What exactly is this “fertile soil” for children alluded to above? Another goal of this book is to answer that question in reference to varied attachment-related issues, populations, and sociocultural arenas. Thus, the chapters in this book focus on attentional deficits, hyperactivity, bipolar disorder, and other psychobiological conditions in children; aggression, violence, and antisocial personality; parenting children with severely disrupted attachment; integrating Western and Eastern perspectives; foster care, adoptive family, and military family systems; community agency, social service, and other child welfare systems; and adult individual and relationship functioning and treatment. An additional goal of this book is to provide a voice for the ideas, perspectives, and solutions found in the subsequent pages. Each chapter focuses on both theory and practice, with the emphasis on specific strategies and methodologies of intervention. The final goal of this book is to offer specific solutions to various attachment-related problems in children, adults, families, and social systems.

This book is intended primarily for mental health, social service, and allied child welfare professionals who are responsible for influencing the lives of children, adults, and families and for determining the moral framework of our society. Clinicians, caseworkers, therapeutic foster parents, juvenile and family court judges, and others who work in these realms will find interesting concepts and effective strategies for positive change in these chapters. Graduate students in child welfare, child development, and family systems, as well as adoptive parents and others interested in salient attachment-related topics, will find these contributions illuminating and useful.

I extend my appreciation to the authors in this volume. I am aware that each of these contributors is extremely busy and involved in his or her particular area of expertise. They took time from their work and tight schedules to complete these chapters. This reflects their high level of dedication and commitment to the issues and solutions discussed herein.

Terry M. Levy

ATTACHMENT DISORDER AS AN ANTECEDENT TO VIOLENCE AND ANTISOCIAL PATTERNS IN CHILDREN

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The United States is the most violent country in the industrialized world—particularly for children. Homicide is the 11th leading cause of death for all Americans, but the third leading cause of death for children between the ages of 5 and 14 (J. D. Osofsky, 1995). The homicide rate for young males is 40 times higher than the country with the lowest rate (Japan). Children and youths are victimized more than adults in every category—physical abuse, assault, bullying, rape. There was a 300% increase between 1986 and 1993 in the number of children seriously injured by maltreatment—mostly by violent parents (Children’s Defense Fund, 1997).

The proliferation of violence has been likened to a national epidemic, breeding more violence at an exponential rate (Levine, 1996). A quarter of all households in the U.S. are victimized by crime each year. Nearly 1 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. Three million crimes occur on or near school grounds each year. One hundred and five fatalities were reported from 1992 to 1994; 40 children have been killed in school each year since 1993 (Kachur, Stennies, Powell, & Lowery, 1994).
Recent reports in the media of declining adult crime rates are misleading because they do not reflect the alarming increases in youth crime. There is a rapidly growing percentage of extremely cruel and violent crimes committed by children under the age of 12. We are experiencing a pace of violence among certain children that has been steadily rising since the mid-1970s. Violent crime among juveniles has quadrupled since 1975. A small percentage of disturbed youths are committing a larger percentage of violent crimes and at a younger age. Between 1983 and 1992, the arrest rate for girls under the age of 18 increased by 85%, while for boys it went up by 50%. The number of youths held in juvenile facilities has increased 41% since 1970s. More than 110,000 children under age 13 were arrested for felonies in 1994; 12,000 were crimes against people, including murder, rape, robbery, and aggravated assault (Berman, Kurtines, Silverman, & Serafini, 1996).

The children committing these violent crimes have a history of chronic aggression. Research shows that by age 4 they display ongoing and consistent patterns of aggression, rage, bullying, defiance, and controlling interactions with others (Greenberg, Deklyen, Speltz, & Endriga, 1997). Karr-Morse and Wiley (1997, p. 6) provide the following recent examples: A 10-year-old boy killed a 9-month-old baby by kicking and hitting her; a 4-year-old stomp an 8-week-old infant to death in her crib; a 10-year-old killed an 84-year-old neighbor by beating her with her cane; four 2nd-grade boys tried to kill a female classmate for breaking up with an 8-year-old gang leader.

Children are becoming more violent. Every 5 minutes a child is arrested for a violent crime. Juvenile homicide has doubled since the late 1980s (Children’s Defense Fund, 1997). Violent crimes perpetrated by youths have recently become the focus of increased national concern and scrutiny. In an 8-month period (October, 1997-May, 1998), school shootings have resulted in 14 killed and 49 wounded. In West Paducah, Kentucky, a 14-year-old boy sprayed bullets into a high school prayer circle, killing three girls and wounding five others. In Pearl, Mississippi, a 16-year-old stabbed and killed his mother, then shot and killed two schoolmates and wounded seven other high school students. Two boys, ages 11 and 13, in Jonesboro, Arkansas, shot and killed four students and one teacher and wounded 10 others. On May 21, 1998, a 15-year-old boy killed two students and wounded 25 others in Springfield, Oregon, when opening fire in the school cafeteria—after he shot and killed his mother and father in their home.

This series of recent killings and injuries by angry youths marks a shift in the nature of youth violence, with incidents moving beyond one-to-one disputes into movie-style scenes of mass mayhem. In essence, there is more firepower, more victims, and an increased sense of callousness and indifference on the part of the young killers (Lewin, 1998). The vast majority of these young offenders have histories of abuse and neglect, lived in single-parent homes with young and highly stressed caregivers, and had parents with criminal records. Most of these children suffer from undiagnosed, untreated, and severe attachment disorders. They go on to commit more numerous and serious offenses, becoming the superpredators of tomorrow (Levy & Orlans, 1998).

Children with a history of severe attachment disorder develop aggressive, controlling, and conduct disordered behaviors, which contribute 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 responsibility, dishonesty, and a blatant disregard for the rules and standards of family and society. Teenage boys 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 3 years of life can lead to “affectionless psychopathy”; the inability to form meaningful emotional relationships, coupled with chronic anger, poor impulse control, and lack of remorse (Bowlby, 1969). These disturbing psychosocial qualities have contributed to a more violent and “heartless” character to the crimes being committed by today’s youths.

CAUSES OF VIOLENCE IN CHILDREN

Prior to focusing on the association between disrupted attachment and violence, it is important to review other significant factors that contribute to aggressive and conduct-disordered behavior. A combination of emotional, social, and biological factors typically interact to promote later violence and antisocial acting-out (Levine, 1996; National Research Council, 1993). The interaction of internal vulnerabilities (e.g., emotional and/or cognitive deficits) and negative environmental factors (e.g., early abuse and/or neglect) create a context that results in youth violence. Extremely aggressive and violent juvenile offenders, for example, were found to have histories of maltreatment as well as cognitive/attentional/impulsivity problems (Lewis, 1990).

Family Influences

Common factors include parental mental illness, substance abuse, chronic discord and criminality, maternal rejection, depression and low I.Q., maltreatment, and multiple caregivers. Consider the following statistics on child maltreatment:

- The number of children seriously injured by maltreatment quadrupled from 1986 (140,000) to 1993 (600,000).
Environmental Factors

These include living in an impoverished atmosphere, modeling of violence in community, access to guns, and violence in the media. Human violence is largely learned. Children learn that violence is an acceptable way to solve problems by experiencing and witnessing violence (e.g., physical abuse, domestic violence). Boys who learn to be violent are more likely to be violent toward their wives and children and to be involved in crime when they become adults (Huesmann, Eron, Lefkowitz, & Walder, 1984). From preschool years through adulthood, violent individuals have thought patterns and belief systems that endorse the use of violence: “aggression is a legitimate way to express feelings, solve problems, boost self-image, and attain power.” These thought patterns are usually learned in early childhood in the family and community (Shure & Spivack, 1988; Slaby & Guerra, 1988). Research on community violence revealed that in one Chicago neighborhood, one-third of school-age children witnessed a homicide and two-thirds witnessed a serious assault (Bell & Jenkins, 1993). Thirty-two percent of Washington, DC children and over half of New Orleans children were victims of violence in their community (Richert & Martinez, 1993). Children are directly exposed to family and community violence. Infants and toddlers, however, are indirectly but profoundly exposed; they are “tuned into” their caregivers’ fears and anxieties about violence, influenced by the adults’ coping strategies, and restricted in their psychosocial development (J. Ososky, 1994).

The widespread availability and use of guns has broadened the scope and lethality of youth violence. One quarter of those arrested on weapons charges are juveniles (U.S. Department of Justice, 1995; cited in Levine, 1996). Firearms account for over 75% of all homicides for those 15 to 19 years old. Guns have become a staple of childhood and teenage life in many American cities. In one study, every child living in public housing in Chicago had witnessed a shooting by age 5. Every 90 minutes a child is killed by someone using a gun (Berkowitz, 1994; Mercy & Rosenberg, 1996).

The average American child spends 900 hours a year in school and 1500 hours a year watching TV. By the time a child leaves elementary school he or she has seen 8,000 murders and over 100,000 other acts of violence on television. Forty years of research has documented that violence is learned from TV and movies. Children’s TV shows contain about 20–25 violent acts per hour. Preschoolers who watch violent cartoons are more likely to hit playmates, disobey class rules, and argue with teachers than are children who watch nonviolent shows. Elementary school children who watch considerable TV violence are more aggressive as teens and more likely to be arrested for criminal acts as adults. Children who watch extensive violence on TV can become less sensitive to the pain and suffering of others, more fearful in general, and more harmful to others. A primary message from TV and movies is that violence is an acceptable solution to human problems (Huston et al., 1992; National Institute of Mental Health, 1982).
Biological Contributions

These factors include prenatal drug and alcohol exposure, failure to thrive, severe and chronic maternal stress, birth-related complications and prematurity, nutritional deficiencies, and genetic background. There is no single “violence gene,” but violence is related to traits that may be partially heritable—a difficult, fearless, and uninhibited temperament, hyperactivity, and attention problems. Temperament differences may partially explain why siblings are different and why, even in violent communities, only some youths turn to violence (National Research Council, 1993). Genetic deficits which result from prenatal drug and/or alcohol exposure, or other environmental causes, can lead to later violent behavior. The brain of the developing fetus can be damaged, resulting in problems with learning, attention, and impulse control later in childhood (Karr-Morse & Wiley, 1997; Schore, 1994).

Additional Factors

These include Attentional Deficit Hyperactivity Disorder (ADHD), low verbal I.Q., and posttraumatic stress symptoms. Children with ADHD are deficient in focusing, attending, planning, impulse control, concentrating, and self-regulating. Attentional Deficit Hyperactivity Disordered children who experience maltreatment and instability in their families often develop Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) over time. These children often become angry, defiant, and violent (Barkley, 1990). Children with symptoms of Post-traumatic Stress Disorder typically display aggressive and violent behaviors, with both a biological and emotional basis (Barkley, 1990; see pp. 22–23 for more details).

SECURE ATTACHMENT

Attachment is an enduring affective bond characterized by a tendency to seek and maintain proximity to a specific person, particularly when under stress (Ainsworth, 1973; Bowlby, 1969). Attachment is the deep and long-lasting emotional connection established between a child and caregiver in the first several years of life. It profoundly influences every component of the human condition—mind, body, emotions, relationships, and values. This 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 guidance and support as a basic human need is rooted in millions of years of evolution. There is an instinct to attach: babies instinctively reach out for the safety and security 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 (i.e., social releasers) from caregivers (smile, eye contact, holding, rocking, touching, feeding). The attachment process is defined as a “mutual regulatory system,” with the baby and caregiver influencing one another over time.

Beyond the basic function of secure attachment—providing safety and protection for the vulnerable young via closeness to a caregiver—there are several other important functions for children developmentally:

- to learn basic trust and reciprocity, which serves 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 identity, which includes a sense of competency, self-worth, and a balance between dependence and autonomy.
- to establish a prosocial moral framework, which involves empathy, compassion, and conscience.
- to generate the core belief system, which comprises cognitive appraisals of self, caregivers, others, and life in general.
- to provide a defense against stress and trauma, which incorporates resourcefulness and resilience (Levy & Orlans, 1995, 1998).

Children who begin their lives with secure attachment fare better in all aspects of functioning as development unfolds. Numerous longitudinal studies have demonstrated that securely attached infants and toddlers do better later in life regarding: self-esteem, independence and autonomy, enduring friendships, trust and intimacy, positive relationships with parents and other authority figures, impulse control, empathy and compassion, resilience in the face of adversity, school success, and future marital and family relations (Jacobson & Wille, 1986; Main, Kaplan, & Cassidy, 1985; Sroufe, Carlson, & Shulman, 1993; Troy & Sroufe, 1987; Waters, Wippman, & Sroufe, 1979).

Many professionals in the child welfare and mental health field focus on the symptoms associated with violence in youths (e.g., defiance, anger, impulsivity). The core issue of attachment, however, is often overlooked.

In order to understand the tide of violent behavior in which America is now submerged, we must look before preadolescence, before grade school, before preschool, to the cradle of human formation in the first thirty-three months of life.
These months, including nine months of prenatal development and the first two years after birth (33 months), harbor the seeds of violence for a growing percentage of American children (Karr-Morse & Wiley, 1997, p. 9).

The creation of a secure attachment relationship between the child and the primary caregiver(s) is a primary protective factor against later violent and antisocial patterns of cognition, behavior, and interaction. The specific attachment-related protective factors that reduce the likelihood of later aggression and violence include:

1. Ability to regulate and modulate impulses and emotions: Secure attachment with a primary caregiver is critical if children are to learn self-control. "The primary function of parents can be thought of as helping children modulate their arousal by attuned and well-time 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).

2. Developing prosocial values, empathy, and morality: 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). Secure attachments foster prosocial values and behaviors, including empathy, compassion, kindness, and morality.

3. Establishing a solid and positive sense of self: Children who experience a secure base with an appropriately responsive and available caregiver are more likely to be autonomous and independent as they develop. They are able to explore their environment with more confidence and less anxiety, resulting in enhanced self-esteem, feelings of mastery, and differentiation of self. They develop positive beliefs and expectations about themselves and relationships ("positive internal working model"). The route to caring for others begins with a positive and secure sense of self, with clear boundaries between self and others.

4. Ability to effectively manage stress and adversity: Resilience refers to an individual's competence and successful adaptation following exposure to significant adversity and stressful life events. Studies of resiliency 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 (Werner & Smith, 1992).

5. Ability to create and maintain emotionally reciprocal relationships: Securely attached children experience warm, trusting, and loving reciprocal relationships, resulting in the internalization of prosocial standards of behavior, cooperation, and self-control. They are able to experience, receive, and give affection and love. The child is "in sync" with the parent and, therefore, is learning to be aware of the feelings and needs of another person. Secure attachment implies greater awareness of the mental state of others, which not only produces a more rapid and effective evolution of morality, but also protects the child from antisocial behavior.

**DISORDERED ATTACHMENT**

Infancy and the first several years of life is the critical developmental stage in which children develop basic trust, patterns of relating, sense of self, conscience, and cognitive abilities. Many children, however, do not experience secure attachments with loving, reliable, and protective caregivers and are left without a crucial foundation for healthy development. They are flooding our child welfare and juvenile justice systems with an overwhelming array of problems and are at a high risk for becoming adults who perpetuate the cycle with their own children. Children who begin their lives with seriously compromised and disrupted attachment often become impulsive, extremely oppositional, lacking in conscience and empathy, unable to give and receive genuine affection and love, angry, aggressive, and violent. A recent newspaper article reveals the seriousness of our current problem:

The nation's juvenile courts, long a troubled backwater of the criminal justice system, has been so overwhelmed by the increase in violent teenage crime and the breakdown of the family that judges and politicians are debating a solution that was once unthinkable—abolishing the system and trying most minors as adults (Butterfield, 1997).

The legal and child welfare systems not only find it impossible to keep up with new cases, but have difficulty monitoring and serving the children and families on their current caseloads. As many as 50% of all fatalities that are due to child abuse and neglect occur in cases that have already been brought to the attention of law enforcement and child protection agencies (Lung & Daro, 1996).

The causes of attachment disorder are grouped into three categories: (1) parental/caregiver contributions (e.g., abuse and neglect, depression, psychological disorders); (2) child contributions (e.g., difficult temperament, prematurity, fetal alcohol syndrome); and (3) environmental contributions (e.g., poverty, stressful and violent home and/or community). The most common causes of attachment disorder are abuse, neglect, multiple out-of-home placements (e.g., moves in foster care system), and other prolonged separations from the primary attachment figure (e.g., hospitalization, prison, postpartum depression). Social service and mental health professionals often suggest that attached disorder is rare. The evidence, however, indicates otherwise. Research has shown that severe attachment disorders are created in up to 80% of children in high-risk families; risk factors include abuse, neglect, domestic violence, poverty, substance abuse, history of maltreatment in parents' childhoods, depression, and other serious psychologi-
cultural disorders of parents. Since there are 1 million substantiated cases of serious abuse and neglect in the U.S. each year, the statistics indicate there are approximately 800,000 children with severe attachment disorder coming to the attention of the child welfare system annually (Lyons-Ruth, 1996). Surveys indicate that the actual number of cases is 10 to 16 times higher (Gallup et al., 1995). These figures do not include the thousands of children with attachment disorder adopted from other countries.

Attachment disorder affects many aspects of a child's functioning. Symptoms exist along a continuum, from mild to severe, and are divided into six categories.

- **Behavior**: oppositional and defiant, impulsive, destructive, lie and steal, aggressive and abusive, hyperactive, self-destructive, cruel to animals, fire setting.
- **Emotions**: intense anger, depressed and hopeless, moody, fearful, and anxious (although often hidden), irritable, inappropriate emotional reactions.
- **Thoughts**: negative core beliefs about self, relationships, and life in general ("negative working model"), lack of cause-and-effect thinking, attention and learning problems.
- **Relationships**: lacks trust, controlling ("bossy"), manipulative, does not give or receive genuine affection and love, indiscriminately affectionate with strangers, unstable peer relationships, blames others for own mistakes or problems, victimized others/victimized.
- **Physical**: poor hygiene, tactlessly defensive, enuresis and encopresis, accident prone, high pain tolerance, genetic predisposition (e.g., depression, hyperactivity).
- **Moral/spiritual**: lack of empathy, faith, compassion, remorse, meaning and other prosocial values; identification with evil and the dark side of life.

Attachment disorder is transmitted intergenerationally; children with disordered attachments commonly grow up to be parents who are not able to create a secure foundation with their own children. Instead of following the instinct to protect, comfort, 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.

**Aggression and Antisocial Patterns**

Neglectful, abusive, and nonresponsive caregivers produce out-of-control, angry, depressed, and hopeless children by 2 to 3 years of age. Attachment-disordered children have frequent and prolonged temper tantrums, are impulsive and accident prone, and desperately seek attention via negative behaviors. 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 for learning. Their inability to control impulses and emotions leads to aggressive acting-out and lack of enduring relationships. Compared to securely attached children, attachment-disordered children are significantly more aggressive, disruptive, and antisocial.

It is the children with histories of disorganized-disoriented attachment who are most at risk for developing severe problems, including aggression. 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 (Main & Solomon, 1990). Disorganized infant attachment has been found to be associated with unresolved loss, fear, and trauma of the parent(s). They have not mourned losses, are frightened by memories of past trauma, may dissociate, and script their child into unresolved family drama (Main & Goldwyn, 1984; Van IJzendoorn, 1995). Mothers of disorganized infants typically have histories of family violence and abuse rather than neglect alone (Lyons-Ruth, Alpern, & Repacholi, 1993). These mothers are "out of sync" with their babies, displaying confusing and mixed messages (e.g., extend arms toward infant while backing away) and inappropriate responses to their infant's cues (e.g., laugh when baby is in distress) (Lyons-Ruth, 1996; Main et al., 1985; Spieker & Booth, 1988). These mothers show high levels of negative and downcast affect to their babies and low levels of tenderness and affection (DeMulder & Radke-Yarrow, 1991). Thus, disorganized 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 irresolvable paradox: closeness to the parent both increases the infant's fear and, simultaneously, need for soothing contact. Closeness and contact with the parent triggers fear rather than safety or comfort (Lyons-Ruth, 1996; Main & Hesse, 1990).

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 et al., 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, Castino, Jarosinski, & Britton, 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. 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 were more aggressive and impulsive and had more conflict with peers and caregivers during their school years (Egeland, Pianta, & O'Brien, 1993; Erickson, Sroufe, & Egeland, 1985; Renken, Egeland, Marvinney, Mangelsdoff, & Sroufe, 1989; Sroufe, Egeland, & Kreutzer, 1990). Among high-risk families, it is clear that early disturbed attachment patterns place children at high risk for later aggression and violent behavior.

Children with a history of severe (disorganized) attachment disorder develop aggressive, controlling, and conduct-disordered behaviors, which contribute to the development of an antisocial personality. As early as the latency years, 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. They are “macro-defiant”; they defy parental authority, social rules, millions of years of human evolution (i.e., evolutionary basis of moral behavior), and even reject the concept of a higher power. They exhibit a level of anger and noncompliance beyond that of typical Oppositional Defiant Disorder. 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. They typically lie as a way of life. 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 feeling of having the “upper hand.” Symptoms and traits of the adult psychopathic and antisocial personality are displayed in severely attachment-disordered children: cruelty to animals, enuresis, fire-setting, predatory and vengeful, controlling and manipulative, lack of empathy, remorse and conscience, pathological lying, self-gratification at other’s expense, inability to form close relationships (Hare, 1993; Yochelson & Samenow, 1993). Davis (1998) reports that serial killers seek control over others, lack conscience, and display other typical symptoms by age 12 (enuresis, animal torture, fire-setting, pathological lying, chronic daydreaming, violent fantasies). Douglas (1998) describes the adult violent psychopathic personality (e.g., sexual predator) as obsessed with manipulation, domination, and control. In essence, children with severe attachment disorders are violent psychopaths in training.

Children with histories of severe attachment disorder commonly display three behaviors that are also found in the childhood histories of adult psychopaths: cruelty to animals, enuresis, and fire-setting. Infamous serial murderers such as Jeffrey Dahmer, Ted Bundy, David Berkowitz (“Son of Sam”), Charles Manson, and Albert DeSalvo (“Boston Strangler”) all tortured animals when they were young. Cruelty to animals is one of the most disturbing manifestations of attachment disorder. It ranges from annoyance of 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. Studies 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 individuals who have committed multiple murders 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). Fromm (1973) noted that children who are sadistic are usually themselves the victims of cruel treatment. Showalter (1983) concluded that cruelty to animals represents a displacement of aggression from the child to a helpless animal.

Fire provides a particular appeal for severely attachment-disordered children. It’s attributes of power and destruction are attractive qualities to the child who is rage filled and feels powerless. The child’s fire-setting behaviors are extremely disconcerting to caregivers. The child senses this fear and apprehension and uses this to his or her advantage in order to gain further power and control. 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 is beginning to recognize the magnitude of this problem; juveniles now account for the majority of all arson arrests (55% in 1994). One-third of those arrested were under 15 years old, and 7% were under the age of 10. No other serious felony has such a high rate of juvenile involvement (Estrin, 1996).

Negative Working Model

The internal working model (core belief system) is the cognitive representation of early attachment relationships. Children develop beliefs about themselves, relationships, and life in general based on the nature of early attachment patterns with primary caregivers. This internal working model affects how the child interprets events, stores information in memory, and perceives social situations. A comparison of the internal working model of children with secure and disordered attachment follows:

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.”
Disordered 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 of children with attachment disorder includes negative self-evaluations and self-contempt. They internalize lack of adequate care, love, and protection as self-blame and perceive themselves as unlovable, helpless, and responsible for maltreatment. 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, & Pettit, 1990). The child is conditioned to perceive threat and hostility even when it is not there and commonly responds with aggressive and coercive behavior (Troy & Sroufe, 1987). These latter core beliefs promote a sense of alienation from family and society; a need to control others and protect oneself at all times; and angry, vindictive, violent, and antisocial behaviors.

Lack of Morality and Antisocial Values

Important prosocial values, attitudes, and behaviors are learned in the context of secure attachment relationships via four psychological processes: (1) modeling by parents or other attachment figures, (2) internalizing the values and behavior of parents or other attachment figures, (3) experiencing synchronicity and reciprocity in early attachment relationships, and (4) developing a positive sense of self. When the family does not promote secure attachment and appropriate socialization experiences, as is the case with attachment disorder, the child is at risk for developing not only conduct disorders, but also a more pervasive lack of morality. Empathic parents rear empathic children. Children with compromised and disrupted attachments lack the models of empathy and compassion and tend to be cruel, controlling, and selfish. They have internalized antisocial values and standards, such as sadistic power, dishonesty, selfishness, and aggressive control. Their inner voice does not include a conscience or feelings of remorse. Lacking a secure foundation, a weak and negative self-identity has been created, and the child assumes a fearful and punitive orientation. There is no room for empathy or caring as the child must survive in a world perceived as lonely and threatening (Waters et al., 1979; Zahn-Waxler, Radke-Yarrow, Wagner, & Chapman, 1992).

Neurobiology of Attachment and Trauma

An extremely damaging and debilitating consequence of disordered attachment in children is their chronic inability to modulate emotions, behaviors, and impulses. This affects the biological and psychological ability to self-regulate and often leads to a variety of psychosocial problems, including aggression against the self and others (van der Kolk & Fisler, 1994). Secure attachment with a primary caregiver is critical if children are to learn self-control. Attachment and nurturing behaviors (eye contact, reciprocal smile, holding, rocking, touching) help to maintain the infant’s homeostatic balance both emotionally and physically (Hofer, 1995; van der Kolk, 1996). This is a process that caregivers and babies accomplish together. This mutual regulatory process breaks down under conditions of anxious and disrupted attachment. Depressed, substance-abusing, or otherwise neglectful and abusive caregivers are not attuned to their infant’s emotions and needs, leaving the baby without any necessary regulatory support (Robinson & Glaves, 1996).

The first 33 months (fetal stage and first 2 years) is the time of most rapid brain growth; the period when the quality of the caregiving environment profoundly affects the structure and function of the developing brain. Trauma affects the young 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. Lack of secure attachment and exposure to traumatic stress alters the nervous system, predisposing the child to be impulsive, overreactive, and violent (Perry, 1994, 1995). These children often develop symptoms of posttraumatic stress disorder, including: (1) recurring intrusive recollections, such as dreams or flashbacks; (2) persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness; and (3) hyperarousal, such as hypervigilance, startle response, sleep difficulties, irritability, anxiety, and physical hyperactivity (Perry, 1994).

The limbic system is the part of the brain that controls emotion, impulses, and maternal functions. The cortex is involved in higher mental functions, such as logic and planning. The orbitofrontal cortex connects these two parts of the brain—a key area that is crucial to both attachment and emotional regulation. The orbitofrontal cortex blends input from the environment with visceral signals from inside the body and is especially sensitive to facial expressions (e.g., mother’s smile). Compromised attachment, resulting from abusive and/or unresponsive caregiving, can inhibit the proper development of this brain system—the result is often impulsivity and violence (Schore, 1994, 1996; cited in Karr-Morse & Wiley, 1997, pp. 36–38). Bessel van der Kolk, a leading researcher in the field of trauma, reviewed the literature on the psychobiology of trauma and attachment. He writes, “Secure attachment bonds serve as a primary defense 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).

TREATMENT

Traditional psychotherapeutic approaches are too often ineffective with severely attachment-disordered children, who do not trust or form a working alliance basic to success in therapy. Compromised attachment in the early years results in a need to control, 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. 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 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. Through refining concepts and methods for the treatment of severely attachment-disordered children and families since the mid-1970s, we have found that effective therapy involves the following components.

- **Creating attachment patterns**: The primary therapeutic goal is to facilitate secure attachment in the parent-child relationship. To achieve this goal it is necessary to recreate the elements of secure attachment which were unavailable in the child’s early developmental stages. In the context of the Holding Nurturing Process (HNP), children are provided with structure, attunement, empathy, positive affect, support, and reciprocity. The HNP is a therapeutic relationship and milieu which promotes secure attachment via social releasers, safe containment, corrective touch, access to “old brain” functions which control attachment behavior, and the development of a secure base in which positive developmental changes occur.

- **Systemic**: Attachment develops and is maintained in the context of overlapping relationship systems, including parent-child, marital, family, extended kin, and community. For example, it is common for attachment-disordered children to “triangulate” parents and other caregivers, playing one against the other. Effective treatment must address the various social systems in the life of the child and family.

- **Holistic and integrative**: Treatment focuses on mind, body, behaviors, emotions, relationships, and values. Therapeutic interventions and strategies are varied—experiential, psychoeducational, cognitive, skill-based. This 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 building upon the next. Attachment trauma is first revisited to address core issues. Next, revisions are facilitated in belief systems, choices, relationship patterns, and coping skills. Last, revitalization includes celebrating achievements, cementing positive changes, creating plans, and enhancing hope for the future.

Many children with attachment disorder are adopted by well-meaning parents who are ill-prepared to handle their severe emotional and behavioral problems. These children are unable to give and receive love and affection, constantly defy 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 and the children do not improve. These parents have been “through the mill” of mental health and social services programs. They are commonly blamed for their child’s problems, denied access to social service records, and thoroughly frustrated in their attempts to get help. They are angry with their child, feel guilty and inadequate, and are often on the verge of relinquishment. The therapeutic challenge is to enhance parents’ motivation, positive emotion, and hope and encourage a more effective framework for conceptualizing their parenting role and relating to their child. Treatment for the child and parents focuses on the following.

1. **Child**: address trauma, attachment disorder, and negative working model (negative belief system and self-image); learn prosocial coping skills (communication, anger management, problem-solving), encourage respect, responsibility, resourcefulness, and reciprocity.

2. **Parent-child relationship**: enhance secure attachment patterns (trust, affection, intimacy, communication, reciprocity); reduce anger and negative patterns of relating.

3. **Family issues**: modify negative relationship dynamics; enhance stability, support from inside and outside the family, and a climate of hope, positivity, and closeness.

4. **Parenting skills**: learn the specific concepts, skills, and attitudes of Corrective Attachment Parenting that are effective with the attachment-disordered child (angry, oppositional, mistrustful, controlling, deceitful).

5. **Parents**: address historical and/or current issues that are unresolved and prevent effective functioning, including family-of-origin (prior loss, trauma, attachment difficulties) and current marital/relationship problems.

**Corrective Attachment Therapy**

The basic assumption is that the child's anger, defiance, aggression, and antisocial behavior is rooted in the early experience of compromised and disordered attachment. Therefore, the treatment framework must provide the physical, emotional, and interpersonal characteristics of secure attach-
The ingredients found in parent–child relationships leading to secure attachment are also made available in the therapist–child relationship, which requires the following:

- **Structure:** The therapist provides limits, rules, and boundaries similar to the clear and consistent structure provided by the sensitive and appropriately responsive caregiver. The structure is consistent yet flexible, changing in accordance with the child’s development. For example, the therapist informs the child of the rules of therapy, and together they establish an explicit contract which defines their responsibilities and goals.

- **Attunement:** The therapist is “in sync” with the child’s needs, emotions, and internal working model and provides the message: “I know what you need in order to feel safe, and I will offer it.” For example, it is understood that the child’s hostile and controlling demeanor is a defensive strategy, a reaction to feelings of vulnerability and fear.

- **Empathy:** Just as the healthy parent cares deeply about his or her child, the therapist conveys a heartfelt level of caring and compassion. The therapist is proactive and empathic and does not react negatively to hostility and distancing behavior. The message conveyed is: “How sad that those terrible things happened to you; I’m sorry you were treated badly; I understand what you feel and how much pain you must be in.”

- **Positive affect:** Parents who foster secure attachment experience and display positive emotions with their children. The therapist also maintains a positive demeanor, particularly when the child is acting-out. This prevents the reenactment of dysfunctional patterns, such as mutual rejection or distancing. 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 and appropriate boundary setting.

- **Support:** Parents of securely attached children provide a scaffold of support, a framework that supports the child as development unfolds. The therapist also provides support tailored to the developmental needs and capabilities of the child. Initially, the emphasis is on rules, expectations, and natural consequences. As therapy progresses, the focus shifts to reinforcing the child’s independent achievements.

- **Reciprocity:** A positive reciprocal relationship involves mutual influence and regulation. The securely attached child achieves a “goal-corrected partnership” with caregivers, characterized by a sharing of control, values, feelings, and goals. 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, basic compliance); next the child learns to balance his or her own needs with those others.

- **Love:** Secure attachment is synonymous with love; the ability to feel a deep and genuine caring for and commitment to another. Children with attachment disorder are generally incapable of experiencing and demonstrating love; they lack the early attachment relationship necessary to create that feeling. Therapy provides this relationship context and in doing so, guides the child to a place where love can be experienced. The open expression of loving feelings occurs with parents holding their children “in arms,” eye-to-eye, face-to-face. Children, however, will only feel safe in experiencing and expressing love if the parent(s) are available to receive that level of intimacy and affection. Thus, therapy also helps the parents become emotionally available.

### Treatment Strategies and Methodologies

The Holding Nurturing Process (HNP), in which the therapist holds the child eye-to-eye, face-to-face, is an “in arms” experience that promotes secure attachment. It stimulates infant and parent attachment behaviors practiced by most cultures throughout the world. It also reduces the effects of the alarm reaction caused by maltreatment, promotes self-regulation, and provides the structure necessary to meet the fundamental limit-setting needs of oppositional, angry, acting-out children. Specific prosocial coping skills (e.g., anger management) are learned within this therapeutic context.

Children with severe attachment disorder are extremely resistant to therapy and therapeutic relationships. There are a variety of therapeutic strategies that are effective in managing their resistance. The therapist is proactive, remains emotionally neutral, and avoids control battles. The therapist also conveys commitment and perseverance, provides paradoxical interventions, acknowledges underlying emotions, and holds the child accountable for choices and consequences.

Contracting with the child and parents is crucial to treatment success. Contracting increases commitment and motivation to change and provides clear structure, expectations, and goals. Therapeutic contracts are relationship agreements that establish a collaborative framework and facilitate accountability and opportunities for success. For example, we contract with the child to verbally express anger and defiance rather than act-out in physically and/or emotionally abusive ways.

Therapeutic goals include developing new belief systems, effectively dealing with emotions, learning prosocial coping skills, creating mastery over prior trauma, enhancing self-regulation, developing a positive sense of self, and facilitating healthy family dynamics. A variety of specific interventions are employed in order to achieve treatment goals.

1. **First-year attachment cycle:** This is an explanation of the attachment cycle that occurs in the first year of life. This intervention focuses on the correlation between need fulfillment, basic trust, and the establishment of secure attachment.
2. *Child's self-report and list:* the therapist and child develop a list of problems based on the information the child provides. This enables the therapist to understand the child's perceptions and forms the basis for a therapeutic contract regarding goals and changes.

3. *Rules of therapy:* the child is told the rules of therapy, which provides structure, a feeling of safety and security, and expectations for specific behavior. An example of a therapeutic rule is: "eye contact is required when you are speaking to the therapist."

4. *Review of historical information:* it is therapeutic to review with the child the relevant documents, such as social history, social service records, life books, and photographs. This reduces avoidance and denial regarding the child's traumatic history, creates a positive rapport, and facilitates revision of misinterpretation of prior events.

5. *Inner-child metaphor:* the child is gently guided back to an earlier time in life and encouraged to visualize him or herself as younger. This promotes understanding of early life experiences and provides a vehicle for the healing of attachment trauma.

6. *Psychodramatic reenactment:* treatment team members role-play scenarios from the child's life. This enhances genuine involvement in the therapeutic process, encourages honest expression of emotion and perception, and promotes emotional resolution and mastery.

Children with attachment disorder have internalized antisocial values, belief system, and patterns of relating: dishonesty, coercion, aggression, mistrust, betrayal, selfishness. Treatment must emphasize 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 receives positive feedback from others (parents, siblings, friends, teachers), which reinforces positive behavior and enhances self-esteem. These skills include anger management, communication, and problem-solving.

**CONCLUSIONS AND RECOMMENDATIONS**

What are the solutions to the vast problems of violence in children and attachment disorder in families, the child welfare system, and society? Solutions are found in four areas: (1) attachment-focused assessment and diagnosis, (2) specialized training and education for caregivers (Corrective Attachment Parenting), (3) treatment for children and caregiver which facilitates secure attachment (Corrective Attachment Therapy), and (4) early intervention and prevention programs for high-risk families (Levy & Orleans, 1998).

Attachment disorder is one of the most easily diagnosed and yet commonly misunderstood parent–child disorders. Many social service and mental health professionals, although adept at assessing behavioral and emotional disorders in children, are not familiar with attachment concepts. Parents and other caregivers (e.g., foster parents) assume the responsibility of childrearing with challenging attachment-disordered children, often without the necessary information, training, and support. Adoptive and foster parents commonly feel frustrated, angry at the child and the "system," demoralized, disillusioned, and burned out. Specialized parenting skills are required in order to be successful in their parenting role. A significant amount of evidence accumulated over the past 25 years indicates that early intervention and prevention programs are effective for at-risk children and families (Guralnick, 1997; Ramey & Ramey, 1998). Early intervention and prevention programs have been shown to enhance parent–children attachment, foster children's cognitive and social development, and reduce later violence.

Forty million children will be entering adolescence in the next few years. A high percentage of these children were reared in physical and emotional environments that cultivated fear, rage, and violence. We, as a society, must not only address the needs of children damaged by attachment disorder, but also help educate professionals and parents so that future generations can engender secure attachment.

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**BIOGRAPHIES**

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TREATING ADHD AS ATTACHMENT DEFICIT HYPERACTIVITY DISORDER

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BUILDING A DEVELOPMENTAL MODEL FOR UNDERSTANDING ADHD

Introduction

Ashley was 8 years old when she was brought to our community mental health agency. Her mother had finally run out of patience with her compulsive, ritualistic behaviors. The little girl presented with a desperate need to control what she wore each day. She would only wear one “special” pair of underpants, which she used to masturbate whenever she was stressed. Each morning, the demands for Ashley to get dressed for school led to verbal and physical combat between mother and daughter.

Tony was 15 years old when he was ordered by the court to receive treatment at the same agency for having sexually molested a 6-year-old girl in the foster home where they had been living. He had been removed from his mother’s care 2 years earlier because he had threatened her with physical violence and could not be controlled by his teachers at school. His aggressive history notwithstanding, he was an extremely shy child who avoided eye contact and did not make friends with peers.
Rick was 18 years old when he voluntarily sought counseling at this agency. He was drinking beer and smoking marijuana on a regular basis and was failing in his effort to obtain a diploma at an alternative high school. He had moved out of his mother’s home and was living with his abusive girlfriend and her mother. An intelligent and gentle young man, he suffered with chronic, immobilizing anxiety and avoided interaction with male peers.

At first glance, Rick, Tony, and Ashley appeared to be quite dissimilar in terms of their presenting problems, other than a pattern of inappropriate, self-defeating behaviors. Looking at their psychosocial histories, however, we discovered a surprising commonality in their diagnoses. Each one appeared to meet diagnostic criteria for Attention Deficit Hyperactivity Disorder (ADHD), a mental disorder identified in children and adults and characterized by chronic problems with inattention, hyperactivity, and impulsivity (DSM-IV, American Psychiatric Association, 1994).

Rick had been labeled ADHD in elementary school and had been prescribed Ritalin, which he adamantly rejected after a brief trial. Tony had been diagnosed as having ADHD in the sixth grade and treated with Ritalin, which he eventually refused because of its unpleasant side effects. He recalled with pride: “That stuff made me sit down but it couldn’t make me shut up!” Ashley had never been assigned an official diagnosis of ADHD. She was oppositional and defiant at home and quite hyperactive in the classroom, she evidenced anxiety related to her fear of making mistakes in her work and expressed anger toward herself. On occasion, she had been admonished by her teacher for not paying attention in class and for her impulsive behaviors. Had Ashley been a male child, and more physically aggressive in the classroom, she might have been identified by her teacher as having ADHD and referred to a physician for medication.

Detailed biopsychosocial assessments of these clients also revealed a fascinating coincidence: in one way or another, each one had been overstimulated and undersoothed in the first 2 years of life. Behaviorally, each of them could be described, at times, as inattentive, impulsive, or hyperactive, depending on where he/she was, who he/she was with, and what he/she was doing. None of the three had learned to maintain friendships with peers. They shared significant deficits in two important areas of their personality: (1) the ability to regulate emotions and behaviors and (2) the ability to form healthy relationships with others.

Intrigued by the realization that three children who appeared to have so little in common could meet the diagnostic criteria for ADHD, we decided to look more closely at their family histories. We eventually learned that each of them had failed to form an adequate bond with their childhood caregivers, or with anyone else, for that matter. Instinctively, we turned to attachment theory for principles with which to interpret what we had found. We learned that the word “attachment” is generally used to describe the enduring, affectionate, reciprocal bond that develops between a healthy child and his responsive caregiver in the first 2 years of life. Consistent with what has recently been discovered about the organization and development of a child’s brain, attachment theory is based on the assumption that a child’s neurological and emotional development is largely determined by the quality of his interactions with primary caregivers during those early years. In other words, the nurturing interactions that enable caregiver and infant to form a secure attachment also determine the neural development of that child’s brain.

We soon realized that the two main areas of deficits we had identified in our three young clients (self-regulation and relating skills) were consistent with the classic symptoms of an attachment-disordered child. Consider the commonalities in diagnostic criteria for the DSM-IV diagnosis of ADHD and the symptoms of attachment disorder: impulsivity, hyperactivity, and impaired social functioning (Cline, 1979).

This realization raised two obvious questions: (1) Is there a causal connection between attachment failure and ADHD? and (2) Would it be possible to create a developmental model, based on attachment theory, that would provide a valid and credible explanation for the origin of ADHD and suggest a treatment plan that could offer a child more than temporary relief from symptoms?

**ADHD as a Psychiatric Diagnosis**

Attention Deficit Hyperactivity Disorder has recently become one of the most controversial of the so-called psychiatric disorders because of a startling rise in its incidence in American children and because it is most commonly treated with the psychostimulant medication Ritalin, which is classified as a controlled substance. This escalating controversy has increased competition, criticism, and conflict between parents, teachers, physicians, and psychotherapists. This debate continues to swirl, primarily in the areas of education and mental health, because we have not been able to reach a consensus on the origin and nature of ADHD or on the most appropriate ways to treat the disorder.

**Diagnostic Criteria**

The diagnostic criteria for ADHD contained in the latest version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, American Psychiatric Association, 1994) are the result of a 25 year effort to create an accurate and reliable list of symptoms for the identification and treatment of a complex syndrome of cognitions, emotions, and behaviors first observed in hyperkinetic children (Barkley, 1998). They are derived from factor
analysis of commonalities found in studies of parent and teacher ratings of children diagnosed as having ADHD and are divided into two separate clusters: (1) symptoms of inattention and (2) symptoms of impulsivity-hyperactivity (Lahey et al., 1994).

In order to qualify for a diagnosis of ADHD, Predominately Inattentive Type, or ADHD, Predominantly Hyperactive-Impulsive Type, a child must be identified as having at least six discrete symptoms from one of the two cluster areas—symptoms that represent clear evidence of significant impairment in social, academic, or occupational functioning. The symptoms must be present in at least two settings (e.g., at school and at home) and must have been present before the age of 7 (DSM-IV, American Psychiatric Association, 1994).

**Suggested Etiologies**

A review of the literature relating to ADHD includes a wide variety of theories or models to explain the origin of the disorder—such theories as genetic transmission, neurological anomalies, imbalance of brain chemicals, viral infections, prenatal and postnatal toxins, faulty childrearing, socioeconomic status, food additives, and lead poisoning. Although no one has proven a specific chromosomal connection with ADHD, the most popular explanation for the cause of ADHD is known as the biomedical or neurobiological model, which basically asserts that ADHD is a genetically inherited medical disease that results in early neurological impairment of the developing brain. While researchers continue to search for a better model with which to explain the origin of this complex problem, psychostimulant medications such as Ritalin, Dexedrine, and Adderall have become the treatment of choice for the symptoms of ADHD in children (Barkley, 1998).

**Current Prevalence**

By 1995, some respected professionals were becoming skeptical of the disease model for ADHD, not only with regard to its assumed etiology of genetic transmission, but even to its classification as a mental disorder and especially to the use of psychostimulant medications for treating children (Armstrong, 1995). Today, many advocates for children are gravely concerned by the rising numbers of elementary school students being diagnosed with ADHD and by the expanding array of psychotropic medications with which they are being treated. It has been suggested that the increase is more likely attributable to a broadening of the diagnostic criteria in DSM-IV, or to changes in the basic structure of families in America, than to some mysterious anomaly in the gene pool of this country (Merrow, 1995).

At a conference in 1996, Gene R. Haislip of the U.S. Drug Enforcement Administration reported that prescriptions of Ritalin for the treatment of ADHD had increased 500% since 1990, and prescriptions of amphetamines for treating the disorder had grown by 400%. He also noted that between 7 and 10% of male, school-age children in America were being prescribed these drugs at one time or another, with the percentage rising to 15% in some locations (Haislip, 1996).

It is possible to identify a variety of other factors that are contributing to the prevalence of the disease model for treatment of ADHD in America. Health-insurance companies, for example, find it costs them less to pay a physician to treat the child pharmaceutically than for a psychotherapist to see the family for regular sessions. Physicians today generally assume that medication is the first and most effective treatment for a child diagnosed as having ADHD. Local school boards may prefer to see ADHD as a medical problem because they are able to obtain increased funding for educating children with disabilities. Teachers may suggest medical treatment for children who display symptoms of ADHD because they believe that medication will quickly eliminate disruptions in their classrooms. And many parents, feeling accused and frustrated, find it easier to accept the idea that their child has a permanent, genetic disease than the thought that they might have contributed to a problem that is temporary and treatable.

**The Connection between Childhood Trauma and Insecure Attachment**

The commonalities identified in the detailed histories we obtained from Ashley, Rick, and Tony gave us our first clues that there might be a causal relationship between childhood trauma, attachment difficulties, and the symptoms of ADHD. We immediately set out to learn as much as we could about bonding and attachment between caregiver and child.

**Principles of Attachment Theory**

The first premise of attachment theory is that nature provides a biologically based, species-specific system of attaching behaviors that serve to bring newborn animals and humans closer to caregivers for the sake of safety and survival (Ainsworth, Blehar, Walters, & Wall, 1978). Beyond this basic function, attachment with the caregiver enables a child to succeed in the accomplishment of other tasks essential for normal development (Levy & Orians, 1998). The book entitled *Attachment, Trauma, and Healing* identifies additional benefits that are derived from healthy attachment between caregiver and child.

- Learning basic trust and reciprocity for use in future relationships
- Developing the capacity for self-regulation of affect and behavior
- Forming an identity that includes a healthy sense of self-worth and autonomy
- Establishing a set of moral values derived from empathy, compassion, and conscience
• Developing the resourcefulness and resilience required to withstand trauma and stress
• Experiencing the stimulating interactions required for development of a healthy brain

When a child experiences sufficient reciprocal, affectionate interactions with a caregiver who is available and responsive to the child’s appropriate needs, the bond that is formed between them is described as “secure” attachment. Children who fail to receive consistent, predictable, reassuring responses from their primary caregivers are likely to learn patterns of attachment that are described as “insecure.” Secure attachment develops as the result of thousands of daily interactions in which the caregiver achieves affective attunement with the child, eventually becoming a secure base from which the child can tackle new tasks and new relationships with the consistent expectation of being successful and loved. Insecure attachment develops within the context of daily interactions in which the child experiences the caregiver as unavailable, unresponsive, unreliable, intrusive, or coercive. The child who does not learn to use his or her caregiver as a secure base for exploring the world will be at high risk for pathological development in the areas of social relationships, emotional development, behavioral control, and cognitive capacity (Hughes, 1997).

Types of Insecure Attachment

Mary Ainsworth developed a method for identifying and classifying the attachment patterns of year-old infants in a laboratory experiment. In addition to the category of secure attachment, she identified two subtypes of insecure attachment: (1) Ambivalent and (2) Avoidant. Infants labeled as Ambivalent were in general more likely to cling to their mother in an unfamiliar environment and less willing to explore on their own. When separated from her, they appeared anxious, agitated and tearful. When the mother returned, they tended to seek contact with her but simultaneously rejected her attempt to soothe them. Infants labeled as Avoidant generally gave the impression of being independent and self-sufficient. They tended to explore the unfamiliar environment with little concern for their mother’s whereabouts, just like the children who were considered to be securely attached. They differed, however, from the securely attached children in that they seemed unaffected by separation from the mother and either rejected or avoided her when she returned (Ainsworth & Wittig, 1969).

Numerous researchers have since demonstrated significant correlation between infants with patterns of avoidant attachment and mothers who suppress anger, lack tenderness in holding and touch, and who are intrusive and rejecting in their interactions with the child (Belsky, Rovine, & Taylor, 1984; Grossmann, Grossmann, Spangler, Suess, & Unzner, 1985; Lyons-Ruth, Connell, Zoll, & Stahl, 1987).

In 1990, researchers identified a third pattern of insecure attachment in some year-old infants. They have labeled it as Disorganized Attachment, using this term to describe infants who apparently lack a consistent strategy for organizing their comfort-seeking behaviors in times of stressful separation or reunion with the mother. Their disorganized reactions include such things as apprehension, helplessness, and depression. Some demonstrate desperate reactions like prolonged motor freezing or dissociation alternated with agitation in unpredictable ways (Main & Solomon, 1990).

It has subsequently been suggested that the incidence of infants who display patterns of insecure, disorganized attachment increases significantly in families where the mother is an adolescent, abuses alcohol, or suffers from depression (Lyons-Ruth, Repacholi, McLeod, & Silva, 1991). Other studies have documented a relationship between disorganized patterns of attachment in infancy and aggressive, controlling behaviors in childhood (Lyons-Ruth, Alpern, & Repacholi, 1993; Wartner, Grossmann, Fremmer-Bombick, Suess, 1994).

Those of us who are interested in developing a model to explain the origin of ADHD should pay close attention to the research that has described the characteristics of insecure attachment patterns in children and adolescents. There are obvious similarities between the behaviors of the Avoidant child and the symptoms of ADHD. Descriptions of the child with a disorganized pattern of attachment reminds us of children diagnosed as having both ADHD and Conduct Disorder (DSM-IV, American Psychiatric Association, 1994).

New Information about the Development of a Child’s Brain

In recent years, brain-imaging technologies have enabled researchers to gather new information about the development of a child’s brain. Whereas experts once believed that a child’s brain is basically inherited and its development determined by his or her unique set of genes, we have recently learned that the individual brain is built from a complex mixture of heredity and experience. Heredity provides some basic parameters for brain potential, but experience determines the quality and quantity of the circuits that are formed and the way in which the brain is organized to process information. The quantity and quality of stimulating interactions between caregiver and child, in the first 3 years of his life, play the largest roles in determining his emotional development, learning potential, and level of adult functioning. Children who enjoy consistent, nurturing interactions with caregivers in their early years become more resilient, emotionally and biologically, and are better able to tolerate stress in later years (Karen, 1994).

The newborn brain is wired only for controlling those functions that are essential for survival; respiration, heart rate, and reflex movements. At birth, the infant has approximately 100 billion brain cells which are not yet...
connected to form the networks that will allow thinking and learning to occur. By the age of 3 the baby will have formed about 1000 trillion of these neural connections—about twice the number found in the adult brain. Around the age of 11 a child’s brain performs a sort of self-pruning, ridding itself of excess neural connections and retaining the strongest ones—those that have been used most often. Connections that have been repeated most consistently in childhood are most likely to become permanent. Conversely, a lack of experience may create deficits in neural connections. For example, the child who is rarely spoken to may have insufficient neurons for mastering language, and the child who is rarely played with may not have enough circuits for healthy social attachment. The best insurance against emotional and behavioral problems in childhood is the formation of healthy attachment between a child and a consistently available, sensitively responsive, nurturing caregiver (Begley, 1997; Perry, 1994).

The Effects of Childhood Trauma on the Developing Brain

By the mid-1980s, researchers had formulated a fair understanding of the impact of extreme trauma on combat veterans of the Vietnam War and on other traumatized adults. In her study of traumatized children, Dr. Lenore Terr identified patterns of symptom clusters that resembled other psychiatric disorders, such as conduct disorders, anxiety disorders, and Attention Deficit Hyperactivity Disorder (Terr, 1991).

Within the past 5 years, a growing body of research has increased our understanding of the ways in which trauma affects the neurological and neurobehavioral functioning of children. We have learned that sustained traumatic experiences like childhood abuse and neglect, or failure to form a secure attachment in the early years of life, can create a chronic state of hyperarousal in a child and alter the neuroendocrine activities of his brain, causing him to become trapped in the “fight-or-flight-or-freeze” response (Perry, 1994; van der Kolk, 1994).

When a child’s stress-response system remains activated for an extended period of time, his brain will adapt in ways that enable him to live with the perception of constant threat. Changes in the neurology of his brain result in cognitive, emotional, and behavioral changes. The following list presents neurobehavioral problems likely to be identified in traumatized, hyperaroused children (adapted from Perry, 1995). It is important to note that the list includes three major symptoms of ADHD: hyperactivity, impulsivity, and impaired social functioning.

- Hypersensitivity and overreaction to neutral stimuli
- Autonomic hyperarousal and motor hyperactivity
- Increased startle response
- Profound sleep disturbance
- Problems controlling emotions

- Cognitive deficits and distortions
- Impaired social functioning
- Impulsivity and aggression

An Etiologic Model for ADHD Based on Developmental Trauma

After 4 years of working with and learning about children and adults diagnosed with ADHD, we have assembled a developmental model that explains the origin of this controversial disorder. It is based on the belief that attachment trauma in early childhood results in developmental deficits which, in the absence of remedial parenting, are likely to be manifested as the symptoms of ADHD. Our model can be stated very simply:

Bonding breaks → Attachment deficits → Symptoms of ADHD.

This model is based on information gleaned from detailed assessments of all our clients diagnosed with ADHD, each of which provided clear evidence of what we have come to call a “bonding break”—an event or combination of events, occurring prenatally or postnatally, that causes physiological trauma and developmental arrest and interferes with a child’s opportunity to form a secure attachment with a caregiver. This developmental model answers the question: “What causes ADHD?” It also provides a treatment plan that makes medication the treatment-of-last-resort and emphasizes the reparation of attachment deficits instead of attention deficits.

Ours is a model based on theory, but is consistent with the scientific research presented above. It begins with three major assumptions: (1) a child who meets diagnostic criteria for ADHD has experienced some sort of bonding break(s) before the age of 2, (2) the bonding break(s) have interfered with the process of healthy attachment between caregiver and child and created developmental deficits in the child, and (3) the family system in which the child grew up was not healthy enough to overcome those deficits. These assumptions have been derived from the histories of nearly 50 clients diagnosed as having ADHD. Every one that we studied over the past 4 years provided real evidence of at least one significant bonding break. We theorize that the failure to attach to an adult caregiver constitutes psychological and physiological trauma that interferes with an infant’s neurological and hormonal maturation, resulting in developmental delays (attachment deficits) that are reflected in emotional and behavioral problems. Hence the simple formula

Bonding breaks → Attachment deficits → Symptoms of ADHD.

Figure 1 illustrates the dynamics of this model.
Four Basic Types of Bonding Breaks

From our collection of detailed biopsychosocial histories of children and adults diagnosed with ADHD, we have identified four relatively discrete categories of bonding breaks: Prenatal Influences, Inattentive Caregivers, Situational Traumas, and Faulty Parenting. The subjects we studied were more likely to have experienced a combination of bonding breaks, sequentially or simultaneously, involving more than one category, than to have experienced a single break.

Prenatal Influences

A healthy newborn arrives in this world already programmed, like a heat-seeking missile, to attach to a suitable caregiver. Some newborns, however, arrive in a state of distress and extreme hyperarousal. These infants are not programmed to seek out a caregiver because their state of emotional alarm prevents them from responding to attaching cues in their caregivers. Because prenatal influences that have interfered with nature’s programming were so often identified as the culprits responsible for attachment problems in our clients, we have concluded that the relevance of this category of bonding break has not been fully appreciated by therapists and developmental researchers. In fact, it is rarely mentioned as a possible contributing factor in the development of ADHD.

For example, researchers suggest that mothers who smoke cigarettes during their pregnancy are three times more likely to give birth to a child who will be diagnosed as having ADHD (Milberger, Biederman, Faraone, Chen, & Jones, 1996). This finding is consistent with our hypothesis that prenatal exposure to certain chemical compounds or toxins may cause hyperactivity and impulsivity in a child. In our clinical practice, we also identified subjects who had undoubtedly been exposed prenatally to stress hormones such as cortisol, adrenalin, and norepinephrine by mothers who experienced chronic anxiety or panic attacks during pregnancy. Cortisol is apparently a major threat to the healthy development of a child’s brain. Produced by the adrenal gland, cortisol helps the human body respond in a time of crisis by moderating its level of stress-response, but elevated levels of this hormone interfere with the building of neural pathways and may even have the effect of dissolving established connections (Begley, 1997; Perry, 1994).

Excess levels of cortisol are also believed to damage the brain’s hippocampus, thereby interfering with memory function and lowering an individual’s ability to control his/her emotions. Cortisol and other stress hormones also have the potential for inhibiting areas of the brain that regulate attention (Nachmias, Gunnar, Mangelsdorf, Parritz, & Buss, 1996).

We identified subjects who were born to mothers overwhelmed by stress due to being depressed, abused, or frightened. We found others who had been severely traumatized during labor and delivery. We documented numerous examples of mothers who failed to bond with the child they were expecting because it was the wrong sex, had the wrong father, or was arriving at the wrong time. Surprisingly, several mothers confessed that they had felt extremely depressed when they learned they were expecting a male child.

We discovered an interesting example of a prenatal bonding break in the case of fraternal twins, one of whom met diagnostic criteria for ADHD. Tim, 7 years old, had become a serious behavior problem at home and at school, in spite of taking his Ritalin as prescribed. His brother was compliant and more social at school and behaved fairly well at home. The twin with ADHD had been born with such an elevated level of anxiety that he could not be easily calmed or soothed. As an infant, he was irritable, agitated, and hyperactive. He had resisted swaddling by arching his back and slapping his hands together over his head. He seemed to lack interest in closeness and nurturing and had failed to make consistent eye contact with his caregivers.

One day, in family therapy, his mother mentioned that her obstetrician had delivered the twins by Caesarean section because she had been carrying Tim in an awkward position, with his brother lying heavily on top of him. It had not occurred to her that the pain her son experienced in utero, and the hyperarousal he exhibited postnataally, had interfered with her opportunity to form a secure attachment with him.
We learned that Ashley, our 8-year-old with the underpants obsession, had apparently been exposed to chronic and acute levels of stress hormones before her birth. Ashley's mother acknowledged that her pregnancy had been very stressful. About the same time she conceived her daughter, she had become bored with her marriage and had been involved sexually with another man. She began to worry that she would give birth to a racially mixed child, thereby revealing her infidelity. In addition, her husband's family had placed great emphasis on the need for a male child to carry on the family name. She began to feel like a failure when she learned she would have a daughter. These two factors contributed to her frequent panic attacks during the last months of her pregnancy. Ashley's parents divorced before she was 3 years old. In therapy, her mother admitted that she had never felt a close bond with Ashley but stated she did feel close to Ashley's 6-year-old sibling, a male.

**Inattentive Caregivers**

A second type of bonding break occurs when a healthy infant is born to caregivers who fail to provide the minimum amount of warmth required for the heat-seeking missile to find its target. Such caregivers neglect their infants because they are self-centered and lack empathy for others or because they lack sufficient information or motivation to provide the nurturing and soothing interactions an infant needs. Interactions that contribute to attunement, synchronicity, and attaching responses in the infant include eye contact, soothing words and touch, breast-feeding, holding, rocking, smiling, and singing. It is the quantity and quality of these interactions that determine a child's neurological development as well as its capacity for empathy, trust, self-soothing, impulse control, initiative, and conscience.

One mother of an 8-year-old boy who was having severe behavioral problems at school first told us that she had not encountered any problems with him during pregnancy or in toddlerhood. She said that she had loved him from the first minute she saw him and that they had bonded perfectly with the exception of one small problem. When asked to explain what had happened, she exclaimed: "I just couldn't stand him pulling at me! It was disgusting! I was so grossed out, I didn't know what to do! My husband came home and found me crying my eyes out and he said: 'Hey, if you don't want to nurse him, don't!' So I stopped nursing him and everything was fine after that." This appears to be an example of a mother who lacked empathy for her nursing infant.

An inattentive caregiver, disappointed and angry about the sex of an infant, might ignore or reject that child. An inattentive mother may not have the patience to teach a child to nurse successfully or the motivation to get up and feed him during the night. A self-centered father might be jealous of the attention being given to the infant by his mother and withhold his cooperation or sabotage the child's care in some way. An inattentive caregiver might lose patience with a crying infant and handle him in a rough or abusive manner. A self-centered parent might reject a child who is born with a major birth defect.

In a therapist's office, the inattentive caregiver might say something like: "What did I do to deserve a child like this?" or "This child never thinks about what I need!" or "This child lives to make my life miserable!" Whatever the specifics of this caregiver's problems, such a person probably did not receive sufficient attention and empathy from his/her own caregivers in childhood. Herein lies a cogent explanation for the intergenerational transmission of ADHD. Parents who have received too little attention and empathy in their childhood may have a difficult time providing these emotional supplies to their own infants.

Rick, our young high school student, was born to an inattentive mother. As an adolescent, she had been required to serve as primary caregiver to her younger siblings. As an adult, she failed to give her own children the attention, affection, and nurturing they needed because she was busy getting her own needs met by the men in her life. When Rick was 15, she kept him out of school for a year so that he could serve as the full-time babysitter for his half-sister and half-brother, ages 1 and 3.

**Situational Traumas**

A third category of bonding breaks includes a variety of conditions and events that occur outside the control of the primary caregivers. These situations disrupt or preclude the formation of secure attachment between primary caregiver and infant. For example, an infant who is born prematurely might be deprived of consistent physical contact with his primary caregiver for weeks or months while being confined to a hospital. This explains the strong correlation between premature birth and ADHD (Szatmari, Saigal, & Rosenbaum, 1990).

There must be an unlimited number of ways in which a child can experience a situational break in bonding. The incidence of ADHD in children who have been adopted or placed in foster care is apparently quite high. Many infants are separated from a primary caregiver by illness or death. Some infants may be born with unrelieved postpartum pain from an injury or from frequent cholic or earache. Some are born with physical defects or with disabilities in sight or hearing that impede the process of attaching with caregivers. Primary caregivers may have disabilities, mental or physical, that prevent them from performing those activities that are likely to elicit attaching behaviors from their infant.

Tony, our physically and sexually aggressive teenager, was born to a mother who was impaired in speech and hearing. Her intellectual function-
ing was well below average. She abandoned Tony when he was 15 months old, leaving him in the care of elderly grandparents. When she returned 4 years later, he refused to accept any affection from her and was physically violent toward her.

**Faulty Parenting**

This last category of bonding breaks is prevalent in home situations where it is very difficult, if not impossible, for a child to overcome the harmful effects of early trauma. Typically, our clients diagnosed as having ADHD have grown up in families that shared three debilitating characteristics: (1) the absence of a healthy relationship between two caring adults; (2) a pattern of exposure to yelling, criticism, sarcasm, and violence; and (3) parenting that lacked respect, discipline, structure, and consistency.

Clearly, this raises an interesting question. Does the experience of growing up with inadequate parents constitute a bonding break in itself or is it coincidence that all of our ADHD clients received inadequate parenting? After all, it is just as easy to find examples of children who experienced an early bonding break but did not develop the symptoms of ADHD as it is to find children who grew up with faulty parenting and turned out to be fairly normal. With our clients, we found many examples of someone having experienced bonding breaks in all four categories. Faulty parenting was the only category of bonding break that showed up in the biopsychosocial assessment of every client who met diagnostic criteria for ADHD.

Some children apparently experience a bonding break around the age of 15 to 18 months. This is normally the time when caregivers begin to say "no!" and to set limits on a child's behavior. When corrected and disciplined by parents who provide sufficient empathy and reassurance, the child will learn that a caregiver can disapprove of his behavior while remaining emotionally supportive and available. When the discipline is coercive, abusive, or rejecting, the child might feel shamed and threatened and withdraw from caregivers, thereby breaking the incipient psychological bond (Hughes, 1997).

What we seem to have discovered is that children who are deprived of the opportunity to witness caring, respectful, and trusting relationships; who fail to receive adequate discipline, structure, and boundaries from their caregivers; and who are exposed to chronic conflict and chaos are unlikely to overcome early bonding breaks and attain healthy development. That is to say, children who experience early attachment trauma and are raised with "good enough" parenting will probably avoid the label of ADHD, while others (especially male children), who encounter similar breaks but grow up in a family where the parenting is faulty, are likely to be diagnosed as having the disorder and treated with psychostimulant medication by age 7.

**Attachment Deficits**

We have coined the phrase "attachment deficits" to designate specific shortcomings in the emotional development of a child. They refer to character traits that appear to be absent or underdeveloped in a child, as evidenced by emotions and behaviors that set him apart from his peers. These deficits might correspond to specific regions of neural circuitry in a child's brain that have not developed normally. Science tells us that developing circuits in the various sectors of the human brain mature on different schedules. Motor skills, for example, begin to develop prenatally. Math and logic skills do not begin to be wired in a child's brain until about the age of 15 months. Two important spheres of neural circuitry that appear highly vulnerable to bonding breaks are the areas of the brain that determine emotional control and social attachment. These two areas of the prefrontal cortex begin to develop by the time an infant is 6 months old. A child who does not receive proper stimulation and consistent nurturing interactions from caregivers in the first year of life is unlikely to develop sufficient neural circuitry required for emotional control and social attachment (Lach, 1997).

It is not surprising that researchers, using magnetic resonance imaging scans, recently found slight abnormalities in the size of the right prefrontal-striatal systems in some males children diagnosed as having ADHD (Castellanos et al., 1996). After all, this is the area of the brain that is responsible for the management of emotional control and social attachment. In our model for explaining the origin of ADHD, we refer to these areas as self-regulation and relating skills. From our clinical experience, nearly all children diagnosed with ADHD appear to exhibit deficits in these two areas of personality.

**Deficits in Self-Regulation**

This category of attachment deficits includes all those human qualities that would ordinarily flow from a healthy individual's ability to regulate his own thoughts, feelings, and behaviors. Although we are only identifying six of them here, their total possible number cannot be estimated. Taken collectively, these capacities represent a major part of what we have come to call a "self." When they are lacking in a child, he will be at high risk for a diagnosis of ADHD.

- **Impulse control:** A child learns to exercise control over his feelings and behaviors when he has received sufficient limits, guidance, and discipline from adult caregivers. A child with attachment deficits lacks internalized limits. Unable to distinguish between thoughts and actions, he or she simply reacts to what he or she is feeling or wants. Children who lack impulse control will usually be perceived as hyperactive.
**Self-soothing:** A child learns healthy ways to soothe his own anxiety when he or she has received adequate and consistent soothing from an adult caregiver. When that is lacking, the child learns to substitute stimulation for soothing and lives in a chronic state of hyperarousal.

**Initiative:** A child learns autonomy and self-motivation when he or she has achieved self-confidence and self-discipline and has developed internal values and goals with the help of an adult caregiver. A child who is insecurely attached has not yet developed a permanent sense of self and is unable to activate internal motivation.

**Perseverance:** A child learns to make the sustained effort required for success when he or she is encouraged, validated, and given realistic expectations. A discouraged child usually receives a steady dose of negative feedback in place of the encouragement and validation needed to persevere. He or she eventually begins to see himself or herself as incompetent and helpless and is easily distracted.

**Patience:** A child learns to wait patiently for what he or she wants when taught to accept delayed gratification. Children who fail to experience sufficient limit-setting and restraint from caregivers will generally act impulsively and will be perceived as intrusive or coercive at home and in school.

**Inhibition:** A child learns healthy inhibitions that help him or her to avoid danger and self-injury when he or she receives consistent guidance and protection from his or her caregivers. When he or she is neglected or ignored he fails to develop proper awareness or respect for potential dangers and is unable to anticipate or avoid injury. Instead, he or she frequently engages in high-risk behaviors and is often viewed as being fearless.

### Deficits in Relating Skills

This category of attachment deficits includes those qualities which, when present in healthy human beings, enable them to form safe, secure, and satisfying relationships with others based on intimacy, equality, and commitment. When they are lacking the child will have a difficult time getting along with others at home and at school and will be at risk for a diagnosis of ADHD.

**Empathy:** A child learns to express empathy for others when he has received consistent caring and consideration from his own caregivers. If he has not experienced caring, he might be capable of hurting others without apparent remorse. Exacting revenge on others might become more important than making friendships.

**Trust:** A child learns to trust others when primary caregivers are accessible, responsive, and benevolent. When caregivers are unavailable, unpredictable, or abusive, the child does not turn to them for soothing or reassurance when he or she is afraid or in pain. Unable to rely on adults to meet his needs and keep him safe, the child becomes his own inadequate caregiver and protector.

**Affection:** A child learns to express affection openly and to accept it from others when he experiences comfortable closeness with primary caregivers. A child diagnosed with ADHD is usually reluctant to offer or accept nurturing physical contact with his parents or his peers. He may resort to pushing or hitting as a way of attracting attention to himself or conveying interest in others.

**Reciprocity:** A child who experiences satisfaction and gratification in the daily give-and-take with primary caregivers will learn to be considerate, playful, and fair in his interactions with others. Children who fail to learn reciprocity from their caregivers may be selfish, inconsiderate, or coercive in their social interactions.

**Expression:** A child learns to express his or her real self when he or she receives encouragement from caregivers and when he or she develops in an environment where it is safe to be vulnerable. Children diagnosed with ADHD are usually afraid of their own feelings and reluctant to acknowledge or express them to others. They may be willing to accept considerable pain rather than to risk emotional vulnerability.

**Respect:** A child learns to respect others when he or she is valued and encouraged by primary caregivers. Children who fail to receive respect from primary caregivers do not learn that they are worthy of respect and are likely to make a habit of disrespecting others. Children diagnosed with ADHD rarely show respect for their parents or adult authority figures.

In our model for explaining the origin of ADHD, these two main categories of attachment deficits (self-regulation and relating skills) are seen as causing the behaviors that drive parents, teachers, and therapists to distraction. We consider them to be treatable problems that develop after conception, the results of traumatic bonding breaks between caregiver and child—not as the permanent symptoms of a genetically transmitted disease.

### The Symptoms of ADHD

The three main symptoms of ADHD in children are thought to be hyperactivity, inattention, and impulsivity. In addition to these primary indicators, there are a number of annoying habits and behaviors which are considered to be diagnostic criteria for this problem. For example, parents and professionals agree that children with ADHD are often defiant, forgetful, irresponsible, oppositional, intrusive, disruptive, manipulative, careless, disorganized, oblivious, and obnoxious. They usually do not get along well with other children. When it comes to identifying the causes for these symptoms, however, there is little agreement as to which of these diagnostic criteria are attributable to genetic defects and which to developmental deficits.
Hyperactivity

This is the symptom that distinguishes ADHD from simple ADD (attention deficit disorder), but there may be as many possible explanations for hyperactivity as there are children. In the newborn, for example, hyperactivity could be the result of pre-natal or perinatal trauma. In the preschooler, it could reflect neurological anomalies in his prefrontal cortex—the result of insufficient soothing interactions with his caregivers. In a 10-year-old, it could be a symptom of chronic autonomic hyperarousal. Children who have been traumatized by abuse, neglect, or insecure attachment develop brains that are hypervigilant to potential threats in their environment. The longer they remain stuck in the “fight-or-flight-or-freeze” response, the more likely they are to experience adaptive changes in their central nervous systems and maintain a baseline state of physiological arousal and hyperactivity (Perry, Pollard, Blakely, Baker, & Vigilante, 1995; van der Kolk, 1994).

Impulsivity

Working with dozens of children diagnosed as having ADHD, we have learned that most of them exercise very little control over their impulses. They seem to share the same immature belief: “When I really, really want something, I should not have to wait for it!” Lack of empathy for others could be a partial explanation for a child’s pattern of impulsive, intrusive behaviors. This symptom could also be the result of neurological deficits in that region of the frontal cortex that is responsible for thoughtful control of behavior. Furthermore, when a child is experiencing a persistent state of anxiety and autonomic arousal, he or she will have a difficult time accessing the part of his thinking brain that would allow him or her to stop and consider the possible consequences of his choices and behaviors (Perry et al., 1995).

Inattention

This has always been the diagnostic cornerstone for ADD and ADHD. It will continue to be a controversial notion until we have conclusive evidence proving that some children are inherently incapable of paying attention as well as others. Our own experience with children diagnosed as having ADHD tells us they can pay attention as well as other children when they are properly motivated. We have also become convinced that children diagnosed with ADHD are only motivated by things that are stimulating or gratifying in some way. It is as though they have become addicted to stimulation. They seem to all share a common belief: “Anything that is not stimulating or pleasurable should be ignored.” This pattern makes sense when you consider that they have grown up in an environment in which they were overstimulated and undersoothed because of bonding breaks. They have become like little cars without brakes, with their accelerators stuck to the floorboard.

It is interesting to note that Russell Barkley, a long-time researcher in the area of ADHD has, in his most recent book, called for a new model to explain the etiology of this disorder. He makes the point that, despite its being consistently reported in parent and teacher ratings of problem children, a measurable deficit in attention has not been found in children diagnosed as having ADHD (Barkley, 1998).

The Cycle of Conflict between Caregiver and Child

Children with attachment deficits spend much of their time locked in a constant power struggle with a primary caregiver because the thing they desire most (emotional closeness) is also the thing they fear most. Consider, for example, the cycle of conflict that usually exists between a child diagnosed with ADHD and his caregiver and how this pattern is the result of his trying to make a connection without having the skills necessary for healthy attachment. As can be seen in Fig. 2, the cycle begins when the child is experiencing a strong negative emotion such as anger, sadness, loneliness, or fear. Lacking the capacity for self-soothing, impulse control, and expression, the child attempts to connect with the parent through intrusive, demanding, attention-seeking behaviors. The parent begins to feel irritation and resentment but is unable to express empathy, affection, or respect for the child and responds by criticizing, threatening, or hitting him or her. The child reacts by tuning the parent out and silently planning his or her revenge or he or she becomes defiant and coercive and raises

![FIGURE 2. The cycle of conflict between parent and child.](image-url)
he level of his acting-out behaviors. At this point the parent, feeling angry and scared, either gives up and withdraws or raises the level of conflict in an effort to defeat the child. After each fight, both the parent and the child are left frustrated and angry and determined to get even by winning the next round. Together, they have created a habitual pattern of traumatic bonding, a relationship based on conflict rather than intimacy.

Eight-year-old Ashley understood the cycle of conflict. One day, during family therapy, she explained it to her mother: “Mom, you need to let me alone when I’m upset. I can handle that problem myself. You should go calm yourself down. Hitting me doesn’t help!” Despite her apparent understanding of this problem, Ashley acted out the same pattern of escalating conflict at school where she was eventually punished for hitting her best friend.

A MODEL FOR TREATING THE FAMILY OF A CHILD WITH ADHD

Whenever possible, the treatment-of-choice for a child diagnosed as having ADHD should be family therapy. This is especially true when the child is between the ages of 5 and 15. The reason is simple: children with ADHD are not likely to make significant changes in their thoughts or behaviors without simultaneous changes in their family systems. Even in the case of a hyperactive and impulsive child entering a new and relatively healthy family system, such as a foster or adoptive family, that system will require extremely competent and effective parenting skills in order to succeed with such a child. We have developed a six-step model for family therapy based on corrective attachment theory, family systems theory, cognitive and behavioral techniques, and some exciting things we have learned recently about the “rewiring” of a child’s brain.

Engaging the Primary Caregivers as Clients and Cotherapists

The most critical prerequisite for appropriate, successful treatment of the child diagnosed with ADHD is the cooperation of the adult caregivers. It is absolutely essential when the primary caregivers are the biological parents because they have probably contributed, in some ways, to the development of the child’s behavioral and emotional symptoms. It is also necessary in foster and adoptive families. All children who exhibit attachment deficits need to experience a positive connection with a willing and motivated adult caregiver in order to become whole. The therapist’s role is that of a “relationship coach”—not a “surrogate parent.”

Overcoming Parent Resistance

Unfortunately, a therapist will frequently encounter major resistance when asking for the trust and cooperation of primary caregivers. The key to overcoming parents’ resistance is to listen carefully to what they are saying and feeling and to look for ways to empathize and join with them. Until caregivers feel heard and understood, the therapist should not begin to focus on their contributions to the child’s problems.

The Exhausted, Overwhelmed Parent

By the time they arrive at a therapist’s office, many caregivers for children with ADHD are mentally and physically fatigued and overwhelmed by negative emotions. They are feeling blamed and criticized by family, neighbors, teachers, and other professionals who have said things like: “There’s nothing wrong with that kid that the right kind of parenting wouldn’t fix!” These parents need to know that someone believes they have been doing their best for their child. They need consistent empathy and compassion from a therapist in order to cope with their own feelings of frustration, hyperarousal, and hopelessness.

The Medication-Seeking Parent

These caregivers have become convinced that ADHD is a genetically transmitted medical problem and that their child will have to take psycho-stimulant medication in order to be “normal.” They may be unwilling to cooperate with family therapy until medication has failed to produce the desired result for their child. One of our clients brought in her 10-year-old son for an assessment of his impulsive and aggressive behaviors, saying: “I want a professional opinion to determine whether or not he has ADHD and needs medication.” The boy’s psychosocial assessment revealed that his biological father had abandoned the family when the child was 4 weeks old and had never seen the boy again. Furthermore, it became clear that the boy was being criticized, humiliated; and abused in a habitual way by his stepfather. When the mother received the recommendation that the entire family should begin therapy, she adamantly insisted on a referral for her son to see a psychiatrist. “But I want to start at the top—with the doctor! If he rules out ADHD, then we’ll consider other treatments. Why waste time with therapy if he just needs medication?” The child was taken to a psychiatrist who prescribed Ritalin “to help him control his anger.” The mother apparently believed that the physician had ruled out the necessity for family therapy. Three months later, she telephoned to say that his aggressive behaviors had escalated to the point that he had been suspended from school for hitting his classmates. From this incident one might conclude that, whenever possible, a therapist should refer this parent to a physician who will emphasize the importance of family therapy to accompany the use of medication.
The Guilty Parent

Caregivers may feel incredible guilt for some surprising reasons, such as for secretly disliking their child diagnosed with ADHD or for passing on to him their so-called “bad genes.” Caregivers who harbor anger and resentment for their child may need help in finding ways to express their negative emotions, without blaming or shaming that child. Because guilt is a counterproductive emotion and an obstacle in the process of engaging the parents, a therapist should assess for feelings of guilt and help the parents to assuage these negative emotions through education and cognitive restructuring. The therapist should reassure them that they are the people best-suited to help solve their child’s problems.

The Hopeless and Helpless Parent

Some caregivers will have already tried a variety of parenting techniques and behavioral interventions without any success and will be very discouraged. They may be convinced that: “We have tried everything possible and nothing works with this kid!” They can be very pessimistic about the usefulness of family therapy. It usually turns out that these caregivers have been inconsistent and irresolute with their discipline and have given up without much of a struggle. A therapist should help the parents understand why their efforts have been unsuccessful and teach them to be creative and persistent enough to gain control of their family. Have them start with limited, sequential goals that can be easily attained.

Parents Who Need Their Child to Be “Ill”

Some caregivers need to believe that their child with ADHD has a medical disease and is “ill.” They may cling to the diagnostic label as though it somehow absolves them from having made the slightest contribution to their child’s problems. They may be reluctant to participate in family therapy without a formal acknowledgment of their child’s medical pathology. Because their greatest fear is that they will be blamed and identified as “bad parents,” these caregivers require plenty of reassurance from a therapist. They may need help understanding their own needs and goals as parents and maintaining hopeful expectations for their child in treatment.

The Narcissistic Parent

A sizeable percentage of the biological parents of children diagnosed as having ADHD appear to be so self-focused that they experience very little empathy for their children. One such mother of an encopretic 12-year-old boy, diagnosed with ADHD, had become so frustrated and angry with him that she literally could not stand the sight of him. She expressed to us the extreme dread she felt when he arrived home from school each day. When asked to guess what he was feeling after being taunted and ridiculed by his peers at school, she responded with hostility: “Oh he doesn’t even notice when they call him names. Nothing bothers this kid!” Truly narcissistic parents are extremely difficult to engage in family therapy because they are so angry at their children. Furthermore, they usually do not tolerate suggestions or corrections from a therapist. The task of engaging such parents as cotherapists will require the expression of genuine concern for their suffering and their plight as well as the consistent modeling of empathy for their child. When working with narcissistic parents, the therapist should be aware that his or her own countertransference issues might interfere with his ability to help them.

The Grieving Parent

Many caregivers for children diagnosed as having ADHD are actively grieving the loss of their expectation for a normal and healthy child—one that would reflect positively on them and their parenting. They have lost the “perfect child” and feel powerless to cope with the “real child” in their home. Our experience has taught us that parents’ feelings must be brought to the conscious level and expressed before we can expect them to relate differently with their child. This has proven true whether the child is their biological offspring or adopted. In either case, the parent has harbored a secret longing for a particular relationship with this child—a relationship that has not developed. Until the parents identify and accept their true feelings about the child, they will probably act out their anger against the child who has disappointed them. Engaging these parents requires that a therapist help them through the stages of the normal grieving process before they are able to accept the reality of their situation and relinquish their lost fantasy.

Polarized Parents

Some pairs of caregivers have become thoroughly polarized and are so focused on blaming one another that they are unable to work on solving the child’s problems. This is especially true in families where parents have experienced a bitter divorce. In some cases, this polarization can be viewed as a reaction to the child’s disturbed behaviors. In others, preexisting conflict between the parents may be a major cause of the child’s problems. The therapist will need to contract with such parents for some basic elements of healthy coparenting in order to be successful with their child. Some couples will need marital therapy before they can truly cooperate with treatment for their child.

Ambivalent Parents

Some foster and adoptive parents have already given up on their child diagnosed as having ADHD and come to therapy secretly hoping that treatment will be unsuccessful so they can justify returning the child to the agency from which he or she came. Refusing to cooperate with family
therapy might represent their unconscious attempt to sabotage their child's placement. Occasionally, birth parents also will be experiencing such extreme frustration that they are prepared to give up custody of their child to the state. This constitutes a very grim situation—one in which the therapist must stop and help the parents make the decision that will be in the long-term best interest of the child.

“Triggered” Parents

Some caregivers for a child diagnosed as having ADHD live each day of their lives in emotional upheaval because their child’s behavior is reminding them of painful events from their own childhood. One mother came in with a 9-year-old boy and his 6-year-old sister, both diagnosed as having ADHD. During the initial assessment, while describing her son’s aggressive treatment of her daughter, she burst into loud, tearful wailing: “I never wanted a boy! I was so afraid he would turn into a little bully like all those boys who tormented me in school, and now look at him! That’s exactly what he is—a bully! I just hate him!” This was a parent who could not be engaged in family therapy until she had worked personally for a while in group therapy. Luckily we had the option of involving the father more actively in the parenting process while the mother concentrated on disarming the “triggers” from her own childhood. The task of becoming a good cotherapist for one’s child requires that the parent offer that child a new and improved relationship.

Engaging the Parents as Cotherapists

The first task for a therapist who is beginning family therapy with a child diagnosed as ADHD is to meet with the parents and tell them flatly that they will be the most important players in the process—that no therapist has enough skill to succeed with their child without their wholehearted and dedicated assistance.

Meet with the Parents by Themselves

It is important to exclude the child from the first meeting with his caregivers. They need to know that the therapist is aligning with them and the child also needs to understand that fact. It may be helpful to start by giving them permission to verbalize their feelings of anger, frustration, and disappointment while explaining that they will have to temper those feelings with considerable empathy when they express them in sessions with their child. Explain the notion that every family can be accurately viewed as a unique and distinct system in which the actions and reactions of one member influence the actions and reactions of every other member. Give the parents a message of hope—not of resignation: “The bad news is that you might have contributed to his problems in some way. The good news is that there is a lot you can do to help him.”

Collect Biopsychosocial Information about the Parents

Look closely at the parents’ developmental histories, especially the emotional traumas from their own childhoods as well as the relationships with their own primary caregivers. Help them to discover the specific attachment patterns they learned from those individuals. Identify and explain all issues that might be interfering with their ability to successfully parent this particular child. Use this information to raise their level of self-awareness and to increase their empathy, tolerance, and consideration for themselves and for their child.

Obtain Details of the Child’s Prenatal and Postnatal Development

Learn everything you can about the first 2 years of his or her life. Explain the cycle of human attachment as it normally occurs for a healthy child in the first year of life as well as the predictable consequences of a child’s failure to learn trust and self-soothing. Identify incidents of childhood trauma and frame them as bonding breaks that have caused important delays in their child’s development. When parents come to understand the significance of unavoidable breaks in the bonding with their child, it may give them permission to feel less guilty. They may experience feelings of relief with the realization that: “There are logical explanations for the problems my child is having. Perhaps I did not give birth to a demon after all!” The therapist should help parents to understand that, although their skills may be adequate for raising the average child, they will need to become “expert” parents in order to succeed with the child they have now.

Outline the Basic Goals and Objectives of Treatment

Explain the priorities and the sequence of the treatment plan. It will be important to spell out specific expectations for the parents, both at home and in the therapy sessions. For example, in the area of parent–child communication, we suggest that the therapist should contract with the parents to avoid all shaming interactions such as hitting, yelling, name-calling, criticism, and sarcasm. They should have concrete, specific alternatives for the habitual negative interactions they have been experiencing with their child. Give the parents a written copy of the individualized treatment plan, emphasizing the main areas of focus for their particular child.

Listen Carefully to the Parents’ Concerns

Allow them as much input as possible in the creation of the treatment plan and ask for their input and feedback at every turn. They might need help maintaining their objectivity but, after all, they know more about their child than anyone else does. Pay close attention to the efforts they have already made in trying to solve problems and encourage them to figure out why these attempts have failed and what they might do differently.
Obtain their input in the setting of realistic treatment goals for their child and work for consensus when possible. If the therapist fails to listen to the parents in good faith, they are not likely to accept the job of cotherapist in good faith.

Teach the First Rule of Good Parenting: “Take Care of Yourself”

Encourage the parents to make sure they find time for their own recreation and relaxation. Explain to them that one of the keys to mental health is maintaining a balanced lifestyle. Urge them to develop more empathy for one another so that they can avoid their blaming mode and more easily access their problem-solving mode. Remind them that a child learns to take care of himself physically and emotionally by relating to adults who take proper care of their own mental and physical health.

Formulating a Detailed Assessment of the Child’s Problems

The therapist’s next task is to collect current information about the child diagnosed as having ADHD from parents, grandparents, siblings, and teachers and somehow reconcile that data with his or her own observations and interactions with the child. It is important to maintain a healthy skepticism regarding anecdotal reports from anyone who is really angry with the child, especially parents and teachers. Complete a thorough assessment of the child by obtaining the answers to three simple questions.

What Is This Child Doing?

The therapist must develop a thorough and accurate inventory of the child’s aversive behaviors and a reliable estimate of his ability to control them. A careful assessment will also include the determination of whether the behavioral problems occur mainly at home, school, or equally at both. If the problems occur mainly at home, it is important to know whether the child acts-out more in the company of his mother, his father, or equally with each parent. If the problems are mainly at school, it is important to determine whether the child is acting-out because he does not relate well with peers or teachers or because he has he is unable to succeed academically. The child’s aversive behavior will consistently reflect his system of primitive defenses. He will usually rely on habitual mechanisms such as denial, minimization, avoidance, and blaming to protect him from painful feelings. At this point in the therapy process, the caregivers can practice reacting differently to the child’s aversive behaviors, armed with the understanding that his behaviors are driven by his negative feelings, which are the products of his or her distorted thinking.

What Is This Child Feeling?

The next step in the process of developing a thorough assessment of a child diagnosed as having ADHD is the identification of the painful feelings being acted-out as aversive behaviors. The list of negative emotions will always include significant levels of mad, sad, and scared along with some others like loneliness and worthlessness. The child, however, will usually not admit to having these feelings because he fears that will make him vulnerable and deprive him of the power and control he has worked so hard to get.

It is also important to establish a valid estimate of his capacity for self-soothing, self-expression, and other forms of affect-modulation. The child’s history provides information about his or her developmental trauma and should reveal the causes of his or her anger, the reasons for his or her sadness, and the sources of his or her fear. The process of identifying the specific areas of mad, sad, and scared will provide a trail of breadcrumbs to the cognitive distortions responsible for the child’s painful feelings.

What Is This Child Thinking?

A child who has failed to form a secure attachment with a primary caregiver does not think the same thoughts as a healthy child. Distorted thoughts and delusional beliefs are predictable sequela of bonding breaks and attachment deficits in an insecurely attached child. For example, when a child fails to learn trust in the first 2 years of life he may develop core beliefs such as these:

“Adults are unreliable, unresponsive, and untrustworthy.”
“I must control others in order to be safe.”
“Being close to others is not pleasant.”

A child who does not receive the modulating responses he or she needs from a primary caregiver fails to learn self-regulation and may hold these beliefs:

“I am not able to control myself.”
“When I really want something, I should not have to wait for it.”
“Things that are difficult should be avoided.”

A child who lacks sufficient soothing interactions with caregivers does not learn self-soothing and may become convinced that:

“Feelings are dangerous and should be avoided.”
“Things that are not stimulating or pleasurable are a waste of time.”
“Being alone really scares me, but I cannot afford to let anyone know that.”

When a therapist has identified the cognitive distortions that underlie the painful feelings and drive the aversive behaviors of the child with ADHD, he or she is ready to work out the specifics of an individualized treatment plan. The child can develop new beliefs from his new experiences with the caregivers—cognitive restructuring that fosters healthy attachment between parent and child instead of the traumatic bonding that has occurred in their cycle of conflict.
Helping Caregivers Provide a Secure Family Environment and Remedial Parenting

In order for family therapy to succeed with a child diagnosed with ADHD, the caregivers must work together to create a healthy environment—one that will provide the safety, security, and structure required for repairing attachment deficits. Likewise, this ambitious and complicated task will require a set of consistent parenting strategies that will have the effect of containing the child in a sturdy box with a cushioned lining.

Establishing a Secure Family Environment

Many children who have experienced bonding breaks and attachment deficits, and have developed symptoms of ADHD, grew up in chaotic homes where life was unpredictable and the environment unsafe. This explains why these children work so hard to control everything in their lives. In order for family therapy to succeed with a traumatized child, his or her family environment will have to be safe enough for him or her to give up his need for control.

Eliminating All Hitting, Yelling, Criticism, and Sarcasm from Family Interactions

A child who has been traumatized by bonding breaks usually possesses a painfully negative self-image that is being maintained by cognitive distortions and feelings of self-loathing. When a caregiver hits, injures, or abuses a child who dislikes himself, that child's belief that he or she is bad is strengthened, and he or she becomes more likely to do bad things. Because he or she hates being reminded of his or her worthlessness, this child becomes angry and vindictive or tunes the caregiver out when he or she is subjected to verbal abuse. He or she will respond to the slightest criticism with aggressive behaviors (hyperarousal) or may freeze and tune out his or her antagonist (dissociation). The caregiver who tries to control such a child with criticism or intimidation has no chance of helping the child and can only exacerbate the problem. Parents must learn to be calm and firm when correcting their child, but loud and excited when praising him or her. In order to help this child, every attempt to interact with him or her must be framed in empathy. Parents may need to be reassured that the therapist will help them develop more effective, nonthreatening ways to manage the child's aversive behaviors.

Creating a Warm Family Climate Characterized by Empathy, Affection, and Respect

One of the primary symptoms of the child with ADHD is the lack of relational skills. Because the child has been traumatized by bonding breaks, his neurological development has been vandalized and his brain is not programmed for expressing or modulating feelings of love and affection. He is, however, capable of learning the building blocks of attachment when they are modeled by primary caregivers. When a child has the opportunity to feel understood, cared about, and respected on a consistent basis, he or she usually learns to feel those emotions for others and for him- or herself. Thousands of safe, predictable, and empathetic interactions with caregivers have the cumulative effect of helping the child build a realistic, positive self-image.

Establishing Clear and Consistent Rules, Roles, and Routines for Every Member of the Family

Every child needs fair rules and expectations, clearly promulgated and consistently enforced, in order to feel safe and secure in his family environment. He or she needs to have a thorough understanding of his or her role and responsibilities in the family and to trust that the expectations imposed on him or her by his or her caregivers will be realistic and benevolent. Consistent routines and schedules for meals, chores, television, getting up in the morning, and going to bed at night help him or her to learn responsibility, self-discipline, and obedience.

Maintaining Effective Patterns of Communication between Family Members

The child diagnosed with ADHD usually has a difficult time expressing him- or herself. Lacking verbal skills, he or she tends to rely heavily on nonverbal cues such as facial expressions and body movements to know when he or she is in danger. However, our experiences with children diagnosed as having ADHD teach us that they are likely to interpret neutral responses from peers and adults as being negative and threatening. Healthy family communications are honest, clear, calm, and respectful. Adult caregivers usually set the tone and tenor of communication within a family, not only in terms of what they say and what they do not say, but also in terms of how their messages are delivered. Caregivers should be aware that the absence of verbal communication sends a nonverbal message to their children. Children with attachment deficits generally interpret nonverbal communications as being negative. When caregivers communicate with their children in ways that are warm, loving, and accepting, they increase the opportunity for emotional attunement, trust, reciprocity, and attachment.

Modeling Self-Care as a Personal Responsibility

In families where a child is diagnosed with ADHD, conflict often erupts when that child is asked to be responsible for his or her own self-care in dealing with such things as homework, punctuality, and personal hygiene. Caregivers who take care of themselves set a good example and model
healthy responsibility for their children. A child needs to learn that each of us is responsible for guarding his own mental and physical health. “Putting oneself first” is a practical idea, not a selfish one. It is another way of saying: “When I am meeting my own needs for healthy recreation, relaxation, and gratification, I will be better able to protect you and see that you have everything you need to be strong, happy, and successful.”

Principles of Remedial Parenting

Children who display the behavioral and emotional symptoms of ADHD require first-rate parenting in order to overcome the effects of bonding breaks and attachment deficits. They need to experience consistent application of remedial strategies and techniques to constrain their aversive behaviors and emotions and help them to internalize healthy ones. Once again, the therapist’s role is that of a teacher for the parent–cotherapist.

Establishing Structure, Limits, and Boundaries

A child whose early experiences have been characterized by chaos and unpredictability usually lacks impulse control and experiences life in a chronic state of hyperarousal. Impulsivity causes daily interactions with others to also be unpredictable, thereby increasing his or her frustration and anxiety. A child who lacks impulse control normally benefits from the application of clear and consistent boundaries in his or her daily routine. Anchored by the predictability of limits and structure, the child is able to feel secure enough to begin internalizing self control. A child learns to modulate emotion and behavior when the parents monitor and reinforce his or her compliance with prescribed boundaries, both physical and relational.

Parenting That Is Proactive, Not Reactive

Reactive parenting exacerbates the frequency and intensity of power struggles between parent and child. Proactive parenting involves the thoughtful anticipation of circumstances in which the child might experience emotional hyperarousal and provides the child with choices for appropriate decision-making that can help to modulate his or her feelings and lead to self-soothing. The proactive parent avoids power struggles by choosing the time, place, tone, and pace for all interactions with the child.

Contracting for the Child’s Cooperation

Children with attachment deficits and a diagnosis of ADHD often lack the capacity for reciprocity and synchronicity in their interactions with others. Parents can work to remediate these deficits by contracting with their child for the attainment of specific behavioral and relational goals that are based on expectations appropriate to the child's developmental level. When mutual satisfaction results from the successful performance of a contract, it can build trust and respect between a parent and a child.

Promoting Interaction, Attunement, and Attachment between Caregiver and Child

This is perhaps the most important element in our model for family therapy with a child diagnosed as having ADHD. This is the part that requires the therapist to be most active and to employ the highest skill. It is here that the therapist uses his knowledge of human attachment and attaching behaviors to help caregiver and child form a healthier bond that will be the foundation for their new and improved family.
Holding by Therapist and Parent

If the child's history includes a pattern of inappropriate or hurtful physical interactions with adults, both the parent and the child will benefit from learning specific ways to use physical contact to promote affection and trust. In severe cases, when a child has been diagnosed with a serious attachment disorder, holding therapy with a specially trained therapist might be required. Children who have been identified with lesser problems (attachment deficits) can benefit greatly from being held by their parents. The parent, with the joint roles of caregiver and cotherapist, is the best person to teach the child that healthy touch can soothe his or her anxiety and alleviate his or her fear of being alone. The therapist teaches the parents how to hold the child in appropriate ways. Some children may need cradling, stroking, and rocking although their chronological age might suggest they are beyond that. Being held on a parent's lap, breathing in synchrony with the parent, listening to lullabies, or just gazing into the parent’s eyes—all of these things offer the child tangible experience of soothing and allow him to imagine how it might feel to soothe himself. Surprisingly, few children will refuse an offer to be held by their parent in the therapist's office. Therapeutic holding allows the child to experience safety and security within the context of closeness and physical contact. It also helps to build reciprocity and repair attachment deficits.

Videotaping Parents and Child in Therapy Sessions

It can be very helpful to videotape sessions in which a caregiver and child interact in a significant way. Schedule time to review these videotapes with parents, using the rewind and slow-motion buttons on the VCR. Therapist and parents work together to identify important elements that might have been overlooked when viewing the action in real time. For example, parents will often be astonished to see how many of the child's cues and expressions they had failed to observe or acknowledge. This process can help parents to improve their communications with the child, both verbal and nonverbal, and enable them to see, understand, and correct their own faulty relational behaviors.

Teaching the Parents to Express Empathy for the Child with Every Interaction

A child who exhibits behavioral patterns of hyperactivity and impulsivity usually receives a constant stream of criticism, contempt, and negative commands from parents, teachers, and others. Eventually, the child sees himself not only as doing bad, but as actually being bad. When he acts out the bad feelings as bad behaviors he completes the self-defeating cycle by generating more criticism and contempt from his caregivers.

The most powerful tool available to the parents for breaking this cycle of acting-out behaviors is their expression of empathy for the child. In order to provide empathy for him or her on a consistent basis, the parents must learn to separate their feelings about the aversive behaviors from their feelings about the intrinsic value of their child, responding to him or her with understanding and acceptance even when he or she is trying to provoke them. The therapist can help by interpreting the bad behaviors as the child's misguided efforts to connect with his or her parents without risking rejection. When the child realizes that his or her parents understand and accept his or her feelings as appropriate responses, that child can begin to give up the behaviors he or she used to avoid those feelings. Their empathy helps the child accept what he or she has been feeling and gives permission to change what he or she has been doing.

Encouraging the Child to be Affectionate on the Parents' Terms

Children diagnosed with ADHD, although they might express physical affection to peers and family members, are usually reluctant to accept nurturing, physical contact initiated by others. Sometimes they are labeled as “sensory defensive” because they exhibit a startle response when touched without warning. The therapist looks for opportunities to encourage the child to tolerate situations in which he cannot control the expression of affection. The parents will need to be patient, but persistent, taking the lead in offering the child affection that is nonthreatening. As the child learns to accept closeness and nurturing physical contacts his or her baseline of anxiety will be lowered and he or she will be able to relinquish his or her need for control.

Demonstrating and Teaching Playful Interactions between Parent and Child

Early bonding breaks rob caregiver and child of the opportunity to fall in love with one another and inhibit the development of secure attachment. The therapist can address these relational deficits by teaching the caregivers how to interact with their child in the play therapy room. These structured, choreographed interactions help the caregivers and child to feel good about having fun together and to learn important qualities like patience, perseverance, initiative, and sportsmanship. The caregivers learn to be more sensitive and more responsive to the child's needs and to be more emotionally available to the child without frustrating him or her or intruding in his or her space. These are important steps in the development of attunement, synchronicity, and reciprocity.

Accessing Collateral Therapies to Increase Self-Regulation and Relating Skills

We have identified a variety of adjunct therapies, some new and some well known, which can be included in a treatment plan to help a child learn
self-regulation and relating skills and to promote attaching behaviors in parent and child. Parents, as cotherapists, should be involved in making decisions about creative options for treating their child. Each of these modalities is considered to be appropriate for treating one or more of the symptoms of ADHD. They are all compatible with our model for explaining the origin of ADHD because they serve to heal attachment deficits by rewiring the neurology of a child's brain in one way or another.

**Group Behavior Therapy**

Group therapy has always been a wonderful place for children to learn self-regulation and relating skills. The artful therapist uses games, rituals, and role-plays to teach children how to control impulses, give verbal expression to feelings, accept delayed gratification, and practice interacting with peers. Likewise, the child will benefit from the structure of the group rules and from the experience of exercising control of his impulses for the good of the group (Halperin & Kymissis, 1995).

**EEG Biofeedback**

Also known as neurofeedback, this treatment option has been used in one form or another for more than 20 years. A current version of the procedure uses a computer video game in conjunction with encephalographic equipment to teach a child to recognize when his or her brain is in a particular state and to actively enhance or suppress that state by focusing his or her thoughts, thereby improving his or her chances of success with the game. Treatment goals include the enhancement of cognitive skills, such as attention, concentration, and academic performance. This protocol is thought to require a minimum of 20 30-min sessions for successful outcome. One major drawback with EEG biofeedback is its cost, which may be prohibitive for many families (LaVaque & Rossiter, 1995).

**Eye Movement Desensitization and Reprocessing (EMDR)**

This is a revolutionary psychotherapy procedure that has become widely accepted during the past 5 years, especially in the treatment of traumatized adults and children. It is being used primarily to treat symptoms of anxiety, anger, guilt, and Post-traumatic Stress Disorder. The basic procedure requires a specially trained and certified therapist to guide the client in concentrating on a traumatic memory or emotion while moving his eyes back and forth in rapid movements. Although we do not have consensus for a precise explanation of the healing dynamic in EMDR, it is assumed that when the rapid eye movement coincides with the client's emotional reexperiencing of the trauma, the brain's processing and interpreting of specific memories is altered and hyperarousal is diminished (Forrest & Shapiro, 1998).

**Thought-Field Therapy (TFT)**

This is another revolutionary therapy that has become quite popular during the past several years. Thought-field therapy is being used by specially trained and certified therapists to treat anxiety, fear, rage, grief, Post-traumatic Stress Disorder, and other symptoms of hyperarousal. The treatment is designed to clear blockages in a person's energy flow that are the result of disturbing thought patterns derived from traumatic experience. The procedure requires the client, at the direction of the therapist, to tap on his upper body at specific places (acupressure points) with his or her fingers or hand in a specific sequence (algorithm) while thinking about a targeted problem. The treatment is believed to approximate the techniques of acupuncture, without the needles, because it focuses on the classic meridians and energy points used in that ancient healing discipline (Callahan & Callahan, 1996).

**Brain Gym**

Also known as Educational Kinesiology, this relatively new treatment program has been promoted primarily as a benefit to cognitive processing in children with learning disorders. It is also being used to treat other specific deficits in children and adults, such as hyperactivity, behavioral dyscontrol, and relationship problems. Brain Gym is a highly structured program of physical movements and activities, sequenced to meet specific needs, and designed to integrate the left- and right-brain functions, thereby improving performance in complex human tasks such as organizing, remembering, concentrating, and communicating. Children who are traumatized by bonding breaks appear to get stuck in a hyperaroused feeling state controlled by the right side of their brains. Consequently, they have a very difficult time accessing the left-brain functions required for academic success, such as remembering, organizing, and expressing themselves verbally. Not surprisingly, Brain Gym practitioners report success in reducing the symptoms of hyperactivity and impulsivity in children diagnosed with ADHD (Dennison & Dennison, 1994).

**Art and Play Therapy**

In addition to their value in the process of assessing children, these therapies may also help the child who has trouble expressing his emotions verbally and has been acting them out as aversive behaviors. Some children appear to derive great benefit from drawing or from role-playing their feelings in the presence of an adult who can reflect them back in the form of words. This mirroring of affect is likely to be something they have lacked during the years they needed it for emotional and neural development. Art therapy or play therapy, when parents are included as cotherapists, may help to break the cycle of negative interactions with their child. When a
child learns that words can be used to gain understanding, empathy, and acceptance from caregivers, he will begin to respond differently in situations where the aversive behaviors had been creating problems for the family (Norton & Norton, 1997).

Martial Arts, Chess, Dance, and Organized Sports

This is a short list of structured activities that can help a child diagnosed with ADHD to learn self-discipline and impulse control. They all require a child to exercise control of his or her mind and body together within the context of specific rules and movements. They are also challenging and stimulating and require consistent concentration and perseverance for mastery. These are opportunities for a child to experience internal and external rewards for hard work. They also require him or her to interact with peers in ways that promote cooperation and reciprocity. The more effort the child applies to the task at hand, the more attention and approval he or she receives. The better he or she learns the rules and tries to follow them, the better his or her chance for success and feeling good about himself or herself.

Suggesting Psychotropic Medications as a Last Resort

We believe that children are programmed for health and have a tremendous capacity for self-healing. For this reason, interventions that promote permanent internal healing for children, like family therapy, are preferred over temporary drug-induced relief that does not bring about real change. More importantly, medications that maintain a child in a state of lethargy or euphoria can be major obstructions in the course of family therapy. There are times, however, when a therapist's best option might be to encourage caregivers to seek medication for their child or to continue its present use.

If, for example, a child's behavior is so outrageous that he or she cannot be managed at home or at school, psychopharmacologic intervention might be advisable as a temporary solution to a crisis. When caregivers are unwilling or unable to participate as cotherapists in family therapy, medication might be recommended for the longer term. Furthermore, most children diagnosed with ADHD who are brought to a therapist's office are already taking psychostimulants, antidepressants, or antihypertensives to control symptoms of the disorder. A therapist should not try to pressure his cotherapists to abandon a treatment plan established by the child's physician.

Still, in order for the therapist to be helpful in establishing a realistic agenda for family therapy, he needs to have a good understanding of what medication can do to help a child and what it cannot do. For example, some medications appear to help many children by decreasing their hyperarousal, their impulsivity, and their hyperactivity for as long as 3 to 8 hours at a time. They may also enhance a child's academic performance by making him or her more attentive in class and helping him or her to complete more work assignments there, with a more legible handwriting. It may even help him or her to reduce negative interactions with teachers and peers.

On the other hand, psychotropic medication cannot help a child to develop motivation or initiative, form lasting friendships, learn to respect and cooperate with others, establish control of his or her emotions and behaviors, or increase his or her intelligence. In other words, medication is of very little help in the reparation of the attachment deficits caused by bonding breaks between caregiver and child.

REFERENCES


INTRODUCTION

Some of the well-known people with documented attachment breaks who did not get help with healing parenting and attachment therapy are Jeffrey Dahmer, Edgar Allen Poe, Hitler, Ted Bundy, Saddam Hussein, and Ted Kaczynski, the "Unabomber."

The first clue is something that happened when Kaczynski was only six months old. According to federal investigators, little "Teddy John," as his parents called him, was hospitalized for a severe allergic reaction to a medicine he was taking. He had to be isolated—his parents were unable to see him or hold him for several weeks. After this separation, family members have told the Feds, the baby’s personality, once bubbly and vivacious seemed to go "flat" (E. Thomas, 1996, p. 29).

Just as a break in the bond from the parents causes the trauma called Attachment Disorder, bonding with parents can heal it. Parents are a crucial ingredient in the healing of a child with Attachment Disorder. The successful, healing team must consist of empowered, educated parents and a competent, skilled attachment therapist.

Parents of a Reactive Attachment Disordered (RAD) child often silently carry bruises where their child has inflicted pain on their bodies and


BIographies

Alice Eicher Massanari

Alice is a clinical social worker, licensed in both Florida and North Carolina. She is the coauthor of a book about raising a child with special physical needs—Our Life with Caleb—and of Raising Special Kids, a curriculum for a parenting program on the same subject. Alice worked with Randall Ladnier for several years at a Family Services America agency where much of their theory and research on ADHD was completed. Alice has also been a presenter, trainer, and facilitator for a number of parenting programs in a variety of settings. Currently, she works in an employee assistance program in Asheville, North Carolina while developing a private practice with her husband, Jared Massanari, under the name InterActive Family Resources. They are the parents of two children, one deceased, the other now an independent adult.

Randall D. Ladnier

Randall Ladnier earned his master’s degree in clinical social work at Tulane University. He is licensed as a psychotherapist in the state of Florida. Randall has worked as an outpatient therapist at Family Counseling Center of Sarasota County for the past 7 years while maintaining a part-time private practice in Sarasota. Prior to that, he worked as a clinical social worker in two privately owned psychiatric hospitals. Randall currently specializes in treating families with recent adoptions and families with children and adolescents who are experiencing problems of emotion and behavior. He has presented at two national conferences of clinicians on the connection between attachment disorder and ADHD. Randall and his wife, Linda, have two teenage sons.
their hearts, yet they still seek answers and solutions rather than turn away.

These child-inflicted wounds are badges of courage. Parents have reported claw marks on their own neck, arms, and faces; hair ripped out; and bite wounds on their arms and breasts from living with a child with RAD. One mother shared the experience of playing baseball with her RAD daughter. She had told her daughter it was not her turn to bat. The mother awoke in the hospital with a lump on her head and was told that her child had knocked her unconscious with the bat. The mother felt sure that it had been an accident. Parents often don’t want to believe the worst in their children. They want and need to hope. This 7-year-old girl revealed, in therapy, that it was no accident—she had fully intended to kill her mother because it was not her turn up to bat.

There is hope for these tough kids. These parents need a plan and a powerful team of support to help them work the plan. The parenting plan in this chapter has been developed and honed for over 2 decades by me and others while working with severely emotionally disturbed children. Ninety percent of the children had already killed before they were moved into our therapeutic home where the plan was begun. This plan has proven to be highly successful when completed in the right balance of structure and nurturing. Eighty-five percent of the children placed in my Professional Therapeutic Family using this plan achieved 6 months of respectful, responsible, fun-to-be-with behavior, at home and at school, before being successfully reintegrated into their prior homes. Some of these children had half and many had all of the symptoms of Attachment Disorder. The successful 85% are now graduating from high school and becoming hard-working, loving adults. This plan is most effective for prepubescent children. With teens and adults there is still hope but it is certainly a more difficult climb for them.

One person with a documented break in attachment who did get help is Helen Keller. She became one of our great humanitarians because one person stood strong and did the things necessary for her to succeed. She said, “The most beautiful things in the world cannot be seen or even touched ... they must be felt with the heart.” We can make a difference; there is hope for these children.

UNDERSTANDING THE CHILD

In order to understand and have a well-defined perspective of the solutions, we must clearly see the problem. Human infants are born in a helpless and hopeless state. Physically they can neither fight nor flee; emotionally they can do both. When faced with overwhelming pain or loss, such as hospitalized infants or those abandoned, adopted or abused, they will do whatever is necessary to survive. The intense pain and subsequent damage suffered by newborns at the hands of well-meaning medical staff is well documented.

NICU infants are at risk for being unattached because (1) they have multiple caretakers; (2) the parents are not always present and after a prolonged stay of the baby, may be “strangers” to the baby; (3) the needs of the multiple caretakers and baby may be asynchronous (e.g., it is “care time,” but the baby is asleep); (4) lifesaving care in the NICU is intrusive, noxious, and painful; and (5) these experiences give the baby a history independent of his or her parents. From the infant’s perspective, the altruistic pain of lifesaving care is indistinguishable from the pain of child abuse (Gardner, Garland, Merenstein, & Lubchenco, 1993, p. 604).

Nancy Newton Verrier writes on the trauma of loss and adoption in her book The Primal Wound (1993, p. 1): “When this natural evolution is interrupted by a postnatal separation from the biological mother, the resultant experience of abandonment and loss is indelibly imprinted upon the unconscious minds of these children, causing that which I call the ‘primal wound.’ ” These children are wounded during what Dr. Foster Cline calls the Soul Cycle:

There is almost a magical cycle that gives birth to our soul. ... The cycle “locks in” our first associational patterns. At any step, if some things go wrong, lasting and severe psychopathology may result. The importance of this cycle cannot be overemphasized. Stage one: Need—Stage two: Rage Reaction—Stage three: Gratification or Relief—Stage four: Trust (Cline, 1979, p. 27).

Because of the trauma these children have endured, they see the world and handle it in a very different way.

Your child believes that the world is unsafe, that you are unloving, that he is unlovable, that he must control at all costs if he is to survive. Your child believes that you are the enemy and that if you get too close to him, his pain/feast/sorrow will be unbearable (Pickle, 1997b, p. 5).

To help understand the Attachment Disordered child’s perspective and help parents to adjust their perception of the child’s behavior the following analogy may help:

Visualize this child in a war zone fighting for his (emotional) life on a horrifying battlefield. Terrified, wounded, and bleeding rather than running into his mother’s arms for comfort, the child turns to the earth to dig a foxhole. With the only tools he has, his bare hands, he begins to claw at the earth. Focused solely on survival, heart pounding in fear, tuning out the perceived explosions and whistling bullets overhead, he shuts out the world and digs. Excavating the escape hole for self-protection consumes his every thought, every moment. The battle up above has ended. He does not notice. The dark, cold, lonely foxhole becomes his entire world. Caring people stand near the opening, peering into the darkness he has chosen and offer words of encouragement to come out. He cannot hear them over the racing pulse thundering in his ears and the distance he has put between himself and others. His terror-filled focus is on digging deeper, feeling safer with each foot of earth he flings upwards and out of the pit. The flying debris hits onlookers, pushing many away. Those who care the most stand nearby to call down to the child, bending...
to heal, must be completed by one primary caregiver. The caregiver, male or female, henceforth in this text will be labeled “Mom.” The Mom needs to be rested and prepared for the task at hand. Whether it be lots of sleep or a vacation, both parents must begin the process with step 1, resting.

Knowledge is Power

Step 2 is to acquire more information. Education about this deeply painful condition is a must. Parents often feel tremendous pain having a child that rejects their love.

‘When parents of unattached children—often children who have suffered early abuse and neglect—are taught child management techniques and then conscientiously carry them out only to see them fail again and again, a sense of futility sets in. Parents then feel increasingly more hopeless’ (Cline, 1982, p. 162).

They often feel like “bad parents.”

Because children with attachment disorder don’t operate in the world in the same way that securely attached children do, parenting techniques that work well for securely attached children don’t work well at all for children with attachment disorder. Normal children (securely attached) can usually be given choices in most areas of their lives, and be allowed to make mistakes because they learn how to handle the consequences of the mistakes they make. However if children with attachment disorder are given choices they will almost inevitably make choices that are extremely detrimental to themselves or to someone else…. And as any parent who has tried to raise a child with attachment disorder can tell you, parenting according to Dr. Spock, Dr. Ginott, Toughlove, Parent Effectiveness Training, Behavior modification, or other approaches to parenting have little to no success with children with attachment disorder either (Randolph, 1997, p. 23).

Books, videos, audio tapes, and seminars focused on Reactive Attachment Disorder may help to empower parents to firm up a plan and prepare to help their child.

All foster parents, adoptive parents, or parents of hospitalized infants should be provided information on Attachment Disorder before they begin dealing with a child at risk due to separation, trauma, or pain. If a child has one or more of the causes of Attachment Disorder, the parents should have a list of the symptoms to watch for and a plan to perform the “healing” parenting required to help these children.

If parents are unable or too exhausted emotionally to perform the parenting techniques presented in this chapter they need to hire Professional Therapeutic Foster Parents. A therapeutic foster parent is highly skilled and trained to work in conjunction with the attachment therapist to treat an emotionally disturbed child in the therapeutic milieu of a family. The therapeutic parents create a healing environment in which to implement the treatment plan on a 24-hour-a-day basis. A professional therapeutic mom is not employed outside the home. In consideration of expertise,
specialized training, intense involvement, and high risk factors, these special people are a rare treasure to the families. Many attachment therapists hire these professionals during the intensive beginning of therapy to give the family a rest and begin the tight structure and powerful nurturing required of a child who does not trust.

Children with this disturbance should not be given more information than is absolutely necessary. In the case of securely or anxiously attached children, they cope better with time to assimilate and digest upcoming changes or events. Attachment-Disordered children act worse when given information about what is going to occur. They use it to manipulate their environment and everyone in it. If a child is to have a stressful visit with someone and is told about it they often use the time to obsess, become destructive, and act out their concerns. If something happens and the scheduled visit or event does not occur the child then is angry, disappointed, or sad about it not happening. If information about an upcoming fun event is shared they will often try to sabotage the event beforehand. Sharing information on a need-to-know basis, at the last possible moment, has shown to be the least stressful for all involved and it gives parents the upper hand in the battle for control. When the child asks, “Where are we going?” the parent may ask, “Is there some reason you need to know?” If there is a valid reason then the information should be shared.

The tight structure that is necessary for the healing of these children can be made clearer with a visual picture. The child, having a “war wound,” is losing his life blood rapidly through a severed artery. In order to stop the bleeding and save his life, firm pressure must be applied. The pressure bandage must not be moved often to check if the bleeding has stopped. Too much blood may be lost with each loosening. It must remain steadily in place until there is no doubt it is no longer needed or the child will not survive. It is painful to hold the pressure for the wounded. They will cry out, “It’s too tight, stop! You are hurting me!” The pressure must not be stopped. The parent holding the pressure on the child feels the pain of their child, yet, knows no matter how difficult, it must be done and persists. When the pressure is held steady, long enough and firm enough for the bleeding to stop, no more pressure is required. With Attachment Disordered children the parents must not set up structure out of a need to be in control, military drill sergeant style, but out of love and compassion to save the child they love.

Progress on any level is not possible if the child has not first learned self-control. Do not attempt to have the child handle any chores or privileges until the child has good self-control when mad, sad, glad, or scared. It is vital that they have control of themselves first. The basic tool used to teach self-control is Power sitting. Parents select a “think spot” according to visibility, convenience, safety, distractions, and destructibility. A special chair is used for children under 4. A spot on the floor with a small washable, rubber-backed rug for children over 4 is best. Correct body position is with legs folded, hands folded, back straight, head straight, and nothing moving especially the mouth. Having them face a blank wall is safer than having them face a wall covered with wallpaper, which is easily destroyed. Begin with 5 consecutive minutes of power sitting. Build up to 1 minute per year of life. Self-control is crucial if you expect the child to function in a classroom or in life.

Give no negative input. Only positive attention is given for the good parts. Silence is golden; use it to your advantage. If the child is laying down or talking, parents can direct them to lay there or direct them to their room to “rest and get strong enough to try again later.” Do not allow privileges until the sitting is correctly completed. Let them take their time doing it wrong first. Time starts when they are in position not when they announce that you may begin timing now. Talking is not part of power sitting.

Sitting is not punishment, it is a thoughtful gift of time for the child to think and get control of him-/herself. There are a number of religions that use this position exclusively to facilitate inner peace, meditation, or prayer. Three times each day for the first 6 months the child needs to have this quiet time to think given to them. Sometimes it will be when they are flashing warning signs and need to think before processing feelings; more often it is used just to practice getting control and getting stronger. Compliance on this basic level is a must before attempting to get compliance, honesty, or any progress on any level. The choice is X minutes of “power sitting” or 2 hours of “wimpy sitting” or parents may choose to stand firm on the strong sitting for X minutes. The comment, “No problem” means it’s no problem for the parent.

The child should also be taught to come when they are called rather than rudely yelling “What?!” from another room. They should go to their room when sent and stay there. These are all things that can be practiced when it is convenient for the parents.

Gather A Support Team

Step 3 is to gather a powerful team together to support the parents’ work. Just as elephants form a very tight circle join their bodies together side by side, facing out, to assure the safety of the encircled baby elephant, an awesome team needs to be joined together for the RAD child. The circle of support may include the parents, therapist, grandparents, the teachers, social worker, friends, respite care provider, and the church community. Those interested people who can be strong enough not to be manipulated by the child should be invited to the team. The support team needs to have a clear understanding of Attachment Disorder and the plan. Tremendous things can happen when all of the people involved in this child’s life link together in a powerful human chain to stand and do what is right for this
child. The strong parenting required to stand firm and set the limits that need to be set is very difficult without a tremendous amount of support. A single goose can fly a long distance, their powerful wings can lift them high and fly far, but in a flock, as a team flying in formation, they can fly 71% farther (Canfield & Hansen, 1995, p. 307). The parents are the ones who begin the circle. They need to be a powerful united team. Disturbed children need a parenting team. It is extremely difficult for a single parent to be the mom and the dad and the financial support system that is necessary for a RAD child to heal. People need to team up so that there is a united front to handle the difficulties that this child is going to throw at them. Two single parents or adult siblings can join together as a team to parent these kids. It has been done very successfully.

The people in the circle need to be nonjudgmental. The team should not be looking to place blame, but solely supporting and seeking solutions to the problems. "I believe that the impact of the child’s trauma upon the family system is greatly underestimated by clinicians and that the focus of the dynamics is skewed to seem as if the problem resides in the parents’ issues" (Verrier, 1993, p. 2). Donovan and McIntyre (1990; cited in Verrier, 1993, p. 3) pointed out that their findings demonstrated a “striking consistency of behavior problems among adoptees whether the family is functional or dysfunctional.” Judging people without the information required or even with it keeps us from being supportive and helpful. It can be and is very damaging:

A profound learning experience I had about judging folks occurred on the Fourth of July. I had been ruminating about the importance of not condemning parents for mistakes. We had a big gathering with hundreds of families on the grass in the park awaiting the fireworks. One child that I could not see was squealing like a toddler. A few of those high-pitched screams was okay, then it continued on. I quickly decided it was obviously inept parents that needed to teach their child the concept of “no.” There was someone rows behind us who began to yell, “Shut that kid up!” I shared my thoughts with my daughter, who looked at me in surprise and said, “Mom, that’s a severely handicapped little boy who can’t help it.” Ashamed, I realized I had judged the parents without all of the facts. I had condemned them.

Our society often reacts that way. To be successful in supporting each other we have to stop judging and laying blame. Even therapists have been guilty of this: “At Bellevue Harry Bakwin had the habit of telling distressed mothers that ‘there are no behavior-disturbed children, just behavior-disturbed parents’” (Karen, 1994, p. 27).

Our eyes speak reams, volumes of information about whether we believe in that parent or whether we don’t. We need to be very aware of that. We need to support with our eyes. We need to look at parents with honor and love that they brought this child into their home, into their lives, whether through birth, adoption, or foster care and are doing their best. Stephen Covey (1997) in his book Seven Habits of Highly Effective Families talks about the family as a plane headed for a destination moved off course by winds and various encounters. We are all off and on course continually. It is part of being human. Keeping the goal in mind helps us get where we need to go. The support system’s goal must be to help parents stay focused and encouraged.

Relief care is an essential piece in the support team for the family. The relief care provider must be trained and selected carefully. This provider must maintain the essential tight structure and must do no bonding activities with the child such as eye contact, touch, and smiles, and sharing sugared foods. The relief provider should support the parents with their difficult work with the child.

Establish Authority

Step 4 is to reestablish authority in the home, especially with the kitchen, the car, and the cash. A child who is “out of control” needs someone to control them until they can build self-control. Food that is prepared for children is a way of nurturing. They will often reject homecooking, choosing self-prepared or fast food to avoid accepting love and human connections. The most successful method to deal with this is for the parent to prepare and provide all meals. There being no other available options, eventually the child will join the family for meals. Rather than forcing food at the child it works better to do the reverse. If a child makes a face or rude comment about a meal that has been lovingly prepared, the plate is quickly and calmly removed. It can be thrown out or, better yet, fed to the dog with the comment “Don’t worry, the dog loves this food!” When the child asks, “What am I going to eat?” the loving parent may say, “Breakfast!”

The car is only used to transport children that are “climbing”, not digging deeper with behaviors to push parents away (unless it is an emergency or a trip to therapy). The child should sit in the back seat behind the passenger seat until they have completed climbing the ladder of success (unless there is an airbag safety issue). Many powerful parents do not allow disturbed children to speak unless spoken to in the car for safety reasons. Having the child ride with a hand over the weak mouth for 5 to 15 minutes has helped children learn not to distract the driver. If the child has weak hands and is hitting other children or playing with windows they may need to ride for 10 to 15 minutes with both hands on top of their head until they get control of their hands. Sometimes practice sessions are required when the driver is less distracted and has returned home. These practice sessions...
can be done in a mock car seat (chair) with hand over mouth or hands on head for twice the time originally asked. The child should take their time and not rush into putting their hand over their mouth until they are ready. Patient parents wait calmly by enjoying the time reading a good book or playing with other children. They consequence the first word or flying hand rather than wait until they are angry.

A driver's license is not a wise option for a child out of control. They must be demonstrating excellent self-control over an extended period of time before they (and the rest of us) are safe on the road. Money is another area disturbed children have trouble handling appropriately. The parents should keep and control all cash until the child displays the skills to make good decisions concerning their life. Drugs, cigarettes, alcohol, lies about thefts, and bus fare for running away are all made easier with cash in hand. Retain control of the kitchen, cash, and car until the child has climbed from the hole they have dug and are on solid ground for at least 6 months.

**Face the Problem**

Step 5 is that adults involved with a RAD child must have their eyes open. It is highly likely that the child will attempt to manipulate because they do not trust that others have their best interest in mind. Parental denial can prevent a child from feeling safe enough to trust adults. Each time parents close their eyes, in denial to the child's behavior, it is equal to wobbling that ladder. The child believes if he/she can outsmart and manipulate the adults, no one is strong enough to protect them. The banners of belligerence that these children carry of lying, stealing, breaking things, fit-throwing, sexually acting-out, hurting animals, and oppositional defiant behavior are thundering cries for help. Children will fail when parents turn a deaf ear to the child's expense. Laughing at the child puts you against, rather than for, the child. In this case, they will not feel safe enough to turn toward you and trust that your outstretched hand will hold them. The sound of laughter has been clocked at over 700 MPH. Kindergartners laugh an average of 300 times a day and an average adult laughs 17 times a day. In the home of an attachment-disordered child there is little laughter. Bring laughter back into the family as a healing tool for all. Set it up and plan it. Eat pizza in the bathtub. Paint on a mustache and laugh. It is said, "Music soothes the savage breast." Appropriate music can help calm a disturbed child. Many have found it helpful. Mozart's music has proven to have a calming, soothing effect that opens the mind to be more creative and have better problem-solving ability and increased memory. Mozart's melodies can substitute for sedatives, boost memory and concentration, and improve thinking (Campbell, 1996). It actually improved students SAT scores by 51 points on the verbal portion and 39 points on the math portion. The result of listening is a nurtured feeling that supports

**SHINE A LIGHT ON THE SUBJECT**

A light must shine to illuminate the child's path into the parents' arms. The most powerful light source is the parents' eyes. Filled with hope and love, shining onto the child, they can be a powerful beacon beckoning the child toward emotional stability. It can be the light of hope to illuminate the cavern they have dug themselves into.

The sound of laughter is a sound that says "all is right with the world" and it is a safe place to be. King Solomon said, "Laughter is good medicine." Laughter is the shortest distance between two people. Studies have shown that after we laugh we go into a relaxed state. Laughter lowers the heart rate and blood pressure. It also indirectly stimulates the release of endorphins, the brain's natural pain killers. Laughter increases creativity and problem-solving. Norman Cousins, in his 1979 bestseller *Anatomy of an Illness*, describes how he cured his own fatal disease with laughter. Studies have shown how it activates killer and T cells as well as increases immunity to disease (Dokskoch, 1996, p. 1G). Laughter is, of course, never at the child's expense. Laughing at the child puts you against, rather than for, the child. In this case, they will not feel safe enough to turn toward you and trust that your outstretched hand will hold them. The sound of laughter has been clocked at over 700 MPH. Kindergartners laugh an average of 300 times a day and an average adult laughs 17 times a day. In the home of an attachment-disordered child there is little laughter. Bring laughter back into the family as a healing tool for all. Set it up and plan it. Eat pizza in the bathtub. Paint on a mustache and fix breakfast. Dance a jig. He who laughs, lasts.

It is said, "Music soothes the savage breast." Appropriate music can help calm a disturbed child. Many have found it helpful. Mozart's music has proven to have a calming, soothing effect that opens the mind to be more creative and have better problem-solving ability and increased memory. Mozart's melodies can substitute for sedatives, boost memory and concentration, and improve thinking (Campbell, 1996). It actually improved students SAT scores by 51 points on the verbal portion and 39 points on the math portion. The result of listening is a nurtured feeling that supports of stealing they must make restitution for every stolen item and every suspected stolen item. They need to make restitution for injuries inflicted. They earn the money and pay it back or they give of their time to lift the load of the one they insulted or hurt. One option for restitution is to do chores (e.g., vacuum the bedroom, fold the laundry for siblings). They can rub lotion on the feet of the tired Mom they have hassled (this becomes a favorite of many moms).
well-being. It is not a cure, but, it can be helpful in the car, school, therapist’s office, or at home.

The smells of love wafting toward the child—of homebaked bread, of a good meal in the oven, of herbs used in aromatherapy (chamomile, lavender and lemon balm for calming and stress relief)—can have a helpful effect on healing the heart of a child and the entire family. In research lead by Robert Baron, a professor at the Rensselaer Polytechnic Institute in Troy, New York, they found that with a pleasant fragrance of roasting coffee or baking cookies in the air people were more than twice as likely to be helpful and pleasant than in unscented surroundings. Baron said, “The effects of pleasant fragrance on social behavior stem at least in part from fragrance induced increments in positive affect” (1996, cited in Crenson 1996, p. 4A).

The feeling of peace that emanates from a parent who is organized and in control demonstrates strength that a disturbed child must feel in order to develop trust. Having the household organized with a chore list so that dishes, bill paying, checkbook balancing, laundry, and so on can be done on time takes some of the stress off the family with a high-maintenance child. This allows more quality time to assist the child.

The presence of a full-time parent for the first 6 months to 1 year of the child’s healing time is highly recommended. The act of prioritizing and committing to the child’s needs demonstrates the parents’ commitment to the child’s emotional survival. If that is not possible, a primary caregiver, such as a day care provider, must be enlisted to perform the necessary bonding and skill-building. This person must be selected carefully to replace the parents in the bonding and guidance of the child: “… the parents need to recognize that the alternate attachment figure may now count more prominently in the child’s development” (Karen, 1994, p. 336). “A study of 110 families by Peter Barglow found a shocking correlation. When full-time nanny care began in the first eight months, it was associated with a much higher incidence of insecure attachment to the mother at the end of the first year” (Karen, 1994, p. 341). Barglow’s study was done under optimal conditions with all the parents being “well educated” and deeply involved in “parenting.” The day care provider should be one that will remain in the child’s life for a minimum period of 2 years. At the time of departure the bond must be carefully and slowly transferred to the parent or another caregiver. Each move puts the child at a higher risk for severe emotional problems. A bond cannot be quickly severed without retraumatizing children and forcing them to return to digging (old anxious or avoidant behaviors) in terror for their life. In a presentation for the Attachment Center at Evergreen in 1994, Greg Keck, Ph.D., stated emphatically, “The term ‘moving a child’ should be called ‘inducing loss’ in the child.” Children should not be moved from caregiver to caregiver, especially during the first 3 years of life or during the healing of previous attachment trauma.

**REMOVE OBSTACLES AND BARRIERS**

One of the most difficult types of child to treat is one that is unattached and overindulged. To evaluate if a child is overindulged, assess their balance of give and take. Are they under 18 and have a double bed, TV in their room, private phone, large shelves filled with toys, an extensive wardrobe, and/or more than one bike? Do the parents rescue them from consequences the child needs to handle? Does the child eat what is served or is the entire family fed according to the child’s food choices? Does the family serve the child, while the child does little or nothing to reciprocate?

Overburdening a child with excessive material goods and privileges is akin to having him or her climb the ladder from the dark depths of the fox hole carrying all he owns. The handicap of climbing with only one arm and of having the view of the parents obscured, as the “stuff” blocks the light from above, would make it extremely difficult, if not impossible, for the child to succeed.

To prepare the child for the ascent it is essential to remove obstacles and teach self-control. The child’s room should be prepared calmly, while they are elsewhere, with: a single bed, bedding, blankets and pillow, a maximum of 7-10 sets of seasonal clothing, socks and underwear, two coats, three pairs of shoes/boots, one hat, and a few easy-to-pick-up, age-appropriate toys and books. A desk with supplies that the children can handle alone should be provided for those that attend school. Legos, art supplies, books, and a mini-trampoline should be made available in the family living area. In order for the child to focus on the goal of connecting to the parents, their room must be easy to organize and maintain. Keep it simple. Store or dispose of the rest.

Reactive Attachment-Disordered children usually have trouble with empathy for people and pets. In the beginning, to help them stay focused on the goal of learning to be respectful, responsible, and fun to be around, they should be prevented from interacting with other children and animals. After several weeks of being successful with the goals, these privileges can and should be earned. If the child has a problem with sexual perpetration or predatory behavior then 6 months to a year of success with the goals required would be more appropriate.

The child’s home should be prepared by removing items that are treasured by other family members. This would include heirlooms, jewelry, credit cards, and any such items that would cause distress to the family if they were lost or destroyed. The child must be a priority over material possessions.
Parents need to hold steady by using powerful parenting techniques that do not include anger, warnings, second chances, or waiting to consequence until the parent has become stressed. Anger feeds the RAD child's pathology and assures them they are right in not trusting. The flinging dirt from their digging often causes parents to think the child is "out to get them" rather than to see this as a side-effect of the RAD child's problem. Warnings ("If you do that, I'll have to ...") and second chances ("If you do that one more time ... The next time you do that I'll ...") are not effective with these children and should not be used. These behaviors keep a child from trusting that the parents are strong enough to keep them safe. It would be similar to lowering a ladder for the child to climb up and making it wobble as they reach for it. The ladder must remain steady. Consequence the first time the child does inappropriate behavior or crosses set boundaries. Use action not anger.

Another major obstacle to the child's progress and subsequent healing is the holding of destructive secrets. These would be secrets concerning lies, stolen goods, injuries to others, and any inappropriate behaviors. A complete "clean slate list" is often required of the child before they may begin to earn any new privileges. The therapist usually assigns this task to the child during the beginning phases of therapy. Close, constant supervision to prevent old destructive behaviors, such as molesting children or hurting pets, must be provided until the child develops adequate self-control. Supervision throughout the night requires the use of an inexpensive intruder alarm on the child's bedroom door and window. When installed the child should be told the alarm is there to keep them safe from anyone entering to harm them and from them coming out to get themselves in trouble. The alarm must remain in place every night until the child has been on solid, stable ground for one year or more, depending on their level of conscience development.

Yet another obstacle to healing and connecting can be the acceptance or rejection of the child's past.

Parents need to be non-judgmental and accepting of the child's previous life. It is part of the child. To reject the child's perception of his previous life experience is to reject the child. The more we can share the child's past through their eyes the more we can walk supportively and acceptingly with the child. Lifebooks help to make sense of a child's history. They give tangible evidence to that experience. They provide connection and understanding to a child (Pickle, 1997a, p. 10).

Rejection of the people who gave the child life is extremely damaging to the child. They are, and always will be, a genetic part of them. Pictures of the people and places in the child's life should be gathered and put all together in one book to give continuity to their life.

Sleep is a crucial ingredient to learning, growth, and sanity. Researchers at the Weizmann Institute, in Rehovot, Israel, and at the University of Arizona found that a good night's sleep is an essential ingredient to memory and learning (cited in Reuter, 1994, p. 6c). Children need to be put in their rooms in a regular nightly routine; younger children at 7:00 P.M., older children at 8:00 P.M. This gives parents a break from the full-time job of parenting and gives children a quiet time to do homework, read, relax, or play quietly before they put themselves into bed. Attachment-disordered children with trust issues often insist on having a night light and the door left open as a control attempt. This should not be an option for a child over 5. If a child has trouble sleeping, it needs to be remedied quickly. Sometimes warm milk, a back rub, or some herb teas are helpful. Sometimes medication is required. Lots of exercise has shown to make a big difference in the soundness of sleep. The use of the mini-trampoline daily makes an impact. It is vital that the child gets 8 to 10 hours of sleep every night.

**TURN THE CHILD TOWARD THE PLAN (THE LADDER OF SUCCESS)**

To turn the child from their fight or flight toward the ladder of success in life there are two requirements: the first is Attachment Therapy, the second is removal of distractions.

**Attachment Therapy**

Attachment therapy is required to dissipate enough of the internalized rage to make room for love to enter. It is essential to find an effective therapist. There are no excuses for the professional community not knowing about Attachment Disorder. It has been over 50 years since the United Nations decided to commission a study of the problems and needs of homeless children (Karen, 1994). The World Health Organization commissioned John Bowlby to investigate and report his findings. In 1951 his findings, published as *Maternal Care and Mental Health*, changed the way the mother–child connection was viewed. What emerged from this inquiry, reported by Fraiberg (1977), was that even the life-threatening dangers of
war were not as destructive to the minds and emotions of children as separation from their mothers and fathers.

Bowlby argued that the mother–infant relationship is an extremely important one, that it was not a pleasant amenity for the child but an absolute necessity and that significant early separations are perilous to the child and ultimately to society as well. He advocated that large numbers of people be trained in marriage and child guidance and in work with parents of the very young. He said the large outlays of funds required would be far less than the later costs of institutional care and delinquency (Karen, 1994, p. 62).

In 1980 the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM III) added the term “reactive” to what Foster Cline, M.D., had termed “Attachment Disorder” in 1972, when he co-founded the Attachment Center at Evergreen. This information has been available for over 5 decades.

Misdiagnosing these children, when they have documented one or more of the risk factors for attachment problems, causes the families to waste financial resources and, worse yet, precious time in inappropriate therapy. This is inexcusable. Some of the children who are shooting their classmates and killing teachers have been misdiagnosed and are using the wrong type of therapy. Kipland Kinkel had been in traditional therapy and on medication for years before he killed his parents, prepared a meal and ate it with their bodies present, and then shot and killed his classmates and teacher. He clearly had no conscience. Effective help for RAD children must include attachment therapy. To turn the child from their focus of fight or flight, they need to begin to trust the world as a safe place. They need to see the adults in the world not as the ones who left them or hurt them but as those who are capable of helping and being trusted. This is the purpose of attachment therapy. The therapists job is not to focus the child on the therapist but on the parents and to turn the child from repetitive digging to facing the ladder of help offered by the parents. The RAD child views the mother as the main target because, to an infant, the mother’s job is to keep them safe. As a baby they were not kept safe. “It has been shown that regardless of the intellectual reasons a child has been given for his relinquishment, there are often feelings of betrayal, anger, resentment and sadness, which are projected onto the available mother-figure” (Verrier, 1993, p. 56). The Mom is blamed and targeted. The therapist must use the mother as the “change agent.” Daniel Hughes, a psychologist specializing in attachment therapy in Maine, says, “With the parent present in therapy there are numerous ways to communicate to her child the value and importance of parental authority. The therapist shows the child how she respects his parent’s judgment and skills and how she defers to the parent in decisions about the child” (Hughes, 1997, p. 80). “With the help of a competent therapist, parents can change the way their problem children act and create a future full of hope for their children and themselves” (Cline, 1995, p. 161).

There are skilled attachment therapists in 32 states in the U.S. listed in 1995 in Give Them Roots and Let Them Fly published by the Attachment Center At Evergreen, Inc. (McKelvey, 1995). Since that writing at least five more states, as well as other countries, have been added to that list.

Attachment therapy must be the precursor to other therapies such as play therapy, sand tray therapy, art therapy, talk therapy, EMDR, or any other type that requires a therapist/client relationship and honesty. One textbook, referring to the level of rapport required for this therapy to be effective said,

Clients should be able to feel comfortable with the possibility of experiencing a high level of vulnerability, a lack of control and any physical sensations from the event that may be inherent in the target memory. This means that clients must be willing to tell their therapist the truth about what they are experiencing (Shapiro, 1995, p. 91).

These children do not have the ability to form relationships or to trust others enough to be honest about their feelings. They are not ready to give up control without a fight. That is the nature of the beast we call Attachment Disorder. In one of his studies David Levy (1943; cited in Karen, 1994, p. 16) found that none of the children [with at least 10 symptoms of RAD] seemed able to respond to psychotherapy. Only after the child heals that part of their damaged psyche with attachment therapy can these other modes of therapy be used effectively.

Remove Distractions

To help focus the child on the goal and motivate them to reach for it, we tighten the child’s world into a smaller sphere of activities and remove distractions. The recommended beginning activities are building with legos (or other similar construction type toys), art projects (coloring, drawing, painting), reading, and exercising on a mini-trampoline. All of these activities can be enjoyed within the parents vision. Just as an infant needs to be held close and guarded carefully, so does a child with little or no self-control:

It is important to understand the rationale for this structure and control. The younger the child or the more disturbed the child, the more structure and control a parent must put into place to provide maximum protection for the child. Children with Attachment Disorder tend to be self-parenting and rejecting of parental authority as well as parental nurturing. In order to parent these children, we must structure the environment in such a way that these children begin to see parents as capable of providing safe structure and providing nurturance (Pickle, 1997a, p. 23).

Television and movies are a major distraction to the child’s healing that must be completely eliminated. Statistics from TV-Free America, a Washington, DC based group led by Henry Labalme, say:
The average 18 year old will have seen 200,000 violent acts and 10,000 murders in their homes via the tube. Sixty-six percent of Americans watch the tube rather than converse with each other during the important time of sharing family meals. 1,680 minutes each week the average child watches television. 38.5 minutes a week the average parent spends talking to their children. 9 years of their lifetime the average viewer wastes invested in TV during a 65 year life (TV-Free America; cited in Briggs, 1997, p. IE).

Prime-time needs to be redefined so that it means time with the parents not the tube. Pope John Paul II said, “Parents who make regular, prolonged use of television as a kind of baby-sitter surrender their role as the primary educators of their children” (citied in Rocky Mountain News, 2/25/94, p. 54A). Time must be invested in working on their lives. Many of these children have already lost years of their childhoods to the seething rage of this disorder; they cannot waste any more of it on something that hurts more than helps. Attachment-Disordered children need to be unplugged from the TV so they can plug into life. After the child has healed, 2 to 3 hours of viewing per week may be earned as a special privilege.

Children need to play every day. Playtime can be used as an excellent motivator for the child to start accepting limits. Time for lego-building may be given with the guidelines of playing in a specific 4 ft. X 5 ft. area with no talking. The child is then allowed to play with the Legos until one toe or one toy crosses the set boundary or one sound is spoken. The parent then helps the child clean up the toys. The art supplies are brought forth with two limits—stay in the chair and create quietly. When a limit is breached, the parent calmly helps the child clean up; no discussion, no lecture, no argument. A book is selected by the parent and given with two limits and so on. In the normal course of the day, the child must certainly be allowed to speak but during these brief training periods the child must practice skills for working in school where remaining at one’s desk quietly is essential.

THE STEPS TOWARD SUCCESS (THE LADDER)

The two legs of the ladder are Parenting and Attachment Therapy. Both of these must be in place for the plan to hold. The eight rungs of the ladder that support the child while they ascend from their pit toward the light of love and success in life are listed below.

- Respect for people, animals, and property of others
- Responsibility for their body, their possessions, and their job
- Fun to be with by displaying a good attitude and appreciation

Respect for People

Bowlby’s definition of attachment is “an affectional tie with some other differentiated and preferred individual who is usually conceived as stronger and/or wiser” (Bowlby, 1977, p. 203). Commanding respect is how parents can begin to be that person who is conceived as stronger and/or wiser.

Parents, teachers and other adults who tolerate disrespect are saying to children, “I am not worthy of respect.” The children then say to themselves, “If I can treat others with disrespect and get away with it then people can treat me with disrespect and get away with it. None of us are worth anything at all, not even me.” The damage done to a child’s self-esteem when he or she is allowed to whine, curse, swear and, in numerous other forms of speech and behavior, be disrespectful of the loving authorities in their life is incalculable (Hage, 1997, p. 5).

Respect for people begins with making and maintaining eye contact, especially when speaking or listening to parents. What either parent or child has to say deserves full attention: “Eye contact” is not just looking at the child’s eyes. It is reaching into their soul with eyes that are rested, loving and powerful. “Eyes that say to the child, ‘you’re okay, you have me.’”
Parents can reinforce this message to the child over and over, throughout the day. Eye contact is POWERFUL—even brief eye contact. It can be an expression of love as well as a weapon of pain. You must be very conscious of how you are using this powerful tool. Keep it soft and loving. One brief look of daggers from parents’ eyes can undo weeks of work (N. Thomas, 1997, p. 32).

In the beginning parents must encourage the child to make eye contact even if it is just a brief moment. It is recommended to discontinue conversation when eye contact is broken. Wait quietly to see the eyes again, then continue speaking or listening.

The child should be respectfully opening the door for parents. The child should learn to be respectful by walking beside or behind parents rather than pulling ahead or lagging behind. Walking in a thoughtful way, honoring parents as their leader, makes a clear statement of respect.

To ingrain the positive behavior, it must be noticed and “pizzazzed.” Parents can look in their eyes, smile, and with excitement say, “Yes! Good job with the eye contact! You are getting stronger!” In the beginning, children with RAD do not do things to make parents happy until their hearts are mended. They actually prefer negative attention to positive. In the child’s mind making someone else happy means that they are “losing.” They want to be strong because they do not feel safe. Strength and power are what these children seek. Parents can use that insight to help them heal. “I see your eye contact is getting stronger. You’re strong enough to look me right in the eye! Good job! That’s it! You’re getting better!” Those terms are needed continually throughout the day, with enthusiasm. In the beginning “pizzazz” is used for many of the little things. Later, it is used mainly for more important behaviors. “All right, you made it home on time! Good job. Look at you. You are really acting responsible. You are really starting to make some good strong decisions here.” That positive feedback from a loving parent is what helps to shape the child into a successful adult.

The best time to “pizzazz” is right when the behavior happens, but if the opportunity is missed, it is still effective to say, “You know, earlier today (or earlier this week), when you opened the door for me, I was impressed that your brain was so strong! You were thinking ahead when you remembered to treat me with respect. Good for you! You are getting stronger!” Rewarding that behavior with positive encouragement is essential to get the child to repeat the behavior. The behavior receiving the most pizzazz is the one the child will repeat.

Eventually they can learn to be respectful and responsible because they will feel good about themselves. Similar to toilet-training a toddler, every time they “go” correctly, enthusiastic praise is offered. When was the last time anybody appreciated you for going in the toilet and not in your pants? Adults continue for years doing appropriate behavior with no more positive reward because they feel better about themselves and it is a lot easier. It is the same for these children.

Occasionally these children have a depletion of oxygen to their brain which causes them to stare at parents and answer or say “What?” or “I don’t know” instead of answering respectfully. When these things occur a skilled parent will require the child to do push-ups or jumping-jacks. The number of push-ups or jumping-jacks is decided according to two push-ups or jumping-jacks per year of age of the child. These children require a great deal of exercise. A loving parent looks for opportunities to provide it with love.

Some parents get confused as to what their job is. The job of a parent is to offer opportunities for growth to their child. The child uses or wastes these. It is not the parent’s job to change the child.

A child who knows his problems are the concern of another, concerns himself with none of his problems! ... Tell a fine lazy person that he’s basically lazy and he’ll love it while standing in line for food stamps. On the other hand, take away the food stamps and make finding the meal his problem and suddenly there is a definite satisfying grinding shift as the old rear is put in gear! (Cline, 1982, p. 6).

The parents’ job is to offer the love. The child’s job is to take it.

Respecting parents’ need for quiet and other people’s time for talking is another important area of respect. Emotionally healthy people use their words to convey thoughts and feelings and to ask questions to gather information. Attachment-Disordered children use their words to control, interrupt, and make noise. These behaviors are not appropriate and must be eliminated. Having them put their hand over their mouth when “their jaw gets weak,” so weak that they are not able to keep it closed without extra help, teaches some self-control. Once they get their hand up there then use positive rewards by smiling and saying, “Good job getting your hand up.” That positive feedback has to be there. Then after their hand is up and they are quiet for 10 or 15 seconds parents can then say, “Good, you are getting stronger now.” After about 30 seconds say, “You may take your hand down now. Let’s see if your jaw is strong enough to keep your mouth quiet. Good job! I don’t hear any noise falling out. That is so excellent! I see you’re doing a real good job of getting your jaw stronger by keeping your mouth closed and quiet. Good self-control.”

When they do speak, it needs to be very respectful. They should be saying, “Yes Mom!” “Yes Dad!” “Thank you” and “May I please have a drink of water?” Their communication needs to be complete, clear, concise, and respectful. It should not include shoulder shrugs as communication or grunting noises such as “uh huh” and “huh?” Those are not respectful ways to communicate. “Yes Mom,” “Yes Dad,” using the parents’ title of honor, each time reconfirms in the child that title of authority.
Asking for things that they need, such as a drink or to use the bathroom, is part of replaying that first year of life when their needs were not met by the primary caregiver. In the beginning, they must ask for everything. Complaining as a way to get their needs met is not appropriate. They should not be allowed to communicate their needs by griping, such as “I’m thirsty” or “I have to go to the bathroom really bad.” That is not a respectful way to get needs met. They often try to get their needs met by disrespectfully commanding and demanding. Sometimes they even put a please on the end such as “Give me a drink, please.” A child must learn to respect and to look up to an adult enough to trust them in order to heal. Benjamin Franklin said, “Let the child’s first lesson be obedience, and the second will be what thou wilt.”

Another problem of disrespect that children with Attachment Disorder sometimes have is whining. The first time a whine noise comes from a child, they are immediately put in their room for a nap for 30 minutes. A good parent always listens to their child and when a baby starts getting tired and cranky they whine to announce that they need a nap. Parents can tell the parent always listens to their child and when a baby starts getting tired and cranky they whine to announce that they need a nap. Parents can tell the child, “Please whine to let me know you need a nap.” Threatening, “The next time you do that you are going to take a nap,” is completely ineffective. The instant they whine they are given time for a nap. Expect resistance when they are put in their room to rest. The 30 minutes starts when it gets quiet. Family members must be silent while the defiant one goes through the tantrum of seeking negative attention or any attention for negative cranky they whine to announce that they need a nap. Parents can tell the child’s first lesson be obedience, and the second will be what thou wilt.

This is the time to pass, rather than to flunk, the test. The wise adult should explain to the child that it will be interesting to see how long it takes to get strong enough to tell the truth after they lie. When the child lies have the parent smile and rush to write it in the notebook. No discussion about what the real truth is. When the child does tell the truth the parent should rush with gle to the book and document it with enthusiasm. The score card will show the child telling the truth sooner and sooner until eventually the lie will immediately be followed by the truth at which point the liar will be strong enough to soon stop completely. It is respectful to listen to what people have to say the first time. RAD children often say, “What?” This is a little test that they use when meeting a new adult or to exhaust an adult they are trying to control. Within the first few minutes of meeting an adult, the adult will say something and they will reply, “What?” to see if they can get the adult to repeat themselves. This is the time to pass, rather than to flunk, the test. The wise adult should say, “What was it I just said?” The child will often repeat word for word what was said. Sometimes they say “I really don’t know what you said.” Then say, “Well, my time is very valuable, I need to make sure that your brain is working before I go to the trouble of repeating myself. So, I want you to do ten or twenty-five jumping jacks [depending on how old the child is] to get the blood supply moving to your brain to carry in some oxygen.” After compliance is gained and the push ups or jumping jacks are successfully completed, repeat the information. This way the child wins by getting the information repeated and the adult wins because compliance was given. When both win the battle, the child can feel safe enough to succeed at learning to trust.
Interruptions by the child can drain parents' energy and often convince the child they are in control. One solution is to have them put their hand over their mouth to work on developing strength. In order to be most effective it should be done at the first word of interruption. We have two ears and one mouth. They need to be used in that proportion. Parents need to listen twice as much as they speak. Children need to listen twice as much as they speak.

Name-calling and foul language can be problems of disrespect. When these children are calling names it is often a projection of how they feel or of areas they are concerned about. Rather than getting angry about the term, it is more beneficial to focus on the information the child may be attempting to convey. The consequence for foul language that has been shown to be successful is to have them scrub toilets, shovel manure, or scoop poop. Filthy language problems (or having angry about the term, it is more beneficial to focus on the information that has been shown to be successful is to have them scrub toilets, the child may be attempting to convey. The consequence for foul language that has been shown to be successful is to have them scrub toilets, shovel manure, or scoop poop. Filthy language problems (or having “manure” come out of their mouth) can be solved by having the child develop some strength while moving manure. Most livestock are not bothered by foul language.

Children need to learn to accept, respectfully, a limit being set. Some whine, some throw fits, some argue in an attempt to regain control. A RAD child will often go into an infantile regression, laying on the floor with their entire body wracked with screams from deep within. If the parents can remain patient, calm, and are physically able, they may prefer to hold their child in their arms while the child rages. This method demonstrates strength and support as they are held close by a loving caregiver. With this method they are not alone in their rage, they are safe and kept from hurting themselves or anyone else while they are out of control. Parents need to be physically strong enough to hold the child safely and be emotionally ready to stay calm and loving in the face of intense rage. It is crucial that parents do not get angry while the child is throwing a tantrum. The child must be able to look up into loving eyes and feel safe enough to trust. If parents are not physically strong enough or are not in an emotional position to be able to hold the child without getting angry, parents may choose to leave them lying on the floor alone to scream by calmly walking away or sending the child to their room. When they finish the fit in their room and there is 10 minutes of quiet they then may come out and be held and rocked. At that point processing feelings with them is appropriate with the questions: “What happened? How were you feeling? How did you handle it? How can you handle that better in the future?” These questions are a clear way to process occurrences with them. Feelings must be validated and met with acceptance and love. “I bet you do feel that way.” For children who throw many unscheduled fits another option is to require them to have a “practice fit” daily scheduled by a loving parent. If the child is throwing intensely violent fits for longer than an hour at a time, it is recommended that the child be evaluated by a skilled mental health professional.

Respect for Animals

In 1209 A.D. Saint Francis of Assisi wrote, “If you have men who will exclude any of God's creatures from the shelter of pity and compassion; you will have men who will deal likewise with their fellow man.” With no conscience development there is little or no empathy for other living things. Supervisory Special Agent Alan Brantley, a psychologist with the FBI in the Behavioral Science unit, has interviewed and profiled numerous violent criminals. In an interview he stated,

Something we believe is prominently displayed in the histories of people who are habitually violent is animal abuse. Sometimes this violence against animals is symbolic. We have had cases where individuals had an early history of taking stuffed animals or even pictures of animals and carving them up. That is a risk indicator. You can look at cruelty to animals and cruelty to humans as a continuum. Violence against them [animals] indicates violence that may well escalate into violence against humans (Lockwood & Church, 1996, p. 27).

Pets become items to conquer for the child seeking power and control. One little girl being interviewed months after beginning attachment work was asked about the worst things she had done. Her reply was “killing animals.” When asked how she felt when killing them, her chilling reply was “happy.” Often these young killers do feel joy at the power they feel in the ability to take a life:

Violent offenders often begin their criminal careers by maiming or killing animals. An FBI study of serial murderers found that most had killed or tortured animals as children or adolescents. All of the alleged young perpetrators in a series of recent schoolyard shootings—in Arkansas, Oregon, Mississippi—were notorious for abusing animals. Kip Kinkel, 15, accused of killing one classmate and injuring 23 others when he opened fire in a high school cafeteria in Springfield, Ore., earlier this year, was known to cut the heads off cats and mount them on the end of sticks. (Warren, 1998, p. 5).

Attachment-disordered children must be closely monitored when in the presence of pets. Animal abuse often starts with teasing or tormenting. If a child is displaying this behavior they must not be permitted to care for, feed, or even interact with animals. “The criminal ‘Hall of shame’ is filled with people who as children did nasty things to pets. If their parents or teachers had seen the warning signs or known how to counsel them, history might have been different” (Capuzzo, 1994, p. 6). These disturbed children should never be given a pet to “bond with” when they have not bonded to a human. The damage that is done to the child by being allowed to cross that line of abuse makes it much more difficult for them to attach.

In the case of an Attachment-Disordered youngster, petting, controlling, or being the caretaker of living beings must be an earned privilege. It is recommended that a child be well bonded and respectful, responsible, and fun to be around for at least 6 months to a year (depending on the severity of their disorder) before being allowed even well-supervised access
to pets. When the privilege has been earned the Mom should hold the child on her lap and support the child’s hand as the pet is stroked gently. Guide the feelings by asking questions such as “How do you feel when you are close to this (pup/kitten)?” “How does the pup feel when you do that?” “What are his eyes saying?” “How does the pup feel on your hand?” “Does he like this?” “Does he like you for doing it?” When asked how the child feels being close to a pup or kitten, the often honest reply is “mad” or “like killing.” They frequently tap into the unconscious feeling of their own infant rage when they were in a helpless and hopeless state as an infant. These feelings should be validated and met with love and empathy for the child as they continue to stroke the pet. As long as they are releasing these feelings verbally they seldom act on them. Let them talk them out. Parents should listen with empathy and not aghast horror.

**Respect for Property**

The lines of respect need to include property. Treating furniture and other things in the home respectfully is where a child learns how to treat things in the world. This can deter property damage and vandalism. Children should be expected to sit on chairs with their feet on the floor and without tipping the chair. A defiant challenge on this rule can be handled by having the rule-breaker lose their furniture privilege for the day. An appropriate response is to have the child stand during the rest of the meal if it occurs during a meal or sit on the floor for the rest of the visit or reading time. The consequence should be imposed the first time the rule is broken. Warnings, reminders, and second chances all eliminate the expected consequence. These ineffective actions become a drain on the parents’ energy.

In the 1940s some of the top classroom behavior concerns, as reported by teachers, were talking out of turn, chewing gum, walking on the grass, and short skirts. These are all problems of disrespect. As the limits were moved to allow chewing gum, eating during class, no dress code, talking more informally (without hand-raising), and walking on the grass at will, the problems changed. In the 1980s some of the top concerns of teachers involved drug abuse, alcohol abuse, teen pregnancy, and suicide. The limits need to be moved back so that children are testing the mundane limits such as “walking on the grass” rather than testing the “drug laws.” If we hold the line on the little things in a loving way, we don’t have to deal with the larger ones as often.

Restitution of damaged items is essential for the destructive child to learn to avoid this behavior and feel good about him- or herself. Broken or damaged items that belong to other people must be repaired and/or paid for promptly by hard-earned money on the destroyers part. Over 2000 years ago a wise physician wrote, “Produce fruits to match repentance” (Bible, Luke, 1978). Drawing from birthday or allowance funds seldom has the same impact. Minimum wage should be paid for work done in a timely manner up to the parent’s standards. If the assigned task is done poorly or slowly the child may be fired just like in the real world. An unemployed adult in debt does not get the goodies (vacations and cool toys) that a hard-working debt-free person has. A child can learn this lesson early.

A damage deposit is a very powerful tool to help a child who has expensive destructive hobbies. The child must earn a set amount of money to be kept in a fund. The amount to be earned is decided according to the most expensive item the child has stolen or destroyed times two. The total amount must be earned before the child may have any extra privileges. They remain at the lego level until such time. As the child heals and the funds are required less often, a rebate can be set up. Having no need to repay any thefts or damages for a period of 2 months or more, the child may begin to draw a reasonable amount per week.

**Responsible for Their Body**

Responsibility is an essential skill to survival. Disturbed children often have not been “imprinted” with the patterns that our society has. Patterns such as using the toilet, wiping, flushing, then washing hands; washing your face, brushing your teeth, then combing your hair; taking a shower, washing your hair, washing your body, drying with a towel, then getting dressed. Infants learn these patterns even before they use them by observing adults repeatedly. Disturbed children often do not flush, wash, brush teeth, or dry themselves before dressing. In children over 2 these behaviors must be taught rather than imprinted. It now must become a habit. A morning routine that helps with younger children (under 11) is for Mom to get dressed and use the bathroom, then turn the alarm off the child’s door and open it. At that point the child should be up and dressed with their bed made and room picked up. They do not come out of their room in the morning until those three things are done. Children over 5 should have their own alarm clock to get themselves up on time. The reward for being dressed, their bed made and room straightened, is to come out of their room and be with the family. That is the positive reward for effort. They then go in and use the toilet. The Mom and child then prepare for the day together. They wash their hands, brush teeth, wash faces, and comb hair, together. The shared morning routine should be done in the same order together for at least a month, usually 2 months (depending on the child’s age), to help them set those patterns.

The Attachment-Disordered child will sometimes stink to get the negative attention they seek and are sometimes filthy because they believe they are trash and it does not matter (they don’t care) and/or they want to push the parents’ button. Either way it is not healthy for the child emotionally or physically. Some parents choose to have the child don a swimsuit and
get in the tub to be scrubbed, “till they shine,” by a loving parent. This may continue until the child matures enough to ask to do it on their own. This method has even worked for younger teens. Some odorous youths are confined to the house and yard to save the community from the fumes. The message of unconditional love must be clear. Many people love their horse, dog, or cat no matter what they smell like. A child should be loved even more so. The consequence of paying for drilling and filling decayed teeth has proven successful with some that are toothbrush resistant. No privileges may be earned until the child takes over the tasks of washing, tooth care, and shampooing in an age-appropriate manner.

Many of these children find disgusting hobbies to repulse parents. The hobbies of booger- or scab-collecting, masturbating in front of the family, chewing fingernails, or popping knuckles are all dealt with by prescribing the problem. Setting aside daily time for the child to do these activities in their bathroom or bedroom will often eliminate them. If the parents forget to send the child in for their hobby time, they may request that the child do the particular activity as a reminder for the forgetful parents.

**Responsible for Their Possessions**

The daily task of bedmaking and placing soiled laundry in it's place is a great start of compliance for the day and a simple demonstration of responsibility for the child. A 2-year-old can assist a parent in this morning task. An older child, when able, should make the bed and put laundry and toys away before being allowed out. It becomes the “passkey” for joining the family for the day in a positive way. If the defiant child refuses to make the bed and pick up laundry, the loving parent makes regular visits, approximately every 30 minutes, to the child’s room to hug and let them know they are loved whether in their room or out. It is helpful to let the child know there is no rush. They can come out whenever they have the “passkey” ready. Whatever day that is. The bottom line is that if they cannot make themselves comply with these minor requests the rest of the day will be bad news at school or at home. It is better to be keep them in a safe spot until they are stronger. If the parent must leave, the child may be entrusted to a trained therapeutic respite provider’s home to practice making beds for the day. When the gauntlet of defiance is thrown down by the disturbed child the parents must meet that challenge and win it in order for the child to feel safe enough to trust and develop a conscience.

“Attachment-disordered foster children, unable to express anger directly and verbally, often find an outlet in urine and fecal matter” (Delaney, 1991, p. 91). Until they are strong enough to talk it out they will relieve themselves in more odorous ways. This needs to be handled lovingly by parents, allowing the child to clean all their soiled items personally. White vinegar and cold water in a bucket outside works well for this. If the child wants to play hide and seek with soiled clothing, hire another child to sniff out the item. Give the finder a bonus for this chore. These small matters are all tests by the disturbed child to see if the parents possess the strength necessary for the child to heal. If the parents pass the test the child can then move forward in their emotional progress.

Dr. Foster Cline has an excellent illustration of the stages of conscience development in his book *Understanding and Treating the Severely Disturbed Child*.

All lasting cultures are built upon adequate, pervasive internalization of the Object. ... Freud uses the word ‘Object’ to signify a special internalized person, usually the mother. This person becomes a part of ourselves, and a unity of world and self perception is thus brought about. ... Thus, a child goes through predictable stages as he develops his own conscience. In the case of stealing, it might be illustrated as follows:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“I’ll take it” (1–3 years old)</td>
<td>Represents primary process thinking. (no lid on the id)</td>
</tr>
<tr>
<td>2</td>
<td>“I would take it, but my dad (mom) would kill me!”</td>
<td>Represents causative thinking although primitive and inaccurate. (Even this type of thinking is not present in children who have severe attachment problems—they steal unless the parent is in sight.)</td>
</tr>
<tr>
<td>3</td>
<td>“I would take it but my parents might find out.” (still fearful, 5–7 years)</td>
<td>Shows plans for causative thinking. The child is “playing the odds.” (partial lid on id)</td>
</tr>
<tr>
<td>4</td>
<td>“I would take it, but if my mom found out, she’d be upset.” (wishful, 6–9 years)</td>
<td>Shows solid beginning of internalization of object. The child cares about how he perceives his outside “guiding light” as feeling. (Lid on id)</td>
</tr>
<tr>
<td>5</td>
<td>“I would take it, but I don’t feel good about doing things like that.” (7–11 years)</td>
<td>Internalization is complete and the child’s own moral values are “in place.” (Superego complete)</td>
</tr>
</tbody>
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Children who do not have parents that they can “perceive as all-powerful in size, power, mental and physical ability” commonly do not progress through Stage 2 of conscience development. When they can con and manipulate parents, parents are seen as weaker than the child and not to be trusted and conscience development is derailed. Parents who expect respect and responsibility and impose or allow consequences to occur the first time there is a “test” by the child can make a clear impact on the all important growth of the conscience.
Responsible for Their Job

Kahlil Gibran said, "Work is love made visible." These children need love made very visible: "... good parents give their children appropriate chores to do, and expect the chores to be done well. They do not accept excuses for poor or incomplete work, as this gets the children comfortable with meeting lower expectations" (Cline, 1995, p. 167). If the child is over 2 years old the "job" would be family chores. If they are school-age the job then includes schoolwork and family chores. Helping the family teaches work skills for the real world. It is crucial to their emotional healing that they work to help the family. In 25 years of work with difficult children, I have not seen one child heal without being successful with regular chores.

Doing chores teaches children how to give back. Children can be taught how to "take" very well by constantly being giving to. They must be taught how to give back in order for them to be able to have a loving relationship. General Colin Powell (1997, p. 135), Chairman of America's Promise—The Alliance for Youth, wrote, "Young people—like adults—usually find that when they make a real effort on behalf of others, they get back more than they contribute." Giving back to their family and eventually their community makes a child feel important as a valued member.

Teaching them how to work and work well (to go the extra mile) is how parents can effect student's schoolwork. When they get an "A+" on their household chores, they know how to put out the extra effort to get an "A+" on their science fair project or their schoolwork. It can fine-tune their work ethic. Doing chores teaches life skills. In adulthood the skills to maintain a home and job are essential. When these skills are learned from loving parents, it can be a very bonding and a powerful self-esteem-building tool.

Some appropriate chores for a 2- to 3-year-old would be to sweep porches, fold washcloths, fetch items, match socks, help set the table, fold napkins. More advanced skills such as vacuuming, dusting, floor-scrubbing, laundry-folding, raking, mowing, weeding, and bathroom-cleaning should be added as the child matures. The highest level of chores in most homes is usually dish-washing. Work that should not be included as family chores would be caring for their own body and possessions such as their laundry and bedroom. Each child should be expected to do 30 minutes worth of family chores each day. Younger children can have several small chores throughout the day that equal 30 minutes. The job can be done for a length of time the parents feel is appropriate. The disturbed child can dawdle for hours if given the opportunity to waste time. Productive energy output is the aim. Building the child is the goal. Parents do well to remember the job is not as important as the child.

Parental instruction and supervision of chores must be carried out with high age-appropriate expectations, clear goals, and in a loving way. When they are scrubbing the floor, for example, each corner must be checked. Under the rug should be inspected in case they attempt to cheat. Parents should let them know they care enough about the work that they have done to spend time to carefully look it over and give a big hug for a job well done. Doing a good job (to the level the parent would have done it) teaches children pride in a job well done and builds self-esteem. Quality of effort on chores is a good barometer for the need for more or less frequent therapy sessions. A compliant, eager-to-please child is bonding and growing emotionally and needs less frequent therapeutic intervention than one who is still struggling with defiance and trust.

When a child is being defiant about helping the family with chores it is imperative that no new privileges be given until the child rises above the difficulty.

Use "thinking" rather than "fighting" words. Make positive statements ("Feel free to join us for lunch when your chores are done"), in contrast to negative statements ("you can't eat until you do your chores"). Thinking words promote positvity and cooperation. Fighting words promote animosity, defiance, and conflict (T. M. Levy & Orleans, 1998, p. 203).

Schoolwork must be solely the child's responsibility. Parents who remind, cajole, and push to get the homework done usually end up with a losing battle on their hands. Pounding knowledge into minds does not work. They must seek it in order for it to penetrate. The school system has built in consequences for homework negligence. Let the consequences fall.

If the child is too disturbed to attend school they should be maintained in a therapeutic environment and a qualified tutor hired to offer opportunities for learning, if the child is responsive. Homeschooling with the mother as a teacher is usually an enormous battle that damages the parent-child relationship further and pushes the child to further reject education or the mother. This is not due to the skill or lack thereof on the mother's part to teach, but rather is due to the pathological thinking of the child to reject the mom and everything she believes.

Emotionally disturbed children have no business being employed outside the home unless the age of emancipation is within 1 year. Then, in preparation for independent living, it is recommended. If college is a clear option, their job, their only job outside the home, should be school until they graduate from high school. Teen jobs often sabotage school work. A study done over a 25-year span on 1700 participants by Delbert Elliot indicates even more problems.

Teens who work before graduating from high school are 1 to 1 1/2 times more likely to commit serious criminal offenses and use alcohol, and are more than twice as likely to experiment with marijuana than those who do not have jobs. ... If students work grades suffer. Work also reduces the bond to family and school (Elliot, 1992; cited in Brown, 1992, p. 2g).
It is too much cash, too much power, too much freedom, too soon. Small part-time jobs, less than 10 hours a week, occasionally still leave time for study and relaxation as well as the time to help the family and participate in church and family fun. Emotionally disturbed children are seldom a benefit to the employer. Being employed outside the home distracts from the healing that must be a priority.

Fun To Be With—Attitude
An attitude of “poor, pitiful me” is often seen in those children attempting to control adults with tear-jerking manipulations. When unsuspecting adults are ensnared by this ploy and mirror the child’s eyes full of pity, the message received by the child is that adults are stupid enough to fall for their con; that adults believe that they are poor, poor children; and that adults are against the parents. These are not poor, poor children. They now have a home and loving parents. Parents are obviously caring and committed when they are looking for resources or they wouldn’t be reading information and seeking the counsel of wise therapists. They wouldn’t be looking for answers. So, to look into that child’s eyes with a “poor you” message is not appropriate. Adults need to look into their eyes and express, “Child, you are so blessed to have a mom and a dad like this.” Mom and dad’s eyes should be greeted with hope and encouragement with the message, “Hang in there, I believe in you.” That message of belief in the parents must come through with everything professionals say and do. Maybe the child was abused or left in the past. They are no longer an abused/abandoned child. That is the past. This is the present. To heal, the children need to learn to trust adults. The con must stop.

Triangulation is a common “sport” among children with attachment disorder. They behave defiantly to one adult and victimized to another in order to split the team. Unsuspecting adults begin to mistrust other adults in the child’s life. This destructive game can be an attempt to control by dividing and conquering. Mom and Dad begin to doubt each other. Even strangers can be pulled into this game. Be proactive in dealing with this problem. Parents should discuss this with each other, the teacher, the social worker, church members, and relatives. The healthy adults need to believe and trust each other over the tales told by the pathological child. The child learns from action not words. Action, not anger.

Fun To Be With—Gratitude
One of the most important ingredients of a child who is fun to be around is an attitude of gratitude. Children need to appreciate the things that are done for them so they are not wallowing in the “have nots” but are celebrating the “haves.” Looking for what they are thankful for is a positive attitude rather than a negative attitude. Parents should model that for them by appreciating each of the things that they do as well as the things parents do for each other. Parents should expect thankfulness. A tool to help with this is the “feelings book.” This is a daily journal in which the child writes three feelings they had that day and includes three things they are thankful for. Younger children draw pictures of “the best thing that happened today” and “the worst” as well as what they are thankful for. To make the younger child’s “feelings book,” five pages of typing/copy paper are folded in half and stapled. This book should be completed daily before the child has
The normal nurturing that occurs during the first year "soul cycle" must be repeated many times during the bonding of an older child as well.

Loving eye contact is a vital, powerful healing connection well.

Eye contact must be soft and loving. Every minute you spend looking lovingly into your child's eyes will save you about an hour of pain when they're teenagers. "The eyes are the window to the soul." While making eye contact you are giving love from your heart—through your eyes—into your child's eyes—straight into their heart. They will try to avoid it. Be compassionate and firm. They must accept your loving eye contact to heal their heart (N. Thomas, 1997, p. 40).

Seeing is a form of touching at a distance, but touching provides the verification and confirmation of reality. That is the reason why eye contact is the perfect example of touching at a distance. Dr. Abraham Levitsky has pointed out that by its very nature, "touch is close and sight is far." We permit contact with those things and people we trust and enjoy. We withdraw from contact with what we don't trust and what we fear (Montagu, 1986, p. 124).

Touch is essential to life. "The communications we transmit through touch constitute the most powerful means of establishing human relationships, the foundation of experience. Where touching begins there love and humanity also begin" (Montagu, 1986, p. xv). "When the need for touch remains unsatisfied, abnormal behavior will result" (Montagu, 1986, p. 46). The angry younger child will often get the touch they need by grabbing another child or hitting or punching. Children need 12 hugs a day during the healing process. They should be hugged when they do a great job to celebrate it. They should be hugged when they do a bad job to cheer them up. Hug them when they are mad, sad, glad, or scared. Hug them just because they are.

Teenagers need a tremendous amount of touch. They do fit on a lap in the rocking chair, they just have long "legs that hang over the side. Teens are often looking for touch in all the wrong places. Teen sex and pregnancy are rampant in our country. "Many women—especially single ones—become promiscuous to get the holding they want" (Verney & Kelly, 1981) In a study (Hollander, 1961, 1973; cited in Verney & Kelly, 1981, p. 123) on women and holding, over half admitted to having sex to entice a man to hold them. Investigators in a different study (Malinquist, 1966; cited in Verney & Kelly, 1981, p. 123) found that in women who had three or more illegitimate pregnancies almost half revealed that sex was the price they willingly paid to be held. Parents need to hug their teens: 7 hugs a day for maintenance; 12 hugs a day for healing.

Movement such as rocking has been found to be very healing. Rocking motion was found by Dr. Sung Choi, of the Medical College of Virginia, to significantly reduce the time spent in intensive care units. He reports in the Rocky Mountain News (4/7/1992, p. 8G) that movement helps reduce the risk of infection and complications from pneumonia and other problems. Rocking is good for mother and child.

Rocking chairs are comfortable and relaxing for both mother and child. "As the mother gently rocks, she improves the circulation in her legs. The to-and-fro motion stimulates the vestibule apparatus in the child's inner ears, contributing to his better control of balance and position" (Montagu, 1986, p. 166). "I believe that the deprivation of body touch, contact, and movement are the basic causes of a number of emotional disturbances which include depressive and autistic behaviors, hyperactivity, sexual aberration, drug abuse, violence, and aggression" (Prescott, 1985; cited in Montagu, 1986, p. 226).

Smiles are a critical part of connecting. "Smiling and laughter, as Lorenz tells us, are among the tribal signs that unite the members of the human fraternity" (Fraiberg, 1977, p. 47). It is the smile in the mother's eyes that the child connects with. As René Spitz (1965) demonstrated in his studies, the smile is elicited by the configuration of the upper half of the human face.

Sugar is closely interwoven with love in our culture. We call each other endearing terms such as "sugar, honey, muffin, and sweetie" to express fondness for one another. "Among the mammals, human milk is the sweetest of all, containing seven percent milk sugar, compared with four percent in cow's milk" (Montagu, 1986, p. 95). Sugar is an important part of bonding. According to researchers led by Elliott Blass, a psychologist at Johns Hopkins University in Baltimore, infants given sugar before the painful procedures of circumcision and drawing blood by lanceing the heal cried significantly less than those given a placebo (cited in Rocky Mountain News, 2/6/91, p. 12E). Sugar has been proven, in studies at Duke University by
As the child reaches for each of the rungs of the ladder and continues the ascent they become stronger. As the child attains new strength he or she becomes more able to handle more privileges. When parents are clear that this child is now on steady ground and ready to move forward with their mother, they become stronger. As the child attains new strength he or she becomes more able to handle more privileges. When parents are clear that this child is now on steady ground and ready to move forward with

MOVING ONTO STEADY GROUND

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PATTERNS OF HEALING

As the child is climbing out of the pit they have dug, there are some time bombs that may sabotage them. One of those time bombs is self-esteem. A crucial part of healing, the ability to believe in themselves, grows more slowly than their accomplishments. In the beginning they often have extremely low self-esteem; they believe they are bad, evil, and/or useless. Then they start doing things well, doing their chores well, making good eye contact, speaking respectfully, and getting appropriate positive feedback. They begin to heal emotionally and make faster progress but their self-esteem grows at a much slower rate. Often a child will halt their forward progress and either regress or plateau until their self-esteem growth catches up. This often worries parents. They often begin thinking the plan is not working or that the child has stopped healing or may again get worse. This is a time for parents to catch their breath. They should continue to support the child’s self-esteem as they step back to again build up the momentum to move forward. One of the best things parents can do during the healing process, but especially during these lapses or regressions in behavior, is pray. The powerfully effective healing of prayer has been well researched and documented in Dr. Larry Dossey’s works (1992, 1993). The studies are fascinating and, more importantly, they provide scientific data to support the hours many parents and grandparents have spent, heads bowed in prayer for these children. It does work. Hearing parents pray, being thankful, especially at mealtime and at bedtime, is an excellent example for children.

Parental involvement and religious activities are the two most effective protective factors for teens…. Teenagers who attend religious services regularly are far less likely to use drugs, know drug dealers, or have friends who smoke, drink or do drugs than those who attend such services less than once a month (Califano, 1998, p. 4).

Eleanor Roosevelt rightly said, “The future belongs to those who believe in the beauty of their dreams.” Self-esteem, defined as who we see ourselves to be, cannot be built until the bond is well established. Words do not change the distorted damaged image inside. These children must see and feel themselves as different before the words mean anything. Self-esteem is the foundation on which a person’s personality is built. “There is a direct correlation between low self-esteem and crime, violence, substance abuse, the high school dropout rate, teen pregnancy and other social problems” (Rocky Mountain News, 1991, p. 21C). Building it is crucial to success. They then can believe and dream because you do.

Self-esteem is developed by internalizing the positive feelings projected by a loved one. Acceptance, not just in words but through the eyes, builds self-esteem—rejection destroys it…. Eyes speak volumes to a child. Be aware of what they say! (N. Thomas, 1997, p. 83).

Avoid labeling (good or bad) “You are lazy,” “You are clumsy,” “You are wonderful,” “You are a terrific kid!” They know they aren’t “wonderful” or “terrific” and it makes an adult look like a liar or a fool. They will often blow out for days after one of these positive labels is bestowed on them! They believe they have to prove they aren’t “wonderful” or whatever! They usually just agree with the negative labels. Neither one works to build them up to believe in their abilities. DO NOT use them (N. Thomas, 1997, p. 84).

Use positive statements, after the child has shown some effort, with several conditions to build the child’s belief in their goodness, ability and appearance. “What a nice smile you have today,” “You are getting to be a good helper,” “Right now you are doing a good job.”

A child who has not internalized a parent stronger than himself can not develop self-esteem. Children with no conscience often have no self-esteem. They will start to take you in when they start to trust you because you are strong (N. Thomas, 1997, p. 84).

They take in self-esteem-building comments much more powerfully if they hear it from parents talking to someone else other than them. An example is, calling grandma to brag about their new accomplishment: “He was quiet for three minutes today!” When they hear parents telling other people positive comments, the child absorbs it more quickly than if you tell them directly.

Anniversary dates and holidays are other time bombs that should be expected. If they’ve had traumas during their lifetime resulting from moves from one family to another, deaths, surgeries, or abuse that happened at certain times of the year, parents should be prepared for behavioral changes when the anniversary date approaches. Different things may remind them of past pain, such as the first snow reminding them of a trauma that happened during the winter. On an unconscious level, feelings, reflected through behavior, will be stirred up that need to be dealt with by the therapist. Dates of painful events need to be documented as much as possible so all on the team are aware and can be helpful during these times. The child can then overcome that obstacle, climb the wall, and continue forward in his or her progress.

Positron-Emission Tomography scans have shown that we can make physical changes to the brain structure by talking and sharing feelings in therapy. It was reported as “substantial improvement with significant changes in brain function” after only 10 weeks of therapy “this tells us
that effective behavioral treatments can have biological effects, not just psychological ones," said Dr. Eric Hollander of Mount Sinai School of Medicine (Hollander, 1996; cited in Goleman 1996, p. 6G). The brain is very elastic and can heal from severe damage as observed in cases of stroke. These children's brains, hearts, and souls can heal from this devastating disorder. It is not an easy undertaking. Dr. Cline believes it takes about 1 month for every year of age of the child. That is time spent creating opportunities for each child to reach for and climb the ladder to success. "It is our firm belief that children hurt by abuse and neglect can learn to love and trust adults in a family setting. Growth and development continue throughout the life span, and it is rarely too late for a child to change" (Keck & Kupecky, 1995, p. 15). "... [Families] invariably share a deep pride and profound joy at playing such an important role in a child's life" (Keck & Kupecky, 1995, p. 179). The children that have ascended from the depths of this disturbance have led the way. Their smiling parents report "victory."

REFERENCES


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**BIOGRAPHY**

**Nancy Thomas**

Nancy Thomas, the mother of three birth children, one adopted child, one child being raised under legal guardianship, and grandmother of six, has been a Therapeutic Parenting Specialist since 1985. Nancy has worked as cotherapist with children in intensive attachment therapy with many renowned experts in the attachment field. Nancy worked as secondary lay-therapist with Connell Watkins, M.S.W., for over 2000 hours with children that had symptoms of being borderline psychotic, ritualistically abused, abusive to animals, mood disordered, ADD, ADHD, Reactive Attachment Disorder, and having Tourette’s Syndrome. Many had histories of homicide, arson, and/or sexual perpetration.

Nancy trained and worked with Foster Cline, M.D., psychiatrist and founder of The Attachment Center at Evergreen, who has praised Nancy as “the foster parent of foster parents” (keynote address, National ATTACh Conference, 1997). Dr. Cline said of Nancy, “She has been acclaimed by national as well as local audiences. She has taught both professionals and front line workers.” Nancy spent several years under the mentorship of the top therapeutic mom at the Attachment Center at Evergreen, Lori Wilson.

Nancy and her family live in the high mountains of western Colorado in a home centered around healing the hearts of children. Nancy and her husband, Jerry, have shared their life and home for over 25 years with severely emotionally disturbed children with attachment problems. Ninety percent of the children placed in her care are kids who had killed. She has an 85% success rate with these high-risk children which is one of the highest in the country. She specializes in bonding and conscience development.

Based on her years of hands on experience and high success rate Nancy has authored a parenting guide, entitled *When Love Is Not Enough: A Guide to Parenting Children with Reactive Attachment Disorder*, which has been well received by parents and professionals. Recognized internationally as one of the leading authorities on parenting emotionally disturbed children, Nancy was asked to join several esteemed attachment professionals in coauthoring *The Handbook of Attachment Interventions*.

Nancy was honored in a front-page article by the Glenwood Post, April 12, 1997, entitled “Using Love, Woman Opens Heart To Children Of All Types.” The publication of the American Psychological Association, the APA Monitor in the June, 1997 edition, quoted Nancy along with top specialists of Attachment Disorder in an article entitled “When Children Don’t Bond With Parents.” The Cline/Fay Institute (the Love and Logic folks) recently published her audio tapes “Healing Trust: Rebuilding The Broken Bond.”

Since her work was highlighted in an HBO special in 1990 entitled “Child of Rage” she has become a much-sought-after speaker.

Currently, she spends her “spare time” teaching Power-Parenting classes for parents of children out of control.