. This "social referencing" provides the child with an opportunity to develop morality and values. Pride emerges when the child receives parental approval and then feels good about him- or herself. Parental disapproval creates negative feelings in the securely attached child, extinguishing unacceptable behavior and leading to the development of a conscience. The child with attachment disorder is not concerned with pleasing the unavailable or maltreating attachment figure, and therefore, is without healthy external limits and may not develop a prosocial conscience.

By the time babies reach their first birthday, they have rudimentary *internal working models* of their attachment relationships, based on their experience of caregiving (Bowlby 1969). The internal working model includes perceptions about self and expectations of the attachment figure(s); they are encoded in the child's procedural memory, based on sensorimotor experiences (preverbal memory, not conscious). Securely attached toddlers develop a positive internal working model (caregivers are trustworthy and reliable; I am worthwhile and lovable; my world is a safe and joyous place), and are emotionally and cognitively competent. Avoidantly attached toddlers are learning to cope with rejection and punishment, but not how to elicit protection, nurturance, and love. They are hypervigilant and block awareness of their anxiety, feelings, and needs. Researchers have found that the heart rates and stress hormone levels of avoidantly attached 1-year-olds significantly increased upon separation and reunion with their mothers, while their outward appearance seemed calm. Prior to the development of language, these babies are already deactivating their attachment behavior, defending against vulnerability and the expression of attachment needs, and displaying rejecting behaviors toward their caregivers (Sroufe and Waters 1977; Grossman and Grossmann 1991). Anxiously attached toddlers cannot make sense of their inconsistent experiences with caregivers; they cannot predict whether their attachment figures will be nurturing and protective, or hostile and rejecting. These youngsters hyperactivate attachment behavior, are angry and anxious much of the time, and exhibit extreme dependency. Toddlers with disorganized attached patterns have no consistent strategy to handle separation, reunion, needs, or feelings in response to their disturbed, depressed, or abusive attachment figures.

During the preschool years, the ability to use language and semantic memory expand considerably. Semantic memory involves generalization or summaries regarding the meanings of recurring patterns. An example is a child pretending that his or her doll is mommy going to work. Episodic

memory, the ability to recall specific events, also begins to develop at this time. The child has an increased ability to organize mental representations; to form detailed internal working models of attachment relationships, and to develop emotional and behavioral strategies in response, including defense. Securely attached children can use information from all three memory systems (procedural, semantic, and episodic) and can learn that open and direct communication is most effective. Caregivers are sensitive to their needs, encourage open communication about thoughts and feelings, and validate the child's perceptions. They tolerate negative emotions, while setting clear and appropriate boundaries regarding dangerous exploration and negative behavior toward others. These caregivers facilitate a goal-corrected partnership by encouraging negotiations and constructing cooperative plans.

Avoidantly attached children are extremely defended and have learned to deny their anger, anxiety, and need for nurturance. Some caregivers are openly hostile and rejecting, while others are withdrawn and unresponsive. Either way, the child is rejected. By age 3 or 4, these children openly avoid and ignore attachment figures and do not give signals that suggest a need and desire for closeness. Children of withdrawn and depressed caregivers often become "*compulsively caregiving*"; the child tries to reassure the parents and makes few demands ("parentification"). Children of hostile and rejecting attachment figures become "*compulsively compliant*"; they are hypervigilant, monitoring the dangerous social environment, and comply in order to avoid threat and hostility (Crittenden 1994).

The internal working model of these attachment-compromised children involves denial of their need for closeness. A "false self" begins to develop (Winnicott 1965) as the child buries his or her true feelings and needs. Children with anxious attachment show inconsistent and unpredictable behaviors similar to their caregivers. They alternate between anger and neediness, show limited exploratory competence and self-reliance, and become selfish and overdependent preschoolers. They often develop a coercive pattern of behavior in order to keep the attachment figure involved and controlled. The child and caregiver become enmeshed in a coercive, angry, and dishonest relationship.

A nonresponsive, neglectful, or abusive environment produces angry, depressed, and hopeless children. Most young children who are referred for mental health services have coercive–threatening attachment patterns and internal working models (Crittenden 1994). These children have frequent and prolonged temper tantrums and tend to be loud, demanding, and disruptive. They are accident prone, emotionally and behaviorally impulsive, and want to be the center of attention, desperately seeking the attentiveness lacking in their attachment relationships. They are typically restless, irritable, and have

a short attention span; they appear to have attention deficit/hyperactivity disorder (ADHD) and learning disabilities, with no neurological basis. They are "bossy," oppositional, and cannot take "no" for an answer. They have little frustration tolerance, demand instant gratification, and antagonize others. Keeping objects and people at the appropriate distance is difficult; they move away when they should be close and get close when they should be moving away (boundary problems). They become either victim or victimizer, being the recipient of others' abuse, or themselves being the bully.

The School-Age Years

During the school years, children with severe attachment disorder become extremely manipulative, controlling, and are often diagnosed with oppositional defiant disorder. They are at risk of developing Axis II disorders as adults, such as narcissistic, borderline, and psychopathic personalities. By adolescence they are commonly sexually promiscuous to obtain physical closeness without emotional intimacy and become more aggressive, antisocial, and depressed. Although some turn to substance abuse, others avoid this destructive coping strategy, due to their inordinate need to be in control. Many of these teenagers displace their rage into theft, vandalism, and assaultive behaviors.

Children with histories of attachment trauma have often been deprived of fundamental experiences necessary to nurture the development of the "new brain" (neocortex). Their sensorimotor and emotional development remains fixed in the lower brain center ("old brain"). The child is dominated by a basic survival drive for control and safety, and the emotionality of the limbic system. They lack the ego development and self-control to modulate violent impulses. In normal child development, thinking moves from concrete to abstract. Children with attachment disorder, however, remain in the realm of concrete thinking and so lack the logic and reasoning abilities necessary for planning ahead. They have little or no respect for authority, rules, and the rights of others. They seek out safe targets, weaker peers, and helpless animals in order to vent their hostility and aggression.

The experience of major loss during the early developmental years can produce children fearful of closeness and love. They feel alone, alienated from others, and possess an attitude of self-protection. They are motivated by a need for power: "If I am in control, I feel less threatened"; "I do not trust others to have influence over me." Fear of abandonment is a force that runs their lives. They do not allow anyone to be close, and maintain elaborate defenses to guard against intimacy and subsequent loss.

4

Personal and Social Competencies

The Attachment Foundation

Secure attachment in the early years provides the developing child with a foundation that leads to a variety of healthy psychological and social outcomes, as discussed in Chapter 2. Securely attached children compared with those with insecure–anxious–disorganized attachments, demonstrate advantages with the following:

- self-esteem
- relationships with caregivers
- friendships with peers
- ability to control impulses and emotions
- cooperation and compassion
- independence and autonomy
- positive core beliefs.

This chapter will focus on three additional areas of psychosocial functioning that are associated with caregiver–child attachment. Observations of child development and family life, as well as extensive research findings, have shown that secure attachment results in development of the following:

- a solid and positive sense of self
- prosocial values and morality
- resilience (the ability to handle stress and adversity well).

Development of Self

The development of an autonomous sense of self is an early stage-salient task and is unequivocally linked to attachment. Patterns of attachment that develop as a result of the infant–caregiver relationship directly affect the child's emerging sense of self. Maltreated children and children with attachment disorder typically have extreme disturbances in self-concept, self-regulation, and the ability to function autonomously.

Children who experience a secure base with an appropriately responsive and available caregiver are more likely to be autonomous and independent as they develop. The child is able to explore his or her environment with more confidence and less anxiety, resulting in enhanced self-esteem, feelings of mastery, and differentiation of self. Contrary to the belief of some observers, children who experience consistent and considerable gratification of needs in the early stages do not become "spoiled" and dependent; they are more independent, self-assured, and confident. They learn to trust reliable, sensitive, and attuned caregivers. This secure attachment relationship is a foundation for a positive sense of self, and a template for future relationships.

Internal State Language

Research has shown that by 28 months of age, most children are capable of using words to label their perceptions, physical states, and feelings (e.g., happy, sad, hungry). These internal state words reflect the child's developing sense of self as distinct from others and also promote behavioral and emotional self-control (e.g., the ability to express anger with words rather than assault another child) (Pearce and Pezzot-Pearce 1997). Children with attachment disorder, however, are less able to label their internal states; they are often not aware of thoughts, feelings, and levels of physiological arousal (Beeghly and Cicchetti 1994). There are two reasons for this. First, there is a lack of modeling in their environment; caregivers do not commonly discuss feelings in a sensible and meaningful way. Second, lack of knowing and expressing feelings (or other internal states) is a self-protective strategy. The goal is to avoid further emotional pain and negativity by withholding information (Dunn and Brown 1991).

Children with attachment disorder are often superficially charming and engaging and/or compulsively compliant. They will passively and falsely comply rather than express their feeling and needs (Crittenden and DiLalla 1988). By repeatedly avoiding the awareness of expression of thoughts and emotions, they hope to avoid additional conflict or trauma. There is a high price to pay, however; their sense of self is both underdeveloped and damaged. What remains is a superficial, "phoney," or "false self" (Winnicott

1965). As the years pass, their self-esteem diminishes further; they become less confident and more impulsive, distractible, and unhappy (Erickson, Egeland, and Pianta 1989).

Negative Working Model

The internal working model, first described by Bowlby (1969, 1988a), is the cognitive representation of early attachment relationships. Based on attachment patterns with primary caregivers (e.g., secure, avoidant, anxious, disorganized), children develop beliefs and expectations about themselves, others, and life in general (see Table 4.5). These early attachment experiences become internalized as core beliefs and anticipatory images that influence later perceptions, emotions, and reactions to others (e.g., foster and adoptive parents, adult romantic partners.

Table 4.5 Internal Working Models

1. Secure attachment
• *Self:* "I am good, wanted, worthwhile, competent, lovable." • *Caregivers:* "They are appropriately responsive to my needs, sensitive, caring, trustworthy." • *Life:* "The world is safe, life is worth living."
2. Insecure attachment
• *Self:* "I am bad, unwanted, worthless, helpless, unlovable." • *Caregivers:* "They are unresponsive to my needs, insensitive, hurtful, untrustworthy." • *Life:* "The world is unsafe, life is not worth living."

The internal working model affects how the child interprets events, stores information in memory, and perceives social situations (Zeanah and Zeanah 1989). Pearce gives an example:

> Given different internal working models, one child may interpret another's refusal to play as a devastating rejection and evidence of personal unworthiness. Another child with a more positive internal working model may perceive and interpret such a refusal as a minor slight. The subsequent behavior of these two children may well be different (sulking or an angry outburst by the former versus readily approaching another potential playmate by the latter. (Pearce and Pezzot-Pearce 1994, p.427)

The internal working model of children with disrupted attachment includes negative self-evaluations and self-contempt. Children internalize lack of adequate care, love, and protection as self-blame, and perceive themselves as unlovable, helpless, and responsible. Negative messages communicated to the child, as well as the child's interpretation of these experiences, become a part of his or her self-image. Research has shown that this framework of negativity results in misinterpretation of social cues, including the tendency to attribute hostile intentions to others (Dodge, Bates, and Pettit 1990). Thus, the child with attachment disorder is conditioned to perceive threat and hostility, even when it is not there, and commonly responds with aggressive and coercive behavior, as well as a lack of empathy for others in distress (Troy and Sroufe 1987). This results in ongoing conflict and alienation from peers and others, further damages self-esteem, and leads to aggressive and antisocial behaviors in later years.

Modifying the negative working model is a major goal of therapy with traumatized children and adults. This is extremely difficult, however, because these core beliefs become fixed, rigid, operate outside of conscious awareness, and do not often change as a result of modifying the child's environment (Flaherty, and Richman 1986; Sroufe 1988; Alexander 1992). Placing such a child in a loving foster or adoptive home may only serve to exacerbate the problem. The child will push the love away due to lack of trust, expectation of maltreatment, and an unconscious attempt to recreate prior negative attachment patterns. This negative working model is imposed on therapists, teachers, foster and adoptive parents, siblings, and romantic partners in adulthood.

Empathy, Morality, and Attachment

As discussed in Chapter 3, the development of pack hunting among humans facilitated the evolution of a more cooperative and sharing mentality. Small tribes and communities could only survive if people helped one another. As social animals, considering the wants and needs of others was in our evolutionary interest. Sharing with the young, weak, and vulnerable made us more altruistic. This altruism became reciprocal, forming the evolutionary basis for "good behavior" (Morris 1994).

Cooperation, caring, and empathy are learned in the secure attachment relationship. Secure attachment leads to healthy psychosocial development and is a protective factor guarding against the development of antisocial behavior. It is also associated with fostering important prosocial values, attitudes, and behavior: empathy, caring, compassion, kindness, and morality. Piaget (1965) defined morality as the tendency to accept and follow a system

of rules that regulate interpersonal behavior. Morality also involves feelings of obligation to foster the welfare of others and is acquired early in life (Hoffman 1983). The earliest signs of obedience appear in the last quarter of the baby's first year and consist of compliance to simple commands ("come here; no, don't do that"). Between 18 and 26 months, toddlers learn to be sensitive to adult standards (e.g., integrity of property, harm to others, cleanliness), and increase their ability to meet these standards (Kagan 1981). Children can distinguish conventional rules (e.g., addressing a preschool teacher by her second name) from moral issues (e.g., bullying another child is wrong) by their third and fourth years, and are increasingly willing to offer help to others at that time (Turial 1983).

The family, of course, is most influential in the child's social and moral development, because it provides the initial learning environment. Socialization involves the transmission to the child of social and moral codes by the family or other agents of society (e.g., school). The child acquires, by learning and identification in the early attachment relationships, both the *content* of the parents' moral code and a *willingness* to act in accordance with those rules (Herbert 1987). When the family does not promote secure attachment and appropriate socialization experiences, as is the case with abuse, neglect, or multiple out-of-home placements and caregivers, the child is at risk of developing not only conduct disorders, but also a more pervasive lack of morality.

How does secure attachment promote the learning of empathy and the ideals of right human conduct? Empathy and morality are learned in the context of safe and secure attachment relationships by four psychological processes:

- *modeling* by parents or other attachment figures
- *internalizing* the values and behavior of parents or other attachment figures
- experiencing *synchronicity* and *reciprocity* in early attachment relationships
- developing a positive *sense of self*.

Modeling

Learning prosocial or antisocial values and behavior is a function of the nature of the caregiver–child relationship and the modeling provided. Simply stated, *empathic parents rear empathic children*. Research has shown that children show signs of empathy as young as 1 year old, and by age 2, show concern for a peer in distress (Zahn-Waxler *et al.* 1992). Children with

histories of secure attachment during infancy were found to be more caring toward peers and more likely to be sought out as playmates by age 3½, as compared to children with insecure/anxious attachments (Waters, Wippman, and Sroufe 1979). At 4 and 5 years old, securely attached children were more caring and compassionate and had the best friendships, while avoidantly attached children were more often cruel, taking pleasure in a peer's distress (Sroufe 1983; Troy and Sroufe 1987). These same patterns of empathy and friendships were found to continue through adolescence and into adulthood.

Parents who provide a balance of discipline, warmth, and positive experiences are more likely to rear children who are empathic and cooperative with others (Eisenberg and Mussen 1989). 4 and 5 year olds were found to display more empathy with peers when their mothers used reasoning techniques with them to teach compassion and sensitivity. In contrast, children were less empathic when their mothers used negative control practices, such as threats (Miller, Eisenberg, and Gular 1989). Adults in their 30s who showed empathy for others were found to have parents who modeled empathic care both inside and outside of the family when these individuals were youngsters (Franz *et al.* 1994). Parents' modeling of empathy and altruism influences their children's lifelong altruism. A study of 162 volunteers at a Minneapolis telephone crisis counseling center found that those most likely to break their commitment and leave the agency quickly reported lower levels of parental altruism in their family of origin (Murray 1996). Thus, parents who model caring and empathy are most likely to have empathic children, and empathy is one of the building blocks that contribute to prosocial morality.

Brazelton (1981) discusses the routes to "goodness and selflessness." He suggests that children behave in socially acceptable ways, even when it creates conflict with self-interest, because of a powerful fear of admonishment by caregivers. The conscience serves as a mechanism that motivates the child to avoid negative responses from attachment figures. In the early years, children accede to parental demands out of a desire for approval and fear of disapproval (e.g., losing love and affection). Thus, children reluctantly sacrifice their desires in order to feel safe and positively connected.

Internalization

The second psychological process that contributes to developing empathy and morality is internalization. Internalization involves the learning of standards of conduct, not merely obeying rules, i.e., developing a moral inner voice. Secure attachment involves internalizing prosocial values and behaviors, such as caring, compassion, kindness, and fairness. Securely attached children have an inner voice that guides them in the direction of

social behavior, providing self-control over selfish and aggressive impulses (Schulman and Mekler 1994). Children with relational trauma have often internalized antisocial standards, such as selfishness, violence, sadistic power and control, and dishonesty. Their inner voice, based on lack of trust and prior maltreatment, does not provide a viable conscience or feeling of remorse.

During a child's first years, internalization is based on compliance: the child's desire to please the parent and the distress experienced when the parent is unhappy with him or her (e.g., "sharing is good because mommy said so"). This initial disposition toward compliance is critical for later development and is lacking in children with attachment disorder, due to their avoidant and fearful reaction to attachment figures. When internalization actually occurs, the child does not behave well only to receive a reward or avoid a punishment, but now has the ability to judge his or her own behavior. Children with attachment disorder always need external structure, because they have not developed this ability. Additionally, securely attached children can express love for their parents by following their rules ("I want to make you feel good because I care about you; you are good, therefore, your rule must be good"). Children with attachment disorder do not generally experience the necessary trust and safety to feel and express love, and are inclined to act out anger through oppositional and controlling behaviors.

Children go through five predictable states as they internalize parental values and develop a conscience. The attachment figure becomes an internalized object, the internal compass to help the child navigate through experiences in the world (Cline 1995):

- *Stage One (12–27 months):* The child thinks, "*I want it, I'll take it.*" This represents primary process thinking: no thought to consequences, consideration of danger, or understanding of the feelings of others.
- *Stage Two (2–3 years):* The child thinks, "*I would take it, but my parents will be upset with me.*" Parents seem threatening and intimidating because of their size and capabilities. The child begins to show primitive causative thinking; he or she would "take it" if the parents were not present.
- *Stage Three (3–5 years):* The child thinks, "*I would take it but my parents will find out.*" The child is showing causative thinking, thinking things through, and weighing the risks of his or her actions.
- *Stage Four (6–7 years):* The child thinks, "*I would take it, but if my parents find out, they would be disapproving.*" The child's behavior is now being influenced by internal control: more connected to others, caring about how they feel, wanting to do the "right thing."

- *Stage Five (8–11 years):* The child thinks, "*I want it, but don't feel good about doing things like that.*" The child's internalization is complete; his or her own moral values have developed based on attachment to parents and society, and he or she understands not only self-interest, but also the good of the group.

Synchronicity and Reciprocity

The third aspect of secure attachment that fosters empathy and morality involves synchronicity and reciprocity: the way in which the primary attachment figure is finely attuned to the signals, needs, and emotions of the infant and developing child, and the ongoing give-and-take nature of the relationship. Children of sensitive, accepting, and cooperative mothers were found to show signs of internalizing prosocial standards and were more cooperative and self-controlled by 2 years of age (Stayton, Hogan, and Salter-Ainsworth 1971; Londerville and Main 1981). The same qualities of parenting that foster secure attachment (sensitive, attuned, affectionate, and consistently available caregiving) also encourage the child to follow and internalize the parent's model. The child is "in-sync" with the parent and, therefore, learning to be aware of the feelings and needs of another person. Secure attachment implies greater awareness of the mental states of others, which not only produces a more rapid and effective evolution of morality, but also protects the child from antisocial behavior (Fonagy, Target, and Steele 1997).

Sense of Self

The route to caring for others always begins with a solid sense of self. A strong and positive self-identity, with clear boundaries between self and others, is the fourth necessary psychological process. During the second year the child typically becomes increasingly oppositional ("terrible twos"), reflecting his or her initial efforts to be independent and autonomous. When there is a solid foundation of secure attachment, this transitional phase is managed and transcended without major negative or long-lasting consequences. In Winnicott's (1965) terms, the parent provides a "holding environment," a safe and secure context with healthy boundaries and support for appropriate forms of self-control and emotional expression. The child with attachment disorder, conversely, lacks this solid and secure foundation and has a weak and negative sense of self, with blurred or violated self–other boundaries. The negativity and defiance characteristic of the second year become pervasive and chronic, as the child assumes a controlling, fearful, and punitive orientation toward others. There is no place for empathy, compassion, or kindness, as the child fights to survive in a world perceived as threatening.

There is a growing national movement to teach prosocial values to America's youth. Programs are being initiated that aim to teach youngsters to care for others and to encourage parents and teachers to do the same. For example, group homes in New York City for abused and neglected teens began such a program. More than 100 teens, who have severe attachment difficulties due to histories of abuse, abandonment, and multiple placements, are taught to show concern and empathy for others' feelings. Staff model caring behaviors, such as empathic listening, welcoming newcomers, and acknowledging others' emotions, and the teens are encouraged to offer comfort to peers who are depressed (Murray 1996).

Mirror Neurons

Mirror neurons were discovered in the early 1990s and have revolutionized our understanding of how people learn from and communicate with one another (Rizzolatti *et al.* 1996). Basically, the idea of mirror neurons is that there are networks in our brains that allow people to feel what others experience as if it were happening to them. Human brains have an intrinsic ability for imitation, and are able to share mental processes and emotions. Brain cells not only fire when a person performs an action, they also fire when observing someone else's behavior. For example, a person watches a race and his or her own heart rate begins to increase with excitement as the runners cross the finish line. A person sees someone else sniff food and make a face of disgust, and then the observer's stomach begins to ache. When a person smiles, areas of the brain are activated and release neurochemicals that produce positive feelings. The same brain activity and emotional response occurs when observing someone else's smile (Gazzaniga 2008).

Humans begin life with a rudimentary mirror neuron system. Newborns are able to imitate mouth opening, tongue protrusion, lip pursing, finger movements, and facial expressions. The anterior insula, a brain region that receives input from all parts of the autonomic nervous system, responds in the same way when study participants sniff a foul-smelling substance and when they observe videos of faces displaying expressions of disgust (Wicker *et al.* 2003).

Mirror neurons explain why people seem to "read" others' minds and have empathy and heartfelt compassion for another's pain. Parents can often feel their child's pain as if it were their own pain. Spouses can feel their partner's distress as if it were their own. Human brains are built with the ability to understand one another.

Attachment and Resilience

Why do some individuals collapse under the stresses of life, while others seem to do well coping with the same conditions? Why do some children who experience maltreatment and other disadvantages develop severe psychosocial difficulties later in life, while others with similar unfortunate backgrounds mature into normal and successful adults? Understanding the factors that contribute to vulnerability and resilience provides valuable answers.

Resilience refers to an individual's competence and successful adaptation following exposure to significant adversity and stressful life events. Vulnerability is defined as susceptibility to negative developmental outcomes under high-risk conditions. Werner (1989) identified factors that place children at risk:

- poverty
- family environments characterized by discord, desertion, violence, parental substance abuse, or psychological disturbance
- low educational level
- single parent
- lack of family resources and support
- perinatal health problems, congenital handicaps, or other biological and genetic deficiencies.

Individual and environmental "protective factors" have been identified that mediate the effects of adversity and promote resilience. Individual protective factors in children include cognitive skills, alertness, curiosity, enthusiasm, goal setting, high self-esteem, internal locus of control (take responsibility, feel competent), and temperament (easy, uninhibited). Environmental protective factors include family–community ties; parents who set rules, show respect for the child's individuality, and foster secure attachment; and a stable family environment (Herrenkohl, Herrenkohl, and Egoff 1994).

Studies of resilience have consistently found that the most basic and important protective factor is the history of caregiver–child attachment. *Secure attachments are a primary defense against the development of severe psychopathology associated with adversity and trauma*. In children who have been exposed to early loss and stress, the quality of parent–child attachment is the most important determinant of long-term damage (McFarlane 1988; van der Kolk 1996). Even when securely attached children deteriorate in the school years due to extreme adversity, they are more likely to rebound later, compared to children who are anxiously attached from early life

(Sroufe, Egeland, and Kreutzer 1990). Secure attachment to secondary caregivers (extended kin, fathers, mentors) can help a child overcome adversity, including an anxious attachment with his or her mother (Egeland, Jacobvitz, and Sroufe 1988).

One of the largest interdisciplinary investigations of resilience in vulnerable children was a 40-year longitudinal study by Emmy Werner (Werner 1989; Werner and Smith 1992). Werner's study showed that one-third of the children who experienced perinatal stress, poverty, parental alcoholism and emotional problems, and family disruption, developed into caring and competent adults. Three types of protective factors were identified: 1) dispositional attributes, such as sociability, intelligence, communication skills, and confidence; 2) affectional ties within the family that provide emotional support in times of stress; and 3) external support systems at school, church, or in the community that provide validation, support, and a positive belief system by which to live. The researchers emphasized that "the developmental outcome of virtually every biological risk condition was dependent on the quality of the rearing environment" (Werner and Smith 1992, p.191). The most important ingredient in establishing a positive rearing environment is high-quality interaction between parent and child, i.e., secure attachment (Letourneau 1997).

Interventions that attempt to promote high-quality parent–child relations and secure attachment patterns are effective in enhancing resilience in high-risk children and families. Following a home intervention program designed to improve parent–infant interaction, preterm, low birth weight infants were found to have better cognitive development and improved interaction with parents during feeding and playing (Barrera, Rosenbaum, and Cunningham 1986). First-grade children of depressed mothers were found to have fewer behavior problems and better coping skills when high-quality mother–child interaction was fostered (Harnish, Dodge, and Valente 1995). Low-income, at-risk mothers and infants, provided with education and support that started prenatally and lasted until the infants were 6 months old, were found to improve the quality of their attachment relationships (Starn 1992). Thus, although there are other factors that contribute to resilience, such as temperament and external support systems, the development of high-quality, stable, and secure attachments in infancy and early childhood provides a foundation that is crucial to later adaptation, success, and health.

Posttraumatic Growth

It is well known that trauma has many negative effects on children and adults, including PTSD, depression, medical conditions, and substance

abuse. An alternative perspective, however, is that trauma can result in positive outcomes. Individuals can experience positive changes in the wake of traumatic events. The study of *posttraumatic growth* (PTG) reveals that many people increase in personal strength, appreciation of life, emotional intimacy with partners and family, creativity, sense of spirituality, and life possibilities following traumatic events (Tedeschi and Calhoun 2004). The factors that have been found to be associated with PTG and resilience are hope, sense of meaning and purpose, positive emotions, social support, acts of kindness, and internal locus of control:

- *Hope:* Building hope is a key aspect of healing with traumatized children and adults. Hope is linked to better physical and psychological health, academic and work performance, and recovery from trauma. Traumatic experiences shatter one's belief in a safe world and lead to a sense of a foreshortened future. Hope empowers and motivates individuals to believe in the possibility of a brighter future. Envisioning a future worth living is essential to recovery (Gilman, Schumm, and Chard 2012).
- *Meaning and purpose:* Trauma affects beliefs about self, the world, and the future, leading to negative mindsets (e.g., "It's my fault; I'm helpless; people are bad"). Helping people make sense of traumatic events, and creating a sense of meaning and purpose, fosters resilience and PTG by increasing optimism, positive emotions, and self-esteem. Those who find meaning in traumatic events, such as the loss of a child, do better in their recovery than those who do not (McIntosh, Silver, and Wortman 1993). People who tell a story reflecting their ability to overcome an adverse event, and discover positive results, are better adjusted (McAdams *et al.* 1997).
- *Positive emotions:* Positive emotions activate biochemical changes in the brain, flooding our brains with dopamine, serotonin, and endorphins, neurotransmitters that stimulate the brain's reward system and are associated with positive moods, motivation, pleasurable sensations, and enhanced cognitive abilities. Positive emotions are linked to resilience and PTG. People who experienced positive emotions before the 9/11 attacks recovered faster from trauma than their less positive counterparts (Fredrickson *et al.* 2003). Optimism buffers against the negative effects of traumatic events because it fosters active problem-solving and constructive action (Peterson 2006).
- *Social support:* Social support, both received and perceived, increases resilience and PTG following trauma. Positive relationships provide a sense of connectedness, the opportunity to experience the healthful

side of life, and reduce loneliness and worthlessness. They also connect people to available resources, such as therapists, physicians, and community services. New Yorkers with emotional support had fewer PTSD symptoms and faster recovery following the 9/11 attacks than others with less social support (Fraley *et al.* 2006).

- *Acts of kindness:* Giving support—not only receiving—is tied to resilience and PTG. Acts of altruism decrease stress and enhance mental health. Volunteering to help has been found to increase self-efficacy ("I can make a difference"), enhance self-worth, and heighten the sense of meaning and purpose (Post 2005).
- *Internal locus of control:* Individuals with a strong sense of ownership over their fate are more resilient than those who view themselves as victims. People with an internal locus of control believe they have a hand in everything that happens to them, and are more apt to perceive trauma as something they can overcome. This belief in one's capability to produce desired effects by your own actions is also called "self-efficacy," which leads to perseverance in the face of obstacles and challenges (Maddux 2009).

Cultural Variations

The results of numerous studies in the United States show that about one-third of the children in middle-class families are insecurely and anxiously attached. The percentage is higher in low-income, multiproblem families. In all cultures studied (using the same assessment procedure, the Strange Situation) the results are the same; most infants (65 percent to 70 percent) show secure attachment patterns, while the remainder show some form of insecure attachment. These findings must be considered within the realm of cultural norms and variations. Does the Strange Situation, which was based on an American population, actually measure attachment security and insecurity in other cultures? How do the variations in the 1300 human cultures that exist on our planet influence attachment patterns? Which aspects of attachment are universal and which are culture specific? Even with a similar attachment pattern, to what extent do cultural and community differences result in different implications of this attachment pattern for later development? For example, the developmental consequences of avoidance for suburban Anglo American children may be different than the consequences for inner-city African American children (Colin 1996).

Ainsworth (1973) found many similarities in attachment behavior in both the United States (Baltimore, MD) and African (Ganda) cultures. Two-thirds of the babies were found to be securely attached in both populations.

Also similar were the phases of attachment development and the importance of the primary caregiver as an attachment figure and a "secure base." Cultural differences were also apparent. The Ganda babies were considerably more distressed by brief separations from their mothers, showed more fear of strangers, and did not hug or kiss upon reunion. These differences reflect cultural variations in childrearing practices and resultant differences in infants' expectations. The Ganda babies were not used to separation (even brief) from their mothers and seldom interacted with strangers in their village. American babies were more familiar with brief separations in their home environment, were used to seeing strangers in public, and were encouraged to hug and kiss parents after an absence (Karen 1994; Colin 1996). These studies demonstrated both the universal and culture-specific aspects of attachment.

Grossman and Grossman (1991) replicated Ainsworth's research with German families. They found that German children had similar attachment patterns to American children. Those children who were securely attached had advantages by age 5 years: they had better social skills and ability to handle peer conflict and were more likely to seek out their parents when distressed. A difference was found, however, among the anxiously attached German children compared to other United States studies; there were fewer behavioral problems among the anxious German children. Again, cultural differences seem to be at work, reflecting variations in parenting attitudes and cultural norms. The avoidantly attached children in the United States had mothers who were rejecting and showed an aversion to having a warm and loving relationship with their child. The German mothers were not rejecting—they cared a lot for their children and were behaving according to cultural norms that valued self-reliance and independence at an early age. When the German children were evaluated at age 10, however, those who were avoidantly attached looked like their counterparts in the United States: they had more problems getting along with peers and were less confident, self-reliant, and resilient, as compared to securely attached children. The Grossmans concluded, "The mere fact that parents are behaving in accordance with cultural norms does not necessarily spare the children any harm" (cited in Karen 1994, p.266).

Cultural variations in childrearing practices and patterns of caregiving have been found around the world. Keefer *et al.* (1982) found that among the Gusii, an agricultural culture in Kenya, mothers turn away from their infants when the infants are most emotional, positive, and excited. Culturally, this looking-away pattern is normative, and the mothers are merely socializing the young according to cultural restrictions (i.e., younger individuals do not look directly at older individuals, especially under emotional conditions). This pattern is quite different from that of American middle-income mothers,

who tend to make eye contact in response to their babies' excitement and arousal. Takahashi (1990; cited in Colin 1996, p.149) studied Japanese families and found that 12-month-old babies experienced an unusually high level of stress during separation (in the Strange Situation), and not a single baby showed avoidant attachment patterns. There were, however, many more babies in the anxious category than in the United States. These findings reflect cultural differences. Japanese children are socialized to maintain harmonious relationships; avoidant behavior is considered rude. Also, in traditional Japanese society it is rare for babies to be separated from mothers, and a close mother–child bond is encouraged throughout life.

Children reared on the kibbutzim in Israel had much different child-rearing experiences than American children. Sagi (1990) found a higher percentage of anxious children, which is probably a result of "multiple mothering," and the inconsistency and unpredictability of caregiving practices. Infants on the kibbutzim were monitored by hired caregivers during the day, spent only a few hours with their parents (usually around dinner time), and were responded to during the night (slowly) by another caregiver who was responsible for watching over many babies. These findings are consistent with attachment theory; anxious attachment patterns are often related to the child's preoccupation with the unavailable primary caregiver.

Jean Liedloff (1975) wrote about the two and a half years she spent with the Yeguana, a stone-age tribe living in a South American jungle. Mothers carried their infants everywhere; the babies shared the "family bed," and were showered with love and attention. Despite little training in obedience, the children were reported to be well-behaved (compliant, friendly, nonaggressive), and grew to be self-reliant, self-confident, and caring members of the community. These culture-specific norms are in keeping with the basic attachment principles and are obvious in American culture today. For example, it is becoming more common to see parents carry their babies close to their bodies in soft carriers. This practice has been found to help promote secure attachment (Anisfeld *et al.* 1990).

If it is true that attachment is instinctive and adaptive, based on biology and evolution, then basic aspects of attachment should be universal, found across cultures, races, and ethnic groups. The evidence suggests that there are universal attachment behaviors, but that specific behavioral patterns vary according to culture. In cultures that value distal patterns of caregiving and early independence (e.g., Northern European), avoidant patterns are more likely to develop. In cultures that encourage more contact and closeness with babies and avoid separation (e.g., Japanese), we are more likely to observe infants and children seeking contact with caregivers when under stress. In the short term, forming an insecure attachment, regardless of culture, is most

likely adaptive, i.e., a strategy for the child to cope with an unavailable or abusive caregiver. The general consensus, however, is that forming secure attachments early in life (i.e., keeping anger, anxiety, and defensiveness to a minimum), is probably the best formula for psychosocial well-being in any culture (Colin 1996).

5

Disrupted Attachment[1]

Self-Regulation, Trauma, and Attachment

One of the most damaging results of abuse, neglect, and interpersonal trauma in children is their chronic inability to modulate emotions, behaviors, and impulses. Maltreatment affects the biological and psychological ability to self-regulate and often leads to a variety of psychosocial problems, including aggression against self and others (van der Kolk and Fisler 1994; D'Andrea *et al.* 2012).

The ability to manage stress and control impulses is a crucial task children learn throughout development. However, self-regulation problems are common when young children experience significant fear, loss, and disrupted attachment. There is evidence that chronic stress experienced prenatally influences the biological development of stress reactivity and self-regulation in infants and children (Calkins and Hill 2007). From birth to 3 years, children rely heavily on parents and caregivers to help them learn to control their emotions, impulses, and behavior. Self-control skills continue to develop throughout childhood and adolescence. A classic study in the 1960s, called the "marshmallow test," demonstrated the importance of impulse control. Four-year-olds were told they could eat one marshmallow now, or wait until the adult returned and then have two marshmallows. More than a decade later, the children who waited were healthier emotionally and behaviorally, and had much higher scores on their SATs. As adults, those who were able to delay gratification as children again scored higher on mental health and relationship measures (Mischel, Shoda, and Peake 1988).

Secure attachment with a primary caregiver is critical if children are to learn self-control.

1 **Note:** The drawings in this chapter were done by clients at Evergreen Psychotherapy Center as part of their treatment.

> The primary function of parents can be thought of as helping children modulate their arousal by attuned and well-timed provision of playing, feeding, comforting, touching, looking, cleaning, and resting—in short, by teaching them skills that will gradually help them modulate their own arousal. (van der Kolk 1996, p.185)

The reliable and appropriately responsive caregiver provides a balance of stimulation ("up-regulation") and soothing ("down-regulation") to modulate the infant's level of arousal. Neglectful and abusive caregivers, or separations and other attachment disruptions, can result in chronic over- or under-arousal in infants and toddlers. Researchers found that as many as 80 percent of maltreated children develop disorganized–disoriented attachment patterns, resulting in numerous symptoms, including an inability to modulate emotions and impulses (Lyons-Ruth 1991).

Regulation of emotion and behavior is a crucial ingredient in healthy early childhood development, a process that caregivers and babies accomplish *together*. Signals from the infant (e.g., gazing, crying, cooing) arouse emotional reactions in the caregiver. These signals can influence what parents attend to and how they communicate response. Conversely, caregivers influence the infant's emotions and level of arousal. Providing stimulation by playing, feeding, or encouraging active exploration, for example, is helpful for the lethargic or withdrawn infant. This "mutual regulatory process" breaks down under conditions of anxious attachment. Depressed substance-abusing, or otherwise neglectful or abusive caregivers are not attuned to their infant's emotions and needs, leaving the baby without any necessary external regulatory support (Robinson and Glaves 1996).

The infant is dependent on the attachment figure to help regulate physiology and behavior. For example, the infant's temperature and needs for security and comfort are best regulated by being lovingly held in the arms of the caregiver (Dozier *et al.* 2005). During the first year of life, caregivers assist babies by responding in a sensitive and attuned way to physical and emotional needs, and by reducing stress. Caregivers provide these "co-regulating" functions and over time children learn self-regulation.

Children who experience maltreatment and compromised attachment, however, often fail to develop self-regulation abilities, because their caregivers did not provide the necessary support and security. For example, maltreated children have dysregulation of the hypothalamic–pituitary–adrenal (HPA) hormonal systems, which affects emotional, behavioral, and cognitive responses, and can impair brain development (Tarullo and Gunnar 2006).

Research has shown that attachment security during infancy predicts self-control six years later (Olson, Bates, and Bayles 1990). In another study, mothers who were taught to be sensitive and responsive with their 1-year-

olds, talk about emotions, and to be supportive while also encouraging independence, had children with increased self-control 12 months later (Bernier, Carlson, and Whipple 2010). Sensitive parenting that supports autonomy helps children develop self-control strategies. When caregivers offer tangible support for self-regulation, such as a predictable routine, and dividing complex activities into manageable parts, children are more capable of managing emotion, behavior, and attention.

A child's internal working model or core beliefs (see Table 4.1) is defined to a great extent by his or her ability to regulate emotions, impulses, and responses to external stress. The self-concept that develops in children with attachment disorder who lack self-control often leads to 1) disturbances in sense of self (e.g., sense of alienation and separateness, body image distortion); 2) inability to control impulses (e.g., physical and sexual aggression, self-mutilation); and 3) relationship disturbances (e.g., lack of trust and intimacy, perceive others as threatening) (Cole and Putnam 1992).

A neglectful, abusive, or nonresponsive caregiving environment produces out-of-control, angry, depressed, and hopeless children by 2 to 3 years of age. Children with attachment disorder have frequent and prolonged temper tantrums, are accident prone, impulsive, and desperately seek the attention not previously experienced. They are restless, irritable, have a brief attention span, demand instant gratification, and have little frustration tolerance by the preschool years. By age 5, they are angry, oppositional, and show lack of enthusiasm. Their inability to control impulses and emotions leads to aggressive acting out and lack of enduring and satisfying relationships with peers and others.

Self-Control and the Brain

The child's experiences—primarily the quality of their attachment relationships—play an important role in shaping brain development and in building connections between parts of the brain. Chronic and toxic stress can impair the proper development of brain circuitry, resulting in self-control problems. Several brain regions are involved in the ability to learn self-control skills. The *prefrontal cortex*, located behind the forehead, is involved in attention and organizational skills, including following rules, suppressing impulses, reasoning, and decision making. The *orbitofrontal cortex*, located behind the eyes, is involved in decision making and reward, especially when the decision involves delay of gratification (e.g., the "marshmallow test"). The *anterior cingulate* receives messages from various brain regions and regulates cognitive and emotional responses. It is involved in controlling behavior in challenging situations and adjusting behavior when a strategy is not working. These brain regions develop normally under conditions of safety and low to

moderate stress, but development is impaired when there are high levels of stress and interpersonal trauma (Tarullo, Obradovic, and Gunnar 2009).

Maternal and Infant Depression

Depression in mothers had profound and long-lasting effects on their babies. It is estimated that 10 to 12 percent of pregnant women experience chronic depression, which can be directly transmitted to the fetus. Newborns of mothers who were depressed during pregnancy were more irritable, less consolable, and had less developed motor tone than newborns of nondepressed mothers (Abrams *et al.* 1995). An estimated 40 to 70 percent of new mothers have postpartum depression caused by radical changes in hormonal levels, which can last up to three months; 30 percent have long-lasting and severe postpartum depression (Behavioral Health Treatment 1997). A more recent meta-analysis found postpartum depression in about 20 percent of women within the first three months of delivery (Gavin *et al.* 2005). These mothers have difficulty providing quality caregiving due to their depressed mood and diminished sensitivity to their infant's cues. If depression continues into the infant's sixth month, growth and developmental delays can occur at 1 year (e.g., slower to walk, weigh less, less socially responsive). When depression lasts through the infant's first year of life, babies show a profile of behavioral and physiological dysregulation, which can result in behavior problems and aggression at the preschool stage (Field 1995).

Many studies have found maternal depression to result in avoidant and disorganized attachment. Depressed mothers interact less with their babies. They are less likely to breastfeed, play with, and read to their children, and are often inconsistent and inattentive. This interrupts the bonding process between mother and baby, setting the stage for behavioral, emotional, and social problems over time (Goodman and Brand 2009).

Research has found that children of depressed mothers have a heightened sensitivity to and sense of responsibility for other's distress. Two- and three-year-old children of mothers with unipolar depression were more likely than children of well mothers to become upset and preoccupied when exposed to conflict or distress and were more appeasing in play with peers (Zahn-Waxler *et al.* 1984). These children displayed more caregiving and comforting responses with their mothers. The depressed mothers were more likely to blame their children for their distress, expressed more disappointment in their children, and used guilt-inducing strategies to regulate their children's behavior.

More than two decades of research at the Touch Research Institute (University of Miami Medical School) has demonstrated effective solutions

to maternal depression and the negative effects on babies (Field 1997). Relaxation exercise and massage therapy both had positive effects, but the results were more dramatic for massage therapy. After four weeks (two massages of the mothers per week), the mothers' anxiety levels and depression were significantly reduced (Field *et al.* 1996). In another study, depressed adolescent mothers were taught to massage their babies. The infants' stress level and depression decreased, they gained more weight, and improved on scales of emotionality, sociability, and soothability (Field *et al.* 1996).

"How I Feel"

Interactive coaching is another intervention found to be effective in improving reciprocity and sensitivity with depressed mothers and their infants. The mother is coached or guided on how to positively relate to her baby while the two play together. Two interactive patterns were identified: intrusive mothers engaged in rough handling, poked their babies, and spoke in an angry tone of voice; withdrawn mothers were unresponsive, affectively flat, and unsupportive. Coaching the intrusive mother on being less active and more sensitive to her infant's cues improved responses of the infants. A more active "attention-getting" technique was found to have positive results for the withdrawn mothers and their babies (Malphurs *et al.* 1996).

The Unresponsive Infant

Some infants are not physically and/or emotionally responsive to caregivers' efforts to satisfy their needs. This lack of responsiveness is the result of numerous factors: difficult and irritable temperament, in utero drug or alcohol exposure, unrelieved pain associated with medical conditions, response to prenatal or postnatal stress from caregivers or environment, and genetic and/or congenital impairments or handicaps. A vicious cycle develops in the caregiver–infant relationship, as shown in Figure 5.1 (adapted from Cline 1992).

There are four components to this cycle:

- The infant does not respond with comfort and relaxation to the caregiver's efforts to soothe and console.
- The caregiver becomes anxious, angry, insecure, and begins to lose confidence in their caregiving abilities ("What am I doing wrong?").
- The caregiver either withdraws or becomes increasingly intrusive and punitive.
- The infant responds to the caregiver's heightened stress and anxiety, becoming increasingly anxious, fearful, and unresponsive. The caregiver's negative cues and signals cause the infant to cry more, and the infant perceives the caregiver as increasingly unsafe.

A common example of the vicious cycle of the unresponsive infant is found with the colicky baby. These infants cry more than twice as much as other infants, regardless of caregiver efforts to console. Mothers of crying infants have been found to be more anxious and tentative in dealing with their babies, while mothers of infants who cried less were more deliberate, calm, and serene. The anxious mothers reported feeling exasperated, less confident, frightened, confused, resentful, and unloving. Some reported feeling extreme hostility toward their infants (Jones 1983). Not surprisingly, infant crying and child abuse are highly correlated. Eighty percent of parents who physically abused their infants reported excessive infant crying as the trigger for abuse (Weston 1968).

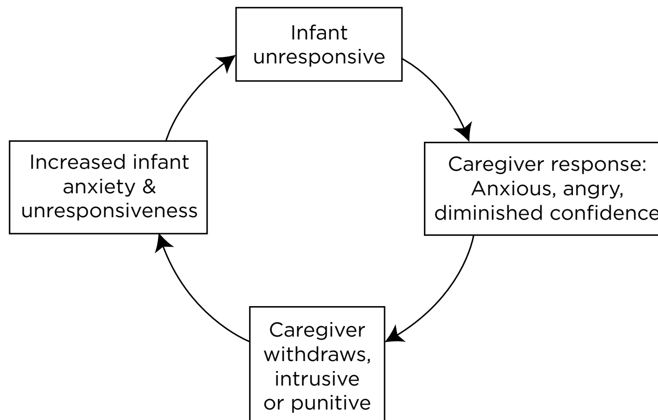


Figure 5.1 Vicious Cycle of the Unresponsive Infant

The cause of colic is unknown, and it usually ceases around 3 to 4 months of age. Some child development experts believe that colic in infants is caused by ineffectual caregiving; others believe that the ineffectual caregiving is a response to the infants' physiological condition. Either way, the vicious cycle develops, with negative consequences for both infant and caregiver. Although it is a difficult and challenging task, the caregiver must not convey agitation and anxiety to the infant who experiences chronic discomfort.

Disorganized–Disoriented Attachment

Three organized patterns of behavior toward the caregiver were originally identified using the Strange Situation, a laboratory-based approach to studying the infant's response to separations from and reunions with the parent. The three attachment patterns were secure, avoidant, and anxious–ambivalent (Ainsworth *et al.* 1978).

- *Secure:* The infant is upset when his or her mother leaves the room, but distress is not excessive; the infant and mother greet one another actively and warmly upon reunion; the infant quickly relaxes and returns to play.
- *Avoidant:* The infant shows little or no distress when his or her mother leaves, and actively avoids and ignores the mother upon reunion; the mother also avoids, looking away from her child.
- *Anxious–Ambivalent:* The infant is extremely distressed by separation, clinging on to his or her mother and staying near the door crying, seeks contact upon reunion, but cannot be settled by the mother and pushes her angrily away.

These infant responses to separation and reunion reflect the history of the parent–child relationship, the parenting style, and predict later psychosocial functioning (Ainsworth *et al.* 1978; Bretherton 1985).

Further research revealed an additional attachment pattern. Certain infants did not fit the original three categories: they seemed to lack any coherent, organized strategies for dealing with separation and reunion. These infants were classified as *disorganized/disoriented*, and their behavior was found to reflect seven types of reactions (Main and Solomon 1986, 1990).

- *Sequential display of contradictory behavior patterns:* Extremely strong displays of attachment behavior or angry behavior, followed suddenly by avoidance, freezing, or dazed behavior. For example, the infant greets his or her parent with raised arms, but then retreats and freezes.
- *Simultaneous display of contradictory behavior:* The infant displays proximity-seeking and avoidant behavior at the same time. For example, the infant approaches his or her parent with head averted or by backing toward parent.
- *Undirected, misdirected, incomplete, and interrupted movements and expression:* The infant moves away from rather than toward his or her parent when distressed or frightened. For example, the infant approaches the parent, but then follows a stranger; the infant appears frightened of the stranger, but retreats from the parent and leans his or her head on the wall.
- *Stereotypes, asymmetrical movements, mistimed movements, anomalous postures:* The infant shows repeated movement, such as rocking, hair twisting, or ear pulling; asymmetrical creeping, moving only one side of body; sudden and unpredictable movements, such as rapid arm and leg activity after sitting tense and still; uninterpretable postures, such as head cocked with arms raised for long periods of time.
- *Freezing, stilling, slowed movements and expressions:* Holding of positions, such as sitting with arms held out, waist high and to sides; apathetic or lethargic movements or facial expressions, such as a dazed expression when greeting the parent.
- *Direct indices of apprehension regarding the parent:* Display of extreme fear in response to the parent. For example, looking frightened, flinging hands over his or her face, running away, a highly vigilant posture, when the parent returns and approaches.
- *Direct indices of disorganization or disorientation:* Clear displays of confusion and disorganization upon reunion. For example, greeting a stranger with raised arms instead of going to the parent; rapid changes

of affect, such as crying–laughing; falling when approaching the parent; wandering with a disoriented expression.

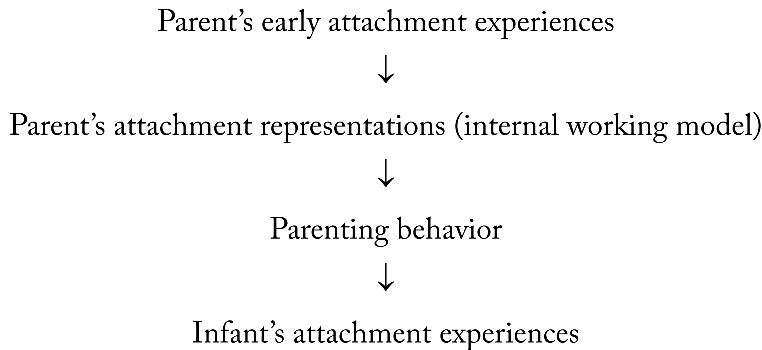
Therapists, social caseworkers, therapeutic foster parents, and others who work with maltreated children and disturbed families will recognize some of the previously described behaviors. Clinical experience is consistent with research findings regarding children with disorganized–disoriented attachment patterns and their family contexts. Approximately 15 percent of infants in two-parent, middle-class families display disorganized attachment patterns (van Ijzendoorn 1995), but the incidence of this severe attachment-disordered behavior increases to a high of 82 percent among high-risk, maltreating families (e.g., maternal substance abuse and depression, abuse and neglect, adolescent parenthood, multiproblem family status (Lyons-Ruth 1996).

Disorganized infant attachment has been found to be associated with unresolved loss, fear, and trauma of the parent(s). These parents, who complete the Adult Attachment Interview (George, Kaplan, and Main 1984; Hesse 2008) have been found to be "unresolved" in regard to their own attachment histories. They have not mourned losses, are frightened by memories of past trauma, may dissociate, and script their child into unresolved family drama (van Ijzendoorn 1995). They also actively and contemptuously devalue prior attachment figures and often abuse and/or neglect their children (Crittendon 1985; Carlson *et al.* 1989; Lyons-Ruth *et al.* 1991; Mikulincer and Shaver 2007).

Mothers of disorganized infants typically have histories of family violence and abuse, rather than neglect alone. These mothers are "out of sync" with their babies, displaying confusing and mixed messages (e.g., extending their arms toward the infant while backing away), and responding inappropriately to their infant's cues (e.g., laughing when the baby is in distress) (Main *et al.* 1985; Spieker and Booth 1988; Lyons-Ruth, Bronfman, and Parson 1994). Not surprisingly, these mothers show high levels of negative and downcast affect to their babies and low levels of tenderness and affection (DeMulder and Radke-Yarrow 1991).

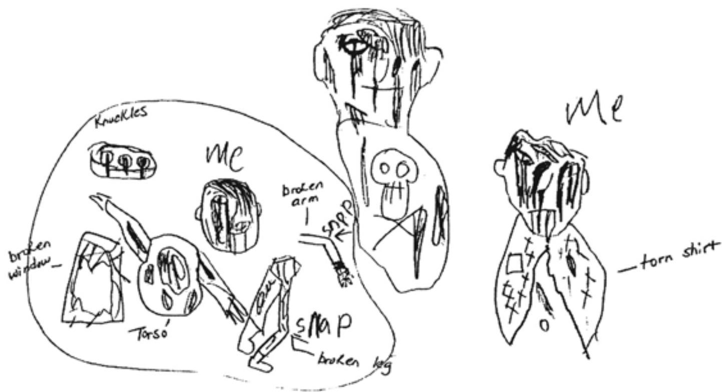
Thus, disorganized infant attachment is transmitted intergenerationally: parents raised in violent, frightening, and maltreating families transmit their fear and unresolved losses to their children through insensitive or abusive care, depression, and lack of love and affection. The infant is placed in an unresolvable paradox: closeness to the parent both increases the infant's fear and, simultaneously, their need for soothing contact. Closeness and contact with the parent triggers fear rather than safety or comfort (Main and Hesse 1990; Lyons-Ruth 1996).

This intergenerational process is conceptualized in the following ways (van Ijzendoorn and Bakerman-Kranenburg 1997):



There are additional factors, of course, that influence parenting behavior. The parent's current attachment representation (internal working model, belief system) is influenced by later relationships, not only early attachment experiences. A supportive social network (friends, spouse, therapist) can ameliorate the negative effects of early attachment trauma (Belsky, Rovine, and Taylor 1984), and a positive relationship with a secondary caregiver can help a person overcome adversity (Egeland, Jacobvitz, and Sroufe 1988). A child's temperament and special needs also play a role. Due to physical handicaps or highly irritable temperament, some children make it extremely difficult for parents to respond in a sensitive and warm manner to their attachment needs (Kagan 1984; Chess and Thomas 1987; van Ijzendoorn 1995b).

Nevertheless, based on numerous studies, as well as vast clinical experience, intergenerational transmission of attachment patterns is considered an established fact. It is not, however, the specific traumatic events in parents' childhoods that cause disorganized attachment in the child. Rather, it is the parent's mental and emotional representation of prior attachment experiences that are most important (van Ijzendoorn and Bakerman-Kranenburg 1997).



Portrait of Self and Perpetrator

Drawing by Angry, Aggressive Child

Aggression, Control, and Conduct Disorders

"How I See Myself in the World"

The DSM-IV-R (American Psychiatric Association 2000) describes three diagnostic categories of aggressive or "externalizing" disorders in children: oppositional defiant disorder (ODD), conduct disorder (CD), and attention-deficit/hyperactivity disorder (ADHD). The term "externalizing" refers to a core set of negativistic, defiant, and hostile behaviors (e.g., noncompliance, aggression, and tantrums, in response to limit setting (Greenberg *et al.* 1997). ADHD is characterized by symptoms of inattention and/or hyperactivity and impulsivity. Oppositional defiant disorder is characterized by a pattern of negativistic, hostile, and defiant behavior. Conduct disorder involves behavior that violates the basic rights of others and societal norms and rules. By far, the largest group of children referred to mental centers is for externalizing problems (Offord, Boyle, and Racine 1991; cited in Greenberg *et al.* 1997). Many of these children continue disruptive behavior in later years (Campbell 1991), and often repeat the poor parenting practices of their own parents (Huesman *et al.*1984; cited in Lyons-Ruth 1996). These children often show deficiencies in impulse control, emotional regulation, and problem-solving (Moffit 1993; Cook, Greenberg, and Kusche 1994).

Findings from the Minnesota High Risk Study, which followed a large community sample of impoverished mothers and infants from birth into adolescence, documented the relationship between insecure attachment and later conduct disorders. Insecurely attached infants, particularly those with

avoidant attachment, were more aggressive and impulsive, and had more conflict with peers and caregivers during their school years (Erickson, Sroufe, and Egeland 1985; Renken *et al.* 1989; Sroufe *et al.* 1990; Egeland, Pianta, and O'Brien 1993). Among high-risk families, it is clear that early avoidant attachment patterns place children at high risk for later aggression and other externalizing problems.

It is the children with histories of disorganized–disoriented attachment who are most at risk for developing severe problems, including aggression. Again, disorganized attachment refers to a lack of, or collapse of, a consistent or organized strategy to respond to the need for comfort and security when under stress (e.g., separation and reunion). Kindergarten children who were classified as disorganized in infancy were six times more likely to be hostile and aggressive toward peers than were those classified as secure (Lyons-Ruth, Alpern, and Repacholi 1993). Infants of impoverished adolescent mothers are at risk for developing severe attachment disorder and subsequent aggression. Sixty-two percent of these infants had disorganized attachment relationships and were more likely to initiate conflict with their mothers by aggressive and oppositional behavior by 2 years of age (Hann *et al.* 1991). These mothers were less affectionate and more rejecting of their child's overtures than other mothers. By the time they became toddlers, these children were aggressive, avoided and resisted their mothers, and were developing a controlling and coercive strategy to cope.

The tendency to be controlling toward caregivers and others is a foremost symptom of disorganized attachment and a constant challenge for those who care for these children. While infants and toddlers with disorganized attachment patterns are often helpless, frightened, and confused, as they enter the preschool and early school years they develop various forms of controlling behavior. The *controlling–caregiver* type is characterized by a role reversal, where the child is overly solicitous, attempting to take care of the parent. In the second category, *controlling–punitive*, the child is hostile, coercive, rejecting, and humiliating toward the parent (Greenberg *et al.* 1997). Among clinic-referred preschoolers diagnosed with ODD, a majority were found to be *controlling–disorganized*. Mothers were typically classified as "unresolved," the adult counterpart of controlling–disorganized attachment (Greenberg *et al.* 1991).

The Antisocial Child

Children with a history of interpersonal trauma are at risk of developing aggressive, controlling, and conduct-disordered behaviors, which contributes to the development of an antisocial personality. As early as the latency

years and preadolescence, these children exhibit a lack of conscience, self-gratification at the expense of others, lack of reliability and responsibility, dishonesty, and a blatant disregard for the rules and standards of family and society.

Many of the key symptoms and traits of the adult antisocial personality are displayed in the child with attachment disorder (Yochelson and Samenow 1976; Hare 1993). These symptoms include glibness and superficiality; egocentric and grandiose thinking; lack of remorse, guilt, and empathy; deceitful and manipulative behaviors; emotional shallowness; impulsivity; need for excitement; irresponsibility; not learning from experience; and lack of meaningful relationships.

All children lie occasionally to avoid punishment; the antisocial child, however, lies as a way of life. This pathological lying becomes a habitual strategy to avoid punishment and gain power and control ("I know the truth and you don't"). They often lie even when they do not have to, for no apparent purpose, which provides a sense of excitement and a feeling of having the "upper hand." These children perceive others as pawns to be manipulated and have few friendships, due to their inordinate need to control. They are superficially charming and engaging, but the longer you know them, the less you like them. They often prefer to relate to younger children whom they can control and manipulate. They secretly yearn for family connections and are jealous of others who are capable of intimacy and love, but are too fearful of closeness to reveal their needs and desires. They perceive themselves as "bad," defective, and unworthy of love.

Maltreatment

Childhood exposure to maltreatment and interpersonal trauma is extremely common. Worldwide, approximately one-third of children experience physical abuse, and 25 percent of girls and 20 percent of boys experience sexual victimization (United Nations 2006). Decades of research and clinical practice confirm the long-term negative consequences maltreatment can have for children. Studies by the U.S. Department of Health and Human Services (2011) and the National Child Traumatic Stress Network (Pynoos 2008) show that children who are abused and neglected have an increased risk of severe mental and physical health problems, including PTSD, depression, suicide, substance abuse, heart disease, pulmonary disease, and liver disease. Exposure to traumatic events can alter psychobiological development and increase risk of low academic performance, engagement in high-risk behaviors, difficulties in peer and family relationships, and long-term physical health problems. Children exposed to multiple traumas are

at greater risk of subsequent trauma exposure and cumulative impairment. These studies have revealed the following statistics:

- Three million children per year experience abuse and neglect in the United States; 70 percent are neglected and 30 percent suffered abuse (18 percent physical, 12 percent sexual).
- Eighty-one percent of child victims were maltreated by a parent acting alone or with someone else.
- The youngest children are most vulnerable; those under 1 had the highest rates of abuse; almost 50 percent of all child fatalities caused by maltreatment were under 1 year of age.
- Up to 65 percent of maltreated children develop PTSD; as many as 90 percent of infants and children acquire anxious and disorganized attachment patterns.
- Maltreated children are 53 percent more likely to be arrested as a juvenile and 40 percent more likely to commit a violent crime.
- Fifty to eighty percent of all child abuse cases involve drug and/or alcohol abuse by parents or caregivers.
- Poverty plays a role; children in families with annual incomes below the poverty line were 45 times more likely to suffer neglect and 60 times more likely to die from maltreatment.
- The fiscal cost of childhood maltreatment, including mental health, medical, and social services, and justice system services, is estimated at $104 billion per year.

The prevalence of mental health problems is particularly high among maltreated children placed in out-of-home care. Compared with their nondependent peers, children who become involved in the child welfare system (e.g., foster care) are more likely to exhibit aggressive and antisocial behavior, use drugs and alcohol, and enter the juvenile justice system (Hazen *et al.* 2009). These children must cope with the traumas resulting from placement as well as the stress of adjusting to life in new environments.

Maltreatment and Attachment

Attachment theory has guided a considerable amount of recent research on abuse and neglect of young children. Studies have found maltreated children have the highest rates of anxious and disorganized–disoriented attachment. Secure attachment is the antithesis of maltreatment, in that the caregiver's sensitivity and responsiveness to the baby's needs and signals are basic to

attachment quality. In the Harvard Maltreatment Project, maltreated infants were more likely to be insecurely attached than nonmaltreated infants (Schneider-Rosen *et al.* 1985). Crittenden (1985, 1992a) found anxious attachment among maltreated infants and toddlers, with developmental differences. Abused children were angry at 1 year, but inhibited that anger with their mother at 2 years of age. Neglected children remained angry. By 2 years, children have already learned to avoid provoking abuse from their parents. The Minnesota Mother–Child Project, a longitudinal study of children in high-risk families, also found a high incidence of anxious attachment among maltreated children. Two-thirds of neglected babies were anxiously attached by 1 year of age, and remained so through their school years. More alarming, however, was the finding that nearly *all* the children who were emotionally neglected ("psychologically unavailable mothers") developed anxious attachment, with most classified as anxious–avoidant (Erickson *et al.* 1989). Disorganized–disoriented attachment, the most severe pattern of attachment disorder, was found in as many as 82 percent of children in high-risk, maltreating families (Lyons-Ruth *et al.* 1991).

Maltreated children are unable to rely on caregivers for emotional and behavioral support and regulation (Cicchetti and Valentino 2006). Children in maltreating families do not experience safe, sensitive, and responsive caregiving, and their relationships with attachment figures are characterized by pain, fear, inconsistency, and unpredictability. Some children adapt by minimizing their attachment needs and behaviors and avoiding closeness with their attachment figures ("avoidant" pattern). Other children adapt by becoming clingy and demanding of attention ("anxious" pattern). Children who are victims of extreme relationship trauma are unable to develop any organized response, and often display fear, freezing, aggression, withdrawal, or an incoherent combination of these behaviors, in the presence of their caregivers ("disorganized–disoriented" pattern). Insecure and disorganized attachment patterns persist over time, making it difficult to master future developmental tasks, and resulting in a range of symptoms and problems (e.g., anxiety, depression, aggression, stress management difficulties, dissociation, future familial and parenting difficulties).

What are the factors that predict which children are likely to be maltreated? Several studies provide valuable information about the antecedents of maltreatment. Since multiple factors influence quality of child care, variables of interest are grouped into *parental characteristics*, *child characteristics*, and *environmental factors* (Erickson and Egeland 1996):

- *Parental characteristics*
    - lack of understanding of the emotional complexity of the parent–child relationship

    - difficulty understanding the child's needs, perspective, and developmental level
    - thinking in global, all-or-nothing terms
    - maltreatment and attachment disorder in their own histories of care
    - unresolved issues of trust, dependency, and autonomy
    - high incidence of depression
    - lacking impulse control, particularly under stress
    - drug and alcohol abuse.
- *Child characteristics*
    - irritable and difficult temperament
    - disabilities and special needs
    - prior history of loss, psychosocial problems, and attachment disorder (e.g., multiple moves in child welfare system).

Child characteristics alone do not account for maltreatment. Parents, with extra support, education, and maturity, can provide the necessary sensitivity and guidance to overcome a child's difficulty.

- *Environmental factors*
    - poverty
    - violence in the marital relationship
    - parental unemployment, family stress and disorganization
    - lack of supportive social network, especially among single parents who lack intimate emotional support.

Not all parents who experienced maltreatment in their families of origin abuse and/or neglect their own children. What characterizes parents who transcend their unfortunate histories and provide loving and secure care for their offspring? There are three major factors (Main and Goldwyn 1984; Egeland 1988):

- a supportive and loving relationship with an adult during childhood (e.g., kin foster parent, counselor)
- support partner and/or social supports during parenthood
- a therapeutic intervention that facilitated resolution of early issues, directing anger and responsibility toward perpetrators rather than self, and providing a clear account of childhood loss and trauma.

There is a great deal of support for the belief that in the majority of cases, children do not lie about abuse allegations. Children with attachment disorders, however, are at risk of making false allegations of abuse against parents, teachers, therapists, and others. Often their motivation is control, revenge, diversion, or even mere amusement. Their ability to appear believable, adeptness at lying, and lack of concern for others can fool the most experienced professionals. Therefore, it is crucial to have a thorough understanding of the child's background and symptomatology when assessing the validity of allegations. There are certain "red flags" that can place a child at risk of making false allegations of abuse. Children who are extremely angry about prior maltreatment and exploitation are high risk. The risk grows further if they have a previous history of making false accusations and do not want to be in their current placement.

Neglect

Child neglect is the most frequently reported and substantiated form of child maltreatment, accounting for up to 70 percent of all child abuse reports. Between 1986 and 1993, the number of children physically neglected increased by 163 percent, while the estimated number of emotionally neglected children tripled (188 percent increase). Rates of neglect have remained at these levels into the present time. Birth parents are the perpetrators of neglect in most cases (91 percent); children are most often neglected by females (87 percent), because for so many a female is the only caregiver (NCCAN 1995; U.S. Department of Health and Human Services 2011).

There is great variability in definitions of neglect. Some focus on the specific behaviors or omissions of caregivers that endanger the child's physical, cognitive, or emotional health (Zuravin 1991). Others argue for a broader definition that focuses on the conditions of the child, regardless of the cause (Dubowitz *et al.* 1993). An even broader view of neglect is suggested by Hamburg (1992), the past president of the Carnegie Foundation. He indicts our society for "collective neglect," failing to provide adequate health care, child care, and policies that support families in caring for their young children (Hamburg 1992; cited in Erickson and Egeland 1996, p.6).

Regardless of the definition, several types of neglect have been identified by health care providers and mental health professionals: *physical*, *emotional*, *medical*, *mental health*, and *educational* (Erickson and Egeland 1996). Physical neglect is the most commonly identified form and includes failure to protect from harm or danger and meet basic physical

needs (e.g., shelter, food, clothing). Emotional neglect involves inattention to the child's emotional needs, nurturing, or well-being. The most extreme consequence of emotional neglect is "failure to thrive," which produces stunted growth, physical illness, and is often fatal. Medical neglect refers to the caregiver's failure to provide necessary medical treatment. Mental health neglect involves refusal to comply with recommended therapeutic procedures when a child displays serious emotional or behavioral disorders. Educational neglect includes the caregiver's failure to comply with requirements for school attendance or resistance to follow through with special recommended programs.

Studies on the consequences of maltreatment have found differences between abuse and neglect. Abused children were more aggressive, angry under stress, and showed mild developmental delays, while neglected children interacted less with peers, were passive, tended toward helplessness when under stress, and showed significant developmental delays (Hoffman-Plotkin and Twentyman 1984; Crittenden and Ainsworth 1989). Findings from the Minnesota Mother–Child Project, a longitudinal study designed to follow children of at-risk mothers (poor, young, low education, unstable, lack of support), provided information regarding neglect. They found that emotional neglect ("psychologically unavailable caregivers") was more harmful to children than physical neglect or other forms of maltreatment. Psychologically unavailable mothers were detached and unresponsive, interacted in a mechanical manner, and showed no satisfaction or joy with their child. Nearly all the children in this group were anxiously attached at 1 year of age; at 24 to 42 months they displayed anger, noncompliance, lack of persistence, little positive affect, and steep declines on scales of development; in preschool they were negativistic, noncompliant, impulsive, highly dependent on teachers, and severely anxious; in the school years they were socially withdrawn, unpopular with peers, and exhibited internalizing problems (e.g., depression) (Erickson *et al.* 1989). Mothers who were emotionally unavailable and neglectful were likely to have been neglected as children themselves, and consequently, insecurely attached to their own mothers (Crittenden and Ainsworth 1989; Belsky 1995). Most mothers studied in the Minnesota Project who were neglected as children neglected their own infants and toddlers. Other antecedents of neglect included disorganized and stressful home environment; tense, depressed, angry, and confused mothers; isolated families with lack of social support; low intellectual functioning of caregivers (Pianta, Egeland, and Erickson 1989).

Child's Idea of "Having Fun"

Neglect, especially emotional neglect during the first three years, has an extremely damaging and long-lasting effect on children's functioning in the family, with peers and teachers, and in regard to coping skills and learning. Attachment theory provides a meaningful framework for understanding the sequelae of neglect (Erickson and Egeland 1996). Children with early anxious patterns of attachment (emotional neglect) develop *negative working models*—negative expectancies and belief systems about self, caregivers, and the world in general. They expect *not* to get their needs met, so they shut down and do not even try to solicit care or affection. They expect to be ineffective and unsuccessful in tasks, so they give up. Their dependency needs are so strong they are barely able to become motivated and stay task oriented. The negative feedback they receive from others perpetuates their low self-esteem and negative expectations of self and others (vicious cycle).

Violence

The United States is consistently ranked among the industrialized countries with the highest rates of overall violence. National statistics indicate high rates of traumatization of children through abuse and through the violence they witness in homes and communities. Numerous research studies have documented the adverse effects of violence and maltreatment on children's emotional, social, and cognitive functioning, as well as on their physical health (Osofsky 2011).

Children are routinely the victims of violence. Homicide is the 11th leading cause of death for all Americans, but the second leading cause of death for children under the age of 18 (CDC 2009). The proliferation of violence has been likened to a national epidemic, breeding more violence at an exponential rate. Nearly one million teenagers are victims of violent crime annually, with African American males and those living in poverty at greatest risk. Even schools cannot provide a safe haven; 105 fatalities were reported from 1992 to 1994 (Kachur *et al.* 1994). One quarter of those arrested on weapons charges were juveniles (U.S. Department of Justice 1995; cited in Levine 1996). In a Chicago neighborhood, one-third of school-age children had witnessed a homicide and two-thirds had witnessed a serious assault (Bell and Jenkins 1993). Thirty-two percent of Washington, DC children and more than one-half of New Orleans children were victims of violence in their community (Richters and Martinez 1993). Children are directly exposed to community violence. Infants and toddlers, however, are indirectly but profoundly exposed; they are "tuned into" their caregivers' fears and anxieties about violence and influenced by the adults' coping strategies (Osofsky 1994).

Infants, toddlers, and children who experience and/or witness violence in their home are seriously affected, due to the literal and psychological proximity. More than three million children witness parental abuse each year, including fatal assaults and physical abuse. Domestic violence is associated with maltreatment of infants; mothers abused by their male partners have higher rates of child abuse (Strauss 1993). Physical abuse is the leading cause of death among children less than 1 year old. Two thousand children die a year—five each day—at the hands of their parents or caregivers. From 1986 to 1993, the number of physically abused children in the United States increased to 600,000 recorded incidents (a 100% increase) (NCCAN 1993).

Self-Portrait

Exposure to violence, including physical abuse, has severe and damaging consequences for many aspects of functioning: physical, developmental, cognitive/attributional, social, emotional, behavioral, and academic (Kolko 1996). Infants and toddlers experience the three hallmark symptoms of PTSD, similar to older children: reexperiencing the traumatic event, numbing of responsiveness and avoidance of reminders of the trauma, and hyperarousal. Other common symptoms include sleep disturbance, night terrors, separation anxiety, fearfulness, aggressiveness, difficulty concentrating, and emotional detachment (Zeanah and Scheeringa 1996). Young children may play out aspects of the trauma in posttraumatic play, repeating the same play sequence over and over (Terr 1990). The following behaviors and effects on development are common for young children exposed to violence (Osofsky 1994):

- affects the development of perceptions of self and others, including trust and dependability
- repeated exposure leads to more severe symptoms as children grow older
- memory impairment due to avoidance and intrusive thoughts
- developing anxious and disorganized attachment
- play becomes more aggressive, imitating behaviors children have seen and trying to "master" the trauma
- "acting tough" to compensate for fear, developing a counterphobic reaction
- appearing depressed, withdrawn, or becoming aggressive
- becoming severely constricted in activities, exploration, and thinking, for fear of reexperiencing the trauma
- difficulty concentrating in school, due to lack of sleep and intrusive imagery.

Sexual Abuse

Sexual abuse is common in the histories of children who develop severe attachment disorder. Sexual abuse involves any sexual activity with a child where consent is not or cannot be given. This includes sexual contact that is accomplished by force or threat of force, regardless of where there is deception or the child understands the nature of the activity (Finkelhor 1979). Sexual activity includes penetration, sexual touching, or noncontact sexual acts such as exposure, voyeurism, or displays of explicit materials.

Child sex abuse is extremely traumatic and occurs more frequently than often assumed. Estimates of lifetime prevalence are 17 percent for women and 8 percent for men (Beach *et al.* 2013). Other surveys have found 27 percent of women and 16 percent of men reported a sexual offense by age 18 (Finkelhor 1990).

Multiple episodes of sexual abuse are common, occurring in more than half the cases in nonclinical samples and in 75 percent of clinical samples of abused children (Conte and Schuerman 1987; Elliott and Briere 1994). Compared to girls, boys are found to be older at the onset of victimization, and more likely to be abused by nonfamily members, women, and by offenders who are known to have abused other children (Faller 1989). Girls are at higher risk for sexual abuse than boys by a ratio of two to one (Everstine and Everstine 1989). Both males and females are more at risk to be sexually abused if they live without one of their birth parents, have an unavailable mother, or perceive their family life as unhappy (Finkelhor and Baron 1986). The incidence of sexual abuse among disabled children is 1.75 times higher than nondisabled children (NCCAN 1993). Unlike other forms of child abuse, sexual abuse does not appear to be related to socioeconomic status (Berliner and Elliott 1996).

Research indicates that children who have been sexually abused suffer from a wide range of psychological and interpersonal problems both in the short term (Beitchman *et al.* 1991; Berliner 1991; Kendall-Tackett, Williams, and Finkelhor 1993) and in later adult functioning (Browne and Finkelhor 1986; Finkelhor 1990; Beach *et al.* 2013). Damage occurs because sexual abuse is always nonconsensual, developmentally inappropriate, invariably alters the nature of the relationship within which it occurs, and interferes with normal developmental processes, leading to an increased risk of maladjustment later in life (Berliner and Elliott 1996). Finkelhor (1987) synthesized the clinical issues common to sexually abused children in four "traumagenic dynamics": traumatic sexualization, stigmatization, powerlessness, and betrayal. These four dynamics were shown to be strong indicators of symptom formation in children (Mannarino and Cohen 1996).

Sexually abused children have more behavior problems than nonabused children (Cohen and Mannarino 1988; Einbender and Friedrich 1989; Gomes-Schwartz, Horowitz, and Cardarelli 1990). They tend to lack social skills, are more aggressive, and are more socially withdrawn than nonabused children (Friedrich, Beilke, and Urquiza 1987). They commonly suffer from somatic reactions, sleep and eating disturbances, night terrors and nightmares, bedwetting, and phobic reactions. The majority of child sexual abuse victims have been found to suffer from mild to acute posttraumatic symptoms (DeFrancis 1969; Burgess and Holmstrom 1984). Researchers have found

PTSD symptoms in up to 48 percent of sexually abused children (McLeer *et al.* 1988). Particularly prevalent were the posttraumatic symptoms of fear, anxiety, and lack of concentration (Conte and Schuerman 1987).

Adolescents with a history of sexual trauma are more likely to have high levels of suicidal ideation and attempts than those without a sexual abuse history. Persons with a history of childhood sexual trauma are two to five times more likely to attempt suicide over their lifetime (Diamond *et al.* 2012).

Recent studies have found that child sexual abuse has affected as many as 25 percent of women in the United States (Pereda *et al.* 2009). Sexual abuse is linked to severe mental and physical disorders in women, including depression, PSTD, substance abuse, antisocial and borderline personality disorders, and medical conditions. Women abused as children are significantly more likely to have cardiovascular and respiratory disease, gastrointestinal illnesses, cancer, and chronic fatigue syndrome (Kendall-Tackett 2009).

Sexual abuse victims are four times as likely to develop a major depression during their lifetime (Stein *et al.* 1988). There is a high correlation between childhood sexual abuse and dissociation, including psychic numbing, depersonalization, and disengagement (Briere and Runtz 1987; Chu and Dill 1990). Sexually abused children are more likely to be diagnosed with depression, exhibit suicidal behavior, have lower self-esteem, greater symptoms of anxiety, and more substance abuse problems than nonabused peers (Berliner and Elliott 1996). Adolescents who have been sexually abused are more likely to run away from home, use drugs, and be bulimic (Hibbard, Ingersoll, and Orr 1990). Teenage mothers with a history of sexual abuse are more likely to abuse their children (Boyer and Fine 1991). Sexual behavior problems are common among children who have been sexually abused; they display sexualized behavior more than physically abused, neglected, or psychiatrically disturbed children (Gale *et al.* 1988). Cognitive functioning is affected by sexual abuse. Guilt, shame, self-blame, loss of trust, and stigmatization, are common reactions. These children often perceive themselves as different from peers, and abuse-related cognitions are common: negative self-attributes, a disbelief in self-efficacy, and a perception of self as helpless and life as dangerous and hopeless (Gold 1986; Mannarino, Cohen, and Berman 1994).

Children are conditioned to obey adult rules and invariably feel betrayed and helpless when molested by someone in a position of trust. The child is forced into an "abuse dichotomy" when attempting to understand the perpetrator's behavior: "Either the abusive caregiver is bad or I am bad." Young children by nature are egocentric and commonly accept responsibility for the actions of others toward them. Due to the child's inherent lack of power, and acceptance of social messages ("adults are right"), he or she assumes that the

abusive act is justifiable punishment for some misdeed, thus "it must be my fault and I am bad" (Briere 1989). Consequently, these children internalize a sense of shame, guilt, and self-blame. They feel intrinsically bad, damaged, worthless, unlovable, or even evil.

Sexually traumatized children often act out sexually with other children, engage in autoerotic acts, or behave in a seductive way toward adults. This may be an attempt to gain a sense of mastery over the trauma by repetition of these events in a symbolic form. They typically engage in sexualized play that was similar to their victimization and seek to undo their feelings of helplessness by identifying with the aggressor, doing to other children what was done to them (Everstine and Everstine 1989).

Incest

Incest is defined as any sexual contact between a child and parent, stepparent, relative, or anyone who fills the role of parent surrogate. Sexual assaults by adults in positions of trust are more traumatic than by strangers, due to the intensity of betrayal and confusion. Research has provided insight into the family characteristics of incestuously abusing families (Trepper *et al.* 1996). The vast majority of these families are socially isolated, enmeshed, quite rigid, and nonadaptable to change. Communication patterns include secretiveness, unclear and inconsistent messages, infrequent discussions of feelings, little attentive listening, and lack of conflict-resolution skills. There is limited or erratic leadership. Fewer than one-third of families were "father-executive" type (contrary to the popular notion that there is usually a strong, domineering father and a weak, ineffectual mother). Lack of family member role clarity is common, with undefined, shifting, and reversing roles (e.g., "parental child"). Most offending parents (78%) did not engage in nurturing activities of the victim when he or she was a baby, reflecting the lack of positive and secure attachment. More than two-thirds of offending parents used alcohol or drugs often, and used just prior to an abusive episode. Substance abuse is clearly a precipitant and a vulnerability factor. Most of the marriages (82%) were rated in over-all quality as poor and characterized by emotional separateness.

Family members tend to deny aspects of incestuous abuse. Four types of denial have been identified (Trepper and Barrett 1989):

- *Denial of facts:* The individual openly challenges the realities of the abuse.
- *Denial of impact:* The individual admits incest has occurred, but lessens the intensity of the meaning of the abuse.

- *Denial of responsibility:* The individual admits to the occurrences of abuse, but questions the offender's culpability and places blame on another person.
- *Denial of awareness:* A family member states that if the abuse has occurred, it happened without his or her cognizance.

Offenders in abusing families most often deny the facts. Nonoffending spouses most commonly deny the impact. Victims also tend to deny the impact of abuse more frequently. Trepper concludes:

> To understand incest we clearly will have to go beyond looking at the individual psychopathology of the offending parent, or even the dyadic relationship between the offender and the victim. Instead, we will need to focus our attention and research on the multiple systems variables which structure family systems. (Trepper *et al.* 1996, p.15)

There are a number of mediating factors that influence the psychosocial effects of childhood sexual abuse, including specific characteristics of the abuse and family support. Children, for example, who experience a single incident of less intrusive abuse and then disclose to a supportive and protective parent, are likely to report few long-term problems. The degree of psychological trauma a child experiences is related to the amount of violence and terror associated with the event (Everstine and Everstine 1989). Increased negative impact of sexual abuse involves penetration, violence, closer relationship to the offender, multiple offenders, longer duration, and frequency (Berliner and Elliott 1996). The younger the child, the more vulnerable he or she is to being overwhelmed and traumatized (Burgess and Holmstrom 1984; Peters 1988).

The child's cognitive appraisal is one of the most important mediating factors. Greater distress is associated with higher levels of cognitive functioning (can understand the implications), blaming self, and using "wishful thinking" to cope (Spaccarelli 1994). Family dysfunction may exacerbate the effects of abuse. Increased distress occurs when families have more conflict and violence, less cohesion and support, and more psychiatric and substance abuse problems (Conte and Schuerman 1987; Friedrich *et al.* 1987). Maternal support, or a supportive relationship with another adult, is associated with decreased negative effects (Conte and Schuerman 1987). Mothers are most likely to fail to provide support when the offender is a stepfather or mother's live-in boyfriend. Children who lack maternal support are more likely to recant the original allegation or refuse to report it (Elliott and Briere 1994).

Ritualistic Abuse

Reports of ritualistic abuse occasionally occur when working with sexually abused children. Ritualistic abuse is one of the more controversial issues in the field of child maltreatment; there is much debate over its existence, prevalence, and the veracity of child victims' accounts (Kelley 1996). Ritualistic abuse has been defined as abuse that occurs when some religious, magical, or supernatural connotations are used in conjunction with the fear and intimidation of children (Finkelhor, Williams, and Burns 1988). Lloyd (1991) has defined it as the intentional, repeated, and stylized abuse of a child by a person responsible for the child's welfare, typified by such other acts as cruelty to animals, or threats of harm to the child or others. In 1994, the National Center on Child Abuse and Neglect funded a study on ritualistic abuse in the United States, and found that 31 percent of mental health professionals surveyed had encountered a ritualistic abuse case. They also found that 23 percent of protective service and law enforcement agencies had encountered at least one case of ritualistic or religion-based child abuse (Goodman, Bottoms, and Shaver 1994).

Allegations of ritualistic abuse typically involve reports of forced sexual activity; physical abuse or torture; ingestion of blood, semen, or excrement; ingestion of drugs; threats of violence or death; threats with supernatural powers; satanic reference or paraphernalia; witnessing animal mutilations; and killing of adults and children (Kelley 1996). Research has found that children who reported ritualistic abuse had greater symptomatology than children who only experienced sexual abuse (Finkelhor *et al.* 1988). Reports of ritualistic abuse are consistently associated with increased impact on and traumatization of victims (Watermann *et al.* 1993; Briere 1988; Kelley 1989).

In Utero and Postnatal Drug and Alcohol Exposure

Substance abuse affects infant and child development in numerous ways. Exposure to drugs and alcohol in utero often leads to difficulties with self-regulation, attention, and lifelong social and learning problems. The environmental aspects of substance abuse are damaging, including impoverished and chaotic living conditions, malnutrition, lack of prenatal care, and unstable life styles. Physical consequences involve exposure to toxic fumes, accessible drugs, and weapons. Family environments are characterized by lack of supervision and care due to unavailable caregivers, and children without parental protection from dangerous people, leaving children vulnerable to physical and sexual abuse (Bates and Huston 2007; Bromberg and Frankel 2011). Substance abuse is highly correlated with domestic violence, and up to 70 percent of children have also been abused by

the same perpetrator. Witnessing their mother's abuse is extremely traumatic for children (Bates and Hutson 2007). These infants and children are at risk of disrupted attachment patterns and PTSD.

Many treatment and early intervention programs focus on parent–child relationships, not only on the substance abusing adult. Caregivers have a lack of basic parenting knowledge, are typically insensitive, angry, and intrusive, are highly stressed, and have conflictual and chaotic relationships. These mothers are unable to care for their children because of their own histories of trauma and disrupted attachment, and use substances to cope with their pain. One program that concentrates on the mother–child relationship and family system is the Harris Program in Child Development and Infant Mental Health at the University of Colorado School of Medicine (Bromberg *et al.* 2010). This training and treatment program emphasizes the health of the parent–child relationship, the caregiver's internal working model based on childhood attachment experiences, parent education, and developmental assessment and therapy for children. The goal is to interrupt intergenerational cycles of abuse and facilitate secure attachment relationships.

The impact on children, both prenatally and postnatally, of exposure to drugs and alcohol is a major public health problem and definitely a form of child abuse. Psychoactive substances used during pregnancy can affect the developing brain and cause future learning, behavioral, developmental, and physiological problems. An estimated 625,000 newborns each year are exposed to drugs prenatally; 10 to 17 percent of the women used cocaine during pregnancy (Jaudes and Ekwo 1997).

The increase in out-of-home placements parallels the explosion of substance abuse. One study found that one-third of substance-exposed infants had out-of-home placements and were extremely vulnerable to death in the first few years of life (Jaudes and Ekwo 1997). The number of substantiated reports of maltreatment was three times higher for substance-exposed infants than nonexposed. The costs are not only emotional and physical, but also economic. The average hospital cost for delivery and care is $13,200 for a cocaine-exposed infant, compared to $1300 for a drug-free baby (Calhoun and Watson 1991).

Fetal alcohol syndrome (FAS) is the result of excessive alcohol consumption by mothers during pregnancy, which causes physiological damage to the brain and body. Symptoms include prenatal and postnatal growth deficits, central nervous system dysfunction, specific facial characteristics, and body malformation. Children who display all the symptoms are considered to have fetal alcohol syndrome, while those who display some are diagnosed with fetal alcohol effects (FAE). Learning and behavioral disorders that result from FAS/E include poor impulse control; attention deficit disorder (with or without hyperactivity); speech and language disorders; poor short-term

memory; lack of cause and effect thinking; poor personal boundaries; anger-management difficulty, poor judgment; and no connection to societal rules (McCreight 1997).

Psychoactive substances cross the placenta and the blood–brain barrier. Use of cocaine, alcohol, and narcotics during pregnancy are all associated with smaller head circumference in the newborn, indicating a potential structural effect on the brain. Infants exposed to cocaine have a higher risk of premature birth and low birth weight (Zuckerman 1994; Jaudes and Ekwo 1997). Cigarette smoking diminishes the blood flow to the placenta and can lead to prematurity. Methamphetamine is comparable to cocaine in its negative effects on the fetus, and can cause developmental and behavioral problems in children. Heroin and other narcotics may lead to over-withdrawal in the newborn as well as developmental abnormalities (Alexander and Moskal 1997).

Prenatal and postnatal drug exposure affects development and attachment. For example, an infant or toddler with FAS/E characteristics may not be able to experience the care and nurturance that may be available from caregivers, thereby disrupting the attachment process. Children exposed to drugs in utero were found to have depressed developmental scores at 6 months, which continued through 24 months of age. The postnatal environment, however, has an important impact. One hundred percent of children living with drug-using mothers showed attachment disorders, including avoidance, fear, and anger toward their mothers. The majority of children (64 percent) of mothers who stopped using drugs after birth displayed secure attachments (Howard 1994).

Impact of Childhood Trauma

Although every child is unique, there are a number of factors that determine the biopsychosocial impact that trauma has on children. These factors are listed below:

- severity of the traumatic event
- developmental stage: younger children are more vulnerable
- genetic predispositions
- perception: every experience is unique; child's cognitive appraisal
- premorbid functioning: child's trauma history
- family functioning: caregiver response to traumatic event
- attachment history: secure attachment mitigates negative impact

- intervention: the sooner the better; reduces defenses and enhances coping skills.

Developmental Issues and Trauma

In order to understand and help children with histories of maltreatment and compromised attachment it is crucial to focus on developmental issues. Emotional and behavioral reactions to trauma are associated with the child's ability to understand and internalize experiences, which depend on the child's stage of emotional and cognitive development. For instance, children typically feel responsible for maltreatment, as if they caused the abuse or neglect to occur. This contributes to the development of the child's negative internal working model: "I'm bad, unworthy of love, defective."

A developmental perspective focuses on how development occurs over time among psychological, biological, and social systems. Development consists of a series of age- and stage-relevant tasks that are essential to learn. Learning early stage-salient tasks increases the likelihood that subsequent developmental issues and tasks will be mastered successfully.

The development of attachment relationships is a stage-salient task that is essential in the first few years of life and continues to affect development into adulthood. Secure attachment in the early stages leads to the mastery of many skills and abilities as development unfolds. For example, children with secure attachments have more trust in others, confidence, success in relationships with family, peers, and teachers, behavioral and academic competency, and positivity in their views of self and others (Toth, Manly, and Hathaway 2011).

Neurobiology of Trauma and Attachment

Trauma affects children on many levels of biological functioning. Threats to the infant and young child that are of sufficient intensity, duration, or frequency, such as abuse, neglect, and anxious–disorganized attachment, trigger an alarm reaction ("fight, flight, freeze"). This instinctual response to real or perceived danger is a normal response to acute stress. Traumatic experiences during infancy and childhood, however, can trigger prolonged alarm reactions, which alter the neurobiology of the brain and central nervous system. The brain develops sequentially, with the vast majority of structural organization occurring in childhood. Thus, early life experiences have a disproportionate influence on the developing brain. Lack of critical nurturing and exposure to traumatic stress and abuse alters the nervous system, predisposing the child to be impulsive, overreactive, and violent (Perry 1994, 1995; Schore 2012).

Interpersonal trauma, lack of stress-reducing secure attachment, and chronic activation of fear often results in PTSD in children. PTSD develops in children, adolescents, and adults following extremely stressful and frightening events, such as abuse, violence, or a disaster, during which the person feels helplessness, fear, and horror. The diagnosis of PTSD requires three criteria: 1) *reexperiencing*, such as flashbacks, nightmares, and memories; 2) *avoidance and numbing*, including dissociation and avoidance of trauma reminders; and 3) *hyperarousal*, involving impulsivity, agitation, and hypervigilance. Additional symptoms include physical problems (e.g., headaches, stomach pain), sleep disturbance, eating disorders, depression, anxiety, and substance abuse. The symptoms are both psychological and biological. Maltreatment and compromised attachment activates the stress response, increasing heart rate, respiration, and the release of stress hormones. The child remains in a heightened state of anxiety, leading to emotional, cognitive, and physical problems.

Interpersonal Neurobiology

The relatively new field of interpersonal neurobiology is a developmental theory that integrates psychology and biology (Siegel 1999; Cozolino 2006; Arden and Linford 2009; Schore 2012). The focus is on the early stages of life, which are central to building the brain's structures and functions. During the "decade of the brain"—from about 1995 to 2005—new technologies, such as MRI, enabled researchers to learn about the brain as it processes internal and external information. The essence of these studies is clear and now widely accepted in the mental health field: in utero and early postnatal experiences shape brain development and the children, adults, and parents we become. The infant's attachment relationships play a primary role in shaping the developing brain and the neuronal connections in the brain.

Brain development begins two weeks after conception and continues most rapidly during the first three years of life. Our brains are basically social in nature. Prenatal stress produces increased norepinephrine (arousal and agitation) and decreased levels of dopamine and serotonin (depression, anxiety, emotional dysregulation). Brain circuits are being created rapidly in the early stages, and are largely determined by the quality of the infant–caregiver relationship and the level of stress. Babies are right-hemisphere dominant, responding primarily to preverbal and nonverbal emotional communication—facial expressions, mutual gaze, touch, tone of voice, and in arms security and safety. The infant's right brain and the attachment figure's right brain are in-synch and attuned during moments of connection. This "limbic resonance" is the fundamental building block of secure attachment, and leads to the child's ability to self-regulate and to the formation of the

child's core beliefs (i.e., internal working model). The sensitive caregiver calms, soothes, and down-regulates the baby's emotions and physical stress response, and later the child learns self-regulation. Early experiences of secure or insecure attachment are encoded into the implicit (preverbal and unconscious) memory systems in the limbic brain, and become mindsets and expectations that guide subsequent behavior (e.g., attachment figures are safe or unsafe, accepting or rejecting). Studies have found that infant attachment security predicts self-control six years later (Olson, Bates, and Bayles 1990).

Prenatal brain development is influenced by genetics and environment. Poor nutrition, drugs and alcohol, chronic maternal stress, and other environmental factors can have adverse effects on the fetus's brain. Most postnatal brain development is experience dependent; the brain (especially the limbic system) is an *open-loop system*—it relies on attuned and sensitive caring from attachment figures for healthy growth and functioning (Tierney and Nelson 2009). Relationship experiences wire the brain circuits, affecting the structure, chemistry, and genetic expression of the brain.

Neurons are brain cells that play a central role in processing and communicating information. Communication between neurons occurs via neurotransmitters that excite or inhibit electrical and chemical messages. Relationship experiences of the infant and young child develop into neural networks that determine thoughts, moods, behaviors and attachment style: *what fires together, wires together* (Badenoch 2008).

Children deprived of quality relationships have abnormal brain development, as illustrated by the findings demonstrated by the Bucharest Early Intervention Project (Zeanah *et al.* 2003). This research follows three groups of children: 1) institutionalized group—children living in an orphanage all their lives; 2) foster care group—children institutionalized at birth then placed in foster care at a mean age of 22 months; and 3) never institutionalized group—children living with their biological parents in the Bucharest, Romania area. The institutionalized children have stunted and delayed patterns of brain activity, cognitive development, and physical growth. Children placed in foster care before age 2 show patterns of brain activity similar to never institutionalized children, indicating the importance of placing children early to reduce the negative effects of deprivation. This study confirms that placing babies in institutional settings can have dire consequences for brain function, and these effects are worse for children older than 2 years (Marshall *et al.* 2008).

Limbic System

The limbic system is the social and emotional part of the brain, governing attachment, nurturing instincts, learning, implicit memory (preverbal,

unconscious), motivation, stress response, and the immune system. The circuits of the limbic brain are wired together almost entirely by attachment experiences, and are altered by stress and trauma. In other words, the neurons of the limbic regions are genetically programmed to connect with one another via early child–caregiver interactions. The primary structures of the limbic system are:

- *Amygdala:* Regulating emotion, learning, memory, interpreting facial expressions, and fear conditioning, it serves as an "alarm bell" activated by threatening and frightening experiences. It is programmed to respond to fear and potential threat. It is where *implicit memory* is created and stored, in utero and during the first 18 months of life.
- *Hippocampus:* This organizes *explicit memory*, in concert with the cerebral cortex, which allows us to remember facts and autobiographical events consciously. By around age 2, a child is learning language, has conscious awareness, and can remember him- or herself in a specific past event. The hippocampus is also vital to retrieving information encoded in the past; it can become impaired due to chronic stress, which can affect the ability to accurately remember.
- *Hypothalamus:* Interacting with the pituitary, it regulates the autonomic nervous system and neuroendocrine system by releasing hormones and neurotransmitters, such as oxytocin (the bonding chemical). It regulates primal drives and functions, including hunger, sexual arousal, blood pressure, heart rate, thirst, and the sleep–wake cycle.
- *Middle prefrontal regions:* Located at the intersection of the brain stem, limbic system, and cortex, they include the anterior cingulate, orbitofrontal cortex, cingulate gyrus, and the prefrontal cortex. These structures play a key role in modulating attention, self-regulation, awareness, and the integration of cognitive and emotional information.
- *Thalamus:* A major relay station to the cerebral cortex, it sends signals to the brain stem to stimulate the release of norepinephrine throughout the brain, resulting in alertness and arousal.

Neurochemicals

The brain and nervous system are composed of billions of neurons, which form connections with many other neurons to create a neural network. Neurons communicate with one another between gaps, or synapses, via electrical and chemical messages. Neurons that fire together become wired together. Over time, the brain circuits and networks that result from these firings lead to "wiring" of the brain. The social and emotional environment of

the infant—early attachment experiences—are critical to the development of those neural networks. Changes in the wiring of brain circuits can occur at any time in life as a result of new and healing experiences (neuroplasticity). The following is a list of the most significant neurochemicals that relate to attachment, mood, behavior, and stress:

- *cortisol:* Released by the adrenal glands during the stress response; increases heart rate and blood pressure and results in arousal and anxiety.
- *dopamine:* Associated with attention, motivation, bonding, and pleasure; drugs such as cocaine and methamphetamines trigger the release of dopamine; mobilizes the body for fight, flight, freeze response.
- *serotonin:* Affects mood, impulse control, and survival; plays a key role in depression, aggression, and anxiety; selective serotonin reuptake inhibitors (SSRIs) are popular antidepressants and increase serotonin flow.
- *norepinephrine:* Regulates arousal, alertness, attention, and motivation; makes senses more alert under stress.
- *epinephrine (adrenaline):* Prepares us for danger or threat by focusing attention, sharpening senses, and increasing fear.
- *neuropeptides:* Endorphins buffer stress, reduce pain, and increase pleasure (e.g., runner's high). Endorphins increase during parent–child connection.
- *oxytocin:* Promotes maternal behavior (nurturing, nursing) toward children. Loving touch increases oxytocin in the blood of caregivers.
- *vasopressin:* Also plays a role in bonding and attachment, as well as inhibiting fear and reducing stress hormones.

Stress Response

The stress response is critical to the understanding of the neurobiology of trauma and attachment disorder. Stress is an automatic physiological response to any situation that is threatening, overwhelming, or requires adjustment to change. The stress response includes many physical changes, including increased heart rate and breathing, and inhibited digestion and immune response, triggered by stress hormones released in response to real or perceived danger (i.e., fight, flight, freeze). This survival-based alarm system helped our primitive ancestors deal with their environment. When they encountered danger they had extra energy and strength to attack or

escape. When the danger passed the stress response would abate. However, when the stress response is chronically triggered, such as during childhood maltreatment and compromised attachment, key biological systems become altered and dysregulated. Chronic stress is linked not only to many mental health problems, such as anxiety and depression, but also to numerous physical health problems, including heart disease, ulcers, and asthma.

There are three interrelated components of the human stress response: *catecholamines*, *HPA axis*, and *immune system response*. Catecholamines include epinephrine, norepinephrine, and dopamine, which are released by the sympathetic nervous system in response to threat. The hypothalamic–pituitary–adrenal (HPA) axis responds with a cascade of stress biochemicals. The hypothalamus releases corticotrophin-releasing hormone (CRH), which triggers the pituitary to release adrenocorticotropic hormone (ACTH), finally causing the adrenal glands to activate the flow of cortisol, raising the blood glucose level to respond to threat. The third portion of the stress response involves the immune system. Elevated levels of stress hormones depress immune function. Under normal conditions, the immune system releases proinflammatory cytokines, which increase inflammation to help the body heal wounds and fight infection. Severe and chronic stress causes inflammation levels to be abnormally high, resulting in vulnerability to physical problems and disease. Research on Psychoneuroimmunology (PNI), which focuses on the mind–body connection, has found that people who suffer trauma have higher rates of serious illnesses than the general population. The Adverse Childhood Experiences (ACE) study found that adults who experienced trauma and disrupted attachment as children—including physical and sexual abuse, and parental mental illness, substance abuse, and criminal behavior—had higher rates of cancer, heart disease, bronchitis, diabetes, stroke, and gastrointestinal disorders, than nontraumatized adults (Felitti *et al.* 1998). Similar outcomes have been found in other studies: women maltreated as children had a ninefold increase in heart disease; 60 percent of women treated for gastrointestinal illness had an abuse history; significantly higher rates of chronic pain, chronic fatigue syndrome, and fibromyalgia occurred when there was a history of trauma and PTSD diagnoses (Kendall-Tackett 2009).

"How I Feel"

Two parts of the primitive "old brain" (limbic system), the amygdala and hippocampus, are particularly involved with the processing of emotion, memory, and fear responses. The amygdala evaluates the emotional meaning of incoming stimuli and is the storehouse of emotional memory. The hippocampus records in memory the spatial and temporal dimensions of experience and plays an important role in categorizing and storing stimuli into short-term memory. During times of threat or danger, the amygdala reacts instantaneously, bypassing the rational brain (neocortex), and triggering an alarm reaction:

- activating the hypothalamus, which secretes corticotropin-releasing hormone (CRH)
- stimulating the autonomic nervous system (ANS), which affects movements
- raising heart rate and blood pressure, and slowing breathing
- signaling the *locus ceruleus* in the brain stem to release norepinephrine, which heightens overall brain reactivity, releasing dopamine that causes the riveting of attention on the source of fear (LeDoux 1992; Goleman 1995; Arden and Linford 2009).

The amygdala is most fully formed at birth and matures rapidly in the infant's brain. Thus, traumatic experiences such as abuse, neglect, and anxious attachment, are stored in preverbal memory. These memories are intense perceptual experiences and later in life intrude on awareness in the form of hypervigilance, nightmares, hyperarousal, and anxiety.

Biochemical and hormonal reactions occur in children during traumatic stress that produce long-term changes in the mind–body system. In a series

of studies on the effects of sexual abuse on young girls, researchers found three areas of physiological change:

- higher levels of catacholamines (the neurotransmitters epinephrine, norepinephrine, and dopamine), which cause hyperarousal
- dysregulation of the HPA (hypothalamic–pituitary–adrenal) axis, which releases ACTH and cortisol, and prepares the body for the alarm reaction
- twice the normal level of ANA (antinuclear antibody), which leads to impaired immune system functioning (Putnam 1991, 1995; DeAngelis 1995).

Perry (1994) reviewed numerous studies on the effects of trauma and the alarm reaction in children. Again, he reports that this reaction involves the brain, autonomic nervous system, HPA axis, and the immune system. The brain stem neurtransmitters, or catecholamines, were found to play a major role in PTSD, anxiety disorders, and affective disorders. The abnormal persistence of the alarm reaction results in a dysfunctional and maladaptive set of brain activities. This process is extremely costly in terms of the energy required to trigger and sustain the physiological responses. Additionally, persistent threat can "redefine" the baseline level of the central nervous system, resulting in hypervigilance and hyperarousal.

Another leading researcher in the field of trauma, Bessel van der Kolk, reviewed the literature on the psychobiology of trauma and attachment. He writes, "Secure attachment bonds serve as primary defenses against trauma-induced psychopathology … the quality of the parental bond is probably the single most important determinant of long-term damage" (van der Kolk 1996, p.185). He compares attachment and trauma in children in reference to physiological regulation/dysregulation, and the instinctual neurobiological reaction in the "old brain" (brain stem and limbic system). The psychobiological effects of severe trauma, according to van der Kolk (1996, 2003), include the following:

- extreme autonomic responses to stimuli reminiscent of the trauma
- hyperarousal to intense but neutral stimuli (loss of stimulus discrimination)
- elevated catecholamines, including norepinephrine
- decreased glucocorticoids, which provokes the stress response
- decreased serotonin levels, associated with inability to modulate arousal and increased aggression

- shrinkage of the hippocampus due to heightened levels of cortisol, resulting in impaired declarative memory (conscious awareness of facts or events) and skill-based memory
- activation of the amygdala and deactivation of the Broca's area during flashbacks, reflecting reexperiencing of trauma and difficulty with verbal emotional expression.

Working Assumptions: The Child with Attachment Disorder

While it is common for traumatized children to display both caregiving and punitive control behavior, it is the latter form—angry, manipulative, threatening, and coercive control—that is most typical of children who are the focus of our work. Therapy with these youngsters and their parents (usually adoptive), as well as consulting with social services and therapeutic foster parents, has led us to the following working assumptions and conclusions:

- *The child's controlling–punitive orientation is a major defense linked to survival:* The child truly believes he or she will not survive without controlling and distancing others, especially caregivers. This control strategy is a form of compensation for lack of trust and internal control. Since these children have not learned to effectively regulate their own emotions and impulses, they focus on regulating and controlling their outer world.
- *A feeling of empowerment accompanies controlling, oppositional, and defiant behavior:* Parental caregiving and limit setting is perceived as a threat, rather than as an opportunity for need fulfillment or learning. Efforts to care for or help the child are filtered through the child's negative working model and are interpreted as abuse, rejection, or control. When a caregiver or therapist provides support or shows affection toward the child, the reaction is often an increase in hostile, punitive, and controlling behavior.
- *Reciprocity in relationships is extremely limited:* These children avoid needing others, asking for help, and many forms of positive interaction. They have difficulty accepting praise, affection, and love. They do not believe that caregivers possess nurturing qualities, or that they themselves are worthy of love and caring. Relationships are a "one-way street"; they believe that distancing and controlling others is the only safe way to relate.
- *Adoptive parents, foster parents, and counselors are often frustrated when dealing with these children:* Many parents are afraid of their children

("Will he or she burn the house down, stab me while I sleep?"), and there is typically a history of various treatment failures. Foster parents often request that these children be removed from their home. Adoptive parents contemplate and sometimes follow through with relinquishment.

- *There are both historical and current family factors that contribute to the child's problems:* The child's family of origin was typically abusive, neglectful, violent, and chaotic, with one or both biological parents having antisocial and criminal profiles, severe depression and/or other emotional disorders, substance abuse problems, and histories of maltreatment in their own childhoods. The dynamics of their current family are also problematic. Adoptive parents are commonly angry and "burned-out," unresolved family-of-origin issues and marital distress are common, and dealing with the child is so difficult and frustrating that the parents can become rejecting, abusive, and/or depressed. This enables the child to feel a sense of control ("I can frustrate my parents"), and replicates the "victim" scenario from earlier years.
- *Genetic and biological factors are relevant:* There is typically an intergenerational history of biologically based conditions in the birth families (e.g., unipolar or bipolar depression, severe mental disorders). These conditions contribute to extremely dysfunctional parenting practices, as well as problematic traits and symptoms in the children.
- *Parenting concepts and strategies that are recommended by mental health professionals are often ineffective:* Approaches such as time out, reinforcing positive behavior, and verbal communication do not succeed in changing the child's negative attitudes or antagonistic behavior. Parents have lost faith in the mental health and social service systems, and feel helpless and hopeless regarding any positive outcome.

6

Assessment

Basic Concepts and Assumptions

Assessment procedures and diagnostic categories are not helpful if merely used to label a child or parent, while ignoring the strengths, coping capacities, and desire for growth and development inherent in most people. Rather, systems of classification are useful in identifying symptoms, challenges, and abilities necessary for planning and implementing effective treatment and parenting interventions. Children's functioning is greatly influenced by the quality of their environments. A child with a particular diagnosis can behave differently depending on the level of emotional support, cognitive stimulation, form of structure and discipline, and sense of well-being or stress (Lieberman, Wiedes, and Fenichel 1997).

Effective assessment must be comprehensive—based on as complete an understanding of the child and family as is possible (Levy and Orlans 1995). There are three aspects to a comprehensive assessment:

- First, assessments are ecological, i.e., children live and develop within relationships (usually family), and families are part of larger social, community, and cultural systems. There must be an understanding of historical and current caregiver influences, as well as external social forces (e.g., extended family, child welfare system).
- Second, assessment must focus on numerous and diverse facets of the child's and family's functioning (e.g., six symptom categories outlined later in this chapter).
- Third, assessments of the child and family involve a variety of methods and settings. Multimethods provide more information and increased reliability of findings. Behavior and functioning often vary in different environments, and it is important to observe these varying responses as a part of treatment planning (e.g., home, school, therapeutic foster

> home, therapy session). Therapeutic interventions may be ineffective, or even destructive, if introduced prior to a comprehensive assessment of the child and family (Pearce and Pezzot-Pearce 1997; Zero to Three 1994).

It is difficult to separate assessment and therapy; assessment is part of treatment, and treatment involves ongoing assessment. Assessment is the first stage in the therapeutic process, that is, establishing rapport and building a collaborative alliance. For example, parents and caregivers receive support and empathy during assessment, which often reduces their anxiety, hopelessness, and guilt. Children receive limits, safety, empathy, and support, necessary to initiate the process of change and healing. Assessment occurs at regular intervals during each session and throughout the course of the treatment. This model utilizes continuous feedback in order to develop optimally effective interventions: *assess* → *goals* → *intervene* → *reassess*.

Effective assessment is developmentally and culturally sensitive. Symptoms and behavior patterns must be evaluated in the context of normal childhood development. The developmental stage of the child during attachment trauma will determine, to a large extent, the subsequent psychosocial effects. Understanding the child's current developmental stage will help the clinician determine appropriate assessment and intervention methods. The clinician must be careful not to apply his or her own beliefs and traditions to family members from different cultural backgrounds. For example, eye contact is considered a form of intimacy in some cultures, while others consider it rude and inappropriate. Additionally, individual differences must be considered; children vary in sensorimotor, cognitive, affective, and interpersonal patterns of development.

Assessment is based on a variety of theories and paradigms: developmental, psychodynamic, family systems, and attachment theory. Since attachment disorder is basically a relationship disturbance, it is crucial to evaluate the relationship between the child and current caregiver(s). This provides valuable insight into prior attachment experiences (e.g., birth parents), as the child projects those prior patterns onto current attachment figures. The child's internal working model is also a primary assessment focus. These core beliefs and expectations regarding self, caregivers, and the world in general, formed in the early attachment relationships, influence ongoing behavior, emotion, and relationship patterns.

Pillars of Assessment

Assessment and diagnosis of attachment disorder and interpersonal trauma rest on three pillars: 1) *developmental history*; 2) *symptoms and diagnoses*

(current and previous); and 3) the *attachment history of parents/caregivers* (e.g., adoptive parents). The specifics of these three pillars are described in this chapter in the sections on child, parent, and family assessment, and the six symptom categories.

Early history and symptomology provide the initial diagnosis prior to treatment, and are gleaned from the intake packet (Table 6.1; see Appendix A for a sample intake packet reproduced from the online application forms for the Evergreen Psychotherapy Centre's Attachment Treatment and Training Institute, www.attachmentexperts.com). Once treatment begins, however, direct observation of the child's attitudes and behaviors with attachment figures is primary. Direct observation of relationship patterns, as well as parental descriptions of interactions in the home, enable the clinician to focus on specific signs of attachment disorder. Table 6.2 summarizes important behaviors in the assessment of attachment disorder in young children (adapted from Zeanah, Mammen, and Lieberman 1993). Attachment disorder occurs as a result of a variety of factors, which can be grouped into three major categories: caregiver, child, and environmental contributions. These etiological factors, listed in Table 6.3, place children at risk of development of attachment disorder.

Assessment information is collected from several sources: adult reports and checklists (e.g., see Appendix A for a symptom checklist); clinical observations (e.g., parent–child interactions in therapy); and psychodiagnostic data (e.g., prior testing and social history).

Table 6.1 Intake Packet

• Symptom checklist: completed by parents, caregivers, teachers, and/or caseworkers
• Descriptive explanation of each symptom on checklist
• History: developmental, birth family, moves and disruptions, current family, social, and medical
• Parents' autobiography: attachment and family history
• Schools: current and historical issues
• Psychodiagnostic testing: prior results, diagnoses, and recommendations
• Psychotherapy and medication: prior and current

Table 6.2 Signs of Attachment Disorder in Young Children

• Showing affection ◦ Lack of warm and affectionate interactions ◦ Indiscriminate affection with unfamiliar adults
• Comfort seeking ◦ Lack of comfort seeking when frightened, hurt, or ill ◦ Comfort seeking in odd or ambivalent manner
• Reliance for help ◦ Excessive dependence ◦ Does not seek or use attachment figure for support when needed
• Cooperation ◦ Lack of compliance with caregiver requests ◦ Excessively demanding ◦ Compulsive compliance
• Exploratory behavior ◦ Failure to check back with caregiver in unfamiliar surroundings ◦ Exploration limited by unwillingness to leave caregiver
• Controlling behavior ◦ Excessively bossy and punitive controlling of caregiver ◦ Oversolicitous and inappropriate caregiving behavior toward caregiver
• Reunion responses ◦ Failure to reestablish interaction after separation ◦ Includes ignoring and avoiding, intense anger, lack of affection

The relevant areas of child and family functioning to focus on include the following:

- presenting symptoms and problems: individual and in social context
- developmental history: biological, psychological, and social background; attachment history; pre-, peri-, and postnatal factors
- internal working model: child and caregivers (prior and current)
- current parents/caregivers: attachment history, psychosocial functioning, marital and other significant relationships
- child–caregiver relationship patterns
- family, community, and cultural systems
- current environmental conditions and stressors.

Table 6.3 Causes of Attachment Disorder

- Parental/caregiver contributions
    - Abuse and/or neglect
    - Ineffective and insensitive care
    - Depression: unipolar, bipolar, postpartum
    - Severe and/or chronic psychological disturbances: biological and/or emotional; Axis II diagnoses
    - Teenage parenting
    - Substance abuse
    - Intergenerational attachment difficulties: unresolved family-of-origin issues, history of separation, loss, maltreatment
    - Prolonged absence: prison, hospital, desertion

- Child contributions
    - Difficult temperament; lack of "fit" with parents or caregivers
    - Premature birth
    - Medical conditions; unrelieved pain (e.g., inner ear), colicky
    - Hospitalizations: separation and loss
    - Failure to thrive syndrome
    - Congenital and/or biological problems: neurological impairment, fetal alcohol syndrome, in utero drug exposure, physical handicaps
    - Genetic factors: family history of mental illness, depression, aggression, criminality, substance abuse, antisocial personality

- Environmental contributions
    - Poverty
    - Violence: victim and/or witness
    - Lack of support: absent father and extended kin, isolation, lack of services
    - Multiple out-of-home placements: moves in foster care system, multiple caregivers
    - High stress: marital conflict, family disorganization and chaos, violent community
    - Lack of stimulation

Attachment Disorder Classifications

The DSM–IV (APA 1994) described two types of attachment disorder of infancy and early childhood:

- *Inhibited*: In which ambivalent, contradictory, inhibited, or hypervigilant responses occur with the caregiver (e.g., resistance to comforting).
- *Disinhibited*: Includes indiscriminate oversociability and lack of selective attachments (e.g., excessive familiarity with strangers).

Both types refer to a markedly disturbed and developmentally inappropriate social relatedness, beginning prior to age 5. This diagnosis requires a history of pathogenic care, evidenced by at least one of the following:

- persistent disregard of child's basic emotional needs for comfort, stimulation, and affection
- persistent disregard of child's basic physical needs
- repeated changes of primary caregivers that prevent the formation of stable attachments.

DSM-V (American Psychiatric Association 2013) has a new diagnostic category, *trauma- and stress-related disorders*, which includes reactive attachment disorder, disinhibited social engagement disorder, PTSD, acute stress disorder, and adjustment disorders. Although reactive attachment disorder and disinhibited social engagement disorder share a common etiology—the absence of adequate caregiving during early stages of development—the former is expressed as an internalizing disorder with withdrawn behavior and depression, while the latter is marked by disinhibition and eternalizing behavior.

- *Reactive Attachment Disorder:* Reactive attachment disorder of infancy and early childhood is characterized by disturbed and developmentally inappropriate attachment behaviors, in which a child fails to turn preferentially to the attachment figure for comfort, support, protection, and nurturance. These children show a lack of positive emotions during interactions with caregivers, their emotional regulation capacity is compromised, and they display negative emotions of fear, sadness, and irritability that are not readily explained, even during nonthreatening interactions with caregivers. They have experienced neglect and deprivation, and a persistent lack of having needs for comfort, stimulation, and affection met by caregivers. They typically had repeated changes of primary caregivers (e.g., moving foster homes) and/or were reared in institutional settings (e.g., orphanages).

- *Disinhibited Social Engagement Disorder:* The essential feature of disinhibited social engagement disorder is a pattern of behavior that involves culturally inappropriate and overly familiar behavior with relative strangers (i.e., lack of "stranger anxiety"). They will talk to, have physical contact with, and go off with unfamiliar adults with no hesitation. They do not check back with caregivers after venturing away (i.e., lack of "secure base behavior"). As with reactive attachment disorder, they experienced extremes of insufficient care by caregivers and were often placed in foster care and/or institutions (e.g., orphanages).

Numerous studies have shown that interpersonal trauma (e.g., abuse, neglect, abandonment, witnessing violence, disrupted attachments) can seriously alter psychological, social, cognitive, and biological development. The National Child Traumatic Stress Network (Pynoos *et al.* 2008), a task force of numerous researchers and clinicians, has endeavored to improve diagnosis and treatment by focusing on the developmental effects of interpersonal trauma. The diagnosis of *developmental trauma disorder* includes the following predictable consequences that affect many areas of functioning (D'Andrea *et al.* 2012):

- *Dysregulation of affect and behavior*
    - flat or numbed affect, explosive anger, inappropriate affect, depression
    - withdrawal, aggression, impulsivity, defiance, self-injury, substance abuse
    - difficulty understanding and expressing emotions, acutely sensitive to perceiving facial cues connoting anger and rejection
    - anxiety and eating disorders
- *Disturbances of attention and consciousness*
    - dissociation, depersonalization, memory disturbance, inability to concentrate
    - disrupted executive functioning (e.g., inability to problem-solve and plan)
    - overall disruption in ability to maintain attention and integrate cognitive functioning
- *Distortions in attributions*
    - negative belief systems and cognitive styles (e.g., negative internal working models) about themselves, others, and the world, leading to shame, guilt, and self-blame

    - distorted locus of control (e.g., "I caused abuse, I'm not worthy of love, I can't change or succeed"), low self-esteem and self-worth, identity confusion

- *Interpersonal difficulties*
    - anxious, avoidant, and disorganized attachment styles, inability to trust, poor social skills, difficulty understanding social interactions (e.g., misinterpreting social cues)
    - expectation of harm from others, poor boundaries, social isolation, interpersonal conflict and lifelong relationship problems.

Lieberman and Pawl (1988) clarified the clinical manifestations of attachment disorder in the context of assessment and treatment of infants and their parents in an infant mental health program. They emphasized the characteristics of the child–caregiver relationship, as well as chronic situational stresses, and described three types of attachment disorder:

- *Nonattachment:* Infants have been reared with no opportunity to form emotional connections with caregivers, which results in severe impairment in their capacity to form relationships, cognitive functioning, and impulse control.
- *Anxious/ambivalent:* The infant was able to form a relationship with an attachment figure, but it was characterized by severe conflict regarding emotional and physical availability.
- *Disrupted attachment:* Considerable and damaging separation and loss with attachment figure(s) has provoked intense anxiety and long-term negative consequences for development and trust.

Zeanah *et al.* (1993) suggested that disorders of attachment represent profound and pervasive disturbances in the child's feelings of safety and security. Referring to the diagnostic categories in the DSM-IV, they state, "Our clinical experiences suggest that the disorders as defined do not adequately capture the presentations of disordered attachment" (Zeanah *et al.* 1993, p.337). They proposed criteria for five types of attachment disorder:

- *Nonattached:* Failure to develop a preferred attachment figure.
- *Indiscriminate:* Fails to check back with caregiver in unfamiliar settings and fails to use attachment figure as secure base when frightened. May be indiscriminately friendly and/or reckless and accident-prone.
- *Inhibited:* Unwilling to venture away from attachment figure to engage in age-appropriate exploration. May display excessive clinging or compulsive compliance.

- *Aggressive:* Anger and aggression are pervasive features of the relationship with attachment figure. May also be angry and aggressive with others and toward self.
- *Role-reversal:* Controlling behaviors toward caregiver(s), either caregiving (e.g., oversolicitous) or punitive (e.g., bossy, rejecting, hostile). Child assumes roles and responsibilities ordinarily assumed by parent.

The Diagnostic Classification Task Force of the National Center for Clinical Infant Programs developed the *Diagnostic Classification: 0–3* (Zero to Three 1994). This assessment and evaluation system was designed to serve as a guide for clinicians and researchers to facilitate diagnosis, treatment planning, professional communication, and further research. It utilized the following mutiaxial classification system:

- *Axis I:* Primary classification (e.g., traumatic stress disorder, reactive attachment deprivation/maltreatment disorder).
- *Axis II:* Relationship classification (e.g., overinvolved, underinvolved, abusive).
- *Axis III:* Physical, neurological, developmental, and mental health disorders (e.g., language disorders, chronic otitis media, failure to thrive).
- *Axis IV:* Psychosocial stressors (e.g., abuse, foster placements, neglect, parental illness, violence in environment).
- *Axis V:* Functional emotional developmental level (e.g., capacity for mutual attention and engagement, reciprocity, symbolic and affective communication).

Zero to Three's diagnostic classification system was based on three primary principles. The first principle is that children's psychosocial functioning develops in the context of their interactions and relationships. The second principle is that individual differences in temperament and constitutional strengths and vulnerabilities play a major role in how children experience and process life. Caregivers' responses, including their acceptance, nurturance, and skill in dealing with areas of difficulty, can transform early challenges and risk factors so that they do not handicap development. The third principle is the importance of understanding the family's cultural context regarding the child's functioning and development (Lieberman *et al.* 1997).

Assessment of the Child

Child assessment focuses on symptoms, developmental history, internal working model, and current relationships, as outlined in Table 6.4. Attachment disorder is, in essence, a relationship disturbance. Therefore, it is necessary to understand the child in the context of historical and current family and other significant relationships.

Presenting Problem

- The symptom checklist is completed by the current caregivers (e.g., adoptive parents), teachers, or others familiar with the child. There are six symptom categories: behavioral, cognitive, affective, social, physical, and moral/spiritual. (See Assessment of the Child below for a detailed explanation.)

Table 6.4 Assessment of the Child

• Presenting problem ◦ Six symptom categories: behavioral, cognitive, affective, social, physical, and moral/spiritual ◦ Environmental factors ◦ Frequency, duration, and severity ◦ Child's interpretation of problems; behavior during assessment ◦ Family systems context
• Developmental history ◦ Birth parents and family; pre- and perinatal factors ◦ Postnatal experiences and developmental milestones ◦ Attachment history ◦ School history ◦ Relationship history ◦ Sexual history ◦ Strengths and resources ◦ Additional problems and concurrent diagnoses
• Internal working model ◦ Core beliefs about self, caregivers, and life in general ◦ Assessment methods: sentence completion, first-year attachment cycle, inner child metaphor, drawings, psychodramatic reenactment

- Symptoms must be understood in context. What factors and events increase or decrease the child's symptoms (e.g., acting out may escalate with mother and decrease when father is present)? In which environments do symptoms occur (e.g., compare nature and severity of symptomatology in home and school settings)?
- The frequency, duration, and severity of symptoms are considered. Severity is determined by categories on the symptom checklist (none, mild, moderate, severe). This information is used to generate a discussion with the caregivers about the child's symptoms, including frequency, duration, and severity (e.g., parents describe how often their child has outbursts of anger, how long they last, and the resulting level of damage and disruption for the child and family).
- The child provides his or her own perception and interpretation of symptoms and problems. Two methods used are the sentence completion task (see Appendix C) and the child-based problem list, in which the child is asked to state his or her treatment goals during the initial interview. The goals must be specific (e.g. "better communication with parents") and form the basis of a treatment contract. The child is requested to fill out the sentence completion form during the first day of treatment. Valuable information about the child is derived by observing the way in which this task is approached (e.g., is the child honest, serious, cooperative, defiant, or motivated?).
- Symptoms are explored and understood in the family context. Family members' reactions are identified (e.g., parents', siblings', and extended family members' responses; family members' perceptions, interpretations, and feelings about the child). Prior attempted solutions are discussed, including the nature and outcome of previous therapeutic interventions, medications, parenting strategies, and child welfare efforts (e.g., out-of-home placements). The goals, expectations, and resources of the family are explored in detail. Are their goals and expectations realistic or unrealistic? What emotional, intellectual, social, and economic capabilities exist?

Developmental History

- Information about the child's biological parents and family is ascertained (when available) by reviewing social service, medical, and forensic records, and from the verbal reports of the current caregivers. Relevant information includes issues regarding the biological parents prior to the pregnancy (e.g. psychosocial functioning, desire for the

child, family background); prenatal factors (e.g., feelings about the pregnancy, medical care, nutrition, and the health of mother, drug, or alcohol exposure, support systems, stress level and emotional climate, and health of the fetus); perinatal factors (e.g., preterm or postterm birth, birth experience, health of the mother and infant at birth, their bonding experience immediately after birth).

- Neonatal and postnatal experiences, as well as early developmental milestones, are examined. These include the infant's temperament (e.g., level of arousal, activity, and response to stimuli); general responsiveness to caregivers; growth patterns; and eating–sleeping–elimination routines.
- The child's attachment history is reviewed in a detailed and comprehensive manner. The first three years of the child's life are crucial in reference to attachment, and the following information must be gathered:
    - length of time with, and nature of relationship to birth mother, birth father, and other biological family members
    - history of placements (e.g., infant receiving facilities, foster and group homes, orphanages, disrupted adoptions)
    - availability and competency of primary caregivers
    - attachment behaviors and indicators (e.g., separation and reunion responses, ability to give and accept affection, secure base behavior, sensitivity toward others, synchronicity and reciprocity)
    - maltreatment (e.g., abuse, neglect, abandonment, disruptions, and moves), including the child's age at the time; duration; details of the child's emotional, cognitive, and physical response; response of significant others; and prior interventions
    - additional environmental and family stressors (e.g., postpartum depression of the birth mother, domestic violence, divorce, death, physical and emotional illnesses of the caregivers).
- The child's school history is reviewed, including behaviors, attitudes, relationships, and academic performance. The nature of the child–teacher relationship is assessed; conflict with female authority figures is especially common. Relationships with peers; attentional difficulties; responses to rules, boundaries, and limits; and the child's general ability to process information and learn are determined.

- Significant relationships are examined. How does the child relate to important people in his or her life (adoptive and foster parents, biological or adoptive siblings, extended family members, peers, social workers, therapists, guardian ad litem, and mentors)?
- Evaluation of the child's sexual attitudes and behaviors, both historic and current, is imperative. Many of these children have been sexually abused or exposed to inappropriate and traumatic sexually oriented experiences. Information is garnered regarding prior sexual acting out (e.g., victim or perpetrator), age-inappropriate sexual attitudes and behaviors, sexualized play rituals, and self-stimulation and masturbation.
- It is important to assess and focus on the child's strengths and inner resources, not only limitations and deficits. Positive traits and characteristics identified include special abilities and interests, intelligence, sense of humor, resilience and protective factors (e.g., easy temperament, positive caregiving history, healthy adoptive parents, desire to change).
- Additional problems and concurrent diagnoses are common. In addition to attachment disorder, other diagnoses often include PTSD, ADHD, ODD, conduct disorder, unipolar or bipolar depression, eating disorders, and other externalizing behaviors (e.g., aggression, criminality, impulsivity).

Internal Working Model

- The child's internal working model includes core beliefs about self, caregivers, and life in general. This internal working model serves as a blueprint for all current and future relationships. The child's specific perceptions and expectations are identified (e.g., "I am bad, defective, and deserve to be abandoned and abused; caregivers can never be trusted; I must be in control of others to survive"). (See Table 4.1.)
- A variety of assessment methods are used to identify the child's internal working model: sentence completion, first-year attachment cycle, inner child metaphor, drawings, and psychodramatic reenactments. These methods are described in detail in Chapter 8.

Parent and Family Assessment

Corrective Attachment Therapy is a family systems intervention. Assessment focuses on significant family influences in the child's life: psychological and biological functioning and background of the birth family and current caregivers; attachment history, parenting skills, and attitudes of current caregivers; and family structure, dynamics, and quality of the marital relationship, as outlined in Table 6.5. Current caregivers are usually the adoptive parents.

Life Script

Our childhood experiences with attachment figures are where our scripts are written. These experiences develop into core beliefs: the mindsets, attitudes, and expectations that define who we are, how to relate to others, and what roles we play. A child's beliefs about him- or herself are based on how his or her parents or caregivers act toward that child. For example, messages such as "You can't do anything right," or "Why are you so stupid?" communicate to a child that he or she is inadequate and incompetent. Unspoken messages can be even more powerful. For example, a parent who abandons a child conveys the message, "You are not worthy of love and connection."

From before birth and well into childhood, our subconscious receives a tremendous amount of input from which we formulate our beliefs about self, others, and the world. This is how we are taught to view ourselves as capable or inept, good or bad, deserving of love or unacceptable. This is how we learn to expect and anticipate certain behaviors from caregivers and others—safe or dangerous, kind or mean, available or rejecting. Children also learn how relationships operate by observing how their parents treat one another; how they deal with conflict, power, intimacy, and communication. For example, witnessing his or her father abuse his or her mother teaches a child that domination and violence are acceptable ways to solve problems and that females should fear males.

Many adults have some degree of emotional baggage from their pasts—unhealed pain, losses, resentments, and fears stemming from early life experiences. As explained, these childhood experiences develop into "working models,"—the core beliefs, mindsets, and expectations about who we are and how to relate to others. Without self-awareness, we will be controlled by these outdated beliefs. Awareness of why we make certain choices frees us to make healthier choices. The *Life Script* is an excellent tool for becoming aware of your early programming, and the associated perceptions, emotions, and behaviors.

The *Life Script* is completed and discussed in detail with the treatment team. Content ("what") and process ("how") are focused on. That is, in addition to the details of the adult's prior experiences, significant clinical information is gathered by observing individual and interactional responses during the discussion (e.g. how do they deal with emotions; do they provide empathy and support to one another?). The *Life Script* questions can be found in Appendix H).

Parent's Attachment History

- An in-depth exploration of the family background is paramount (e.g., relationship with own parents, foster care or adoptive history, relationship with siblings and extended kin, description of family dynamics and attachment patterns).
- Family-of-origin information, including specific stressors, is identified. This includes psychosocial or biological conditions (e.g., depression, aggression, substance abuse), maltreatment, losses, violence in the home and/or environment, medical and emotional illnesses, criminality, parents' marital relationship, and prior therapeutic interventions.
- Education and employment history are reviewed. Educational achievements, as well as relevant life experiences, provide information about intelligence, motivation, and desire to learn and grow. Factors related to stability are identified (e.g., work history, number of relocations).
- Assessment methods used: autobiography completed prior to treatment, life script, and clinical interview.

Parents' Current Functioning

- The parents' psychological and physical health are disclosed and discussed. Relevant health issues may include debilitating medical conditions, clinical depression, stress and anxiety, and the impact of prior physical and/or psychological traumas.
- Current and historical marital and relationship issues are ascertained. Information is reviewed regarding history of marital or other significant adults relationships (e.g., reasons for and circumstances around divorce, custody and visitation, relationship discord, and conflict resolution); current marital relationship (e.g., communication, problem-solving, and conflict management skills; dynamics and patterns; intimacy, support, stability, and satisfaction); attachment styles.

Table 6.5 Parent and Family Assessment

• Parents' attachment history ◦ Family background ◦ Additional family-of-origin information ◦ Education and employment history ◦ Assessment methods: autobiography, life script, and clinical interview
• Parents' current functioning ◦ Psychosocial and physical health ◦ Marital and other significant relationships
• Parenting attitudes and skills ◦ Parenting history ◦ Parenting practices with siblings ◦ Parenting practices with child with attachment disorder ◦ Parental commitment ◦ Out-of-home placements ◦ Parenting philosophies and competencies
• Family system ◦ Structure, dynamics, and relationship patterns ◦ Support systems ◦ Stressors and stress management

Parenting Attitudes and Skills

- A parenting history is taken, including planned and unplanned pregnancies, losses (miscarriages, abortions, infertility issues), and responses to biological, foster, and/or adoptive children entering the family system.
- Parenting practices with other children in the family are explored (e.g., strengths, problems, prior treatment). Some parents are successful with other children in their family but not so with the child with attachment disorder. This may be indicative of competent parents and an extremely difficult child, or of parents who are only effective with less challenging children. Some parents are ineffective with all their children, which may indicate either a lack of parenting skills or unresolved family-of-origin issues triggered by their children.

- Parenting successes and failures with their child with attachment disorder (e.g., types of difficulties, prior attempted solutions, maltreatment considered and/or acted out).
- The continuum of parental commitment is assessed:
  - highly committed (for the correct reason of wanting to help the child, or unhealthy reason of meeting own needs, such as fear of failure or unresolved prior losses)
  - ambivalent commitment (parents are burned out, confused, frightened, and struggling with their commitment to the child),
  - noncommitted (parents are covertly or overtly considering relinquishment).
- Out-of-home placements are reviewed (e.g., reasons, duration, outcomes and feelings regarding placement and reintegration).
- Parenting philosophies and competencies are identified and discussed in detail:
  - Feelings toward and perceptions of the child (e.g., extreme emotional reactions including love, hate, pity, resentment, guilt, shame, and fear): positive or negative perceptions may include seeing the child as a victim of maltreatment who must be protected and rescued, or as a threat to family safety.
  - Feelings toward social systems and external resources: parents often feel misunderstood, blamed, frustrated, and angry regarding child welfare, school, mental health, and legal systems. Thus, they often begin therapy with a defensive and hopeless attitude.
  - View of attachment: coherent, dismissive, preoccupied, and unresolved views of attachment are associated with prior attachment experiences and influence current parenting practices. (See Appendix D.)
  - Promote secure attachment: ability to perceive their child accurately, meet individual and developmental needs appropriately, set limits, and provide a healing emotional environment.
  - Discipline attitude and style: ability to provide the necessary balance of caring and structure; parents may be overindulgent, rejecting, critical, abusive, confused, and lacking in self-control.

Family System

- The structure, dynamics, and relationship patterns in the family must be identified and understood. The family system is both influenced by, and directly impacts, the emotions and behaviors of the child with attachment disorder. Assessment focuses on the following:
    - *Boundaries:* The emotional and physical barriers that enhance and protect the integrity of family members, subsystems, and the family as a unit (e.g., a demanding and aggressive child violates the physical and emotional space of siblings and parents).
    - *Subsystems:* Units in the family, determined by generation, sex, or function. The three family subsystems are parental, marital, and sibling (e.g., the mother and father in their leadership role form the parental subsystem, and in their spousal roles form the marital subsystem).
    - *Triangulation:* Detouring conflict between two people by involving a third person (e.g., a child acts out toward mother and is charming and engaging with father; father blames mother for the child's problems, and forms a coalition with the child; the parental subsystem is in conflict and, therefore, is ineffective in managing the child).
    - *Relationship skills:* Communication, problem-solving, and conflict management skills are assessed. Effective communication between parents–child and adult partners is crucial to family functioning.
    - *Roles and rules:* Family members either create or are assigned specific roles, which determine behavior and function in the system (e.g., scapegoat, rescuer, victim, perpetrator, placator, disciplinarian). Rules are the "laws" by which the family operates and can be realistic/unrealistic, appropriate/inappropriate.
    - *Power and control:* The healthy family system operates on the basis of a hierarchy of power and control, with the parents in the executive role. The extreme power and control needs of children with attachment disorder result in chronic and debilitating power struggles with authority figures.
    - *Intimacy:* A basic function of the family is to meet the members' emotional needs for affection, closeness, and connection. Children with attachment disorder avoid intimacy and promote a conflictual family climate in which others have difficulty meeting intimacy needs.

- *Patterns:* Ongoing, reciprocal patterns of interaction, either positive or negative, occur in the family system. Destructive patterns must be identified (e.g., the child is oppositional and angry toward parents, parents respond with hostility and rejection, a vicious cycle of mutual negativity ensues).

- A review of family support systems and external resources is important. Support systems include extended kin, friendship networks, social service agencies, support groups, religious affiliations, and other community resources. External systems can be supportive and helpful or unsupportive and nonhelpful (diluting and disempowering the family).
- Although stress is a part of life, families who have children with attachment disorder experience extreme levels of ongoing stress ("secondary traumatic stress"). The nature of the stressors, and the way in which family members react to these stressors, must be assessed.

Symptoms of Attachment Disorder

The symptoms of attachment disorder are divided into six categories: behavioral, cognitive, affective, social, physical, and moral/spiritual. Each of these symptom categories will be described below, with specific examples by parents (in their own words, as provided on intake forms).

Symptoms exist along a continuum, from mild to severe (Table 6.6). Children vary in the number of symptoms they display and in the severity of each particular symptom. Symptoms can change in frequency and duration over the course of development. Without effective treatment, the most serious symptoms of the child with attachment disorder escalate as the child gets older.

Behavioral

Children with attachment disorder manifest a variety of antisocial and aggressive acting-out behaviors. They are often self-destructive, including self-mutilation (e.g., head banging, cutting), and display suicidal gestures and other self-defeating behaviors. They destroy the property of others, their own material possessions, or both. Impulsivity and physical aggression toward other children and adults is common. Aggression can be overt, such as acts of physical violence, or passive–aggressive, such as manipulative and surreptitious behaviors. Sadistic cruelty to animals, often secretive, can occur. Stealing is typical, including theft outside and inside the home. Lying is of a pathological nature; they remain deceitful regardless of concrete evidence to the contrary. A preoccupation with fire, gore, and blood sometimes occurs,

as they establish an affiliation with evil and the dark side of life. They can be ingenious, devious, and "phoney," giving the appearance of sincerity, but with ulterior and self-serving motives. For example, helping professionals may assume the child's seemingly cooperative responses are sincere, when in reality this behavior is often manipulative and controlling.

Problems regarding food and eating patterns are common, such as hoarding and gorging, and may reflect control issues and a need to fill their emotional emptiness. Children who have been sexually abused manifest inappropriate sexual behavior, attitudes, and concerns, such as victimizing others, excessive masturbation, seductive manipulation, and sexualized play. Sleep disturbances include recurrent nightmares, night terrors, disturbed sleep patterns, and wandering at night. Enuresis and encopresis are typical manifestations of anger, aggression, control issues, and physiological dysregulation.

Table 6.6 Continuum of Attachment

Secure	Avoidant	Anxious	Disorganized
• comfortable with closeness and trust • felt security • vulnerability acceptable • positive working model • individuality/ togetherness balanced	• deactivates attachment needs and behaviors • denies needs and avoids closeness • negative working model (moderate) • pseudo-independent	• resists or ambivalent about closeness and trust • moderately controlling and insecure • negative working model (moderate) • rejecting or clingy	• unable to trust and be close • lacks remorse • aggressive and punitive control • negative working model (severe) • no organized strategy to connect

Extreme defiant and oppositional behaviors include refusal to comply with authority, demanding and intrusive social styles, and persistent nonsense questions and incessant chatter.

Lack of Impulse Control

Gina doesn't just open her mouth and insert her foot. She sticks her foot in her mouth when it's not even open. If she wants to do something she doesn't think, she just reacts. She never considers the consequences of her actions. She just does what the spirit moves her to do. For example,

she often tries to get out of the car without looking to see if another car was coming.

Self-Destructive Behaviors

When we brought Tony home from Romania she rocked in her crib, hit her head against the wall, pulled her hair out, and bit her hands and arms. When she walks or runs, she runs into things on purpose and falls down. She is always setting herself up to fail.

Destruction of Property

Billy trashes his room when he is angry. He will pick up the nearest item and throw it. He has cut up my bedspread and pillow with scissors. He has put holes in the walls and has carved on our furniture. He has drawn all over his bed and has picked the wallpaper off the wall. He has mutilated pictures of himself and has broken all of his toys. He poked holes in the seats of his chairs and wrote with a marker on the carpet and sofa. He will break someone else's most precious toy, then laugh.

Aggression Toward Others

Johnny will scream he hates us and writes on the wall that he hates us and wishes we were dead. He purposefully pushed his younger brother down the stairs. The other day he sang at the top of his lungs, "I hate you, you hate me, I am going to get my ax and chop you up." My 16-year-old daughter said to me, "Mom, do you think maybe the reason he is not nice to you and me is because we are the women figures in his life and women are who have hurt him before, so therefore he thinks if he hurts us, then he is getting back at them?" I really think she hit the nail on the head.

Consistently Irresponsible

Sarah tells us her homework is done, but it rarely is. She puts up a big fuss when she has to do a chore and never gets it done right. All she wants to do is watch TV. She is consistently irresponsible and forgetful. She leaves behind lunch pails, backpacks, and her homework.

Inappropriately Demanding and Clingy

Dan yells at his sisters and anyone else who doesn't do exactly as he sees fit at the moment. He wants full attention and demands that more time be spent with us, even when we give him a large amount of attention. When we have company around he can become clingy. Going to the doctor he can be clingy or when any new situation arises. He usually does it when we are busy with something or on the phone.

Stealing

Ellen steals incessantly. She has gone through my purse many times. She stole $20 from a friend's bedroom. She also has stolen two pocket knives and was caught shoplifting. We had to resort to full body searches after she took my diamond pin to school hidden in her waistband. She also stole something off her teacher's desk. At Easter our daughters have to lock their Easter baskets in their rooms.

Deceitful (Lying, Conning)

Keith lies to stay out of trouble, but he also lies for no reason at all. It's almost a habitual thing. He has absolutely no remorse when he gets caught lying, only for getting caught. He will hold on to his story even when you have proof in hand. When he steals candy, he comes downstairs with the chocolate on his face and denies eating candy. He is always conjuring up stories to suit his need to manipulate. We never know when he is telling the truth.

Hoarding

We are constantly finding candy wrappers under Lisa's bed. We also find them under the couch and in corners. I recently found a half-eaten sandwich, old stale cookies, and packets of sugar between her mattress. We always give her all the food she wants and are puzzled why she has all these little stashes. Most of the time the food is never even eaten.

Inappropriate Sexual Conduct and Attitudes

[Mother reports the following information revealed by her daughter.] "Sex stuff I've done to other kids. I once touched a boy's private parts. But every time I touched him I got caught and I had to have a spanking, but I never learned. I also touched a girl on her private parts, who I sometimes had over to play. There was another boy across the street who one day came over to play, and he took me behind a bush and started to touch me, but I didn't care because I was doing it back."

Cruelty to Animals

I began to notice that Mary was very nice to the animals as long as she knew someone was watching her. As soon as she thought she wasn't being watched she would kick or hit both the dog and the cat. Then, anytime she pet them, she would pull a tail or pinch. Now, the cat is neurotic and fearful around her and the dog avoids her altogether.

Sleep Disturbance

Robert has a very difficult time getting to sleep. He often yells for Dad or Mom several times a night. He also tosses, turns, and talks in his sleep.

He sometimes gets up and wanders in the middle of the night. I once opened my eyes and there he was staring at me. It gave me a funny feeling. He also steals food during the night.

Enuresis and Encopresis

The areas around using the bathroom are another fiasco. Tina would refuse to wipe when she had a bowel movement. She has smeared poop on the toilet seat and waited for someone to sit on it. She wets her pants almost every time her will is crossed in any way, or when she feels like she is losing control. She usually doesn't wet them enough to soak through, but just enough to make a point. She recently began to urinate on clothes in her closet and on her rug. Of course, she denies it.

Frequently Defies Rules (Oppositional)

When I ask her to do anything, I get a look. The "look" is the most horrible expression I have ever seen on a child's face. It is mad, sad, and defiant all at once. At kindergarten she is noncompliant most of the time, running down the hall, sitting in other people's seats and screaming, "I'm the boss!" She has bit, spit on, and thrown sand at her teachers. She shows little regard or respect for most authority figures, including parents, teachers, babysitters, and adults in general.

Hyperactivity

Morning in our house is chaotic. Adam wakes up first and usually makes a lot of noise to wake us all up. Next, he gets out food and milk, which he often spills. The counter is left in a mess. He bumps into tables, walls, and counters, and goes from one room to the next leaving mess after mess. I give Adam his Ritalin and I have a cup of coffee. I ignore all his behavior until I've had some coffee. Once his medication kicks in he doesn't bump into things and he doesn't argue constantly.

Abnormal Eating Habits

Michael can eat very slowly, picking at his food and the next day gulp it all down. He can eat two and three helpings at dinner and would eat continually if allowed to. He has an enormous sweet tooth. We have even caught him eating sugar right out of the sack. He steals candy often right under our nose.

Preoccupation with Fire, Gore, or Evil

We have found a hidden pack of matches in his room. One year ago he was suspended from school for two days for setting a roll of toilet paper on fire in the bathroom. We have found burnt pieces of paper and we have noticed that his coat is singed. He has a preoccupation with violent

and evil characters. We recently passed a dead dog on the road. He was fascinated by it and couldn't stop talking about how cool it was.

Persistent Nonsense Questions and Incessant Chatter

She continually asks questions that are unimportant. When she was younger she would see me sawing wood and ask, "What are you doing?" Then she would come back and ask the same questions. At the dinner table she will go on and on talking about everything and nothing and usually not making a lot of sense. She is particularly bad when we are in the car and she has a captive audience. It drives us crazy.

Poor Hygiene

Ken is not concerned at all about personal hygiene. He could really not care less about having pimples from not washing his face, or not brushing his teeth, or using deodorant. He hates to take a shower and wash his hair. Sometimes he will run the water in the shower and pretend he is washing his hair. He would wear the same socks and underwear every day if he could.

Difficulty with Novelty and Change

Blake can't stand anything new. He must have the same routines day in and day out, or we pay the price. He always needs to know where we are and what we're doing. Sometimes we think he will never grow up.

Cognitive Functioning

A lack of cause-and-effect thinking is evident; failing to recognize and comprehend the relationship between actions and consequences. Thus, these children rarely take responsibility for their own choices and actions, and instead, blame others. Regarding cognitive style (i.e., internal working models), they perceive themselves as unwanted, worthless, impotent and "bad," perceive caretakers as unavailable, untrustworthy, and threatening, and perceive the world as unsafe and hostile. They define themselves as helpless victims unable to impact their world, or conversely, as omnipotent, with a grandiose sense of self-importance as a defense against feeling helpless. Learning and language disorders can occur as a result of early neurological damage (e.g., fetal alcohol syndrome, failure to thrive, physical abuse), or in conjunction with the matrix of psychosocial symptoms mentioned above.

Lack of Cause-and-Effect Thinking

We have tried every form of acceptable discipline known to man applied diligently and faithfully. The child does not or will not learn. He knows,

though! You ask him if he can tell us if he's done something wrong and he says yes and tells what it is. Then you ask him if he knows the consequences. Again, he says yes and tells you. But he still absolutely refuses to abide by the rules. It's only a matter of time before he does the same thing over again. He just does what he wants, not thinking or caring about what will happen. When playing chess with him, I can use the same moves to beat him time and time again.

Learning Disorders

Beth is behind in her age level and her educational level. She is in a special education school, one year behind. They have told us that her problems are related to early childhood deprivation.

Language Disorders

After leaving Guatemala, Carla's English was wonderful within six months. She can understand everything and make herself understandable. She may, however, act like she can't speak much English. She does this at school. They say she has real problems understanding. Carla will try that ploy with me when she is in trouble. She acts likes she can't figure out what you are talking about. She has admitted that she understands you. After she admits it, then she can have a five-minute conversation with you about it.

Perceives Self as a Victim (Helpless)

Mark complains constantly that no one likes him, including his parents, other children, and his teachers. He also complains that his parents and teachers are mean to him, generally over everyday things. As an example, he will tell his mother he hates her for having to take a shower first before coming down to get his cereal, because it means he's not being taken care of or if things don't go exactly his way. Whether with friends, teachers, and others, he feels he is being unfairly treated.

Grandiose Sense of Self-Importance

He seems to think the world revolves around him, and he can't see it any other way. He always has to be in control. His wants always come first. No one else's feelings or desires count. He thinks he is an expert at everything, even things he knows nothing about. He boasts and brags, always trying to make himself seem more important.

Affectivity

The core emotions these children experience are intense levels of anger, fear, pain, and shame. They frequently appear disheartened and depressed, generally in response to unresolved loss and grief. Temper tantrums and

rage reactions are common. They are emotionally labile with frequent and unpredictable mood swings. Due to years of avoidance and denial, as well as a lack of supportive role models, they are not able to identify or express their emotions in clear and constructive ways. They experience shame regarding maltreatment as well as their acting out toward others.

Not Affectionate on Parents' Terms

If we sat down next to her and tried to put our arm around her when she was younger, she would try to get away. Hugging her is like hugging a mannequin. We still try to give her a goodnight kiss. Many times she hides her head under the covers. If you ask her for a kiss, she says "No." There is never any warmth. The only time she has ever hugged us is when others are around and she can make a show, or in inappropriate times to catch us off guard.

Intense Displays of Anger (Rage)

He yells and screams at anyone who doesn't do what he wants them to do. His fuse is nonexistent. This is the time he often lashes out with hitting and yelling. He flies into rages if I assert my turn with the TV or insist he do his homework. He is almost totally out of control. This summer he physically attacked me three different times over trivial slights and being told "No." He has put holes in the walls and threatened me with his hands around my neck. He has even thrown a meat fork at me.

Frequently Sad, Depressed, or Helpless

Cindy is the unhappiest child I know. She is always pouting and sulking. When asked about it she usually says it's for things like not having anything to do, yet she intensely dislikes any social interactions. I have to drag her to Girl Scout meetings or ballet lessons. She would prefer to sit in her room and watch TV to the exclusion of anyone or anything.

Inappropriate Emotional Responses

When she becomes enraged she screams, stomps her feet, and throws objects. This occurs in public all the time, especially in restaurants. She laughs when people get shot on TV, and she laughs hysterically at juvenile TV shows. She never shows sadness in appropriately sad situations ("that's stupid"). When she gets seriously hurt, I would never know it, but if she has a minor injury she cries and screams.

Marked Mood Changes

Lisa can have different personalities from one moment to the next. She can be a normal happy child and then something will set her off and she will act like "Rosemary's Baby" (a horror movie about an evil child). She

can be in a good mood at school and then see me when I pick her up and change into a bad mood. I never know what to expect from Lisa. Each new day is a new challenge.

Social Behavior

Chronic noncompliance is manifested interpersonally as control battles, defiance of rules and authority, and inability to tolerate external limits. Thus, these youngsters create frequent conflict with caregivers, teachers, siblings, and peers. They relate to others in a manipulative, controlling, and exploitative fashion, lacking the ability to connect with genuine intimacy and affection. Lacking trust in others (a direct result of unavailable, unreliable, and hurtful caregivers in the early stages), they overcompensate by pseudoindependence. They are superficially engaging and charming, indiscriminately affectionate with strangers, and lack long-term meaningful relationships. Lack of eye contact is apparent when interaction is perceived as intimate, but they maintain eye contact for purposes of seduction or control. Typical social roles developed and maintained include victim (helpless, powerless) and/or victimizer (perpetrator, bully). Blaming others for their own mistakes and problems, and taking little or no responsibility for their actions and choices further alienates and frustrates others.

Superficially Engaging and Charming

When Marta came off the plane from Columbia she cried for about 15 minutes and then she became everyone's darling. She gave big hugs and kisses to all of the waiting relatives. She showed no apprehension at all. When people are around she immediately launches into her friendly adorable routine. She walks down the street and starts a conversation with everyone she encounters. She has said, "I love you" to people she hardly knows.

Lack of Eye Contact for Closeness

He seldom ever looks people in the eye unless asked to do so, and still has difficulty even then. Whenever his behavior is unacceptable and we tell him, down goes the head to avoid eye contact. On the other hand, he can flat out lie to you, staring you right in the eye.

Indiscriminately Affectionate with Strangers

Ken will go to anyone. When we first adopted him he went up to strangers and hugged them. When he meets people on his terms he is extremely friendly and talkative. He will say "I love you" to anyone on the street.

Lack of or Unstable Peer Relationships

Every day Jessica's best friend changes. A perfect stranger can be her best friend. She lies to them, blames them for things she has done, steals from them, and quarrels with them. They never last very long. Her best friends are kids three to four years younger than her. We hear her bossing them, telling them how a game is to be played. When things don't go her way, she makes new rules. It seems like the only friends she can keep for any length of time are the underdogs, the kids who nobody else likes because they do bad things, or the ones that have the worst family problems.

Cannot Tolerate Limits and External Control

Sheila hates authority of any kind. She does not follow instructions well and has a difficult time obeying rules. She doesn't take guidance from parents, teachers, or other adults. When asked to throw something in the kitchen trash, she will put it in the wastebasket in the living room. She complies with the intent, but has to change the conditions, if only in a slight way, just to be in control.

Blames Others for Own Mistakes and Problems

If he loses something he blames me. If he bumps into someone, they bumped into him. He won't ever take the blame for anything. He will make up any excuse, no matter how ridiculous to avoid blame. If he hits a wrong note, it's because something is wrong with the instrument. If he misses an assignment deadline, it's because the teacher never told him it was due.

Victimizes Others (Perpetrator, Bully)

He doesn't give other children their space. He will get up into their face and will bully them for no reason. It doesn't matter how big they are. He often tries to control the children around him by pushing them, hitting them with his backpack, or bossing them around. He is also verbally manipulative to both children and adults.

Victimized by Others

She sets herself up to be victimized by everyone. Other kids will hurt her or blame her for things and she says nothing. She has even confessed to things and then we find out that someone else really did it. She will purposefully lose a privilege and then feel sorry for herself as the helpless martyr.

Lacks Trust in Others

Katie doesn't trust that I will take care of her even after seven years. She is afraid that I won't be there for her. When I leave town, she gets mad for days, before I go and when I return. She will lie, steal food, and refuse to do anything for the family. She just doesn't trust that anyone will be there for her.

Exploitative, Manipulative, Controlling, and Bossy

At home, Allison is just awful. She is angry, defiant, and mean. The first time Grandma watched her she was fine. I was shocked. The next night Grandma looked awful. She said Allison was the most bossy child that she had ever seen. She commented that she acted like she was 40 instead of 4. Allison says that it makes her mad that we are the bosses. She wants to be the boss. She is angry that we are the parents. She wants to be the parent.

Physical

Anger, grief, fear, and emotional pain are stored and expressed in the bodies of children with attachment disorder. They are typically stiff, chronically tense, and physically defended against closeness and contact. Chest muscles are particularly rigid as a reaction to the suppression of anxiety and fear, which results in shallow and restricted breathing. Tension in the throat and facial area blocks the impulse to cry. They pull back their shoulders, distancing themselves from others. Some appear robotic in nature, with minimal facial expression and a vacant stare in their eyes, their bodies expressing emotional repression and avoidance of others. Problems with personal hygiene are common. They take little pride in their appearance and living quarters, often refusing to shower, brush their teeth, and maintain a clean environment. They are often accident prone, and experience many physical injuries. Minor injuries are magnified and dramatized in order to receive attention through manipulation and control. Serious injuries, conversely, are underemphasized and kept secret, in an effort to avoid vulnerability and helping responses from caregivers. They are tactilely defensive; rigid body armor is a defense against human contact and a somatic reaction to prior trauma. Genetically, their family history is characterized by numerous biologically based problems, such as clinical depression, substance abuse, aggression, and severe psychological disturbance.

Poor Hygiene

Sheila swears that she brushed her teeth, but when I check, I find that her toothbrush is totally dry. When told to wash her hair, she just stands

in the shower, not even wetting her head. Her hair looks just as greasy as when she went in. She sometimes sleeps in her clothes, and wears the same smelly things for days.

Chronic Body Tension

When you hug Chelsea, it's like hugging a 2 x 4. She always seems tense. She sits straight and stiffly, and she only tightens up more if you get close. You can hardly tell when she's breathing. She kisses like stereotypical Hollywood types (hug-hug, kiss-kiss, let's do lunch). There's never any warmth.

Accident Prone

When he walks or runs, he falls down many times. He is always pushing or bumping into his brother. He always says, "It was an accident." He used to turn over furniture and make the pictures on the wall crooked when he was angry. If there is anything special to any other family member, you can be sure that he will accidentally break it.

High Pain Tolerance/Overreaction to Minor Injury

Jim was in the backyard playing with his younger brother. He fell and broke both bones in his arm. He didn't even cry. It wasn't until I said, "Oh my God, your arm is broken" that he reacted at all. On the other hand, when he had a small splinter in his finger, he screamed like someone was killing him.

Tactilely Defensive

When Lucy first came to our home I tried to hold her and stroke her cheek. She screamed and pulled away and said "Don't touch me, you're hurting me." It took six weeks before I could even approach her. She still avoids any physical contact or affection.

Genetic Predispositions

Danny's biological father has been in jail off and on his entire life and his mother was always depressed. I'm told that he was physically abusive to his mother, and later to his sister and animals. Danny has never met his father, but the apple sure doesn't fall far from the tree. He acts just like his dad. He has even said, "I'm going to grow up just like my birth dad because he has power, he hurts people."

Spiritual/Moral

Spiritual health can be defined in various ways: a state of well-being, not just the absence of disease; the quality of being at peace with oneself and

in harmony with the environment; a sense of empowerment, personal worthiness and control; feeling connected to one's deepest self, to others, and to all regarded as good; a sense of meaning, purpose, and hope (Hafen *et al.* 1996). Combining various concepts, one researcher identified four aspects of spiritual health:

- a *unifying force* that integrates physical, mental, emotional, and social health
- a focus on a *meaning in life*, which serves as a powerful inner drive for personal accomplishment
- a *common bond* between individuals, enabling us to share love, warmth, and compassion with others, and to be unselfish while following a set of ethical principles
- based on *individual perceptions and faith*, acknowledging some power or force behind the natural working of the universe (Banks 1980; cited in Hafen *et al.* 1996, p.380).

Children with attachment disorder generally have few of the above qualities. Spirituality is about a relationship. These children have difficulty with intimate and enduring relationships, do not feel a sense of goodness and self-worth, and act on the basis of self-interest. They feel separate and disconnected from personal relationships, including a spiritual relationship.

Since children with attachment disorder reject parental authority, it is not surprising that they also reject the concept of an "ultimate authority figure." Rather than perceiving a higher power as loving and benevolent, they either view God as "bad" and punishing (a projection of their own negativity), or see themselves as unworthy of God's love. They often blame God for their troubles and feel "it does no good to be good."

Early maltreatment and compromised attachments have left these children with "scars on their souls." They are not in harmony with spiritual ideals and purposes. Faith, forgiveness, compassion, and unselfishness are alien to them. Rollo May (1972, p.23) writes, "When children are not loved adequately they develop a penchant for revenge on the world, a need to destroy the world for others as much as it was not good for them."

As previously described, children with severe attachment disorder lack moral and ethical development. They experience little or no remorse, lack compassion and empathy, and have a poorly developed conscience. They do not develop a sense of family, community, interdependence, and the desire to cooperate with others, which is deeply rooted in our evolutionary past. Although they know the difference between right and wrong, they prefer to choose wrong, with no thought of consequences, no concern for others, and no personal accountability for their actions.

Lack of Meaning and Purpose

One day Joey told me that if his birth father was going to abuse him for the first three years of his life, then he was going to be placed in foster homes forever, what's the point—what's the use—he doesn't understand why he was born!

Lack of Faith, Compassion, and Other Spiritual Values

Andy sometimes seems to enjoy watching others being hurt. He will destroy people's things without the slightest concern. He treats his friends poorly and then is surprised when they reject him. When he is angry, the coldness in his eyes is scary. He doesn't seem to care about anyone, including himself.

Identification with Evil and the Dark Side of Life

We are involved in the ministry. Tara does everything in her power to embarrass us and has even told our congregation "When you pray to God, I pray to the devil." She even drew pictures of the devil in the hymnals. She has said, "If there was a God, I wouldn't be like this. God would never let me be abused." She also has said, "If there is a God, he must be bad."

Lack of Remorse (Conscience)

It seems he doesn't care who he hurts, even his brother. He seems to delight in watching others be in pain. If someone gets hurt, he will laugh. He will steal from other kids or call them hurtful names without the slightest care. He will say he is sorry, but he never really means it. He is just sorry he got caught. He truly does not care about right or wrong. If he wants to do something, he thinks it's OK to do it, right or wrong, as long as he wants to do it or thinks he can get away with it.

Special Assessment Considerations

Symptoms of attachment disorder occur along a continuum (see Table 6.6), from mild to severe, as a result of the followings factors:

- developmental stage at the time of disruption
- length of time of disruption
- nature and quality of attachment prior to disruption
- nature and quality of attachment experiences following disruption
- constitutional factors, including genetic background and temperament
- protective factors, including support from extended family and positive out-of-home placement.

Children with moderate to severe attachment disorder typically display the following symptoms: impulsive, angry, and aggressive; controlling and manipulative; unable to form genuine and loving relationships; lying and stealing; lack of empathy and remorse; self-contempt, and poorly defined sense of self. Children with severe attachment disorder sometimes exhibit cruelty to animals and a preoccupation with fire, including fire setting.

Cruelty to Animals

Cruelty to animals is one of the most disturbing manifestations of severe attachment disorder. It ranges from annoying family pets (e.g., tail pulling, rough play, kicking) to severe transgressions (e.g., strangulation, mutilation). These children lack the capacity to give and receive affection with pets, lack the motivation and sense of responsibility necessary to provide appropriate care, and are not able to empathize with the suffering of animals. They often delight in venting their frustrations and hostilities on helpless creatures to compensate for feelings of powerlessness and inferiority.

Margaret Mead (1964) suggested that childhood cruelty to animals is a precursor to adult antisocial violence. Researchers found that the combination of cruelty to animals, enuresis, and fire setting predicted later violent and criminal behaviors in adults (Hellman and Blackman 1966). Researchers at Northeastern University found that children who abuse animals are five times more likely to commit violent crimes as adults. The FBI's Behavioral Science Unit found that a majority of multiple murderers admitted to cruelty to animals during childhood (Cannon 1997).

Parental abuse of children was the most common etiological factor found in cruelty to animals (Tapia 1971). Erick Fromm (1973) noted that children who are sadistic are usually themselves the victims of cruel treatment. Schowalter (1983) concluded that cruelty to animals represents a displacement of aggression from the child to a helpless animal. We have found that animal harassment and abuse is often undetected by the parents. The child can be remarkably surreptitious in his or her offenses.

Attraction to Fire

Fire provides a particular appeal for some children with attachment disorder. Its attributes of power and destruction are attractive qualities to the child who is filled with rage and feels powerless. The child's fire-setting behaviors are extremely disconcerting to caregivers. The child senses this fear and apprehension, and then uses this to his or her advantage in order to gain a sense of further power and control.

Fire-setting episodes are rarely impulsive acts, but are more likely to be carefully considered and planned. Some children establish elaborate alibis at a moment's notice, while others show little inclination to "cover up" their actions. Fire-setting behaviors vary in degree from simple fascination and/or occasional lighting of matches, to more serious actions, such as setting fire to a home. The more serious the nature of the premeditated fire, the more seriously disturbed the child. Society has recognized the magnitude of this problem. One study found that juveniles accounted for 55 percent of arson arrests. One-third of those arrested were under 15 years old, and 7 percent were under 10 (Estrin 1996).

Differential Diagnosis

Attachment disorder shares a particular affinity with ADHD and bipolar disorder. ADHD is estimated to occur in about 5 percent of school-age children (American Psychiatric Association 2013). ADHD involves behavioral and learning difficulties relating to inattention, impulsivity, and hyperactivity. The exact causes of ADHD are unknown, but research indicates there is a physiological component. Environmental and social factors, such as quality of parenting, diet, and toxins affect ADHD, but are not causal factors (Bain 1991). The correlation of ADHD and reactive attachment disorder has been placed at between 40 percent and 70 percent of abused, neglected, and adopted children. ADHD is vastly overdiagnosed in this population.

Children with attachment disorder can also suffer from bipolar disorder. Bipolar refers to a genetically linked affective disorder characterized by both manic and depressive mood episodes. These mood swings can range from overly expansive and irritable, to sad and hopeless, with intervening periods of normal mood. Symptoms of bipolar disorder were thought to show up in adolescence or early adulthood. Young children with bipolar disorder often do not display intense mood shifts, but rather less dramatic variations in behavior that can easily go undetected. The prevalence of pediatric bipolar is about 3 percent. For a comprehensive symptom comparison between ADHD, bipolar disorder, and attachment disorder, see Appendix E.

Key features of autism spectrum disorder can be similar to reactive attachment disorder. Children with both conditions can show lack of positive emotions with caregivers, cognitive delays, and impairments in social reciprocity. However, children with attachment disorder have a history of severe emotional neglect, while those with autistic spectrum disorder only rarely have experienced such neglect. The repetitive behaviors and restricted interests of autism are not found in attachment disorder. Also, children with autistic spectrum disorder regularly show attachment behavior typical for their developmental level (American Psychiatric Association 2013).

7

Corrective Attachment Therapy

Basic Theoretical and Treatment Issues

Our treatment program (Corrective Attachment Therapy) and parenting program (Corrective Attachment Parenting) are grounded in a foundation of basic theories, principles, and research. The following are the key elements of our philosophy which inform our work with children, adults, couples, and families.

Basic Principles

- *Family Systems:* The child, parents, and other family members must be understood in the context of the systems that influence their lives. The focus is on prior and current family systems, and external systems such as social services, extended family, social networks, and community resources. The systems model concentrates on the behavior of family members as they interact in ongoing and reciprocal relationships, and on the family as it interacts with external social influences. For example, family members affect one another—each person's behavior serving both as a response and a trigger. A child who enters an adoptive family with an attitude of hostility may trigger an angry and punitive response from adoptive parents. This parental response reinforces the child's belief that all caregivers are hostile and rejecting. Hostility and rejection become mutually reinforcing in this child–parent relationship. Thus, interventions must focus on both the individual and the social systems in which he or she functions.

- *Interpersonal Neurobiology:* In utero and early attachment experiences significantly affect the wiring of the brain, because the young child's brain grows more than at any other time in life, and relationships shape the developing brain. Lack of secure attachment (i.e., nurturing, support, attunement) and exposure to traumatic stress trigger an alarm reaction, altering the neurobiology of the brain and central nervous system. Traumatized children have impaired wiring in the brain's limbic system and altered levels of stress hormones, resulting in anxiety, depression, and self-regulation problems. Effective treatment and parenting rewires the limbic system and reduces the biochemistry of stress.
- *Attachment theory and therapy:* Early attachment relationships set the foundation for the rest of our lives. Attachment is at the core of our beliefs (internal working model), emotions, behaviors, relationships, and morality. Effective assessment, treatment, and parenting hinges on understanding healthy and disrupted attachment. Facilitating secure attachment with children and adults involves the establishment of healing relationships, which include trust, empathy, safety, dependability, appropriate boundaries, and limbic resonance.
- *Trauma therapy:* Abuse, neglect, and compromised attachment are traumatic experiences that cause psychological, social, behavioral, and biological distress. Trauma results in anxiety, depression, dissociation, shame, the stress response (fight, flight, freeze), and long-term health problems. Effective treatment depends on understanding developmental trauma and PTSD, in order to ameliorate the effects of trauma on self-concept, attachment styles, self-regulation, core beliefs, and depression.
- *Developmental perspective:* Child development consists of a series of stage-relevant tasks that are essential to learn, which lead to the mastery of subsequent developmental tasks over time. The most important task of the first year of life is the establishment of secure attachment, resulting in the mastery of important skills and competencies—trust, self-confidence, positive relationships, optimistic attitude, resilience, success. The emotional and cognitive stage of a child at the time of interpersonal trauma determines the reaction and consequences. The developmental stage of the child at the time of treatment dictates the type of interventions utilized. Further, treatment is sequential and developmental: creating a therapeutic foundation, setting and achieving goals, mastering skills, and integrating healing experiences.

- *Integrative and holistic:* Assessment and intervention occur on all relevant levels of the human experience—emotional, cognitive, social, physical, behavioral, moral, and spiritual. This orientation assumes that all of these dimensions are interconnected. Behavioral change leads to alteration in meaning and beliefs; cognitive changes produce alterations in actions and choices; relationship change brings about rewiring of the brain and reduces stress; emotional security fosters academic achievement. Mind affects body and body affects mind. Interventions are didactic, experiential, skill based, systemic, biological, and community oriented.
- *Experiential change:* Recovering from PTSD, rewiring the brain, developing secure attachment, learning constructive coping skills, and changing core beliefs are best achieved via positive experiences with significant others—therapists, parents, siblings, extended kin, teachers. Effective treatment employs change-producing mental, emotional, and interpersonal experiences, in a safe, sensitive, supportive, and consistent manner. Healing parents realize that the *experience* of a positive relationship with their children is the primary vehicle for change. The process of change is primarily experiential, requiring active participation and genuine involvement on the part of children, parents, families, and therapists.
- *Positive Psychology:* Therapy is strength and competency based. All family members have resources and strengths that must be identified and encouraged. It is helpful to focus on "what is right" and build upon that, not only on "what is wrong." For example, although it is necessary for children to deal with prior traumatic experiences as part of the healing process, it is equally important to build on the child's strengths and teach skills that foster a sense of mastery and hope. Therapists and parents must be aware of becoming frustrated, overwhelmed, and pessimistic. It is crucial to remain calm, positive, use a language of hope, and communicate an expectation of success. Positive psychology teaches that resilience, recovery, and posttraumatic growth following trauma are associated with several factors: hope, sense of meaning and purpose, positive emotions, social support, acts of kindness, and internal locus of control ("I can create change").
- *Theory and research based:* Treatment is based on a variety of theories and paradigms. The underpinnings of the current model are trauma theory (PTSD, neurobiology of stress and trauma); family systems theory (dynamic, structural, strategic approaches); attachment theory and research (internal working model, developmental research,

disorganized–disoriented attachment, parent–infant bonding); experiential therapy (affective expression, process orientation); cognitive–behavioral treatment (cognitive rescripting, developing coping skills); psychoanalytical theory (object relations); and positive psychology (signature strengths, resilience). Current research findings are incorporated into the treatment methods and procedures in order to bring about safe and effective outcomes.

- *Solution focused:* The primary goal of treatment is positive change—new choices, perspectives, options, behaviors, coping skills, and relationships. Every aspect of treatment is oriented toward the growth and evolution of the child and family. It is crucial to have a conceptual framework that defines the process of change. Our theoretical framework is *revisit*, *revise*, and *revitalize*. This framework provides a structure for determining therapeutic goals and methods during the course of treatment. Specific goals for the treatment of child and family are determined. A four-step model guides treatment interventions: *assess* → *set goals* → *intervene (method)* → *reassess*. All methods are based on specific goals for the child, parents, family system, and larger social network (e.g., extended family, community, and agency support).
- *Culturally sensitive:* Behavior, as well as the personal meaning of events, varies depending on cultural background and tradition. The therapist must be aware of the cultural orientation of the child and family, and be careful not to project his or her own cultural biases, perceptions, or beliefs on those individuals. The therapist communicates acceptance and respect for the cultural beliefs and traditions of each family member. Therapists and parents must understand and respect the diversity of beliefs and practices of different ethnic, racial, and cultural groups, and understand the way in which children are affected.

Structure of the Healing Process

It is imperative to have an organized and systematic framework when working therapeutically. This framework helps the therapist develop clear goals, stay focused, and move consistently toward desired outcomes. There is a variety of frameworks that have been conceptualized by practitioners working with maltreated children and adults. Herman (1992) recommends the following three phases during the process of treatment with traumatized adults: 1) regaining a sense of safety; 2) remembrance and mourning; and 3) reconnection with ordinary life. Pearce and Pezzot-Pearce (1997) use a three-stage approach to reformulate the meaning of maltreatment for children: 1) building mastery; 2) reconceptualizing meaning; and 3) developing positive

self-esteem. Gil (1996), in her work with abused adolescents, proposes numerous steps in the structured processing of trauma, which serve two basic goals: 1) reinterpretation and integration; and 2) resolution and closure so that the individual feels more in control. Recovery from posttraumatic stress disorder follows three stages (Brown and Fromm 1986): 1) stabilization; 2) integration of memories; 3) and development of self. Brohl (1996), in discussing the healing process for traumatized children, also conceptualizes three stages: 1) confusion; 2) reorganization; 3) and integration. Hughes (2007) characterizes the therapeutic stance in attachment-focused family therapy by the four traits of: 1) playfulness; 2) acceptance; 3) curiosity; 4) and empathy (PACE).

Regardless of the specific classifications used to describe the process of healing and change, there are a number of benefits to having a framework:

- Organizes otherwise complex information and experiences; interpersonal trauma affects *every* aspect of functioning.
- Makes it easier to stay goal oriented, reducing the possibility of becoming unfocused and overwhelmed; specific goals and methods are connected to each step or stage.
- Provides a "framework for freedom"; the therapist can spontaneously and empathically be in the relationship with the child or other family member knowing there is a secure base.
- Affirms the developmental nature of healing; treatment is a process that builds upon prior accomplishments step by step.
- Enhances hope and optimism, as both the therapist and family members sense positive movement toward attainment of goals.
- Necessary when teaching mental health professionals how to provide effective treatment.

The three phases of the treatment framework used in Corrective Attachment Therapy—*revisit*, *revise*, *revitalize;* each with a specific rationale, goals, and methods—will be described in detail in Chapter 8.

The Sequence of Treatment

The treatment process involves ongoing reassessment. Each phase of therapy—revisit, revise, revitalize—follows a sequential format, incorporating the following clinical tasks and activities: *assess* → *set goals* → *intervene (method)* → *reassess*.

- *Assessment:* Initial assessment begins by reviewing the intake packet (Table 6.1) and speaking with parents, therapists, and caseworkers over the phone and via email (families accepted at Evergreen Psychotherapy Center are often from out of state). Assessment continues at the beginning of treatment with the child, parents, other family members, and hometown therapist (refer to Chapter 6 for a comprehensive review of assessment).
- *Goals:* Specific goals are established for the child and family based on evaluation and assessment (see the section on Therapeutic Goals later in this chapter).
- *Intervene (Methods):* A variety of systematic procedures and interventions are introduced in order to facilitate positive change. Therapeutic methods *must* be based on clinical goals.
- *Reassess:* The therapist evaluates the results of interventions. Therapeutic outcomes occur on many levels: emotional, behavioral, cognitive, social, physical, moral/spiritual. The therapist asks the following question: "How did the child, adult, and parents respond to the specific intervention?" Based on a positive response, the therapist proceeds. Based on a negative response (e.g., resistance, severe anxiety, new information), a different therapeutic direction may be considered.

Corrective Attachment Therapy

The treatment process recapitulates the physical, emotional, biological, and interpersonal characteristics of secure parent–child attachment. That is, the ingredients found in parent–child relationships leading to secure attachment must also be available in the therapist–child relationship, which requires the following necessary ingredients.

- *Structure:* The therapist provides a framework with limits, rules, and boundaries, similar to the clear and consistent structure provided by the sensitive and appropriately responsive ("healthy") caregiver. The structure is consistent and predictable, yet flexible, and changes in accordance with the child's developmental needs. For example, the therapist informs the child of the rules of therapy and together they establish an explicit contract. The contract defines the responsibilities of the child and of the therapist, and the goals they hope to achieve.
- *Attunement:* The therapist is sensitively attuned to the child's needs, feelings, and internal working model ("limbic resonance"). Based on a precise understanding of how the child thinks and feels, the therapist

provides the message: "I know what you need in order to feel safe, and I will meet your needs." For instance, it is understood that the child's hostile and controlling demeanor is actually a defensive strategy designed to protect him or her from feelings of vulnerability, insecurity, and fear.

- *Empathy:* Just as the healthy parent cares deeply about his or her infant and child, the therapist conveys a heartfelt level of caring and compassion. The therapist remains proactive, empathic, warm, and caring, rather than reacting negatively to the child's overtly hostile or distancing behavior. The message conveyed is: "How sad that those horrible things happened to you; I'm sorry that you were treated that way; I understand what you feel and how much pain you must be in."
- *Positive affect:* Parents who foster secure attachments generally experience and exhibit positive emotional responses as they interact with their children. They become irritable and impatient on occasion, but are able to maintain their composure and model healthy coping styles. The therapist also maintains a positive demeanor, particularly when the child is acting out (e.g., verbal abuse, distancing, defiant). This prevents the reenactment of dysfunctional patterns, such as when the child directly or unconsciously "invites" a caregiver to be rejecting, angry, or abusive. The message to the child is: "I will not allow you to control our relationship in unhealthy and destructive ways." This provides modeling of positive affect, appropriate boundary setting, and facilitates change in the child's internal working model. Traumatized children are particularly sensitive and reactive to body language: facial expressions, tone of voice, touch, eye contact.
- *Support:* Parents of securely attached children provide a scaffold of support, i.e., a framework that props up or supports the child as development unfolds: the infant is held in the parent's arms, the toddler explores the environment but checks back with the parent for reassurance, and the preschooler plays independently with friends while still under the watchful eye of the parent. The therapist also provides a scaffolding of support tailored to the developmental needs and capabilities of the child. During the initial phase of treatment, the therapist emphasizes rules, expectations, and natural consequences. As therapy progresses, the focus shifts to reinforcing and celebrating the child's independent achievements.
- *Reciprocity:* A positive reciprocal relationship is one in which there is mutual influence and regulation. The securely attached child achieves a "goal-corrected partnership" with his or her parents, characterized by a

sharing of control, ideas, values, feelings, plans, and goals. This parent–child alliance, achieved by approximately 4 years of age, is based on the successful completion of earlier stages of attachment. Marvin (1977) developed the "cookie test" procedure to access a child's ability to inhibit his or her own impulses for the benefit of the relationship:

> Mother shows the child a cookie, tells her she can have it only after mother finishes a chore, places the cookie in sight but out of reach, waits three minutes, then gives the cookie to the child.

Only 19 percent of 2-year-olds could wait (they cry, reach for the cookie, grab mother's leg in protest). Most securely attached 3- and 4-year-olds, however, were able to wait the three minutes. They could inhibit their impulses, taking the mother's needs and feelings into consideration. Children with attachment disorder, regardless of their age, fail the cookie test. They have not achieved the state of a goal-corrected partnership due to prior insecure and pathological attachment experiences.

The therapist guides the child toward a reciprocal relationship based on mutual respect and sensitivity. This begins with the establishment of a foundation for secure attachment (safety, protection, empathy, trust). The child begins to learn to balance his or her own needs with those of others.

- *Love:* Secure attachment is synonymous with love: the ability to feel a deep, special, and genuine caring for and commitment to another human being. Children with attachment disorder often have difficulty experiencing and demonstrating love toward themselves and others, because they lack the early attachment relationships necessary to create the feeling. Corrective Attachment Therapy provides that relationship context and in doing so, guides the child to a place where love is suddenly an option. During the course of successful treatment, a child will commonly say for the first time, "I am feeling love in my heart." This open expression of loving feelings occurs with parents eye to eye, face to face, heart to heart. Children however, will only feel safe in experiencing and expressing love if the parent(s) are available to receive that love. Thus, therapy also helps the parents become emotionally available.

Limbic Activation Process

This section will describe the rationale, goals, and functions of the Limbic Activation Process (LAP), utilized as a therapeutic context with traumatized

children and adults. As is the case with most clinical interventions, the LAP cannot be understood outside of the therapeutic milieu in which it occurs, or without considering the skillful implementation of the experienced, trained, and sensitive therapist. *The LAP is not a method or technique—it is a relationship context in which other methods are employed* (e.g., cognitive rescripting, inner child metaphor, psychodramatic reenactment). The therapist must provide a balance of structure and nurturance, and respect the child's individual needs and choices. It is imperative to avoid establishing a complementary relationship of coercion and compliance, characteristic of prior unhealthy attachment relationships.

Goals and Functions

Facilitates "Limbic Resonance"

A major goal of the LAP is to facilitate limbic resonance between therapist and client, parent and child, and adult partners. Limbic resonance naturally occurs in the parent–child secure attachment relationship, and between adult partners in secure, intimate relationships. Limbic resonance implies a mental, emotional, and biological connection that is safe, close, and mutually fulfilling. Limbic resonance is a connection of minds, emotions, and the limbic systems of two brains, achieved via empathy, understanding, and security.

Promotes Attachment Behavior

The LAP creates an experience that promotes secure attachment behavior. This is done in the parent–child bonding position on a comfortable sofa, face to face and eye to eye. It stimulates infant and parent attachment behaviors practiced by most cultures throughout the world. These species-specific behaviors have changed little over the past 100,000 years.

An important feature of attachment behavior is the eye contact, touch, and positive affect that occurs in the "in arms" position. Secure attachment forms when a consistent and appropriately available caregiver provides the infant/child with limits, love, eye contact, positive emotional responses, nurturing and safe touch, gentle movement, stimulation, and soothing. The mother and baby create a mutual regulatory relationship that includes reciprocity, synchronicity, pleasure, and safety. Children who experience maltreatment and multiple relationship disruptions miss this necessary mother–baby attachment context, i.e., they have not experienced fulfillment of many of these precisely evolved attachment-oriented needs. The LAP simulates the original attachment relationship. The healing of the effects of these childhood deprivations can be best facilitated by utilizing this same "in arms" approach.

Biologically based attachment behaviors, although instinctual, must be activated by signs or signals from caregivers. These environmental triggers are referred to as social releasers and "cues of attachment." Cues that activate attachment behavior include eye contact, smile, gentle touch, and the provision of a safe and secure environment. In the LAP, the therapist and/or caregiver activates previously dormant attachment needs, feelings, and behaviors. This process stimulates the old brain (brain stem and limbic system), the part of the brain that regulates attachment behavior, maternal instinct, and stress-related responses.

Activates the Neurobiology of Attachment

As part of healthy development, mother and baby form a reciprocal relationship that includes soothing, safety, and security. Neurotransmitters are released in the limbic brains of both caregiver and child during this interaction. Dopamine is a chemical messenger central to reward, pleasure, emotional connection, and motivation. Endorphins reduce pain, increase pleasure, buffer stress, and enhance feelings of calmness and contentment that mother and infant share. Serotonin also creates calmness while reducing stress and anxiety. Oxytocin, called the "love chemical," is triggered by nurturing touch, and fosters maternal behavior (e.g., nursing), trust, and bonding.

Clinical experience and research have shown that the most effective way to activate the neurobiology of attachment in the limbic systems of traumatized children and adults is to utilize the Limbic Activation Process. This is basically the same strategy that humans have been using for millennium, and is biologically programed into us for the purpose of creating attachment. LAP provides the social, emotional, and physical milieu for the release of the neurochemicals of attachment. It increases feelings of safety, calmness, and security. Our brains are programmed for attachment and love, and the LAP awakens these feelings. Research has shown that physical closeness and affection, such as loving touch and hugs, reduce blood pressure, lower stress hormones, increase oxytocin, and promote calmness, trust, and secure attachment (Holt-Lunstad, Birmingham, and Light 2008).

Reduces the Effects of the "Alarm Reaction" Caused by Maltreatment

The LAP reduces the effects of the severe and chronic stress response associated with maltreatment. Abuse, neglect, and traumatic disruptions in the caregiver–child relationship cause a portion of the limbic system (amygdala) in the brain to trigger the release of stress hormones. Norepinephrine increases the brain's overall reactivity, making the senses more alert. Dopamine mobilizes the body for action (fight or flight), increasing heart rate and blood pressure,

and rivets attention on the source of the fear. This alarm reaction is designed to trigger automatically when danger or threat is sensed. Maltreated children, however, experience a chronic alarm reaction, resulting in symptoms of PTSD (hyperarousal, intrusive recollections, compulsive avoidance).

The Reticular Activation System (RAS) is a switching device between the old brain and the new brain. When we are threatened and sense danger, the RAS shuts down energy to the cerebral cortex, allowing training and instinct to dominate. When we are calm and relaxed, the limbic system shuts down, allowing our higher brain center characteristics of creativity and logic to return. Maltreated children perceive their emotional and physical survival to be constantly threatened. They are in need of a therapeutic environment that reduces their biological level of stress and fear. The LAP provides a context in which the child can be calmed, soothed, and relaxed, thereby reducing the release of stress-induced hormones. The child is better able to process information, pay attention, and utilize the neocortex for learning and change.

Promotes Self-Regulation

A primary parental function is to teach the child to self-regulate, i.e. to modulate and control emotions, impulses, and behavior. Initially, the attachment figure regulates the infant's arousal level by providing attuned and sensitive caregiver responses (e.g., soothes when overstimulated, stimulates when bored or lethargic). Over time, the securely attached child internalizes the parent's lessons and achieves self-regulation. Children with attachment disorder, however, do not learn this important lesson, and consequently display such symptoms as aggression, impulsivity, chronic hyperarousal, difficulty concentrating and staying on task, and inability to control emotions (e.g., temper tantrums).

The LAP provides a milieu in which the therapist facilitates the development of the child's self-control. The therapist can choose to soothe (down-regulate) or stimulate (up-regulate) the child. Eventually, the child learns to manage his or her own internal reactions. For example, a child can be guided through a temper tantrum, learning to talk about anger and frustration as an effective coping skill. The child begins to learn self-control and to appreciate a newfound sense of mastery over previously out-of-control emotions.

Provides Necessary Structure

The LAP provides the structure necessary to meet the fundamental limit-setting needs of oppositional, angry, acting-out children. Children with attachment disorder are typically diagnosed with ODD and, later, conduct disorder. They are "bossy," manipulative, and defiant, and require clear and

consistent external boundaries. The LAP engenders a feeling of safety and security for children who are deficient in internal control. They are extremely anxious regarding their own angry and aggressive impulses, fearful of hurting others and/or themselves. The firm yet nurturing context of the LAP is reassuring. They begin to feel safe and secure with a caring, limit-setting, helpful adult.

Facilitates Corrective Emotional Experiences

Children with attachment disorder have an inordinate need for punitive and/or coercive control of others. This control orientation precludes the development of a positive rapport and working alliance, often resulting in treatment failures. The firm yet caring structure of the LAP diminishes the child's ability to manipulate or control the therapeutic process, which facilitates the development of respect and trust.

These children are extremely emotionally defensive. Although they experience sadness, worthlessness, rejection, and fear, they generally only allow the direct expression of anger. They feel empowered by demonstrations of anger and aggression. The LAP allows the child to identify, explore, and express a wide range of emotions. Chronic defenses are transcended in an atmosphere of safety and security, leading to favorable emotional and social outcomes.

The LAP reduces the reinforcing of negative behavior patterns. Children with attachment disorder are often reinforced for aggression and destructiveness. For example, they learn at an early age that anger works: if others retreat in response to their anger, they believe they have won; if others escalate in response to their provocation, they also believe they have won, because they have engaged others "on their terms." Certain caregiver and/or therapist responses, such as anger, helplessness, or emotional distance, serve to empower the child's negative patterns. In the LAP, however, acting-out behaviors are drastically reduced, and negative behaviors are not reinforced. Prosocial choices and actions are encouraged and learned.

Changes Belief Systems

The development of a new belief system (internal working model) is a primary goal of treatment. Children with attachment disorder operate with negative core beliefs: "I am worthless, defective, unlovable; caretakers are unsafe, unavailable to meet my needs; I must control others to survive." This negative working model develops as a consequence of pathological parent–child experiences (e.g., abuse, neglect, abandonment). The therapist–child relationship established in the LAP provides curative messages to the child.

The child begins to internalize a model of authority and caregiving that is based on qualities of secure attachment.

The oppositional orientation of the child with attachment disorder results in chronic power struggles and control battles. The physical and emotional proximity, firm yet caring approach, and thorough understanding of the child's modus operandi, substantially reduces these power struggles. The child begins to feel safe with a therapist in a position of authority, and now has an opportunity to relate in a new way (affiliative, cooperative) in contrast to the old way (resistant, defiant).

The LAP provides a safe context to address and work through traumatic, painful, and frightening experiences. Children with attachment disorder have typically managed to deny, avoid, displace, and/or dissociate from prior trauma, despite many prior treatment efforts. In our experience, working with children using the LAP leads to the establishment of a deep rapport, a sense of trust, appropriate risk taking, honest disclosure, emotional genuineness, openness to change, and receptivity to the therapist. Healing occurs when experiences that were previously frightening and adversive are dealt with in the safety, security, and acceptance of the therapeutic relationship.

Touching and being touched are fundamental to the human experience. Unfortunately, children with attachment disorder, as a result of physical and/or sexual abuse (traumatizing touch) or neglect (insufficient touch), are typically tactilely defensive and afraid of closeness and touch. In the LAP, the therapist is physically close to the child and is able to provide corrective touch—safe, caring, and nurturing. As therapy progresses, the child learns the difference between "bad touch" and healthy touch. Anxiety associated with physical closeness and touch decreases, and the child begins to feel comfortable and safe.

Therapeutic Style

There is a wide variety of styles and demeanors displayed by therapists. Stylistic differences include intellectual–emotional, distant–engaged, proactive–reactive, didactic–experiential. Certain therapeutic styles are more effective with some populations, while different styles are more effective than others. In working with children with histories of maltreatment and relationship trauma and their families, we have found that the most effective therapeutic style is *proactive*, *engaged*, and *experiential*. The components of effective therapeutic style and structure are listed below.

Interviewing versus Reciprocity

The therapist who employs an interviewing style maintains an objective clinical distance. The goal is to obtain information by receiving answers to questions. The therapist who employs a reciprocal style becomes deeply involved and engaged with the child, in addition to obtaining information. Reciprocity between parent and child is a basic ingredient in the development of secure attachment. Thus, reciprocity in the therapist–child relationship is a basic ingredient in correcting attachment disorder. The reciprocal relationship with the child occurs on four levels:

- *Physical:* Eye contact, safe and nurturing touch, firm and caring structure promote a positive physical connection.
- *Emotional:* Empathy, compassion, warmth, and caring are communicated to the child to set a curative and secure emotional tone. Feelings are encouraged and must be expressed in nondestructive, acceptable ways.
- *Intellectual:* Understanding the etiology and current manifestations of attachment disorder creates a deep connection; the therapist can have genuine empathy for the child's mindset, personal interpretations, and psychosocial sequelae. Children's sense of safety increases when they feel understood.
- *Interpersonal:* The relationship established is characterized by firm and caring authority, appropriate boundaries, mutual respect, and genuine involvement. The therapist provides a healthy role model of managing emotions, setting limits, and sensitivity to others, which was lacking in early attachment relationships.

Proactive versus Reactive

Parents and helping professionals commonly express frustration regarding their inability to develop an alliance and rapport with children with attachment disorder. Yet a positive rapport and collaborative alliance are crucial to the success of therapy. Therapeutic styles can be either reactive or proactive. Therapists with a reactive style may feel helpless, angry, and frustrated, become rescuing or rejecting, and engage in nontherapeutic control battles. The therapist utilizing a proactive therapeutic style guides the child to mastery and success by maintaining a firm, consistent, and curative structure. The therapist sets the tone, determines the pace, and circumvents debilitating power struggles, while being sensitive to the child's needs and capabilities.

Orchestrating the Tempo and Emotional Tone

The pace or tempo of music creates different moods: to build excitement, the tempo is increased; to create calm and a feeling of relaxation, the tempo is decreased. Variations in therapeutic style and demeanor promote similar changes in mood, emotion, and physiology. The therapist "ups the tempo" by modulating the tone and rhythm of his or her voice and communicating animation through facial expressions and eye contact. This is similar to the way a parent activates or "up-regulates" an infant or toddler. The goals of activation are acknowledging and expressing feelings; transcending such defenses as denial, avoidance, dissociation, and resistance; and promoting active involvement and engagement with the therapist for children who are passive, withdrawn, or depressed. The therapist also employs humor and conveys excitement to stimulate and activate the child. An experience of positive connection occurs when the therapist and child share a humorous and lighthearted moment together. Parental excitement (e.g., parent conveys joy to the child who accomplished a task) is a natural component of secure parent–child attachment. The therapist genuinely feels and conveys excitement to the child in order to reinforce positive choices and celebrate achievements.

The therapist "slows the tempo" by using a soft, slow tone and rhythm of voice, gentle and soothing touch, and an accepting, empathic, patient attitude. This is also similar to the manner in which parents "down-regulate" or soothe their young children. The goals of calming and relaxing the child therapeutically include reducing impulsivity and hyperarousal of the anxious and traumatized child, promoting a sense of comfort and safety, processing and integrating therapeutic experiences, and facilitating a secure and trusting connection, as the child relaxes with a therapist perceived as safe and protective.

Managing Resistance

Children with severe attachment disorder are typically angry, oppositional and defiant, mistrustful, contemptuous of authority, and lack genuine and caring relationships. It is not surprising, therefore, that they are extremely resistant to therapy and therapeutic relationships. Many families that enter our treatment program have experienced a number of prior treatment failures. There are two basic patterns of resistance:

- *Active resistance:* The child overtly opposes, challenges, and avoids participation. These children can become physically and verbally aggressive, hostile, punitive, and coercively controlling. These resistive behaviors and attitudes are direct, transparent, and blatant.

- *Passive resistance:* The child's resistance is covert, often subtle, and more challenging to manage therapeutically. These children are commonly superficially compliant and solicitous, self-pitying, "helpless," and employ a variety of methods to manipulate and control (e.g., act "dumb," forget, leave tasks incomplete, not follow rules, respond slowly to questions and tasks).

There are a variety of therapeutic responses and strategies that we have found to be effective in managing and reducing resistance:

- *Remain proactive:* Therapist sets the tone for the relationship and the treatment process.
- *Neutral emotional response:* Therapist avoids negative emotional responses (e.g., anger, shock, rejection); does not get "triggered" by the child's attitudes and behaviors.
- *Avoid control battles:* Resistance has no power or influence when it "falls on deaf ears." The therapist does not engage in most control battles and power struggles.
- *Doing more of the same:* Prescribing the symptom or current behavior "takes the wind out of the sails." For example, a therapist may encourage an oppositional child to look into his or her eyes and say, "I don't want to do it your way." The child is now complying with the therapist's request, and the therapist can praise the child's honesty.
- *Acknowledging choices and consequences:* The child is given the message that resistance is a choice and has certain consequences. For example, a child may be told that he or she is free to choose to be noncompliant in therapy, and a dialogue ensues regarding all the possible consequences of that choice.
- *Convey commitment and perseverance:* These children have learned to "wait the other person out," i.e., realizing they have succeeded in getting their way because others become frustrated, confused, or hopeless in dealing with them. The therapist gives the message, "I will persevere with you no matter how long it takes."
- *Do not resist the resistance:* The therapist allows the child to express resistance while remaining calm and projecting an air of indifference regarding behavior (not the child). For example, the therapist may dialogue with a co-therapist (third-party conversation) about the child's resistant behaviors in a nonchalant way, which eliminates the power of resistance.

- *Identifying underlying emotions:* Resistance is generally fueled by fear and anxiety. Acknowledging and displaying genuine concern and compassion for the child's underlying fears of vulnerability, abandonment, abuse, and loss switch the focus from superficial manipulation to meaningful emotions.
- *Providing empathy:* The therapist communicates the message, "I understand why you do not want to participate in therapy; if I had a background like yours, I would not trust anyone either; how sad that you were taught to be afraid and mistrustful." Children feel understood and validated and often reduce their defensiveness and resistance.
- *Positive frame:* The therapist encourages, validates, empowers, and guides the child to success and hope. The message conveyed is, "I know you can do this; you can be a winner, not a quitter; I have faith in you."

Contracting

Contracting with the child and parents is a basic and crucial component of the initial stages of treatment and also occurs throughout the treatment process (recontracting). Therapeutic contracts are verbal agreements regarding specific desired outcomes. Therapeutic contracts are established between therapist and child, therapist and parents, and parents and child.

The child contracts with the therapist, for example, to follow the rules of therapy, learn to express feelings verbally, and to develop trust. Therapists help the child compile a list of their treatment goals in the initial interview. This becomes a contract: therapists agree to support the child to achieve his or her goals; child agrees to work hard to achieve the goals. The parents, for example, agree to learn effective parenting skills, reduce resentment toward their child, address their family-of-origin issues, and form a united team with the therapist. Parent–child agreements focus on expectations and consequences for the child's behavior, such as the necessity to learn to trust, cooperate, and be sensitive to others in the family. There are four benefits to therapeutic contracts.

- *Increases motivation:* There is a direct correlation between the strength of the treatment contract and the desire, commitment, and motivation to change (Levy and Orlans 1995). Contracting promotes the child's and parent's active involvement and ownership in treatment.
- *Provides structure:* Contracts are established regarding the goals of treatment and the general framework of treatment (Hughes 1997). Specific goals regarding the child, parents, and family system are identified and agreed upon. Aspects of the therapeutic framework,

such as "rules," expectations, and treatment format are established. The roles and responsibilities of each participant (child, parents, and treatment team) are defined.

- *Promotes positive relationship:* Therapeutic contracts are relationship agreements that establish a "collaborative framework" for treatment. They focus on a willingness to accept and comply with behaviors and goals within the context of a relationship. Agreements between the therapist and child, for example, provide a context in which trust, reciprocity, and honest communication can occur. This forms the basis for a "goal-corrected partnership." When the child forms agreements with the therapist, he or she is saying, "Yes, I will," instead of the oppositional response, "No, I won't." As the child maintains his or her agreements, there is an increase in caring and sensitivity toward the needs and feelings of another person. Parent–child contracts provide the opportunity for caregivers to praise the child for maintaining an agreement, and begin a positive cycle of interaction.
- *Facilitates accountability and self-esteem:* Therapeutic contracts provide a vehicle to address accountability. When the child does not maintain his or her agreements, the therapist confronts the "breaking of the contract." Conversely, the therapist offers praise and approval to the child who maintains agreements. This reinforces the child's honesty and positive responsiveness in the relationship, and initiates the process of enhancing self-esteem. As the therapist attributes the child's success to his or her own efforts, feelings of inadequacy and negative self-image are reduced, i.e., the child now perceives him or herself in a positive light.

Therapeutic contracts must be age- and stage-appropriate, based on the emotional, cognitive, and developmental capabilities of the child. The contracts are exclusively with the parents when treating children under the age of 5. Contracting is an ongoing therapeutic process. Agreements are discussed and evaluated in every session, and recontracting occurs as needed. Contracts are established on the basis of various therapeutic tasks and interventions. The stages, objectives, and responsibilities of therapeutic contracting are outlined in Table 7.1 (adapted from Heinssen, Levendusky, and Hunter 1995).

Table 7.1 Therapeutic Contracting

1. Define problem
Goal: Understand the nature of the problem and believe that it can be solved; therapist characteristics of empathy and optimism create atmosphere of hope and collaboration; stress child's and parents' active role in treatment as well as responsibilities of both family and therapist. *Therapist's responsibilities:* Provide a framework for understanding problems; create a safe atmosphere ("secure base"); introduce idea of collaboration; focus on problem-solving that is achievable. *Child's and parents' responsibilities:* Develop an understanding of problems and need for treatment; develop a sense of ownership of ensuing treatment plan; agree to roles and responsibilities.
2. Reframe problems as goals
Goal: Reduce perceptions of helplessness and hopelessness by establishing realistic goals—e.g., treatment goals for the child with attachment disorder include enhanced self-concept, reduction of self-destructive behavior, increased trust, reciprocity, and emotional closeness with parents. *Therapist's responsibilities:* Mobilize child's and parents' cognitive and emotional resources by encouraging attainment of short-term goals (e.g., child's positive attitude and choices in session and at home). *Child's and parents' responsibilities:* Elaborate core beliefs (i.e., negative working model), emotional responses, and behavioral symptoms; commit to goals and "rules" of therapy. *Parents' responsibilities:* Collaborate with treatment team; openness to learning, dealing with personal issues, and receiving support.
3. Psychosocial change
Goal: Specific tasks in session and at home are defined; "small victories," as each task is successfully completed, increase belief in competency and counteract feelings of helplessness (victim mindset); create a "success momentum." *Therapist's responsibilities:* Propose methods and tasks for the child (e.g., first-year-of-life attachment cycle, inner child metaphor, direct verbal communication); explain reason for each method and task; provide support and positive reinforcement following accomplishment; address family issues (e.g., marital conflict, family-of-origin issues of parents, sibling conflict). *Child's and parents' responsibilities:* Express a personal commitment to goals, or express in honest way reluctance to work on goals; establish daily goals that are concrete, observable, and attainable; discuss and evaluate attainment (or nonattainment) of goals.

Therapeutic Goals

Effective therapy is contingent on the establishment of clear and concrete goals. Goals must be framed positively ("desired outcomes"), stated in specific behavioral terms, and be realistic and achievable. A sense of ownership regarding goals increases motivation for children and parents. Therapeutic goals for children, parents, and Corrective Attachment Therapy are listed below.

General Treatment Goals

- Develop a therapeutic context that facilitates a constructive working alliance with the child and parents.
- Clarify parents' (or primary caregivers') level of commitment to the child.
- Encourage family members to identify their expectations and attitudes about therapy and, if pessimistic and limiting, to consider new possibilities.
- Encourage parents and child to personally invest in the treatment process; this promotes a genuine desire to change (contracting).
- Provide information about trauma, attachment disorder, treatment, and parenting, to reduce anxiety and educate.
- Increase expectation of success and sense of hope.

Therapeutic Goals for Child

- Reduce acting-out behavior and other symptoms.
- Identify and express emotions verbally in face-to-face interaction.
- Address prior attachment-related trauma in a direct and honest manner with the therapist and primary caregivers.
- Experience positive (safe, genuine, nurturing) interactions with significant others (therapists, caregivers, siblings).
- Direct anger and responsibility for maltreatment toward perpetrators, rather than toward self or current caregivers.
- Identify the source of his or her negative working model, understand the current manifestations, and develop a belief system that includes positive self-regard and a realistic perception of others.

- Interrupt the vicious circle of negative relationship patterns by experiencing trusting, supportive, and nurturing interactions.
- Reduce the negative emotions associated with past traumatic events and memories by dealing with those traumas in new and effective ways (empowerment, mastery, desensitization).
- Acknowledge and express a range of difficult emotions (anger, fear, sadness, pain, guilt, shame) in a direct and genuine manner with positive personal and interpersonal consequences.
- Take responsibility for one's own actions and decisions; learn to solve problems constructively and make prosocial choices.
- Relinquish the extreme control orientation; rather than equating survival with vigilance and control, learn to allow safe and trusting relationships.
- Learn how to trust and whom to trust.
- Experience a constructive grieving process regarding the loss of attachment figures.
- Develop positive regard (trust, respect, caring) toward one's self; reduce self-contempt associated with the negative (internalized) self.

Therapeutic Goals for Parents

- Develop a collaborative alliance with the treatment team.
- Explore family-of-origin issues and attachment histories.
- Improve communication and problem-solving in their marital relationship; maintain a united and supportive parental team.
- Learn effective parenting attitudes and skills.
- Create a secure base for their child.
- Develop and maintain support systems.

Corrective Attachment Therapy Goals

- Enhance secure attachment behavior in the parent–child relationship (trust, attunement, positive affect, nurturance, safe touch, need fulfillment, affection).
- Develop a reciprocal, goal-corrected parent–child partnership; sharing of control, ideas, values, emotions, plans, and goals.

- Increase attunement, empathy, support, and positive affect from parent to child.
- Create a parental framework and structure with developmentally appropriate limits, rules, and boundaries.
- Enable the parents to function as a "secure base" for the child.
- Facilitate signs of secure attachment with the parents:
  - warm and affectionate interactions
  - seek comfort when in need
  - rely on for support and help
  - cooperative and reciprocal
  - check back in unfamiliar or threatening surroundings
  - experience closeness and display relief after separation and upon reunion.

8

Corrective Attachment Therapy

Methods and Interventions

This chapter will describe various therapeutic methods, procedures, and interventions—cognitive, emotional, interpersonal, systemic, biological, and psychoeductional. It is important to keep in mind, however, that the skill of the therapist and the quality of the therapeutic relationship is of utmost importance regarding the success of therapy. The combination of effective interventions and a caring and competent therapist is the formula for positive results. Thus, before explaining the goals and methodologies of specific interventions, it is necessary to focus on the therapeutic relationship.

Therapist as a Secure Base

Reviewing hundreds of studies on psychotherapy outcome, the factor that most often is associated with successful therapy is always the same—*the quality of the client–therapist relationship*. The therapeutic relationship is more important than the theoretical orientation or particular methods used (Orlinsky and Howard 1986; Wampold 2001; Norcross 2002).

The therapeutic relationship—be it a therapist and client, or a healing parent and wounded child—is the most powerful curative factor. Since interpersonal trauma is created by hurtful relationships, the "cure" requires a relationship that has the same ingredients as a healthy ("secure") parent–child relationship: trust, safety, empathy, emotional attunement, limbic resonance, support, and helpfulness.

It is generally accepted that therapists function as a secure base for their clients. Therapists possess the same characteristics as secure attachment

figures. For children, attachment figures provide a secure base so that they can explore, learn, and develop in healthy ways (Ainsworth 1967; Bowlby 1988a). Similarly, therapists serve as a reliable and trustworthy figure—a secure base. Clients use the safety of the therapeutic relationship to acknowledge and discuss feelings and experiences that were denied and avoided, and to try out new behaviors, mindsets, and relational patterns. The therapist's support and acceptance helps reduce anxiety and distress, so clients can learn about prior and current relationships and begin the process of change (Farber, Lippert, and Nevas 1995).

There are many therapist characteristics that engender a secure base. Therapists are emotionally available, sensitive, and responsive in predictable and consistent ways. They are attuned to client's needs and emotions, both verbally and nonverbally. Therapists provide empathy, understanding, support, encouragement, and positive mentoring. They mitigate anxiety, stress, and emotional pain, and facilitate new solutions and experiences. The therapist and client establish a positive working alliance, a psychologically protective holding environment (Winnicott 1985). Research supports the idea that therapists function as a secure base. Studies show that therapists are perceived as providing the same secure base as spouse and family, are considered a safe haven to turn to for comfort during distress, provoke separation protest when absent, and produce feelings of safety, acceptance, and support in clients (Farber and Metzger 2009).

Clients will naturally reenact behavioral patterns and expectations in the therapeutic relationship ("transference"). Employing an attachment-focused model, the therapist can assess how they cope with stress and respond to the therapeutic relationship, including deactivating (avoidant), hyperactivating (anxious), or secure attachment strategies. *Avoidantly* attached adults are reluctant to come to therapy because they are self-reliant and avoid depending on others. However, when in therapy, they typically intellectualize, brag about their own accomplishments, do not take responsibility for their own part in issues, and criticize others. They let it be known they do not need help. The therapeutic relationship is emotionally distant. *Anxiously* attached adults are prone to self-disclosure and intense emotions, but are limited in their ability to explore new ways of behaving, thinking, and relating. They find it hard to accept support, and react to the therapist based on their expectation that he or she will be inconsistently available. Adults with a history of severe trauma (*unresolved*) do not feel safe enough to use the therapist as a secure base. As a result of severe maltreatment and relationship trauma, they view themselves as bad and unlovable, and others as dangerous and unreliable. Thus, therapy is a slow process; it takes a long time to develop a trusting relationship, if ever.

Therapists' own attachment security allows them to constructively challenge and confront client's self-defeating behavior and mental models. Clinical techniques may differ based on various theories and approaches (e.g., cognitive–behavioral, psychodynamic, emotion-focused, family systems), but the essential beneficial therapeutic ingredients remain the same. The result is positive mental, emotional, and social change: new core beliefs, from the expectation of others being unavailable and unsafe to responsive and secure; from mistrust to trust; enhancing self-concept and self-esteem; increasing self-awareness and the understanding of others' mental and emotional states; lessening and/or eliminating emotional pain; experiencing positive emotions, hopeful mindsets, and fulfilling relationships.

Hope

A positive therapeutic relationship also instills hope in clients. Research on hope has magnified in the last 30 years. Regardless of the therapeutic approach, hope has been found to be a critical component of positive change. Hope is linked to better physical and psychological health, academic performance, and recovery from trauma (Gilman, Shumm, and Chard 2012).

Hope develops within the context of early attachment relationships. When children feel safe and have their needs gratified they learn to trust, which gives them the opportunity to experience hope. Traumatic experiences shatter one's belief in a safe world and in trustworthy and dependable relationships. This leads to a sense of a foreshortened future and the loss of hope, and the symptoms common to PTSD, depression, and complicated grief.

Building hope is a key aspect of healing with traumatized children and adults. Hope empowers and motivates traumatized individuals to believe in the possibility of a brighter future. Connectedness to others plays an important part in engendering hope; the therapeutic relationship serves as a vehicle to combat hopelessness. Increasing hope with trauma survivors involves: 1) creating trusting and close relationships; 2) teaching coping strategies that bring about positive change (e.g., anger management and relaxation skills); and 3) identifying and working toward goals.

Using the therapeutic relationship as a secure base (i.e., safe, supportive, encouraging), clients are encouraged to think about specific goals (*agency thinking*; "I want to be close to my parents"), and learn methods to achieve those goals (*pathway thinking*; "I am learning communication skills"). For instance, in our initial interview, we assist children and adults to write a list of their treatment goals and discuss how to reach those goals. They often report that this exercise makes them feel more "hopeful."

The therapist's hope is important. It is essential to convey a sense of hope and a vision of a positive future. Helping demoralized parents acquire and convey hope to their children is also a major goal of our therapy. Maintaining hope in the face of trauma, loss, and depression is difficult, but necessary when helping children, adults, and families. Envisioning a future worth living is essential to recovery. To heal, one must learn to feel safe, build a positive view of self, and create trusting and secure relationships. Hope is a basic part of this process.

The Placebo Effect: The Power of Belief

The therapeutic relationship enhances positive beliefs. One of the variables linked to positive results in psychotherapy is expectation of success. In other words, if we believe in something enough, we can make it happen. The importance of belief and expectation is found in the placebo effect—the beneficial result in a patient from an inert substance (e.g., sugar pill) or bogus procedure. Research has shown that sugar pills reverse insomnia, fake injections relieve pain, and sham surgeries cure arthritic knees (Gura 2013).

Research at the Harvard Program in Placebo Studies found that 82 percent of the improvement in mood associated with widely prescribed antidepressants could be duplicated by giving patients sugar pills (Kirsch 2010). These studies found that antidepressants worked better than sugar pills only in patients with the most severe depressions. Researchers at Baylor School of Medicine found the placebo effect in surgery. One group of patients was given arthroscopic knee surgery as a remedy for arthritis. The second group had a sham operation; they were sedated, did not have the real procedure, and were told the operation was a success. Two years of follow-up showed that pain relief and improved function were the same for the placebo patients and those who had the actual operations (Moseley 2002).

Placebos are most effective in illnesses and symptoms that have a strong psychological component, and when a treatment's success depends largely on the subjective experiences of patients. Depression, pain, insomnia, fatigue, nausea, stomach problems, migraine headaches, and sexual problems are most amenable to the placebo effect.

There are psychological, social, and biological explanations for the placebo response. Expectations play a significant role. Beliefs have a powerful influence on experiences. When an intervention is believed to help a condition, many people will benefit due to their expectation of receiving help. A famous study in the classroom demonstrated the power of expectations. Teachers were told at the beginning of the school year that certain students were the most intelligent, when they actually were the same as other students. At the end of the year, the "exceptional" students were tested and demonstrated superior

cognitive abilities. The beliefs the teachers had in the students' abilities and potential were subtly communicated to the students—a self-fulfilling prophecy (Rosenthal and Jacobson 1968).

The placebo response is also explained as favorable response to receiving care and positive attention from others (e.g., physicians, therapists) who patients believe can help relieve their discomfort and distress. The doctor's behavior—"bedside manner"—plays an essential role. Instilling hope, being empathic, and building trust enhance the placebo effect and lead to positive change. Researchers found that patients suffering from irritable bowel syndrome reported more symptom relief when their physicians showed empathy, listened actively, and touched the patient, compared to not providing these caring behaviors (Kaptchuk *et al.* 2008). The placebo effect may also have an element of psychological conditioning. Once a person benefits from an intervention, that person associates the intervention with a benefit. For example, learning that the act of swallowing a capsule precedes relief, taking a sugar pill may bring on the physiological changes real drugs can yield.

Researchers have used brain scans to show that there is a physiological explanation for the placebo effect, including objective changes in brain chemistry. When people believe they will get better, the brain releases endorphins, a natural pain-relieving substance. Measurable changes in brain chemistry may explain the large placebo effect seen in the treatment of depression. Parkinson's disease is associated with a shortage of the neurotransmitter dopamine. Placebos have triggered dopamine production; expecting relief caused patients to have a biochemical response (Kirsch 2010).

Understanding the placebo effect provides valuable insight into psychotherapy and therapeutic parenting. It is critical to appreciate the power of ritual, imagination, hope, trust, compassion, empathic witnessing, and the therapeutic relationship in the healing process. The psychological, social, and neurobiological aspects of the placebo response activate the mind–body self-healing processes and contribute to symptom reduction and overall well-being.

The next section of this chapter will describe the three phases or stages of the treatment process—*revisit*, *revise*, *revitalize*. The rationale, goals, and methods of each stage will be explained.

Revisit

The first stage of the therapeutic process involves revisiting prior significant attachment and trauma experiences (e.g., separation, abandonment, abuse, neglect, multiple placements, and violence in the home). Many theorists and clinicians who deal with maltreated children and adults acknowledge the need

to revisit early life events in order to identify emotional, cognitive, social, and physical sequelae (Friedrich 1990; Terr 1990; Crittenden 1992b; James 1994; Gil 1996; Pearce and Pezzot-Pearce 1997). Through the process of revisiting, the therapist gains valuable diagnostic information and understanding of the internal working model, emotional responses, and interpersonal patterns. "You have to go back to the trauma; you have to do exposure therapy, you have to bear witness; the person has to come to terms with the meaning" (Herman 2012, p.19). The basic question is: "What was this child's unique response to prior life events, and how does this affect current and future attachments?" This stage focuses on four elements:

- personal meaning and interpretation
- a detailed review
- acknowledging and expressing affect
- managing defenses.

Personal Meaning and Interpretation

It is necessary to understand the child's subjective and idiosyncratic meaning of events, i.e., the child's personal understanding and interpretation of what happened. As discussed in Chapter 4, internal working models and core beliefs are formed in the early stages of life and become templates through which the child subsequently perceives self, others, and life in general. These core beliefs become a child's point of reference, a standard by which he or she measures all later experiences. The securely attached child develops a belief system with a positive orientation toward self ("I am good, worthy of love, competent"); caregivers ("they are trustworthy, safe, loving, and responsive to my needs"); and humanity ("people are basically good, life is worth living"). The belief system of the child with interpersonal trauma is oriented negatively toward self ("I am bad, unworthy of love, impotent"); caregivers ("they are untrustworthy, threatening, unloving, and unresponsive to my needs"); and humanity ("people are basically bad, life is not worth living").

What one believes to be true, based on early experiences, to a large extent governs emotions, actions, and choices. Attribution theory suggests that children construct beliefs about how and why things happen, i.e. different causal explanations or types of attributions (Kelley 1973; Seligman *et al.* 1984; Peterson, Maler, and Seligman 1993). The meaning the child assigns to important life events significantly determines subsequent psychosocial functioning and adaptation. For example, maltreated children routinely attribute blame and responsibility to themselves ("It was my fault that I was abused," "I must be bad because I'm treated bad"). Research has shown that

subjective factors (i.e., personal meaning and perception) accounted twice as much as objective factors (e.g., injuries, force) for the severity of psychological distress in children who experienced violence and abuse (Weaver and Clum 1995; cited in Pearce and Pezzot-Pearce 1997, p.55).

The concept of learned helplessness also explains how children perceive themselves as inadequate, powerless, and defective due to their inability to respond effectively during threatening and traumatic situations (Seligman 1993). Our core beliefs become self-fulfilling prophecies; we draw situations to us that validate our beliefs. For example, the child with attachment disorder consciously and unconsciously creates social scenarios that justify and support his or her negative working model ("I will push you away until you reject me, which then reinforces my belief that I am not lovable"). Figure 8.1 depicts the vicious cycle of the child with a negative working model.

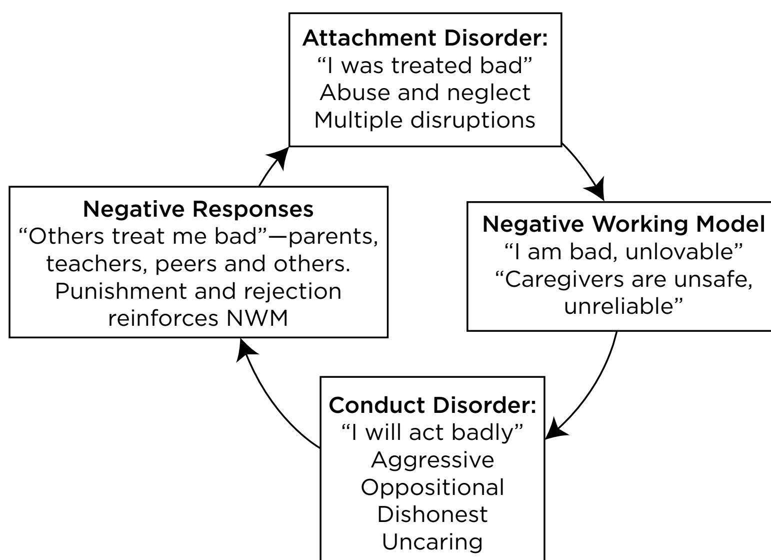


Figure 8.1 Vicious Cycle of the Acting Out ("Bad") Child

A Detailed Review

The child is guided through a verbal accounting of events, the context in which events occurred, personal meaning, affective and somatic responses, and imagery. Honesty is encouraged to reduce denial, distortion, and dissociation. The child acknowledges and shares thoughts and feelings about painful events with the therapist. Timing, however, is crucial. This sharing must occur in the context of a safe and secure therapeutic relationship. This detailed account includes the following components:

- child's perception of events

- emotional and somatic reactions
- associated imagery and memory
- responses of significant others.

There is a universal belief in the value of "truth telling" as part of a healing ritual (Herman 1992). As the child shares his or her story honestly, often for the first time, in the accepting and empathic eyes of the therapist (and later the parent), a meaningful connection is created. Further, telling and retelling the story desensitizes the negative emotional charge associated with traumatic events. The acceptance and validation received from the therapist reduces the child's shame and guilt.

Acknowledging and Expression Affect

More than 100 years ago, Breuer and Freud wrote, "Recollection without affect almost invariably produces no result" (cited in Herman 1992, p.177). The controversy over the efficacy of addressing affect and encouraging catharsis has existed for all these years. Some clinicians view catharsis as a necessary part of the therapeutic process (Moreno 1977; Nichols 1986; McGuire 1991), while others consider it unnecessary (Binstock 1973; Lewis and Bucher 1992). Our clinical experience has demonstrated that, "if you can feel it, you can heal it." The release of repressed emotions that could not be safely expressed earlier (i.e., during traumatic events) is validating and empowering for the child. Again, the therapeutic context is crucial. The safety of the therapist–child relationship provides a "secure base" from which to explore painful and frightening emotions and memories.

Managing Defenses

Defense mechanisms such as idealization, projection, displacement, dissociation, denial, and splitting are designed to protect the child from overwhelming and intolerable feelings and memories of traumatic experiences. Although these defenses are adaptive for survival, they have damaging long-term psychological consequences. For example, overidealizing an abusive or neglectful mother allows the child to avoid and deny the painful reality that she provided insufficient nurturance, love, and protection. Denial saves the child from having to experience the grief and anger that accompanies facing the truth. Dissociation is an automatic response that protects the child during trauma; the child splits off from the experience, no longer having to feel the pain, fear, or humiliation of the moment. Displacement enables the child to project onto foster or adoptive parents the feelings and perceptions that he or she actually has toward maltreating biological parents or others.

Defenses are acknowledged, confronted, and challenged in a safe and sensitive manner, enabling the child to reduce defenses while telling his or her story and sharing emotions. This results in enhanced trust and a sense of mastery and empowerment.

Revise

The second stage in the therapeutic process is revision. The focus now becomes both developing and revising: *developing* secure attachment patterns that were never previously established, and *revisiting* disturbed attachment patterns that were created early in life. All previous interventions have provided a foundation for assisting the child and parents to achieve the following goals:

- construct new interpretations
- deal effectively with emotions
- develop secure attachments
- learn prosocial coping skills
- create mastery over prior trauma and loss
- develop a positive sense of self
- enhance self-regulation
- address family systems issues (family-of-origin work with parents, marital issues, parenting skills, mobilizing community resources).

There are several basic issues to consider during this phase of treatment. First, during therapy it is difficult to separate cognitive, emotional, and social change. There is an ongoing process of weaving interventions that focus on various components of change. Second, cognitive rescripting (i.e., challenging the child's negative working model) is only effective when combined with positive emotional change. The emphasis must be on changing both thoughts and feelings, since one affects the other, in an ongoing and reciprocal manner. Third, the climate and context in which these changes occur is crucial. The therapist functions as a "secure base" for the child, providing safety, predictability, empathy, guidance, and support. It is common knowledge among mental health professionals working with maltreated and traumatized children that a major goal is always empowerment of the "victim." The therapeutic environment must provide a safe context for appropriate risk taking, honest disclosure, and emotional release, which leads the child from helplessness to empowerment and from inadequacy to mastery.

Personal Meaning and Interpretation

The modification of the child's negative working model and maladaptive core beliefs (i.e., "cognitive rescripting") is accomplished in a four-step process:

- *Identify and acknowledge beliefs:* Common beliefs of the child with attachment disorder are: "I don't deserve love, I am helpless, I cannot trust anyone, I must control others to survive." These beliefs are identified during the initial interview and the first-year-of-life attachment cycle intervention.
- *Therapist challenges negative working model:* Employing a variety of treatment methods (first-year-of-life attachment cycle, psychodramatic reenactment, inner-child metaphor, parent–child dialogues, and discussion of prior behavior) the child's belief system is questioned and challenged.
- *Child challenges negative working model:* Children with attachment disorder deny, blame, and idealize in an attempt to avoid painful realities. For example, a child will place a previously abusive or neglectful parent "on a pedestal," rather than face the truth about being unloved. Children must "own" and acknowledge the truth about their current belief systems before they can change them.
- *Repetition and rehearsal:* Acknowledgement and change require many repetitive therapeutic experiences and numerous rehearsals of new ways of thinking. Repetition is particularly crucial with these children due to chronic denial and avoidance.

Emotional Change and Healing

The word emotion comes from the Latin *ex movere*, which means "to move out of." Emotion literally refers to an impulse toward outward expression. As a result of the loss of primary attachment figures, maltreatment, multiple relationship disruptions, and repeated moves, children with attachment disorder experience intense negative emotions. The primary distressing emotions are anger, fear, sadness, and shame, which remain unresolved, stored in the body–mind system, and continually influence daily choices and behaviors. The treatment process must help the child develop masterful management over previously overwhelming feelings.

Emotional Processing

It is common for children and adults with histories of maltreatment, trauma, and compromised attachment to avoid painful memories and reminders

of prior negative experiences. Although such avoidance reduces anxiety in the short term, in the long run it maintains fear, feelings of powerlessness, and other trauma-related symptoms, and prevents healing via emotional processing. When children acknowledge and talk about painful and frightening memories, emotions, and events with supportive and attuned therapists and caregivers, they learn they can effectively deal with these issues, they can tolerate the distress, that the anxiety and distress decrease rather than increase, and that others can be trusted to understand and help.

In addition to avoidance as a defense, those with traumatic histories have typically developed negative cognitions, interpretations, and mental models. They believe they are helpless, incompetent, and controlled by their fear ("My world is dangerous, and I am unable to cope with it"). Their stories and narratives of past events are often disorganized and fragmented, a result of traumatic experiences being encoded in the limbic brain under conditions of intense distress (Amir *et al.* 1998; Foa, Hembree, and Rothbaum 2007). Communicating about distressing emotions and experiences with supportive and attuned therapists and parents helps children organize memories in a meaningful way, make sense of their past, and create a logical story. As they create an acceptable narrative, erroneous cognitions are reduced ("It was my fault; I'm unlovable; I'll lose control if I talk about this") and are replaced by self-enhancing mindsets ("I'm not to blame; I'm worthy of love; I can manage my thoughts, memories, and feelings").

The process of revisiting and retelling memories of loss, pain, and fear in our therapy program parallels the theory of *Prolonged Exposure Therapy*, the most empirically validated approach to trauma-related symptoms and conditions (Foa *et al.* 2007; Institute of Medicine 2007). This therapeutic process includes several procedures and interventions: 1) emotional processing in a safe and supportive interpersonal context; 2) psychoeducation about early life experiences, attachment, and trauma, and the importance of talking about difficult issues; 3) relaxation techniques, which help the person reduce anxiety both emotionally and biochemically; and 4) recounting traumatic memories and emotions aloud via imagery and role-playing. The visualization and role-playing interventions are experiential; the child is having a genuine psychosocial experience in the present moment. The limbic brain can only be rewired by direct experience. As children are guided through a detailed revisiting via inner child metaphor, psychodramatic reenactment, and processing with parents, they establish new neuronal networks, develop acceptable narratives, and reduce fear by repeated exposure. Their fear is activated without negative outcomes, leading to less fear and anxiety. They learn others can be relied on for comfort and support, reducing the need for controlling, punitive, and intimacy-avoiding defenses.

In order for therapy to be effective the client must be at a level of engagement where genuine emotions (i.e., sadness, fear, anger) are experienced, and a level of tolerable distress is evident. Therapists must provide sufficient support, empathy, encouragement, and guidance to help clients achieve goals and positive change.

Telling and Retelling a Traumatic Story

Many parents and mental health professionals avoid talking with children about their prior traumas, fearing that such discussions will cause more pain and reinforce the trauma. Conversely, when children share their stories within a context of attunement, support, and safety, while developing a coherent and sensible narrative, they can face their fears and pain, and begin to heal the trauma. There are a number of reasons why communicating one's story is therapeutic.

As previously noted, one therapeutic goal is to facilitate integration of the two brain hemispheres. The right side of the brain processes emotions and explicit (autobiographical) memory. The left side is logical, making sense of feelings, experiences, and memories. When children, teens, and adults talk about their experiences and emotions, while being helped to create an honest and logical narrative, their right and left hemispheres are working together. The task of developing a rational narrative is accomplished during several therapeutic interventions, including *first-year attachment cycle*, *inner child metaphor*, and *psychodramatic reenactment*.

The child is sharing his or her story in a context of support and attunement, both crucial for the development of secure attachment, but absent for traumatized children. Therapists and parents listen to the child's emotions and perceptions with verbal and nonverbal responses of empathy and understanding ("limbic resonance"). The child learns that he or she is no longer alone—now able to face and share painful emotions and memories with the support of caring adults. This promotes a change in the internal working model from the old ("caregivers are dangerous, not to be trusted"), to the new ("caregivers are safe, can be trusted"). Since new experiences rewire the limbic brain, sharing one's story in the context of support, empathy, and safety fosters changes in the architecture and biochemistry of the brain. It creates connection, biologically and emotionally.

Retelling stories also helps to modify self-identity. Children learn that they can face their scary and painful past, and tolerate their emotions and anxiety, without losing control, going "crazy," or using old defenses (e.g., avoidance, denial, disassociation). They evolve from the old "victim" mindset ("I am helpless and can't cope") to a new "survivor" mindset ("I am competent and can cope"). Using language—helping children to use words to describe

and communicate their feelings and experiences—calms the fear circuits of the brain and reduces acting out. Children learn to identify and talk about their thoughts and emotions in a safe environment rather than displaying their inner struggles through negative behaviors. Effective communication is key.

The Emotional Body

Our bodies and minds are inseparable. Research in the field of psychoneuroimmunology has revealed an undeniable connection between physical and mental functions and their relationship with health and disease (Borysenko and Borysenko 1994). Anger, fear, sadness, and shame are not merely emotions, they occur and are stored on a somatic level, i.e., in the body. These feelings do not vanish as a result of intellectual understanding. Although cognitive mediation is a necessary part of treatment, traumatically charged emotions must be directly addressed on a somatic level. For example, people experience emotions in their bodies; we "burn" with anger, "shake" and are "pale" with fear, become "heavy hearted" and "choked" with grief.

We are biologically programmed to experience and release emotions physically. Among certain primitive cultures, for example, lengthy dancing rituals facilitate the release of grief and loss, thereby avoiding physical and emotional repression. Infants instinctually express both painful and pleasurable emotions via physical action: kick their legs, wave their arms, arch their backs, move their heads from side to side, and erupt in piercing screams. Children with attachment disorder experience trauma, including painful emotion and memory, in their bodies. During treatment children are encouraged to express their feelings naturally in a safe and secure environment.

An instinctual response to fear and threat is to hold your breath. Another effective body-oriented technique is to encourage the child to breathe deeply and fully. Deep breathing cleanses carbon dioxide from the body and increases oxygen supply and available energy. It also promotes the release of genuine and deep-seated emotion.

Guided Imagery and Visualization

Visualization techniques are also useful to help children identify and express their emotions. For example, the therapist asks the child the following questions: "What color is your heart? Is it hard or soft? Where in your body do you feel your anger, sadness, fear, and shame? What physical action would you match to the emotion you are feeling?" The child's response is diagnostic of his or her emotional state: "My heart is black and hard as a rock. My stomach hurts and I have a headache. I feel like punching someone." As

therapy progresses the child's response is diagnostic of positive change in emotional states: "My heart is pink and becoming softer. I feel more relaxed and my stomach-ache went away. I need lots of hugs."

Guided imagery, also called visualization and mental imagery, is a safe and effective technique that focuses and directs the imagination, and involves the body, emotions, and the senses. It is based on the concept that mind and body are connected; the body responds as though what is imaged is real. For instance, when individuals are asked to imagine biting a lemon, many people will actually salivate.

Guided imagery can be used to create a relaxed state, reducing anxiety, distressing thoughts and emotions, and physiological stress. Research has demonstrated the positive effects of guided imagery on health (e.g., lowers blood pressure, enhances immune system, lessens headaches and pain), and on trauma (e.g., reduces PTSD symptoms, increases optimism and resilience) (Battino 2007).

Visualization is used extensively in sport psychology. An example is a famous study with basketball players, who were divided into three groups and tested on their ability to make free throws. The first group practiced 20 minutes each day. The second group only visualized themselves making free throws, but no real practice occurred. Group three did not practice or visualize. There was significant improvement with the group that only visualized; they were almost as good as the group that actually practiced (Reyes 2012).

Guided imagery is a right-brain activity and, therefore, taps into the unconscious mind and the limbic system of the brain (i.e., early encoded messages and experiences). Due to the inherent mind–body connection, images created can be as real as actual external events, particularly when strong emotions are involved. Imagery often brings about an altered state in which children and adults are capable of greater learning and healing. This is a state of relaxed focus, calm alertness, and concentrated attention. This experience fosters an "internal locus of control," a sense of being in control of emotions, recovery, and change, a sense of mastery over previously distressing and painful experiences.

Imagery is used during various experiential interventions in our therapy with traumatized children and adults. The *inner child metaphor*, for example, incorporates guided imagery and the inner child, symbolized by a teddy bear: "Picture in your mind yourself as a young child. Tell this child he/she is loveable and worthwhile and that it was not his/her fault that bad things happened (e.g., abuse, abandonment). Hold the teddy bear close to your heart; give him/her love and support." The imagery, combined with the symbolic "inner child," elicits feelings of love, care, support, safety, and compassion, to

replace feelings of fear, anger, anxiety, shame, and self-contempt. Children and parents participate in this experience together, increasing the parent–child bond via empathy, support, and emotional honesty. Adults participate with significant others (e.g., spouse), when available, which enhances the adult–adult attachment relationship.

Catharsis

Cathartic release of emotions has been found to be helpful for grieving losses (Scheff 1979), treating PTSD and sexual abuse (Allen and Borgen 1994), and in reducing and managing anger (Chandler 1993). However, catharsis is useful in the treatment process only when integrated with other therapeutic techniques, when occurring within the context of a safe and healing relationship, and when combined with a cognitive component (e.g., cognitive rescripting).

Traumatic memories of infants and young children are organized on a nonverbal, sensory-based level (visual images; olfactory, auditory, or kinesthetic sensations; intense waves of feelings) (van der Kolk 1996). Emotional experiences and strong, affectively charged memories are disconnected from language and rational thought. Though many of these incidents occurred before conscious memory, the feelings provoked are not forgotten. Cathartic methods provide access to these sensory-based memories.

The child with attachment disorder is a hostage to powerful emotions. Anger, fear, and unresolved emotional pain dictate his or her choices and actions. These children spend a great deal of time and energy in service to these emotions rather than the emotions being in service to them. Prior traumatic experiences have taught them to deny, avoid, repress, or dissociate from emotions. They must be taught to experience, process, and express emotions in a constructive way. A crucial part of this process involves emotional release, which is effective under the following conditions:

- The child expresses affect within the context of a corrective relational experience, i.e., the child internalizes acceptance, empathy, and support from the therapist.
- Shame is reduced as the child releases intense emotions, eye to eye, face to face, in an accepting environment.
- The therapist models constructive expressions of his or her own affect, i.e., does not react to the child's emotions with anger, anxiety, or shock. Important messages are conveyed: "You are safe with me because I can handle your intense feelings. I will teach you how to handle your emotions, and also show you by my example."

Mourning Losses

It is difficult but essential to confront losses of significant attachment figures in the child's life. Children with attachment disorder experience a variety of losses.

- *The loss of a primary attachment figure:* The child is removed from abusive or neglectful parents by social services, or placed in an orphanage.
- *The loss of a subsequent attachment figure:* The child must leave foster parents or caregivers in an orphanage.
- *The experience of multiple losses:* The child moves through a variety of foster homes or other out-of-home placements.
- *The loss of never having a biological attachment figure after birth:* The child is born drug exposed and immediately placed in foster care, or the child is adopted at birth.

Children with attachment disorder typically avoid or deny their grief about losses by being chronically angry, controlling, or aggressive. Also, fantasies or revenge or false "forgiveness" are designed to avoid grief, sadness, and shame. Through the use of various therapeutic vehicles (inner-child metaphor, first-year cycle, psychodramatic reenactment) the child can express his or her grief directly and honestly.

Trust

A hallmark of attachment disorder is lack of trust in caregivers and self. The child's core belief (negative working model) about caregivers is "I cannot trust that caregivers will keep me safe, fulfill my needs, or love and value me." The child's core belief about self is: "I cannot trust that I will ever be safe; my needs are not valid; I do not trust that I am capable, lovable, or worthwhile." Children with attachment disorder begin therapy not trusting the therapist, their current caregivers, or their ability to improve.

A salient developmental task of the first year of life is to develop basic trust in the context of a secure attachment relationship. Infants who are securely attached learn that helplessness and vulnerability are tolerable physical and emotional states. They trust their caregivers to provide safety, protection, and need fulfillment. The infant and toddler with insecure or disorganized attachment learn that helplessness and vulnerability are not tolerable states. Insufficient or nonexistent parental care results in a lack of trust and high levels of anxiety associated with helplessness. As development unfolds, the child becomes increasingly more angry, controlling, and oppositional, to defend against feelings of intense helplessness and vulnerability.

The first step in the therapeutic process is to assist the child in acknowledging his or her lack of trust. The following dialogue exemplifies the beginning stages of trust development, employing the "story of attachment during the first year of life."

Therapist: Did your birth mother take good care of you and meet your needs?

Child: No, she wasn't around very much, and anyway she was drunk a lot.

Therapist: So, did you learn to trust her, and did you learn to trust that adults would take good care of you?

Child: No, I don't trust anybody.

Therapist: Is that why you don't trust your forever mom and dad [adoptive parents]?

Child: I guess so.

Therapist: Did you ever know this before—why you don't trust anybody?

Child: No, I never did know.

Therapist: Can you look into my eyes and tell me why it's hard for you to trust?

Child: [Looks directly into therapist's eyes.] It's hard to trust because my mom left me.

The child in the example above is allowing honesty and vulnerability with the therapist; she is honestly sharing her lack of trust in caregivers. The key ingredients of early secure attachment, as discussed previously, are now available in the therapist–child relationship, and the child begins the initial stage of trust development.

Prosocial Coping Skills

Children with attachment disorder have often internalized antisocial values, belief systems, and patterns of relating: dishonesty, coercion, aggression, mistrust, betrayal, selfishness. Treatment must provide an opportunity to learn prosocial coping skills so that they can function successfully in families and in society. These children lack the ability to identify and manage emotions, communicate honestly, regulate impulses, and solve problems effectively. Teaching prosocial coping skills not only reduces acting out, but also builds self-confidence and self-esteem. The child feels a sense of mastery as he or she leans to curb impulses, control anger, and solve problems effectively. Further, the child receives positive feedback from others (parents, siblings,

friends, teachers), which reinforces positive behavior, enhances self-esteem, and leads to healthier relationships.

Research has shown that maltreated children with attachment disorder are least likely to identify and understand their feelings, compared to children with other psychosocial disorders (Beeghly and Cicchetti 1994). Thus, the first step is to help the child identify what he or she is feeling. The child is asked to choose among four feelings ("are you feeling *mad, sad, scared, or glad?*"). Next, communication skills are taught in the context of the therapeutic relationship: empathic listening, "eye-to-eye, face-to-face" verbal sharing of thoughts and feelings. The child is encouraged to practice honest verbal communication, rather than acting out emotions physically and behaviorally.

Attachment Communication Training

Communication is the basis of meaningful relationships and secure attachment. It promotes empathy, understanding, support, and need fulfillment, and fosters constructive problem-solving and conflict management. The communication method we have developed is Attachment Communication Training (ACT), which can be used with any dyad (i.e., parent–child, adult partners, siblings). ACT has a number of goals and desired outcomes:

- Provides a framework conducive to safe and constructive confiding; fosters a healthy and healing emotional environment.
- Teaches effective communication skills, including listening and sharing skills.
- Employs ground rules that increase positive ways of interacting and prevents destructive behaviors, such as criticism, contempt, defensiveness, or stonewalling.
- Facilitates constructive verbal and nonverbal communication, including mental, emotional, and physical connections.
- Results in attunement to each other's needs, feelings, and states of mind (limbic resonance).
- Encourages empathy, warmth, and genuineness; allows for nonthreatening confrontation and constructive conflict management.
- Leads to secure attachment patterns in parent–child and adult relationships.
- Fosters "secure base" behavior and emotional support in times of distress.

The ACT is a structured, goal-oriented, and directive approach to teaching communication skills and mitigating destructive patterns of interacting. Therapists teach family members specific communication skills in order to interrupt habitual negative behaviors and dynamics. It is important to first "set the stage," creating the milieu most conducive to constructive emotional communication. The individuals communicating sit in chairs facing one another, so they can be physically close, have eye contact, and hold hands (if and when appropriate). A *contract* is established; clients are asked if they will agree to learn communication skills, and the therapist agrees to guide them through the exercise. It is important to follow the guidelines and steps closely, and practice the skills as described, to ensure success. There are six steps: *share* → *listen* → *restate* → *feedback* → *reverse roles* → *discuss results*.

- *Sharing:* One person speaks while the other person listens. Use the following *sharing skills*:
    - Be honest with yourself and partner about what you are thinking, perceiving, and feeling, even if you are worried about "making waves."
    - Share both thoughts and feelings; "The way I see the situation is ____, and this makes me feel ____."
    - Make "I" statements. You are taking responsibility for your own perceptions and emotions. No questions, blaming, or criticizing.
    - Be specific, clear, and give concrete examples. Don't talk in generalities or expect your partner to "mind read." "When you did ____, I viewed this as ____, and then I felt ____."
    - Be brief. Say one or two things, and say it once. Lengthy speech is annoying and difficult to follow.
    - Be aware of your nonverbal as well as your verbal messages. What is your body language communicating: eyes, facial expressions, tone of voice, posture? Your nonverbal messages may determine how much your partner wants to listen.
    - Be assertive and positive. Do not attack, blame, or criticize.
- *Listening:* While your partner is expressing his or her thoughts and feelings, your job is to be a good listener. Use the following *listening skills*:
    - Be empathic. Understand what your partner is telling you, whether you agree or not. "Walk in your partner's shoes." Really *hear* your partner's ideas, opinions, perceptions, emotions, and needs, even if you see the situation differently.

  - Be nonjudgmental. Do not judge your partner's comments as right or wrong, good or bad. Put aside your judgments so you can understand your partner.
  - Don't censor what you hear (selective listening) or silently rehearse your rebuttal. Relax your mind and body so you can totally hear your partner's message without being defensive.
  - Be aware of your nonverbal messages. Do your eyes, facial expressions, gestures, and body positions let your partner know you are safe, supportive, and interested?
  - Tune into both content and process. The content is the words, ideas, and topic. The process is the deeper meaning, the meta-message—the "message behind the message." What is your partner's emotional message?
- *Restating:* When your partner is done expressing his or her thoughts and feelings, you now restate what you heard: "I heard you say ____." This is called "reflective listening," as you are reflecting back the messages you received.
- *Feedback:* Your partner will now tell you how well you did as a listener. "Yes, you heard me accurately; you got my message, thank you." If you did not think your partner heard all your messages accurately, or misinterpreted your message, you can say, "No, I did not say what you heard; let me try again." It is OK to clarify your thoughts and feelings, giving your partner another chance to listen. The goal is: message sent; message received. No distortions or misinterpretations.
- *Reverse Roles:* The speaker becomes the listener, and the listener now takes a turn at sharing. Follow the same rules and guidelines previously described. You and your partner have several chances to practice sharing and listening skills.
- *Discuss Results:* After you and your partner have had several turns sharing and listening, talk with one another about how it was to use the ACT method. Share your thoughts and feelings considering the following:
  - What was it like to communicate this way?
  - How does it feel to share honestly? How do you feel when you sense your partner is really hearing you or not hearing you?
  - What was more difficult for you, sharing or listening? Why?
  - How will your relationship be improved by using ACT?

- What are some of the issues you want to discuss in the future using ACT?

Examples of ACT with children, parents, and siblings, and adult partners will be presented in subsequent pages in the context of case examples.

Self-Regulation and Anger Management

The ability to regulate and control one's impulses, emotions, and level of arousal is learned in the context of the secure attachment relationship during the first three years of life. A child with attachment disorder has failed to master this stage-specific task, due to a lack of healthy role models and internalization. The therapist provides a model and encourages the child to practice self-control skills: think before taking action, time out to calm down, positive self-talk, verbal expression of feelings, asking for feedback and help, monitoring the body for cues of tension and emotions, mind–body relaxation techniques.

Anger management skills are particularly important to learn, as these children often act out in aggressive and violent ways (e.g., temper tantrums, assaultive behavior, destruction of property). A primary goal is to learn to manage anger constructively—to achieve appropriate self-control and to be able to cope effectively. Before anger can be managed, however, it must be understood. Anger is an emotion that often results from your *thinking*: your attitude and beliefs about anger and conflict, early messages you received from role models, and your "self-talk" that determines your feelings and actions. Anger is typically a *secondary emotion*; it covers up depression and emotions, such as fear, loss, rejection, and sadness. For example, anger often results from unresolved grief. Children who lost birth parents often act out anger toward their foster and adoptive parents. This covers their pain and loss and grief and provides protection against future loss ("I'll push you away before you reject me").

Anger often results from feeling threatened. Children with backgrounds of maltreatment and compromised attachment feel threatened when they perceive a loss of control. Early trauma and lack of secure attachment also result in changes in the *developing brain* that make it difficult to handle impulses, arousal, and anger. These children lack frustration tolerance and flexibility, and easily become distressed, agitated, and angry. A child's *physical condition* is also important to understand. High levels of stress caused by lack of sleep, poor diet, and lack of exercise can lead to anger. For example, a drop in blood sugar (hypoglycemia) or too much sugar in the blood can both trigger stress and anger.

Anger management is a skill and can be learned by both children and adults. Learning involves practice. First, practice skills in a safe setting via role-playing. Next, practice these same skills in a real-life situation.

Anger management includes the following skills and steps: identify and address underlying emotions, be aware of external and internal triggers, understand early messages received from role models, recognize self-talk, know your anger sequence, be aware of body signals and body language, and identify your conflict style. The following describes each step and skill, and provides a task for the client to complete.

Identify and Address Underlying Emotions

Anger is often just the tip of the iceberg; there are other emotions beneath the surface.

Task: Practice identifying the emotions under your anger. Describe a situation in which you became angry and name your underlying emotions.

Situation/anger ____________________________

Emotions below surface ____________________

Be Aware of External and Internal Triggers

There are certain situations or actions that trigger angry feelings and behavior. When someone pushes your buttons, you always have a choice as to how you respond; you have control over, and are responsible for, your own behavior.

Task: Describe what triggered your anger in a specific situation.

Situation/anger ____________________________

The trigger ________________________________

Understand Early Messages Received from Role Models

People often behave in the same ways they were taught, based on messages received and behaviors demonstrated by role models early in life. You have a choice: which messages and values about anger do you want to keep or let go of?

Examples of anger messages: "violence is OK"; "don't be angry"; "talk or don't talk about your anger"; "men can be angry, but not women"; "anger leads to abuse and pain."

Task: Identify the anger messages you received from important role models.

Role model ________________________

1. What did he or she teach you about anger and handling anger? ____________________
2. Describe a memory about this person's anger. ____________________
3. What messages and values do you want to keep or reject? ____________________

Recognize Self-Talk

Self-talk is what you tell yourself about yourself, others, and situations. These preconceived ideas and beliefs have a major influence on how you deal with conflict and anger because feelings follow thoughts. Self-talk can be positive ("I can do this") or negative ("I'll never succeed"). Increasing your positive "scripts" will lead to more positive attitude and behaviors.

Task: Describe a situation in which you got very angry. Now describe your self-talk before, during, and after the situation. Include self-talk about yourself, the person you were angry with, and other self-talk (e.g., others, the world in general).

Know Your Anger Sequence

Anger often feels like a sudden explosion, but as you have realized there are specific thoughts and feelings that come before anger. Knowing your thoughts (self-talk) and emotions will allow you to de-escalate before you explode.

Task: Complete the chart below for a number of situations that involved anger.

Situation	Thoughts	Feelings	Actions

Be Aware of Body Signals and Body Language

Anger is usually a reaction to a perceived threat. All animals have physiological reactions for self-protection and to be able to respond—"fight, flight, freeze".

Task 1: Identify physical cues so you know when your anger is escalating: fast heartbeat; hyperventilate; clenched jaws; headache; flushed face; knots in your stomach; clenched fists; sweaty palms; shaking arms or legs.

Task 2: Know your *body language*. Nonverbal communication often conveys more than your words. Is your body language physically or emotionally

threatening? Do your nonverbal signals convey lack of caring or interest in resolving conflict? Your goal is to send messages that help others feel more comfortable and safe, and lead to conflict resolution.

Identify Your Conflict Style

There are four styles of dealing with conflict and anger.

1. *Passive*: You are anxious, inhibited, indirect, and do not speak up for your rights. You are often ignored or taken advantage of. Anger builds up inside, and you may become depressed, develop anxiety and physical symptoms (e.g., headaches, stomach aches), or explode. You find it hard to say, "No," avoid and feel immobilized with conflict, often assume you are wrong, and feel resentful of others.
2. *Passive–Aggressive*: You don't address problems directly, but retaliate by hurting others without drawing attention to yourself. You sulk, pout, make negative comments behind the person's back, give the silent treatment, hold a grudge, or get even.
3. *Aggressive*: You are dominating, threatening, and attacking toward others. You may get your way, but do not gain others' respect. You may speak loudly and yell, get into physical fights, ignore others' feelings, interrupt, be sarcastic, never admit you're wrong, and blame.
4. *Assertive*: You are confident, send clear messages, and are in control of your emotions. You stand up for your rights and respect the rights of others. You tend to use "I messages," make good eye contact, listen to others' point of view, say, "No," and set healthy boundaries, offer solutions rather than complaints, accept criticism without becoming defensive, and apologize when you know you are wrong.

Task: Identify your style of handling conflict. Make a plan of how you will be assertive, and create a constructive and positive style of dealing with conflict and anger.

> Ten-year-old Matt does not follow instructions well and has a difficult time obeying rules or taking guidance from adults. He often overreacts emotionally to minor things by screaming, stomping, or throwing objects. After dinner, Dad asked Matt to take out the trash. Matt responded by throwing a fit and stating, "I don't have to, and you can't make me."
>
> The next thing Dad knows he is overcome with anger. He becomes beet red, grabs Matt by the collar and screams, "Don't you talk to me that way, young man. I'm sick and tired of your crap. You're grounded for a month!" Dad felt personally attacked and responded by attacking back.

> Remember, when you feel attacked, your body responds by producing adrenalin for use as a defense against the perceived threat. Focus is directed toward self-protection, leaving little energy for clear thinking and good decision making. Instead of brushing off the remark and responding calmly, Dad felt he had no alternative but to attack.
>
> Dad learned to be conscious of his escalating self-talk. He was then able to take a deep breath and change his self-talk to a more constructive inner dialogue; "This is not about me. I am not getting upset. He is just trying to take control because he feels unsafe. I choose to respond with compassion and understanding. I am in control of my emotions."
>
> Over time, Dad became more and more astute. Eventually, his positive self-statements became automatic responses. By not escalating, Dad was able to stay calm and respond with true power, becoming a safe and comforting influence on his son. He was being the kind of person he wanted his son to become. (Orlans and Levy 2006)

Problem-solving

Children with attachment disorder are unable to manage conflict (internal or interpersonal) and solve problems because of chronic emotional turmoil and their refusal to reach out for help. Thus, learning to solve problems effectively involves both the ability to utilize internal resources and turn to others for guidance and support. Children learn these skills and practice them in various settings:

- identify a specific problem
- brainstorm possible options and solutions
- communicate with a "trusted" significant other about alternatives
- make a list of pros and cons, choices, and consequences
- evaluate the results of the particular solution chosen.

Therapeutic Methods

A number of therapeutic methods, described in detail (with case examples) below, provide the structure to achieve treatment goals:

- first-year-of-life attachment cycle
- child's self-report and list
- rules of therapy
- review of historical information

- inner child metaphor
- psychodramatic reenactment
- forgiveness ritual.

First-Year Attachment Cycle

This intervention is used in the initial phase of treatment and includes an explanation of the attachment cycle that occurs in the first year of life. A salient psychosocial task during the first year of life is the development of basic trust in reliable and appropriately responsive caregivers. This therapeutic intervention focuses on the correlation between need fulfillment, basic trust, and the establishment of secure attachment. The goals for the first-year-of-life attachment cycle intervention include the following:

- To educate the child about early attachment experiences and their psychosocial consequences. This provides a cognitive frame; the child develops an understanding of his or her thoughts, feelings, and behavior, both historically and currently.
- To provide the message to the child: "I understand you and can help you; lack of good care was not your fault; you have responded in an adaptive and understandable way to unfortunate circumstances (abuse, neglect, abandonment)." This is a positive reframing and normalizing experience for the child.
- To set the stage for cognitive–affective revision, the development of positive regard for self and others, and the working through of emotional trauma.
- To initiate a therapeutic relationship, based on genuine engagement, cooperation, and empathy.

The therapist explains the first-year-of-life attachment cycle to the child (adolescent or adult), using the diagram (see Figure 3.1). This can be done in several ways: 1) client with therapist using the LAP; 2) child with parent using the LAP; and 3) client lying on the couch with the therapist sitting adjacent.

The first-year-of-life attachment cycle involves four stages: need, arousal, gratification, and trust. The infant is helpless, has very basic needs, and must depend on caregivers to meet those needs. (The child is asked to describe a baby's needs.) The infant signals that he or she has needs and/or discomfort via arousal (cry, scream, kick). The reliable and responsive caregiver gratifies those needs (nourishment, eye contact, smile, touch, rocking), which leads to secure attachment and the development of basic trust. When the caregiver

does not gratify the baby's basic needs (or there is no consistent caregiver available), insecure attachment occurs, i.e., the infant does not learn to trust him- or herself or caregivers.

The child is told about the consequences of insecure attachment: anger; inability to trust and be emotionally close; discomfort with touch; perceives him- or herself as defective and caregivers as unsafe; inordinate need to control others ("bossy," manipulative); and lacks self-control. The child is asked to evaluate him- or herself in reference to these prior traits: "What happened in your early family life? Were your needs met? Did you learn to trust caregivers?"

CASE EXAMPLE: FIRST-YEAR ATTACHMENT CYCLE (ANNIE)

Angie, the birth mother, was sexually abused by her alcoholic father from ages 5 through 12. She had virtually no attachment to her birth mother. She entered the foster care system when she was 12. She became pregnant at age 15 by a 32-year-old man who took no responsibility before or after the birth of her daughter, Annie. Annie was born drug exposed, and was placed immediately with her 87-year-old great-grandmother. She could not be soothed, screamed every night for two years, and had a variety of "caregivers" who helped the great-grandmother. She was reunited with her birth mother at age 2; for seven months she suffered severe neglect and sexual abuse (her mother's boyfriend was a registered sex offender). Social Services placed Annie in a foster home where she remained for several years; the foster parents planned to adopt her, but relinquished after deciding she was too aggressive and disturbed. After two brief additional foster placements, Annie, age 6, was placed with the current parents on a foster–adopt arrangement.

Annie was 7 years old at the time of treatment. Her current parents reported that Annie displayed the following symptoms: cruelty to animals, violence and aggression, self-mutilation, enuresis and encopresis, constant lying, lack of remorse, and behaviors that were manipulative, oppositional, controlling, and sexually provocative. The parents were frustrated and demoralized. The mother was experiencing health problems, was angry and "numb," and resented her husband for not supporting and understanding Annie's problems. The father was angry at both his wife and Annie, and had considered leaving the marriage. They reported that prior therapy attempts had failed because Annie constantly lied.

Therapist: This is called the circle of the first year of life. Can you look into my eyes and tell me what it is called?

Annie: The circle of the first year of life. [Maintains eye contact on the second try.]

Therapist: I'll draw a circle. Here it is. Not perfect, a little crooked.

Annie: No one's perfect, except the Lord!

Therapist: OK. There's the four parts of this circle. [Draws four lines on the circle.] It begins when a baby is born. What can a baby do?

Annie: They can't do nothing.

Therapist: That's right, babies are very helpless. But they do have needs. What do little babies need?

Annie: Food.

Therapist: That's right, food. What else?

Annie: Love.

Therapist: Yes, love; what else does the baby need?

Annie: A home.

Annie, previously resistant and agitated, is now calm, engaged in the task, and even enjoying herself (laughter). She seems interested in the first-year-of-life story. The therapist and Annie make a list of babies' needs: "food, love, a home, milk, eye contact, touch, movement (rocking), care, smiles from caregivers." The therapist explains the importance of eye contact, smiles, loving touch, and other caregiver–baby behaviors, as they relate to secure attachment. Annie is attentive.

Therapist: So, how does the little baby tell the mother or father she has needs when she can't talk?

Annie: Cry.

Therapist: That's right. Is it a little cry or a big cry?

Annie: A loud cry! [Screams out in a loud baby-like cry.]

Therapist: Very good. You sound just like the baby who has many needs. [Annie smiles, enjoying the "game."]

The therapist explains that babies use various signals of arousal (crying, screaming, kicking, facial expressions) to let caregivers know they have needs and/or discomfort. Annie participates eagerly in the dialogue.

Therapist: Now, let's say the baby has a really good mom or dad, who comes along and takes care of the baby's needs. What does that mom or dad do?

Annie: Feeds it.

Therapist: Yes, and rocks, holds, gives loving touch and eye contact and smiles. What do we call this: can you sound it out? [Writes *gratify* on paper.]

Annie: G-R-A-T-I-F-Y.

Therapist: Very good. You sure have a smart brain. Gratify means to take care of, to meet the baby's needs.

Annie maintains good eye contact with the therapist during this dialogue, but seems to be getting more agitated and anxious. Emotions and memories are provoked by the discussion of caregivers and babies.

Therapist: So, the baby has needs, expresses those needs by crying and other signals, the mom or dad takes good care of the baby. What does the baby feel toward that mom or dad?

Annie: Cared for?

Therapist: That's right, what else does that baby feel?

Annie: Happy.

Therapist: Yes, what else?

Annie: Loved.

Therapist: That's right. Is that baby feeling safe?

Annie: Yeah, safe.

Therapist: And there is a special feeling that the baby has toward the person who is taking good care of her. I'll write it down. Can you sound it out? [Writes *trust* on the paper.]

Annie: T-R-U-S-T.

Therapist: Very good! That baby learns to trust the mom or dad who takes care of her in a good and loving way.

The therapist explains that the baby learns to trust caregivers, self ("my needs are OK"), and the world in general ("life is good, I feel safe"). The therapist also explains how trust leads to the perception of caregivers as safe, reliable, and loving. Annie is still engaged and responsive.

Therapist: Now, how did this circle work out for you when you were a little baby?

Annie: I wasn't taken care of. I had to crawl in crap. There was cat crap all over the house.

Therapist: How do you know this? Do you remember or did someone tell you about it?

Annie: My mom told me. [Referring to current pre-adoptive mother.]

Therapist: Yes, it is true. Let's talk about what else happened to you and how it made you think and feel. You had a birth mom, right?

Annie: Yes, Angie; she threw me away. She put me up for adoption.

Therapist: Angie was only 16 years old when you were born. She didn't take good care of herself when you were in her tummy, and after you were born.

Annie: She took drugs.

Therapist: Yes. And you had to go to your great-grandmother's house a lot. She was old but tried to take care of you. What do you think you were feeling and learning back then?

Annie: I don't think I ever learned how to trust. [Begins to cry.] I don't trust at all.

A dialogue ensues regarding lack of trust in and anger toward caregivers. Annie admits that her anger and mistrust toward her pre-adoptive parents is really meant for her birth mother. She begins to talk about her feelings ("mad, scared, sad") and self-contempt ("I feel like a bad baby"). The parents (observing on a TV monitor in another room) were pleased, and later reported that Annie had not been cooperative or verbally responsive in prior therapy.

CASE EXAMPLE: FIRST-YEAR ATTACHMENT CYCLE (MEGAN)

Megan spent the first 3½ years of her life in a Romanian orphanage, where she was the victim of physical abuse, neglect, and multiple caregivers. She assumed the role of caretaker with other children as a survival strategy. An American couple adopted her at 3½; she began to act out aggressively as soon as she arrived at their home. The family started our program when Megan was age 10, following several prior unsuccessful treatment attempts.

Therapist: What does a baby need?

Megan: A bottle, warmth, attention, diapers, and a blanket. [Appears interested and attentive for the first time during treatment.]

Therapist: That's right, and let's talk about what else babies need and then what happens.

Megan and therapist engage in a half-hour dialogue about the attachment cycle: needs → arousal → gratification → trust. Megan is engaged in the conversation, cooperative, and emotionally genuine.

Therapist: So, did you learn to trust good caregivers?

Megan: No, I was in the orphanage. I didn't trust anyone.

Therapist: You were a normal little baby with needs. Who took care of you?

Megan: No one. [Cries.]

Therapist: What did you learn?

Megan: I learned to lie.

Therapist: If you could not trust adults to take care of you, what did you do?

Megan: I wanted to be bossy.

Therapist: You couldn't even be a little girl? How did that make you feel?

Megan: Sad. [Cries, genuine sadness for the first time.]

Megan began to sob and talked about holding in her sadness for a long time. Next, she talked about being afraid ("someone will hurt me") and compensating for fear via aggression.

Therapist: You have lots of scared feelings too?

Megan: Yes. [Maintains good eye contact.]

Therapist: What do you do with all that scared?

Megan: Hurt people; I let it out on other people. That's not good!

The first-year-of-life attachment cycle exercise was an effective vehicle for Megan to become genuinely involved and emotionally available in the initial stage of treatment. Information gleaned from this experience was integrated into a treatment contract (e.g., learn to be less "bossy," more honest about feelings, verbal communication rather than aggression).

Child's Self-Report and List

During an initial interview with the child a list of problems and goals is generated. The child is asked: "What are your goals; What do you want to learn, change, or accomplish while you are here?" The emphasis is on the goals of the child, not the therapist or parents. The goals of this therapeutic task include the following:

- To increase the child's engagement and motivation, as he or she has ownership ("these are my goals").
- To send this message to the child: "I value you and want to hear your ideas and opinions." Children need validation because they typically feel inadequate and inept.
- For the child's list to become a treatment contract; on the last day we review the list and the child's accomplishments.
- For the child and therapist to work together cooperatively, which sets the tone for honesty and reciprocity in the therapeutic relationship.
- To provoke emotions as the child discloses perceived problems. The therapist's empathic response provides comfort, encourages further

disclosure, and creates a climate conducive to a "secure base" for the child.

- For the therapist's interaction with the child to provide a model for the parents, as they observe from another room (closed-circuit TV). The parents become more optimistic as they see their child interacting in an honest and cooperative manner.

CASE EXAMPLE: CHILD'S SELF-REPORT AND LIST (ADAM)

Adam, age 7 ½ at the time of treatment, spent his first two years in Russia with his birth mother, and experienced physical abuse, neglect, and negligible attachment. Although he has been in the adoptive home for five years, he has refused to form attachments to the parents. Despite prior therapy, he continued to be rageful, oppositional, destructive, deceitful, cruel to pets, self-destructive, and displayed no remorse.

Therapist: We will make a list. What's your number-one problem?

Adam: Telling the truth.

Therapist: Telling the truth or telling lies, which is your problem?

Adam: I tell lies.

Therapist: OK, what's your next problem?

Adam: Can you do some with me?

Therapist: Sure, but first I want you to tell me your ideas, OK?

Adam: OK. Forgetting, I keep forgetting things.

A reciprocal relationship is developing. The therapist invites Adam to honestly disclose his perceptions; Adam asks for the therapist's help ("Can you do some with me?"). Eventually, Adam lists 12 problems that his parents verified as accurate:

- Telling lies.
- Forgetting things.
- Picking on sister and brother.
- Don't ask for help.
- Cheating.
- Bossy.
- Don't mind Mom and Dad.
- Lots of mad, sad, scared.
- Stealing.

- Break things.
- Hate myself.
- Mean to my family.

The goals were achieved: Adam was honest, worked cooperatively with the therapist, and began to experience and share genuine emotions as he discussed his problems. The parents felt more optimistic as they observed their child's efforts. The "list" was translated into a treatment contract and served as the foundation for subsequent therapy.

Rules of Therapy

The child is told the rules of therapy during the initial interview. Each rule is explained and discussed. Rules become contracts for specific behavior on the part of the child and the therapist. Rules also provide structure, necessary for developing a feeling of safety and security. Listed below are the rules of therapy.

- *Eye contact is encouraged in all therapist–child dialogues:* Eye contact is a crucial component of secure attachment.
- *"We will not work harder on your life than you":* The child is told that the treatment team will work hard to provide help, but it is the child's responsibility to also work hard. A discussion ensues about personal responsibility and the desire to change.
- *The Four Rs:* We share our philosophy that all children are expected to be respectful, responsible, resourceful, and reciprocal.
- *"I don't know" is not an acceptable answer:* Children generally say, "I don't know" as an avoidance technique. Two alternative responses are acceptable: the child can ask for help from the therapist—children with attachment disorder have difficulty asking for help, or the child can offer his or her best guess, which encourages introspection and resourcefulness.
- *Verbal responses must be expressed in a timely fashion:* A form of interpersonal control and passive aggression is making others wait for a response. Instead, we encourage a timely response.
- *No physical violence:* Most of these children have been physically abused and/or witnessed violence. Consequently, they act out abusively and aggressively. They are encouraged to express their anger verbally. A mutual contract is established between the therapist and the child, to protect both from harm.

CASE EXAMPLE: RULES OF THERAPY

Adam, age 7½ (previously described) was told the rules of therapy during the first treatment session:

Therapist: Are you ready to hear the rules of therapy?

Adam: OK.

Therapist: If I tell you the rules, will you want to follow them? Because I hear that you usually don't follow rules.

Adam: Yeah, I will.

Therapist: Great, so look into my eyes and say, "Dr. Levy, please tell me the rules."

Adam: Dr. Levy, please tell me the rules. [Good eye contact, strong voice.]

Reciprocity and contracting have begun. Initial stages of rapport building occur in the therapist–child relationship.

Therapist: First rule, good eye contact when we talk together. Do you know why that's important?

Adam: It's not polite if you don't look in someone's eyes?

Therapist: You're right, but there are other reasons too. I'll tell you more about eye contact later, when we talk about how babies feel close and safe with moms and dads. Did you feel safe when you were a baby?

Adam: In Russia?

Therapist: Yes, in Russia.

Adam: I don't remember who my Mom was. [Starts to cry, becomes agitated.]

Going over the rules became a springboard for the identification and expression of emotions (sad, mad, scared) and of Adam's negative core beliefs. Contracts were developed that specified therapeutic and family goals. A positive therapeutic relationship was established. The parents were more helpful and optimistic as they observed the interaction. Due to prior treatment failures, they were feeling hopeless and considering relinquishment.

Review of Historical Information

As noted in Chapter 6, historical information is reviewed as a part of assessment and treatment planning. It is also therapeutic to review with the child relevant documents, such as social history, social service records, police reports, life books, and photographs.

Although some mental health professionals believe this is threatening and may retraumatize the child, our experience does not confirm this. We have found that honest and open discussion of maltreatment and compromised attachment is crucial to the healing process, and that most children are capable of effectively dealing with these issues with proper guidance and support.

The goals of reviewing historical information together include the following:

- To reduce avoidance and denial regarding the child's traumatic early history.
- To revise misinterpretations of prior events.
- To create a positive rapport and collaborative therapeutic alliance.
- To provide a springboard to address the child's emotions, memories, and interpretations necessary for later therapeutic progress.
- To allow the therapist to provide empathy and support.

CASE EXAMPLE: LETTER (ERIC)

Eric was 10 months old when social services removed him from his 16-year-old birth mother due to neglect. He was placed in a foster home, but after two years he was moved to another foster home because of his aggression and self-mutilation. He was adopted at age 5, continued oppositional and aggressive behaviors, and would not attach to his adoptive parents. He began our program at age 10, after three prior unsuccessful treatment efforts, including hospitalization and a group home.

Eric was minimally cooperative and engaged in the therapy process until he (and the therapist) read a letter written years earlier by his first foster mother. The mother wrote, "He was out of control, picked his nose until it bled, then smeared the blood on our walls. I just couldn't keep him anymore." Eric began to sob as he and the therapist read the letter together. He talked about hating his birth mother for "giving me up," and hating himself because "I'm not a keeper." He began to work hard in therapy, and later apologized to his adoptive parents for "taking my anger out on you."

CASE EXAMPLE: PHOTO (ASHLEY)

Ashley, age 7 at the time of treatment, was the victim of abuse (physical and sexual), neglect, and multiple disruptions. She was removed by social services from her drug-abusing birth parents at age 3, placed with an aunt, then in a shelter and foster home. She was adopted at age

6 and continued to act out aggressively and sexually, including behaving violently toward a younger sibling.

Ashley was resistant for the first several days of therapy; she would laugh, close her eyes, and refuse to talk. On the third day, she was shown a photo of her birth parents. She expressed anger, then sadness ("they gave me away"), and began to talk genuinely about being abandoned. Eventually, she said to her adoptive mother, "I'm afraid you will give me away too." As her mother held her close, they cried together. This initiated the process of attachment between mother and daughter.

CASE EXAMPLE: SOCIAL SERVICE RECORDS (DANNY)

Danny, age 10 at the time of treatment, was severely neglected by his substance-abusing birth mother and grandmother. His birth father had abandoned the family. Danny was also physically abused and witnessed violence in the home during "parties." He had three foster placements and two failed adoptions prior to entering the current adoptive family at age 6. Danny was diagnosed with ODD and attachment disorder; he was manipulative, dishonest, angry, and refused to form an attachment to his adoptive parents.

The therapist and child read social service reports together, while in the LAP:

Therapist: These were complaints to social services from people who didn't like how your birth mother treated you. How old were you then?

Danny: I was only 3 months old.

Therapist: So, bad treatment started when you were 3 months old?

Danny: Yes.

Therapist: It says here that your birth mother would go out partying and leave you with your grandmother, who was drinking and did not take good care of you.

Danny: Can I see? [Looks closely at the report.]

Therapist: It says that your birth mother left you from Monday morning until Wednesday night.

Danny: Jeez!

Therapist: What does a 3-month-old baby need?

Danny: Love.

Therapist: From who?

Danny: My mom.

Therapist: Of course; all babies need their mom.

Danny: I was 3 months old and my mom was dumping me already!

Therapist: What a start you had. How did that make you feel about yourself?

Danny: I felt like people dumped me all the time, like I was a piece of garbage.

Danny is deeply involved in the dialogue provoked by the social service records. His negative working model ("I felt like a piece of garbage") is surfacing, and he is honest and open with the therapist. Parents later reported being surprised by his level of honest disclosure and vulnerability.

Therapist: Here it says that your birth mother was intoxicated, gave you watermelon filled with liquor, and you received a severe sunburn in a park. She was told to get counseling in order to keep her children. She either missed her appointments or came to counseling drunk. What does that tell you?

Danny: Alcohol and drugs were more important than me. [Starts to cry.]

Therapist: So, what happened?

Danny: They took me away.

Danny is facing the reality that his birth mother made a choice; she chose drugs and alcohol rather than her child. This initiates the process of cognitive rescripting ("I was not a bad baby; my mother made bad choices"), and sets the focus on choices and consequences.

Therapist: What are you thinking and feeling about this information? How has this affected your life?

Danny: I have been acting like her; saying I don't have to do things and I don't want help!

Therapist: If you continue to make these kinds of choices, how will your life work out?

Danny: I'll end up just like her, or in jail.

Therapist: Is that what you want for your life?

Danny: No.

Therapist: What do you want to do about this?

Danny: I better get to work. [Crying, gazing at therapist.]

This intervention accomplished several goals: his negative working model and genuine emotions surfaced, a positive therapeutic relationship developed, a contract was established, and he was motivated to work hard in therapy.

Inner Child Metaphor

A metaphor is the application of a word or phrase to something that it does not apply to literally, in order to indicate a comparison with the literal usage. Although there is no literal "inner child," this concept provides an effective framework to therapeutically address early life perceptions and emotions. Other clinicians have described and utilized this concept. It has been referred to as the divine child (Jung 1969); true self (Miller 1983; Winnicott 1985); child within (Whitfield 1987); and the real self (Horney 1959; Masterson 1985; cited in Whitfield 1987, p.1).

The child is gently guided back to an earlier time in life. The child is asked to visualize him or herself as that baby or child, then asked to choose a teddy bear to represent or symbolize the "inner child." The child holds the teddy bear and is encouraged to pretend "this is you when you were younger." The goals of revisiting the inner child are:

- To facilitate the identification and understanding of early life experiences, when belief systems were first developed and powerful emotional experiences shaped the child's life. Future perceptions, behaviors, and choices emerge from this basic foundation.
- To provide a vehicle for the healing of prior interpersonal trauma.
- To promote the development of the coping skills and emotional capacity necessary for healthy attachment and relationships.
- To enable the child to learn to relate positively to him- or herself, leading to increased self-esteem, positive self-regard, a positive working model, and a sense of mastery over trauma.

The therapist–child dialogue includes all or some of the following questions and topics:

"*Picture the little girl. How old is she? What is she doing? What is she thinking and feeling?*" This dialogue facilitates a child-directed sharing of thoughts, feelings, and memories. Children typically find this experience interesting and become emotionally engaged. They commonly identify feelings of sadness, fear, loneliness, helplessness, anger, and shame.

"*What does this little girl need?*" The child commonly responds by identifying the needs of the little girl (e.g., "She needed someone to hold and protect her"). Children with attachment disorder have learned to discount and dissociate from their emotional needs. This portion of the therapy process enables them to acknowledge and "own" their basic needs.

"*Can you tell this little girl the story of her life, from the beginning? When does life start?*" Since traumas often occur in utero, the child is encouraged to start in the womb (e.g., "Your birth mom used drugs; you were not really wanted,

because your birth mom was poor and young"). The use of an external symbol (teddy bear) facilitates expression of perceptions, memories, and emotions in a less threatening manner. The child is asked to speak directly to the "little girl," and they make statements such as, "You needed love, you thought it was your fault, you needed a mommy." The child is asked to review stages, milestones, and significant events in her development.

"*What does that little girl want to say* (to mommy, daddy, or other caregivers?) *Can you pretend you are that little girl? What is she thinking and feeling?*" Children find it easier to share perceptions and emotions associated with early loss and trauma by putting a "voice" to the "little girl." Common responses are: "I'm afraid of you; I hate the way you treat me; you don't take care of me."

"*Have you taken very good care of this little girl?*" The response to this question reveals the child's self-contempt and the vicious circle of attachment disorder ("My caregiver mistreats me; I feel defective and unlovable; I hate myself; I treat others badly; others mistreat me"). The child is encouraged to display nurturing, supportive behaviors toward the "little girl" in order to teach self-acceptance and self-love, thereby breaking the negative cycle and promoting the development of a positive working model. The child's ability to identify and meet the needs of the "little girl" reflects the extent to which her negative working model is changing. The goal is to change from a negatively internalized self ("I am bad and do not deserve love") to a positively internalized self ("I am good and I do deserve love").

"*Can she forgive you for not taking good care of her?*" The response is diagnostic of the child's capacity to mitigate self-contempt. The therapist informs the child, "You were treated badly and you learned to treat yourself badly." Self-empathy and self-forgiveness are encouraged over time.

"*Who is in control of your life if you continue to treat yourself badly?*" This question elicits the paradox of control. These children are motivated by a profound need to control, yet their choices and actions are driven by prior events and relationships (lack of self-control). The basic message to the child is: "As you learn to accept, support, and love yourself, you are free to make healthy choices."

"*How does life work out for her?*" The therapist instructs the child to give the "little girl" a detailed accounting of her life up to this point in time, emphasizing the information gleaned from therapy. This exercise provides a vehicle for the child to synthesize and integrate therapeutic experiences, and is diagnostic of his or her capacity for awareness, disclosure, and cooperation.

"*Do you know anyone else who can help you love this little girl?*" Children consistently respond by identifying their current caregivers (e.g., adoptive mother or father) as an appropriate source of love and protection. This

represents a shift from pushing the caregiver away to inviting the caregiver into their life. Children express this change concretely by inviting the mother and/or father into the session and asking her for help ("Mom, will you help me learn how to love my 'little girl'?"). The mother is instructed to place the child and "little girl" into the "in arms" position, and to provide a healthy model of affection, support, and comfort. This enhances positive mother–child attachment as well as the bond between the child and her "little girl" (positive internalized self). Mothers (and fathers) who were previously angry, defensive, and emotionally unavailable to their child, can now experience the giving and receiving of affection. The parent(s) and child are connecting in a safe, secure, trusting, and intimate manner, often for the first time.

"*Do you wish this could have been your mom from the beginning?*" This question serves as a springboard for enhancing mother–child attachment. Mutual acceptance and affection increases intimacy, trust, and secure attachment. The mother is asked a similar question ("Do you wish you could have been this child's mother from the beginning?"). Mother now has the opportunity to tell the child her thoughts and feelings about the child's prior trauma and how she is wanted and loved.

This portion of the session ends with 10–20 minutes of positive attachment (eye contact, smiles, snuggles) between mother and child. Mother–child and father–child attachment exercises are repeated many times during treatment. Repetition and rehearsal are crucial to the process of change for parents and children.

CASE EXAMPLE: INNER CHILD METAPHOR (KELLY)

Kelly and her siblings lived with their maternal grandmother, an active alcoholic, for the first four years of her life. Kelly's birth mother was in prison for drug-related offenses and child molestation; her birth father was unknown. Kelly was neglected, physically and sexually abused, and both witnessed and was the victim of violence. After one year of foster care, she was adopted (age 5), and for the next five years acted out through temper tantrums, oppositional behavior, lying, stealing, not making friends, destroying property, showing no remorse, and forming no attachments. Prior treatment efforts were not successful, and the parents were considering relinquishment. She began our program at age 10.

Kelly's negative working model was revealed as the inner child metaphor began:

Kelly: I don't want to talk to her; I don't want to take care of her. [Referring to the teddy bear representing Kelly as a baby.]

Therapist: Can you tell the baby why?

Kelly: I wasn't taken care of, so I won't take care of you. I take care of myself, so you should take care of yourself.

Kelly's self-contempt, which she developed by internalizing the abuse and neglect, was identified and expressed:

Therapist: How mad have you been towards little Kelly?

Kelly: I'm really mad at you, little Kelly. [Yells.]

Therapist: Tell her how you have been feeling toward her.

Kelly: I hate you! [Screams.]

Therapist: Is that true, you've been hating little Kelly?

Kelly: I hate you because you're a rotten kid; I've been hating myself for a long time. [Cries.]

Cognitive rescripting now begins: an opportunity for Kelly to change her interpretation of prior events and attribute responsibility for maltreatment to the hurtful adults, rather than towards herself.

Therapist: Can you tell little Kelly what she was thinking back then?

Kelly: Little Kelly, you thought you were bad and that you didn't deserve love.

Therapist: You thought you were bad because bad things were happening to you?

Kelly: Yes, I was a bad kid. [Cries.]

Therapist: It wasn't your fault, but when you were very young, you couldn't figure that out. When babies are loved they feel lovable and good. But if they are treated bad, they feel like they don't deserve love, and feel bad about themselves. Tell little Kelly the truth as you know it to be now, as a big girl.

Kelly: You did deserve love, because you were just being a baby, but your mom didn't come to help you. You thought you were bad, but you weren't. [Cries.]

Kelly is now ready to experience positive feelings towards herself (self-acceptance, support, and love), rather than self-contempt and self-blame.

Therapist: You have been treating little Kelly badly, do you want to keep doing that? This is your chance to change.

Kelly: I want to treat her good now.

Therapist: How can you show little Kelly you are caring for her?

Kelly: I can give her a hug. [Wraps the "baby" up in her arms, hugs her tightly, gently strokes her leg.]

> *Therapist:* Feel your love going into the baby's heart; what is the baby feeling?
>
> *Kelly:* She's feeling safe and happy; I'm giving her a real hug. [Kelly appears relaxed and calm.]

At this point the therapist recommends that Kelly tells the story of "little Kelly" to her mother. Mother and child dialogue about the early life experiences, how Kelly was hating herself and her birth mother, and the positive changes now occurring. Mom provides empathy and support; they feel close for the first time.

Psychodramatic Reenactment

Children, in general, are less apt to verbally express cognitions and emotions and are more likely to demonstrate internal states through action and behavior. This is the principle behind play therapy; increasing motivation, involvement, and self-expression through action-oriented tasks. Children with attachment disorder are emotionally and socially detached, avoiding the painful realities of their past and current lives. Psychodramatic reenactment reduces the child's denial and detachment, while encouraging genuine participation. This intervention is also used with adults.

During psychodramatic reenactment, treatment team members role-play individuals and scenarios from the child's life to "revisit" and work through prior attachment trauma. The goals of this intervention include the following:

- To enhance genuine involvement in the therapeutic process via an action-oriented activity.
- To encourage the child to experience and express the perceptions, emotions, and behavioral responses associated with early life attachment-related and traumatic events.
- To discuss the thoughts and feelings associated with early trauma and loss in a safe and secure therapeutic context.
- To achieve a corrective and curative experience, involving alternative ways of perceiving self and others, managing emotions, and responding behaviorally.
- To promote a healing experience that leads to emotional resolution, enhancing the child's sense of mastery, and rewiring the limbic brain via interpersonal experience.

It is important to prepare children, adults, and parents for these emotionally challenging experiences. A contract is established with both the child and parents; they are informed of what to expect during the exercise and asked if they are willing to participate. Psychodramatic reenactment is an effective

therapeutic method that enables the child to confront and resolve traumatic emotions and memories, revise maladaptive perceptions of events, feel increased competence, and connect in a secure and trusting way with his or her parents. The child has an opportunity to perceive the parents as protective and caring, rather than threatening and untrustworthy. Parents are able to take concrete and positive action to help, protect, and defend their vulnerable child, which diminishes their feelings of helplessness and pessimism.

Preparation for psychodramatic reenactment involves three components:

- *Prepare the child:* The therapist explains why this exercise is recommended and what will happen. This reduces the child's anxiety and enables him or her to feel a sense of control. A verbal agreement (contract) is established if the child gives permission.
- *Prepare the parents:* The therapist gives a similar explanation to the parents, and the roles and responsibilities of each participant are defined. This reduces the parents' level of anxiety regarding the safety of their child and helps to clarify their own emotions. A contract is established.
- *Set the stage:* The client gives a detailed description of a prior traumatic situation, including feelings, perceptions, body sensations, reactions of significant others, and consequences. The client is given the role of "director," telling participants how to play the roles of others in the reenactment. This helps the client feel empowered and enhances genuine involvement and motivation. Child and parents are encouraged to "be real," to allow genuine emotions and reactions.

CASE EXAMPLE: PSYCHODRAMATIC REENACTMENT (SARA)

Sara, age 10, was physically abused and neglected when under the care of her drug-addicted birth mother during the first three years of her life. In the psychodramatic reenactment, a therapist played the role of the mother's physically abusive boyfriend. In phase one, the "boyfriend" enters the treatment room and pretends to physically threaten Sara:

Boyfriend: I'm going to throw you against the wall.

Therapist: What are you thinking and feeling now, Sara?

Sara: I'm scared he's gonna kill me and no one is here to help me.

Therapist: That must have been awful to be so alone and scared. Do you have anyone in your life now who would protect you?

Sara: My Mom and Dad [adoptive] would never let anyone hurt me.

In phase two, the "boyfriend" once again pretends to threaten Sara, but this time Sara's adoptive parents storm into the room and shout at the "boyfriend."

> *Parents:* You get out of here. Leave our daughter alone. We won't let you hurt her anymore! [They then embrace Sara and hold her on their laps.]
>
> *Sara:* I really know you guys will protect me and I'm learning to trust you more.

Twenty to 30 minutes of "positive attachment time" follow the reenactments. During this time, parent(s) and child integrate and enjoy the positive emotional experience of secure attachment (increased trust, safe and relaxed closeness, positive affect).

CASE EXAMPLE: PSYCHODRAMATIC REENACTMENT (LAUREN)

Lauren was 3½ years old when social services placed her in a foster home due to neglect and abuse. Her birth parents had been in and out of jail for various criminal offenses. Her mother had been neglectful; her father was violent toward his wife and had physically and sexually abused Lauren. After a second foster home placement, she was adopted at age 5. Treatment began at age 7½; she was aggressive, oppositional, depressed, and isolated from the family.

The psychodramatic reenactment focused on several scenes from the child's memory, confirmed by social service records and the adoptive parents' knowledge of events. These scenes included the birth mother yelling at Lauren and then expressing love and caring (inconsistency); the birth father hitting the mother in front of Lauren; the birth father giving Lauren a bath (sexual abuse) and locking her in the bathroom; and the social worker taking Lauren away as the parents were taken to jail.

Lauren was able to express genuine affect regarding events: "I thought I was going to die, or Mommy was going to die. Daddy had a knife. I was really scared"; "I was locked in the closet and bathroom. It was dark and I was scared." Asserting herself led to empowerment; she was able to communicate through strength and personal boundaries to her "birth father" ("Stop it, you're hurting me"), and attribute appropriate responsibility to her "birth mother" ("I'm not a bad little girl, you are a being a bad mom").

Lauren was able to be closer and more vulnerable with her adoptive parents following the reenactment, as they processed the experience "in arms." She spoke with her parents about never feeling safe before and using aggression to protect herself. The parents began talking about prior losses in their lives, and decided to work more on those issues in

therapy the next day. The parents reported that they had never seen Lauren this honest, open, and intimate.

Revitalize

The final stage in the therapeutic process is *revitalize*. During the first two stages of Corrective Attachment Therapy, the focus is on revisiting and revising the past. This final stage is oriented more toward the present and the future. The key components of revitalization are discussed below.

Redefining Self

The child who has successfully dealt with prior attachment trauma is able to develop a new and increasingly more positive identity. People and events from the past are placed in perspective, and the child is able to function without feeling overwhelmed or devastated by traumatic memories. Discussing the past no longer provokes intense negative emotions and physiological reaction. The old self has been mourned, and a new sense of self is emerging—new beliefs, relationships, coping skills, and a sense of hopefulness. Helplessness and isolation, the core experiences of the old self, are replaced by empowerment and connection with others. The child no longer feels compelled to consciously or unconsciously reenact pathological patterns; new choices of thinking, feeling, and interacting are now available. The child is capable of trust, affection, empathy, and reciprocity in his or her relationships with family and others. The old need for power and control over others, to compensate for feelings of fear and helplessness, are replaced by a sense of personal competency and power. Pseudoindependence is transformed into genuine autonomy and self-reliance. As the child allows attachment needs to be fulfilled (intimacy, interdependence, trust, safety), he or she develops a stable sense of self.

Secure attachment is a protective factor, creating resilience in the face of adversity. The child now has an emotional storage bank from which he or she can draw during stress. The child becomes equipped to cope effectively with emotions, relationship conflicts, developmental milestones, and the challenges of life.

Family Renewal

Revitalization of the family occurs on two levels: relationships within the family and interactions between the family and others. Family members experience safety, enhanced trust and intimacy, effective communication, improved problem-solving and conflict-resolution abilities, clear and

respected boundaries, and a sense of cohesiveness and felt security. The family climate of hopelessness and negativity is replaced by optimism, excitement, and playfulness. Family members can have fun and enjoy each other's company.

The parents are feeling more positive in both their marital relationship and parenting role. Marital communication, conflict management, and emotional closeness are enhanced. They are functioning as a united team and feeling increased confidence in their ability to parent effectively. Sibling relationships also improve with increased trust, safety, and respect.

The family is able to utilize and benefit from outside resources such as support groups, extended kin, religious affiliations, and recreational opportunities. The family shifts from fear, isolation, and crisis management, to interactions within their community that are fulfilling and validating.

Moral and Spiritual Evolution

Disconnection from self and others is converted into self-love and the ability to form loving relationships. As the child and family members let go of fear, resentment, and the self-protective need to survive under threatening conditions, minds and hearts are now open to uplifting emotional and spiritual beliefs and values: compassion, forgiveness, empathy, faith, charity, joy, peace, contentment, love, and harmony.

Forgiveness

Forgiveness is an important component of emotional recovery following interpersonal trauma. Forgiveness is associated with mental, relational, physical, and spiritual health. Research has shown that anger declines after forgiveness and that unforgiveness leaves people hostile and ruminating about their pain and trauma (Harris and Thoresen 2005; Lawler *et al.* 2005). Forgiveness involves cognitive, emotional, and behavioral elements, and focuses on two emotional processes: 1) resolving anger, hurt, shame, and fear; and 2) generating positive emotions of empathy, understanding, and compassion. Thus, forgiveness reduces negative feelings and increases positive feelings. Corrective Attachment Therapy facilitates a variety of forgiveness experiences:

- self-forgiveness
- child forgives birth parents for maltreatment and abandonment
- adoptive parents and child forgive one another
- siblings and child express forgiveness for each other.

Forgiveness can be defined in both psychological and spiritual ways. In our work with children with attachment disorder and families, forgiveness occurs when one is no longer controlled by negative emotions. This occurs through a four-stage process:

- Experience and express anger directly. Remaining angry, consciously or unconsciously, prevents both grieving and forgiveness.
- Genuinely acknowledge and experience grief as it relates to the loss of a specific person.
- Coming to terms (accepting) the loss without distorted perceptions or unrealistic fantasies.
- Integrate prior losses into one's life. Moving toward the future with new personal resources, skills, meanings, and positive relationships.

Additional studies have demonstrated the beneficial effects of forgiveness in adult romantic relationships. Forgiveness increases marital satisfaction, emotional closeness, and commitment to the relationship (Fincham, Beach, and Davila 2004). A study of divorced mothers found that women who forgave their ex-husbands were less anxious and depressed and became better parents than those who could not forgive. Other research has shown that people who scored high on forgiveness scales had significantly lower levels of blood pressure, anxiety, depression, and higher self-esteem (Briggs 1997).

CASE EXAMPLE: FORGIVENESS RITUAL (MAGIC WAND)

Jackie's birth mother was 16 years old when she was born. Her birth father was unknown. She was placed in a foster home immediately after birth and reunited with her birth mother at 3 months of age. For the next two and a half years, there was a series of disruptions and reunifications. At 3 years of age, the birth mother's parental rights were terminated and Jackie was placed for adoption. Jackie was 11 years old at the time of treatment.

At the end of a two-week Corrective Attachment Therapy program with Jackie and her adoptive parents, a "magic wand" forgiveness ritual was introduced. During the course of treatment, Jackie dealt with her anger and grief regarding neglect and abandonment from her birth mother and was now ready to begin the process of forgiveness.

> *Therapist:* Let's pretend for ten minutes that I have a magic wand, and you can now speak openly and honestly to your birth mother who will listen and understand. What do you want to say to your birth mother?

Jackie: [Speaks to co-therapist who is role-playing the birth mother.] Why did you give me up? Why didn't you take care of me and love me?

Birth mother: I was very young, scared, and alone. I didn't know how to take care of a little baby.

Jackie: I've been hating you all these years and hating and blaming myself.

Birth mother: It wasn't your fault, you deserved to be loved. I just couldn't do it.

Jackie: Now, after this therapy, I understand you didn't get what you needed either, when you were young.

Birth mother: Can you ever forgive me for not being there for you?

Jackie: Now that I have gotten rid of a lot of my mad and sad, maybe I can start to forgive you.

Following the dialogue between the child and "birth mother," the adoptive mother discussed Jackie's feelings with her "in arms." The adoptive mother was supportive of Jackie's desire to forgive her birth mother. This intervention initiated a process of forgiveness, strengthened the attachment between Jackie and her adoptive mother, and reduced the "loyalty conflict" (i.e., "I have to choose which mom to love").

9

Corrective Attachment Therapy

The Family System

Basic Principles

Historically, much of attachment theory and research has focused on the mother–child relationship. This is a simplistic and limited view; attachment occurs within the broad emotional network of the family system, including the role of father, siblings, extended kin, and external social systems. The basic principles of a systems approach, *context*, *circularity*, and *organization*, are outlined below.

- *Context:* No family member (or relationship) can be understood outside of the context in which he or she functions. Thus, mother–infant attachment patterns can only be understood within the network of all other family relationships (e.g., husband–wife, father–infant, parent–grandparent) and extrafamilial systems (e.g., extended kin, cultural context, social programs).
- *Circularity:* Traditional models in the mental health field were based on the belief that relationships are "linear," i.e., there is a cause and effect. The systems model presumes that relationships are "circular," i.e., based on ongoing, reciprocal, interactive patterns, in which each family member's behavior serves as both a trigger and a response. A clear example is the reciprocal nature of mother–infant attachment behavior (see Chapter 3).
- *Organization:* Family systems are organized around rules, role, boundaries, and subsystems. For example, subsystems in the family include spouse subsystem, parental/executive subsystem

(parent–child interactions), sibling subsystem, and other subsystems (e.g., alliances with extended kin). Each of these subsystems has its own set of operating rules, communication patterns, and boundaries that separates it from other subsystems. In well-functioning families, for instance, a child may be appropriately excluded from the spouse subsystem ("this is mommy and daddy's time to be together"). In contrast, a dysfunctional family may allow a child to have too much power and control ("we will allow you to intrude on our time and space").

It is important to evaluate and understand the context of the whole family, as well as external supports, when considering attachment security or disorder. Byng-Hall (1995a) describes a "secure family base," and delineates several family situations that undermine such family security.

- *Loss of attachment figure:* Actual loss or fear of losing an attachment figure, such as prior abandonment or separation.
- *Capture:* A family member "captures" the attachment figure, e.g., an insecure father takes control of the mother, preventing a child from attaching securely.
- *Turning to an inappropriate attachment figure:* Due to the lack of availability of an appropriate attachment figure, a family member relies on another who is inappropriate, e.g., a mother relies on a child for need fulfillment and security, due to an absent partner.
- *Relationship conflict:* Conflicts regarding power and authority between caregivers or caregivers and children undermine a secure family base, e.g., an abusive parent becomes both a source of danger as well as the protective attachment figure for the confused child.
- *Reenactment of loss and trauma:* Parents and caregivers are unable to respond appropriately to a child's attachment needs when they are unresolved about their troubled past, e.g., a parent may repeat patterns of maltreatment learned in his or her family of origin.

Family Systems Influences

The family systems approach to attachment focuses on three major influences: marital relationship, attachment histories of caregivers, and extended social networks. Each of these areas of influence is described below.

Influence of Marital Relationship on Parent–Child Attachment

The process of attachment occurs within the dynamic and emotional setting of the parents' or caregivers' relationship to a significant other (spouse or partner). Marital conflict interferes with the formation of secure attachment between parent and child. Marital conflict affects the quality of mother–child and father–child attachment and emotional reciprocity (Cummings and Davies 2002; Davies and Woitach 2008). Many studies show that the quality of the parents' relationship influences the security of the child's attachment (Belsky, Gilstrap, and Rovine 1984a, 1991; Goldberg and Easterbrooks 1984; Amato 1986; Brody, Pellegrini, and Sigel 1986; Dickenson and Parke 1988). Mothers living without a husband or boyfriend were found to be more likely to have babies with deteriorating attachment, i.e., the babies were securely attached at 1 year of age, but became insecurely attached by 18 months (Egeland and Farber 1984). Another study found that mothers felt more confident and competent in the maternal feeding role with their 1-month-old infants when husbands had high esteem for their wife as a mother; tensions and conflict between husband and wife were negatively associated with maternal feeding competence (Pedersen *et al.* 1978).

Father–child attachment is influenced in a similar way by the emotional field. Fathers who witness the birth of their infants are much more likely to be "engrossed" with their babies and supportive of their partners (Greenberg and Morris 1974). Some research indicates that poor marital quality has a more negative impact on father–child relationships than on mother–child relationships (Cummings and O'Reilly 1997). Conflict between parents, in general, is most consistently linked with children's adjustment problems. Adults' conflicts, particularly physical aggression, have negative effects on children's emotional, social, and physical functioning, including increased aggressiveness toward peers, which disrupts the process of attachment in the early years (Cummings and Davies 1994).

Further, as has been discussed in Chapter 5, mothers who are depressed are more likely to have infants and toddlers who are insecurely attached. A supportive relationship with a husband or partner significantly reduces depressive symptoms in mothers, while lack of support and the stress of marital conflict increase their risk of depression (Beach and Nelson 1990).

Intergenerational Transmission

Patterns of attachment are transmitted over generations. The parents' attachment histories influence their current relationships and parenting practices. "A child attaches not only to his or her primary caretakers, but also attaches *through* the primary caretaker(s) to the entire emotional field" (Donley

1993, p.11). Thus, there is a high correlation between the child's patterns of attachment and the experiences the parents had in their childhoods. Parents who can make sense of their childhood experiences in an honest, responsible, and realistic way ("coherent" story), are more likely to have securely attached children. Parents who are dismissive, preoccupied, or unresolved in reference to childhood attachment difficulties ("incoherent" story) are likely to have children with insecure/anxious attachment (Main, Kaplan and Cassidy 1985). Parents with unresolved traumatic experiences (e.g., abuse, abandonment, severe parental psychopathology) more often have children with the most dysfunctional attachment pattern, i.e., disorganized–disoriented attachment (Main and Hesse 1990). These parents have not mourned the loss of prior attachment figure(s), remain anxious and unresolved about past trauma, and may even dissociate to avoid their pain. They transmit fear and anxiety to their children, inhibiting the establishment of secure attachment.

Parents with a history of childhood trauma often develop *dismissing and avoidant* attachment styles. They experienced suboptimal care as children (e.g., rejection, abandonment, abuse), resulting in the undermining of a sense of security, self-regulation difficulties, and negative core beliefs. Interactions with their own children reactivate or trigger early trauma and attachment-related distress. Parents with dismissing and avoidant attachment styles use *deactivating strategies* to avoid thoughts and feelings related to early trauma. That is, they deny emotional needs and avoid closeness to prevent anticipated rejection, abuse, and pain. Their difficulties with attachment cause considerable problems with parenting, particularly when parenting children with their own attachment problems. These parents must understand their attachment history (Life Script), grieve prior losses, develop positive internal working models, and learn effective parenting skills (Corrective Attachment Parenting), so that they can facilitate secure attachment with their children (Foroughe and Muller 2012).

Parents who have troubled and unresolved attachment histories often do not relate to their infants and young children in a genuine and meaningful way, but rather, they *script* their children into some past drama from their family of origin (or other childhood experiences, such as foster care placements). Parents may have conscious or unconscious scenarios from childhood that they repeat or reenact with their own children ("replicative script"). For example, abuse or neglect from childhood is repeated in the next generation ("cycle of abuse"). Parents may react to uncomfortable childhood experiences by attempting to be different with their own children ("corrective script"). A parent who was abandoned in childhood, for example, may become an overindulgent and overprotective parent with his or her own children.

Object relations theory refers to this process of scripting as *projective identification*, in which one family member causes another to take on a role that he or she has disowned. Again, the parent with a history of abuse may project negative attributes on to his or her child, reflecting unresolved pain and loss. Stern (1985) calls this *selective attunement*; the child is not perceived as a separate and unique being, but becomes molded to fit the parent's fantasies. The parent responds selectively to the infant's or young child's emotions and behavior, e.g., "happy moments are acceptable, but distress and anger are not." This not only prevents the child from forming healthy attachments, but also hinders the child's ability to learn to manage emotions and damages his or her emerging sense of self (see Byng-Hall 1995b for a review of family scripts).

Extended Social Network

Many factors external to the primary parent–child relationship affect attachment, such as extended family kinship network; community support systems (e.g., church, school, neighborhood programs); and social service agencies that influence family life. Parents who perceive their neighbors as friendly and supportive, for instance, are more likely to have securely attached children (Belsky, Rovine, and Fish 1989). Other studies show the importance of social supports for family and attachment (Crockenberg 1981; Belsky and Vondra 1989; Colapinto, Minuchin, and Minuchin 1989). Family support programs are vital in helping and supporting high-risk families and children. Home visiting, for example, in which the professional and parent develop a "partnership" in order to foster secure attachment and healthy childhood development, is a primary means of service delivery in many of these programs (Klass 1996). High-risk families can be helped by education, prevention, and early intervention programs, which focus on promoting secure attachment patterns. Social service programs, however, can also have a "diluting effect" on the family, in which "the regulatory intervention of a social service agency in the life of a family tends to loosen connections among family members" (Colapinto 1995, p.61). The goal of social programs must always be to nurture, strengthen, and empower the family in a positive direction.

Fathers

Multiple attachments during infancy are common. The father is particularly likely to become an attachment figure early in the infant's life. Just as with mothers, infants are more likely to be securely attached to fathers who have been sensitively responsive. Although an "attachment hierarchy" usually exists—a strong tendency for infants to prefer a principal attachment figure

(e.g., mother; special caregiver in an orphanage)—fathers have a significant influence on attachment and child development (Bowlby 1988b).

Until quite recently in human evolution, infants remained close to their mothers because of the necessity of breastfeeding for survival. The major role of the father was to protect the family from external threats. Cultural anthropologists who study primitive hunter–gatherer societies offer evidence of this gender-role adaptation; close relationships between fathers and infants were found in only three of the 80 nonindustrial cultures surveyed (West and Konner 1976; cited in Colin 1996, p.167).

More recently we have come to realize that fathers are capable of caring for and attaching to their children. Mothers possess qualities that place them in the role of primary attachment figure, such as breastfeeding ability and secretion of hormones during pregnancy and after birth that promote caregiving. Gender role socialization and expectations also encourage mothers to care for their young more than fathers. Nevertheless, research and observation clearly show that fathers are important attachment figures and crucial members of the family system.

Mothers are biologically, hormonally, and emotionally programmed to bond. This does not mean that the father's role is unimportant. Although fathers are not as biologically and culturally primed, they are capable of the same "motherly" behaviors as women. The sight of their newborn triggers a similar range of loving behaviors, including protection, giving, and responsiveness to the infant's needs. Human fathers stay with their offspring and care for them more than any other primates. Studies show that the more the father is involved in the pregnancy and delivery, and the sooner he holds the child after birth, the more absorbed and interested he is in continuing a positive involvement (Greenberg and Morris 1974). The father's self-confidence increases as he handles the baby, and as his parenting instincts emerge, so does his level of commitment.

Despite the growing awareness of the importance of active and involved fathers, the problem of absent fathers is increasing and producing long-term damage to children.

Consider the following:

- In 1986, the United States became the leader in fatherless families, passing Sweden. Between 1950 and 1996, the percentage of children living in mother-only families climbed from 6 to 27 percent.
- Eighteen percent of European American children, 28 percent of Hispanic children, and 53 percent of African American children in the United States live with their mothers only.

- More than one million American babies (one in four) are born each year to unmarried mothers, most of who are in households without fathers.
- Thirty-five percent of children living with mothers *never* see their fathers; 24 percent see their fathers less than once a month (Crowell and Leeper 1994; Hutchins 1995).

There are a number of negative effects of father absence on the family and in reference to the psychosocial adjustment and development of children (Lamb 1997). First, there is the absence of a co-parent, i.e., two partners to help with child care, participation in decision making, and giving the mother a break from the demands of parenting. Second, there is the economic stress that accompanies single motherhood; the income of single mother-headed households is lower than any other family group (Peterson and Thoennes 1990). Third, a high degree of emotional stress is experienced by single mothers who feel isolated and alone, and by children who are affected by perceived or actual abandonment. Last, children suffer as a result of hostility and destructive conflict between caregivers (e.g., predivorce and postdivorce marital conflict). Children living with their mothers are often exposed to violence and conflict between parents (current or historical). Overt hostility between parents is associated with child behavior problems, including childhood aggression (Grych and Fincham 1990; Cummings 1994). Thus, father absence is harmful to children and families, not only due to the lack of a gender-specific role model, but because the emotional, social, and economic aspects of a father's role are not fulfilled.

Research has shown that fathers tend to spend a larger percentage of time interacting with children through play than do mothers (Pruett 2001, 2009). Paternal play with children is characterized by more active and stimulating interactions ("rough-housing"). This type of play may serve the purpose of preparing children for the rough and tumble "real world" beyond mother's more intimate attunement style. Young children who play regularly with their fathers have better peer relationships, greater self-confidence, and are better at coping and learning, compared to children who do not have engaged fathers (Pruett 2001).

When men do care for their children, they tend to interact with, nurture, and generally rear children competently, but differently from women. *Not worse, not better, but differently* (Pruett 2001). Mothers typically hold their infants in a relaxed and quiet manner, whereas fathers more often activate or stimulate their infants prior to holding them close. Again, this trait leads to more playful and novel interaction over time (Parke 1990). Fathers encourage their babies to solve physical and intellectual challenges, even past the signs

of frustration. Mothers encourage exploration but are more apt to help the child once frustration is apparent (Biller and Meredith 1974).

Research and family observation (and fathers who know) clearly reveal that fathers are important and highly valued attachment figures in many families. Pedersen (1980) found that the more actively involved a 6-month-old baby had been with his or her father, the higher the baby scored on infant development scales. Paternal involvement was also found to significantly reduce the effects of long-term vulnerability for at-risk, premature infants (Yogman 1989). Laboratory procedures designed to assess separations and reunions found that the father's presence had similar effects on babies and toddlers as the mother's, just less intense: babies *cried* when the mother or father left, but cried less for the father; they *explored* and *played* less during the absence of either parent, but less so when the mother was gone; they would *cling* to the mother and father on reunion, but less intensely to the father. The children clearly related to their fathers as attachment figures who served as a secure base (Kotelchuck 1976).

Infants observed in the home, ages 7 to 13 months, showed no preference for mothers over fathers on most attachment measures (e.g., proximity seeking, touching, crying, signaling a desire to be held, protesting on separation, greeting on reunion) (see Lamb 1997 for a research review). When infants are distressed, however, they consistently prefer their mothers, supporting the notion that children arrange their attachments in a hierarchy. Finally, the distribution of infant patterns of attachment to mothers is basically the same as for fathers (65% secure, 25% avoidant, 10% resistant) (Main and Weston 1981). While one secure attachment was better than none, children found to be securely attached to both parents were most competent and confident, and displayed more empathy (Main and Weston 1981; Easterbrooks and Goldberg 1991).

Karen writes, "Although fathers are usually secondary caregivers, they are not merely secondary mothers" (1994, p.204). They provide valuable stimulation, playfulness, and serve as a stepping-stone to the outside world, where people are commonly not "in-synch" and attuned. They facilitate the child's ability (especially sons) to move outside the mother's orbit. They provide role models for their sons and invaluable models to daughters regarding a relationship to male figures. Lamb (1997), in his book on the father's role in child development, offers a number of salient conclusions based on 30 years of research and observation in the field:

- Fathers and mothers influence their children in *similar ways*; warmth, nurturance, and closeness are associated with well-adjusted and healthy children whether the caregiver is a mother or father.

- Characteristics of individual fathers (e.g., masculinity, intellect) are much less important than the *quality of the relationship* established; children who have secure, supportive, reciprocal, and sensitive relationships with their fathers (or mothers) do better on every measure.
- The amount of time fathers and children spend together is less important than the *quality* of their time together.
- The *family context* is often more influential than individual relationships; the father–child relationship must be viewed within the broader family context (e.g., the father's relationship with his partner or spouse and with other children; how significant others perceive and evaluate the father–child relationship).
- Fathers play *multiple roles* in the family—nurturing parent, protector, disciplinarian, breadwinner, emotional partner, playmate. Fathers affect their children's development and adjustment based on their success in all of these roles.
- A father can only be understood within the standards of his *sociocultural context*; his role varies according to individual, familial, and cultural values.

Siblings

Sibling relationships are typically the longest-lasting close relationships in life. The quality of sibling relationships is associated with each sibling's attachment to the mother. Studies found that infant–mother attachment security resulted in less sibling conflict in the home five years later (Volling and Belsky 1992), and that infant–mother attachment security was related to positive treatment from an older sibling (Teti and Ablard 1989).

Sibling relationships serve an important function in the emotional and social development of children. Siblings actively shape one another's lives and prepare each other for later experiences both within and beyond the family. Many crucial lessons children learn about sharing, competition, rivalry, and compromise are learned through their negotiations with siblings (Lobato 1990). Sibling relationships also provide an arena in which children learn about intimacy, empathy, and love.

Conflict is inherent to all sibling relationships. Sibling conflicts, however, are amplified and multiplied in the family with a child with attachment disorder. These difficulties and disagreements go beyond "normal" sibling squabbles. The infant who had consistent and appropriate need fulfillment becomes secure and has a higher tolerance for sharing attention, affection, and possessions with siblings. Early unmet needs and insecure attachment,

conversely, leave children feeling chronically fearful, jealous, demanding, and self-absorbed. They reject parental love, yet resent their siblings who are "easier" to love. Sibling relationships and conflicts are characterized below:

- When parents acquiesce to the demands of their child with attachment disorder, siblings perceive this as favoritism and a double standard. They may resent their parents, imitate the negative behavior to gain attention, or distance themselves from the family to avoid stress and conflict. Siblings often experience resentment when "special needs" children in the family are indulged or permitted to engage in behaviors unacceptable by other family members (Meyer and Vadasy 1994).
- Siblings are commonly ambivalent. They want to love, support, and accept their brother or sister, yet they feel angry and mistrustful. This often results in feelings of guilt and shame.
- Siblings may feel shortchanged due to the disproportionate time and energy the child with attachment disorder receives from parents. The parents or caregivers generally feel desperate, hopeless, and exhausted, having little or nothing left over for their other children. Siblings feel neglected and isolated.
- Siblings perceive the family as "marked." They are often embarrassed at school by the acting-out behavior of their brother or sister who has attachment disorder, and avoid bringing friends to their home. They feel ashamed and embarrassed about the ongoing battles among family members and resent the needs to restrict social activity.
- Siblings often adopt or are assigned the role of "parental child." They become overly responsible as a result of their desire to protect their overwhelmed parents and to compensate for their sibling's lack of responsibility. They routinely avoid expressing their anger and discontent, assuming that their parents have "enough to deal with."

CASE EXAMPLE: A SIBLING'S FRUSTRATION

A sibling of a child with attachment disorder writes:

> Wendy makes me mad because she screams so much, and we're always hiding everything. She demands total attention and you can't disagree with her, because if you don't always watch her or agree, she will go crazy. She will make a mess and try to hurt you until she gets what she wants. I can't bring friends over because she hits them and embarrasses me, and because she goes wild and screams and cusses and hits them in bad places. It is also embarrassing in public, like going out to eat because she's loud and all the bad language. I

> don't want to ride in cars with her because my head aches with her awful behavior and screaming. I can't do anything fun with her or anything at all because she can't be still and under control unless everything goes her way. She's more a pain than anything else.

CASE EXAMPLE: YOUNGER SIBLINGS

The most frequent victims of aggression from the child with attachment disorder are women, smaller children, or helpless animals. Younger siblings become convenient targets for their angry wrath. A mother writes:

> Darlene and Caroline are the family members who feel threatened by John, because they are the ones he abuses. Darlene gets most of the verbal abuse with some physical (a kick or punch). Caroline gets more of the physical abuse (kicks, punches, and bites), because she is the little sister. John threatened Darlene once with a butcher knife, but Bud wrestled it away before his threats got too menacing.

Family Systems Intervention

Family systems principles provide the foundation for Corrective Attachment Therapy. It is necessary to understand the child within the context in which he or she functions—the family. The family systems approach focuses on assessing and changing relationship patterns. Family relationships are reciprocal and circular, with the behavior of each family member serving as both a trigger and response for one another. These ongoing patterns of interactions maintain the family system and often the behaviors and symptoms of family members. In our book *Healing Parents*, we refer to the modification of family dynamics as, "change the dance, change the child" (Orlans and Levy 2006, p.9).

Children with attachment disorder enter a family with a variety of prior psychosocial patterns and symptoms. For example, when a child with a history of maltreatment, several out-of-home placements, and anxious and/or disorganized attachment, is adopted into a family, the focus becomes not only the child's history of problems, but also the constellation of family-related issues: parents' attachment histories, marital relationship issues, sibling issues, parenting attitudes and skills, relationship patterns and dynamics, and external social systems.

The Traumatized Family

Families who enter treatment are commonly demoralized, angry, and "burned out." The parents were often intellectually and emotionally unprepared when they adopted the child with attachment disorder. After several years of having the child in their home, high levels of stress and ongoing negative patterns of relating have produced a climate of hopelessness and despair. Prior treatment failures are common, including a variety of ineffective therapeutic interventions and parenting approaches.

Parents have often been blamed by mental health and social service professionals who lack an understanding of attachment disorder. Helping professionals may assume that the child's acting out is entirely a result of ineffective parenting, without identifying the child's prior attachment difficulties. Symptoms of PTSD are routinely observed in the parents, the siblings, as well as the child with attachment disorder.

Some parents who adopt special needs children are psychologically capable of meeting the challenge. Others, however, have histories of dysfunctional family relationships, as well as current individual and marital difficulties. In these cases, treatment must focus, in part, on the parents' issues to avoid scapegoating the child. The therapist must walk a tightrope to maintain a delicate balance. On the one hand, provide empathy and support to parents who are feeling disgruntled, hopeless, and blamed. On the other hand, confront the parents' own issues to effect necessary change.

Secondary Traumatic Stress

Many parents, and sometimes siblings, have *secondary traumatic stress* (STS). STS, also called compassion fatigue and vicarious traumatization, refers to the cumulative effects of living with and dealing with a survivor of traumatic life events. STS is also seen in nurses, first responders, trauma therapists, and military personnel. The symptoms of STS include anxiety, depression, fatigue, physical illness, emotional numbing, social withdrawal, loss of motivation, and feelings of hopelessness and despair (Figley 1996, 2002; Osofsky 2011b). The risk factors for STS include: measuring one's self-worth by how much one helps, having unrealistic expectations of oneself and others, being self-critical and a perfectionist, fear of being judged by others, being unable to receive emotional support, overextending oneself, and having a history of trauma in one's own background.

Parents participating with their children in our treatment program often have STS symptoms. These symptoms are a result of dealing with challenging children and, in many instances, due to their own histories of interpersonal trauma. Discussing their Life Scripts with understanding and

supportive therapists helps them to become aware of issues from their past that are triggering strong emotional reactions. Support is crucial. Studies have shown that support and social connectedness reduce the emotional strain and increase positive coping abilities of caregivers and parents of children with severe emotional and behavioral problems (Munsell *et al.* 2012). We provide substantial support to parents and encourage them to develop and maintain helpful support systems at home (e.g., family, friends, religious and community connections).

Power and Control

Families whom we treat are characterized by both a control-oriented child and parents who lack the information and skills necessary to effectively deal with their child, resulting in chronic power struggles. Positive changes for the child and parents become the focus. The therapist creates a climate of healthy limits, boundaries, and structure for the child by providing rules, a contract, and clear expectations. The dynamics of power and control shift, as the child's control strategies become ineffectual with a firm and confident therapist. Over time, the child learns to feel safe with external limits. This is crucial modeling for the parents, who become more hopeful by observing strategies that are effective with their child and increasingly motivated to learn new parenting attitudes and skills. During the course of treatment, the therapist spends considerable time educating the parents about attachment disorder and rehearsing effective parenting approaches.

CASE EXAMPLE: FATHER–DAUGHTER

Megan, age 10, had been chronically dishonest and controlling in the family, at school, and in prior therapy attempts. She would physically threaten and hurt her younger siblings, then lie about feeling remorse. One week into therapy (seventh session), she conversed with her father and was honest for the first time.

Father: [Megan starts to cry as soon as she looks into father's eyes.] Why are you crying?

Megan: I told you a lie. [Sobbing.]

Therapist: Can you look into your father's eyes and tell him what the lie was?

Megan: When I told Katie and Sam [adoptive siblings] I was sorry for hurting them, I lied.

Father: So, you're not sorry; you don't really feel sorry for hurting them?

> *Megan:* I said it, but inside I don't really mean it. I'm sorry deep down, but I won't let it come out.
>
> *Father:* What's holding it in, sweetie?
>
> *Megan:* The bad part of me. [Sobs, buries head in father's chest.]
>
> *Father:* Do you want to feel bad about the things you've done to your brother and sister?
>
> *Megan:* I want to feel bad; but I'm not sure I really do.
>
> *Father:* Why do you lie so much?
>
> *Megan:* I feel safer when I lie, like I have some control over things, like I have a secret and you don't know what it is.
>
> *Father:* I'm so glad to hear you say that. Thanks for being honest now. I'm proud of you. I love you. [They hug one another, Megan sobs.]

During this session, the father later reported, Megan let go of "needing to be in control" for the first time. Her aggression and dishonesty had been control strategies.

Triangulation

Children with attachment disorder are experts at "working one against the other." For example, a child may form a coalition with one parent against the other, or with a counselor against the parents. This is one of the child's strategies of manipulation and control. The structure of treatment prevents this triangulation. The treatment team and parents create a strong and unified collaborative alliance, while the parents are also helped to develop and maintain a unified parental team. An emphasis is placed on the parents' learning communication and problem-solving skills so that they can be "on the same page." It is also important that treatment team, parents, and external systems (e.g., social services) are united and working toward common goals.

CASE EXAMPLE: CAUSING PARENTS TO ARGUE

One mother writes:

> It is impossible for me to put into words the effect this child has had on our marriage. She intentionally causes arguments between me and my husband. The bad thing is we know that she is doing it and we try not to let it happen, but sometimes she had done it before we even realize what is going on. I know this sounds hard to believe for a 4-year-old child, but she does it. After she has gotten my husband to do whatever it is that she wants him to do, she gives me the most superior look. It just blows my mind.

CASE EXAMPLE: TRIANGULATION

Severe marital conflicts occurred following the adoption of Annie. She would be hostile, controlling, and aggressive toward her mother, yet charming and cooperative with her father when he came home from work. The father blamed his wife for Annie's problems, the wife felt betrayed by her husband; Annie had managed to triangulate the parents.

Annie had successful sessions with her (adoptive) mother, including honest dialogues, contracting in reference to prosocial coping skills, and positive attachment time. Next, positive father–daughter connecting was needed. The mother, however, was still angry at her husband for prior lack of support, and she lacked confidence in his parenting abilities. The therapist asked the mother to observe and then facilitated a father–daughter "in arms" dialogue.

Father: How are you feeling right now?

Annie: I don't feel love inside right now.

Father: You don't feel love inside? How come?

Annie: I don't know.

Father: Well, Dad feels a lot of love inside. I love Mom; I love you. [Holds Annie gently, looks into her eyes, begins to cry.]

Annie: Oh, well, you must feel warm inside. I learned that when you feel love you feel warm inside.

Father: Oh, yes, definitely. Definitely warm inside. And I feel happy that you are working hard in therapy.

Annie: Me too. I feel good I'm getting better. [She puts her head on her father's chest and hugs him tightly; they hug for several minutes.]

Therapist: Annie, can you look in your dad's eyes and tell him how you have been treating him and Mom before you came here?

Annie: I wasn't treating you very good. I said mean things and disobeyed. [Starts to cry.]

Therapist: Can you tell your father why you are crying?

Annie: I had a lot of bad thoughts. I'm sorry for the way I've treated you and Mom. [Father gently wipes her tears.]

Father and Annie dialogued for almost one hour. Annie shared her "bad thoughts" ("I wanted to hurt you"); fears ("I was afraid you would abuse me too"); and displayed remorse ("I'm sorry"). Father was firm yet loving, expressed his own feelings, and provided the ingredients of secure attachment.

The mother felt increased confidence in her husband's parenting ability after observing the father–daughter interaction. Subsequent marital communication sessions focused on resolving anger and

disappointment in the parents' relationship, and contracting to avoid triangulation in the future. The father apologized to his wife for being nonsupportive and for not understanding the serious nature of Annie's problems.

Reenactment of Prior Patterns

Due to a history of maltreatment and lack of secure and loving attachment, many children compulsively reenact negative patterns of relating. For instance, they often unconsciously invite rejection and abuse. Parents with histories of attachment-related problems also reenact negative relationship patterns. A mother, for example, who was emotionally abandoned in her family of origin, has a need for acceptance and love from her children, but her adopted child offers rejection and anger. She responds by rejecting the child, being angry and resentful, and distant. This dynamic perpetuates old patterns, thereby creating a self-fulfilling prophecy for child and mother: it fulfills the child's expectation that mothers are untrustworthy and rejecting, and also fulfills the mother's expectation that getting close only leads to emotional pain. Both are embroiled in an ongoing, mutually reinforcing pattern of negativity and disconnection. Changing this pattern involves three components:

- Therapeutic assessment and interventions address the mother's (or father's) attachment issues and patterns.
- Therapeutic interventions address the child's attachment issues and patterns.
- Parent–child interventions promote changes in relationship patterns. As the child and mother (or father) become more open and emotionally available, they are ready to interact with one another with improved communication, less anger and defensiveness, and increased closeness and trust.

CASE EXAMPLE: REENACTMENT AND DISPLACEMENT

The first session with Annie was productive, and the following interventions were accomplished: rules of therapy, first-year-of-life cycle, and dialogue regarding her "birth mother." Annie revealed her rage toward her birth mother for neglecting and abandoning her ("I want to kill her, cut her head off with scissors, burn her house down"). The final part of the session focused on the relationship between Annie and her adoptive mother; her mother held her in arms as they discussed Annie's progress in therapy.

> *Therapist:* You did a good job today, worked hard. Are you ready to tell your forever mom what we talked about?

Annie: Yeah! [Excited about seeing mother.]

Mother: [Comes into treatment room and places Annie "in arms" on couch; Annie is receptive and cooperative.]

Therapist: Look at your mom and tell her some of the things we talked about today.

Annie: Mom, those things I told you I want to do to you—burn the house down, kick you, kill you—well, I really want to do those things to Angie [birth mother].

Mother: Wow. How do you feel now, after realizing all of that?

Annie: Better; half of my body got the anger out. [Annie and her mother are smiling at one another; Annie is relaxed in her mother's arms.]

Mother and daughter dialogue for the next 45 minutes about anger, the first-year-of-life cycle ("I didn't learn to trust"), and sexual abuse ("Angie's boyfriend touched me the wrong way"). The end of the session allowed "quiet attachment time" (eye contact, in arms, dimmed lights, relaxed closeness). The mother later reported this was the first time she had experienced a close and positive connection with Annie since the adoption.

Between sessions Annie practiced anger management skills, cooperation with safe caregivers, responsibility, and reciprocity. The next session she expressed cognitive and emotional issues about compromised attachment with her birth mother: "I hate you/I love you; I needed you; you should have gone to parent school to learn to be a good mom." Again, mother–daughter attachment was facilitated during the final part of the session.

Mother: [Enters room; Annie gives her a hug; they hold one another for several minutes, rocking and talking.]

Therapist: Annie, can you tell your forever mom what you worked on today?

Annie: [Looking in mom's eyes.] My birth mother didn't take care of me because she had to take drugs. I am sad and mad about that. I take it out on you and dad.

Mother: It's very sad that your birth mother made that choice, but you are making good choices to work on your life.

Annie: I know. And I hate my birth mom, but I still love her, too.

The therapist helped mother and Annie process the issues of her birth mother (love/hate, abandonment, anger, and loss) while in arms. The session ended with mother–daughter attachment time, followed by father–mother–daughter time together.

Annie revealed "four worries" in a subsequent session: "Mom will leave family; Mom and Dad will abuse me; Mom will leave me; I'll die."

She shared these fears with both her mother and father. A plan was developed so that Annie can express her anxieties verbally, rather than act out with aggression and control.

> *Annie:* I'm afraid to love you, Mom. [Sobbing, looking in mother's eyes, in arms.]
>
> *Therapist:* Love is scary for you, Annie. Can you tell your mom why?
>
> *Annie:* I'm afraid you'll leave me, like Angie did. I'm afraid you or Dad will hurt me, too.
>
> *Mother:* [Crying; holding daughter.] I'm sorry you were hurt. We will never hurt you or leave you. Maybe with time, you will learn to trust us. It's good you are using your words to tell me how you feel.

These mother–daughter sessions point out the importance of both content and process. Content includes the verbal sharing of important issues. Most important, however, is the process that is occurring, i.e., the context of the attachment experience. The ingredients of secure attachment (eye contact, loving closeness and touch, empathy, limbic resonance, positive affect, protection) are experienced and rehearsed by mother and daughter.

CASE EXAMPLE: PARENT AND CHILD REENACTMENT

Despite living in his adoptive family for three years, Adam, age 9, did not develop an attachment to his parents. He was especially hostile, distant, punitive, and controlling with his adoptive mother. In addition to dealing with her son, the mother had her own difficult challenges: maltreatment and anxious attachment in her family of origin, unresolved grief regarding miscarriages and infertility, and ongoing and severe marital conflicts. Adam's hostile and rejecting demeanor triggered and exacerbated her pain, anger, and depression.

Therapy sessions with Adam addressed early maltreatment and attachment issues, negative working model, and the development of prosocial coping skills. Sessions with the mother addressed prior losses, helped reduce the anger and fear in her reaction to Adam, and enhanced effective communication and problem-solving with her husband. The groundwork was now established for initiating positive parent–child attachment. Following a successful "inner child" intervention with Adam, the mother was invited to participate in the session, while holding her son in arms.

> *Therapist:* OK, Adam, your forever mom is now going to switch places with me.
>
> [Adam eagerly places himself on his mother's lap, gazes directly into her eyes, and smiles; he appears ready.]
>
> *Adam:* I want to give you a real hug. [Hugs mother tightly.]

Mother: You do? OK. [Seems amazed at his desire for closeness.] Jeepers, this feels good. I don't think you've ever given me a hug like this before.

Therapist: Does it feel like Adam is giving you a real hug and accepting yours?

Mother: Yes. [Begins to cry.] Have you ever felt this before?

Adam: No. [Mother and son hold one another for several minutes.]

Adam: Why are you crying? [Seems concerned about his mother's tears.]

Mother: Part of me is sad; part of me is happy; and part just feels good.

Adam: Do you think I'll be OK when we go home?

Mother: We are all working on it. I hope so.

It is important not to allow the content to get in the way of the process. Considerable time is spent in mother–child attachment "practice" (eye contact, gentle touch, positive affect, smiles, attunement, and reciprocity).

Therapist: Can you tell your mother what happened to baby Adam?

Adam: He had worms in his tummy, didn't get milk, good care, or a blanket. [Good eye contact with mother.]

Therapist: You didn't get what you needed as a baby, but you can now. Let's pretend you are that little baby and your forever mom will take good care of you.

Adam and his mother spend half an hour in arms. He relaxes into his mother's arms, and they remain quiet and close. The increase in mutual caring, empathy, and honest communication—as well as the decrease in anger, defensiveness, and control struggles—initiated the process of establishing secure attachment between mother and son. Subsequent sessions continued the Corrective Attachment Therapy.

Enhancing Intimacy and Affection

Once old destructive patterns are abated, positive patterns of relating can be experienced and rehearsed. Considerable therapy time is spent in practicing the behaviors and interactions of secure attachment. For example, to finish a session, a mother or father spends 20 to 30 minutes with the child lovingly held in arms.

CASE EXAMPLE: ENHANCING CLOSENESS

Adoptive parents were considering relinquishing their daughter, Kelly, age 11, after several years of escalating problems and unsuccessful prior treatment. Mother was particularly angry and demoralized when they came to our program for help. She reported being "totally closed; I don't want to get hurt by Kelly anymore." The parents worked on their own issues (anger, hopelessness, lack of effective parenting skills), while Kelly addressed early maltreatment and attachment issues. On day four of the two-week treatment program, mother and daughter were ready to discuss their relationship and begin the process of attachment.

Therapist: [To mother.] Is there any part of you that gets worried about becoming close to Kelly now?

Mother: She's hurt me a lot; been there, done that. I don't want to get my heart broken again.

Therapist: Can you tell your daughter what it's like to get your heart broken?

Mother: [Starts to cry.] When you hurt me or hurt yourself, it's like cutting a part of me off, because you are a part of me; you're my daughter! [Sobs.]

Therapist: Kelly, what feeling does your mom have now?

Kelly: She's sad; she's crying.

Therapist: Do you know why she's sad? Can you tell her?

Kelly: Mom, you're sad about what I've done in the past, that I wouldn't let you love me, and I wouldn't love you.

Therapist: You wouldn't take your mom's love, and wouldn't give your love to her?

Kelly: No.

Therapist: So, your mom is sad because she's not getting love, just like baby Kelly felt sad when she didn't get love?

Kelly: Yeah; I know that my mom is sad, too.

Therapist: What are you feeling now?

Kelly: I feel sad, too; I feel sad about what I've done to you, not let you love me and try to help me. [Kelly starts to cry; mother and daughter seem relaxed and genuinely close.]

Therapist: Should your mom worry, if she opens her heart to you now, when you go home you will hurt her again?

Kelly: No, because I'm learning how to let other people's love into me, and let my love go back to them. [Smiles at mother, mutual eye contact.]

Therapist: Tell your mom.

Kelly: I'll let your love go into my heart and my love go into your heart.

Therapist: That would be nice. But are you all ready now, or do you have to work on it more? Tell your mom if you are ready and if this will be easy or hard.

Kelly: Mom, I want that, but I have more work to do. It will be hard, but I'm working on it.

This dialogue was followed with half an hour of "quiet attachment time." Next, the therapist helped mother and daughter contract regarding new behaviors and coping skills: Kelly agreed to express feelings verbally, "eye-to-eye" with mother, rather than act out with aggression and distancing; her mother agreed to work on learning to trust and being emotionally available again. The father joined them toward the end of the session, and they hugged one another, talked, and laughed.

CASE EXAMPLE: FATHER–SON CONNECTING

Parents can reenact and displace prior unresolved emotional and family issues onto their children, just as their children do to them. Honest and open parent–child communication facilitates positive change.

Father (adoptive) has been furious at Adam and expressed guilt and shame about losing his temper ("I hit him; even thought about him dying"). Additionally, his prior unresolved issues (death of siblings; wife's miscarriages) exacerbated his negative reactions to his son. The following in arms dialogue initiated a process of sharing and connecting.

Father: I'm glad we can do this. I'm glad you're hugging Mom and me. I used to get angry at you because you rejected me and Mom and you wouldn't obey. That hurt! [They hug one another.]

Therapist: Can you tell your son what you're afraid might happen if you open your heart and start loving him?

Father: I built an imaginary wall between you and me. I didn't want to love you anymore because of all the hurt. Now I'm trying to get rid of that wall, just like you. I feel bad I got so mad at you in the past. I do love you.

Adam: [Starts to cry; buries his head in father's chest.]

Therapist: Can you tell your father why you are so sad?

Adam: When he told me he built a wall, I want him to love me. [Sobs; father also cries; they hold one another close.]

Father and son spent the next hour discussing plans for the future. They made agreements about better ways to express their anger ("talk about it together, not get hurtful or rejecting"). The session ended with 30 minutes of quiet, relaxed connecting.

Ecological Patterns

Changes occur in the relationship between the family system and other social systems (i.e., school, mental health and social services agencies, extended family, and other support networks). For example, parents are encouraged to join support groups in their local community. Also, identifying and facilitating effective follow-up therapy is important to maintain positive change. The treatment team is instrumental in helping the parents develop positive attitudes and working relationships with resources outside the family.

CASE EXAMPLE: SOCIAL SYSTEMS

Madison's birth mother was an 18-year-old college student who was raped. Mother was angry during her entire pregnancy and rejected Madison at birth. Madison spent her first month of life in the hospital with medical complications, was placed in a foster home, and then was adopted at 3 months of age. Her parents reported that Madison would not attach through infancy and early childhood, and became destructive and violent by preschool. By age 8, she had attacked teachers and her mother, was cruel to pets, and showed total lack of remorse.

At the time of treatment there were serious problems not only in the family, but also between the family and external systems. Madison fabricated a story about her mother abusing her, which the school counselor reported to social services. Social services initiated a child abuse investigation. The parents felt betrayed and wrongly accused by the school and social services. A major therapeutic goal, therefore, was to develop a collaborative treatment team, i.e., parents, school, social services, and therapists united in order to help Madison and empower her parents.

This goal was accomplished in several ways: 1) educating school and social services about trauma and attachment disorder; 2) ongoing communication with school and social services regarding therapeutic progress and helpful interventions for dealing with Madison; 3) including school personnel and social services case workers in follow-up treatment planning; and 4) clarifying roles, responsibilities, and intervention strategies for all parties involved.

These interventions facilitated the necessary structure and limits for Madison, and provided the parents with understanding and support. The school placed Madison in a special needs program. Social services terminated the child abuse investigation. The parents now had renewed motivation and energy to learn effective parenting attitudes and skills. Madison could no longer triangulate one system against the other, and she began genuine participation in therapy.

10

Adult and Couple Attachment

Four distinct adult attachment styles have been identified, each corresponding to childhood attachment styles. The four child/adult attachment styles are: *secure – autonomous*; *avoidant – dismissing*; *anxious – preoccupied*; and *disorganized – unresolved*. Adults with these attachment styles differ in a number of significant ways:

- how they perceive and deal with emotional and sexual intimacy
- ability to communicate their emotions and needs, and listen to partners
- mode of responding to conflict
- expectations about their partner and the relationship (internal working models).

There are three primary underlying dimensions that characterize attachment styles and patterns. The first dimension is *closeness*, the extent to which people feel comfortable being emotionally close and intimate with others. The second is *dependence/avoidance*, the extent to which people feel comfortable depending on others, and having partners depend on them. The third is *anxiety*, the extent to which people worry that their partners will abandon and reject them (Collins 1996). These attachment style dimensions are depicted in Figure 10.1 (Bartholomew 1990; Brennan, Clark, and Shaver 1998).

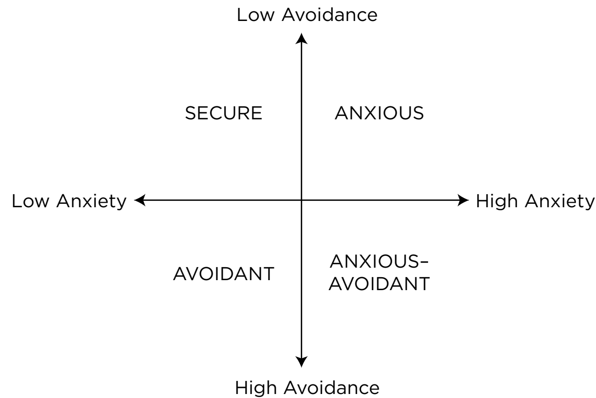


Figure 10.1 Dimensions of Attachment Style

The outline below describes the four attachment styles regarding avoidance, closeness, and anxiety, and prototypical descriptions of each.

- *Secure:* Low on avoidance, low on anxiety. Comfortable with intimacy; not worried about rejection or preoccupied with the relationship. "It is easy for me to get close to others, and I am comfortable depending on them and having them depend on me. I don't worry about being abandoned or about someone getting too close to me."
- *Avoidant:* high on avoidance, low on anxiety. Uncomfortable with closeness and primarily values independence and freedom; not worried about partner's availability. "I am uncomfortable being close to others. I find it difficult to trust and depend on others and prefer that others do not depend on me. It is very important that I feel independent and self-sufficient. My partner wants me to be more intimate than I am comfortable being."
- *Anxious:* low on avoidance, high on anxiety. Crave closeness and intimacy, very insecure about the relationship. "I want to be extremely emotionally close (merge) with others, but others are reluctant to get as close as I would like. I often worry that my partner doesn't love or value me and will leave me. My inordinate need for closeness scares people away."
- *Anxious–Avoidant:* high on avoidance, high on anxiety. Uncomfortable with intimacy, worried about partner's commitment and love (least common style). "I am uncomfortable getting close to others, and find it difficult to trust and depend on them. I worry I will be hurt if I get close to my partner."

Child – Adult Attachment Styles

The outline below explains the four child and adult attachment styles, the behavioral, cognitive, and social aspects of each style, and the way in which they differ regarding closeness, dependency, avoidance, and anxiety.

Secure – Autonomous

Child (Secure)

- Strange Situation (attachment assessment procedure): distressed on separation, very happy on reunion; mother and child greet warmly; calms down quickly and resumes play.
- Can trust and depend on parent to be safe, loving, and meet needs, especially in times of distress; uses parent to help regulate distress.
- Positive *internal working model* (IWM): "I trust parent; I am worthwhile and lovable; I feel safe"; expects and anticipates positive relationship.
- Parent is a *secure base*: can explore environment, learn, and develop, knowing parent is available and supportive if and when needed.
- Parent attuned to child's needs ("limbic resonance").

Adult (Autonomous)

Adult Attachment Interview (AAI):

- Coherent view of attachment and its importance; details about past are consistent with memories.
- Balanced and objective perspective regarding positive and negative qualities of past relationships.
- Able to easily access autobiographical information; comfortable discussing prior experiences.
- Can reflect on mental processes of self and others ("reflective function"); self-aware and insightful.

Traits

- Comfortable in a warm, loving, emotionally close relationship.
- Depends on partner and allows partner to depend on them; is available for partner in times of need.

- Accepts partner's need for separateness without feeling rejected or threatened; can be close and also independent ("dependent–independent").
- Trusting, empathic, tolerant of differences, and forgiving.
- Communicates emotions and needs honestly and openly; attuned to partner's needs and responds appropriately; does not avoid conflict.
- Manages emotions well; not overly upset about relationship issues.
- Insight, resolution, and forgiveness about past relationships.
- Sensitive, warm, and caring parent; attuned to child's cues and needs; children are securely attached.

Avoidant – Dismissive

Child (Avoidant)

- Strange Situation: does not show signs of being upset when mother leaves, explores surroundings; ignores mother on reunion; mother also avoids child, looking away; when picked up wants to be put down; plays alone (heart rate and cortisol level are elevated despite calm façade).
- Learns not to trust or depend on parent, who is emotionally unavailable, insensitive, and rejecting; suppresses (deactivates) attachment behavior to avoid rejection.
- Negative IWM: "I can't trust parents so I must rely on myself; I am not worth loving; I feel unsafe but will pretend to be independent."
- Deactivates emotional needs; avoids closeness with friends and family; devalues relationships; disconnected from own emotions.

Adult (Dismissive)

Adult Attachment Interview (AAI):

- Incoherent view of attachment; details not consistent with memories; description of past contradicted by facts.
- Dismissing of relationships; little recall of relationship experiences.
- Brief responses; does not want to reflect on the past.
- Reports lack of emotional connections; rejection and neglect from parents.

Traits

- Emotionally distant and rejecting in a relationship; keeps partner at arm's length; partner always wanting more connection (deactivates attachment needs and behaviors).
- Equates intimacy with loss of independence; prefers autonomy to togetherness.
- Not able to depend on partner or allow partner to "lean on" them; independence is a priority.
- Communication is intellectual, not comfortable talking about emotions; avoids conflict, then explodes.
- Cool, controlled, stoic; compulsively self-sufficient; narrow emotional range; prefers to be alone.
- Good in a crisis; non-emotional, takes charge.
- Emotionally unavailable as parent; disengaged and detached; children likely to have avoidant attachment.

Anxious – Preoccupied

Child (Anxious)

- Strange Situation: extremely upset when mother leaves, clingy, stays near door crying; rushes to mother on reunion then pushes her away in anger; fails to settle down and accept comfort; clings and does not play.
- Anxious and preoccupied with parent's whereabouts, due to parental anxiety and inconsistency (intrusive one minute, then aloof or gone); desperate for contact but unable to be soothed.
- Learns to hyperactivate attachment behavior: protests and cries loudly and persistently; hypervigilant about loss of support and separation; works hard to get parent to respond; controlling, demanding, clingy, babyish, caregiving toward parent.
- Negative IWM: "I can't rely on parent or feel secure with love; I'm not worth loving; I am always anxious and uncertain."

Adults (Preoccupied)

Adult Attachment Interview (AAI):

- Incoherent and confused; preoccupied with unresolved emotional issues.

- Excessively long responses; flood of upsetting memories; does not address questions.
- Angry and fearful; stories of disappointment, frustrating efforts to please parents, role reversals.

Traits

- Insecure in relationship; constantly worried about rejection and abandonment; preoccupied with relationship (hyperactivated attachment needs and behavior).
- Needy; requires ongoing reassurance; want to "merge" with partner, which scares partner away.
- Ruminates about unresolved past issues, which intrude into present perceptions and relationships (fear, hurt, anger).
- Over sensitive to partner's actions and moods; takes partner's behavior too personally.
- Highly emotional; can be argumentative, combative, angry, controlling; poor personal boundaries.
- Communication not collaborative; unaware of own responsibility in relationship; blames others.
- Unpredictable and moody; connects through conflict, "stirs the pot."
- Inconsistent attunement with own children, who are likely to be anxiously attached.

Disorganized – Unresolved

Child (Disorganized)

- Strange Situation: no organized strategy for handling separation or reunion; displays both avoidant and anxious reactions; may freeze, become disoriented, and/or move away from mother suddenly.
- Approach–avoidance conflict: due to severe abuse and neglect, attachment figure is the source of fear and terror; need to move toward, and impulse to go away from parent.
- Negative IWM: "Expect pain from parent; I'm bad, worthless, unlovable; I never feel safe."

- Controlling and punitive toward parent; pervasive fear and anxiety; dissociates as survival defense; exhibits bizarre and uncoordinated behavior under stress.
- Parents display frightening and frightened behaviors; severe maltreatment; clinical depression, personality disorders (e.g., borderline, antisocial), traumatic background.

Adult (Unresolved)

Adult Attachment Interview (AAI):

- Incoherent narrative; confused and disoriented during discussions of maltreatment, loss, and trauma.
- Disorganized thinking; lapses in reasoning, incomplete sentences, prolonged silences; may dissociate.

Traits

- Unresolved mindset and emotions; frightened by memories of prior trauma; losses not mourned or resolved.
- Cannot tolerate emotional closeness in a relationship; argumentative, rages, unable to regulate emotions; abusive and dysfunctional relationships.
- Intrusive and frightening traumatic memories and triggers; dissociates to avoid pain; severe depression, PTSD.
- Antisocial; lack of empathy and remorse, aggressive and punitive, narcissistic, no regard for rules, substance abuse, criminality.
- Maltreats own children; scripts children into past unresolved attachments; triggered into anger and fear by parent–child interaction; children developed disorganized attachment.

Attachment Styles: Additional Factors

The common assumption is that adult attachment styles are a product of parent–child interactions. Thus, adults with secure attachment had sensitive and emotionally available caregivers. Anxious adults had inconsistent parents. Avoidants had caregivers who were distant and rejecting. Evidence suggests that additional factors play a role in the development of attachment styles. Children with secure attachment were found to have an easy temperament (easy to soothe), positive maternal conditions (low stress, satisfying marriage,

no depression, social support), and less time spent with a nonparental caregiver, such as day care (Atkinson, Niccols, and Paglia 2000). In addition, new research indicates genetic influences on attachment styles. Genes found on dopamine receptors have been linked to anxious attachment, and genes on serotonin receptors are linked to avoidant attachment (Gillath, Shaver, Baek, and Chun 2008). Psychological, social, and biological factors contribute to the development of attachment patterns and styles.

Secure Attachment

Numerous studies have shown the positive effects of adult attachment security on self-image, stress management, values, and overall mental, physical, and relationship health. The ability to trust and depend on a partner results in a "broaden-and-build" cycle, i.e., the sense of security increases a person's emotional stability in times of stress, acting as a resource for resilience, the ability to recover following adversity (Fredrickson 2001).

Secure attachment in adults is positively associated with measures of well-being and negatively associated with depression and anxiety (Birnbaum *et al.* 1997; Mickelson, Kessler, and Shaver 1997). Securely attached adults have constructive and optimistic beliefs and attitudes. They appraise problems as manageable, view stressful events as opportunities for learning, and have a more positive view of human nature (Collins and Read 1990). They have more positive expectations regarding their partner's behavior, and are less negative when reacting to a partner's hurtful behavior (Baldwin *et al.* 1996). Secure adults score higher on measures of trust, intimacy, open communication, prosocial behavior, self-disclosure, support seeking, marital satisfaction, and self-esteem (Mikulincer and Shaver 2007). Attachment security has been found to be associated with curiosity, learning, change, taking calculated risks, facing challenges, and engaging in exploration of new and different information and situations (Elliot and Reis 2003).

Achieving secure attachment—having a partner who fulfills our intrinsic attachment needs and serves as a secure base—is vital to emotional and physical health. Securely attached adults are more calm and confident, have prosocial values, a sense of purpose and meaning, are able to maintain intimate and reciprocal relationships, and are better able to cope with life's challenges and hardships. In 1938, researchers began a study of students at Harvard University and tracked them throughout their entire lives. Over time, the importance of intimate relationships became clear. During the 1940s, the men who grew up with warm and loving parents were much more likely to become lieutenants and majors in World War II, while those who had cold and unloving parents were more likely to be privates. Resilience was affected

by secure attachment. The positive effect of even one loving and supportive friend, mentor, or relative helped to overcome adverse events in the men's lives. Those who were better at maintaining intimate relationships also lived longer. The study concluded that the capacity for intimate relationships was the primary factor related to flourishing in all aspects of the men's lives (Vaillant 2002). The following is a list of traits associated with attachment security in adults:

- *Desires closeness:* Seeks and enjoys intimacy without being afraid of becoming "too close"; does not fear rejection, have a need to push partner away, or engage in a negative relationship "dance" (e.g., pursuer–distancer dynamic; one wants closeness and the other maintains distance); positive mindset about closeness—desires closeness and assumes partner wants closeness too; allows intimacy to evolve over time; doesn't "play games."
- *Emotionally available:* Aware of, and able to regulate, own emotions; able to discuss feelings in an honest and coherent way; has empathy and understanding for partner's emotions; not afraid of commitment or dependency.
- *Protective:* Partners feel safe and sheltered, helping them to face the realities of life with a secure feeling; treats partner with consistent support, respect, and love.
- *Communication and conflict-management skills:* Open and honest sharing and empathic listening; able to have a disagreement without becoming defensive or attacking, which avoids escalation and expedites resolution; confident that problems can be solved and the relationship will thrive; makes decisions as a team.
- *Flexible:* Adaptable, not rigid in thinking; able to accept feedback and consider partner's ideas without feeling criticized or controlled; can modify ideas and actions when appropriate.
- *Forgiving:* Can forgive partner for mistakes or hurtful actions, and can practice self-forgiveness; does not hold onto resentments; positive view and expectation—assumes partner's intentions are good and realizes no one is perfect.
- *Sexuality:* Realizes that sex is part of emotional intimacy, not merely physical; is both emotionally and sexually intimate; partner is secure in his or her commitment and faithfulness (avoidants most likely to have affairs).

Contact with a secure partner acts as a buffer against stress and anxiety. Researchers at the University of Virginia studied how physical contact with a spouse reduces anxiety, both psychologically and biologically. They used functional MRIs to scan the brains of women under stressful conditions (telling them they would receive an electric shock). The brain scan focused on the hypothalamus, a region of the brain that becomes activated under stress. When the women held a stranger's hand, the scans showed some reduced activity in the hypothalamus. When they held their husband's hand, the activity in the hypothalamus was negligible, indicating no stress response. The women who reported the highest marital satisfaction had the best results from spousal hand-holding (Coan, Schaefer, and Davidson 2006).

Numerous studies show that when two people have a significant attachment they regulate each other's physiological reactions (i.e., heart rate, blood pressure, breathing, hormone levels). A study at Case Western Reserve University found that negative relationships undermine health. Men with a history of high blood pressure and angina were asked, "Does your wife show you love?" The men who answered "no" had twice as many angina episodes over the next five years as compared to those who answered "yes." Women who report significant conflict in their marriages are more likely to have high blood pressure, high levels of stress hormones, and are three times more likely to have a second heart attack than women with less discord in their marriage (Kiecolt-Glaser *et al.* 2005). Researchers at the University of Toronto found that being in a satisfying marriage lowers blood pressure in men and women with high blood pressure. Conversely, having contact with a spouse in an unsatisfying marriage raises blood pressure, which remains elevated while in physical proximity (Baker *et al.* 2003).

The quality of our adult attachment relationships affects our emotional and physical health. When our partner does not meet our basic attachment needs for security and safety, our emotional well-being and physical health decline. People in high-conflict marriages have a ten times higher risk for depression (O'Leary *et al.* 1994). Attachment insecurities have been linked to many health problems: chronic pain and other somatic symptoms, troubled sleep, non adherence to medical regimes, fewer health care visits, and negative patient–physician relationships (Mikulincer and Shaver 2007).

Dependency Paradox

Western culture has a long history of emphasizing self-sufficiency and independence. John Watson and the behaviorists in the 1940s warned parents that children should learn to soothe themselves; otherwise they would become weak and overly dependent (Watson 1928). Parents were advised to maintain

an emotional and physical distance with their children, allowing them to cry alone, in order to foster self-reliance and fortitude. Adults have been given similar advice regarding romantic relationships. In popular psychology, people have been warned about the dangers of "codependency." The basic message is that fulfillment and happiness should come from within, and you should not rely or depend on your partner to make you whole or happy. The assumption is that dependency in a relationship is harmful and unhealthy, and reveals a psychological deficiency in the person. (Some codependency can be unhealthy, of course, such as in a dynamic involving substance abuse or domestic violence).

Attachment theory and research have shown that dependency is a natural part of our biology as well as psychology. People who are securely attached, both parent–child and adult partners, become physiologically connected and interdependent. This reciprocal relationship begins during pregnancy; mother and unborn baby are in sync, even coordinating sleep and activity cycles. An infant's nervous system is not well developed, and it is through the interdependence between baby and caregiver that healthy development occurs. The baby's smile brings joy to mom, motivating her to cuddle and stay close, and the mother's smile soothes and relaxes her baby, enhancing trust and security. The mother's support and love help regulate her baby's body and brain; maternal touch stimulates growth hormones, and her milk regulates the baby's heart rate. Infants and their attachment figures continuously affect one another, the *dance of reciprocity* (Orlans and Levy 2006). When parents and children are attuned, and when adult partners form a secure attachment, a rush of oxytocin floods through their brains. Oxytocin, referred to as the "love hormone" or "affiliative neuropeptide," stimulates the release of dopamine and the reward center of the brain, creating a feeling of calm and contentment, while suppressing the stress hormone cortisol (Johnson 2008).

The truth is that being able to trust and depend on your attachment figure, a *secure base*, leads to increased independence, not less. This is demonstrated by observing separation and reunion behaviors during the "Strange Situation" (Ainsworth *et al.* 1978). Children who are securely attached protest their parents' leaving, but are calm and confident in exploring the environment when their attachment figures are present. They have a secure base; feeling secure that a parent is available to support and protect, they can explore and learn in an optimal way. As Bowlby expressed, "All of us, from cradle to grave, are happiest when life is organized as a series of excursions, long or short, from the secure base provided by our attachment figures (Bowlby 1988a, p.39). Therefore, the more a person (child or adult) feels secure at home, the more he or she can venture out to explore with confidence and independence.

Attachment Insecurity

As previously noted, each attachment style involves specific strategies to deal with closeness, dependence, avoidance, and anxiety. Anxiously attached adults employ hyperactivating attachment behaviors, avoidantly attached adults deactivate attachment needs and behaviors, and adults who are unresolved have no organized strategy to manage their emotions and relationships. The list that follows describes the goals and traits of each adult insecure attachment style.

Deactivating Strategies (Avoidant)

- The main goal is to deny attachment needs and be compulsively self-reliant, because the attachment figure is perceived as dangerous, distant, and rejecting.
- Inhibits primary attachment strategy of seeking proximity; ignores and denies needs; maintains distance, control, and remains self-reliant.
- Avoids emotional involvement, intimacy, interdependence, and self-disclosure; needs to get away or explodes during a disagreement.
- Suppresses attachment-related thoughts and feelings.
- Mistrustful; fears being taken advantage of.
- Unwilling to deal with partner's distress or desire for intimacy and security.
- Avoids feelings of vulnerability, neediness, or dependence.
- Denigrates and distrusts partner; dismisses and downplays their needs.
- Keeps anger and resentments inside; views relationships as unsatisfying.
- Fantasizes about other sexual partners; most likely to have affairs.

Hyperactivating Strategies (Anxious)

- The main goal is to get the attachment figure, who is perceived as unresponsive and unreliable, to pay more attention and provide support and protection.
- Intense monitoring of partner; suspicious that their partner is unfaithful.
- Persistent efforts to maintain proximity; excessive demands for care and attention; preoccupied with the relationship.

- Desires enmeshment and merger; overdependence on partner for comfort.
- Attempts to minimize emotional, cognitive, and physical distance; clingy and controlling behavior.
- Exaggerates seriousness of problems and their inability to cope; intense expression of distress and emotions; protests any hint of unavailability.
- Acts childish, helpless, and excessively needy.
- Intrusive, coercive, and aggressive behavior that leads to eventual rejection—the very outcome most dreaded ("self-fulfilling prophecy").

Disorganized (Unresolved)

- Fears the negative consequences of closeness and reliance on others, due to severe abusive and attachment-related trauma.
- Enacts both deactivating and hyperactivating strategies in confused and chaotic manner; vacillates between approach and avoidance behavior; scores high on anxiety and avoidance measures.
- PTSD symptoms: attempts to avoid frightening thoughts and memories; unable to control intrusive traumatic emotions and memories ("flashbacks"); hyperarousal of anxiety, emotions, and physiology.
- Least secure and trusting; most severe psychological problems; extremely distressing and violent relationships; personality disorders.

Adult Attachment and Communication

Attachment theory offers a way of understanding intimate adult relationships, including issues such as trust, support, loss, emotional reactions, patterns of interacting, and core beliefs. Just as children need their parents and caregivers to be a secure base and safe haven, adults need their partners to provide safety and security. It is important to view your partner as emotionally available, responsive to your needs, and dependable, especially during stressful times. When you turn to your partner for support and comfort, and he or she is not emotionally available, an "attachment wound" often occurs. Trust is damaged and there is a predictable response to the loss of connection: angry protest, despair, and detachment. Depression and anxiety are common responses to this disappointment.

There are two basic strategies people use in these situations. The first is characterized by increased attachment behaviors ("hyperactivated"), including anxious clinging, pursuit, and other frantic attempts to connect with their partner. The second strategy is detached avoidance; attachment needs and behaviors are reduced ("deactivated") to avoid the pain of loss. Couples can get engulfed in ongoing and repetitive patterns using one or both of these strategies, which is extremely damaging to the relationship. For example, there is a high incidence of divorce among couples who have a pattern of angry accusations followed by avoidance and emotional distance (Gottman 1999).

Many of the behaviors and patterns of interacting in adult intimate relationships can be traced back to the internal working models formed early in life. These mindsets and core beliefs become biases and expectations, the lens through which we view ourselves and our partners. Secure adults view themselves as worthy of love, and trust their partners to be dependable and supportive. Adults with insecure attachments view themselves as not deserving of love, and expect their partners to reject, abandon, or abuse them. These mental models and beliefs influence behavior and emotional reactions, and eventually develop into ongoing patterns—the dance of relationships.

A useful and practical way to change negative patterns is to learn how to communicate effectively: how to share and listen in honest, deep, positive, and constructive ways. This can be accomplished by learning the concepts and skills of Attachment Communication Training (ACT). After completing the Life Script, family members are ready to create secure and fulfilling relationships, using the communication skills outlined in the next section.

Attachment Communication Training (ACT)

Attachment Communication Training (ACT) is a method to learn the concepts and skills of effective communication and conflict management, which provides a vehicle for couples (or any dyad) to understand and fulfill attachment needs. Healthy adult romantic and coparenting relationships occur when partners have a secure attachment, which includes trust, support, attunement, closeness, and open emotional communication. Conversely, insecure attachments are distinguished by lack of trust and security, resulting in isolation, anxiety, anger, and depression (Johnson and Whiffen 2003).

ACT makes use of an *enactment-based* procedure, which research shows is more effective than a *therapist-centered* approach in achieving effective communication and attachment security. Enactment-based methods have several components: 1) face-to-face interaction that is guided by therapists; 2) therapists function as coaches to assist the partners in achieving

constructive and secure interactions; and 3) therapists serve as "proxy voices" (i.e., alter egos) for partners—giving a voice to underlying emotions, attachment needs, and cognitive biases (mental models) that are not being acknowledge or articulated. In a therapist-centered approach, conversely, most of the interaction is channeled through the therapist, including direct instruction, advice-giving, and serving as a "go-between" in the relationship. Research shows that using the enactment-based approach leads to a number of constructive outcomes. First, it helps people develop new patterns of communicating that foster genuine emotional sharing, supportive listening, and fulfillment of attachment needs. Second, this approach actively engages participants in their own "healing journey," rather than relying on therapists to have control over the process. This results in the partners taking ownership over their own positive growth, being more self-reliant, and better able to manage conflicts on their own. This leads to an increased sense of responsibility, mastery, competency, confidence, and empowerment (Butler, Harper, and Mitchell 2011).

The ACT model is a structured, goal-oriented, and directive approach to teaching communication skills and mitigating destructive patterns of interacting. Therapists guide and coach clients to learn specific communication skills in order to interrupt habitual negative behaviors and dynamics. It is important to first "set the stage," creating the milieu most conducive to constructive emotional communication. The individuals communicating (e.g., adult partners, parent–child, siblings) sit in chairs facing one another, so they can be physically close, have eye contact, and hold hands (if and when appropriate). A *contract* is established; clients are asked if they will agree to learn and practice specific communication skills, and the therapist agrees to guide them through the exercise. It is important that clients are aware of the structured nature of the exercise, and that they give their permission for therapists to intervene in order to help them follow the rules. The therapist explains the goals and rules of ACT in the following way:

> Effective communication is the basis of close, trusting, and healthy relationships. Today you are going to learn Attachment Communication Training, which will help you accomplish several goals: 1) change negative patterns and learn to communicate effectively; 2) learn to talk in a safe and constructive way, so you can create a trusting and secure relationship; 3) practice the skills of sharing and listening; 4) understand each other better, which will help you feel closer; 5) learn the skills of productive problem-solving and how to deal with conflict constructively; and 6) talk in a way that is positive, avoiding destructive behavior, such as criticism, defensiveness, stonewalling, or contempt, which can ruin relationships.

> This communication method will help you to be a secure base for one another; meaning you will be supportive, safe, and dependable. For this exercise to work well, you will have to follow the guidelines, which I will describe in a moment. Are you both willing to learn the skills I'm going to describe and follow the "rules?" When you first try this communication approach it will probably feel unnatural and sort of contrived. That's OK; with practice you will find it to be helpful and rewarding. Are you willing to try this?
>
> I'm going to tell you the rules for *sharing* and *listening*. When you are *sharing* with your partner it is important to: 1) be honest, even if you think you might "make waves"; 2) share your thoughts and feelings; they are separate; 3) make "I statements"—share your own perceptions and emotions; no questions, blaming, or criticizing; 4) be brief, specific, and give examples: "when you did _____, I viewed this as _____, and then I felt _____"; and 5) be aware of your body language, such as facial expressions, posture, tone of voice—these are powerful messages.
>
> Next are the rules for *listening*—this is called nonjudgmental and empathic listening: 1) be nonjudgmental; put aside your judgments of what your partner is saying as right or wrong, good or bad, and try to understand your partner's thoughts and feelings; 2) have empathy; try to "walk in your partner's shoes," even if you have a different opinion; 3) don't censor what you hear ("selective listening") or rehearse your rebuttal; try to really hear your partner without being defensive; and 4) be aware of your body language; are you looking safe, supportive, and interested? If not, your partner may not feel comfortable in opening up.

At this time, the therapist asks if there are any questions regarding the rules of sharing and listening. This is a time to respond to concerns, clarify the skills to be practiced, and address any additional issues. The therapist describes next the five steps in the ACT exercise: *share*, *listen*, *restate*, *feedback*, and *reverse roles*. The therapist explains the steps in the following way:

> Step 1 is *sharing*. It is important to use the rules of sharing that I previously described. Step 2 is *listening*. While your partner is expressing his or her thoughts and feelings, your job is to be a good listener. Remember to follow the listening guidelines that I talked about. Step 3 is *restating*. This is also called reflective listening, or mirroring, because you are reflecting back to your partner what you heard. "What I heard you say is _____." The next step is giving *feedback*; tell your partner how he or she did as a listener. If you feel your partner listened well, then say, "You heard me, you got my messages, thank you for listening." It is always good to thank the other person for listening. If you feel your partner did not hear you, or misinterpreted your messages, you can tell them so and try once more.

> It is OK to clarify your thoughts and feelings, as we don't always hear accurately on the first try. The goal is: message sent; message received. The goal of an argument is to get the other person to agree with your opinion. The goal of this exercise is to be honest and hear one another. Understanding with empathy is key. The last step is *reversing roles*. The sharer becomes the listener, and the listener now takes a turn at sharing. You can stay on the same topic or change the topic. You both will have several chances to share and listen. Any questions?

A typical ACT session lasts 1 to 1½ hours. Remember to encourage the participants to follow the rules of sharing and listening and follow the five-step exercise. For example, it is common for the listeners to begin sharing their opinions. You must remind them to stay in listener mode; otherwise the interaction will regress into old, negative, and destructive patterns (e.g., arguing, debating, attacking, defending). To end the ACT session, ask each person to share with their partner how they feel about the communication exercise. Ask them to talk about the following:

- What was it like to communicate in this way?
- How does it feel to share honestly? How do you feel when you sense that your partner is really hearing you?
- What was more difficult for you, sharing or listening? Why?
- How will your relationship be improved by using ACT?
- What are some of the issues you want to discuss in the future using ACT?

Family members are encouraged to practice ACT at home, and are given a handout outlining the rules and process. Repeated practice in-session and at home is typically necessary to become proficient at the communication skills. Most people report positive results—less conflict, increased emotional closeness, trust, and attunement, and feeling more hopeful about their relationship.

Traits of Healthy and Happy Couples

Over 50 percent of marriages end in divorce due to various reasons: incompatibility, betrayal, substance abuse, attachment problems, faulty communication. Many people lacked role models of healthy long-term love and commitment growing up. When partners are committed to creating a healthy relationship, old wounds can be healed and new ways of relating can be learned. The following are traits of healthy and happy couples. Partners:

- have "come to terms" with their past and are able to fully invest in the relationship
- are able to balance togetherness and autonomy, dependence and independence
- can trust and rely on one another; be a "secure base" for each other
- have good communication and problem-solving skills; are respectful and constructive when talking about conflicts and disagreements
- do not become defensive, angry, critical, or aggressive when their partner shares feelings or gives feedback; apologize for wrongdoings
- share power and control; are a partnership between equals
- meet one another's needs for security, support, affection, and love
- both take responsibility for their own part in problems and solutions: no blaming, avoiding, or stonewalling
- keep the relationship alive, vital, and a priority; spend time, have fun, show love regularly
- use self-control; do not take out stress and frustration on their partner
- resolve problems; continue to repair grievances and wounds so hurts do not grow into big resentments
- adapt successfully to changes and challenges, such as having children; form a united team in raising children
- are both comfortable with closeness; do not take part in destructive dynamics, such as "pursue–distance" pattern
- share basic values, interests, and moral codes of behavior.

CASE EXAMPLE: LYNNE AND DAVE

Lynne, 40, is married to Dave, and has two children, a biological son, age 8, and an adopted son, age 6. Her Life Script revealed significant trauma in her family of origin. Her father was physically abusive to Lynne, her two younger siblings, and her mother. She described him as "mean, selfish, womanizer, abuser, and gone." His major message to her was "something is wrong with you." Lynne's mother was an alcoholic, had severe anxiety, and was sexually abused by an uncle as a child. Lynne described her mother as "alcoholic, childlike, pitiful, no boundaries, gone, and loving sometimes." Lynne characterized her mother's major message to her as a child as "be passive and take care of others." The major traumatic events as a child were "left alone to take care of my sibs, father beating mom, and being bullied." She described herself as a child as "terrified,

freak, alone, helpless." She has suffered with anxiety and depression most of her life and is currently on medication, which she reports to be helpful. Lynne requested help and contracted to participate in therapy. The session begins with Lynne and her husband in the context of the Limbic Activation Process. Dave said he wanted to help Lynne through the therapy, and was instructed to provide emotional support during the session.

Inner Child Metaphor

Lynne chooses a teddy bear to represent "little Lynne." She is instructed on how we will use the teddy bear to explore the thoughts and feelings of her "inner child."

TML: Tell Little Lynne the story of her life.

Lynne: [Lynne holds little Lynne, looks in her eyes, and says] You were the firstborn—to young parents who were not ready for a child.

TML: How was the pregnancy?

Lynne: Mom was told to have a baby by her in-laws; she was very anxious.

TML: What happened next?

Lynne: Mom wrote in the baby book, "We need this baby." This was the beginning of my taking care of them. I was there to meet their needs.

TML: Why was your mom so needy?

Lynne: She was raised in an unstable family and married an abusive husband. She had abuse and alcoholism in her childhood, and her mother was absent.

TML: What do you remember about growing up?

Lynne: Five years old, my birthday party. I feel like a freak, I was different.

MO: Why were you different?

Lynne: I felt ugly, and I was scared all the time. I had all this anxiety and I didn't know what to do.

TML: Who did you turn to?

Lynne: My mom would listen, but she couldn't help me because she had her own problems. [Dave places his hand over Lynne's, as if to say, "Your Mom was not there for you, but I am."]

Lynne is describing an anxious attachment pattern, in which she could not rely on her mother for safety and support. She is also describing an anxiety disorder which became magnified as she grew older.

TML: If no one could help you, what does a kid think?

Lynne: I'm helpless and hopeless. I didn't want to go on living. [Lynne begins to cry. She is genuinely engaged in the therapeutic process and, therefore, open to change and healing.]

TML: What else happened as you got older?

Lynne: Mom worked at night in a bar. Dad would be gone for days. I would be home with no parents, at age 10, and have to take care of my younger brother and sister. I was the caretaker and terrified. I was also bullied at this time by neighborhood boys.

TML: Do you still view yourself in this negative way?

Lynne: I feel I have no value, except what I can do for others.

Lynne expresses her negative working model: "I don't like myself; I have no value; I'm only worth something when I can take care of others." The goals of the next intervention are *cognitive rescripting* (encouraging a more positive self-concept) and *self-soothing* (accept, support, and nurture Little Lynne—the self).

TML: What's the truth; is she worth something? Tell her what you think about her now.

Lynne: [Looks at Little Lynne and says] You are beautiful, wanted, a child of God, and you have a purpose here.

TML: Can you hug Little Lynne?

Lynne places Little Lynne on her chest and holds her close, as one would lovingly hold a baby. Dave places his hand on Little Lynne, providing support and compassion to Lynne and her inner child. They are both instructed to close their eyes and send Little Lynne messages of validation, self-worth, love, and support. This corrective emotional experience rewires the limbic brain, facilitates self-acceptance, and initiates a change in the narrative ("internal working model").

Lynne: [Looks at little Lynne, gently strokes her head, and says] You are worth everything; I love you. I wish I was there for you back then like I am now, because you had nobody then. [Lynne cries.]

TML: What do you want to say to Little Lynne, Dave?

Dave: You're very special; you're beautiful and smart; I love you. [Dave cries and says] I'm sad for that little girl. [His empathy and support is a "secure base" for Lynne—good for Lynne and for their relationship.]

Psychodramatic Reenactment

The goal of this intervention is for Lynne to "give a voice" to little Lynne; to tell her parents her honest thoughts and feelings. One therapist (MO) role-plays father and another (MV) role-plays mother.

TML: Little Lynne needs to talk with mom and dad, say things she didn't feel safe to say back then.

Lynne: [Speaking to mother] Are you OK Mom?

TML: Tell mom how little Lynne was feeling.

Lynne: You made me feel like I had no value unless I was taking care of you. And you left me alone; I was terrified.

MV: I need you to listen to me; to help me.

Lynne: [Gets angry and shouts] I don't want to hear it, Mom! Get a friend; get a therapist; I don't want to hear it anymore. [Lynne is sounding and looking like the helpless child.]

TML: Tell Mom what you have learned and how you have changed, in a more powerful voice.

Lynne: I am valuable; I'm not your therapist; I love you, but I can't fix you.

MO: Just say "No more, Mom. I have worth; I have value."

Lynne: No more, Mom. [Lynne is now looking and sounding confident and assertive, not the helpless child.]

TML: If you don't have to fix your mom anymore, do you still have to be the fixer for your husband? Tell Dave how you are changing.

Lynne: [Looks at mom, cries and says] I thought you would die and I wouldn't have anybody. [Looks at Dave and says] I'm afraid you'll die, too. [Dave cries and says "I'm not going to die." They hug one another.]

TML: Are you that frightened, helpless little child anymore?

Lynne: [Looks at mom and then husband and says] I hope you don't die but I'm not helpless; I can make it; I'm strong.

Lynne is changing her internal working model from "I'm helpless and have to rescue others" to "I'm competent and others can help themselves." The role-playing is an experiential context to facilitate changes emotionally, neurobiologically, cognitively, and interpersonally.

MO: [Role-playing father, looks at Lynne and says] What the hell is wrong with you?

Lynne: [Looks into father's eyes] You are so wrong, Dad; I know who you are, just a scared little boy. I'm not going to let you hurt me anymore. [Lynne appears confident, assertive, and composed.]

MO: You're unlovable.

Lynne: I thought I was unlovable then, but no more; I am loveable. I used to think it was my fault, but it was not my fault, it was your fault!

MO: I still run your life.

Lynne: No more. I feel sorry for you, but I'm not going to let you hurt me or yell at my kids. If you can't behave yourself around my kids, you're not going to be around them! [Lynne sets healthy boundaries for the first time.]

TML: [Asks Dave what he wants to say to father.]

Dave: You are not going to treat our kids the way you treated Lynne! [Dave supports Lynne as a united front to set boundaries with father.]

TML: [To Lynne] Close your eyes, go inside, what do you feel?

Lynne: I feel very strong. I can honor my parents but not be in their unhealthiness anymore. I feel 10 feet tall! [Looks at Dave and says] I'm strong; I can do this; I am doing this.

The session ends with the therapists instructing Lynne and Dave to connect; then the therapists leave the room. They spend about 20 minutes together talking and hugging.

Attachment Communication Training

Following Lynne's emotional processing and cognitive rescripting (i.e., inner child metaphor and psychodramatic reenactments), it is important for the couple to learn communication and conflict-management skills. Lynne and Dave are taught ACT concepts and skills, and the following are excerpts of their interaction.

Dave: When we first met I thought you were much smarter than me. I was a grease monkey; you were the executive. I still think you are much smarter.

Lynne: I hear you saying you feel inadequate, and that's why you want me to take charge.

TML: [Alter ego; TML stands behind Dave and gives a voice to the meta-message, the deeper message] "I still feel scared and inadequate like I did as a child." Is that correct, Dave?

Dave: Yes. I never had confidence. You helped me, believed in me; that gave me more confidence. I still think you are smarter. I get lost, you know where to go.

Lynne: I hear you don't feel like my equal.

MO: Dave, how do you feel about yourself?

Dave: [Pauses to think about his emotions, then says to his wife] It makes me feel safe, when I'm inadequate and you take charge.

Dave never had security, protection, or safety with his parents growing up, so he maintains the "helpless" role in his marriage so that Lynne takes control—then he feels safe, his partner is protecting him.

This is the "dance" in their relationship: Dave acts helpless and inadequate; Lynne takes control, the "parental child." This has negative consequences in their marriage.

TML: But for you Lynne, this keeps you in the role you always had—the "parental child"—in charge, in control, responsible for others; how is that working for both of you?

Dave: Not good. We talk about this all the time.

Lynn: It's not working for me! [She looks angry and frustrated about this pattern in her life and marriage.]

TML: Lynne, how do you really feel when your husband tells you that you are smarter and more capable than him?

Lynne: I hate it. I'm really angry right now. I hate it! I think it's a cop-out; it keeps you from having to do scary stuff.

Dave: You are right. But you get angry with me, criticize me, then I retreat and feel like, "Why bother? I'll just let you run the show if you don't like the way I do things."

Dave is honest about his anger regarding feeling judged and criticized by Lynne. They are both repeating patterns from their childhood: Dave acts helpless and expects a critical and punitive response; Lynne takes control, resents this role, then gets angry with Dave, just like her father was angry with her.

TML: [To Lynne] Dave says you are mean-spirited and you put him down. Is that true?

Lynne: I'm angry at you [Dave]. But I don't want to treat you mean. I really think you are very smart.

MO: [To Lynne] From your Life Script, your father was mean to you. Are you acting like him?

TML: So are you doing to your husband what your father did to you?

Lynne: I feel horrible. I don't want to be like him. He was a bully. [Lynne realizes she is acting hostile and punitive toward her husband, repeating a childhood pattern.]

TML: Hold hands. Dave, tell your wife what you are going to change.

Dave: [Looks into Lynne's eyes] I've always thought of myself as a "goober"; it's been part of my identity. But it's time to let go of that.

TML: Lynne, what are you willing to change?

Lynne: [Looks at Dave, holding hands, and says] I learned growing up I had to be in control otherwise everything would fall apart, and I'm letting that go. I don't have to fix everything and control everything. I'm letting that go. I'm also not going to be mean and angry like my father.

Dave and Lynne contract with one another regarding specific changes in behavior. They make this "contract for change" in the context of emotional and physical closeness—holding hands (therapeutic touch), eye contact (cue of attachment), safety and security of constructive communication (ACT format), insight about their patterns and emotional honesty (integrating left and right hemispheres of their brains).

TML: Can you tell each other what you think and feel about this communication exercise?

Lynne: This is a lot better. I want to be better for you and the family.

Dave: I'm glad we're talking this way. It's going to make our relationship a lot better. [They stand up and give each other a warm hug.]

11

Intensive Outpatient Psychotherapy

Structure and Format

The treatment format used at Evergreen Psychotherapy Center (EPC) for traumatized children, families, adults, and couples is *Intensive Outpatient Psychotherapy* (IOP). The program involves 30 hours of therapy for ten days: three hours per day for two weeks, with a break on the weekend. This treatment modality was originally developed to provide help for children and families in need of specialized services unavailable in their own geographical locale (Levy and Orlans 1995). Families traveled to Evergreen from every region of the United States, as well as from other countries, to receive therapy for attachment-related trauma. We realized this short-term, goal-oriented, intensive-treatment approach was highly effective in facilitating positive change for resistant, traumatized children, for adults with histories of interpersonal trauma, and for traumatized family systems.

There are a number of advantages and benefits to the IOP procedure. First, families leave their usual home–work–school environments and come to our facility and town. They leave their well-established routines and habitual patterns to focus on personal and relationship change for two weeks—truly a "healing journey." This commitment of time and energy heightens their sense of purpose, focus, and determination to achieve goals and improve lives.

Second, the IOP format is a constructive context in which we observe, assess, and modify individual behavior and family dynamics. Parent–child, marital, family-of-origin, and sibling issues become apparent in daily therapy sessions, and while discussing their experiences out-of-session (e.g., hotels, restaurants, activities). Family members practice and learn new behaviors, coping skills, parenting concepts and methods, and ways of communicating and problem-solving. These new behaviors, skills, and patterns of interacting

are reviewed and reinforced each day in therapy sessions, and family members are encouraged to continue the process of change by repeated practice following therapy sessions.

Third, the consistency, momentum, and intensity of daily therapeutic experiences increase motivation, reduce defenses, and enhance therapeutic rapport. Well-established defenses are difficult to penetrate in traditional once-a-week outpatient psychotherapy, especially with traumatized individuals who are reluctant to reveal deeper emotions and are fearful of vulnerability. Defenses are more likely to be lowered in the intensive format. Motivation and hope are enhanced as goals are set and achieved, and family members have a sense of master (from "victim" to "survivor"). Trust in therapists increases as children and adults perceive these helping agents as knowledgeable, supportive, understanding, and helpful.

The fourth benefit of the IOP approach is "family togetherness," opportunities for new, positive, and enjoyable experiences. Traumatized families rarely have positive interaction in their day-to-day lives. Even though therapy is emotionally challenging and painful at times, there is ample time for families, couples, and individuals to have satisfying and fulfilling experiences. We encourage entire families to come, including siblings. Fathers, for instance, who are typically away from the family working, are now available to the spouse and children. Family members can learn and grow together, creating an enhanced level of intimacy and connection.

Another advantage of the IOP model entails the possibility for continued positive growth and change during follow-up therapy. Intensive therapy fosters self-awareness, facilitates emotional, behavioral, and interpersonal change, and incorporates parent training and trauma therapy, and "opens the door" for conventional outpatient therapy to be more effective in the future. Referring therapists are invited to participate with the family in the IOP, which results in better follow-up treatment, and also provides training and supervision to those mental health professionals.

Sixth, the IOP uses a treatment team of four therapists. Male and female therapists provide diverse input, role models, viewpoints, and opportunities for transference. The treatment team is advantageous and necessary during various therapeutic interventions. For example, one or two therapists will communicate with the child, while other treatment team members offer support and guidance to parents observing via closed-circuit TV. Another example is one therapist role-playing a family member (e.g., "birth mother"), while other therapists help the child or adult process their emotions regarding past interpersonal trauma. The treatment team is also a support system for family members and therapists. Working with traumatized individuals and families can be stressful, and the supportive nature of the treatment team

prevents "secondary traumatic stress" in helping professionals. Finally, the team approach allows for diverse observation and feedback, which results in more effective assessment and therapy.

Last, the structure of the IOP is conducive to training graduate students and mental health professionals. Psychologists, social workers, marriage and family therapists, and other helping agents receive training by participating in the IOP. Graduate students on internship learn clinical knowledge and skills as treatment team members. As mentioned, referring therapists join the IOP to provide better follow-up and enhance their clinical skills. The IOP offers an excellent learning environment—the opportunity to develop diagnostic and therapeutic knowhow and expertise with diverse and challenging individuals, relationships, and family systems.

The therapeutic setting consists of a treatment room and several other rooms equipped with closed-circuit TVs. This allows therapists the option of working with the family as a unit or having the parents observe the child's therapy from another room. The benefits of using this format are:

- It allows the parents to be a part of the treatment process while interrupting destructive and inhibiting relationship patterns.
- It provides the parents with effective role models regarding the management of behavioral and emotional problems of their child.
- It enables the therapist to assess the affective responses and emotional availability of the parents as they observe their child in therapy.
- It provides parental feedback on child's honesty.

These sessions are routinely videotaped in order to offer feedback to family members, serve as teaching tools in the training and supervision of therapists, and provide valuable clinical information to the follow-up therapist.

Parents, hometown therapists, and other helping professionals complete the child/family, or adult/couple application, found on our website, prior to treatment. Many parents have read our books (*Healing Parents* (Orlans and Levy 2006); *Attachment, Trauma, and Healing* (Levy and Orlans 1998)) prior to treatment, and are somewhat familiar with the concepts of parenting and the goals of therapy. There is a comfortable waiting room that has a living room type atmosphere. This is important because the therapists spend time with family members in this area, and learn a lot about attitudes, emotions, and dynamics by observing their interactions in a more "naturalistic" setting.

Population

There are two IOP programs at Evergreen Psychotherapy Center: 1) children and families; and 2) adult/couples. Many families that seek treatment are adoptive families; parents have adopted children with histories of maltreatment and interpersonal trauma from foster care in the United States or foreign orphanages. The IOP includes the traumatized child or children, parents, and siblings—the entire family system. The traumatized child or children display many challenging behaviors and symptoms, including: angry, aggressive, defiant, controlling, and distancing; negative core beliefs; antisocial attitudes and behaviors; depression, anxiety, and shame; school and peer group problems. Additionally, the entire family is under extreme stress—a "traumatized family system." The parents were typically emotionally unprepared to deal with the child's problems, and were often not given pre-placement and post-placement services. Many parents have experienced their own losses (e.g., infertility) and have histories of unresolved trauma that contribute to the parent–child conflicts. Ongoing negative and destructive relationship patterns create a climate of tension, hostility, and despair. Triangulation is common, in which a child forms an alliance with one parent against another. For example, the child is rejecting with mother and cooperative with father, resulting in a lack of unified coparenting as well as marital conflict. Marital stress and conflict are common, as is severe sibling conflict. Traumatized children are often abusive and resentful toward and jealous of siblings. Siblings commonly feel resentful toward their parents because of the amount of time and resources devoted to the "problem child." Traumatized children reenact negative relationship patterns learned earlier in life. For example, children will provoke rejection or abuse from parents to confirm their core beliefs ("I'm not worth loving; parents are hurtful"). Parents and siblings frequently have STS—anxiety, depression, and "burnout."

Families with biological children also participate in the IOP. Interpersonal trauma and a breakdown in family functioning occur due to many factors, including medical problems of children and/or parents, postpartum depression, parental mental illness and/or substance abuse, abuse and neglect, absence due to military deployment or incarceration. Attachment problems, PTSD, depression, and acting-out behaviors are common in family members.

The second IOP program involves adults and/or couples. Individual adults with histories of maltreatment, compromised attachment, and relationship failures participate in the IOP. They present with PTSD, depression, anxiety, substance abuse and other self-destructive behaviors, and severe attachment disorders in childhood and adulthood. These adults have usually been in outpatient psychotherapy on a number of occasions, but are in need of a more intensive therapy format for positive change to occur. Mental health

professionals identify this need and refer these individuals to our IOP program.

Adults in committed, romantic relationships participate in the IOP. These couples are experiencing individual and interpersonal problems that create destructive patterns of attaching and relating. The IOP focuses on learning new, healthy, and fulfilling ways of communicating, problem-solving, and managing conflict. The goal is to both heal from personal trauma and develop secure adult attachment relationships with trust, intimacy, need fulfillment, honesty, and safety.

Treatment Goals

This section describes the treatment goals of the ten-day IOP for children, parents, and family.

Session One

Therapeutic goals:

- parent interview and assessment
- assessment of the child
- developing a therapeutic relationship
- contracting.

The parent interview provides detailed information regarding the child's early history, current symptoms and behavior, parenting styles, and family dynamics. Important issues to identify include strengths and deficits of marital relationship; support systems of the parents; similarities and differences in the parents' perception of the child's behavior; level of functioning of the siblings; parents' level of stress, frustration, and emotional availability to the child; effectiveness of specific parenting attitudes and techniques; and parents' prior attempted solutions. Parents are asked to bring such historical records as life books, family albums, court documents, diaries, social service reports, and letters and adoption records, which provide additional information and can be used therapeutically at a later time.

Parents often present as highly frustrated, desperate, wary, and exhausted. For example, adoptive parents are often told by professionals, "All this child needs is love and a stable home." However, the child with attachment disorder has little or no foundation to understand or accept love, and therefore, the parents typically experience rejection, feelings of inadequacy, despair, and hostility toward the child. They are often blamed for their child's inability to

respond positively to the family environment. One of the primary goals of the initial session is to join with the parents and let them know we understand the nature of their frustration. The parents are educated about the causes and consequences of attachment disorder, and that knowledge enables them to be more objective and feel less responsible and guilty regarding their child's problems. The therapists provide considerable empathy, support, and validation in order to build a working alliance with the parents.

Another primary goal is the development of a specific treatment contract in which parents and therapists agree on certain desired outcomes (e.g., learn parenting skills or reduce resentment toward the child). It is important that parents end the initial session with a sense of hope and enhanced expectation of success, thereby increasing their investment in the treatment process. Also during the initial session, the child is asked to fill out a sentence completion questionnaire (Appendix C) that provides information about content (attitudes, perceptions, and emotions) and process (how the child responds to the task). The child is also asked to complete drawings (i.e., "house–tree–person"; family as animals), which provide additional psychosocial information. These initial contacts with the child offer opportunities for rapport building.

During the first session with the parents it is often possible to begin parent training, i.e., teaching the concepts and skills of Corrective Attachment Parenting. Homework assignments are provided. For example, parents are encouraged to communicate differently, set boundaries, and offer choices and consequences to their children. It is essential to instill an expectation of success and a sense of hope, because most parents (as well as children, adults, and couples) are feeling demoralized and pessimistic. The treatment team informs them that if they are willing to work hard goals can be achieved and progress can be accomplished.

Parent training is psychoeducational, skill-based, and involves an understanding of the parent's attachment histories. The parents are informed that conventional parenting skills are often ineffective with children who have attachment disorder, due to their desperate need to control, lack of trust with and attachment to the parents, and perception that authority figures are abusive, neglectful, and unreliable. The parenting skills taught in this session (and reviewed and reinforced throughout therapy) stress the importance of the parents "not getting hooked" into the child's attempts to manipulate, control, and compulsively replay prior dysfunctional relationship patterns. Parents are taught to stay neutral and provide logical consequences in an empathic manner, in contrast to becoming angry, hostile, and punitive. The angry, punitive parent is unknowingly "playing the child's game," allowing the child to maintain control and repeating prior patterns of parental hostility

and rejection. These and other parenting techniques provide concrete tools that enhance the parents' sense of competency, improve their self-esteem, prevent further marital discord, and offer an alternative context in which the child's chances of changing are improved (see Chapter 11 for a discussion on parenting skills).

It is necessary to help the parents identify and explore psychosocial issues from their family of origin. The parents complete the Life Script in a discussion session with the therapist to obtain such information as the roles, messages, and discipline techniques of their own parents; their parents as role models regarding conflict management, communication, and affect; family relationship patterns; and their self-perceptions as children. The therapists encourage the parents to examine the association between their own attachment history, family of origin, and current marital and parent–child relationships.

Session Two

Therapeutic goals:

- process past 24 hours
- Life Scripts with parents, adults, or couples
- teach parenting skills.

The second day, and each subsequent session, begins with a discussion of the prior 24 hours. How did it go? What specifically happened? What were the results of using new parenting skills and strategies? Parents are asked to keep a written log of situations and behaviors, so that we can review and provide specific feedback and recommendations.

The parents, adults, or couples complete their Life Script. First, treatment team members ask specific questions from the Life Script (see Appendix H) and the clients write down their answers. Next, these answers are discussed with the entire treatment team. This provides valuable information about family-of-origin and attachment history, which affects their parenting behavior and adults' relationships (e.g., marriage). The Life Script typically evokes memories and emotions, and is an opportunity to assess the way in which clients deal with their feelings, manage stress, perceive situations, and relate to one another.

Parenting skills training is continued on the second day, and is worked on each subsequent session. Parents are given an outline of salient concepts, strategies, and skills in addition to our book, *Healing Parents*. We discuss parenting issues in detail, in reference to specific parent–child issues that occur in the family. Parent–child interactions are role-played with treatment

team members to give parents practice with new methods, behaviors, and attitudes. Next, parents are encouraged to practice these new behaviors and approaches with their children post-session (e.g., in hotel, car, restaurants, activities). We discuss the results each day and help the parents "fine-tune" their parenting approach. Parents commonly refer to their Life Scripts as they become aware of issues from their pasts that influence the way they perceive and respond to their children. For example, a father who grew up in a harsh and controlling family may have difficulty setting limits with his own children; he wants to give his children what he missed. A mother who lacked warmth and affection as a child may find it challenging to be loving with her own children.

Session Three

Therapeutic goals:

- initial interview with child
- complete Life Scripts
- teach parenting skills.

The initial interview with the child takes place in a treatment room with the parents observing on closed-circuit TV in another room (with the child's knowledge). This allows the parents to observe without the distraction of being in the same room, and enables the therapists to serve as role models of communication. This interview provides information about the child's motivation, self-awareness, honesty, emotional availability, perception of self, parents and family ("internal working model"), level of stress, and ability to handle questions, feedback, and nonthreatening confrontation. Reviewing the Sentence Completion and drawings furnishes additional information.

The child and therapists generate a "list of goals," the child's goals while in the program (e.g., argue less with parents, be more respectful, learn to communicate, be less angry, get along with siblings better). The child is more motivated to work hard in therapy if he or she feels a sense of ownership—"these are my goals." The list of goals becomes a *contract* between the child and therapists, and the child and parents. Contracts are agreement about specific goals, ways to achieve those goals, and desired outcomes. There is a direct correlation between the strength of the treatment contract and the desire, commitment, and motivation to change. On the last day of the IOP, we review the list of goals and discuss the child's achievements.

The therapists inform the child about the "rules of therapy" during the initial interview. These rules are expectations for positive and constructive behavior: "I don't know" is not helpful, so take a guess or ask for help rather

than saying "I don't know"; try to look at us when we are talking; please don't make us wait a long time for your answers (the "silent treatment"); we will work hard to help you, but you also have to work hard (reciprocity). When the child follows the "rules" we offer praise; and when they break the rules we can discuss their thoughts and feelings about compliance and defiance.

The parents and therapists discuss the child interview, which generates useful information about the parents' attitudes, perceptions, and parenting methods. We continue teaching parenting skills, often role-playing scenarios from real-life parent–child interactions. We also complete the Life Scripts from the previous day. The Life Scripts are of vital importance in reference to understanding the histories, mindsets, and patterns of the parents, and therefore, we spend considerable time on this assessment procedure—both content and process.

Session Four

Therapeutic goals:

- process with parents
- first-year-of-life attachment cycle intervention
- continue parent training
- discuss results of Life Script.

As always, the session begins with the parents and treatment team discussing their progress implementing new parenting ideas and methods. This is also a time to discuss their thoughts and feelings regarding the Life Scripts. We talk about individual, marital, parent–child, and family-of-origin issues. The therapists encourage the parents to examine the association between their attachment histories and current parent–child and marital relationships.

Next, the child and therapists discuss the "first-year-of-life attachment cycle." This is an experiential therapeutic intervention using the context of the LAP. This discussion focuses on need fulfillment, basic trust, and the establishment of secure and insecure attachment during infancy. The explanation of the first-year-of-life attachment cycle is as follows (with variations in age- and stage-appropriate language):

> The first year of life involves four stages: *needs*, *arousal*, *gratification*, and *trust*. The baby is a bundle of needs, and expresses those needs and discomfort through signals (cries, screams, kicks). The sensitive and loving parent or caregiver gratifies the baby's needs (smiles, eye contact, love, affection, nourishment, rocking, holding, touch), which leads to the development of trust and secure attachment. When the baby's needs are

not met and his or her discomfort is not reduced because of unreliable and insensitive care or because of lack of care, the baby learns to mistrust and anxious attachment occurs.

The child is informed about the consequences of anxious attachment: anger and rage; discomfort with touch, closeness, and intimacy; lack of eye contact for affection; unable to trust others and him- or herself; views self as defective and "bad"; views relationships as unsafe; inordinate need to control situations and people; lack of compassion and remorse; and oppositional and defiant behavior.

Educating the child about his or her early attachment experiences and the resultant psychosocial difficulties gives the message, "We understand how you got to be this way, and we can help you." Further, this positive reframing gives the message, "This is not your fault, but rather, an appropriate and predictable response to unfortunate circumstances." This sets the stage for cognitive–affective revision, the development of positive regard for him- or herself and others, and the working through of emotional trauma.

A specific therapeutic style and response is essential for treatment to be effective. The therapist must provide a balance of confrontation and support, be nurturing yet firm, avoid power struggles, maintain a positive focus, provide validation and encouragement, and instill hope.

The child's negative working model is now addressed. Specific perceptions and expectations are identified: "I am bad, defective, and deserve to be abandoned and abused"; "Adult caregivers can never be trusted"; "To survive I must be in control at all times"; "It was my fault that I was maltreated"; "If I get close to people I will be hurt and abandoned." The process of cognitive rescripting begins, which will be repeated many times in current and future interventions. The goal of *cognitive rescripting* is to modify the child's trauma-based negative belief system ("I am bad; it was my fault I was maltreated; adults cannot be trusted"), and help the child to develop a more optimistic and positive mindset. Therapists are empathic regarding negative perceptions; "We understand that you don't trust adults because you were abandoned and/or abused." However, these negative mental models must be challenged, helping the child to consider new possible viewpoints; "Your adoptive mother and father love you and treat you well, so maybe you can start trusting them."

When age appropriate, the child is helped to understand the relationship between current behavior and prior traumatic experiences. This information is not provided with the premise that insight produces change, but rather, because it helps the child realize that he or she was a victim of another's maltreatment, reducing the burden of self-blame and shame. The therapists offer empathy and validation, giving the message: "It was not your fault.

You were not responsible for the maltreatment, but you are responsible for your behavior and choices now and in the future." This discussion is often very emotional for children, and it is an opportunity to help them identify and learn to effectively manage their feelings. The child is helped to label specific emotions ("are you mad, sad, scared?"), and encouraged to verbalize feelings eye to eye with empathic and supportive therapists. The ability to verbally communicate emotions in a safe relationship builds trust, reduces acting-out behavior, and helps children to work through their traumas. This communications skill is subsequently transferred to the child–parent relationship.

The parents observe the first-year-of-life discussion on the closed-circuit TV in a separate room with treatment team members to provide support and information. Parents are often impressed with their child's ability to participate in the therapy and develop increased understanding and empathy for their child in reference to the traumas suffered. The parents also benefit by observing the therapist's way of relating to their child—role models of communication, support, empathy, limits, boundaries, and how to respond to the child's emotions.

Session Five

Therapeutic goals:

- process with parents
- Attachment Communication Training (ACT)
- process with child
- prepare for weekend.

The treatment team and parents begin the session reviewing parenting methods and skills, discussing their progress implementing these new ideas and methods, and addressing any additional thoughts and emotions related to the Life Script. Parents commonly share many insights regarding emotional and relationship issues, current and historical, and are working hard to change and grow in their marital and parent–child relationships.

This session focuses on teaching family members the concepts and skills of effective communication, problem-solving, and conflict management—Attachment Communication Training (ACT). We begin with the parents, so that they can apply these skills of communication with their children. We also commonly facilitate sibling communication.

ACT is a structured, directive approach to teaching communication skills and mitigating destructive patterns of relating (parent–child, adult partners in marital and coparenting relationship, siblings). Parents must learn effective

communication skills to coparent effectively—avoid triangulation (e.g., one parent siding with child), be "on the same page," provide consistency to the child, and be supportive during the stress of managing challenging children. Parent–child communication brings about safe and constructive confiding, attunement to one another's needs and feelings ("limbic resonance"), empathy and compassion, "secure base" behavior, and secure attachment. Parents are often pleasantly surprised at their children's ability to share honestly, listen with empathy and respect, and adhere to the "rules" of communication.

The child is given the opportunity to talk about the "first-year-of-life attachment cycle" exercise from the prior session. They often have memories, thoughts, and feelings triggered by that therapeutic experience, and it is valuable to help the child emotionally process these reactions.

The session ends with a review of the first week; "How do you feel, what is your level of hope and motivation, how do you evaluate the therapeutic progress so far?" Finally, we discuss the coming weekend, when the family has a break from therapy. We make sure the parents have a realistic plan and goals, and are prepared to cope effectively with any circumstance, by reviewing parents' skills and strategies.

Session Six

Therapeutic goals:

- review weekend
- inner child metaphor
- parenting skills training
- ACT with siblings.

This session begins with the parents and treatment team reviewing the weekend: the children's behavior, parenting skills, coparenting relationship, marital and family interactions, and other psychosocial issues. Parents typically report mixed results; they have some positive experiences mixed with some stressful ones. We encourage an "opportunity mindset"; everything that happens is a learning experience, a teachable moment, and a springboard for change.

Another primary experiential therapeutic method with the child is the "inner child metaphor." The child chooses a teddy bear to symbolize his or her "inner child," to "pretend that this is you when you were young." As children review their life experiences with their "inner child," they revisit prior losses, traumas, and other painful events. With support and understanding, they begin to modify negative perceptions ("cognitive rescripting"), process their

emotions (anger, fear, sadness, and shame), and initiate a sense of mastery over the trauma (from victim to survivor).

At this time, we invite the parents to participate with their child (using the LAP format). The child talks with his or her parents about the information previously shared with the therapists: “Tell your mom and dad what happened when you were young, how it affected you, and how you are changing now.” As the parents listen with understanding and empathy, this communication serves several purposes: reduces child’s shame about maltreatment (“it wasn’t my fault”); reduces the negative emotional impact of prior trauma (desensitization); allows parents to “bear witness” with compassion; and enhances closeness and trust between child and parents. The session ends with 10–20 minutes of positive connection time; the therapists leave the room and allow the parents and child to savor their closeness.

Parents and other children in the family take part in ACT. Siblings of the child with attachment trauma are often traumatized due to abuse and family stress. Siblings are taught the concepts and skills of ACT. Parents and siblings also spend time in communication sessions. The IOP is a family systems treatment program, and all family members must participate to modify family dynamics and improve family relationships.

Session Seven

Therapeutic goals:

- process with parents
- psychodramatic reenactment
- ACT with parents.

Session seven begins with the parents discussing various issues with the treatment team: progress with learning and implementing therapeutic parenting; emotions regarding the Life Script, coparenting, and marital issues; evaluating the progress of their children; stress management techniques utilized; extended kin (e.g., grandparents and other family).

Next is another important experiential procedure, “psychodramatic reenactment (PDR).” Treatment team members role-play individuals from the child’s life to revisit and work through prior interpersonal trauma. For example, a child will speak to his or her “birth mother” from the vantage point of the inner child—a time when he or she was younger. This exposure therapy technique enhances genuine emotional involvement and facilitates the expression of perceptions, emotions, and defenses associated with prior trauma. Positive change occurs as the child learns alternative ways of perceiving him- or herself and others (cognitive rescripting), managing

emotions, and responding behaviorally. It is a healing experience that fosters emotional resolution and a sense of mastery over the trauma.

The parents serve as a support system for their child during psychodramatic reenactment. In the context of the LAP, the parents provide empathy, support, and validation, and also have a chance to express their own emotions during the role-playing. For example, an adoptive mother thanks the "birth mother" for giving the gift of life to the child, so that he or she can be part of the family. Role-plays become very real, and offer an opportunity to resolve trauma and connect in a secure and trusting way with the parents.

A second ACT with the parents is done. The parents deepen their communication regarding their marital and coparenting relationship. They discuss issues of intimacy, trust, patterns of relating, attachment wounds (betrayals and disappointments), prior traumas in their families of origin, and parenting issues. They contract with one another regarding new behaviors and ways of interacting in the future, to improve their marriage, be better role models for their children, and create healthier lifestyles emotionally, physically, and spiritually.

Session Eight

Therapeutic goals:

- process with parents
- forgiveness ritual
- ACT—parents and children.

The session begins with the parents and treatment team discussing progress and issues regarding parenting, the coparent and marital relationship, the children's behavior, family-of-origin issues, and family dynamics. Parents role-play scenarios to practice parenting and communication skills.

Grieving and mourning loss is an essential component of the healing process. Although sad and painful, it promotes a letting go of the past, creates the possibility of a new future, and can lead to the beginning of forgiveness. A "magic wand" technique is used, in which the child can speak directly to "birth parents," who are role-played by treatment team members. The child is told, "For the next ten minutes your birth parents will be healthy. They will be open, honest, and available to address your comments, questions, and concerns." The child can move toward closure on birth parent issues by expressing feelings of loss and asking questions about the parents' lives. For example, the "parents" may explain what happened to them in their own childhoods that influenced them to be abusive or neglectful. The child's increased understanding of the parents serves several purposes. It helps

the child understand that he or she now has the tools to break the cycle of abuse. Unlike the parents, the child is receiving help and is now free to make different and better choices. Second, it promotes a more empathic and forgiving attitude. Therapeutically, forgiveness involves the release of pain and anger associated with a traumatic event. The goal is for the child to acknowledge the parents' responsibility for maltreatment, but also to release him- or herself from the burden of emotional pain.

The forgiveness ritual also serves to further enhance the parent–child bond. The parents provide emotional support to the child during the grieving and forgiveness discussion. Their empathy, understanding, and support during this emotional experience increase the trust and closeness in the parent–child relationship.

ACTs are done again with the parents and all the children in the family. This provides another opportunity for the parents to communicate with the "identified patient" and his or her siblings, and an opportunity for siblings to communicate with one another. Sibling conflict is often severe in these families, and it is necessary to discuss and resolve anger, fear, shame, abuse, and other sibling issues. Siblings often decide to "start over" with a more caring and healthy relationship.

Session Nine

Therapeutic goals:

- process with parents
- family meeting
- parenting practice.

Following the initial processing with the parents, there is a family meeting to discuss a variety of behavioral, emotional, and social issues, and to develop contracts for new ways of relating. The Autonomy Circle (see Figure 12.1) is explained to the children, so they understand that receiving privileges, freedom, and rewards in the future is based on them demonstrating competencies: knowledge, skills, judgment, and self-control. A parent–child contract is established—an agreement about the parents' expectations and "rules," and an understanding of the consequences for following and violating the agreements. The goal is a win–win: the parents are pleased that they are creating a more positive relationship with their children, and the children are "buying into" the contract in order to earn privileges and rewards by their own positive behaviors and attitudes. Many additional topics are discussed in the family meeting: school, homework, sibling relationships, chores, changes in routines at home, extended kin, and quality family time.

To firmly secure new parenting skills and parent–child interactions, various scenarios from family life are role-played. For example, we role-play a situation in which chores are not completed. First, it is role-played in the old way—anger, conflict, resentment, rupture of the parent–child relationship. Next, we role-play the new way—constructive communication, honesty, taking responsibility, effective problem-solving. This increases the confidence level of parents and children as they practice new behaviors. Family members typically enjoy these role-plays; there is humor and feelings of optimism and mastery.

Session Ten

Therapeutic goals:

- process with parents
- review list of goals
- follow-up plan
- final ritual.

This is the final session with the parents; a time to review progress, address concerns and follow-up issues, and reinforce positive changes. A family meeting follows. First, the "list of goals," created in the third session with the child and therapists, is reviewed. The child is asked to what extent he or she believes these goals were achieved. It is customary for children to report significant satisfaction with the attainment of their goals. Parents and siblings typically feel proud of their child, brother, or sister, which is reinforcing for the child and also helps to change the child's role in the family from "problem child" to a healthy family member.

Follow-up issues are also discussed in the family meeting: school, medication, follow-up therapy, contracts for new behavior, and other topics for the future. These follow-up treatment issues become plans and goals for follow-up therapy in the future.

The final ritual involves asking each family member, "What have these two weeks meant to you; what are the most important things you have learned?" Parents often share their relief because of having learnt skills and solutions, their joy regarding improved family relationships, and their hope for a better future. Children commonly share their increased confidence and self-esteem, their reduced depression and increased sense of contentment, and their feelings of trust and closeness to parents and siblings.

We end with hugs, tears, smiles, and a photo of family and therapists all together.

Effectiveness

Benefits and Risks

Treatment outcome research as well as anecdotal feedback indicates that significant improvement occurs for children, adolescents, adults, couples, and families in the following areas: symptom reduction, core beliefs (internal working models), attachment styles, communication, problem-solving, conflict management, parenting practices, marital and sibling relationships, trauma-related problems, depression, anxiety, and morality.

As with any therapeutic process there is a level of emotional discomfort when dealing with painful and anxiety-provoking issues, events, and memories. To mitigate this emotional distress the therapists provide an environment of support, compassion, and safety, and parents are encouraged to be empathic and supportive with their children. Treatment is developmental, with the initial stages focused on rapport, trust, contracting, assessment, and emotional preparation. The timing of interventions is crucial, and based on an accurate assessment of clients' level of readiness and capability. When working with traumatized children, adults, and family systems, there are some individuals who do not achieve their goals. Rarely, however, is it reported that symptoms increase or family relationships decline following the IOP.

Treatment Outcome Research

A restrospective longitudinal research study was conducted at the Evergreen Psychotherapy Center (Pearson 2002). This study was designed to determine the effectiveness of Corrective Attachment Therapy, a combination of emotional, cognitive, and family systems therapy, as well as parenting-skills training. The study contained two parts. The first part examined the demographic and clinical characteristics of 50 children and families who participated in the two-week IOP treatment program. The second part examined changes in the behavior and attitudes of children who completed therapy. Symptom reduction was determined by comparing scores on the 50-item parent-reported Symptom Checklist pre- and post-therapy.

Findings: Part 1

Table 11.1 Adoption Background

Adoption Background	% of Studied Group
Adopted	84
Different race/ethnicity than adoptive parents	46
Adopted as part of sibling unit	45

Serious disruption and damage in the children's attachment histories was found.

Table 11.2 Placement History

Placement History	% of Studied Group
One or more foster care placements prior to adoption (average of three placements)	72
Experienced severe and chronic physical, sexual and/or emotional abuse prior to adoption with a mean of 48 months	90
Were forcefully removed against biological parents' wishes	56
Spent considerable time in foreign orphanages	34

These children had severe psychosocial problems: 92 percent had a prior diagnosis of RAD, and 76 percent had multiple diagnoses (ODD, ADHD, PTSD, depression).

Parents reported more severe symptoms in their children prior to treatment due to:

- parents and child had cultural and ethnic differences
- length of time abuse and neglect occurred prior to adoption
- number of years child spent with biological parents
- prior diagnosis of PTSD and/or several diagnoses in addition to RAD.

Parents with secure attachment histories reported lowest symptom severity (34% of mothers and 38% of fathers).

Findings: Part 2

An analysis was conducted of the pre- and post-Symptom Checklist scores, measuring the child's improvement on six symptom categories (behavior, emotion, cognition, relationships, physical, and moral/spiritual).

Statistically significant positive changes were found on all six symptom categories up to three years after therapy. Improvements held over time. Children improved more when they had the following characteristics:

- fewer moves in the foster care system
- fewer pre-therapy diagnoses
- were not adopted as a sibling unit

- were not taking psychotropic medications during therapy
- had an adoptive mother with a secure attachment history.

These research findings have important implications for children and families. First, the research shows that Corrective Attachment Therapy and Corrective Attachment Parenting do help children with histories of maltreatment and compromised attachment. It also confirms that multiple placements in foster homes are damaging to children and make treatment more difficult. Interestingly, although there are times when adopting sibling groups is appropriate, the findings show that certain sibling group adoptions can result in severe problems for children and parents, and inhibit the development of secure attachment (e.g., when the siblings have pathological patterns of relating, such as physical and sexual abuse). The research also illustrates that the pros and cons of medication must be weighed, as it can interfere with treatment results. Finally, the findings show that the parents' attachment history and current level of emotional maturity play an important role in the success of treatment and the child's long-term improvement.

IOP CASE EXAMPLE: KRISTINA AND PARENTS

Kristina was left at a hospital in Siberia by her 17-year-old mother, who never returned. After one year in the hospital, Kristina was sent to an orphanage, where she suffered chronic neglect and failure to thrive. Adam, age 50, and Beth, age 38, had been married for ten years and were unable to conceive due to medical issues. They decided to adopt, and learned about Kristina through an international adoption agency. They traveled to Siberia to get Kristina when she was 2 ½ years old. The parents reported that for six weeks after returning home Kristina screamed, kicked, bit, punched, and refused to be comforted. As she grew older she became increasingly aggressive, defiant, and dishonest, at home and in school. Mother wrote, "She goes into a rage when she doesn't get her way. She tells us she hates us and wants a new mommy and daddy." Despite three years of play therapy, Kristina was acting out more and the parents were becoming increasingly frustrated, hopeless, and depressed. Their marriage was deteriorating, in part because they were "not on the same page" in their coparenting. They contacted us when Kristina was 7 years old to participate in our ten-day IOP program. Their stated goals were to "learn how to parent Kristina, teach her that she is loved, and help heal her heart."

The first session focused mostly on the parents, with Kristina spending time reading and playing with toys in our waiting room. The goals of this session were to join with the parents, review the symptom checklist, begin parent training, and assess the marital and coparenting

relationship. On the 50-item Symptom Checklist, Kristina's symptoms were about 70 percent severe (e.g., impulsive, angry, aggressive, lying, stealing, oppositional, cruelty to animals, lack of remorse, not affectionate with parents). Beth appeared anxious and depressed, but eager to learn better parenting skills. Adam was very distressed about his marriage and child, but also motivated to improve the situation.

The parents were given specific instructions regarding Corrective Attachment Parenting concepts and methods in the final portion of the first session. They were encouraged to set firm boundaries, remain calm and loving, avoid engaging in control battles, provide appropriate consequences, and work as a team.

The primary task of the second session was to complete Adam and Beth's Life Scripts. Adam described his father as alcoholic, abusive, rejecting, and irresponsible, and his mother as hardworking, worried, depressed, and tired. He described himself as a child as scared, shy, unsafe, and smart. He revealed that his parents would drink and fight (domestic violence) and he would "hide under the covers in his bed." He displayed symptoms of PTSD and depression. He reported that his parents owned a restaurant and he would be home alone frightened or "sitting in a booth" until closing time. He is a recovering alcoholic, in AA for many years, and has suffered with depression and taking medication for this condition throughout adulthood.

Beth described her father as rigid, scary, depressed, alcoholic, and unpredictable, her mother as controlling, perfect, image-conscious, a martyr, and nurturing. She describes herself as a child as compliant, spoiled, bossy, good manners, and perfect. She disclosed that her family was well-off and she "never had to earn anything, so doesn't understand the value of hard work." She also shared that she never felt listened to as a child and becomes angry when her husband doesn't listen to her.

The family dynamic was: the mother and Kristina argue about power and control, the father retreats from his wife and parenting role (afraid of conflict), Kristina does not receive firm boundaries and a collaborative parental team, and the marriage disintegrates into unresolved conflict and emotional distance.

We decided that the marital and coparenting relationship must be the starting point, so that the family dynamic is improved and Kristina receives the necessary structure, consistency, and role models. The next day (session three) centers around teaching the skills of communication, problem-solving, and conflict management to Adam and Beth, using the ACT method.

Terry Levy (TML) begins the session by explaining the rules and steps of ACT to Adam and Beth. They are given an outline to take home for when they practice. Michael Orlans (MO) is the cotherapist (the reader is encouraged to review the ACT in Chapter 10).

Attachment Communication Training: Husband and Wife

Adam: I want you to know that I'm really glad you're here with me, and that we're doing this together. I couldn't do this without your help. I feel very fortunate that we're partners and that we've been through tough times, and it's really been workin' for us for ten years. I want you to know how important that is to me, and how important you are to me. It's been a great journey so far, and I appreciate you for that. [Adam reaches out for Beth's hands, but she appears stiff and unresponsive.]

Beth: I hear you saying that you're glad you married me. I hear you saying that you really love me. I hear you saying that you're willing to stick with this family no matter what. And that feels really good. I feel that sometimes when I'm really upset about something and I share it with you, you really don't hear me. Your immediate reaction is to think I'm attacking you, and so you get angry and in a mode of being attacked. Then, what you say back to me is all about you and how you're feeling instead of really listening to what's going on with me.

MO: And that makes me feel?

Beth: And that makes me feel sad, like you don't care about what's going on with me. [Beth takes a risk and tells her husband that he gets defensive, and therefore, she is reluctant to open up. Adam must listen and repeat back her message according to the rules of ACT.]

Adam: I heard you say that you don't feel like I'm really listening to you. That when you're trying to tell me something, I take it as an attack rather than hearing your side of the story. And that makes you sad. [Adam hears Beth's message and his body language indicates understanding and empathy. Beth begins to cry, feeling relieved that Adam was able to hear her.]

MO: [At this point MO stands behind Beth, places his hands on her shoulders for support, and gives a voice to the message from her father gleaned from the Life Script (Alter ego).] So, let me help you. My dad only saw his way, and I could never tell him something where he'd hear my point of view. And when you tune out or get defensive it makes me feel the same way.

Beth: [Shakes her head in agreement.] You are right; it seems so easy. [She then shares in her own words.]

MO: [MO stands behind Adam (Alter ego) to give a voice from his Life Script.] In my family there was a lot of conflict and criticism. When I perceive you to be criticizing me, even though you might not be, I go to that scared little boy, and I go inside a shell to protect myself.

TML: Is that true, Adam? [Adam cries.]

Adam: That's true. [Adam then says it in his own words.]

Beth appears more animated and engaged, because 1) her husband heard her without becoming defensive; and 2) she is gaining insight into Adam's reasons for becoming defensive from his past.

TML: As a side bar, let me just share at this moment why a marriage can be such a healing place for people. You can create a healing environment. So the way you deal with each other gives you the opportunity to heal old wounds, scars, and patterns. [TML explains that a healing marriage is a context for support and positive change. It provides an opportunity to be aware of your own triggers and patterns, and without blaming your partner, take responsibility for personal change.]

Adam: I don't feel like you really appreciate how hard I work. And that you feel like, that the money's just gonna keep comin' in, comin' in, comin' in. And that you're critical of me 'cause I take my work as seriously as I do. Yet, you get to enjoy the benefits in that work. So, I don't feel appreciated for what I do to provide for the family. That makes me feel unloved and unappreciated. [Adam takes a risk and shares his resentment. The structure of the ACT provides a context of safety and support so that partners can communicate without arguing and conflict.]

Beth: You're saying that you're not getting from me what you need, about how hard you work to support this family. And that I don't build you up enough, and I don't let you know enough how great that is. I think I do that. I'm trying to figure out why I do that. [She cries and reaches for a tissue, as she hears Adam's message. She feels remorseful because she can hear his message and realizes he is correct.]

MO: [MO stands behind Adam (Alter ego) and gives a voice from his Life Script.] My mom taught me life is a struggle. You gotta keep working and people will take advantage of you. And I had to take care of her, and I didn't feel appreciated then, so this is bringing that all up to me again. [Adam shakes his head in agreement.]

MO: Say that in your own words.

Adam: When I was little, you know, I was having to take care of everything, and I just don't want to be taken for granted. And that's how I feel, that you just take all this for granted. And I guess, 'cause your father was such a good provider, you didn't have to worry about it. It was just gonna always be there when you were little, so you don't understand exactly where I'm comin' from with that.

Beth: [Repeats Adam's message, and then shares.] Yeah, I do know why I do it. Because my father moved into a family business, and I

never got the feeling from him, or from my mother and my whole family, that he was working that hard, which is really sad 'cause I know he was. My grandparents were wealthy, and we were wealthy for our small town, so we never hurt for anything; we never really had to work for anything or earn anything. And I don't really appreciate and understand the value that comes behind really making something of yourself and working hard. I know that's what you've done 'cause you started out doing this all by yourself. You didn't have any help, or any dad's business to go into.

Adam and Beth are following the rules of honest sharing and empathic listening. Consequently, they are connecting intellectually and emotionally, as evidenced by their body language (e.g., eye contact, holding hands, both leaning into one another).

Beth: [After Adam repeated back Beth's message, Beth took responsibility by offering a solution; showing her desire to appreciate and validate her husband's efforts.] Now that I'm not working, if I would have a nice dinner fixed every night, I think that's important to you.

TML: Would that matter to you, Adam?

Adam: Yeah, it would matter to me. I thought about it but I felt silly saying that I want a nice supper on the table when I got home.

TML: What's silly about that?

Adam: See, we never ate at home when I was growin' up. We never had that. I guess I'm not used to a home-cooked meal. [Adam's parents owned a restaurant.]

MO: Oh, so that's doubly important to you.

Adam lowers his head and is reluctant to accept his wife's generous offer, due to 1) growing up in his parent's restaurant ("no home-cooked meals"); and 2) lacking the self-esteem to feel he deserves his wife's positive gesture.

Later in the session TML makes a process comment about Beth's controlling behavior.

TML: You're a bit like Kristina; you like things your way.

Beth: Yeah, I do. I'm a brat. Even in my marriage, I want things in my way, in my time.

TML: How are you going to expect to help your daughter not be bossy and want everything her way, at her time, if you're gonna model that?

Beth: Mm-hmm.

MO: Because kids do what we do, not what we say.

Beth: I know.

Adam: I know.

The family dynamic is revealed. Beth and Kristina, both oriented toward control, engage in arguments and power struggles. Adam, with his history of witnessing domestic violence, responds with anxiety and withdraws from his wife and child. Triangulation results: marital conflict, lack of coparenting team, child has too much power.

At the end of the session, the couple is asked to evaluate their ACT experience.

TML: What is it like to talk like this, to be open, to communicate, to listen, to share?

Adam: I really got that this has really moved you. And I really appreciate it. I'm so glad you're with me. You know I'm here for you.

Adam and Beth are both tearful, and Beth reaches out for Adam's hand. Their emotional honesty, compassionate listening, and body language (i.e., physically close, hands intertwined) signify "limbic resonance," a connection of minds, brains, emotions, and bodies.

Beth: I'm going to figure this out. I think it's going to make our marriage better. I don't know why I couldn't see it before. 'Cause you've said things to me over and over again, and I just couldn't hear it, couldn't see it before now. I'm gonna take this, and I'm gonna grow from this. I'm gonna be a better partner because of this.

We conclude the ACT with the couple giving one another a hug. Adam and Beth's prolonged genuine and affectionate embrace reflected their positive experience with the ACT, their enhanced trust and attachment, and their readiness to coparent Kristina in a healthy way.

Session four began with discussing parenting issues and processing Adam and Beth's communication from the prior day. They both reported the ACT was very helpful in building trust, reducing conflict, and improving cooperative coparenting. We discussed and role-played parenting methods in order to practice the skills of limit-setting, communication, consequencing, and connecting, using the COPE approach (calm, opportunity mindset, predictable, empathic).

The next task of Session four focused on Kristina and the mother–daughter relationship. The *First Year Attachment Cycle* intervention was done in the context of the LAP. The goals were: 1) activate the brain's limbic region via the cues of attachment (eye contact, smiles, positive affect, nurturing touch, emotional safety, empathy); 2) explain to Kristina in a child-friendly way her history, to foster a constructive narrative and normalize her behavior; 3) initiate the grieving process; 4) emotional processing regarding loss of her birth mother, orphanage, negative working model; and 5) begin building a positive connection with her mother, including trust, safety, closeness, dependency, and limbic resonance.

First-Year Attachment Cycle: Mother–Daughter Attachment

The session begins with Kristina in the lap of the female therapist (AJ).

> *TML:* What a nice dress.
>
> *AJ:* It is pretty.
>
> *TML:* Butterflies. And what else is on your dress?
>
> *AJ:* It's got birds, and fans, and little princesses.
>
> *Kristina:* That's me; I'm the princess.
>
> *AJ:* That's you? The little princess?

The goals of commenting on her dress were: 1) join with her; having a topic of conversation that is non-threatening; 2) reducing anxiety and stress; 3) beginning reciprocity; the give-and-take communication process; and 4) noticing that Kristina is aware of her power in the family system (i.e., "little princess").

> *AJ:* The reason we have you in this position is because this is the way mommies hold their babies. When babies are born they can only see this far, just far enough to see into their mommy's eyes. [Kristina gazes into the therapist's eyes.]
>
> *Kristina:* Strange.
>
> *AJ:* When they look up, they see their mommy. And then mommy's happy to have them, mommy smiles, and the baby smiles back. And then they make that connection through the eyes. And you're lookin' at me real good. That's real good eye contact.

AJ explained the LAP and the importance of early mother–baby attachment via eye contact, smiles, and emotional connection. AJ's tone of voice and demeanor is calm, warm, and non-threatening, to down-regulate the physiology of stress. Kristina gazes into the therapist's eyes and appears more relaxed and engaged.

AJ uses a pad to draw a circle, which will be the "First-Year-of-Life Attachment Cycle." AJ and MO explain how babies develop attachment, and what happens when secure attachment does not occur.

> *AJ:* I'm going to draw something. There's a circle. This is the first year of life. This is about brand new babies. This is about babies, every baby in the world who's born. When they're first born babies have needs. What does a newborn baby need? What do you think tiny babies need?
>
> *Kristina:* Birth.
>
> *AJ:* After the birth what do they need?
>
> *Kristina:* Milk, love.

The therapists review the first-year attachment cycle, including needs, arousal (i.e., crying), gratification, and the development of trust. The

goal is to help Kristina acknowledge and constructively deal with her emotions and narrative (i.e., internal working model) associated with early loss and lack of secure attachment.

Kristina begins to pull her hair, indicating anxiety associated with the topic (i.e., mothers and babies) and genuine engagement in the conversation. She also touches her hand to her mouth. Placing her fingers on her lips is early-stage oral behavior, common in infants, denoting her emotional participation in the therapeutic process.

> *AJ:* So the baby says, "If I don't have a good mommy to trust, I'm gonna need to be bossy; I'm gonna need to be the boss." Know anybody like that? [Kristina smiles as if to acknowledge her controlling style.]
>
> *MO:* How do you think it worked for you; do you think you got your needs met when you were a baby?
>
> *Kristina:* [Nods head.] Yes.
>
> *MO:* You didn't sweetie, because what happened is, when you were born your birth mom just left you at the hospital, so she wasn't there to take care of your needs. Did you know that?
>
> *Kristina:* [Shakes head.] No.
>
> *AJ:* It's true. What do you think about that? Is that kind of sad?
>
> *Kristina:* It is sad. [She grips her throat as if to choke off painful emotions, gazes into AJ's eyes, and begins to cry.]
>
> *MO:* So when you cried for your mommy to hold you, she wasn't there. So you learned, "I can't trust my mommy, so I'm gonna have to be bossy."

The therapists tell Kristina what happened in Russia ("You were abandoned at the hospital") so that, with support, guidance, and empathy, she can begin emotional processing and resolution.

> *AJ:* She spent a year in the hospital.
>
> *Kristina:* All by myself?
>
> *AJ:* Well, without your mommy. You probably were alone a lot.
>
> *TML:* How does a baby feel when a baby's alone a lot?
>
> *Kristina:* Sad.
>
> *TML:* 'Cause what does a baby need?
>
> *Kristina:* Love.
>
> *TML:* Were you gettin' plenty of love in the hospital?
>
> *Kristina:* No.
>
> *TML:* So, can you look at AJ and say, "When I was a baby I was sad 'cause I didn't have enough love"? Can you tell her that?

Kristina: When I was a baby I didn't have enough love in the hospital. I was alone a lot without my mommy. I was sad. [Kristina cries.]

Kristina is asked to tell her story to AJ, in her eyes, for several reasons: telling your story in the eyes of someone you trust is healing; "limbic resonance" is achieved as Kristina shares her early experience in Russia, and AJ listens with a look of understanding and empathy; Kristina is learning the skill of verbalizing emotions rather than acting out; she acknowledges the sadness and loss which was previously repressed and denied. The therapist (AJ) provides gentle and nurturing touch, caring facial expression, and soothing voice—the cues of attachment, stimulating Kristina's limbic brain, which is prewired for attachment.

Kristina starts to cry, her first expression of loss and grief with anyone. She is becoming emotionally available to grieve her loss with caring others. She also talks about feeling scared as a baby, lowering her defenses to allow more vulnerable emotions to surface (i.e., pain and fear).

TML: Are you ready to tell Mommy the story about what happened to you when you were a baby in Russia?

Kristina: I don't want to tell her. [Shakes her head.] No.

TML: Would you do it anyway? Just because we're asking you to do it?

Kristina: Yeah, OK.

TML: Oh, thank you.

AJ: Thank you, sweetheart. [Gives Kristina a hug.]

At this point, we determined that Kristina was ready to communicate with her mother in order to facilitate secure attachment. We had checked with Mom as she observed the session on a TV in another room, and observed her appropriate affect (i.e., crying) and emotional availability. Kristina first refused to bring Mom in, but then said "yes," a result of her feeling safe and trusting with the therapists.

The next task is for Kristina to call for her mother: "Mom, I need you; please come in." This is a corrective emotional experience. When Kristina needed her birth mother in the early stages, she was not there. This time, her adoptive mother will respond to her needs in a sensitive and timely way. Limbic wiring changes via emotional experiences. Initially, Kristina does not want to call for Mom, but then decides to take a risk.

TML: So, call Mommy. Say, "Hey Mom ... come on in; I need you." Can you do that?

Kristina: I don't want to.

AJ: Could you call for Mom?

Kristina: [Whispers] Mommy.

AJ: She won't hear you like that.

TML: Where's that big voice that I heard about?

Kristina: Mommy, I need you. [She raises her voice, smiles, and calls for Mom. Mom comes and asks Kristina to lay on her lap.]

Mom: [Mom sits next to Kristina and asks] Want to lay down on my lap?

Kristina: No. [Kristina frowns.]

Mom: Please?

Mom is sitting next to her and Kristina initiates a hug—the first time she hugs her mother. Kristina's spontaneous hug is a result of Mom's responding to her needs. Kristina then lays in Mom's lap.

The next task is for Kristina to tell Mom about the first-year attachment cycle and what happened to her as a baby. Kristina is encouraged to look into Mom's eyes; as she makes eye contact, she sucks on her fingers like a baby.

Mom: I wanna hear what y'all were talkin' about.

TML: Mommy will hold the pad for you. Tell Mom what babies need.

Kristina: They need love, and bottles, and to be rocked. [Looks into Mom's eyes as she shares.]

TML: Now, tell Mommy how this happened for you when you were a baby, when you were in Russia; tell Mommy what happened to you.

Kristina: I was in the hospital all by myself for a year. [Kristina cries; Mom has a look of compassion and support.]

Kristina's response to feeling sad is to bury her head in the couch, turning away from the attachment figure—typical for children who perceive caregivers as untrustworthy and unsafe. The goal is to have Kristina turn to the love, comfort, and protection of Mom.

TML: Cuddle up with your mom. [Kristina allows Mom to cradle her, with her head on Mom's chest.]

Mom: Does that make you feel sad that you were all by yourself?

TML: You just cuddle up with your mommy and let that sad out, and Mommy will give you love.

Mom: That makes Mommy sad too. [Mom cries with Kristina, as she is cradled in her Mom's arms.]

TML: Mommy has sad feelings too.

Mom: It makes me sad too, 'cause I didn't know you then. I would have held you, and loved you, and rocked you.

Mom: Let me wipe your tears. There we go. There, let me get them. There we go. [Kristina allows herself to be vulnerable and accept comfort.]

TML: What you need to do honey is you need to cuddle up with your mom. No talking.

This is the "window of attachment," the moment when Kristina allows comfort, support, and connection when she is distressed. This begins to change the internal working model from negative ("I can't trust") to positive ("I can trust and feel safe"), initiates the rewiring of the limbic brain through positive interpersonal experience, and allows Kristina to grieve her losses in the context of a secure mother–child relationship. Mom's maternal instincts are displayed (e.g., gentle stroking of hair, rocking) as her limbic brain is also activated. Kristina allows Mom to wipe her tears, reflecting her openness to Mom's caregiving.

The therapist (TML) instructs Mom and Kristina to "cuddle up; no talking." The goal is to maintain the limbic connection via emotion, touch, and nonverbal communication, rather than go to the cerebral cortex, which is intellectual and cognitive.

TML: It's so good that you're letting your sad feelings out with the mommy who loves you. That's a good thing, honey. Yeah, you hold onto that momma. [Kristina holds on tight to Mom as she releases sadness.]

All the cues of attachment are evident in the mother–child relationship: eye contact, smiles, loving touch, safe and secure connection in the "in arms" position. This facilitates secure attachment.

TML: Can you look at your mommy and ask her, "Mommy, will you ever leave me?"

Kristina: Mom, will you ever leave me?

Mom: [Looks into Kristina's eyes] No.

Kristina: [Appears relieved and hugs Mom tight.]

Mom: No. No, no, no. Never, ever, ever.

Kristina's deepest fear is abandonment; her core belief is that mothers leave. As Kristina looks into Mom's eyes at this moment of genuine connection, she receives reassurances that Mom will not abandon her—part of the process of changing her fear-based expectation.

TML: [Explains to Mom] The most important thing about attachment is when a child is scared, lonely, or needy, without words, and the child feels the love and comfort of the mommy or daddy. That's when it happens. This is when it's going to happen, so we want to take advantage of moments like this.

Kristina: I love you so much. [First time Kristina said I love you to Mom.]

Mom: I love you too, darling.

MO: Kristina, I want to ask you a question. Do you ever wish this could have been your mom from the beginning?

Kristina: [Looks in Mom's eyes and says] I wish you were my mom from the beginning.

Mom: You know what, I do too.

Kristina: Then why did someone else grow me in their tummy?

Mom: 'Cause, you know what, your mommy, me, I couldn't grow a baby in my tummy.

Kristina: Why?

Mom: It just didn't work for me. Sometimes it doesn't work. [Mom cries.]

Mom cries as she tells Kristina that she was unable to conceive. Kristina wipes Mom's tears with a tissue, showing empathy and compassion for the first time.

The session ends with Kristina and Mom cuddled up together in a calm, comfortable, and safe manner. They are encouraged to remain this way for as long as they want.

Adult Trauma Therapy: Adam

The father, Adam, told the treatment team that he was relieved and happy that we helped his marriage and daughter, and that he wanted help with his depression. He agreed to participate in a therapy session to address his family-of-origin issues. The session begins with Adam and the therapist (TML), using the LAP.

TML: We have to stop meeting like this. [TML and Adam share a laugh: a good way to reduce anxiety and connect.]

Adam: Right. [Laughs.] I feel like I'm not going to be able to do this. I feel a little resistant, which is not like me.

TML: When you say, "I'm not going to be able to do it," what's behind that statement?

Adam: I don't know if I have the energy to go back in there.

TML: Energy?

Adam: No, it's not energy; I'm afraid to think about my past.

TML: Thank you for being honest; it's fear and anxiety, and certainly understandable, based on your past.

Adam: Right, I had a very tough time.

TML: So, can you look in my eyes and say, "I have anxiety about addressing these issues"?

Adam: [Looks into TML's eyes and says] I do; it's scary to deal with those issues. [Adam shares his fear and anxiety in the eyes of the therapist, which is an experience of emotional honesty and positive connection.]

TML: Thank you. When we have fear there are two options—let it stop us or proceed anyway. What do you want to do?

Adam: Yeah, I want to do this.

This is a therapeutic contract. Adam expresses his apprehension and his desire to push ahead and work on his issues. TML agrees to support Adam through the process. The cues of attachment are present: eye contact, supportive touch, safety, empathy, emotional honesty, understanding (limbic resonance).

INNER CHILD METAPHOR

TML explains the purpose of using a teddy bear to represent the "inner child." Adam picks the teddy bear he wants, and it is placed on his lap for him to hold.

TML: We are going to pretend this is you as a child—little Adam. The reason we use a prop (teddy bear) is because it's much easier to visualize and verbalize when you have something like this. Tell little Adam about his life. Start in the beginning.

Adam: [Looks directly at little Adam and says] You didn't know what was going on, you were confused and afraid. You never felt secure and comfortable. And then you would hear your mommy and daddy fighting and that was so scary. You would pull the covers over your head in the bed. You can feel it, can't you? [Adam begins to experience the fear and anxiety of little Adam. He shakes the teddy bear to show the panic, and his own body becomes tense. He is genuinely engaged in the therapeutic experience.]

TML: That must have been so scary for you.

Adam: [Looks at little Adam and says] Sometimes you'd even go in there and ask them to stop fighting, but they wouldn't. You needed a momma to hold and take care of you, but you didn't get that. [Adam expresses the fear, anxiety, and helplessness of his youth.]

TML: Can you give him the love and comfort he didn't get? Hold him close to your heart and tell him he's safe now.

Adam: [Holds little Adam on his chest, looks at him, gently rubs his back, and says] I'm going to take care of you now; you're safe now.

Traumatized children often become adults who are not able to self-soothe or display self-care. This intervention provides an opportunity for adult Adam to nurture and support little Adam, the beginning of cognitive rescripting—changing from a negative to a positive internal working model (core belief). Valuing and loving his "inner child" is a vehicle for positive change in self-concept and neural rewiring, and is a valuable coping strategy to reduce anxiety.

TML: You know, little children take these things very personally. An adult can say "It wasn't my fault, it was them." A little kid can't say that. So, how is he feeling about himself?

Adam: Yeah, you weren't feelin' too good about yourself. You thought it was your fault. [Adam confirms that he viewed himself negatively as a child.] It must be my fault, I'm a bad kid.

TML: Was it?

Adam: No.

TML: Alright then. Tell him the truth.

Adam: This was not your fault. They did this to you. You didn't do it to them. [Adam looks into the eyes of little Adam and strokes his head lovingly] It must have been your fault, that's what you thought.

TML: How did that affect his self-confidence and self-esteem, thinking it was his fault?

Adam: You suffered from that. You were afraid, and you didn't feel good about yourself. They robbed you of that childhood, that sweet childhood that you should have had.

Adam appears sad as he processes his early emotional pain. He begins to realize that he has been blaming himself, resulting in self-contempt and depression. He is beginning to change his narrative.

TML: By the way, can you understand how Kristina triggers you? What have you realized about that?

Adam: I feel sorry for her, just like I feel sorry for myself as a little child. Then I don't do what I need to do as a parent. I don't set limits.

Adam realizes that his childhood issues are affecting his parenting of his daughter. As he resolves the early pain and self-blame, he will be able to be a better parent (e.g., firm but loving) and husband (e.g., stop avoiding conflict).

PSYCHODRAMATIC REENACTMENT

The next intervention is psychodramatic reenactment. A female therapist (AJ) role-plays Adam's mother (she has a cigarette, because the mother smoked). The task is for Adam to give a voice to little Adam as he talks with his mother.

TML: What's that like for a little kid to think it's his fault, he put his mother in the hospital? [Adam was told by his mother that it was his fault that she had to be hospitalized for a "nervous breakdown."]

Adam: I just feel terrible about that. I want you to be with me, Momma.

"Mother": I'm too busy [pretending to smoke]. Go sit in the booth. [Adam spent many hours sitting in the booth in the family restaurant.]

Adam: I was sitting in the booth, waiting for you to come home. Other times I was home by myself a lot of the time. And I'd be standing out on the road waiting for the car to come home. [He begins to cry, feeling the loneliness, fear, and pain of his childhood.] I'd be scared somebody was after me.

TML: What a sad picture that is, standing on the road waiting. She broke your heart, that's your pain.

Adam: [Looks at Mother and says] You broke my heart; I needed you and you weren't there.

There are several therapeutic components to psychodramatic reenactment. It is healing to speak the truth, eye to eye, face to face. The limbic brain is rewired by the "corrective emotional experience," expressing the emotions of the "inner child" in a supportive, empathic milieu.

TML: Is it true, by the way? Did you put her in the hospital? Did you make her crazy or depressed, or cause her nervous breakdown? Did you do that? Was that your fault?

Adam: [Looks at Mother and says with anger] I'm not buying it anymore. It's not my fault. I'm not going on a guilt trip anymore. It was your fault.

Next, MO enters the room in the role of "Father," and initiates a heated argument with "Mother," to simulate the domestic violence Adam experienced as a child.

TML: What is little Adam feeling?

Adam: I feel scared. [Adam starts crying and sweating, clutching the teddy bear in his arms. He is re-experiencing fear and panic, and begins to dissociate.]

TML: Open your eyes and look at me. Tell me what you're feeling. [The therapist uses a calm voice, supportive touch, and empathic listening to convey safety and understanding.]

Adam: I'm so afraid. [Adam looks into the therapist's eyes, and is comforted by the support and compassion.]

TML: Must have been so terrifying for you.

The therapist's calm and supportive demeanor helps Adam to interrupt the dissociative coping strategy. He is now ready for an alternative response—from victim to survivor, from powerless to empowered.

Adam: [To "Mother"] I can't believe you did that to me. I hate what you did to me. [Adam expresses genuine anger for the first time.]

Adam: [To Father, who sits in front of him] I'm angry; you never gave me a chance. You never paid attention to me. [Again, Adam verbalizes anger about how he was treated.]

"Father": [Looks around the room, ignoring and rejecting Adam, to simulate the childhood rejection.]

Adam: [To "Father"] Look at me, look at me. I'm not that scared little boy anymore. I'm a big guy now. I hate what you did to me. I didn't deserve it, that little boy didn't deserve it. I'm not going to be depressed about it anymore.

The corrective emotional experience is Adam expressing his anger directly to his "father," eye to eye, rather than withdrawing and avoiding.

Adam: [Clutches "little Adam" in his arms and assertively says to "Father,"] I've got my power. I'm going to take care of Kristina like a parent should. I'm going to be in charge, not my past. I'm not going to feel sorry for Kristina like I used to feel sorry for myself.

Adam is instructed to stand up and talk with his "parents" who are sitting down. This symbolizes his empowerment—no longer a frightened victim.

Adam: No more. I'm done with it. You understand? I'm done with it. What y'all did was wrong and I'm done with it. I'm through with it. I'm taking care of my little girl like I'm supposed to. You understand that? No more guilt from me 'cause it wasn't my fault. It wasn't my fault. It was your fault [points to "Mother"] and yours [points to "Father"].

Adam becomes animated and excited. He pumps his fists and kicks his leg in celebration. He "faced his past" and feels successful and accomplished. Beth enters the room and gives him a big hug. She was observing the session on a TV monitor with treatment team members, and wants to tell Adam how proud she is of his courageous work in therapy.

FORGIVENESS RITUAL

We pretend that "Mother" and "Father" are healthy and Adam can talk with them for forgiveness and closure.

Adam: [To "Mother"] I forgive you. I know you had your own problems.

TML: Can you tell your Mom how life will be different for you now that you released all this?

Adam: I'm no longer a victim of my past. I've let go of my fear and anger. I can move on.

MO: [Role-plays "Father" and says to Adam] I'm sorry for what I did to you. I didn't know any better.

Adam: I'm no longer angry with you. I'm doing good, aren't I, Dad?

MO: You sure are. I'm really proud of you.

Follow-Up

An analysis of post-treatment symptom checklists indicated a significant reduction of Kristina's symptoms in all six categories. The parents wrote, "Her behavior at school and home is so much better and we are really enjoying our family life together." The father (Adam) reported a significant reduction in his depression, and was able to discontinue antidepressant medication. Adam and Beth reported continued improvement in their marital relationship, regarding trust, intimacy, communication, support, and conflict management. They also reported improvement in their coparenting relationship, and wrote, "We are now on the same page when parenting our daughter."

12

Corrective Attachment Parenting

There is a considerable amount of scientific research regarding evidence-based parent education programs. Effective parent education programs help parents acquire constructive problem-solving and child management skills, and increase parents' sense of competence, self-worth, empathy, and attachment to their children. These programs increase parents' knowledge of child development, help parents with emotional adjustment and stress management, increase social support for families, and change unhealthy child-rearing beliefs (e.g., corporal punishment is not constructive). Parent education programs have been found to improve family relationships and prevent child abuse (Lundahl, Nimer, and Parsons 2006).

Corrective Attachment Parenting (CAP) (Orlans and Levy 2006) was developed to meet the needs of children who have experienced maltreatment, significant losses, and disrupted attachment. Parenting such children—being a *healing parent*—is quite a challenging task, as they are typically mistrustful, angry, defensive, defiant, and reluctant to be emotionally close. Effective parenting requires the maturity to look in the mirror (self-awareness), the patience to remain calm, the firmness to set appropriate limits, the heartfelt desire to give plenty of caring, compassion, and love, and the flexibility to meet the unique needs of your child. To be a therapeutic parent, you need the right information, skills, support, attitude, self-awareness, and hope.

Maintaining a positive attitude is a key to success, but not easy to do. Parents often feel hopeless, demoralized, and powerless to help their children and create family harmony. When parents are demoralized they lack the motivation and determination necessary to create positive change, and may project their hopeless feelings onto their children. How do parents increase their sense of hope and then instill it in their children? Hope is increased when you believe you are able to produce a workable pathway toward your

goals ("I know I can do this"), and have the ability to move consistently toward these goals ("I have the skills"). This leads to success, and hope is a by-product of success. Confident parents are more likely to succeed with their children, and children feel more hopeful when their parents are confident and optimistic.

The importance of a positive expectation of success is found in the placebo effect. A placebo is a harmless substance (sugar pill) given as if it were medicine. Research has shown many people have positive reactions because they believe they will get better—they have a positive expectation of success. In other words, if we believe in something enough, we can make it happen.

Therapeutic parents realize that their *relationship with their child* is the primary vehicle for creating positive change. Through thoughtful and corrective actions, reactions, and a safe and constructive emotional environment, parents can foster positive behaviors, character traits, mindsets, and brain growth. Parents help shape the growth of their child's brain by helpful and healing experiences. Brain cells (neurons) "fire" during social and emotional experiences, and neurons firing together facilitate the growth of new connections, causing a "rewiring" in the brain.

By employing the concepts and skills of CAP, children can develop the following skills and abilities, which are essential for success in life:

- experience secure attachments with parents/caregivers; give and receive affection and love; feel empathy and compassion; and have a desire to belong
- view oneself, others, and the world in a realistic and positive way; have positive core beliefs, mindset, and self-esteem
- identify, manage, and communicate emotions in a constructive manner; exercise anger management, stress management, and self-control
- make healthy choices; solve problems and deal with adversity effectively
- utilize an inner moral compass, prosocial values, morality, conscience, and a sense of purpose
- be self-motivated; set and persevere toward goals, and achieve a sense of mastery, competence, and self-confidence
- maintain healthy relationships; be able to share, cooperate, resolve conflicts, communicate effectively, and be tolerant of others
- experience joy, playfulness, creativity, and a sense of hope and optimism.

Neuroscience of Parenting

Researchers have used functional MRI scans to investigate which regions of the brain are activated during parenting—how our brains are wired for rearing children, and how parenting can shape our brains. They found that humans' neural circuitry is primed to respond to babies in ways that are key to the infant's development. Mothers' brains actually grow in size in the early months of parenting. The brain regions associated with motivation, reward, emotional processing, and reasoning and judgment (hypothalamus, amygdala, and prefrontal cortex), increase in size in the first three months. Looking at an infant's face activates the inferior frontal gyrus, an area associated with empathy and emotion. Seeing a baby's face also prompts increased activity in the supplementary motor area, the part of the brain involved with talking to and moving toward the baby. By the time their babies are 3 months of age, mothers' brains are attuned to their faces, and infants' brains are attuned to their mothers' faces (Winerman 2013).

There is considerable evidence regarding the effects of stress and trauma on the developing brains of children. It is also important to understand how stress affects parents' brains, and how changes in neurobiology influence parenting behavior. When parents and children are attuned, emotionally close, and securely attached, the neurotransmitters oxytocin and dopamine are released in the parents' limbic brain region, activating the pleasure and reward systems in the left hemisphere. The parent experiences calm, loving, and gratifying feelings, and can rely on the higher brain centers for emotional regulation, empathy, and self-awareness. This is the neurobiological state that brings about limbic resonance and positive parent–child relationships (Baylin and Hughes 2012).

Parents of traumatized children commonly experience severe stress and conflict, due to habitual rejection, defiance, anger, and controlling behavior from their children. Parents also have stress reactions when children trigger unresolved emotional issues from the parents' past. The parents' brain systems go into survival and stress response mode—"fight, flight, freeze." They become rooted in the primitive brain regions which activate defensive and self-protective reactions, and deactivate the balanced and mature responses of the cerebral cortex. Oxytocin and dopamine, the "feel-good" biochemicals, are blocked. Cortisol and epinephrine, the anxiety-producing chemicals, are released. The result is a deficiency in warm and caring feelings toward the child, an increase in fearful and avoidant responses, and an inability to problem-solve in a composed and creative manner.

Parents must learn to identify and tone down their neurobiological stress responses. It is helpful for parents to learn how to remain calm by modifying negative self-talk, being aware of their emotional triggers, not personalizing

their child's behavior, accepting support, and practicing self-care (mind–body–spirit).

Creating a Healing Environment

Parents are responsible for maintaining a emotional, social, and moral climate that is healthy and healing for their children. This context is the fertile soil in which children can recover from trauma and develop in positive ways. The ingredients of creating a healing environment are described in this section.

Cannot "Fix" a Child

Parents cannot "fix" a child, but can create an environment with opportunities for positive change, healthy growth and development, and secure attachment. Parents can only control their own choices and actions. Trying to control or change their child usually leads to increased defiance and power struggles. Parents can encourage, guide, and be a role model for their children, but cannot control them.

Look in the Mirror (Self-Awareness)

Parents' own background—how they were raised and the type of attachments formed—play a major role in how they parent their children. This is especially true with challenging children; they can trigger unresolved issues and sensitivities left over from childhood. By knowing oneself well—looking in the mirror—parents are more likely to be proactive rather than reactive, and will respond constructively to their child's attempts at blaming, distancing, and controlling.

Research shows a parent's *mindset about attachment*—how they think about and deal with emotional and relationship issues—is the number one factor that determines their child's attachment. There is a 70 to 75 percent correlation between the parent's mindset regarding attachment and their children's attachment patterns (Sroufe *et al.* 2005).

Parents who are *unresolved* about their past often have emotional and relationship problems and are easily triggered by their children. Parents who openly and honestly face their pasts usually have more fulfilling lives and can create and maintain a healing environment for their children.

Labels Affect Solutions

The way you interpret and label a child's behavior will determine how you intervene to help that child. This is true for parents, therapists, teachers, and

others who work with children. For instance, children labeled as biochemically imbalanced are given medicine to change their behavior. Parents who see their child as emotionally and socially delayed often become "helicopter parents"—hovering over the child, rescuing, and overprotecting—thereby reinforcing the very incompetency they worry about. Understanding a child's behavior as symptoms of interpersonal trauma changes the lens. Therapeutic parents endeavor to connect with their children, and avoid becoming triggered into destructive reactions and interactions.

Family and Community Systems

In families, all members affect one another, in ongoing, circular patterns—the *dance of family dynamics*. Everyone works together to keep the dance going, either in a healthy or dysfunctional way. All parts of the family system affect each other. When parents change what they are doing, their child will change in response. *When the system changes, the child changes*. Children can only be understood and helped within the context of the family and social systems that shape their lives—the bigger picture. Attachment develops within the larger emotional network of the family system. Creating a healing environment involves looking at the bigger picture—how the family operates, including the rules, roles, boundaries, and the nature of the family's connection to outside social systems. This is illustrated by the family–school connection. It is crucial for parents and school personnel, such as teachers and counselors, to be a cooperative team for the benefit of the child.

Love and Limits

Balancing love and limits is important for all children, but especially crucial when creating a healing environment for wounded children. Nurturing and loving care fosters the learning of trust, empathy, and a positive mindset. It teaches children that closeness and heartfelt human connections are safe and rewarding, leading to future closeness in adulthood with partners and children, and giving a special meaning to life. Loving and nurturing care results in positive core beliefs: "I am wanted and valued; caregivers are dependable and trustworthy; life is good."

Providing limits and structure, including rules, clear expectations, and appropriate consequences, helps children feel safe, secure, and learn from their mistakes. A sense of order and predictability is particularly important for children who come from chaotic and frightening backgrounds. It is essential that limits and consequences be given with patience and understanding for children to benefit.

Opportunity Mindset

In order to create a healing environment parents must be aware of their mindsets. Healing parents don't just do things differently—they *see* things differently. Do you view stressful and challenging situations as crises to be dreaded or as opportunities for teaching, learning, and growth? One's frame of reference will determine how you respond.

The opportunity for learning and growth is available for parents, not just for children. When a parent is triggered into a strong emotional reaction, he or she can ask: "What can I learn about myself; what can I change?" Parents often report in therapy that their children provide rich opportunities for personal and marital growth.

Proactive versus Reactive

To maintain a healing environment parents must be proactive: they create the emotional climate, take the initiative, and maintain the rules. When parents are reactive, they allow the child to set the emotional tone, placing him or her in a position of control. To be proactive, parents have to know their goals and *stay the course*—persevere toward those goals. Children feel more safe and secure when they can count on their caregivers to be in charge in a sensitive and caring way.

Being proactive involves remaining calm and not taking their child's behavior personally. Being proactive also means parents deal with issues and problems as soon as they occur—on the front end—not waiting until the situation escalates out of control. Being proactive means parents are prepared to deal constructively with their child's behaviors. Children reenact and project their problems and patterns on parents. Being proactive prevents the negative dance, offering children the opportunity for change and healing.

Positive Role Model

All parents are role models for their children. A parent's job is to show by example how to effectively communicate, solve problems, cope with stress, manage emotions and conflict, and care about self and others. By presenting children with a positive role model *parents will make a difference*. Remember, the mind of a developing child is mostly formed by experiences with significant others—parents and caregivers. Parents can promote positive change in their child's brain, mind, and behavior.

Ten Cs of Therapeutic Parenting

The ten Cs of therapeutic parenting are the foundation for creating a healthy and healing relationship with children, based on compassionate care, appropriate structure, and mutual respect. "Discipline" comes from the root word "disciple," which means "follower of a leader or teacher." Effective discipline depends on building the right relationship with a child, not merely about using a particular technique, and to encourage a child's total development—mind, body, emotions, relationships, and values.

Parents can have a positive influence on children when guided by the ten Cs of therapeutic parenting, which are described below.

Connection

Connecting with children involves empathy, support, nurturance, structure, and love. The ability to form and maintain positive connections is essential for healthy childhood development. Parents who successfully connect with their children are emotionally available, actively involved in their lives, and model respect and compassion. *Children are most influenced by those with whom they feel the deepest respect and strongest connections*.

Calm

To be calm is synonymous with being levelheaded, peaceful, patient, and composed. The only effective way to positively influence children is to gain their trust, and a calm and consistent approach works best. Although it is important to be calm and centered with all children, it is critical to remain emotionally balanced with children who have compromised attachment. These children did not receive adequate emotional regulation from caregivers, and did not develop the ability to regulate their emotions and impulses. Parents must teach them to be calm by providing an example of calmness, which reduces the "alarm reaction" (fight, flight, freeze), and allows them to feel safe and secure enough to think rationally and learn.

Commitment

A parent cannot create secure attachment without a commitment. Commitment is a promise and a pledge to be available to a child through thick and thin; a moral obligation to take certain actions and respond in certain ways, which leads to safety, security, and trust. Parents must commit to the following: keeping their child safe; truly knowing their child; providing appropriate structure; having compassion for their child; being a positive role model; and supporting their child's growth and development. Healing

parents make a commitment not only to their child, but also to their own emotional, social, and spiritual health. Helping challenging children requires that parents are "on top of their game."

Consistency

All children need consistent nurturance and stability, as a supportive framework to guide, organize, and regulate their behavior. Children who have endured adverse conditions—lack of protective, loving, and secure attachments—need even more. Failing to receive the requisite nurturance and structure in the early stages of development has left these children emotionally, behaviorally, and biochemically disorganized. These children desperately need consistent routines, guidelines, and love. Consistent and appropriate structure—rules, limits, and consequences—enables children to depend on a reliable caregiver, whom they begin to respect and then trust. *Providing structure engenders feelings of safety and security in children, anchoring them for the rest of their lives*. It is important for consistency to occur among all the adults in the child's life. Teachers, counselors, daycare providers, child welfare workers, and family members must all be on the same page. Children will be more likely to learn and improve when everyone provides consistent messages.

Communication

Communication is at the heart of attachment. To communicate is to connect. There is no greater gift to children than to be attuned; they see it in their parents' eyes, and hear it in their tone of voice. *Parental sensitivity to the child's signals is the essence of secure attachment*. Communication begins in the womb, via a neurohormonal dialogue between mother and unborn baby. From the moment of birth, babies communicate with their caregivers verbally and nonverbally through facial expressions, gestures, crying, cooing—the language of infancy.

Effective communication is the foundation of all relationships. Communicating for attachment creates the conditions in which a child is more likely to confide and connect. Realizing that so much of communication is nonverbal (eye contact, facial expressions, tone of voice, body language, touch), a parent's style of delivery is often more important than the words. Messages register in the emotional region of the child's brain (limbic system), and affect learning, trust, stress response, memory, and development.

Choices and Consequences

One of the most important jobs as a parent is to prepare children to function in the real world. To accomplish this, children must learn to live with the consequences of their choices. This leads to the development of responsibility, accountability, and maturity. There is a difference between consequences and punishment. The goal in giving a consequence is to teach a lesson, which encourages a child's self-examination, acceptance of responsibility for actions, and the ability to learn from mistakes. The definition of punishment is to cause to suffer. Punishment is harmful to a child's sense of self, emotional development, and the parent–child relationship.

Confidence

Confidence is the ability to rely on yourself with assuredness and certainty. Confident parents have trust in what they are doing to help their children. Children feel safe with confident parents, who they see as capable and dependable. Parents need information, skills, support, self-awareness, and hope to develop confidence. When parents understand their children they are more likely to help them. Learning the skills of CAP leads to success, and success builds confidence. Having support provides the care and encouragement so crucial during difficult times. Self-awareness prevents parents from responding in negative ways. Knowing children do change under the correct conditions creates optimism and hope.

Cooperation

Children with compromised attachments become self-absorbed, believing their survival depends upon "looking out for number one." Children need opportunities to learn about the give and take of relationships, including cooperation, empathy, and reciprocity. Parents who are *resonant* in their attitude and delivery are more likely to have children who are motivated to cooperate. Resonant parents are attuned to the feelings, needs, and mindsets of their children. Parents who are *dissonant* are out of sync with their children, and their children are not motivated to cooperate. Parents must model cooperative attitudes and behaviors with children, spouse, extended kin, friends, and others. Children learn by watching what we do, not what we say.

Creativity

An important rule when dealing with wounded children is: *if something doesn't work, do different, not more of the same*. When children experience

interpersonal trauma their limbic brains are primed for a fight and they remain in a state of high stress and arousal. The part of the brain responsible for controlling rational thinking, problem-solving, and creativity does not function normally. Creativity is the "language of childhood." These children are focused on survival at the expense of flexibility and imagination.

An important aspect of creativity is humor. Laughter is the best medicine. It reduces stress, creates positive connections, and gives a new perspective on one's situation. Laughing with, not at, a child increases emotional bonding and interrupts negative patterns of relating.

Coaching

A coach is a mentor who guides, teaches, supports, motivates, and inspires positive values and characteristics in children. Healing parents are role models and coaches and set an example of who to be and how to behave. *Children learn more from modeling than by any other way*. A good coach not only imparts knowledge, but also facilitates the attainment of wisdom. Wisdom is knowledge applied: figuring out a problem for yourself by using critical thinking and problem-solving skills. Coaches teach life skills, including self-awareness, self-control, conflict resolution, communication, and cooperation. Coaches encourage the development of positive traits such as tolerance, enthusiasm, industriousness, integrity, loyalty, and perseverance.

Parenting Skills and Solutions

The following are practical skills, strategies, and solutions successfully used by therapeutic parents. Using these skills increases confidence, enables parents to convey a healing attitude, and leads to positive change.

Limits, Choices, and Consequences

Children who did not get the necessary love and limits in the early years commonly become controlling, manipulative, and defiant. They became guarded and controlling because they could not rely on caregivers to keep them safe and secure. There should always be a balance of structure and nurturance, limits and love. This is a key to promoting secure attachment. Rules without love are perceived as cold and punitive. Love without ample limits does not provide a framework for healthy development. The amount of structure and support parents offer should be based on their child's stage of development, emotional/social age, and competencies.

Offer Suitable Choices

Children learn by facing the consequences of their choices. This is how self-examination, responsibility, and cause-and-effect thinking are learned, leading to the establishment of an inner voice of accountability and self-control: "I'd better think about my choices because I'm responsible for the outcome." Parents should only offer choices acceptable to them, and always strive for a win–win. It is always best to remain emotionally calm. The goal is to maintain the integrity of the relationship.

Consequences

A consequence is the result or direct effect of an action. The goal for giving consequences is to teach a lesson that leads to positive choices. It encourages self-examination, accepting responsibility for one's actions, the ability to learn from mistakes, and the development of an inner voice of self-control. The definition of punishment is to cause to suffer. The goal is to inflict hurt, pain, and get even. Punishment causes resentment, rarely teaches a child a lesson, and does not facilitate secure attachment. One primary job of a parent is to prepare children for life, and the real world operates on the principle of *natural consequences*. Children who forget their coats are cold, and who don't study fail a test. Parents must allow their children to learn from the consequences of their choices and actions.

Clear Expectations

Expect children to be four Rs: 1) *Responsible*: hold children accountable for their choices and actions, and also allow them to be responsible family members by having a role and contributing; 2) *Respectful*: children must first respect parents in order to trust, and trust is essential for attachment. Parents should model respect, act respectfully toward children, and talk with their children about disrespectful attitudes and behaviors; 3) *Resourceful*: using skills and abilities to accomplish a goal rather than acting incompetently. Give children a "can do" message; failure is only a stepping-stone to success; and 4) *Reciprocal*: the give and take of healthy relationships. Everyone in the family "pulls their weight," with a balance of giving and getting. Encourage sharing, cooperation, and empathy for others' feelings and needs.

Competency-Based Parenting

How do you know how much structure or freedom to give a child? The answer is found by using the ideas of competency-based parenting: *children need to be contained within the limits of their capabilities*. The amount of structure

should be based on a child's competencies in four areas: *knowledge*, *skills*, *self-control*, and *judgment*. Children must have responsibilities and obligations, as well as power and freedom. When children have many responsibilities and little power, they become malcontent and rebellious. When they have too much power and freedom and too few responsibilities, they become "spoiled" (Figure 12.1, The Autonomy Circle).

Many well-meaning parents give their children too much power and freedom. There are a number of reasons for this. First, it is easy to feel sorry for a child who has suffered abuse and neglect. Second, parents may not understand their child's emotional needs and, therefore, are not aware of the proper limits to set. Third, it is common to avoid conflict, particularly if a parent learned avoidance growing up in his or her own family. Parents also avoid conflict because they are worn out and take the path of least resistance. Last, parents can be embarrassed and worried about their image, not wanting to be seen as mean or unable to control their child's behavior.

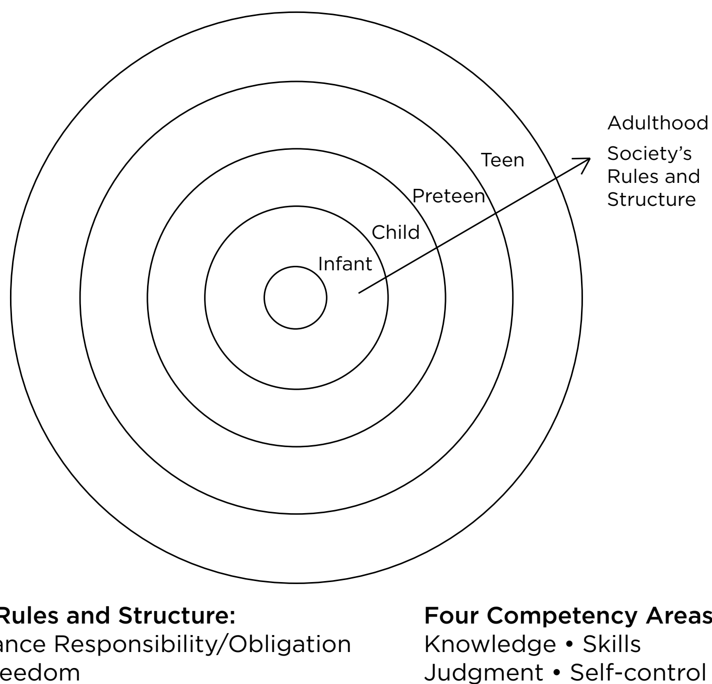


Figure 12.1 The Autonomy Circle

Units of Concern

Children are only motivated to solve a problem when they "own" the problem. Without a sense of ownership there is little concern, accountability, or motivation. Instead, there is avoidance, denial, and blame. Parents who take

on too many units of concern for their child's problems are unintentionally teaching him or her to be irresponsible and helpless. Let's assume that for any problem in life there are ten units of concern, ten slices of pie. There is a direct correlation between the number of units a parent has and how many the child accepts. When a parent takes on too many units of concern, the child will take on too few, robbing him or her of valuable experiences that can lead to the learning of life skills, maturity, and wisdom. It is important to determine "whose problem is whose." If it is the child's problem (e.g., doesn't do homework), show empathy but expect him or her to work it out. It is the parent's problem if it impacts the parent directly (e.g., stealing from parent), and then the parent takes action. Parents who take on too much responsibility for solving a child's problem, or rescue a child, only reinforce the child's sense of inadequacy.

Chores

In today's world, children are not needed to preserve the family. They have a significantly lower level of maturity and sense of responsibility compared to earlier generations. Children now spend much of their time uninvolved in the family. They are involved in sports, lessons, the Internet, video games, TV, and social media. They have become "me" directed rather than "us" directed.

Doing chores is a way for children to increase self-confidence, internalize values, and become cooperative family members. Parents who do not have their children doing chores are missing an opportunity for character building. Chores build responsibility, strengthen moral development, and enhance self-esteem. Give children chores when they are young to learn good habits, make chores age-appropriate, and show them how to do the chore initially. Do not pay for chores; chores are done to be part of the family. Post a list of chores and show appreciation; praise reinforces behavior and strengthens attachment.

Know Your Triggers

Emotional triggers are strong reactions associated with past experiences and memories. Parents cannot avoid bringing emotional baggage into their relationships with children. Parenting style, attitudes, and reactions are heavily influenced by one's own attachment history. Parents are emotionally triggered when their reactions are excessive, when they have a "knee-jerk" response, and when patterns are repeating, despite their best efforts to change.

To avoid becoming emotionally triggered, it is important *not* to take a child's negative behavior personally, and to be able to "look in the mirror." It is helpful to be aware of the following:

- *mindset:* your belief system or internal working model
- *self-talk:* what you tell yourself about yourself, others, and situations
- *emotional reactions:* feelings that are triggered
- *attachment history:* relationship patterns learned in the past
- *body signals:* physical reactions, especially in response to threat and stress
- *coping strategies:* typical ways you respond to situations, such as rejection, threat, anger, disappointment, and frustration.

Change Core Beliefs

Early experiences with caregivers shape a child's core beliefs about him- or herself, others, and life in general. Wounded children see caregivers as rejecting, punitive, and unreliable, and themselves as bad, helpless, and unlovable. Negative mindsets cause children to misinterpret a parent's behavior, viewing the parent as controlling and threatening rather than helpful and supportive. New relationship experiences can change a child's belief system and subsequent behavior. Looking beyond behavior and understanding core beliefs will help a child develop a more trusting, positive, and healthy mindset. *The goal is to help the child anticipate something new; to expect positive responses, such as empathy, support, and honesty*. Slowly, over time, as the child is unable to provoke hostility or rejection, core beliefs will change, trust will grow, and behavior will improve.

Change the Pattern

Parents often do not have a relationship with their child, but have a relationship with their child's defenses. Children project anger, fear, pain, and negative expectations onto parents, and mold the current relationship into a familiar pattern from the past. When parents offer a different response than the child is used to, they create the opportunity for change. *New relationship experiences lead to new expectations and behavior*.

Reactive parents are manipulated into old and destructive patterns. They become angry and rejecting, take it personally, and feel hopeless and demoralized. *Healing parents* are not manipulated into old patterns. They offer new and helpful responses, including firm limits, constructive communication, empathy, and models of healthy anger management. They do not take it personally. *Change the dance, change the child*.

Calm

It is difficult to stay calm when feeling threatened, angry, or frustrated. However, this is the most important time to do so, especially when dealing with wounded children. Losing one's temper and overreacting only leads to saying or doing something nonconstructive. There are three steps to staying calm:

- *Stop:* Don't act impulsively. Take a deep breath. Relax your body. Calm your mind.
- *Be aware:* Be aware of *self-talk*. Positive self-talk is calming (e.g., "I can be a good role model"); negative self-talk is emotionally agitating (e.g., "My child will never learn"). Be aware of *body signals*. Physical reactions such as racing heartbeat and clenched jaws are signs that a parent needs to calm down.
- *Act:* After calming down, the parent can think logically, use constructive problem-solving, and communicate in a clear, honest, and helpful way.

Parents can help their child to calm down ("down-regulating"). When children feel threatened, their brain's limbic system triggers the "fight, flight, freeze" response. Parental calmness switches the child's brain out of survival/fear mode into emotional safety and reasonable thinking, reducing the flow of stress hormones throughout the child's brain and body. Parents can down-regulate children's agitation and stress response by:

- *Responding therapeutically:* Do not escalate with the child (e.g., child is angry and parent becomes angry). Do not give in to the child's demands or threats to avoid conflict. Rather, communicate calmness in tone of voice, facial expressions, and body language, and "stay the course."
- *Using one-liners:* These are brief responses that prevent a parent from being "hooked" into an argument and negative interaction: "I understand how you feel"; "Thank you for sharing"; "What do you think I think?"

Proactive

Parents create the emotional climate in the family when they are proactive, and children create the emotional climate when parents are reactive. Parents remain proactive when they have skills, goals, and persevere consistently toward achieving their goals. Anger management skills are particularly important in order to be proactive (see pages 206–208). The following are examples of a parent being reactive and proactive:

- *Reactive parent:* Every time 10-year-old Kyle plays Monopoly with the family, he tries to control the game and throws a temper tantrum if he doesn't win. Dad gets upset, yells at Kyle, sends him to his room, and the game is ruined for everyone.
- *Proactive parent:* Before the game begins, Dad tells Kyle, "I notice you get very upset when we play this game, so at the first sign of losing your temper, you will be given a time out to think about your choices and calm down." Kyle knows what to expect and the consequences of his actions. If he loses his temper and receives a consequence, it can be a learning experience. Over time, he will learn new and better ways to cope with his frustration, while building a healthy bond with his father. By being proactive, Dad is prepared, and the game is not ruined for everyone.

Secure Base

Fear and discomfort activate attachment needs in young children. When frightened, lonely, and feeling stress, children rely on their caregivers for protection and need-fulfillment. When a child's fear and stress are reduced by a dependable caregiver, he or she associates closeness with safety and security. This is the essence of secure attachment. When young children have no emotionally available caregiver to depend on, they must face anxiety and stress alone. With little or no support, the child is overwhelmed with stress, associates closeness with pain and fear, and concludes he or she is better off alone. This is the essence of anxious–avoidant attachment.

The elements necessary for a caregiver to provide a secure base are:

- *emotional availability:* accessible, dependable, self-aware (does not personalize, knows own triggers), mature, good role model
- *sensitivity:* attuned to child's feelings, needs, anxieties, and defenses; empathic, nurturing, patient, and loving
- *responsiveness:* responds appropriately to behavior and needs; firm and loving; does not ignore negative behaviors; proactive, not reactive; promotes safety not fear; provides consistent, predictable, and developmentally appropriate structure and support
- *helpfulness:* mindset of opportunity rather than crisis; helps child learn coping skills, such as anger management, communication, and problem-solving; understands the role and attitude of a healing parent.

Communication

Communication is the key to secure attachment. Sharing and understanding emotional information enables us to feel deeply connected. Communication begins even before birth. Pregnancy is the dawn of attachment, the time in which parents and unborn baby begin to communicate and attach. A mother's thoughts, feelings, and stress are communicated via a neurohormonal dialogue, and are preparation for communication after birth.

Reciprocal and collaborative communication is the basis of attachment after birth. *The caregiver's sensitivity to the needs and signals of his or her baby is the essence of creating secure attachment*. Infants communicate their needs and feelings by crying and body language. The way the primary attachment figure responds determines the type of attachment pattern established (secure, avoidant, anxious, or disorganized).

A parent's style of communication often determines the quality of the relationship. Effective and secure communication includes:

- *Connect with eye contact:* This is the key to gaining your child's attention, giving and receiving clear messages, and creating an emotional connection.
- *Be aware of nonverbal messages:* Body language, facial expressions, and tone of voice send powerful messages. Gently touch a child's arm or shoulder; have a firm, yet empathic, tone and look. Get down to the child's level, eye to eye, rather than being in an intimidating position, such as standing over him or her. The goal is to teach and connect, not intimidate or control.
- *Set the stage:* Take the time to find a quiet space where the focus is on the child. Be in the right mood so that the child is more likely to be receptive.
- *Focus on the behavior, not the child:* Convey the message, "I dislike your choice and behavior, not you." The goal is for the child to learn from the experience rather than feel criticized, rejected, or ashamed.
- *Work as a team:* It is important that parents talk about behavior and consequences so they are on the same page.
- *Don't lecture:* Listen more, talk less, and children are more likely to trust and open up.
- *Control anger:* Children learn more when adults are firm, yet calm. Yelling, criticizing, and lecturing do not provide a positive role model of coping and communication, and create anxiety in children.

- *Don't threaten or give warnings:* Repeated warnings undermine authority. A single warning can be effective. This allows the child to correct his or her behavior or face the consequences.
- *Give positives:* It is very important to give children positives. The best rewards are emotional—smiles, hugs, words of appreciation, and praise: "I really like the way you helped clean up. How about a hug."

Think-it-over time is an effective communication and problem-solving strategy. The goals are to help children learn from their "mistakes," learn to identify their thoughts and feelings, and learn communication skills. Following a negative behavior, the parent employs these three steps: 1) asks the child to sit quietly and think about his or her behavior; 2) asks the child, "What did you do?" What were you thinking and feeling at the time?" "What is a better choice next time?"; and 3) If the child is honest and takes responsibility, gives praise and a big hug; if the child is not cooperative, asks him or her to think some more.

ACT is used extensively in our treatment and parenting programs with all family members (see Chapter 8 for a description of ACT). ACT is an effective procedure to change negative patterns of relating, learn constructive communication and problem-solving skills, and facilitate secure attachment.

Sense of Belonging

A sense of belonging to family and community is essential for healthy emotional and social development. Children are social beings. Beginning in infancy, they have a strong need to fit in and find their place in the group. Securely attached children have a deep sense of belonging; they feel connected to parents, extended family, friends, community, and culture. The experience of being a part of a clan, with regular customs and traditions, gives children a feeling of security, a sense of identity, and teaches loyalty and altruism.

When attempts to belong are met with rejection, betrayal, and shame, children do not develop a sense of belonging or identification with family, community, and culture. Children develop several strategies to deal with the lack of belonging. The first is self-protection; they isolate and alienate themselves from the group, denying their need to belong. The second strategy is to desperately try and fit in by getting attention any way possible. They become superficially charming and engaging, chatter incessantly, have tantrums, whine—all attention-getting behaviors to let you know "I am here trying to belong."

Family routines and rituals increase children's sense of belonging. Family *routines*, such as eating dinner, getting dressed, or preparing for bed, are "patterned interactions that occur with predictable regularity in the course

of everyday living" (Kubicek 2002). Routines organize family life, reinforce family identity, and enhance a sense of belonging. Research has shown that young children did better cognitively and socially, and were more cooperative with teachers, when caregivers provided consistent routines (Norton 1993). Family *rituals* are emotionally meaningful and convey the message, "This is who we are; this is what it means to be a part of this family" (Fiese 2002). Rituals foster a sense of belonging and identity and are especially important for children with insecure attachments. Children from families with meaningful rituals do better academically and socially. When rituals are disrupted or lost, children develop behavioral and school problems (Fiese 2000). Rituals include celebrating birthdays, religious holidays, and cultural traditions.

Praise

Praise is one of the most basic methods parents use to encourage good behavior and positive self-esteem. However, children will only accept positive comments if consistent with their self-image. Unconditional praise and approval backfire with children who have negative core beliefs, because they contradict their self-perceptions, and two reactions may occur: the parent loses credibility ("You are stupid; you don't know the real me"); the child's acting out increases ("I'll show you how wrong you are"). When praising a child with low self-esteem, consider the following: 1) be specific, giving the child praise for specific actions; 2) be genuine, never praising a child if not authentic; and 3) be positive, noticing and validating something positive—"catch a child doing something right."

Play

Play is crucial to children's cognitive, physical, social, and emotional development. Through play, children learn communication, creativity, problem-solving, morality, and social skills, essential to success in family, school, and life. Play is a primary way for children and caregivers to connect. Through play, parents learn about their child's special needs and talents, convey love and support, and build a positive and enjoyable relationship. Children with backgrounds of maltreatment and disrupted attachment have had little experience with play and have not had caregivers who engaged with them in playful ways. These children need to be taught how to play. Teaching children how to play will take time, but with patience, support, and perseverance, they will eventually learn to play by the rules, cooperate, and even have fun.

Helping Traumatized Children

Trauma is an exceptional experience in which dangerous and frightening events overwhelm a person's ability to cope. Many children are affected by trauma, including community and domestic violence, natural disasters, accidents, medical conditions, abuse and neglect, and unhealthy attachments. Over three million reports of suspected child abuse occur each year in the United States, and one million are substantiated. Ten million children a year witness the abuse of a parent. The actual numbers for child maltreatment are believed to be much higher (U.S. Department of Health and Human Services 2011).

Children are especially vulnerable to trauma because they have fewer coping strategies than adults, and because the brain grows at the quickest rate in the first three years of life. Brain circuits are being developed in these early stages and this "wiring" is influenced by stress and the quality of child–caregiver attachments. Trauma can affect brain development. When a young child is exposed to trauma, the brain and body focus on survival. The stress response turns on ("fight, flight, freeze") increasing heart rate, breathing, and stress hormones. The child remains in a state of anxiety and may not be able to sleep or learn (Rice and Groves 2005).

Children with emotionally unavailable caregivers are more negatively affected by trauma. Young children depend on sensitive and loving caregivers to keep them safe, reduce stress, and learn to trust. When parents are the perpetrators of maltreatment the children have no one to depend on and learn to fear attachment figures. They project that fear onto foster and adoptive parents (Levy and Orlans 1998; Orlans and Levy 2006).

Signs and Symptoms

Traumatized children show distress through their behavior and thought patterns. They experience many emotions, including fear, shock, anxiety, grief, and anger, and are often aggressive, impulsive, disruptive, defiant, controlling, or withdrawn. While each child has his or her own experience of and reaction to trauma, many have symptoms of PTSD, which include:

- reliving the trauma
    - distressing images and flashbacks
    - repetitive and anxious play routines
    - nightmares and sleep disturbance
    - anxiety due to reminders of the trauma (e.g., sounds, smells, touch)

    - anniversaries can trigger fear and acting out (e.g., day removed from home)
- hyperarousal
    - irritable, impulsive, difficult to soothe
    - hypervigilant; always looking for danger
    - problems going to sleep and staying asleep
    - hyperactive and attention problems
- avoidance and numbing
    - avoid people and places that are reminders of the trauma
    - withdraw from activities that used to be pleasurable
    - numb and closed-off from emotions; detached from others
- additional symptoms
    - physical complaints; headaches, stomach aches, nausea
    - sexualized behavior; result of sexual abuse or witnessing adult sex
    - fearful of separating from caregivers or changes in routines
    - regress; return to baby talk or relapse in toilet training.

Parenting Tips

Resilience means "bouncing back" from adversity. The primary factor in resilience is having supportive and caring relationships that include trust, love, good role models, encouragement, and reassurance. Nurturing relationships between therapeutic parents and children have the power to heal trauma.

Therapeutic parents offer a sense of safety. Traumatized children do not believe the world is safe or that adults will protect them. Promoting a sense of safety reduces their alarm reactions and changes those negative beliefs. Exposure to trauma makes children feel out of control. They crave structure and a stable environment. All children need calm and caring caregivers, but especially traumatized children. Remaining calm when they are agitated and teaching calming techniques reduce the anxiety and emotional arousal that affects their mood, sleep, and concentration.

Children need to learn that adults can be dependable, caring, patient, and loving to counteract the negative messages they received in the past. Therapeutic parents become their secure base by being emotionally available, sensitive, responsive, and helpful. To do so means you have to be able to

manage your own feelings and stress. The following *tips for therapeutic parents* facilitate healing:

- *Talk with your child:* Communication builds trust and is a constructive coping skill; find times they are likely to talk; start the conversation—let them know you are interested.
- *Listen:* Listen to their thoughts, feelings, and point of view with empathy—don't interrupt, judge, or criticize; this opens the door to a healing relationship.
- *Accept feelings:* Anxiety, irritability, anger, and depression are normal reactions to loss and trauma and will subside over time in a safe environment.
- *Be patient and supportive:* It takes time to come to terms with trauma and grieve losses; each child's path to recovery is unique; offer comfort and reassurance and be available when they are ready.
- *Encourage healthy expression:* Children act out distress negatively without constructive outlets; foster the use of talking, art, play, music, sports, journaling, and other healthy methods.
- *Maintain consistency:* Structure and routines enhance security and stability; provide appropriate rules, expectations, boundaries, and consequences.
- *Promote a sense of control:* Children feel helpless and powerless in response to trauma; help them believe they can successfully deal with challenges via constructive activities (e.g., hobbies, sports, clubs, volunteering).
- *Make home a safe place:* Your home should be a "safe haven," a place of comfort, security, and peace; stress and chaos provoke traumatic reactions; minimize conflict and discipline with calmness and love.
- *Foster new beliefs:* Children were often taught not to talk, trust, and feel by hurtful adults; offer "listening time" and "meeting time" to give children a chance to share feelings, problem-solve, bond, and establish trust.
- *Be honest:* Children make up their own stories if adults don't help them understand the truth; honesty is essential, but keep in mind their age and emotional ability; avoid details that could re-traumatize them.
- *Help with trauma stories:* Children are asking for help when they tell their stories; listen, be supportive, help them "make sense" of what

happened, send the message it was not their fault, and help them understand their feelings.

- *Advocate for ongoing connections:* It takes time to build trust; children should remain with the same caregivers over time (e.g., foster parents, child care workers); the "looping" model in schools keeps young children with the same teacher for two years.
- *Don't take it personally:* Children can "push your buttons"; you are less likely to be angry or anxious if you know your triggers—then you can remain calm and respond therapeutically.
- *Focus on the positive:* Notice and praise positive behavior; "catch your child doing something right"; have fun, laugh—humor reduces tension and creates connection; playing is a great way to bond.
- *Limit media:* TV, movies, and video games may be frightening and over stimulating; monitor and supervise based on your child's needs and reactions.
- *Be aware of body language:* Your tone of voice, facial expressions, and body language communicate more than your words; show via nonverbal messages that you are safe, understanding, and dependable.
- *Maintain perspective:* You can't change the fact that tragic events happened, but you can change how you interpret and respond to those events; help children accept what can't be changed and focus on things that can be changed.
- *Have an "opportunity mindset":* People often grow following tragedy and hardship—better relationships, self-worth, inner strength, spirituality, and appreciation for life; help children use their experiences to learn and grow.
- *Inspire a sense of belonging:* Being a part of a family and community enhances children's security, identity and loyalty; traditions and rituals increase their sense of belonging (e.g., celebrate birthdays, holidays, cultural customs and practices).
- *Volunteer as a family:* Charitable actions turn pain into something positive, create a sense of purpose and control ("I can make a difference"), and lead to reclaiming hope; assisting others also benefits the helper.
- *Avoid labels:* Labeling a child can have negative consequences; the child labeled as "difficult" can develop a reputation that follows him or her everywhere; when children see themselves as bad they act bad.

- *Take care of yourself:* Stay healthy so that you can take care of your children; be a good role model of self-care and stress management—eat well; exercise; get plenty of rest and support; avoid alcohol and drugs; do yoga, meditation, and spiritual practices; surround yourself with love.

Questions and Concerns

Although there are myriad issues, questions, and concerns parents share in therapy, there are several that are common in most families. This section describes these issues including medication, school, motivation, media, sibling conflicts, and therapy (Orlans and Levy 2006).

Medication

Many mental health professional are concerned about the rapid rise in the use of psychotropic medications by adults and children. The use of psychotropic drugs by adults (e.g., antidepressants, antipsychotics) increased 25 percent from 2001 to 2010; one in five adults now takes at least one psychotropic drug, and one in ten takes antidepressants (Smith 2012). One in five American youth experiences mental health problems each year, and many of these children are treated with medication alone. ADHD is the most widely diagnosed mental health disorder in children: 11 percent of school children and 20 percent of high school boys have been diagnosed with ADHD. Up to two-thirds are given stimulant medication such as Ritalin and Adderall (Morris *et al.* 2013). Alarmingly, there is virtually no information regarding long-term effects of these drugs on child development and the developing brain.

Many children and adults in the United States are prescribed psychotropic medications by their primary care physicians. In fact, four out of five prescriptions are written by physicians who are not mental health professionals (Smith 2012). This is problematic, because primary care physicians have limited training in treating mental health disorders, and often their patients are not made aware of psychological treatments that might work better, without the risk of side effects. Especially for children, it is always best to consider psychological and behavioral treatments with the child and family before giving medication. The primary care physicians and mental health professionals should always work collaboratively to determine the best treatment plan and the appropriate use of medication.

There are many unanswered questions about medicating children and teens. The majority of medications, with the exception of those for ADHD, have been tested and approved by the U.S. Food and Drug Administration

(FDA) for *adults only*, and are being used "off label" for children. This practice is legal but risky for a number of reasons. The brain chemistry of children is different from that of adults. The brain's frontal lobes, vital to "executive functions" like managing feelings and mature decision making, do not fully mature until about age 25. Children metabolize medications differently than adults. Many experts are concerned about what these drugs are doing to still-developing brains. How does medication affect a child's ability to learn emotional and social skills? Do antianxiety drugs prevent a child from learning to manage stress and anxiety without medication? Side effects can also be alarming and dangerous, including weight gain, high blood pressure, jitteriness, and flat emotions.

On October 15, 2004, the FDA issued a "black box" warning, its strongest safety alert, linking antidepressants to increased suicidal thoughts and behavior in children and teens. One theory regarding the suicidal tendencies is antidepressants lift fatigue and passivity, resulting in a more energized but still very depressed person (DeAngelis 2004). The response in England has been even stronger. NHS England does not recommend the use of antidepressants for children. The National Institute for Clinical Excellence recommends doctors encourage children to improve diet, get more exercise, and provide therapy focusing on the family, school, and social network. In cases of severe depression when antidepressants are absolutely necessary, they recommend using Prozac, which has shown the weakest link to suicidal tendencies, monitoring children weekly for adverse reactions, and using the medication only in conjunction with ongoing therapy (Cooper 2005).

On February 9, 2006, the FDA suggested issuing a "black box" warning for ADHD drugs, including Adderall, Ritalin, and Concerta. It was found that between 1999 and 2003, 25 people died suddenly and 54 others developed serious cardiovascular problems after taking these medications. Children accounted for 19 of the deaths and 26 of the cases of cardiovascular problems. The FDA reported "uncertainty" about the safety of these medications (Bridges 2006).

There are various factors that have contributed to the widespread use of psychotropic medication in the United States. The first is "medicalization"—for example, labeling children as medically ill without knowing all the individual, family, social, and cultural aspects of the child's behavior. In our treatment program, we find that children are often diagnosed with ADHD when, in fact, their symptoms (inattention, hyperactivity, impulsivity) are the result of trauma and compromised attachment.

The next influence is the pharmaceutical industry. In 1998, the FDA changed their rules and allowed direct-to-consumer advertising (e.g. TV), which resulted in a 50-fold increase in the sales of psychotropic drugs from

1985 to 2008 (Morris *et al.* 2013). This sends a dangerous message to children: "If you do not like the way you are feeling, take a drug."

The third factor is managed care. Pressure from insurers and health maintenance organizations (HMOs) has dramatically shifted the way health care services are delivered. In an attempt to reduce costs, HMOs dictate to psychotherapists how many sessions they can provide and how much they can charge for services. Managed care views short-term therapy and medication as a more economical approach. Consequently, psychotherapists are finding it difficult to remain in practice, pharmaceutical companies are increasing profits, and children are not receiving adequate care.

The increase in psychological and behavioral problems is the next contributing factor. Surveys show a constant increase in depression, stress, and other emotional and behavior problems. The World Health Organization estimates that by 2020 psychosocial disorders in children will increase by 50 percent, making them one of the five leading cause of childhood illness, disability, and death (DeAngelis 2004). As the number of children with serious problems rises, so does the use of powerful medications.

The fifth factor involves symptom-focused treatment. Many mental health professionals believe we are over-reliant on chemical solutions for emotional problems in children, focusing on the suppression of symptoms rather than addressing the underlying issues that contribute to problem behaviors. A growing number of mental health professionals realize children are being medicated for impulse control problems and thought patterns caused by a combination of unfavorable social influences and ineffective parenting, not for true neurological disorders.

The last factor that has contributed to the increase in medication entails child-centered rather than relationship-focused diagnosis and treatment. Child-centered approaches that do not address family interactions and influences are often ineffective. Attachment disorders are created in relationships and can only be healed in relationships. Effective therapy needs to address the child's prior attachment-related traumas while also promoting secure attachment in the current parent–child relationship. We have found when the right type of help is provided for children, parents, and the family system, there is a reduced need for medication.

The decision whether or not to medicate a child is difficult. Under the right circumstances children can benefit from medication. Advocates argue there can be negative consequences for not using medication for children who lack impulse control, cannot concentrate, or are depressed. An out-of-control child does not feel good about him- or herself or function successfully at home or at school. If brain chemistry is out of balance owing to genetic

factors, medication can help in gaining control of behavior and emotions. Medication can also lower a child's frustration level to facilitate learning.

When considering medication, it is best to consult mental health professionals who do the following:

- conduct thorough evaluations, including a review of past and present symptoms, and a detailed developmental history; discuss with caregivers the dynamics of current family relationships and social networks (school, extended kin, and social services)
- take the time to listen to and address parents' questions and concerns
- ensure they are knowledgeable about the latest research, including the side effects and interactions of medications
- understand the benefits of trauma and attachment-focused treatment approaches
- start conservatively with the lowest possible dose, and use medications with the fewest side effects
- monitor the child's progress consistently and carefully over time
- are interested in the parents' observations and those of others who are regularly involved in the child's life (e.g. teachers).

School

Infants and young children who are insecurely attached are more likely to be oppositional, impulsive, and aggressive, and these behaviors are often displayed in the classroom. Schools are generally well equipped to teach the "average" child. However, children with histories of trauma and compromised attachment have special challenges. They are commonly behind academically, have social problems with children and teachers, and exhibit behavior patterns that are barriers to learning.

Children whose parents are involved with their school in positive ways have both academic and emotional advantages: higher test scores, better self-esteem and attitudes, improved attendance, and fewer behavior problems. There is a positive two-way effect: parents implement teacher recommendations at home, and teachers feel more positive toward children in school (Christenson and Sheridan 2001). With middle- and high-school-age children, this may mean that parents do not rescue the children, but allow them to deal directly with teachers. Children are responsible for homework and face school-related consequences if necessary.

A common complaint we hear from parents is a lack of cooperation and communication with the school. The parents and school personnel are

not on the same page. Teachers and counselors, although well-meaning, do not always have an understanding of these children and the nature of their problems. Consequently, children can play one against the other—turn the school and parents against one another. The best scenario is when the school system, parents, and mental health professionals collaborate and develop a unified, realistic, and therapeutic plan for the benefit of the child. Children are most likely to learn when the adults in their lives have relationships that involve trust, communication, and respect, and are working toward common goals. The following tips help parents enhance school success:

- *Be assertive:* Make sure the school understands the child's academic, social, and emotional challenges, and takes appropriate action. Do so without being aggressive, angry, and alienating school personnel.
- *Provide information:* Give the teacher information about the child's background so he or she understands the special needs and challenges.
- *Foster relationships:* Build a relationship with the child's teacher and do this soon, rather than wait until a problem occurs. Get to know school personnel. Volunteer to help. Attend school meetings, especially the individualized education program (IEP) review.
- *Communicate regularly:* Talk frequently with the teacher about both positives and negatives. Discuss discipline with the teacher—consistent, firm, caring, and consequence-driven approaches work best.
- *Promote understanding:* Help the teacher understand that learning difficulties are often associated with lack of stability and security, not necessarily learning disabilities or lack of intelligence.
- *Accentuate success:* Help the teacher encourage the child's success in areas of competence, for example, giving the child responsibility for feeding a classroom pet or handing out supplies can provide positive attention and boost self-esteem.
- *Provide resources:* Share books, websites, and other resources to help the teacher learn about attachment and related issues. Make sure the child receives the understanding, support, and services required for success.
- *Be respectful:* Teachers and other school personnel may feel challenged by a highly involved parent. Be respectful of the teacher's position, responsibilities, and other children in the class with special needs. Help the teacher see you as a resource who offers to help.
- *Know your role:* Leave the teaching and learning assignments to the teacher and child. Provide a regular place and time for homework, and offer assistance when requested. The consequence for school-related

problems (e.g., misbehavior in class, incomplete assignments) should be dealt with at school.

Motivation

Parents spend a great deal of time trying to motivate their children. They cannot motivate their children directly, but can create an emotional environment in which children will become self-motivated. Children with positive mindsets and attitudes are motivated and resilient; they deal constructively with challenges and accomplish goals. Wounded children have a negative sense of self; they view themselves as damaged, inadequate, and powerless. A child who sees him or herself as a failure will find a way to fail. Thus, the first step to increasing motivation is to help the child develop a more positive and hopeful self-image. The self-image is changed for better or worse through experiences. The best way to help a child to change a belief acquired through a life experience is to provide an alternative life experience. Children cannot be taught about love, empathy, and compassion; they must experience it. They can only become what they experience. They require relationships that promote self-worth and dignity, which enables them to reevaluate their beliefs and see themselves in a new light. Children who view themselves positively are motivated to succeed.

The second ingredient to help children develop motivation involves parents' attitudes and practices. A parent's job is to prepare their child for the real world. However, some parents enable, rescue, and over-protect their children. For various reasons—feeling sorry for their child, avoiding conflict, meeting their own needs—they do not want their child to experience pain, frustration, distress, or disappointment. This prevents the child from learning to cope, handle life's struggles, and develop inner strength. They grow up in a bubble of over-protection and feel lost and helpless in the real world, resulting in little belief in their abilities and in lack of motivation.

Parents must provide love, limits, and allow children to learn from consequences. Children only develop true self-esteem and self-motivation when they learn the skills associated with fulfillment and success—perseverance, resilience, sense of meaning and purpose, responsibility, accountability, and the give and take of meaningful relationships.

Media

In 2005 the American Psychological Association released a resolution on videogame violence linking violent videogames with aggressive behavior, thoughts, and affect, and decreased prosocial behavior (APA 2005). Since that statement, some researchers suggested the APA's position is not valid

and there is not sufficient scientific evidence to prove the link between video games and violence.

Common sense and anecdotal evidence indicate that children who are stable, have prosocial values and morality, and have loving and trusting family relationships, are generally not at risk of violence due to playing videogames. However, children with histories of interpersonal trauma and who display symptoms of anger, aggression, and antisocial behavior are at increased risk of violence after playing violent video games. These children often displace their anger on others (e.g., parents, sibling, peers), are biochemically and emotionally dysregulated, and perceive others to be threatening, even when they are not. The violent and revenge-seeking elements of some video games and media can provoke aggression, anger, and destructive behavior in children and adolescents who display serious psychosocial problems.

The American Academy of Pediatrics Council on Communiaction Media (2010) set guidelines suggesting children under 2 years old should not spend any time in front of screens (i.e., TV, computers, video games). This is the time when parents and caregivers should be interacting, playing, and talking with their children. Talking to a child is the most important vehicle for language development. Interacting with young children with warmth, empathy, and support leads to secure attachment.

Research has shown there are four main effects of viewing media violence: *aggression*, *desensitization*, *fear*, and *negative messages*. The average American child spends three to five hours per day watching TV. Children's TV shows contain about 25 violent acts per hour. The average child sees 8000 murders by the end of elementary school and 200,000 acts of violence by age 18. More than 60 percent of TV programs contain violence. Preschoolers who watch violent cartoons are more likely to hit playmates and disobey teachers than children who view nonviolent shows. Children between the ages of 6 and 9 who watch a lot of media violence are more aggressive as teens and adults, including spouse abuse and criminal offenses (Murray 2000).

Children who witness considerable media violence can become desensitized—less shocked, less sensitive to the pain and suffering of others, and less likely to show empathy for victims of violence. Many of the popular video games can desensitize youngsters to violence. These violent video games are similar to modern military training techniques that desensitize soldiers to killing.

Fear is another result of media violence. Children can be made anxious by the violence they see on TV and in movies. Studies have found when children, ages 8 to 13, view media violence, the part of the brain activated (right posterior cingulate) is an area used for long-term memory of traumatic events. Just as in nightmares and flashbacks common in PTSD, these violent

and fearful memories keep returning to guide or disrupt current behavior (Murray 2000).

Media violence gives children the message that aggression and violence are acceptable solutions to conflicts. In many homes, especially at-risk families, children identify with TV, movie, and video game characters, and look to them as heroes and role models. The message is that violence is painless and a desirable problem-solving tool. Again, the negative effects of media violence are multiplied for children with traumatic backgrounds. Their anger, fear, and lack of self-control are easily triggered.

Telling children stories has been part of our heritage since time immemorial. The story causes the child to create mental pictures to correspond with the spoken words. This internal imaging stimulates the child's brain, and is the foundation for the development of *symbolic* thought (how we picture things) and *metaphoric* thought (transforming meaning from one object to another). Media presents both a verbal and a visual image at the same time. The child is deprived of the self-generated imaging required by his or her developing brain. Without adequate stimulation, the brain does not make new connections (neural fields). Media does not challenge the brain; it pacifies the brain and impedes the development of imagination. The following are tips for parents regarding children and media:

- *Monitor viewing:* Limit the amount of time children watch TV or other media, and limit the type of exposure.
- *Set Location:* TVs and computers should be in an area of the house in which parents can monitor and supervise; not in bedrooms.
- *Encourage reading:* Children watch less TV when they read more, and are more likely to watch educational programs.
- *Provide guidance:* Parents watch programs with children to foster communication, and reinforce positive messages while buffering negative messages.
- *Set age limits:* Do not allow children under age 2 to watch TV, as it may hamper language development and social interaction.

Sibling Conflicts

Sibling fighting is a common cause of parental annoyance and frustration. Many parents believe it is their duty to settle disagreements and protect the innocent. Other parents believe it is best to stay out of sibling conflicts. The key is to know *when* to intervene and *when not to*. Children need coaching in how to resolve conflicts in a healthy way. It is part of the job of a healing parent to model and teach children communication and problem-solving skills.

However, it is not helpful to continually settle disagreements for children. Intervening might stop fighting temporarily, but it doesn't teach siblings how to resolve conflicts themselves. Give them the support, guidance, and skills, and the opportunity to implement those skills.

It is also important to recognize that sibling conflict is often for the benefit of the parent, to gain attention and/or maintain power and emotional distance. Parental intervention can also reinforce the roles of "good/bad child" in the family, keeping children stuck in these roles and the corresponding behaviors.

There are times where a parent must intervene to keep a child safe. If a child is abusive and harming a sibling, that child should lose the privilege of playing with other siblings until he or she can act appropriately. There are a small percentage of disturbed children who are a true safety risk for other children. These children may need more structure than a family can reasonably provide and might need a more restrictive environment.

Therapy

Parents routinely tell us they have endured years of therapy for their children with limited results. They also share their confusion and frustration in being given different types of, and often contradictory, parenting advice. The first step is to get a proper assessment. Assessments should only be done by knowledgeable and skilled mental health professionals who can determine the proper diagnosis and who understand child development, family systems issues, and the effects of interpersonal trauma. Assessments should include the following perspectives:

- *Ecological:* An understanding of the family and social systems that influence children.
- *Comprehensive:* Focuses on diverse aspects of the child's and family's functioning. Includes emotional, mental, social, physical, and moral behavior as well as strengths, coping abilities, and the desire for growth inherent in most children.
- *Eclectic:* Involves a variety of methods and settings. Children's behavior often varies in different contexts, and it is necessary to understand their behavior under different conditions (i.e., home, school, day care, and friends).
- *Culturally sensitive:* Careful not to apply their own beliefs and traditions to families from different cultural backgrounds. Behavior considered normal in one culture may be labeled as abnormal in a different culture or society.

- *Developmentally sensitive:* Understands and evaluates behavior in the context of normal childhood development. The developmental stage of the child during trauma will influence psychosocial aftereffects.

It is important to choose a qualified mental health professional who parents and child are comfortable with. The following are treatment recommendations:

- *Systems model:* Therapy should involve the child, parent/caregivers, and other family members. The focus should never be on the child alone and always include family and external influences (e.g., social services, school, and community resources).
- *Didactic and experiential:* Therapy should be both educational and experience-based. Positive change occurs as a result of information, skills, and participation in growth-enhancing activities.
- *Reputable and respected:* Treatment techniques and parenting approaches should be safe, ethical, and based on solid theory and research. Treatment and parenting methods should never involve physical or psychological coercion, domination, or control.
- *Secure base:* Treatment that focuses on facilitating secure attachments should include secure-base behavior by therapists and parents: emotionally available, sensitive and responsive to needs, supportive, appropriate limits and boundaries, and genuinely helpful. Treatment should focus on improving a child's *internal working model* (core beliefs), not merely modifying behavior.
- *Skill building:* Children need to learn impulse-control, anger-management, problem-solving, and communication skills. Parents must learn the skills associated with being a healing parent: self-awareness; understanding their child's core beliefs; being proactive, not reactive; engaging positively; staying calm; down-regulating their child; communicating for attachment; and constructive coparenting.
- *Positive psychology:* Identify the strengths, talents, and positive attributes of the child and family, not only focusing on "what's wrong." Build on the positive.

13

Foster Care, Adoption, and the Child Welfare System

Attachment disorder permeates the social service, mental health, and child welfare system in the United States. This chapter will examine the problems and challenges inherent in foster care, adoption, and substitute child care, and provide possible solutions. Early intervention, education, and prevention programs, which have successfully enhanced healthy family attachment and child development, will be described.

Foster Care System

Approximately 500,000 children are in foster care in the United States. Virtually all of these children have been abused and/or neglected. Children entering foster care have an abundance of risk factors and an absence of protective factors: abuse and neglect; poverty; lack of prenatal care; prenatal drug and alcohol exposure; teenage pregnancy and birth; family history of mental illness, substance abuse, and criminality; violent homes and neighborhoods; and anxious and disorganized attachments with caregivers. These traumatic experiences are confounded by multiple losses—separations from biological parents, siblings, communities, and cultural ties (U.S. Department of Health and Human Services 2011).

Young children who experience maltreatment and interpersonal trauma have numerous problems; 80 percent have emotional, developmental, and behavior disorders. During the first years of life the brain undergoes the most significant development. Maltreatment can damage the architecture of the developing brain, resulting in psychological difficulties, cognitive delays, poor self-regulation, and problems paying attention. These children have a high incidence of depression, PTSD, anxiety, and dissociation. As they get older, maltreated children placed in foster care are more likely to exhibit antisocial

behavior and aggression, use alcohol and drugs, and become involved in the juvenile justice system, compared with their peers. There are lifetime consequences of early trauma. Researchers have found that many of the most life-threatening health conditions, including heart disease, immune system disorders, obesity, and substance abuse, are related to childhood trauma (Pynoos *et al.* 2008).

Child welfare agencies receive about six million referrals per year regarding child maltreatment, with over 700,000 substantiated. There are multiple family and environmental factors associated with maltreatment and interpersonal trauma. Family factors include parents' history of abuse, substance abuse, mental health problems, and negative parenting behaviors. Maltreatment is more likely to occur in single-parent families, and the younger the parent is. Environmental factors include socioeconomic status, social support network, and work history. Families living below the poverty line are 25 times more likely to experience child maltreatment. Parents who are cyclically employed versus consistently employed, and who lack a positive support network, are also at higher risk (McWey *et al.* 2013).

A prime predictor of child abuse and neglect is the parents' own childhood histories of maltreatment. There is an intergenerational pattern of maltreatment and compromised attachment. While not all abused children grow up to abuse their own children, many parents who are reported for child abuse were abused themselves. For example, a maternal history of abuse accounts for 30 to 50 percent of the risk for such maltreatment (McWey *et al.* 2013). Thus, multiple generations in the same families are involved in the foster care system.

Historical Overview

Prior to 1800, children rarely were involved in public care. In the 19th century, the development of public concern and policy for dependent, abused, and neglected children came almost exclusively from private, secular agencies like Societies for the Prevention of Cruelty to Children. These organizations were the leaders in protecting children, advocating for better legislation and public sector support for safeguarding children's interests. Only one state, Indiana, had a governmental body to overlook child welfare. The community's responsibility for abandoned and unwanted babies led to the creation of foundling hospitals in the early 19th century, and the practice of institutionalizing children (Schene 1996).

In 1920, the Child Welfare League of America was founded. The CWLA helped to standardize national child welfare programs that stressed temporary rather than permanent institutional care for dependent children, and attempted to preserve the natural family whenever possible. By the

1930s, the private humane societies' functions of child protection were being taken over by public organizations. The Social Security Act of 1935 marked the first federal government attempt to fund child welfare services. Title IV-A, later Aid to Families with Dependent Children (AFDC), addressed the financial needs of children deprived of parental support. Title IV-B (Child Welfare Services) encouraged the expansion of services to vulnerable children by providing states with formula grants. Funds were available through IV-B to pay for foster care, but not to provide supportive services to biological families.

In the 1930s and 1940s, the development of social casework methodologies led to a change in child protection from a law enforcement, punitive model, to an emphasis on an aggressive social service rehabilitative model. In the 1960s and early 1970s there was a significant increase in federal funding for state social service programs. Child abuse emerged as an issue of major importance. Reporting laws were passed in all states mandating professionals to identify children who needed protection.

The Child Abuse Prevention and Treatment Act, passed in 1974, provided funds to assist in developing programs and services for abused and neglected children and families. The Adoption Assistance and Child Welfare Act of 1980 was the federal government's first attempt to develop and implement a national policy regarding child welfare. A major goal of this policy was to maintain and reunite children with their families (family preservation) and to reduce the large number of children who were drifting permanently in the foster care system (Schene 1996). This legislation initiated federal adoption assistance, which spurred the effort to find homes for children with "special needs" by offering monthly subsidies to families who would adopt. The term "special needs" was introduced as social service agencies began to increase their efforts to find homes for hard-to-adopt children. This group included children who had varying racial backgrounds, were older, in multisibling situations, and were physical and/or mentally disabled. Prior to the 1970s most adoptions were with healthy same-race infants. Today, approximately 90 percent of children adopted from agencies are "special needs."

Most social service and mental health programs did not realistically anticipate special needs problems and were not adequately prepared to respond. Adoption agencies and social services had little experience or training to enable them to deal with the problems confronting this new wave of adoptees and their families. The system became severely taxed in its ability to meet the needs of children in placement. In 1989, the Select Committee on Children, Youth and Families of the U.S. House of Representatives issued a report entitled *No Place to Call Home: Discarded Children in America*. The report exposed the nation's failure to provide for children and families in

crisis, and documented a dramatic deterioration in the foster care, juvenile justice, and mental health systems during the 1980s. The report concluded that there was a massive failure at all levels of government to enforce the laws that provide children with services and protection: "As a result, children bounce from one system to another, and fail to receive the counseling and safeguards necessary to enable them to find permanent families and essential services" (U.S. Select Committee on C.Y.F. 1989, p.3). The report also found the child welfare service system to be totally overwhelmed; an estimated 70 to 80 percent of emotionally disturbed children received inappropriate mental health services or no services at all. Excessive caseloads contributed to overburdening the system's ability to provide minimal care and appropriate services.

A study by the Casey Foundation found that the quality of foster care deteriorated as a result of several factors: a national preoccupation with child abuse and neglect, cutbacks in federal funds, federal legislation that denigrated foster care, and the belief that the needs of troubled families were best met with a minimum of government intervention (Kamerman and Kahn 1989). The goal of the Federal Adoption Assistance and Child Welfare Act of 1980 was to preserve families. However, political agendas and subsequent funding cutbacks left the social service system unable to provide services to address serious family problems, such as increased drug abuse, homelessness, poverty, violence, teenage pregnancy, and AIDS. The goals of child protective services was to remove children from dangerous and maltreating homes and place them in alternative environments, such as foster homes. Again, foster parents lacked adequate emotional support, economic support, and specialized training to enable them to handle these damaged children.

In November 1997, President Clinton signed into law the most significant overhaul of the nation's foster care system in 17 years—the Adoption and Safe Families Act. This legislation is designed to improve the safety of children, to promote adoption and other permanent homes, and to support families. It includes an adoption incentive plan where states are paid bonuses for each foster child adopted and for each special needs adoption. The law also requires states to document reasonable efforts to place a child for adoption (including kinship care), and provides health care coverage to all special needs children who receive adoption assistance. States continue to be required to make reasonable efforts to reunify families; however, the child's health and safety is the paramount concern. It is a well-meaning and worthy goal to place children in permanent adoptive homes. This goal, however, will only lead to more frustration and failure without appropriate preplacement assessment of children and families and effective treatment for children with attachment disorder. Adoptive families must be prepared

to effectively respond to the special needs of these angry and mistrustful children. Additionally, postplacement treatment and support reduces the likelihood of disruption.

Siblings in Foster Care

There are approximately 500,000 children who are currently in foster care in the United States. Between 65 and 85 percent of these children have at least one sibling and 30 percent have four or more siblings. Seventy-five percent of sibling groups are separated after they enter the foster care system (Phillips 1998). In theory, siblings are supposed to be placed together; however, this is the exception rather than the rule. The reasons for separating sibling groups in foster care are numerous, but the most common reasons are logistical. Foster homes tend to fill their placement quotas with children from several different homes and lack sufficient space when a sibling group needs placement (Lawrence and Lankford 1997). Siblings are also separated because it is difficult to find families willing to accept a sibling group.

Relationships with siblings over a lifetime are usually our most enduring. The intensity of the sibling bond is enhanced by several factors: accessibility of siblings to one another, lack of parental protection and need fulfillment, and the ongoing search for personal identity. Children who enter the foster care system rely heavily on sibling attachments due to inadequate parental attachments. The presence of a sibling relationship minimizes the trauma of parental separation and loss. When siblings are separated through foster care and adoption, they experience further trauma (Schouler 1997).

There are situations, however, when the separation of sibling groups is warranted. Quite often members of a sibling group are suffering from severe attachment disorder. If one sibling has attachment disorder, it is likely that other siblings have varying degrees of this problem. Taking on the special needs of such a sibling group can be overwhelming for one foster family. This can place the family at risk of disruption and jeopardize the well-being of other children in the home. Another legitimate reason for separating siblings occurs when one has victimized another (physical or sexual abuse). Even the most diligent foster parent cannot watch the siblings 24 hours a day. The abused sibling(s) are at risk of further victimization. Making the decision to separate siblings is never easy for courts and social service agencies. A comprehensive attachment disorder assessment is often helpful in determining placement appropriateness for sibling groups.

ABC Intervention

A successful program for foster children and foster parents is the Attachment and Biobehavioral Catch-Up (ABC) Intervention. This program helps foster parents overcome their own emotional issues that diminish their abilities to nurture children, and to create an environment that promotes positive attachment and biobehavioral regulation. ABC is a ten-session program that targets four critical issues. First, parents are taught to provide nurturance even when children are avoidant or resistant. Young children who have experienced interpersonal trauma often push parents' care and support away. Second, parents learn to "override" their own issues, so that they can respond with support and nurturance. Third, parents are taught to pay close attention to children's signals and needs, and respond in calm and empathic ways. Children with histories of trauma are extremely susceptible to frightening behavior. Finally, parents are coached on how to enhance children's self-regulation abilities. Traumatized children often are behaviorally and biologically dysregulated. Research has shown that the ABC intervention helps children develop secure attachments, improved behavioral and biological regulation, and fewer problematic behaviors, compared to children in a control intervention (Dozier, Lindhiem, and Ackerman 2005).

Recommendations

Family Preservation

The goal of keeping families together failed because the child welfare and mental health systems could not keep pace with the vast increases in drug abuse, poverty, violence, and resulting child maltreatment. The "myth of family preservation" (Pelton 1997) suggests that there have actually been two child welfare systems operating—one oriented toward preserving families, and the other toward removing children from maltreating homes. The reality is, it is impossible to keep families together when children are at risk of abuse and neglect. Removing a child from a dangerous environment, placing him or her in temporary foster care, then returning that child to abusive parents is not family preservation—it is insanity!

Early intervention and prevention programs that focus on training and supporting high-risk parents and encouraging secure parent–child attachment in the first three years of life offer the best hope for family preservation. Programs that identify high-risk families and provide education, support, and appropriate treatment before and during pregnancy, and during the crucial early developmental stages of infancy and toddlerhood, have been successful in preventing family disruption, establishing secure attachments, and improving psychosocial functioning of children as they develop.

Place Early—Don't Move

Children in the foster care system who are subjected to multiple placements are deprived of stability, continuity of caregivers, and the opportunity for developing secure attachments. Children who are placed at any early age, and remain in that family for at least ten years, have the lowest rates of behavioral problems, delinquency, adult violence, and criminality (Widom 1991). Children not adopted out of the system benefit from establishing long-term secure attachments with foster parents.

Early Assessment and Intervention

There are increasing numbers of children who enter the foster care system with severe behavioral and emotional problems. These antisocial children lack conscience and morality, lie and steal, defy and mistrust authority, and are hostile, aggressive, and controlling. In short, they have severe attachment disorder. Research shows that these are the children who experience frequent placement moves, because they are dangerous and disruptive in foster homes (Widom 1991). It is imperative to accurately diagnose attachment disorder prior to placement in order to 1) provide the appropriate therapeutic foster care placement; and 2) provide proper corrective attachment therapy and parenting.

Training and Support of Foster Parents

Children with severe attachment disorder must be placed with therapeutic foster parents who receive ongoing training and support. Specialized foster parents must be skilled in CAP and serve as a member of a unified treatment team. Support must be ongoing, including emotional support from placing agencies, appropriate financial reimbursement, and available and appropriate respite. It is a well-known fact that foster parents do not receive adequate recognition or reimbursement. In many states, foster parents do not receive sufficient compensation to cover the cost of caring for a child (Vick 1997). Foster parents—the true heroes of child welfare—are commonly angry and frustrated due to lack of agency and community support, understanding, and recognition. They are charged with the responsibility of maintaining disturbed children in their homes 24 hours a day, seven days a week, yet the child welfare system has not been responsible in assisting them in this task.

Kinship Care

Fifty percent of foster care placements in larger states are now through kinship care—placing children with grandparents, aunts and uncles, cousins, or other extended family. Siblings are more likely to be placed together

through kinship care than within traditional foster homes. Relatives are more likely to make a commitment to a sibling group, and the children are better able to maintain a sense of identity, connection, and continuity. Since attachment disorder and its causes (maltreatment, poverty, violence, drug abuse) are intergenerationally transmitted, it is crucial that extended kin are evaluated regarding their ability to care for the children being placed.

Adoption: Children and Families

Although many children with attachment disorder are adopted, not all adopted children have severe attachment problems. Many infants, if adopted early, will develop secure attachments to their adopted parents and live healthy, productive lives (Schaffer and Lindstrom 1989). The key factors in regard to severity of attachment disorder are the child's age at adoption, the number of prior moves, and abuse and neglect in the first two years of life. These factors seriously affect children's ability to form close relationships throughout their lives. Unfortunately, a high number of adoptive children fall into the attachment disorder category, and are coming to the attention of the mental health, social service, and criminal justice systems.

Developmental research pertaining to the adjustment of adopted children indicates they are at greater risk of developing emotional, social, behavioral, and/or academic problems than nonadopted children (Borgatta and Fanshel 1965; Kenny, Baldwin, and Mackie 1967; Bohman and Sigvardsson 1980, 1985; Brodzinsky *et al.* 1984; Lindholm and Touliatos 1980; all references cited in Brodzinsky and Schechter 1990). Adopted children, who comprise only 2 percent of children under 18 in the United States, represent approximately one-third of children who are placed in residential treatment and adolescent psychiatric centers. Adopted children are referred for psychological treatment two to five times more frequently than their nonadopted peers; they are twice as likely to display psychosocial problems in childhood or later life, and are two to three times more likely to display psychopathic conduct disorder behaviors (Jones 1997). Attention deficit disorder is ten times higher among adoptees. An inordinate number of adoptees are sexually promiscuous and become pregnant or impregnate someone in adolescence. They have a higher incidence of running away and have more difficulties in school, both academically and socially, than nonadopted children. Adopted children are involved in disproportionate numbers in the criminal justice system (Verrier 1994).

Adoption may trigger issues of abandonment. There are two quite opposite responses to being abandoned as a child. One way adoptees deal with their abandonment fears is to provoke rejection by others ("I'll reject

you before you reject me"). They accomplish this by provocation, aggression, and other antisocial behaviors. The other coping strategy is to be acquiescent, compliant, and withdrawn ("If I please you and stay out of your way, you won't leave me"). Regardless of which approach is used, most children who have been abandoned have issues in one or more of the following areas: separation and loss, trust, rejection, guilt, shame, intimacy, identity, loyalty, power, and control.

Although, as previously stated, many infants adopted early do establish secure attachments, it is not uncommon for children adopted at birth or soon after to display attachment difficulties. Recent advances in prenatal psychology have provided insight into why this is so. The fetus and mother shared a nine-month experience where they were biologically and emotionally bonded. For example, the womb is a sound chamber where the fetus is never beyond the range of mother's voice or heartbeat. A newborn will recognize and respond to the mother's voice, face, and biorhythms (Stern 1985). Neonates can also recognize the mother's smell: sweat, urine, breath, saliva, and breastmilk all contain scent-communicating chemicals (Furlow 1996). At birth, the newborn "knows" who his or her mother is and is not.

A child's primary connection is the lifeline to his or her biological family, no matter how insufficient or limiting it is. Even children with strong, enduring attachments with adoptive parents have this lifeline to biological parents. The best adoptive parents cannot replace what the child yearns for. This longing is always there, either on the surface or unconsciously. Until they are able to come to terms with deep unresolved feelings toward their birth family, children may continue to experience both profound grief over their loss and rage directed toward a world that hurt them (Jernberg 1990).

An Adoption Saga

Genuinely warm and caring parents adopt children and bring them into their homes with the intention of offering a stable, loving environment and a commitment to making them a part of the family. They have a vision of bestowing on the child all the love required, and believe they will be loved and appreciated in return. However, it does not take long before some children are showing their skills and imagination in maintaining chaos in the family. No parenting methods seem to work and punishment only seems to make the child worse. After vacillating between techniques, and experiencing confusion, anger, and despair, some parents finally give up (Orlans 1993).

An adoptive parent writes:

> We've tried point systems, rewards for good behavior, and taking privileges away. I have never been successful making time out work. Our family has

> been torn apart by him. We have a hard time finding babysitters who can handle him, so we don't go anywhere anymore. We feel totally helpless and hopeless. We are tired of all this craziness and manipulation. We just feel terribly frustrated, angry, and want to give up. We want to believe that somewhere out there is a way to break the stranglehold on him and offer our whole family the bright future that could be.

The desperate family begins to seek help, but counselors unfamiliar with attachment issues offer few solutions. They are told by therapists and social workers that "all the child needs is love and a stable home." Little do these professionals realize that these children have no foundation upon which to understand or accept love. The parents have exhausted every resource only to receive frustration, placation, and even condemnation for their efforts. Uneducated friends and extended family also add to the adoptive parents' frustration.

Another adoptive parent writes:

> As far as others are concerned, Sarah is a perfectly normal … even "sweet" little girl. When we attempt to correct her in front of my family, they make excuses for her: "Oh, that's just little girls," or "It's the age," or "I don't' mind, she's so cute," or "Don't be so hard on her."

A vicious cycle soon develops where, due to extreme exasperation, the parents (particularly the mother) appear increasingly angry and frustrated. The child is an expert at appearing charming and engaging to others, and the problem is assumed to be due to rejection and hostility from the adoptive parents. Unwitting professionals see this anger and frustration as reaffirming of their assumptions that the parents need to "lighten up" and be more loving. This total lack of understanding serves to further alienate the family and to increase their isolation, resentment, and hostility. Many mental health professionals are still under the false presumption that a loving adoptive home is a cure for children who have been abused and neglected and who have attachment disorder. We have learned, however, that abuse most often has lingering effects that love alone is incapable of curing. The child with severe attachment disorder who comes into an adoptive home is unable to respond positively to stability or love. He or she is bent on maintaining chaos, perpetuating hostility, and avoiding closeness.

International Adoption

Since 1971, over 450,000 international children have been adopted by United States citizens. Although many show significant improvements, a considerable number of these children are at risk of various health, emotional, behavioral,

social, and learning difficulties. Many of these children experienced early interpersonal trauma, in addition to being institutionalized, and display impairment in attachment, self-regulation, neurobiology, self-identity, interpersonal relationships, cognitive functioning, and morality.

Children were initially adopted from foreign countries following World War II and the Korean War. During the 1990s, Russia, China, and Romania were the top countries from which children were adopted into the United States. Over the last decade, children have been adopted from Guatemala, Kazakhstan, and Ethiopia, in addition to Russia and China. The most recent statistics available (2012) indicate the top five countries for adoption into the United States: China, 2697; Ethiopia, 1568; Russia, 748; Korea, 627; and Ukraine, 395 (U.S. Department of State 2013).

International adoption has grown in popularity in the United States; more than 216,000 children were adopted from abroad from 1998 to 2008. Parents often prefer international adoption to avoid the possible legal and custody-related problems associated with adoption from the United States. However, as discussed, institutional care (i.e., orphanages) commonly has severe negative effects on children's psychological, social, physical, and cognitive development. Maltreatment, lack of stimulation and social interaction, limited medical care, drug and alcohol exposure pre- and postnatally, and multiple losses and caregivers have been traumatic for children.

Studies have shown that later-placed children suffer more problems than those placed earlier, and that a combination of late placement and early adversity is particularly damaging (Gunnar *et al.* 2007). A study of children comparing a cohort adopted from Romania into the United Kingdom with a cohort adopted within the United Kingdom found that over one-third of children placed after 6 months of age received mental health services when older (between the ages of 6 and 11), whereas the rate for children placed earlier was only 11 to 15 percent (Castle *et al.* 2006). It is clearly in the best interest of children and adoptive families for children to be removed from institutions and adopted at the earliest possible age.

Adoptive parents in our treatment program often express significant frustration regarding their lack of knowledge about the type and severity of their children's problems prior to adoption. They were not intellectually or emotionally prepared to cope with their child's attachment, emotional, and behavioral problems. A proactive approach should be taken. Prospective adoptive parents should be made aware of the issues and challenges they may confront with their children, and mental health and educational services should be available to help parents and children cope successfully with these problems.

Transracial Adoption

Approximately 50,000 children per year are legally free for adoption in the United States, and more than one-half are children of ethnic and/or cultural minorities, primarily African American (Child Welfare League of America 1993). Nationally, these children constitute more than 60 percent of the 500,000 children in foster care, which is twice their representation in the total United States child population (47% African American compared to 15% of the U.S. child population). The number of European American children entering foster care each year is greater than the number of African American children. Yet, African Americans make up a disproportionate and increasing number of children who remain in the system (Adoptive Families 1997a). African American and interracial families adopt at a higher rate than any other group in our population. Generally, agencies try to place African American children with African American families. However, due to the high numbers of African American children in need of homes, the minority community has been stretched to its limits. If they are not to grow up in institutions or the foster care system, many of these children have to be adopted by European American families (Schaffer and Lindstrom 1989).

An institutional belief persists that the emotional and developmental needs of minority children can only be met by adoption into families of the same race and culture. To date, there is no scientific evidence suggesting that African American children raised in European American or interracial homes are poorly adjusted and/or isolated from the African American community (Vroegh 1997). More than 20 years of transracial adoption (TRA) research has confirmed that it is better for African American children to be placed with European American families than to remain without permanent homes (Silverman 1993). In one long-term study of 300 Midwestern families in which European American parents had adopted African American children, it was found that these children developed into teenagers and adults who fared well personally and in their families. They had little problem with racial identification and did not develop more psychosocial problems than other adoptees (Simon and Alstein 1992). Another longitudinal study, begun in 1969, compared African American children adopted transracially and within race. No differences were found among adoptees regarding general adjustment, self-esteem, racial self-identity, and family relationships (Shireman and Johnson 1986). Opponents of transracial adoption suggest that it undermines a child's sense of racial identity and leads to a form of racial and cultural genocide (National Association of Black Social Workers 1994).

Although secure attachment patterns develop and are maintained in transracially adopted families, raising a child from another culture or race requires knowledge and sensitivity. Parents must be aware that the child has

a right and a need to know who he or she is, culturally and racially, as well as confirming the child's identity as a family member. Parents also need to be conscious about the prejudicial reactions of others toward the child and family (Schaffer and Lindstrom 1989). Vroegh (1997, p.568) writes, "The ideology of transracial adoption opponents appears to lie in an adult political agenda of separatism rather than in a humanist agenda of fulfilling children's best interests." Secure attachment in the family, including trust, intimacy, and morality, appears to be more important for the healthy psychosocial development of children than racial and cultural differences.

Courtney (1997, p.765) writes, "A consideration of available evidence suggests that TRA does not have the potential at any time in the near future to move a significant proportion of African American children from out-of-home care." He cites considerable evidence to suggest that the major reasons for out-of-home placements (poverty, substance abuse, child maltreatment) are prevalent among African American families, which results in these children being placed in the category of "special needs." A child's race, even more than physical or emotional disability, influences the preferences of potential adopters. Consequently, Courtney suggests, minority children have an extremely low chance of adoption, transracially or otherwise. "Nothing short of a massive effort to improve the condition of impoverished families is likely to significantly stem the tide of children being placed in out-of-home care" (Courtney 1997, p.768).

Adoption and Attachment

It is estimated that adoption affects the lives of 40 million Americans. In many cases, particularly with infant adoptions, the child and family fare well. There are, however, many other adoptive children and families who struggle with severe emotional and relationship problems, sometimes leading to relinquishment, and the child being placed back into "the system." Many of these adoptive children are classified as "special needs" due to age (over 5 in the foster care system); ethnic and cultural background; members of a sibling group who must stay together; infants born drug exposed, HIV positive, or with fetal alcohol syndrome; or otherwise physically and/or psychologically challenged. Currently, there are more than half a million such children waiting to be placed in homes. More than half the children in the adoption/foster care system are considered high risk because of prenatal vulnerabilities, problems resulting from early maltreatment, multiple out-of-home placements, and compromised attachment.

Children who have experienced insufficient, disrupted, or pathological attachment relationship in their early years are high risk for disruption. These are the children and parents who are in need of specialized services in

order to prevent disruption. Adoptive families who receive ongoing support and effective therapeutic services are more stable and better able to manage stress and adversity than those who do not. The following factors increase the probability of successful adoption:

- *Place early:* Infants do best adjusting to adoptive homes.
- *Minimize moves:* Frequent moves and foster placements are traumatizing.
- *Plan for permanency:* Developed at the time child enters the child welfare system.
- *Preplacement services:* To assess, educate, and support parents and child, and ease the transition.
- *Fit:* Attempt to match temperaments between child and parents.
- *Full disclosure:* Child's history, including realistic appraisal of risks.
- *Postplacement services:* Support and intervention prior to crises.
- *Ongoing help:* Education support, and therapeutic services for family, lasting through adolescence (McKelvey and Stevens 1994).

There is a variety of issues that are salient to adoptive children, parents, and families. These issues, discussed below, are even more dramatic when applied to children with various attachment disorders prior to adoption.

Separation and Loss

The adoptive family is a system built upon "necessary losses." Experiences of separation and loss are fundamental to all members of the adoption triad. The child has lost his or her original bond with the birth mother and early attachment to birth parents or other caregivers (e.g., grandparents, foster parents). Despite neglectful or abusive care, there is still a sense of loss when the child is separated from his or her birth parents. There is often a loss of self-worth and self-identity for the child, who wonders "Why did they give me up?" Separation from siblings, extended kin, friends, and teachers is also common. Birth parents have lost a biological child, and experience feelings of inadequacy, failure, damaged self-esteem, and a sense of loss of control over their lives. Many birth parents suffer unresolved losses stemming from their early years, which has both contributed to and exacerbated current losses. Adoptive parents struggle with a variety of losses. Many have dealt with the pain of infertility for years: feeling of inadequacy, strain on the marriage, lack of understanding and support from extended family, lost fantasy of a biological child. Despite popular belief, adoption does not "fix" the pain of

infertility, and feelings of loss often continue for years. Adoptive parents also have feelings of loss associated with miscarriage, death, sense of inadequacy, lack of control over their own bodies and events, and the difference between the fantasy of the child they planned to adopt and the reality of the child who entered their home.

A child's reaction to separation and loss is determined by two major factors: the nature and quality of the attachment being disrupted, and the abruptness of the separation. The stronger the relationship, the more traumatic the loss. The more abrupt the transition, the more difficult it is to work through the loss. Fahlberg (1991) describes additional factors that influence a child's reaction to loss of an attachment figure:

- age and developmental stage
- attachment to birth parents/caregivers
- prior separation experiences
- child's perception and interpretation
- preparation for move
- parting and welcoming messages received
- child's temperament
- environment child is leaving and moving to.

Infants can feel the effects of separation and loss associated with a disruption of the maternal bond, inadequate early care, and multiple moves. It is between the ages of 6 months to 4 years, however, that the loss of attachment figures can cause the most emotional change. Loss at this stage of development often results in a lack of trust in caregivers, and problems with autonomy, identity formation, and social adjustment. Children commonly react to loss with regression of recently acquired skills. The toddler, for example, may display regressive eating, sleeping, or elimination behaviors. Important developmental tasks may not be accomplished when the child is preoccupied with feelings of loss. The child with multiple moves, for instance, may show little reaction to another separation, as a defense against emotional pain. This child will lag behind developmentally, be less likely to form subsequent attachments, and is more likely to act out in ways that lead to additional moves. Studies show that children with attachment disorder have numerous moves in the foster care system (Widom 1991).

The Grief Process

Grief is a natural and necessary reaction to the loss of an attachment figure. Children who have experienced early attachment failures and disruptions are struggling with, or stuck at some point in, the grieving process. As previously described, children typically go through three stages when they are separated from attachment figures: protest, despair, and detachment. The child who feels despair is preoccupied and depressed, but can still grieve for his or her unavailable caregiver. The detached child, however, has "shut down" emotionally and has not completed the grieving process. Children in this latter category are routinely placed in adoptive homes, but will not trust, relate positively, or develop a secure attachment.

The grieving process as a reaction to separation and loss has been described as a series of stages culminating in resolution (Kubler-Ross 1969; Jewett 1982):

- shock and numbing
- alarm reaction ("fight, flight, or freeze")
- denial
- intense emotions (anger, sadness, guilt, shame, fear)
- yearning and bargaining
- despair and disorganization
- reorganization and resolution.

Children with attachment disorder are grieving losses, or defending against those losses and the accompanying emotional pain. It is important that child welfare and mental health professionals, as well as adoptive parents, understand the nature and depth of their grief. Children who are withdrawn, emotionally detached, and unwilling to connect with caregivers may be demonstrating a reaction to loss and grief, rather than symptoms of severe disturbance. Adoptive parents must be taught to be proactive, not reactive, i.e., not withdraw from the reticent child, but rather, provide support, patience, empathy, and appropriate structure. Adoptive parents or other family members who are unresolved in their own grief process will be limited in their ability to help the child through his or her own losses and grief. Honest and open communication is often helpful, creating an "empathic bridge" between parent and child.

Bonding and Attachment

Bonding is the physical and psychological connection between mother and infant that begins at conception, grows during pregnancy, intensifies at birth, and exists forever. All children are bonded to their biological mothers, regardless of what transpires after birth. *Attachment* is the enduring emotional connection between caregivers and child, characterized by the development of trust, security, and the desire for closeness, particularly when the child is under stress. In most cases, parents who adopt infants must provide a context in which attachment is learned. Parents who adopt toddlers or older children, especially with a history of separations and loss, must help them overcome attachment fears and disorders.

A child's adaptation to an adoptive home depends on the nature, quality, and patterns of prior attachments, as well as his or her reactions to separation and loss. The grief process affects subsequent attachment; *unresolved grief inhibits the development of future attachment*. Attachment disorder also results from prior family dynamics and traumatic experiences (abuse, neglect, domestic violence); vulnerabilities of the child (biological depression, fetal alcohol syndrome, fetal alcohol effects, temperament); and multiple out-of-home placements. These children are commonly placed with an adoptive family, but do not form positive or meaningful attachments to their new caregivers. They are fearful of trusting and loving, certain that it will only lead to pain once again, and hide these fears under angry, aggressive, and controlling behaviors. Confusion about loyalties also prevents attachment, as children struggle with relationships with birth, foster, and adoptive parents. Unresolved attachment issues of the adoptive parent can prevent the establishment of a family atmosphere conducive to healing and promoting attachment. These parents function in a reactive mode, rather than being proactive and utilizing effective parenting approaches with the angry, frightened, and mistrustful child. Parents must work through their own losses to help a child with loss.

In general, facilitating secure attachment with adoptive children involves the same three processes as with biological children: *attachment cycle*, *positive interaction cycle*, and *claiming*. In the attachment cycle, the caregiver gratifies the child's needs in a sensitive, appropriate, and consistent manner, resulting in a reduction of anxiety and discomfort, and feelings of security, safety, and trust. Parents initiate the positive interaction cycle, creating an ongoing, positive reciprocal relationship in which the child learns to respond favorably to feelings, messages, limits, and behaviors. Claiming helps the child feel "a part of" the family, a sense of belonging.

Intense Emotions

Children commonly are dealing with a variety of powerful and confusing feelings associated with loss, grief, and interpersonal trauma: anger (often rage), sadness, fear, helplessness, hopelessness, shame, and guilt. It is crucial that adoptive parents are given training and support so they can respond in helpful ways to this emotionally. Effective therapy can aid the child in managing and resolving emotional difficulties, as well as provide education and support to the parents. The child's pain cannot be avoided. Again, parents with unresolved emotional issues may be "triggered" by the negative emotionality of the child, which can result in destructive responses and negative ongoing relationship dynamics.

Belief Systems

Negative perceptions and interpretations (i.e., cognitive appraisals) of separation and loss have long-term harmful influences on the development and stability of children. The child may believe, "I was given away" (not wanted); "taken away" (angry at "the system"); or "it was my fault" (feels responsible). Young children employ magical thinking, a natural component of the egocentric stage of development and blame themselves for the losses. This leads to self-contempt, damages further self-worth and identity, and prevents the formation of future attachment ("I am not worth loving"). Preparing children for transitions can prevent damaging perceptions.

Loyalty Conflicts

As previously stated, every child has a bond with his or her birth mother. Children in foster or adoptive families must deal with several sets of parents (birth, legal, parenting). Caregivers must accept the place of birth parents in the child's emotional life. Children who have experienced abuse, neglect, and abandonment from birth parents need a way to "come to terms" with those important biological attachment figures. Children must be protected from adult conflicts and rivalries, whether these are legal battles (e.g., visitation, custody, termination of parental rights), or emotional battles. Adoptive parents often feel threatened by a child's desire to maintain ties with biological or prior foster parents. These ties, however, when appropriate and supervised, can enhance the child's sense of self, reduce internal emotional conflict, and allow more energy to be available for current family relationships.

Belonging

Feeling alienated, isolated, and disconnected, are common feelings for children in adoptive families. They lack a secure attachment to both prior

and current caregivers, and often act out to get attention. It is important that the child and family learn to feel they belong to one another ("claiming") and develop a family identity that includes the adoptive child. Parents are sometime impatient and need to realize that trust and attachment take time, particularly when the child has a history of painful loss and maltreatment.

Moves

Losses are psychologically traumatizing and interrupt the necessary tasks of child development. Abrupt, unplanned moves are most traumatic for children and adults alike. It is common, however, to move children through the foster care system; one study reported an average of between three and five moves for children in foster care in a five-year period (Widom 1991). It is easy to blame "the system" for these placement moves, but research shows that, in fact, it is usually the acting-out children with attachment disorder who are moved most. Approximately 75 percent of children in out-of-home placements are victims of abuse, neglect, or abandonment. The emotional and behavioral problems of these children result in more frequent placements, as foster parents are not able to tolerate the difficulties and disruptions on family life (Widom 1991). Again the best outcomes for children in the foster care system are associated with two factors: 1) place early (those placed under 1 year old did best); and 2) do not move (those who remained in one home did best).

When a child must be moved, the transition can be eased by appropriate preplacement planning and preparation. The child (and adults involved) needs understanding, support, and help learning to cope with the emotions associated with separation and loss. Additionally, children do better when they have a sense of control during stressful times; explaining to the child what is happening and what they can expect is often helpful (see Table 13.1).

Trust, Autonomy, and Identity

Trust develops during the first-year-of-life attachment cycle: need, arousal, gratification, and trust. The baby learns to trust *caregivers* (reliable and sensitive; will meet my needs); *self* (my needs are acceptable; I am worthwhile); and the *external world* (I feel safe and protected; my world is OK). The development of basic trust is a primary developmental task for the first year of life and serves as a foundation for future emotional and social growth. Maltreatment, abandonment, and out-of-home placements contribute to the lack of trust in children who are adopted. The child's lack of trust in prior caregivers is projected onto the current (adoptive) caregiver. Adoptive parents must be emotionally prepared to deal with this mistrust, and the associated anger, acting out, and low self-esteem.

Table 13.1 Minimizing the Trauma of Moves: Developmental Considerations

• **Infants:** Emphasis on transferring attachment and caregiving routines during preplacement contacts. Maintain as many routines as possible in new setting. After move, provide consistency and *meet needs on demand*.
• **Toddlers:** Preplacement preparation is crucial to reduce long-term anxiety and fear regarding separation, loss, and lack of safety with caregivers. Primary goal during moving process is to transfer attachment; best facilitated by cooperative contact between the parents the child is leaving and new parents/caregivers. Provide support and understanding if regression occurs after move; undue pressure may have negative long-term effects. Note events surrounding the move on the child's permanent record, as this information may help caregivers and helping professionals understand the child's future actions and issues. Postplacement contacts with previous caregivers are important so that children understand the reasons for the move as they grow older.
• **Preschool Years:** Explaining in "child-friendly" language what is occurring and why reduces magical thinking and helps the child attain a sense of control over events. Preplacement services aid in transferring attachment to new caregivers and initiating the process of grieving. Identifying and modifying the child's negative perceptions (e.g., "It is my fault I lost my mom") prevents future emotional problems. As child develops increased cognitive skills, around 8 or 9 years old, caregivers and/or helpers need to review the past, so that the child is not misinterpreting those events.
• **Grade School Age:** Despite increased cognitive and verbal skills, it remains necessary to identify and correct magical thinking and misperceptions. It is important to help the child understand what is happening, and to provide aid in identifying and constructively expressing emotions. Adults are responsible for decision making, but the child needs to be included as an active participant in the moving process. The child is encouraged to share feelings, worries, and desires regarding the transition. After the move, discussions about grief-related (or other) feelings help the child free up energy for social, academic, and additional activities and accomplishments.
• **Adolescence:** Moves during early adolescence (12 to 14) are more difficult than in later adolescence, because individuation is a major developmental task of this stage. It is difficult to encourage attachment to new caregivers when the child is in the process of emotionally separating from family. Parents need to be sensitive to these development issues; children do best with a clear and concrete commitment ("contract") to the new caregivers. Adolescents need to have input into decision making about their lives and future, consistent with their need to have increasing control over life events in general. They should be a part of the process of deciding where to live, except in special situations (e.g., displaying poor judgment). Commitments and contracts are helpful in clarifying and attaining goals. Parents, caregivers, and helping professionals can assist the adolescent to "come to terms" with prior losses and trauma, and encourage a healthy balance of dependence and independence.

Adapted from Fahlberg (1991)

The emergence of a sense of autonomy is an important developmental task of the second and third years of life. Dependence on a caregiver and independence from that caregiver are continuously balanced within the context of the attachment relationship. The child with the "secure base" can explore autonomously, knowing he or she is safe and protected. Children with attachment disorder do not have this safety net; they either become afraid to explore (clingy, overdependent), or develop a false type of independence ("I do not need anyone"). The adopted child with attachment disorder is needy, fearful, and emotionally immature, but compensates by working hard at demonstrating "pseudoindependence."

Identity is who the child believes him- or herself to be. Identity formation is based on the child's experiences, interpretation of those experiences, others' reactions to the child, and the significant role models the child identifies with (Van Gulden and Bartels-Rabb 1994). Self-worth is at the core of identity. Children with attachment disorder develop a shame-based identity, due to abandonment, real or perceived, and their sense of self as flawed, unlovable, and "bad." They carry this negative working model into the adoptive family, pushing away the nurturance and love they believe is not deserved. Lacking a positive and clear sense of identity, these children are at risk for antisocial behavior, susceptibility to negative peer influence, and a chronic feeling of alienation in the adolescent years.

Fit

Adoptive parents go through a "psychological pregnancy," as they prepare for and fantasize about the new child entering their family. The closer the child is to his or her fantasy prior to adoption, the stronger the attachment. Children with attachment disorder deviate from these parents' fantasies; they distance themselves emotionally, are angry and aggressive, and do not accept limits and authority. A poor fit also occurs when the child and adoptive parents are different in temperament (e.g., active and energetic child, subdued and restrained parents). Although it is not possible to match a child and prospective parents on all dimensions, efforts should be made to consider these factors. Preplacement services aid the parents in developing a realistic appraisal of the child, which may differ considerably from their desires and fantasies.

Shifts in the Family System

The addition of a new member is a critical transition that always requires an adjustment in the family system. An adoptive family is extremely vulnerable to these changes, because of the tentative nature of the tie between the adopted child and the family (Reitz and Watson 1992). The place and role

of the child in the new family must be determined. An adopted infant has special status, and is typically able to form attachments with appropriate and sensitive parenting. The older adopted child, however, brings roles, patterns of relating, and expectations learned in prior families (birth, foster). The family and child may have difficulty in adjusting to one another. “To return to its prior equilibrium, any system tends to cast off what it perceives as foreign” (Reitz and Watson 1992, p.131). The adopted child who continues prior behaviors and roles in the new family is vulnerable to rejection and scapegoating, a major reason for relinquishment.

Preplacement Preparation

Planned transitions help to minimize the trauma of separation and loss and facilitate the development of new attachments. The process of moving children out of biological homes, through the child welfare system, and into adoptive families, must incorporate the following factors:

- Address the fears, anxieties, and emotions of the child, the parents/caregivers the child is separating from, and the new caregivers.
- Recognize and support the grieving process for child and adults.
- Educate, support, and empower the new parents.
- Encourage realistic expectations for the child and new parents. Providing full disclosure of the child’s history and psychosocial difficulties helps parents develop realistic expectations. Discussions and training sessions enhance preparation. Parents can role-play not only parenting strategies but also “being the child,” to increase understanding, empathy, and skills. Talking to experienced foster and adoptive parents (“old timers”) provides insight and support.
- Help the child develop accurate perceptions and reduce the harmful effects of self-blame.
- Consider the messages that the child is given. What are the “parting messages” as a child leaves a family (supportive, blaming, vague)? What are the “welcoming messages” received as the child enters the new family (apprehensive, surprised, confident, mistrustful)?
- Preplacement contacts and visits with the new family are useful in diminishing anxiety about the unknown, dealing with loss and grief, and beginning the process of transferring attachment. Visits are usually supervised and evaluated.

- Commitments to work together in the future from everyone involved in the child's life (prior and new caregivers, child, caseworkers) ease the transition and help to achieve long-term goals.

Postplacement Services

A major component of effectively dealing with separation, loss, and disruption of attachment is the quality of the new family environment that the child moves to. The new adoptive parents must be prepared to provide a healthy balance of structure and caring, help the child cope with grief and other emotions, and make decisions regarding the role played by prior attachment figures in the child's current and future life. Postplacement services involve the following:

- Ongoing support, education, and treatment services available for the child and new parents. This encourages effective coping and significantly reduces disruption rates.
- Allows contacts with prior attachment figures when appropriate. This decreases the child's magical thinking, loyalty conflicts, denial of feelings, and enhances self-worth, resolution of separation issues, and the transfer of attachment. Contacts are preferably in person, but can also occur through phone calls, letters, or audio/video tapes. *Interrupt contact when prior caregivers sabotage the goals and send damaging messages to the child.* Contact is not recommended when prior caregivers have been severely abusive.
- An assessment process is necessary in order to measure success in achieving specific goals with the child, prior caregivers, and new caregivers. Positive changes in family dynamics, parenting practices, coping skills, and the development of new attachments should be evaluated on a regular basis, as a part of an ongoing follow-up plan.

Helping Services

There are many studies that indicate adopted children are at greater risk of emotional, social, behavioral, and academic problems than their nonadopted peers (Brodzinsky *et al.* 1984, 1990). Adopted children are more likely to come to the attention of the mental health system. This occurs for two possible reasons: 1) due to early insecure attachment and loss; and 2) as they reach school age, these children develop the cognitive skills to understand the implications of adoption (e.g., abandonment and identity issues). It is not possible, however, to place all adopted children into one category. Each child is unique, with differences in biological/genetic background, early life

experiences, cultural influences, and placement procedures. The long-term prognosis is good for many adopted children with attachment disorder when they receive effective services during childhood and their adoptive parents are well prepared for the challenging task. The confidence and competence of the parents, combined with support from social services, mental health professionals, and extended family, are important components of a successful outcome.

Substitute Child Care

About 8.2 million children—40 percent of children under 5 years old—spend at least part of their week in day care (Cohen 2013). In many countries, child care services are subsidized and well regulated. In the United States there is no organized child care system. High-quality day care is available for those who can afford it, but overall quality is inconsistent, and many providers do not offer adequate care.

Quality child care is important, especially in the early stages of life, when the young child's experiences create a foundation for subsequent development. This period affects the architecture of the child's brain and the development of emotional, social, and cognitive skills. Young children need safe, nurturing, and stimulating environments provided by nurturing caregivers who have an expertise in child development.

The use of out-of-home, substitute child care has become a necessity for the majority of families with children in our society. Economic and social conditions often force both parents to work, penalize those who put their careers on hold for several years, and provide little support to parents. More than 50 percent of preschoolers in the United States are in some form of substitute child care (30 percent in a child care facility, 17 percent in provider's home, and 5 percent at home with babysitters) (Kantrowitz 1997). Traditionally, families benefited from an abundance of secondary attachment figures. Families tended to remain in one place, and were surrounded by relatives and life-long neighbors who helped with child care. Currently, one out of five families moves every year.

Research and Discussion

Despite much research over the years, controversy remains over whether nonmaternal care has deleterious effects on young children's development. However, there are several firm conclusions. First, poor-quality day care places children at risk. Second, most children who participate in good-quality day care cope well. Last, children from disadvantaged backgrounds often benefit

from child care, when the care provided is better than what they receive at home (Rutter 2008).

The issue of substitute infant and child care has prompted a significant amount of debate and research within the public policy and scientific arenas. The relationship between early substitute child care and children's psychosocial development (as reflected in attachment style), has received considerable attention. Some studies found that nonmaternal infant care is strongly correlated with insecure attachment patterns, while others found that attachment is influenced by a combination of factors, including the quality of child care, time spent in child care, and maternal sensitivity during the first 15 months (Belsky and Rovine 1988; NICHD 1996).

The National Institute on Child Health and Human Development (NICHD) began a large-scale longitudinal study in 1989 to examine the effects of day care on child development. The researchers found that more than one-half of the babies at age 15 months displayed insecure attachment patterns when their mothers were insensitive and unresponsive, or showed signs of depression and anxiety. The risk of insecure attachment was compounded by poor quality day care, being in day care for ten hours or more a week, and switching child care arrangements (NICHD 1996). Thus, the combination of poor quality day care and unresponsive maternal care was most damaging for healthy attachment and subsequent child development.

More recent NICHD research provided further information about the effects of child care. Teens who were in high-quality child care settings as young children scored slightly higher on measures of academic and cognitive achievement, and were slightly less likely to report acting-out behaviors than peers who were in lower-quality child care during their early years. Also, teens who had spent the most hours in child care in their first 4½ years had a slightly greater tendency toward impulsiveness and risk taking than did peers who spent less time in child care (NICHD 2010).

While the effects of day care remain a topic of debate, there is a general consensus that the better the quality of care, the better the outcomes for children (Young *et al.* 1997). Overall quality of care includes training and education of caregivers, staff–child ratios and group size, and appropriateness of care provided (i.e., meeting infants' and toddlers' social, cognitive, physical, and emotional needs). However, even infants and toddlers who attended a high-quality day care program were found to be more aggressive in kindergarten than children who stayed home (Haskins 1985; cited in Moore 1996, p.305). In addition to the quality of substitute child care, two other factors have been found to determine attachment and psychosocial development: the number of hours per week in substitute care, and the age and developmental stage of the children in care. Moore (1996) found that the

effects of substitute care vary with the child's age and developmental level, as well as the amount of time spent. Boys developed more behavior problems than girls as the total amount of time in substitute care increased (aggressive and oppositional behavior in pre school). Moore concluded, "While the first year of life has been viewed as a critical period, the present findings suggest that this critical period should be extended to 2½ years" (Moore 1996, p.308). Other studies found that 24 to 36 months of age is an important transition time for behavioral and emotional reorganization. Bowlby (1982) suggested that after 3 years of age, most children are able to feel secure with a subordinate attachment figure. Bowlby writes, "After children have reached their third birthday, they are usually much better able to accept mother's absence … this change seems to take place almost abruptly, suggesting that at this age some maturational threshold is passed" (Bowlby 1982, p.205).

Young and Zigler (1986) reviewed the status of day care regulations, and analyzed the extent to which day care requirements were followed. They found that not one state met the recommended standards for quality day care. Ten years later, they found similar deficiencies: 67 percent of the states received an overall rating of poor or very poor; not one state received an overall rating of good (Young et al. 1997). Their findings indicate that state regulations current at the time for infant and toddler day care did not establish minimally acceptable thresholds of quality. These researchers conclude, "As a society, it is time we recognize that the sound development of an increasing proportion of children is compromised by inappropriate care during their most formative years" (Young *et al.* 1997, p.543; Schmitt and Matthews 2013).

Recommendations

- *Continuity of caregivers:* Infants and toddlers need one consistent, responsible, and loving caregiver. Day care programs should assign a specific caregiver for each child, and this provider should move up the age range, caring for the same children from infancy through preschool.
- *Stability of child care:* For children under the age of 3, the staff–child ratio must be 1:4, with a maximum group size of eight.
- *Qualifications for day care providers:* Infant and toddler caregivers must have the training, experience, and personal emotional maturity necessary to develop consistent, stable, and supportive relationships with young children. These care providers should receive wages and benefits compatible with their level of training and experience. Providers should be knowledgeable in the fields of infant and

child development, emphasizing trust and emotional security, safe exploration, and effective communication with parents.

- *Parents as partners:* Infant and toddler care providers should be trained in facilitating a partnership with parents. Establishing a relationship with parents which includes discussion of the child's development, and the parents' role in it, is extremely important.
- *Businesses as partners:* Employers should be required to provide job-protected parental leave for at least one year following childbirth and adoption. Additionally, companies should be encouraged to provide high-quality in-house day care to their employees. Infants and young children can be cared for on the premises, and employees should have flexible access to their children.

Early Intervention and Prevention

The goal of early intervention and prevention programs is to make books that focus on the treatment of children with attachment disorder, such as the book you are reading right now, less necessary and relevant. Primary prevention focuses on intervening early in the life of families, infants, and children, to create healthy patterns; meet the physical, psychosocial, and cognitive needs of children; and strengthen families. Secondary prevention identifies at-risk children (e.g., crime committed, referred to mental health agency), or parents (e.g., child abuse and neglect, substance abuse, poverty, teenage pregnancy), with the goal of preventing additional problems in the future. The following discussion focuses on early intervention and primary prevention that provide education and support to families during the initial phases of the parent–child relationship. This is the time when families face both their highest risk for severe maltreatment, and at the same time, their greatest opportunities for creating positive and enduring parent–child interaction and attachment patterns (Guterman 1997).

Concepts and Goals

Early interventions and primary prevention concepts are not new. In 1920, Christian Carstens, the founder of the Child Welfare League of America, stated that child protective agencies should work toward the prevention of cruelty and neglect, not merely the prevention of its reoccurrence. In 1991, the U.S. National Advisory Board on Child Abuse and Neglect recommended a system of neonatal home visiting support programs to prevent maltreatment. In 1992, the National Committee to Prevent Child Abuse initiated the development of early child abuse and neglect prevention

programs, which resulted in the establishment of more than 150 programs in 28 states (Healthy Families America 1996; Guterman 1997). In 1995, the Administration for Children, Youth and Families awarded funds to 63 community-based programs to serve low-income families with infants, toddlers, and pregnant women. This marked the beginning of Early Head Start, which is based on the following guiding principles:

> All children from birth to age three need early child development experiences that honor their unique characteristics and provide love, warmth, and positive learning experiences; and all families need encouragement and support from their community so they can achieve their own goals and provide a safe and nurturing environment for their very young children. (Advisory Committee on Services for Families with Infants and Toddlers 1994; cited in Lally and Keith 1997, p.3).

The American Psychological Association launched a large-scale search for effective prevention programs. Once identified, these model programs could serve as examples to be repeated in other settings (Price *et al.* 1989). This APA Task Force found that effective prevention programs share a number of features:

- *Programs are targeted:* Their focus is shaped by an understanding of the risks and problems encountered by the target group.
- *Long-term change:* Programs are designed to alter the life trajectory of participants; to set individuals on a new developmental course, opening opportunities, providing social support, changing life circumstances, and teaching new skills.
- *Strengthen new support:* These programs strengthen the existing support found in family, community, or school settings.
- *Research:* Programs collect vigorous research evidence to document success and effectiveness.

Sample Programs

Although there are many successful early intervention and prevention programs operating currently, the list below includes programs that have been found to effectively enhance healthy parent–child attachment and prevent an array of child and family problems.

Harris Program in Child Development

Young mothers who are drug addicted typically have babies who are traumatized and develop disrupted and disorganized attachment. Early

intervention programs can help these women with psychological and substance abuse issues and encourage positive attachment experiences. The Harris Program in Child Development and Infant Mental Health in Colorado uses a relationship-based approach, and focuses on addiction, parents' attachment history, parenting training, and mother–infant attachment. This education, prevention, and therapeutic program has proven successful with a high-risk population (Bromberg *et al.* 2010).

San Francisco Unified Family Court

Babies and toddlers are maltreated at higher rates than older children and more frequently enter the child welfare system (U.S. Department of Health and Human Services 2011). Many of these children and families become involved in the court and legal system. Family courts can partner with social service agencies and community-based organizations to help those children and families. The San Francisco Unified Court developed a program to shift the focus from punishment to education and prevention in cases of early childhood maltreatment and trauma, and break the cycle of violence. There have been dramatic results, including fewer out-of-home placements, more effective assessment, planning, and referrals tailored to the developmental needs of infants and young children, and utilization of services in a more consistent and effective manner. The power of courts and clinicians working together for children and families is much greater than that of either group acting alone (Smith *et al.* 2011).

Home Visitation 2000

- *Intervention*: Low-income women during pregnancies and the first two years of children's lives—paraprofessional and nurse teams made home visits in order to improve prenatal health, provide support, teach emotionally sensitive caregiving, improve children's health and development, and enhance women's personal development.
- *Outcome*: Mothers made better use of community resources and improved their health pre- and postnatally; significantly less abuse and neglect of children during the first two years; fewer parent–child coping problems and maltreatment at 50-month follow-up (Robinson and Glaves 1996).

Perry Preschool Project

- *Intervention*: Preschoolers at risk of school failure from low socioeconomic families—children participated in two years of special

education to enhance cognitive skills; parent involvement via groups, and weekly home visits by teachers and staff.

- *Outcome:* Children received higher grades, stayed in school longer, more likely to graduate high school, with a significant decrease in crime and delinquency (50% less likely to be arrested by age 19) (Berrueta-Clement *et al.* 1984).

Seattle School Development Program

- *Intervention:* Families at risk of maltreatment and preschoolers at risk of antisocial behavior: provided parent training and support and special programs for children, focusing on family, school, peers, and community at different stages of child development.
- *Outcome:* Behavioral problems (antisocial behaviors) significantly reduced in children by fifth grade (Zigler 1994).

Healthy Start Program

- *Intervention:* Serving low-income, high-stress (substance abuse, depression) families—paraprofessionals made home visits to provide parent education and support, coordination with community services, support groups for parents.
- *Outcome:* Mothers showed greater positive involvement and sensitivity to infants at 6 months of age; reduction of abuse and neglect at 12 months (Center on Child Abuse Prevention Research 1996).

Houston Parent–Child Program

- *Intervention:* Serving low-income Mexican American families with a 1-year-old child—home visits by paraprofessionals to teach baby care and improve home environment; children participate in special nursery school during second year, while mothers attend child management classes.
- *Outcome:* Children showed less aggression, less hostility, and more empathy, five to eight years after the program (Johnson and Walker 1990).

Teen Mother Program

- *Intervention:* Single, teenage mothers (16½ years old average), gave birth to their first child within the past two years; 12 one-hour group sessions to teach stress management, problem-solving, child care, and provide social support.
- *Outcome:* Significant increase in caregiving competency and baby care, and decrease in violence and abuse toward infants (Schinke *et al.* 1986).

Yale Child Welfare Program

- *Intervention:* Home visits by professionals and paraprofessionals to low-income mothers—provided parent education, pediatric services, support, and linkage to community services during the first 17 months of first-born children.
- *Outcome:* Ten years later, mothers were more likely to be self-supporting and had better parent–child relationships; children had better school adjustment, less aggression and anger, and were more compliant with parents (Zigler 1994).

These early intervention and prevention programs identify and build on the strengths of families and communities. They provide health care, parent support and education, child care and development information, and help in linking parents and children to community resources. By helping parents to understand and fulfill their children's emotional, social, cognitive, and physical needs, they encourage secure attachment and produce lasting improvements in children's psychosocial competence. Further, benefits from prevention programs increase over time. Benefits accrue over time as children engage in less crime, depend on welfare-type services less, and reap the benefits of higher levels of education (Price *et al.* 1989). For example, a benefit–cost analysis of the Perry Preschool Program showed a total net benefit for each preschool child of $5000. At 19 years of age, however, the total net benefit was estimated at $23,000, due to less need for services and less crime (Gramlich 1984; cited in Price *et al.* 1989, p.56).

Appendix A

Intake Forms

This appendix is a sample intake packet required to apply to the Evergeen Psychotherapy Centre's Attachment Treatment and Training Institute. The forms have been reproduced from the online application found at: www.attachmentexperts.com.

Forms

Registration Form

Symptoms Checklist

Child's Biography

Parents' Autobiographies

Hometown Therapist Form

Adult/Couple Registration Form

Consent Form

Registration Form

There are 4 forms required for the child/family application process: Registration Form, Symptoms Checklist, Child's Biography, and Parents' Biography.

Please read these instructions (iPhone/Android not recommended!):

- You must provide your e-mail address (5th line down on the form) in order to save your responses and then retrieve your saved responses at a later time. **If you do not provide an e-mail address, you must submit each form in its entirety in one session. Without an e-mail address on record, you will not be able to save your responses!**
- Periodically as you are filling out each form, click on the "Save Form" button at the bottom of the page and then continue with the form where you left off. Your responses up to that point will be saved.
- If you need to stop and take a break, click on the "Save Form" button at the bottom of the page, just as you had been doing periodically. You may close your browser.
- When you return from your break, enter **just** your e-mail address (5th line down), and then click on the "Retrieve Form" button at the bottom of the page. Your saved responses up to that point will be retrieved.
- When each form is complete, click on the "Submit Forms" button on the bottom of the page. Your completed form will be submitted and **all saved responses will be erased.** Do not submit the form until you are done. You will not be able to continue updating a submitted form.

Completed By:

Child's Name:

Street Address:

City:

State:

Zip Code:

E-mail address:

Child's date of birth: (mm/dd/yyyy)

Date: (mm/dd/yyyy)

Child's Social Security Number: (nnn-nn-nnnn)

Home Phone: (nnn-nnn-nnnn)

Fax: (nnn-nn-nnnn)

Mobile Phone:

Mother's Information

Mother's Name: Employer:
Occupation: Business Phone:

Father's Information

Father's Name: Employer:
Occupation: Business Phone:

Others living at home. Please include Gender, Age, School, and Grade, as applicable.

Other Caregivers. Please include daycare, family members, etc.

Reason for seeking treatment.

Child's History

Is the Child Adopted? Yes ❐ No ❐
History of abuse, neglect, trauma, or significant separations.

Previous treatment and diagnosis (dates, length of treatment, results).

School Information

School:
Grade:
Teacher:
Counselor:
Teacher's Phone:
Counselor's Phone:
Comments:

Family Information

Parents' marriages, separations, divorces.

Who wants help?

Mother's main concerns?

Father's main concerns?

Five adjectives describing mother.

Five adjectives describing father.

Five adjectives describing marriage.

Five adjectives describing child.

Physician & Referral Information

Family Physician: Physician's Phone:

Referred By: Phone:

Credit Card (VISA/MC) Information:

Name on Credit Card:

VISA ❒ MasterCard ❒

Credit Card Number: Expiration Date:

CV (3 digits on back of card):

Street Address (must match your credit card statement):

City: State:

Zip Code:

Phone: E-mail:

Symptoms Checklist

Please read these instructions (iPhone/Android not recommended!):

- You must provide your e-mail address (2nd line down on the form) in order to save your responses and then retrieve your saved responses at a later time. **If you do not provide an e-mail address, you must submit each form in its entirety in one session. Without an e-mail address on record, you will not be able to save your responses!**
- Periodically as you are filling out each form, click on the "Save Form" button at the bottom of the page and then continue with the form where you left off. Your responses up to that point will be saved.
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- When each form is complete, click on the "Submit Forms" button on the bottom of the page. Your completed form will be submitted and **all saved responses will be erased.** Do not submit the form until you are done. You will not be able to continue updating a submitted form.

Child's Name:

Completed By:

Child's Date of Birth: (mm/dd/yyyy)

E-mail address:

Phone Number:

There are six categories of traits and symptoms of attachment disorder: behavioral, cognitive, emotional, social, physical, and moral-spiritual. Children vary in regard to the number of symptoms they have and in the severity of their symptoms.

Please place a mark in the appropriate column for each symptom as it pertains to your child. For each of the symptoms checked as moderate or severe, please give a brief description of your child's behavior. Specific examples (given by parents) are available by clicking on a question, as desired.

		None	Mild	Moderate	Severe
1.	Lack of impulse control	❐	❐	❐	❐
2.	Self-destructive, physical/ psychological	❐	❐	❐	❐
3.	Destruction of property	❐	❐	❐	❐

		None	Mild	Moderate	Severe
4.	Aggression toward others, physical/verbal	❒	❒	❒	❒
5.	Consistently irresponsible	❒	❒	❒	❒
6.	Inappropriately demanding and clingy	❒	❒	❒	❒
7.	Stealing	❒	❒	❒	❒
8.	Deceitful (lying, conning)	❒	❒	❒	❒
9.	Hoarding	❒	❒	❒	❒
10.	Inappropriate sexual conduct and attitudes	❒	❒	❒	❒
11.	Cruelty to animals	❒	❒	❒	❒
12.	Sleep disturbance	❒	❒	❒	❒
13.	Enuresis and encopresis	❒	❒	❒	❒
14.	Frequently defies rules (oppositional)	❒	❒	❒	❒
15.	Hyperactivity	❒	❒	❒	❒
16.	Abnormal eating habits	❒	❒	❒	❒
17.	Preoccupation with fire, gore, or evil	❒	❒	❒	❒
18.	Persistent nonsense questions and incessant chatter	❒	❒	❒	❒
19.	Hypervigilant	❒	❒	❒	❒
20.	Difficulty with novelty and change	❒	❒	❒	❒
21.	Lack of cause and effect thinking	❒	❒	❒	❒
22.	Learning disorders	❒	❒	❒	❒
23.	Speech disorders	❒	❒	❒	❒
24.	Perceives self as victim (helpless)	❒	❒	❒	❒
25.	Grandiose sense of self-importance/entitlement	❒	❒	❒	❒
26.	Not affectionate on parents' terms	❒	❒	❒	❒
27.	Intense displays of anger (rage)	❒	❒	❒	❒
28.	Frequently sad, depressed, or hopeless	❒	❒	❒	❒

	None	Mild	Moderate	Severe
29. Inappropriate emotional responses	❐	❐	❐	❐
30. Marked mood changes	❐	❐	❐	❐
31. Superficially engaging and charming	❐	❐	❐	❐
32. Lack of eye contact for closeness	❐	❐	❐	❐
33. Indiscriminately affectionate with strangers	❐	❐	❐	❐
34. Lack of or stable peer relationships	❐	❐	❐	❐
35. Cannot tolerate limits and external control	❐	❐	❐	❐
36. Doesn't like criticism and blames others for own mistakes or problems	❐	❐	❐	❐
37. Victimizes others (perpetrator, bully), revenge	❐	❐	❐	❐
38. Victimized by others	❐	❐	❐	❐
39. Lacks trust in others	❐	❐	❐	❐
40. Exploitative, manipulative, controlling, bossy	❐	❐	❐	❐
41. Poor hygiene	❐	❐	❐	❐
42. Chronic body tension	❐	❐	❐	❐
43. Accident prone	❐	❐	❐	❐
44. High pain tolerance/ overreaction to minor injury	❐	❐	❐	❐
45. Tactilely defensive	❐	❐	❐	❐
46. Genetic predispositions/ hypochondriac	❐	❐	❐	❐
47. Lack of meaning and purpose	❐	❐	❐	❐
48. Lack of faith, compassion, and other spiritual values	❐	❐	❐	❐
49. Identification with evil and the dark side of life	❐	❐	❐	❐
50. Lack of remorse and conscience	❐	❐	❐	❐

Child's Biography

Please read these instructions (iPhone/Android not recommended!):

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- When each form is complete, click on the "Submit Forms" button on the bottom of the page. Your completed form will be submitted and **all saved responses will be erased.** Do not submit the form until you are done. You will not be able to continue updating a submitted form.

Completed By:

Child's Name:

E-mail address:

Child's date of birth: (mm/dd/yyyy)

Describe what you know about your child's birth family: age of parents, number of siblings, family dynamics, abuse and/or neglect, drug and alcohol abuse, crime, etc.

List the number of disruptions (moves away from a family) your child has experienced, reason for each, length of time and age in each placement, and what degree of abuse, neglect or nurturing she/he received in each placement.

Describe any medical problems your child has experienced: e.g. inner ear problems, colic, hospitalizations, premature birth, lack of prenatal care, etc.

Describe your child's first three years of life:

- Quality of prenatal care, birth and postnatal care?
- Did mother suffer postpartum depression?
- How did your child respond to holding, eye contact, and nurturance?
- What kind of emotional support was available for the mother during the child's early years?

Describe the progression of your child's disruptive behavior. How have you reacted?

Describe your child's positive attributes.

Describe previous therapy your child and family has had, duration, and results.

Describe your hopes for bringing your child and family to Evergreen Psychotherapy Center.

Include a brief narrative describing a typical day in the life of your child.

Parents' Autobiographies

Please read these instructions (iPhone/Android not recommended!):

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- Periodically as you are filling out each form, click on the "Save Form" button at the bottom of the page and then continue with the form where you left off. Your responses up to that point will be saved.
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- When each form is complete, click on the "Submit Forms" button on the bottom of the page. Your completed form will be submitted and **all saved responses will be erased.** Do not submit the form until you are done. You will not be able to continue updating a submitted form.

Completed By:

Child's Name:

E-mail address:

Child's Date of Birth: (mm/dd/yyyy)

Mother's Family of Origin

Describe your mother and father (positive and negative).

How did your parents show affection to each other and their children?

How did your parents handle disagreements and conflicts; what were their main methods of discipline?

How many siblings do you have and what role did each sibling play in the family?

Discuss history of alcohol or drug abuse; physical, emotional or sexual abuse; mental or emotional illnesses in the family; how was each issue dealt with?

Mother's Medical History

List any current/past illnesses/injuries that have impacted you or your family.

Mother's Marital History

Describe your current marriage (positive and negative); i.e. intimacy, communication, problem-solving, togetherness.

Write a brief description of any previous marriage(s).

Mother's Current Family

List your children and give a brief description of each child.

What are your main methods of discipline and how effective have they been?

What concerns do you have with any other member of the family?

How large of a role (if any) does religion play in your family?

Describe positive attributes, strengths, and support systems in your current family?

Father's Family of Origin

Describe your mother and father (positive and negative).

How did your parents show affection to each other and their children?

How did your parents handle disagreements and conflicts; what were their main methods of discipline?

How many siblings do you have and what role did each sibling play in the family?

Discuss history of alcohol or drug abuse; physical, emotional or sexual abuse; mental or emotional illnesses in the family; how was each issue dealt with?

Father's Medical History

List any current/past illnesses/injuries that have impacted you or your family.

Father's Marital History

Describe your current marriage (positive and negative); i.e. intimacy, communication, problem-solving, togetherness.

Write a brief description of any previous marriage(s).

Father's Current Family

List your children and give a brief description of each child.

What are your main methods of discipline and how effective have they been?

What concerns do you have with any other member of the family?

How large of a role (if any) does religion play in your family?

Describe positive attributes, strengths and support systems in your current family?

Hometown Therapist Form

Please provide the following information:

Therapist's Name:
Child's Name:
E-mail:
Date Completing Form: (mm/dd/yyyy)
Phone:
Fax:
Street Address:
City:
State:
Zip Code:

Clinical Background:

Experience with Attachment Disorder, Childhood Trauma, Family Intervention:

Additional Information:

Adult/Couple Registration Form

Completed By: Today's Date: (mm/dd/yyyy)
E-Mail:
Date of Birth: (mm/dd/yyyy)
Social Security Number: (nnn-nn-nnnn)
Home Phone: (nnn-nnn-nnnn)
Street Address:

City:
State:
Zip Code:
Employer:
Occupation:
Business Phone:

Others living at home. Please include Gender, Age, Employer/School, as applicable.

Reason for seeking treatment.

Family of Origin

Describe what you know about your family: age of parents, number of siblings, family dynamics, abuse and/or neglect, drug and alcohol abuse, crime, adoption, etc.

Describe your mother and father (positive and negative).

How did your parents show affection to each other and their children?

How did your parents handle disagreements and conflicts; what were their main methods of discipline?

How many siblings do you have and what role did each sibling play in the family?

Discuss history of alcohol or drug abuse; physical, emotional or sexual abuse; mental or emotional illnesses in the family; how was each issue dealt with?

List the number of disruptions (moves away from a family) you experienced, reason for each, length of time and age in each placement, and what degree of abuse, neglect, or nurturing you received in each placement.

About You

Describe your challenges and problems from childhood through adulthood.

Describe your positive attributes.

Describe previous therapy you have had, duration, and results.

Describe your hopes for coming to Evergreen Psychotherapy Center.

Medical History

List any current/past illnesses/injuries that have impacted you or your family. e.g. inner ear problems, colic, hospitalizations, premature birth, lack of prenatal care, etc.

Marital/Relationship History

Describe your current marriage/relationship (positive and negative); i.e. intimacy, communication, problem solving, togetherness.

Write a brief description of any previous marriage(s)/relationship(s).

Current Family

List your children and give a brief description of each child.

What are your main methods of discipline and how effective have they been?

What concerns do you have with any other member of the family?

How large of a role (if any) does religion play in your family?

Describe positive attributes, strengths, and support systems in your current family?

Credit Card (VISA/MC) Information:

Name on Credit Card:

VISA ❐ MasterCard ❐

Credit Card Number: Expiration Date:

CV (3 digits on back of card):

Street Address (must match your credit card statement):

City: State:

Zip Code:

Phone: E-mail:

Consent Form

I ______________________________ hereby authorize

______________________________ (therapist)

of ______________________________ (city/state) to release any and all information contained in the record of ______________________________ (patient's name) to Evergreen Psychotherapy Center for professional use only.

This consent will expire on ______________________________ (mm/dd/yyyy).

Signed: ______________________________

Relationship to patient: ______________________________ (parent, self, etc.)

Witness: ______________________________

Date: ______________________________

Appendix B

A Day in the Life...

A Day in the Life of Michael (age 10)

A typical day in the life of Michael starts out with a long list of refusals. He typically refuses to get up on time; refuses to get ready for school; and refuses to take care of his wet bedclothes (i.e., taking the wet bedclothes to the laundry room). The morning normally continues with him arguing about what he should wear to school. He usually wants to wear something that is dirty and in the laundry or something that is inappropriate. From here he moves on to breakfast, which he whines about and complains that there is nothing to eat. He refuses to take his medication—Ritalin. He usually makes it out the door just in time to catch the school bus. In response to this behavior, we press him to comply just short of him going into a tantrum and leave him alone. Once he goes into a tantrum we cannot get him to comply with anything. Consequently, we clean up his wet bedclothes and he goes to school without his medication, wearing dirty or inappropriate clothes.

Once at the school bus stop or on the school bus, Michael often teases his sister, making fun of her and calling her obscene names. We believe that this behavior makes him feel big or important in the eyes of the older boys, so our punishments (denying him dessert or some other treat) have had no long-term effectiveness.

At school Michael is somewhat uncooperative, trying to do what he wants to do when he feels like it. Further, he teases and bothers the classmates around him. He marginally obeys the teacher, giving her defiant stares while he slowly and marginally carries out her instructions. He has displayed his defiance a couple of times to the school principal. His interaction with his classmates and neighborhood friends is fairly good in that he has won their approval/acceptance because he is a good athlete. Of course, he gets along with them best when he is in control and they are complying with his wishes. His interaction with his peers nearly always centers around a competition (sports or a competitive video game) and is accompanied with constant boasting and bragging on his part.

Not surprisingly, Michael is a sore loser and behaves best after he has beaten someone at some game.

Upon returning from school, Michael continues his defiant behavior by refusing to do his homework and sneaking out to play when he is supposed to be doing his homework. Sometimes we can coerce him into doing his homework by refusing to take him to sports practice, but on occasion he has outwitted us by claiming he has no homework. If it is an evening that he has a therapy session he frequently runs away long enough to miss the session. To counter his running away we intentionally do not tell him what the time session is. However, while he doesn't get a chance to run away, getting him into the car evolves into a major wrestling match with one of us holding him and the other driving. After a holding session at the therapist's office, Michael is usually rather compliant for the remainder of the evening (what little is left of it) and he is generally calm. If it is an evening where Michael doesn't have a therapy session, he often targets his teasing at the family as a whole, or an individual member by screaming or doing some other inappropriate action while we/they are watching a favorite TV program, reading, or while his brother/sister are doing their homework.

Michael seldom goes to bed at his assigned time. We generally give him about 15 minutes' leeway, before we really press him. Again, if he throws a tantrum someone gets hurt or he destroys the house or somebody's property. At times we have to physically drag him to his room and place him in bed. Sometimes he stays in his room and sometimes he doesn't. If he stays in his room he normally screams and jumps on his bed for a while before settling down and going to sleep.

The neighbors' reaction to Michael is mixed. Generally he gets along with them but we have had a couple of incidents where the neighbors came to us and complained about him. In one case we paid for the damage (a broken window), which seemed to pacify the situation. In the other case, he got into a fight with a girl with asthma who was teasing him. The fight brought on an asthma attack, which scared and upset our neighbor. Luckily, this neighbor was a school teacher, who seemed more willing to understand his situation. She stated that although she was extremely upset, she knew we were trying to take care of the situation and doing the best we could.

A Day in the Life of April (age 8)

April's typical good behaviors are: pleasant, intelligent conversation, and creative play. Her other behaviors at any given moment may include: hitting, kicking, biting, cursing, screaming, punching holes in the wall, throwing objects, slamming doors, stealing, etc… I used to respond in anger and embarrassment. I now respond with removal from the situation, time out, loss of toys.

April doesn't really have much to do with the boys. She doesn't play well with other children. She has one girl who she plays well with (5 years old), but other than that she doesn't do that well with peers.

It bothers me that she has to be in control so much, that she will jeopardize anything to get her way. April's strong will is both positive and negative. Her winning smile and cunning intelligence are very positive. She is a very good reader and speller. Her school behavior has been awful. She is now in an ALC (Alternative Learning Center) most of the day and does much better. She is never great at responding to authority, because it challenges her own. She does, however, have an understanding that Mrs. Smith has more control than any other teacher at school.

Most of the school and church community have been supportive. They are very appalled at April's behavior. Most have had no concept, until this last hospitalization that it was anything other than strong-willed behavior on her part and lenient discipline on my part. Now that we have documentation that April has an actual physical mental problem, it has helped people at least understand my reactions. It is quite unnerving to have your child brought to you screaming and crying, while you are in a rehearsal with forty 4th, 5th, and 6th graders. It took three teachers to carry April kicking, biting, and cursing, and the teachers were shocked because I didn't immediately "spank the fire" out of her. Instead, I isolated her to an empty room, got my sister-in-law, who is great with April, to be with her. Then I spent the next ten minutes bandaging the bitten hand of one teacher while explaining her explosive behavior to the others. Of course, we left church early and she was remanded to her room.

April is constantly challenging me. Every day, every way. In the store, at home, at church, at play. I must constantly be on my guard. I have to watch what I say and do, and keep my wits about me at all times. On a bad day, she really zeros in and works overtime to get me upset, as though she has won.

She is now challenging Jim with statements like, "I don't have to mind you!" She is less likely to disobey him, but it does happen.

This child has been a definite challenge. She has strengthened our marriage in many respects. We know we can't handle too much alone. We need each other. If I call the print shop, exasperated, Jim will come home. If he senses a rough day, he'll take her to the shop or soccer fields. If I sense he's had it, I make plans to divert her attention so he gets a break. It has been quite a financial strain and a strain on our lifestyle—we don't take April to important places or functions. We sit at the back and leave early if we have a problem. The boys don't have a lot of friends to the house because April embarrasses them so often. They never want her at school events. Our house is messed up all the time with her "stuff." They call her "the bag lady." She has made approximately 25 holes in the wall. We have locks on all the boys' bedroom doors, linen closet, sewing room, and pantry to keep her out. She steals their money, breaks their radios, ruins games. Strangely enough, they each profess to love her and are kind to her the majority of the

time. Since we now know that April's left brain is deficient, we have talked to the boys about her being mentally handicapped instead of just "mean spirited." This has really helped them deal with her situation better.

Personally, I am worn out. Some days I just don't want to come home. I often have nightmares of April dying, and wake up feeling incredible remorse. I am working so hard to see April's strengths and hope that long term she will be able to contribute to society in a positive way. I need a rest, but it would take a week just to unwind and no one can handle April for that long outside our immediate family.

The only parenting techniques that work with April are time outs, removal from the areas of dispute, therapeutic holds, and taking away of personal property. A soft voice is a must. Punishment must be swift and strong. No wishy-washy what to do. Action must be immediate with a determination to outlast her best effort. The least effective is spanking. This really revs her up. We have tried everything. Nothing that ever worked with any of the boys works for her. Grounding is ridiculous, charts don't work. She cannot be reasoned with. Washing out her mouth was a real challenge. She would curse right through the bubbles. She'd curse till she threw up.

When the idea of permanent residential care was first mentioned, I cried for two days. I couldn't eat. I still felt there must be more we could do because "good" parents would never entertain that thought. Now, even with high dosages of medicine, I do not see major results. I do see an increased attention span. But I see more and more weird behaviors. More and more acting out and violence at school. I am terrified that the school will say, "She's too dangerous, take her home." I am coming more and more to the reality that I am not equipped to deal with this type of behavior. I'm certainly better than I was eight years ago, and my friends marvel at my newfound patience. But I fear it is not enough.

Tim is the most physically threatened. April picks on him the most. He is most kind to her, hating to hit her back or even protect himself from her. She has hit him with a baseball bat, plastic but very hard, bitten him innumerable times, hit, kicked, etc. He probably loves April more than any of the boys.

My worst fear is that April will commit some awful crime or injure some child or teacher at school or church. My best hope is that you will be able to help April and she will develop a conscience and stop the violence.

Appendix C

Sentence Completion Form

I would like to get to know you better, and one way I thought might be easiest would be for you to tell me what you think and how you feel about these things:

I'm afraid ______________________________

I know I can ______________________________

Other kids ______________________________

People often ______________________________

I secretly ______________________________

My greatest worry ______________________________

I just can't ______________________________

My mind ______________________________

At home ______________________________

There is nothing ______________________________

My mother won't ______________________________

My family ______________________________

I wish I could stop ______________________________

Mother and I ______________________________

When I get mad ______________________________

Most girls ______________________________

When I was very young ______________________________

I'm different because ______________________________

I hurt when ______________________________

I'm sad when ______________________________

When I grow up ______________________________

I need ____

Father and I ____

I wish ____

I hate ____

It would be funny ____________________________________

Most boys/girls _____________________________________

I want to know ______________________________________

My school ____

Three wishes I have are ________________________________

Appendix D

Patterns of Attachment

The Berkeley Adult Attachment Interview was used to assess parents' patterns of attachments (Main *et al.* 1985). This interview procedure elicits details of early family life, relationships with parents, and unresolved emotional issues. It assesses the adult's early attachment experiences and their current "state of mind" about attachment. Based on their responses, adults are assigned to one of four categories, each equivalent to and predictive of infant/childhood attachment patterns (secure–autonomous, dismissing, preoccupied, and unresolved):

1. Secure–autonomous

- coherent view of attachment
- secure base provided by at least one of their parents
- do not portray their childhoods as trouble free; objective regarding the positive and negative qualities of their parents
- able to reflect on themselves and relationships (little self-deception); comfortable talking about attachment issues; communicate in a clear, direct and honest manner
- worked through painful issues from childhood and can discuss these issues without much anxiety or stress; insight into the effects of early negative emotional and family experiences; understanding and some level of forgiveness toward their parents
- able to depend on others; accept the importance of relationships in their lives
- most of their own children were rated as *securely attached*.

2. Dismissing

- unable or unwilling to address attachment issues in coherent and serious way; dismiss the value and importance of attachment relationships
- guarded and defensive answers; often not able to accurately remember their childhoods; do not want to reflect on their past
- idealized their parents; deny true facts and feelings associated with negative parental behavior (e.g., abuse and neglect)
- avoid the pain of early rejection and their need for love and affection through various defensive strategies
- three-fourths of their own children were *avoidantly attached*.

3. Preoccupied

- confused and incoherent regarding memories; unresolved about early hurt and anger in family relationships
- childhoods characterized by disappointment, frustrating efforts to please their parents, and role reversals ("parentification")
- remain emotionally enmeshed with parents and family-of-origin issues; unaware of their own responsibility in current relationship problems
- most of their own children have *ambivalent attachments*.

4. Unresolved

- experienced severe trauma and early losses; have not mourned lost attachment figures and not integrated those losses into their lives
- frightened by memories and emotions associated by early trauma; may dissociate to avoid pain; confused and incoherent regarding past events
- extremely negative and dysfunctional relationships with their own children, including abuse and neglect; script their children into past unresolved emotional patterns and dramas
- produce *disorganized–disoriented attachments* in their children.

Appendix E

Symptom Comparison

ADHD, Bipolar Disorder, Reactive Attachment Disorder

Symptom	ADHD	Bipolar I Disorder	Reactive Attachment Disorder (RAD)
Age of onset	Birth, 6, 13	2–3, 7, 13–35	Birth to 3
Family history	ADHD, academic difficulties, alcohol and substance abuse	Mood disorders, academic difficulties, alcohol and substance abuse, adoption, ADHD	Abuse and neglect, severe emotional and behavioral disorders, alcohol and substance abuse, abuse and neglect in parents' own early life
Incidence	Approximately 6% of general population	2–3% of general population	3–6% of general population
Cause	Genetic, exacerbated by stress	Genetic, exacerbated by stress and hormones	Psychological secondary to neglect, abuse, abandonment
Duration	Chronic and unremittingly continuous, tends toward improvement	May or may not show clear behavioral episodes and cyclicity; worsens over years with increased severe and dramatic symptoms	Dependent on life circumstances, including treatment and innate temperament; worsens over years without treatment, resulting in antisocial character disorders
Attention span	Short, leading to lack of productivity	Dependent on interest and motivation, distractible	Usually prolonged, secondary to hypervigilance; under stress can shorten
Impulsivity	Secondary to inattention or oblivious, regret	Driven, "irresistible," grandiosity, thrill-seeking, counter-phobia, little regret	Usually deliverable actions; Poor cause-and-effect thinking; no remorse
Hyperactivity	50% are hyperactive, disorganized	Wide ranges, with hyperactivity common in children	Common
Self-esteem	Low, rooted in ongoing performance difficulties	Low because of inherent unpredictability of mood	Low, rooted in abandonment; feel worthless and unlovable; masked by anger
Attitude	Friendly in a genuine manner	Highly unpredictable, dysphoric, moody, negativistic	Superficially charming, phoney, distrusting, emotionally distant, nonintimate

Symptom	ADHD	Bipolar I Disorder	Reactive Attachment Disorder
Control issues	Tend to seek approval; get into trouble by inability to complete tasks	Intermittent desire to please (based on mood), tend to push limits and relish power struggles	Controlled and controlling, only for self-gain, underhand, covert, and punitive
Oppositional/defiant	Argumentative, but will relent with some show of authority, redirectable	Usually overtly and prominently defiant, often not relenting to authority	Covertly or overtly defiant, passive aggressive
Blaming	Self-protective mechanism to avoid adverse consequences	Disbelief/denial they caused something to go wrong	Rejecting of responsibility, lack of empathy
Lying	Avoid adverse consequences	Enjoys "getting away with it"	"Crazy lying," "self-centered," "primary process" distortions, remain in control
Fire setting	Play with matches out of curiosity, nonmalicious	Play with matches/fire setting	Revenge motivated, malicious; danger seeking secondary to despair
Anger, irritability, temper, rage	Situational in response to overstimulation, low frustration tolerance, and need for immediate gratification; rage reaction is ususally short-lived	Secondary to limit setting or attempts by authority figures to control their excessive behavior, can last for extended periods of time; overt, assaultive	Chronic, revenge oriented; eternal "victim" position, with rationalizations for destructive retaliation; hurtful to innocent others and pets
Entitlement	Overwhelming need for immediate gratification	Feel entitled to get what they want, grandiose	Compensation for abandonment and deprivation
Conscience development	Capable of demonstrating remorse when calmed down	Limited conscious development, less cruel than RAD	Very "street smart," good survival skills, con artists, calculating, lack of remorse

Sensitivity	Oblivious to their circumstances; inappropriateness shows as result	Acutely aware of circumstances and are "hot reactors"	Hypervigilant, compensating for past helplessness; limited emotional repertoire, insensitive
Perception	Flooded by sensory overestimation, hyperactive, distractible, shuts down	Self-absorbed, preoccupied with internal need fulfillment, narcissistic	Self-centered, primary process, primitive distortions
Peer relationship	Makes friends easily, but not able to keep them	Can be charismatic or depressed, depending on mood; conflicts are the rule	Very poor, controlling and manipulative; not able to maintain relationships
Sleep disturbances	Overstimulated, once asleep "sleeps like a rock"	Inability to relax because of racing mind; nightmares common	Hypervigilance creates light sleepers; tend to need little sleep, arise early in morning
Motivation	Less resourceful, more adult-dependent; OK starters, poor finishers	Grandiose: believe they are resourceful, gifted, creative, self-directed, variable energy and enthusiasm	Consistently poor initiative, limited industriousness, intentional inefficiency
Learning difficulties	Commonly have auditory perceptual difficulties, lack fine motor coordination	Nonsequential, nonlinear learners, verbally articulate	Brain maturational delays secondary to maternal drugs/alcohol effects; early life abuse/neglect can create diverse learning problems

Symptom	ADHD	Bipolar I Disorder	Reactive Attachment Disorder
Anxiety	Uncommon unless performance-related	Emotionally wired and have high potentials for anxiety, fears, and phobias; somatic symptoms common, needle phobic	Appear invulnerable, poor recognition, awareness, or admission of fears
Sexuality	Emotionally immature and sexually naive	Sexual hyperawareness, pseudomaturity, and high activity level	Use sex as a means of power, control, or of infliction of pain, sadistic
Substance abuse	Strong tendencies, more out of coping mechanisms for low self-esteem	Strong tendencies in an attempt to medically treat either hypomanic/depressive moods	Sporadic/uncommon need to maintain control
Optimal environment	Low stimulation and stress, support and structure	Clear and assertive, limits, encouragement	Balance of security and stability, limits and clear expectations, nurturance and encouragement
Psychopharmacology	Medications very helpful: Ritalin, Dexedrine, Cylert, Wellbutrin; Clonidine, Imipramine, and Nortriptyline useful as adjunctive treatments	Medications helpful to stabilize mood: Lithium, Carbamazepine, Valproic Acid, Verapamil, Risperdal	Antidepressants, Clonidine, may help decrease hypervigilance, do not help characterological traits

Appendix F

The Effective Corrective Attachment Therapist

- Tolerance, empathy, patience and compassion
- Emotionally nonreactive; ability to remain "centered"
- Accepting, nonjudgmental and supportive
- Comfortable with anger and other strong emotions
- Free of personal abuse issues
- Confident and able to instill confidence
- Genuine sense of humor, devoid of sarcasm and ridicule
- Able to give and receive love
- Resolved with grief, loss and "wounded child" issues
- Continues to grow and evolve as a therapist and person
- Sensitive to cultural backgrounds and differences
- Adept at dealing with resistance in a creative and flexible manner
- Able to work effectively with a treatment team
- Realistic and able to maintain hope and optimism
- Knowledge and skills regarding attachment formation and disorder, and both child and family systems therapy.

Appendix G

Positive Psychology

Historically, the study of psychology focused on diagnosing and treating mental illness. Psychiatry and clinical psychology has worked within a medical model, the goal being to move people from pathological mental states to more neutral ones. Over the last several decades, a number of mental health professionals began focusing on positive emotions, psychological strengths, optimal functioning, and paths to fulfillment and meaning in life (Siegel 2009). Positive psychology is the scientific study of what makes life most worth living. It focuses on strength, not only weakness; building the best in life, not merely repairing the worst; helping people create fulfilment, not just treating pathology. Positive psychology does not ignore or dismiss real problems, but complements and extends the problem-focused approach that has been dominant for many years (Lopez and Snyder 2009).

The following paragraphs will review salient aspects of positive psychology, including insights into having a satisfying and meaningful life, practical techniques for enhancing well-being, and research findings supporting these conclusions. Additionally, many of the strategies reviewed are helpful for individuals and families struggling to overcome adversity and trauma. Specific interventions reduce anxiety and depression related to trauma, as well as build psychological resources that diminish the negative effects of adversity in the first place. The factors that create resilience and buffer against the harmful effects of trauma include optimism, positive emotions, sense of meaning and purpose, and social support.

Happiness

How is happiness defined? Basically, happiness denotes positive moods and emotions in the present and a positive outlook for the future. Martin Seligman, a founder of the positive psychology field, specified three measurable areas: pleasure, engagement, and a sense of meaning (Seligman 2002). Happiness is synonymous with positive emotions, including joy, gratitude, serenity, hope,

pride, humor, inspiration, awe, and love (Fredrickson 2001). Numerous studies conclude that happiness is causal: happiness results in success, achievement, and fulfillment, not the other way around. Rath and Harter (2010) suggest that well-being is based on the interaction of five elements: our love for what we do each day, the quality of our relationships, our physical health, the contributions we make to our communities, and the security of our finances.

Analyzing the results of over 200 studies on happiness on 270,000 people worldwide, researchers found that happiness leads to positive outcomes in many important realms: physical and mental health, longevity, work, school, marriage and social relationships, energy, creativity, and community involvement (Lyubomirsky, King, and Diener 2005). Happiness improves physical health, protects against illness, and predicts longevity. A review of 19 research projects found that the most satisfied people lived seven to ten years longer than less satisfied people. The health benefits were the same as quitting smoking by age 35 (Seligman *et al.* 2005). In another study, researchers injected subjects with a strain of the cold virus. People who scored higher on a happiness survey prior to the study did not get nearly as sick as those who were less happy; they had significantly fewer cold symptoms (Cohen *et al.* 2003). A common myth is that money buys happiness. However, above the poverty line, increased income does not contribute to happiness at all (Diener and Biswas-Diener 2008).

Individuals who report happiness and fulfillment in their lives have more positive emotions and relationships, have a sense of meaning and purpose, focus on gratitude, perform acts of kindness, and utilize their signature character strengths. These primary aspects of overall happiness and well-being are described in detail below.

Positive Emotions

In hundreds of well-controlled studies, positive emotions have been shown to contribute to success at work, improve immune function, and lead to a longer life and overall well-being. The "nun study" is a perfect example. Twenty-year-old nuns began keeping journals of their thoughts and feelings. Five decades later, these journals were analyzed for positive and negative emotions. The women with more positive emotions lived over ten years longer than those with more negative emotions. At age 85, 90 percent of the happiest nuns were alive, while only 34 percent of the least happy lived (Danner, Snowden, and Friesen 2001). People who experience positive emotions have less pain and disability related to chronic health conditions, fight off illnesses more successfully (Cohen and Pressman 2006), have lower blood pressure, and less stress associated with negative emotions (Fredrickson 2009). Positive emotions are also linked to resilience. People who experienced positive emotions before the 9/11 attacks recovered faster from trauma than their less positive counterparts. Optimism

buffers against the negative effects of traumatic events, because it fosters active problem-solving and constructive action (Peterson 2006).

Positive emotions activate biochemical changes in the brain. Positive emotions flood our brains with dopamine, serotonin, and endorphins, neurotransmitters that stimulate the brain's reward system and are associated with positive moods, motivation, pleasurable sensations, and enhanced cognitive abilities. The "broaden and build" theory offers an explanation of the salutary effects of positive emotions. Fear and stress activate the "fight, flight, freeze" response for survival purposes, restricting our thoughts and actions. When we have negative emotions we have a narrowed range of thought–action responses; we are in quick and immediate stress mode. Conversely, positive emotions lead to broadened and more flexible responses, widening the array of thoughts and actions that are possible. We are more thoughtful, creative, and open to various intellectual, social, and physical resources (Fredrickson 2001).

Creating a positive mindset prior to a task or experience has been shown to produce positive results. Adults who are "primed" for positive emotions before an experiment have more creative and diverse ideas and solutions than those not primed (Fredrickson and Branigan 2005). High school students who were told to think about the happiest day of their lives before taking a math test did much better than students not positively primed (Bryan and Bryan 1991). Four-year-olds were asked to complete several learning tasks, such as assembling different shaped blocks. The children who were told to think about happy situations prior to the tasks did much better than those not primed (Master, Barden, and Ford 1979).

Positive Relationships

A large body of research has shown that close relationships and social support have a profound effect on health and well-being. Adults in close and secure romantic relationships have more positive emotions, hope, optimism, social competencies, and emotional self-regulation than those in less secure relationships (Lopez and Snyder 2009). People with active and fulfilling social lives are 50 percent less likely to die of any cause than less social people. Lack of strong social ties is a mortality risk factor equal to smoking, high blood pressure, and obesity (Uchino *et al.* 2001). Adults with good social connections are better able to fight off illness; they are four times less likely to catch colds than those with fewer social ties (Cohen and Pressman 2006). Strong social support is linked to positive functioning of the cardiovascular, endocrine, and immune systems. Individuals with few social ties are twice as likely to die of heart disease than those with better social connections. Social support increases resilience in the wake of adversity. For example, New Yorkers with emotional support had fewer PTSD symptoms and faster recovery following the 9/11 attacks than others with less social support (Fraley *et al.* 2006).

Meaning and Purpose

Although the sense of meaning in life varies from person to person, numerous studies have demonstrated that people who believe their lives have meaning and purpose profess greater well-being, control over their lives, positive emotions, and self-esteem, and have less depression, anxiety, substance abuse, and need for therapy (Steger, Oishi, and Kashdan 2010). Your well-being is enhanced when you are part of and contribute to something larger than your individual self.

There are different ways to define and conceptualize meaning and purpose. People find meaning by engaging in creative endeavors, having elevating experiences, and through their ability to grow from negative experiences (Frankl 1963). Four domains give rise to meaning: feeling a sense of purpose, having a basis for self-worth, clarifying the value system by which one judges right from wrong, and developing a sense of efficacy in the world (Baumeister and Vohs 2002). Seligman (2002) defined the meaningful life as the ability to use signature strengths and virtues in the service of something larger than one's self. Meaning and purpose are also associated with resilience following trauma. Those who find meaning in traumatic events, such as the loss of a child, do better in their recovery than those who do not (McIntosh, Silver, and Wortman 1993). People who tell a story reflecting their ability to overcome an adverse event, and discover positive results, are better adjusted (McAdams *et al.* 1997).

Gratitude

Gratitude is an important component of a happy and fulfilling life. It is a thankful appreciation for what you receive, whether tangible or intangible. Gratitude is consistently linked with feeling more positive emotions, savoring positive experiences, having better health, dealing effectively with adversity, and building strong relationships (Watkins 2004). People who kept a "gratitude journal" were more optimistic, exercised more, and had fewer doctor visits than those who focused on things that displeased them (Emmons and McCullough 2003). Individuals who wrote a letter of gratitude to a person who had benefited them, but whom they had not thanked, and delivered it, were happier and less depressed afterward (Seligman *et al.* 2005). Grateful people, including Vietnam War veterans, report fewer PTSD symptoms following trauma than less grateful people (Kashdan, Uswatte, and Julian 2006). Gratitude even impacts memory. Grateful individuals recollect more pleasant events than their less grateful counterparts (Watkins 2004).

How does gratitude contribute to happiness and well-being? Gratitude enhances positive emotions by focusing on the enjoyment of benefits. It directs one's focus to the good things one has and away from things lacking, thus preventing the negative emotions associated with social comparison and envy. Gratitude promotes prosocial behavior, positive social relationships, and trust. It leads to adaptive coping strategies by making sense of stressful events. Gratitude

increases the accessibility to positive memories, which in turn, supports one's well-being (Watkins 2004). Grateful people are more likely to seek less and appreciate and care for what they have.

Kindness and Generosity

Committing acts of kindness increases and sustains happiness and well-being. Volunteering to reduce suffering and improve others' lives has been found to increase physical health, life satisfaction, and sense of purpose and meaning. Acts of altruism—giving to friends and family—decreases stress and enhances mental health. Volunteering to help after traumas and adversity increases self-esteem, empowers, and improves overall health (Post 2005). Adolescents who volunteer in their community have higher future aspirations, better self-esteem, and increased motivation in school (Johnson *et al.* 1998). College students told to perform five acts of kindness per day (e.g., hold the door open for a stranger) reported feeling significantly happier than a control group, and the positive feeling lasted for many days (Lyubomirsky 2008). When we help others we realize we can make a difference, and this increases confidence in our ability to create change. Performing acts of kindness bolsters self-regard, positive social interactions, and charitable feelings toward others and the community. Perhaps most importantly, altruism arises from feelings of empathy—caring about the needs and welfare of others. Empathy is basic to the human condition: the interconnectedness among us, the fact that we are social animals, and the prosocial morality that guides our actions.

Character Strengths

Positive psychology focuses on helping people identify and augment their unique abilities and traits—their character strengths. Positive psychologists point out that individual strengths and virtues are as important to understand as are individual problems. Manifesting your strengths is one pathway to happiness, well-being, and fulfillment (Siegel 2009).

Beginning in 1999, a group of scholars, practitioners, and researchers initiated a study of value and qualities considered prized across many cultures and believed to lead to fulfillment in life. Six virtues, or universally valued core characteristics, were identified (Peterson and Seligman 2004):

- *wisdom:* intellectual strengths that help you gain and use knowledge and information
- *courage:* emotional strengths that help you accomplish goals in the face of fear, and internal or external obstacles
- *humanity:* interpersonal strengths that help you tend to your relationships and befriend others

- *justice:* social and civic strengths underlying healthy community life
- *temperance:* strengths that protect against excess and help to avoid temptations
- *transcendence:* strengths that connect you to the larger universe and provide meaning.

Each of the six virtues has a number of character strengths associated with it, which involve thoughts, feelings, and behaviors. For example, a person may display the virtue of wisdom by using the character strength of curiosity—exploring and having new experiences. An individual might show courage by displaying bravery—speaking and acting for what you believe. Research has demonstrated that of the 24 character strengths, the strengths most linked to life satisfaction, happiness, and psychological well-being are: *gratitude*, *hope*, *vitality*, *curiosity*, and *love* (Peterson, and Seligman 2004). Most people are particularly gifted in some areas and weaker in others. However, when you play to your strengths, you are likely to perform better than when you use a strength that comes less naturally.

To obtain the benefits of utilizing your strengths, the first step is to know exactly what those strengths are. To assess specific character strengths, the VIA Institute on Character offers an online "Signature Strength Survey," available at www.viacharacter.org. This questionnaire provides a ranking of your top five strengths. But knowing your strengths is beneficial only if you use them. Studies have shown that people who use their signature strengths significantly increase happiness and decrease depression (Peterson 2006).

Exercises to Enhance Well-Being

There is considerable research and anecdotal evidence which shows that people can increase and sustain their level of life satisfaction, health, and well-being by practicing intentional activities and strategies (Lyubomirsky 2008). Listed below are a number of purposeful activities that lead to meaningful positive changes in happiness and well-being.

- *Expressing gratitude*: Write a gratitude letter expressing your enjoyment and appreciation of a person's impact on you and your life. Send it, or even better, deliver it and read it in person. Send letters on a regular basis; you will feel happier and nurture your relationships as well.
- *Gratitude journal*: Set aside a few minutes each day to write down five large or small things you are grateful for. Be specific and relive the feelings and sensations you experienced as you remember what each thing means to you. Do this "counting your blessings" exercise with your partner and it will improve your relationship.

- *Acts of kindness*: Every day for six weeks, write down large or small acts of kindness you have carried out. Notice how you feel at the time and afterwards. You will improve your own life and the lives of others.
- *Smile*: Positive emotions are contagious. Smiling activates neurochemicals (e.g., dopamine) that result in positive emotions for oneself and others. Consciously add three smiles to each day, where you would not have done otherwise. You will feel better and others will smile back.
- *Savoring*: Learn to place your attention on pleasure as it occurs, consciously enjoying experiences in the moment. Enhance your ability to recognize and enjoy everyday pleasure by: reducing multitasking, the enemy of savoring; celebrating your accomplishments; eliminating less enjoyable activities; slowing down and enjoying pleasurable things without rushing; simplifying—too many choices will diminish your pleasure; sharing the moment with someone you care about; setting new goals and planning new activities—savor your new undertakings; reminiscing about pleasurable events, vacations, and victories—cherish precious memories with loved ones.
- *Flow*: Flow experiences—being immersed in and concentrating on what you are doing—lead to positive emotions, short and long term. You create opportunities for flow experiences when there is a balance between the challenge of an activity and the skill you have in performing it. High challenge and high skill together produce a flow experience.
- *Signature strengths*: Pick one of your signature strengths and use it in a new way every day for one week—try a new activity that is challenging, like public speaking (bravery); learn something new (curiosity); listen to an opinion you disagree with (open-mindedness); write a note to someone you care about (love).
- *Mindfulness meditation*: This is the practice of focusing attention on the present moment and accepting it without judgment. This reduces anxiety about the future and regrets about the past, creates a greater ability to manage adverse events and emotions, and leads to increased wellbeing. Practice mindfulness meditation on a regular basis.

Appendix H

Life Script

This questionnaire is completed with the therapist. It is useful as a tool to facilitate discussion about family-of-origin issues.

1. Where were you born, where did you grow up?

2. Who was living at home in your family when you were growing up?

3. Write four to six adjectives that describe each sibling, from your perspective as a child.

1.	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**
3.	**3.**	**3.**	**3.**
4.	**4.**	**4.**	**4.**
5.	**5.**	**5.**	**5.**
6.	**6.**	**6.**	**6.**

Age?

Married?

Children?

Job?

How do you get along with them now?

4. Write 4 to 6 adjectives that describe each parent, from your perspective as a child.

Mom: _______ Age: ___ Health? _____	**Dad: _______ Age: ___ Health? _____**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**
6.	**6.**
What did your mother do for work?	**What did your father do for work?**
Did you know your mother's parents?	**Did you know your father's parents?**
GF:	**GF:**
GM:	**GM:**

5. Why did your mother marry your father? (Best guess)

Why did your father marry your mother? (Best guess)

How did your parents handle:

Conflict

Emotion

Who handled discipline of the children?

Who had the power in the relationship?

6. Who were you closest to and why? Is this who you turned to for comfort?

Were there any other adults with whom you were close as a child, or any other adults who were especially important to you?

7. Write four to six adjectives that describe you

As a child:	**Now:**	**Health:**
1	**1.**	**1**
2.	**2.**	**2.**
3.	**3.**	**3.**
4.	**4.**	**4.**
5.	**5.**	**5.**
6.	**6.**	**6.**

8. What, if any, were the major/traumatic events that happened to you when you were a child?

9. a. What were the major messages your mother gave you about yourself and how to deal with life?

b. What were the major messages your father gave you about yourself and how to deal with life?

10. a. Based on your observations of your mother, what did you learn from your mother about women?

Women are…

b. Based on your observations of your father, what did you learn from your father about men?

Men are …

11. Who was your favorite childhood hero or heroine?

12. What was your favorite childhood story or fairy tale?

13. Write four to six adjectives that describe each significant relationship you have had.

1 _______________	**2** _______________	**3** _______________	**4** _______________
1.	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**
3.	**3.**	**3.**	**3.**
4.	**4.**	**4.**	**4.**
5.	**5.**	**5.**	**5.**
6.	**6.**	**6.**	**6.**

How old were you?

How long did it last?

How did it end?

14. Write 4 to 6 adjectives that describe each of your children.

1 _______________	**2** _______________	**3** _______________	**4** _______________
Age:	**Age:**	**Age:**	**Age:**
1.	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**
3.	**3.**	**3.**	**3.**
4.	**4.**	**4.**	**4.**
5.	**5.**	**5.**	**5.**
6.	**6.**	**6.**	**6.**

15. What would you write on the tombstone or as an epitaph for mother, father, (spouse), self?

Mother:

Father:

Spouse:

Self:

Appendix I

Follow-Up Treatment Plan

Date

____

Child's Name ____________________ Date of Birth __________ Age ____

Therapist

____

Hometown Therapist/Agency

____

Clinical Director ____________________ Treatment Dates ____________________

Diagnosis

Axis	Code	Diagnosis
I	313.89	Reactive Attachment Disorder
	313.81	Oppositional Defiant Disorder
	309.89	Posttraumatic Stress Disorder

Strengths

Parents' commitment, understanding, and willingness to learn.
Support of hometown agency and therapist.
Extended family support.
Child's intelligence and desire for family.

Spiritual faith and support of family.
Parents working to strengthen marriage.

Treatment Issues

Child's oppositional, defiant, and aggressive behaviors.
Child's lack of trust, reciprocity, and negative working model.
Parenting skills; high frustration and stress.
Mother's depression and demoralization.
Father's resolution of family-of-origin issues.

TREATMENT GOALS AND PLANS

Emotional/Relationships

Goal 1 Family will create a safe and secure environment to facilitate trust and attachment.

Goal 2 Child will increase ability to be reciprocal, trusting, affectionate, and appropriately compliant with parents.

Goal 3 Parents will enhance marital communication and unity, address individual family-of-origin issues, and improve parenting skills.

Goal 4 Family will establish necessary external supports to reduce stress level and achieve goals.

Description of Services

Services:	**Intensity/Frequency:**
Individual, marital and family therapy.	Regular schedule with hometown therapist.
Telephone contact with therapeutic foster parent.	Weekly/ongoing.
Follow-up medication monitoring and management	As per hometown psychiatrist.
Parents establish respite system with help of hometown agency.	ASAP; with hometown agency.
Conference calls with treatment team.	As per schedule and/or as needed.

By signing this treatment plan I agree to follow through with my role in carrying out the plan or will contact Evergreen Psychotherapy Center with any changes or concerns.

Parent

____

Parent

____

Child

____

Treatment Parents

____

Clinical Director

____

Hometown Therapist

____

Primary Therapist

____

Date

____

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