REACTIVE ATTACHMENT DISORDER

INTRODUCTION

An attachment bond contains all of the following elements (Bowlby & Ainsworth):

- Emotional significance.
- Persistence across time and situations.
- The attachment figure is a specific other person and is NOT interchangeable.
- Desire for physical proximity to the attachment figure.
- Emotional distress in response to enforced separation.
- Comfort and safety is sought within the relationship.

An attachment bond is secure if an infant can reliably experience security / comfort / safety within it. This is critically dependent upon the infant perceiving the attachment figure as predictable, available, and competent. (Ainsworth) has described the attachment bond as reflecting the infant / young child's internal organization more than the actual interactional reality. This internal organization has been termed the child's Internal Working Model (IWM). IWM's are not limited to children however. We all have one. The IWM is the sum total of all that an individual has learned / believes about how he and others function and how the world works in general. IWM's work best when they are an accurate reflection of reality and can be revised as new experience warrants. Neither of these is the case with a child who has an attachment disorder.

Research has identified the key initial ingredients to an adult being seen as an attachment figure are the adult's responsiveness to crying, availability for social interaction of any kind, and allowing of clinging / following / related behaviors. However, attachment is greatly facilitated by the attachment figure repeatedly accurately reflecting the infant's internal state. This has variously been called attunement, empathy, or mirroring.

Contrary to popular mythology, infants are capable of more than one attachment. Multiple attachments are not equivalent, but are arranged in an internal hierarchy. The highest functioning infants have TWO working attachment bonds they can rely on. The quality of paternal, or other secondary attachments, primarily reflects the attachment skills of the relevant adult rather than a limitation in the infant's capacity to form multiple attachments. Children in institutions will attempt to form multiple attachments with their caretakers and typically select one caretaker to be the primary attachment figure. To date, we have no research data to inform us as to how the IWM of infants and young children, exposed to conflicting experiences with multiple potential attachment figures, is affected.

The basic physiological function of attachment is protection, and so attachment behaviors reliably increase physical proximity to the attachment figure (vs. the myriad distancing behaviors of children with an attachment disorder). Over time, an infant / young child assembles an expanding repertoire of behaviors for insuring proximity and protection. These various attachment behaviors are organized into an Attachment Behavioral System (ABS) that can be adjusted, over time, to changing internal and external conditions, such that the child can choose a useful behavior for the moment. It is the child's IWM that guides the choice of a particular attachment behavior in a given situation. The ABS of a child with Attachment Disorder (AD) has many fewer behavioral options and is applied quite rigidly so the same behaviors keep appearing over and over regardless of prior experience. In addition, since an AD child's goal is really distancing rather than attachment, the behavioral system could more accurately be named a Distancing Behavioral System (DBS). However, the basic function of both

kinds of systems is the same- protection. AD children just see distance as offering them more protection than proximity.

The protection function is so basic that an infant will seek attachment regardless of whether the primary caretaker is adequately meeting the infant's physiological needs or not. Infants will readily seek to attach to destructive caretakers. The absence of a secure working attachment leaves an infant experiencing the world as devoid of protection and so he must fashion his own. This is a traumatic position for an infant to be in. Here is the origin of the high degree of correlation between attachment disorder and trauma. In other words, having an attachment disorder is traumatic in itself, regardless of anything else.

The quality of the initial attachment is enormously important, for it contours all subsequent development. Attachment has been identified as playing a vital role in all of the following:

- Developing relationships with others.
- Organization of the brain and nervous system.
- Identity and self-esteem.
- Speech and language development.
- Attaining full intellectual potential.
- Regulation of feelings and behavior.
- Acquiring a conscience.
- Developing a sense of time as continuous and sequential.

SUCCESSFUL ATTACHMENT IN THE PRESCHOOL YEARS

0-9 MONTHS

The indications that attachment is progressing in a healthy manner, or twisting off course, vary as an infant grows. In the first month of life, the basic developmental task to be achieved is the establishment of physiological rhythms. This prepares the way for attachment.

From months two to six, an infant experiences an expanding sense of feeling "one with the parent". There now appear a number of signs of an infant's developing attachment to her primary caretaker: smiling, making eye contact which expands from a few seconds to a few minutes during this period; a preoccupation with the parent's face; and making happy noises. This developmental period forms the basis for the emotional significance that eye contact will carry for the rest of life. By the sixth month, an attaching infant is showing the full range of emotions, is responsive to parental wooing, and initiates wooing exchanges.

By six or seven months, an infant has usually begun to experience stranger anxiety. Paradoxically, stranger anxiety is a "witness" that testifies to the strength of an infant's attachment to her parent. It is this attachment that defines everyone else as "strangers". Without an attachment, there are no strangers; everyone is of equal importance or, more accurately, of equal unimportance. Behaviorally, stranger anxiety manifests as distress in the presence of strangers and a checking back in with the parent for reassurance. Over the next two to three months, stranger anxiety intensifies before fading into its successor: separation anxiety.

9-15 MONTHS

Separation anxiety usually begins at nine to ten months, peaks between twelve and fifteen months, and can last until somewhere between twenty-four and thirty-six months. Separation anxiety emerges out of the infant's growing awareness of separateness from his parent. It is yet further testimony to the strength of the infant's attachment.

There is a range of behavioral reactions to separation anxiety: some children cry in protest and cling to the parent; others withdraw from the world until the parent returns; still others protest by becoming angry and aggressive. While these behaviors may seem troublesome in the moment, they are proof that the work of attachment has proceeded well to this point.

The period of ten to eighteen months comprises the well known “love affair with the world”. The fundamental developmental task is exploring the world while refining emerging motor skills. Attachment shows up here in the child repeatedly “checking in” with the parent in the midst of her explorations. A child will go to the edge of his comfort zone and return to check in with the parent before venturing out farther.

At this age children have already invested significant emotional energy in other family members beyond the initial primary caretaker. This reflects the value of that initial attachment in that the child naturally seeks to extend it. Despite this, a child generally turns to mother when hurt, tired, or sick; an indication that the primary attachment still predominates. Other signs of healthy attachment at this age are: experiencing joy in accomplishments, acceptance of comforting from others, and the beginning of self-comforting skills with the aid of cherished objects such as the well known blanket.

15-24 MONTHS

A child's exploration of the world increases his awareness of being separate from mother. For the fifteen to twenty-four month old, this greater awareness gives rise to wooing and coercion as well as shadowing and darting. Wooing is solicitous behavior designed to draw mother's attention. Wooing behaviors usually intensify with time; and at some point, mothers usually come to experience wooing as a coercive demand rather than as an invitation.

Like wooing, shadowing and darting are attempts by the toddler to reconcile the seeming impossible dilemma of extending autonomy while preserving attachment. Shadowing refers to a child's following the parents practically everywhere while darting refers to rapidly moving towards and away from the parent. Both are signs of healthy attachment.

24-36 MONTHS

The final building blocks of attachment are put in place between twenty-four and thirty-six months with the accomplishment of self and object constancy. Self constancy is the child's experience that she is, essentially, “who she is” across different emotional states and situations. Object constancy is the child's experience of others as predictable and available. Much of object constancy comes from a child's mental images of others. Self and object constancy serve to quiet separation anxiety as well as strengthen a child's ability to delay gratification and accept discipline. Self / object constancy is also the basis for accurate temporal perception. With it, time is experienced as a connected continuum, flowing from past into present and out into the future. Without it, time consists of so many discrete moments, each one disconnected from all others- one of the hallmarks of attachment disorder. When all goes well, the foundation for attachment is fully laid by thirty-six months.

3-5 YEARS

Egocentrism (everything in the child's world is somehow a reaction to her) dominates the thinking of this age period; and as a result, most if not all, 3-5 year-olds come to conclude that they caused their abandonment by their birth parents. This is normal, and if things are going well, children will move through, and beyond this conclusion.

Children of this age organize their world on the basis of similarities much moreso than differences. Developing attachment manifests in the child noticing multiple likenesses between himself and his family and this nourishes a sense of belonging in, and to, his family.

Much of what children learn during this time period comes by way of imitation, or "trying on" the behavior of others, both real and fantasy figures. When children are attaching to parents, it is the parents that the child increasingly imitates as time goes on.

WHEN ATTACHMENT GOES AWRY

0-9 MONTHS

For the infant of zero to nine months, poor attachment appears as: poor reciprocal eye contact when gazed at or spoken to; lack of reciprocal smiling or noisemaking; resistance towards physical contact and comforting through pushing, kicking and arching away; frequent screaming and crying spells that lack any apparent cause and are quite immune to comforting (these are the beginnings of what may become intensive rage reactions); repetitive motions {headbanging, rocking} which are unsuccessful attempts at self-soothing; a lack of stranger anxiety which results in extreme precociousness that moves the infant towards an omnipotent position of not needing anyone because the child can handle it all; or an overwhelming stranger anxiety that can't be soothed and results in social withdrawal. It is the lack of stranger anxiety that is the seed of attachment disordered children's notorious indiscriminate friendliness.

9-15 MONTHS

In addition to the earlier symptoms, at this age, separation anxiety may intensify to the point that the child will not leave the parent. This blunts the normal curiosity to explore the world that comes with the ability to walk. If stranger anxiety never developed, then with the mobility of this age, the first incidences of indiscriminately approaching strangers may occur. Lack of effective self-soothing skills can manifest now as behavioral hyperactivity (which may eventually be mistaken for AD/HD). Frustration tolerance does not develop, and in its absence, toddlers begin assembling a repertoire of aggressive behaviors to both vent their frustration and get the world to bend to their wishes.

15-24 MONTHS

Attachment difficulties at this age mire the child in an inability to balance dependence and independence. Frozen in this dilemma, children either choose one of the two extremes and remain exclusively there, or ping-pong between them, never able to find a place of lasting comfortableness. The sense of "failing at life" begins to dawn at this age, and this generates anxiety and shame which usually appears as heightened aggressive behavior and protracted temper tantrums beyond that typical of the "terrible twos".

24-36 MONTHS

Weak or absent attachment in this age range usually precludes the development of self and object constancy. Without self constancy, children have no stable sense of themselves that they feel they can rely on. This riddles them with anxiety and leaves them frighteningly dependent on the external world for meeting all of their emotional needs. This is the breeding ground for the hypervigilance so commonly found in attachment disordered children. In addition, they can neither give nor receive love, because there is “no one home” to give it or receive it.

Without object constancy, children experience all physical separations as absolute abandonment. They live within the prison of “out of sight, out of mind”. If the other is not there physically, the other does not exist. This manifests as either incessant clinging and demandingness from which there is no relief for parents; or in a desperate attempt to live as if they are beyond needing anyone else. This renders others’ comings and goings irrelevant.

Without self and object constancy, there is no experience of time as continuous. Instead, time is so many discrete moments, each one separated from all others. This is the basis for attachment disordered children’s well known difficulties with cause and effect. To understand cause and effect, one has to be able to connect things across time. Children with attachment problems can’t do this. What happens in any one moment has nothing to do with anything that happens in any other moment. Hence, cause does not get connected to effect, behavior does not get connected either to its precipitants or its consequences, there is no learning from experience…

3 TO 5 YEARS

If there are attachment problems, children of this age get mired in the egocentric conviction that they were abandoned because of some intrinsic deficit of theirs. Instead of moving past it, they are likely to expand it such that they come to see themselves as a “jinx” who causes a variety of bad events to occur. This arrests thought at the level of magical thinking which becomes the basis for the well-known symptom of “crazy lying” as the child gets older.

Preschoolers may subsequently develop a terrifying fear of their own power as inherently damaging, which will infuse identity with shame. This will perpetuate an egocentric stance in the world well beyond the preschool years. Once shame gets woven into identity, changing it becomes a terrifying prospect as well, for then the child loses her sense of who she thinks she is. The result: the child is paralyzed in a nightmarish dilemma of being afraid of themselves AND afraid to change themselves. Such is one of the horrors that many attachment disordered children live with, day in-day out.

A faltering attachment will block the child from perceiving any sameness between herself and her family. This precludes experiencing any sense of belonging to the family (or anywhere else for that matter), leaving the child an “alien in an alien land”. The child will evidence little or no “role-playing” of the parents and may exhibit a marked absence of any self-initiated play. Instead, what often emerges is a preference for deviant, aggressive, and powerful figures. These figures are commonly drawn from some media-driven fantasy realm.

ATTACHMENT DISORDER

When the attachment process does not go well, it is almost never because of any single cause; but because of multiple influences interacting. A number of risk factors have been identified as increasing the probability of attachment difficulties:

- Prenatal rejection of the infant.
- Intrauterine exposure to alcohol and /or drugs.
- An early history of loss / abandonment.
- A history of multiple caretakers, and/or multiple changes in living location early in the child's life.
- Failure to thrive; chronic illness or pain.
- Sensory processing deficits and developmental disorders that obstruct interaction with the environment.
- Physical and/or sexual abuse.
- Neglect.
- Extended or repeated hospitalizations {mother and / or child} during the child's first three years.
- Significant parental mental health problems including substance abuse.
- A history of harsh, overindulgent, or extremely inconsistent parenting.
- Chronic severe marital conflict.
- A significant temperamental misfit between parent and child.

While the majority of children with attachment difficulties are, expectably, found in the adoption and foster care systems, they are emerging in increasing numbers out of biologically intact families.

DIFFERENTIAL DIAGNOSIS

Attachment Disordered {AD} children are a diagnostic collage. Aspects of their functioning can be found in all of the following diagnostic categories:

- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Separation Anxiety Disorder
- Generalized anxiety disorder
- Post Traumatic Stress Disorder

- Dysthymic Disorder / Major Depression
- Bipolar Disorder / Cyclothymic Disorder

Because Attachment Disordered children present clinicians with a diagnostic array of possibilities, these children are not so much misdiagnosed as they are "partially diagnosed". One aspect of their functioning, typical of one of the above disorders, may catch a clinician's eye. The child is then given that diagnosis, and the larger Attachment Disorder picture gets lost as "the part is mistaken for the whole". Treatment is then based on the partial diagnosis, and this all but guarantees treatment failure.

THE ATTACHMENT DISORDER SPECTRUM

As is true with other mental health disorders, Attachment Disorder is not a discrete entity, but is a spectrum made up of a number of variants. The attachment spectrum ranges from the wholly unattached child at the severe end down to children at the mild end who, more accurately can be described as having attachment issues / insecurities vs. Attachment Disorder. Children with attachment issues can attach; they just cannot maintain it consistently across time as there are deficits in self and object constancy. Children with Separation Anxiety could be appropriately included here.

THE SUBTYPES OF ATTACHMENT DISORDER

- Anxious Attachment Disorder
- Avoidant Attachment Disorder
- Ambivalent Attachment Disorder
- Disorganized Attachment Disorder

GUIDELINES FOR LIVING AN ATTACHMENT DISORDERED LIFE

AD children will expend effort to “achieve” some or all of the following outcomes. To the AD child, generating these results is more motivating than any conventional idea of success or positive accomplishment.

- Being mysterious, unknown, and confusing to others.
- Ruining others’ happiness because they find it intolerable to be around.
- Avoiding / dismissing any emotionally arousing experience regardless of the kind of emotion involved (with the exception of anger).
- Staying beyond the reach of anyone’s compliments or praise.
- Maintaining and enhancing their negative feelings about themselves.
- Presenting themselves as entirely self-sufficient and therefore not in need of anything from anybody.

- Nourishing their subjective sense of power by striving to win oppositional battles, seeking to influence the behavior and feelings of others, and being unresponsive to others' attempts to reach / influence them.
- Extending their power by claiming the very power to define reality itself ("crazy lying").
- Reinforcing their sense of entitlement by disparaging / attacking others for not giving them what they want.
- Avoiding ALL personal responsibility by playing the "victim role" when it is strategically convenient to do so.

FUNCTIONING OF THE CHILD WITH ATTACHMENT DISORDER

1. AD children deeply believe that their very survival depends on their being in control of other people and situations most of the time. AD children make a decision, early in life, probably not consciously, that they will NEVER be in a helpless position again. They seek to orchestrate not only events, but the very feelings and behaviors of those closest to them. They will work very hard to control the adults' attention. This control can appear in many forms, including: oppositional / defiant behavior, passive aggressive behavior, withdrawal and withholding of information, hairsplitting semantic arguments, giving false information, sexualized behavior, aggressive behavior, infantile behavior, bizarre behavior, appearing "confused", vague / circular / unintelligible language, noisemaking, running away, avoiding physical contact, etc.

2. Hypervigilance is commonly seen in AD children. Hypervigilance is the directing of a significant proportion of energy, attention, and thinking towards monitoring the external environment. Being hypervigilant, AD children tend to scan situations very quickly for cues and then make interpretations of entire situations based on only one or two details. This can lead to responses that are way off base. Because of the energy it consumes, hypervigilance limits an AD child's awareness of what is happening inside herself and interferes with the ability to think reflectively, problem solve, or respond appropriately to external demands. Hypervigilance can be broken down into two kinds: threat hypervigilance and resource hypervigilance. AD children who are threat hypervigilant feel a constant sense of lurking danger and are always scanning situations for possible sources of danger. Those who are resource hypervigilant feel a terrifying sense of inner emptiness, almost as if they don't really exist. As a result, they are always searching out their environments for external resources to "validate" or "prop up" their sense of existing. This validation is obtained by getting others to interact with, or attend to, them in some way. In the absence of such external support, these children begin to feel like they are disappearing, almost as if they were turning into ghosts. This causes their anxiety to rapidly mount. In situations in which they are not sure how to respond, resource hypervigilant children will scan the environment for clues as to how to assemble their response.

3. AD children have tremendous difficulty tolerating emotional experience of any kind. It is their own emotions that they experience as potentially deadly though this thought usually lies beyond everyday awareness. Thus, their "24-7" struggle for survival, while outwardly framed as being against the world, is truly against their own emotional experience. Different emotions are seen as the deadliest for different children; for some it is shame; for others it is sadness; for others it is rage; and for others still, it is anxiety. Often, AD children cannot distinguish one feeling state from another, and different emotions can easily bleed one into the other. Their emotional regulatory skills are primitive at best; and hence, behavior unravels quickly in the presence of feelings. AD

children in general have very high levels of anxiety, and this anxiety is very easily aroused. Its arousal will activate a given youngster's control mechanisms, and behavior will likely deteriorate.

4. Not knowing what to do is a potent source of anxiety for AD children and triggers familiar controlling behaviors as a way of escaping the sense of not knowing what to do. It is for this reason that happiness and other positive experiences can be so problematic for AD children. Lacking experience with feeling positive, AD children resort to misbehavior, not so much to ruin the happiness per se, but to escape the anxiety of not knowing what to do. New situations are also threatening because the child lacks a blueprint for how to behave.

5. Helplessness and sadness are, for AD children, equated with worthlessness. This is one more reason they go to such lengths to avoid these experiences. Anything they acknowledge sadness or helplessness about becomes "evidence" of their worthlessness that could be used against them.

6. When emotionally stimulated, AD children's thinking can deteriorate very rapidly. They often drop to the level of the concrete thinking of a toddler and truly cannot understand more complex language that they normally could understand. Their thinking can get disorganized enough that they border on, or have, miniature psychotic breaks in order to blot out their feelings. When their emotional reaction passes however, they can recollect themselves in the literal blink of an eye. AD children often see the source of their emotional arousal as an enemy who was trying to overwhelm them on purpose. This can result in an aggressive counterattack.

7. To protect themselves from their own own threatening feelings, AD children learn to dissociate or disconnect themselves from their own experience in the present moment. They seem able to almost slide their psyches up and down the developmental scale as circumstances warrant. AD children can appear to shut down parts of their brain in ways the average person cannot comprehend. This is denial in its most fundamental, absolute form- experience itself is erased from consciousness as though it never happened {this primitive denial is beyond the reach of conventional forms of treatment and a major reason why such treatment fails with AD children}. AD children learn how to move and hold their bodies so as not to trigger physiologically stored emotions and memories. Threatening questions, as well as any possible answer that might have immediately arisen can be obliterated right out of awareness. Overall, this dissociative response is made up of many different tactics including: increased distractibility and fidgeting {can look like AD/HD}; becoming confused; circular answers; vague or contradictory language; inaudible or unintelligible speech; loss of short-term memory; shutting down one or more of their sensory processing systems so they literally don't experience their own sensory input {can look like learning disabilities except that processing can improve dramatically as attachment develops}; immature and/or faint tone of voice; loss of eye contact; eyes becoming dreamy, glassy, empty, steely/piercing, or blank; body becoming markedly more limp or rigid; and bodily preoccupations which serve to shut out the external world {picking at skin, scabs, bug bites; fingernail chewing, itching and scratching, hair twirling, aches and pains, repetitive movements, playing with fingers}.

8. Outwardly, AD children present themselves as "victims of life" who are responsible for nothing. Inwardly, these children feel responsible for everything that has happened to them; and this generates overwhelming shame. Avoiding this shame is one reason AD children deny all personal responsibility. Closely connected to this shame is a deeply felt {though usually out of awareness} self-hatred. This self-hatred presents a formidable obstacle to accepting love or caring from anyone when it is offered. The offering of love triggers a strong sense of not deserving it, and so it must be rejected along with the person offering it. In fact, the adult offering love may be looked at as rather dumb for offering love to such an awful child. More likely, the AD child, believing that he doesn't deserve anything of value from another, will perceive the love being offered as something hurtful being trickily packaged by the adult. In either case, the love and the adult are rejected; and the AD child remains caught in the bind of continuing to protest about what he is not getting, but being unable to accept it when it arrives.

9. AD children generally lack integrative thinking. They view life as random. Everything just happens. They have difficulty seeing connections between things, internally or externally. They also do not connect things across time. Hence they often do not grasp things like cause-effect, actions-results, the impact of their behavior on others, sequential events, etc. AD children have enormous trouble managing complexity. When faced with complex situations, they become anxious and deteriorate both behaviorally and cognitively. Their thinking can drop to the concrete thinking of a preschool child (sliding down the scale). AD children do not even see their own behavior as stemming from choices they have made. Their behavior is like everything else: events that just happen to them. As a result, the concept of personal responsibility seems like literal nonsense to AD children.

10. In terms of time, AD children generally live in the "eternal now". They don't perceive time as being continuous, with each moment passing into the next. Instead, each moment stands alone, disconnected from all others. This is the time sense of the fight / flight / freeze crisis reaction workings of the oldest, most primitive parts of the brain where much of the thinking of AD children goes on. Connections between past and present don't get made, and thus there is no learning from experience. Instead, the past gets imported directly into the present with no recognition that this is happening. As a result, the present is mistaken for the past, over and over and over. As for the future, it simply doesn't exist.

11. In terms of conscience / values, AD children typically possess little to none. They have not had the building block experiences with early caretakers out of which conscience grows. In terms of present priorities, conscience is of little value in the pursuit of survival.

12. Behavior can vary dramatically across situations depending upon the emotional significance of the people involved and the situational expectations for relating emotionally. Generally as the emotional importance of others present, or the expectations for relationship increase, the AD child's behavior deteriorates. This is why their behavior is usually worst at home with their families.

13. AD children view learning as having minimal value except as it enhances their survival skills. Consequently, they have a striking lack of curiosity about exploring the world. The first thing they are apt to do with any new information is to try to figure out if it can be used to generate any new self-protective control strategies.

POWER

1. AD children believe that they have power beyond anybody else's. They need to believe this in order to assure themselves that they can maintain the "24-7" control that they believe their survival requires. Hence, they are prone to engage in misbehavior ot power struggles. Like a toddler, AD children derive power simply out of saying "No". In addition, AD children believe they have the power to define reality itself. It is this belief that allows them to deny a misdeed that an adult caught them in the middle of performing. In the AD child's mind, his denial "rewrites history". If he says that it didn't happen, then it didn't. The adult is essentially told that he didn't see what he saw because it never happened.

2. Information is power and AD children know this very well. They will go to great lengths to control the flow of information about them in order to maintain their power to manipulate others' image of them. AD children give out very little real information about themselves, for they view that as giving away their power to others. Telling the truth, therefore, is to be avoided as a matter of policy. Much of their fabricating is intended to keep adults confused about what's real and what isn't. When asked questions, AD children often stall by "playing dumb" or "forgetting", hoping that the adult will get impatient and give a prompt or clue around which the child can fashion an answer that will please the adult while giving away no information.

3. AD children sometimes believe that they literally possess "mind reading radar". Just by looking at an adult, they believe they can determine what the adult is thinking and planning on doing. They often react to these “radar-based conclusions” and such reactions can look like they came completely out of the blue to anyone else involved in the situation.

4. When AD children escape consequences and / or responsibility, they usually see this as "proof" of how powerful they are. When they are disciplined or given consequences they can't escape, they interpret this as a personal failure {"I wasn't powerful enough or clever enough to get myself out of that situation}. This in turn can trigger a feeling of helplessness and the subsequent efforts at control this brings.

INTERPERSONAL RELATIONSHIPS / AUTHORITY FIGURES

1. AD children harbor a pervasive distrust of others. The more an adult seeks to earn an AD child's trust, the more dangerous that adult is likely to appear because efforts to earn trust are usually seen as elaborate "tricks" hiding an intent to hurt the child.

2. Love is defined as weakness and sometimes used against those who offer it. Sympathy or empathy is understood by AD children as entitling them to receive whatever they want from the sympathetic person. Then, if what they want is not offered, the child takes that as proof of adults' dishonesty and as a legitimate basis for revenge. Sympathy or empathy may also be seen as “pity”, and in this case, an angry counter-response is likely.

3. Other people are often seen as essentially interchangeable and are evaluated on the basis of, "What have you done for me lately?". Past history carries little or no weight (time perception). Thus, an AD child’s attitude towards anyone else can change minute-to-minute depending on what you most recently have or haven’t done for her.

4. Adults, as a rule, are viewed as unreliable, unintelligent, and rejecting, if not outright abusive. Adults who are giving to an AD child are generally thought of simply as resources to be exploited. Authority figures are seen as especially threatening should they gain any measure of control over the child. AD children have no faith in anyone's control but their own. This leads them to avoid asking for help when they truly need it because that creates a dangerous context of dependence.

5. Discipline is viewed as arbitrary and intended to humiliate the AD child, and so it only provides further proof that adults cannot be trusted. Discipline is also seen as a failure on the child's part to have effectively manipulated his way out of the situation, and thus it pricks the shame of the AD child. This potential of adult authority figures to activate the AD child's shame is part of what makes them seem so threatening.

6. AD children are likely to assume that if they have not been directly prohibited from engaging in any given behavior beforehand, no matter how outlandish, then it is alright. If consequences are subsequently imposed, the AD child will see this as a betrayal and protest that he was set up by the adult. Similarly, AD children are liable to interpret adults who simply disagree with them as literally lying to them. In both instances, they will see the “adult crimes” as giving them the right to retaliate.

7. For AD children who need external validation of their sense of existing, this validation is often obtained through repetitive nuisance behaviors such as chattering on, asking numerous questions, interrupting, minor behavioral infractions, minor property damage, claiming to forget to

get others to tell them things repeatedly, stealing of objects of little value, etc. The purpose of all these nuisance behaviors is to keep others engaged.

8. AD children frequently use "blackmail" to control adults by implying, or stating outright, that if the adult does as the child wishes, then the child won't get angry and make trouble for that adult in that situation. On the other hand, should the adult block the child's wishes, then there will be hell to pay. This "blackmail" can also take the form of guilt induction, particularly in relation to mothers.

9. AD children often display indiscriminate affection towards strangers, and this serves several purposes. It is a tool of "personal image management" to get others to see the child as charming, polite, etc. This created image can be used to foster the illusion that the parents are the source of the problems at home since such a "charming child" could not possibly be at fault. Indiscriminate affection is also used as a way to procure attention and gratification from others who "don't know any better". It is also one more way for the AD child not to be real- just another disguise pulled from the closet.

10. AD children commonly inquire of authority figures what will happen if a given rule is broken. The purpose here is to gather information to be used to maneuver around that adult in the future. More immediately, the child may use the answer given to conduct a little "cost-benefit analysis" to decide if the contemplated misbehavior is worth the price. This is one reason why being somewhat vague about the range of possible consequences is useful- it blocks this cost-benefit analysis.

11. During what is termed the honeymoon period in a new situation, AD children generally seek to gather information about parents' and other adults' weaknesses / vulnerabilities. This information is used subsequently in efforts to wield influence. In general, AD children are skilled at doing this because their years of hypervigilance have made them keen observers of adult behavior and vulnerabilities.

12. AD children by and large use their behavior to manage interpersonal closeness * distance.

13. Peer social skills are mostly, to entirely, lacking in AD children. Friendships, if made at all, usually last only for a brief time. AD children too often seek to dominate peers or set them up to get in trouble with no understanding of the likely future consequences for the friendship. Then when peers later reject, tease, or avoid the AD child, she does not understand why and feels victimized.

IMPACT ON THE FAMILY

1. The parent in the primary caretaking role generally receives the brunt of the child's acting out as she is usually seen as the symbol for all of the ways adults have failed the AD child previously. Behavior is typically better when the other parent is home. This can create parental conflict, wherein the parents see each other as either minimizing problems or overreacting. The child will nourish this split and take full advantage of it to exercise control over the parents.

2. AD children who have been adopted are quite capable of blending their internal images of adoptive mother and birth mother without any recognition that they are doing so. It is almost as if they look at adoptive mother and see birth mother. In interacting with his adoptive mother, the AD child applies beliefs, feelings, and behaviors that developed with his birth mother, while thinking that he is interacting with his adoptive mother in present time. It is important that parents and child become aware that this mixing up of mothers is going on inside the child and that the maternal images get separated out, identifying birth mother with then and adoptive mother with now.

3. Because AD children give so little back in return for parenting efforts, parents often go through a progression of feeling selfish for wanting a return on their investment, then guilty, then ineffective, and finally enraged. This eventually leads to intense parental ambivalence that can include strong wishes to hurt the child or put the child out of the family.

4. Because AD children are so skilled at charming others, and because the parents are struggling so hard, extended family and friends often offer little support and may even blame the parents for the child's extreme behavioral problems at home. Worse still, professionals all too often make this same mistake.

5. AD children have a knack for ruining most planned, pleasurable, family activities, partly because they don't know how to engage in such activities, partly because they fear being overlooked if everyone else is enjoying themselves, and partly because they are terrified of handing their parents the power to give them happiness.

6. If there are siblings, eventually they become jealous and angry about the amount of family resources in terms of time, attention, energy, and money that the attachment disordered sibling is using up and are likely to ask the parents to get the AD child out of the family.

THE CHILD WITH ATTACHMENT DISORDER

Power and Tactics

POWER

1. AD children believe that they have power beyond anybody else's. They need to believe this in order to assure themselves that they can maintain the “24-7” control that they believe their survival requires. AD children maintain what can be thought of as a *power bank account*, and they keep close track of the balance. When the balance gets too low, they are apt to engage in some behavior, such as lying or noncompliance, simply for the sense of power that this brings them. Essentially, such behaviors are “deposits” into their power bank account.

2. AD children grant themselves the power to define reality itself. It is this belief that allows them to deny a misdeed that an adult caught them in the middle of performing. In the AD child's mind, his denial "rewrites history". If he says that it didn't happen, then it didn't. The adult is essentially told that he didn't see what he saw because it never happened.

3. Information is power and AD children know this very well. They will go to great lengths to control the flow of information about them in order to maintain their power to manipulate others' image of them. AD children give out very little real information about themselves, for they view that as giving away their power to others. Telling the truth, therefore, is to be avoided as a matter of policy. Much of their fabricating is intended to keep adults confused about what's real and what isn't. When asked questions, AD children often stall by “playing dumb” or “forgetting”, hoping that the adult will get impatient and give a prompt or clue around which the child can fashion an answer that will please the adult while giving away no information. When someone shares positive information about an AD child, she is likely to behave in the exact opposite manner at that moment, or shortly afterwards, in order to make the listener doubt what he has just been told.

4. AD children sometimes believe that they literally possess "mind reading radar". Just by looking at an adult, they believe they can determine what the adult is thinking and planning on doing. They often react to these “radar-based conclusions” and such reactions can look like they came out of the blue to anyone else involved in the situation. During what is commonly termed *honeymooning*, AD children use their “radar” to gather data for future use.

5. AD children demonstrate an eager readiness to engage in power struggles. Like the toddler, these children derive power simply out of saying "No"; and will use "No" sometimes simply as a tool to replenish their power supply in their account.

6. When AD children escape consequences and / or responsibility, they usually see this as "proof" of how powerful they are. When they are disciplined or given consequences they can't escape, they interpret this as a personal failure {"I wasn't powerful enough or clever enough to get myself out of that situation}.

TACTICS

1. For AD children who need external validation of their sense of existing, this validation is often obtained through repetitive *nuisance behaviors* such as chattering on, asking numerous questions, interrupting, minor behavioral infractions, minor property damage, claiming to forget to get others to tell them things repeatedly, stealing of objects of little value, etc. The purpose

of all these nuisance behaviors is to keep others engaged.

2. AD children will work very hard to control adults' attention. This can be thought of as being like a magician's "sleight of hand". The goal here is to keep the adults distracted so they won't notice anything real behind all the strategic behavior. In this sense, AD children are like the Wizard of Oz, trying their best to keep anyone from discovering the little man behind the curtain. This is also part of the reason AD children spend significant energy provoking negative moods in adults- anger, frustration, and guilt are very effective "tools of distraction".

3. AD children frequently use "blackmail" to control adults by implying, or stating outright, that if the adult does as the child wishes, then the child won't get angry and make trouble for that adult in that situation. On the other hand, should the adult block the child's wishes, then there will be hell to pay. This is just one reflection of AD children's underlying attitude that threats are a legitimate mechanism for managing interpersonal interactions.

4. AD children often display indiscriminate affection towards strangers, and this serves several purposes. It is a tool of "personal image management" to get others to see the child as as charming, polite, etc. This created image can be used to foster the illusion that the parents are the source of the problems at home since such a "charming child" could not possibly be at fault. Indiscriminate affection is also used as a way to procure attention and gratification from others who "don't know any better". It is also one more way for the AD child not to be real- just another disguise pulled from the closet. One thing indiscriminate affection isn't is an attempt to engage others meaningfully.

5. AD children commonly inquire of authority figures what will happen if a given rule is broken. The purpose here is to gather information to be used to maneuver around that adult in the future. More immediately, the child may use the answer given to conduct a little "cost-benefit analysis" to decide if the contemplated misbehavior is worth the price. This is one reason why being somewhat vague about the range of possible consequences is useful- it blocks this cost-benefit analysis.

6. AD children will "display" feelings and engage in behaviors, as probes, simply to learn how others will react to those feelings / behaviors. This information is then likely to be used to "work" others in the future. Gathering this information is what the AD child is doing during much of the *honeymoon period* in any new situation. *Example*: the child may stage an angry outburst just to find out if the adult involved is intimidated by anger, and if so, then anger will be used in the future to wield influence over that adult. In general, AD children are extremely skilled at finding parents', and other adults', weaknesses and using them as leverage. The children are assisted in this by their years of hyper vigilance which have made them keen observers of adult behavior and vulnerabilities.

7. AD children by and large use their behavior to manage interpersonal closeness ↔ distance. Oppositional, aggressive, and extreme bizarre behaviors are reliably resorted to when the AD child feels a need to generate increased interpersonal distance to feel safely **in control.**

THERAPY FOR CHILDREN WITH ATTACHMENT DISORDER

Attachment disordered children have been notoriously difficult to treat. Traditional psychotherapy approaches, including insight-oriented individual psychotherapy, play therapy, cognitive therapy, behavioral modification, family therapy, and milieu therapy have all failed to produce any lasting change. They all lack the intensity needed to engage the AD child's affects sufficiently. Psychopharmacology can assist with portions of the total symptomatic picture, but has little to no impact on the basic attachment difficulties. In fact, AD children frequently have negative, unusual, or contradictory responses to a wide variety of medications. Though certainly not a diagnostic criteria, a history of poor and / or contradictory responses to multiple medications should bring the possibility of Attachment Disorder to mind.

As with other diagnoses, the prognosis for children with AD is better the younger they enter treatment. Given the present state of treatment technology, the chances of achieving meaningful progress decline rapidly if the child has not begun appropriate treatment by age 12-13.

Successful attachment therapy requires the therapist to be playful and supportive, yet challenging and firm. Therapy, like parenting, must be unpredictable to some degree in ways the child can't imagine, if change is to be facilitated. A consistent, predictable therapeutic structure is one the AD child will likely co-opt. AD children are highly unlikely to give up control voluntarily. Unpredictability assists the attachment therapist in removing control from the AD child’s hands.

The beginnings of progress are usually accompanied by significantly worsened behavior. With AD children, progress is particularly vulnerable to regressive lapses. As a result, these children may need periodic courses of therapy throughout their lives. Without appropriate therapeutic intervention, the most common life course of AD children is Oppositional Defiant Disorder > Conduct Disorder > Mood/Anxiety Disorders, Borderline Personality Disorder and / or Antisocial Personality Disorder.

WHAT DOESN'T WORK

1. Nondirective stances are not useful with the AD child, for he will use such a stance as "permission" to take over control of the entire therapeutic endeavor. Time will be spent simply pursuing desires of the child with the therapist reduced to the role of the child's "gratification assistant". All painful experiences will be avoided. Therapy becomes twisted into an opportunity for the child to sharpen his manipulative techniques.

2. Behavior management techniques tend to be ineffective for two reasons: 1) the child has no internal blueprint for connecting rewards to his own efforts; and 2) behavior management systems usually come to be viewed as simply systems "to work" to achieve gratification rather than change.

3. A conventional focus on establishing a therapeutic relationship that evolves into a treatment alliance. AD children can't form such a relationship in the first place, but they are very adept at creating the illusion that such a relationship is developing. Subjectively, what the child experiences is that the therapist is one more incompetent adult that they have successfully tricked and are controlling. Many a child therapist has been effectively seduced by the AD child's masterful disguise.

4. Interventions aimed primarily at developing insight. AD children are apt to appear to engage in this psychodynamic search for self-understanding. They will absorb the language of this endeavor and parrot it back with uncanny accuracy, creating an illusion of remarkable self-awareness. This is all

smoke and mirrors, and eventually these children figure out how to use their past as a rationalized excuse for the behavior in the present. And so they assemble one more tool of control.

5. Family therapy approaches that begin with the assumption that what is going on with the child reflects a family dysfunction {theoretically, a systems approach}.

WARNING: ***AD CHILDREN ARE MASTERS AT CO-OPTING WHATEVER IS OCCURRING IN THERAPY AND USING IT TO FORTIFY THEIR DISORDER. "HYPERVIGILANCE" IS THUS A VALUABLE ASSET FOR THE CLINICIAN.***

WHAT DOES WORK

1. It is almost impossible to make any impact on an AD child without responsive parents and a home life designed to foster the child's progress. Therapy may take place at home or at school rather than in the clinician's office. The parent(s) need to be viewed as co-therapists. The therapist will need to take an active role in educating the parents about the specialized parenting techniques that the AD child requires.

2. Maintaining an emotional engagement between child and therapist, as much as possible, regardless of the behaviors put forth by the child. Sometimes, this engagement is at a preverbal, unconscious, primary process level. At this level, the visual and tactile / kinesthetic modalities are often more important than the auditory one.

3. Eye contact is an excellent barometer of the degree to which an AD children perceive themselves to be in control of a situation. AD children reliably avert their gaze when they do not feel in control, and so monitoring their spontaneous shifts in eye contact is one thread the therapist should maintain. When speaking to the child, the therapist and parents should insist on eye contact as this potentiates the impact of what is being said and intensifies the child's engagement. AD children often need direct reminders such as “Look at me.” and “Right in my eyes.”

4. Using the child’s behavior in the immediate moment as a device for creating attachment. The goal is for the child to learn that his very efforts to disengage will be transformed into attachment experiences. {Example: Child turns his back away from therapist. Therapist then turns away from child and expresses appreciation for the child thinking of a creative way to have a conversation}. Conceptually, this is somewhat like the family therapy notion of “joining”.

5. Therapy must address both unhealed past traumatic experiences as well as the child's functioning in the present. If the therapist focuses too much on the past, the AD child will learn to use the past as an excuse for present behavior. If the therapist focuses too much on the present, the child will avoid doing the exceedingly difficult work of healing past traumas.

6. Working both sides of the street: AD children need clear praise and recognition for each tiny constructive step they take. They may well fight or dismiss this for a while because it is so at odds with their self image. They may even act out to try to prove the adults wrong. Their rejection should be acknowledged and accepted and they should be reassured that praise from the adults is not conditional upon the child’s acceptance of it. Even if the praise is initially accepted, the child will likely lose all recollection of it. This is to be expected, and so the child will need many repetitions of being acknowledged before anything will accumulate. In addition, the therapist must also work the other side of the street, i.e. to challenge and confront the child’s self-destructive strategic behaviors. Praise and challenge. Praise and challenge.

7. Rather than classifying behavior into "appropriate vs. inappropriate" and then attempting to increase the "appropriate" while decreasing the "inappropriate", therapy with the AD child involves seeking to understand the interpersonal function of the child's moment-to-moment behavior, remembering that most of their behavior is designed to control interpersonal distance and interactions. The focus is not on the content or form of the behavior itself {stealing, lying} but on the purpose that behavior serves for the child and what is its intended impact on others.

8. Effective therapy requires keeping AD children confused and off balance some of the time. From a conventional viewpoint, this can appear almost cruel. However, change can't be leveraged, especially early in treatment, except by way of the "unexpected". Any predictable adult responses or treatment plans will only be co-opted and used to intensify unattachment. Allowing this to occur is cruel.

9. Distrust of self: Describe how everything the AD child does that is not real {e.g. making up answers, playing dumb}, teaches them to be more afraid and distrustful of themselves, even though they think they are just fooling everyone else. Point out how they will then fool themselves further into believing that it is other people they can't trust so that they don't recognize how much they distrust themselves. Identify the possibility that they have become so skilled at fooling themselves that sometimes they really don't know what they are doing and suggest they consider if they want to get better still at fooling themselves.

   This can be particularly useful with "I don't know" answers. Reframe this as "pretending not to know" and tell the child that they have been pretending not to know for so long that they can no longer tell the difference between fooling themselves and really not knowing. Should the child disagree, just point out that time will tell whether they have fooled themselves with their own pretending, or they really don't know. The goal is to begin to create discomfort in the child about all their strategic maneuvering.

10. The basic message all adults should give the child is that he is accepted as he is now; and yet, more is expected of him. This requires empathizing with AD children's need to misbehave as well as their dogged efforts to undermine all adult interventions. The adults communicate an equal doggedness re: not giving up.

11. Transference: the AD child brings very powerful feelings into therapy. The therapist {and parents} will repeatedly be made the target of rage, terror, shame and despair. These evoke primitive {often somatic} preverbal responses from the therapist. It is essential, though often quite difficult, not to personalize this. Sharing these feelings with the parents, as they occur, to determine whether they resonate with the parents' experience is extremely helpful, both in building the bond between therapist and parents and in assisting the parents to put their own experience in perspective. Since attachment therapy must engage the child at a deep emotional level, transference to the therapist is encouraged.

12. Attachment therapists must be directive, given the child's distrust and ensuing efforts to co-opt the therapy situation. However, direction should be given back to the child as soon as he can use it to do other than manipulate. The therapist must take the control back again as soon as the child starts to misuse it.

13. The therapist must be skilled at using voice qualities {loudness, tone, rate} and nonverbal gestures to communicate empathy with the AD child's internal state. EXAMPLE: Using a raised voice, to make a clarifying comment, can be quite effective in reflecting understanding of the child's rage at the moment.

14. Physical contact is almost an inevitability. Often touch is necessary to maintain a preverbal emotional connection. Sometimes physical restraint is required to maintain the safety of people and property. Sometimes, holding therapy may be employed as part of a child's ongoing

treatment. The therapist needs to be willing to engage in such contact and to work with the feelings that it will release.

15. Paradoxical interventions are a mainstay of attachment work. These interventions are very effective at transforming resistance into engagement. They confound the AD child's usual methods for co-opting and taking control of a situation. Paradox throws the proverbial "monkey wrench" into the AD children's functioning, confusing them and throwing them off balance for the moment. Examples of paradoxical interventions are prescribing the symptom, predicting misbehavior, reframing the behavior, aligning with the behavior.

16. AD children often attempt to control the therapeutic endeavor by becoming mute and refusing all active participation. Attempts to explore or interpret this behavior are fundamental mistakes, for these attempts play right into the child's hands. Therapy gets drawn off onto focusing on the child's passive defiance and the attachment work evaporates as a result. At such times, an effective alternative is for the therapist to role play the child with the parents and give voice to what the child is not saying. This produces an almost immediate denial reaction in the child as soon as the therapist says anything which the child cannot or will not accept. Hence, engagement is re-established without ever focusing on the child's controlling oppositional silence.

17. Attachment therapists often operate from an intentional "one down position". By appearing confused and ignorant, the clinician can express curiosity about a child's behavior or statements without appearing so threatening to the child. In addition, this one down position plays right into one of AD children's basic beliefs {i.e., adults are stupid} and so the children readily "fall" for such a presentation. They then often provide valuable clarifying information in order to help "educate" this poor mixed-up adult sitting in front of them. It is useful for the therapist to express appreciation for the child's willingness to "lift" the therapist out of their woeful ignorance.

18. Parts of… exercise: Ask the AD child to complete the sentence, “There is a part of me that…” as many different ways as possible with the therapist writing down the answers. This exercise introduces an element of distance that often helps the AD child disclose more information. Often different parts are clearly in opposition to each other which can provide a doorway for exploring the child’s internal conflict. In addition some parts are usually aligned with therapy goals, and this can be noted. Asking the child to speak from the perspective of one part can also help the child share information as well. {Example: Have the part that does not like to cooperate tell what’s fun about not cooperating.}

19. The Double: The therapist has the child in front of them, leaning against the therapist’s chest with the therapist holding the child. The child and parents have, or continue, a conversation. The therapist is acting as the child’s double and has the job of correcting any distortions or saying anything that the therapist believes the child is withholding. The child often reacts strongly to what the double voices, and in addition, since the therapist is holding the child, subtle bodily reactions can be detected as well.

20. Face tracing: This is done with the parent holding the child. While making eye contact, the child traces the parents’ face with his index finger for a couple of minutes. Then the parent traces the child’s face, still maintaining eye contact. In the final phase, the child follows the parent’s lead- i.e. making the same tracing movements on the parents’ face that the parent is doing on the child’s face. This is best done after some intensive emotional work that has resulted in more closeness.

21. It is very useful for attachment therapists to not take themselves too seriously. Such a stance makes a therapist an easy target for an AD child’s strategic behaviors. To be effective with AD children, clinicians must be able to be playful, ridiculous, to make fun of themselves, to laugh at themselves, to be openly humble to acknowledge being wrong, to acknowledge being fooled.

PARENTING

PARENTING THE CHILD WITH ATTACHMENT DIFFICULTIES

What doesn't work

1. Rescuing the child from the consequences of her behavior and / or attempting to solve the AD child's problems for her.
2. Emotional reactivity. AD children experience parents' frustration and anger as proof that the child is effectively controlling his parents' emotions. This only inflates their grandiose sense of power.
3. Attempting to persuade the AD child to change his mind by presenting “logical, reasonable, or “practical information”. AD children are highly unlikely to be influenced by reasonableness. Adult efforts to do so look “stupid” to an AD child an can intensify his lack of feeling safe.
4. Negotiating with an AD child.

PHILOSOPHY

While love and parental common sense are necessary ingredients to successfully parent a child with attachment difficulties, they are rarely sufficient. This is due to the fact that most children with attachment problems are too guarded and too distrustful to receive the love and support that parents may be offering. The foundational issue for AD children is not love, but safety. In the absence of safety, love becomes an unaffordable luxury.

It is the pursuit of safety that leads AD children to be as strategic and controlling as they are. “Control” has become a prominent word in the attachment world as though it were the problem itself. This leads to conceptualizing parenting AD children as too often a “battle for control” which the parents must win by wresting control from the child. While there is some truth here, this thinking mistakenly defines “control” as the problem whereas it is really only a symptom. “The problem” is a lack of feeling safe in the world, and “control” is no more than a compensatory attempt to make up for the sense of safety that is missing. It is important that parents remember that they are aiming to create a feeling of physical and emotional safety that their child has not known previously, not simply to win a”war for control”.

With safety in place, a bridge develops across which love can flow. Think of safety as converting an “unteachable student” into a teachable one who can now start to learn the lessons of love. Safety makes love “affordable” for the AD child. Parenting an AD child at this point begins to resemble the more conventional, common sense parenting of a child without attachment difficulties.

The specialized parenting techniques outlined below are all aimed at gradually creating safety for the child and removing the child’s blocks to receiving the love that the parents have to give. Many of these techniques are somewhat counterintuitive and reflect the fact that if everything that typically makes sense has been tried without success, than anything else will seem at first not to make sense.

The parental qualities that are most successful with AD children are: sense of humor, curiosity about how things will develop vs. an exclusive focus on the end result, ability to meet the child where he is vs. where the parents want him to be, and emotional availability and responsiveness. Even when parents have most of these qualities, children with attachment problems can be very exhausting whether the parents are adoptive, foster, or biological. AD children have a sixth sense for finding every button a parent has and pushing them all. If you have reached the point of feeling ineffective and discouraged, that is a warning signal that professional assistance should be considered.

A word or two about brain growth and change. The brain adapts to experience, not to information. In this digital age, the tendency to overvalue the impact of information itself, disconnected from experience, has mushroomed. As H.L. Mencken put it, “For every problem there is a solution which is neat, believable, and wrong.” Information is not useless, but by itself, it does not fundamentally lead to change in children, or adults, for that matter. If it did, you probably would not be reading this right now. The mental health of children in the United States has been declining gradually, but steadily, since the 1950’s. All of our digital abundance has done nothing to reverse that trend. So, the message is, to facilitate growth in your children, give them new experience, not simply new information.

A final word / warning: do not care about your child’s problems more than she does. AD children are quite content to allow the adults to carry the worry while they continue the behavior. Nothing is likely to change as long as you are more anxious about your child’s behavior than she is. So, parents need to be careful not to take on anxiety that truly belongs to your child. Parents cannot make their child better. Parents cannot make their child do the work they need to do to grow. Parents cannot make their child be successful. In the spirit of counter intuitiveness, acknowledging that your child has the freedom and the power to make a mess of her life increases the chances that she won’t.

Teaching / Learning

1. Physical touch: AD children are often touch avoidant. Parents should not let this intimidate them into rarely touching their child as touch is a cornerstone of attachment. Therefore look for opportunities for physical contact during calmer moments. Scheduling time for nurturant holding is another option. However, it is not recommended that physical contact be imposed over a child’s oppositionalism should that occur. To attempt to do so only contaminates the notion of physical affection with more conflict and tension which “poisons the well”. It may be better to look for a more propitious moment at another time. AD children also often need to be taught how to relax into being touched as they frequently develop an almost reflexive stiffening or bracing in response to touch.

2. Eye contact : As long as an AD child does not have consistently good eye contact, working on eye contact should be a priority. Good eye contact is the basis for the child learning to "take the parent in emotionally”. Without this "taking in", an AD child is less likely to develop an emotional connection to parents. If a verbal cue is not sufficient to restore eye contact, parents can: 1} gently place their hands on either side of the child's head and turn it or, 2} tap the child lightly on the cheek until her head is pointed towards the parent. Some judgment needs to be exercised here. “Getting eye contact” in any given situation, is not one of those battles to be “won” at all costs. This only contaminates eye contact with tension and conflict, like physical touch above. In addition, remember that extended eye contact in a relationship with a power differential (parent-child) tends to make the one with less power feel defensive. This is unlikely to lead to emotional connection. Do express pleasure and appreciation when eye contact is given.

3. Emotions : AD children usually need to be taught about their feelings. Some of them are so disconnected from their bodies that not only don’t they experience their feelings, they are often unaware of physiological sensations like cold, warmth, pain, hunger, tiredness, etc. They need help with just identifying that they are having a feeling or sensation. In addition, they need to be taught the language of feelings and to apply the correct word to the correct feeling state {much like would be done with a pre-school child}. This task is usually best accomplished if feeling words are limited to the following choices: happy, disappointed/sad, mad/angry, embarrassed/ashamed, and worried/nervous/afraid/scared,. AD children need help learning to read physical sensations {knot in stomach} as signals of feelings {nervousness} happening at the same time. Making photo flip cards can be a useful tool here. The child is asked to make faces representing different feelings. If the faces are accurate representations, photograph them and put them on cards. These can then be used to help identify feelings when they are running strong.

4. Thinking connectedly : Because their early histories usually lack reliable, predictable caretaking, AD children tend to perceive the world as a fragmented place in which things are discrete and separate rather than connected. They are apt to see feelings and behavior as just "happening" without influencing each other. AD children need to be taught, over and over, that behavior is connected to triggers on the front end, to choices in the middle, and to consequences on the back end. The same is true of feelings; they need to learn that feelings are connected to triggers on the front end, to some form of expression (bodily, behavioral, or verbal) in the middle, and to outcomes on the back end.

5. Choice : Because of disconnected thinking, AD children commonly lack any real concept of personal choice in their world view. They must first recognize connections between things before they can grasp how their choices affect the connections. Remedial education is in order here. AD children need to have connections of all kinds made for them repeatedly before the concept begins to take hold. Connections between triggers and feelings, between feelings and behavior, between behavior and its results, connections across time, and connections across situations are all examples. Visual aids (drawing) are useful supplements to verbal explanations.

6. Behavior : AD children tend to see only the payoff of their strategic behaviors as that is what's immediately relevant. Consequently, they rarely have much understanding of what their behaviors may be costing them. It is useful for parents to point out these costs to teach that behavior doesn't come "free". Setting up experiences to make those costs real can be very effective. (Example: A child who lies has almost never given any thought to the fact that this behavior costs him his believability. Besides pointing this out to the child, parents can warn him that the time will come when he will really want to be believed about something ((the boy who cried wolf)), but the parents won't be able to. Then just wait for that opportunity to arrive-that's when the learning will begin to set in).

7. Time : Because AD children typically have a distorted sense of time that lacks reliable continuity running from the past, through the present, and out into the future, they import things from the past into the present, believing those things belong in the present. These misplaced imports in time usually compromise the child's present functioning. To prevent this, AD children literally have to be taught a sense of linear time and this involves repeated instruction in the difference between then and now. Much of this can be done by reiterating the concrete differences between "then vs. now" and the use of a visual time line.

GUIDELINES

1. Safety : Maintaining the physical safety of people and property should always be parents' top priority. This always takes precedence over doing something to promote attachment, to encourage better behavior, etc.

2. Love : Offering and expressing love is the parents' responsibility. Receiving love (letting it in) is the child's responsibility. Parents too often take the responsibility completely onto themselves to find a way to "get their love in". It is far more helpful to your child to challenge him (softly) about his methods for keeping their love out and to remind him it is his choice to remove those obstacles or not.

3. Rules : Behavioral rules need to be specific, clear, and phrased in behavioral language that states what the child needs to do vs. not-do or stop doing. The rules need to be stated proactively because the unconscious mind does not process negatives. Thus, negatively stated rules actually increase subconscious focus on the behavior being prohibited. This increases the future chances that the undesirable behavior will reoccur. The rules need to be

communicated with the expectation that they will be learned and followed. This is best conveyed with a matter-of-fact tone of voice that is free of any emotional edge. *Example*: “You will go to your room right after dinner and do your homework.” Thanking the child in advance for his cooperation can improve compliance. The interaction should be broken off after the parent expresses gratitude for expected compliance. In addition, establish the ground rule ahead of time and always in play, that the AD child needs to ask what the rules might be for anything that has never been discussed before. This removes avoidance efforts by way of ignorance, from the AD child's repertoire.

4. Access to Things : Prohibit access to any item that is not used for its appropriate purpose (Example: using toys to ignore the parent). The child’s misuse of the item is explained as a lack of knowledge (Example: “Toys are for playing with- not for ignoring your parents. So it seems that you are confused about the purpose of toys. Therefore, it wouldn’t be good for you to keep using things you are confused about”). Access is allowed again only after the AD child has: 1) behaviorally demonstrated responsible behavior with things for some significant time period, and, 2) given a verbal promise to use the item in the proper fashion in the future. This promise must be restated in full, by the child. Just agreeing with the adult's rendition of the promise is insufficient.

5. Discipline : In disciplining an AD child, speak succinctly without defending or explaining the discipline. This minimizes the chances of either overwhelming the child with too much information or providing information that can be used for evasive, argumentative purposes. In addition, explanations undercut parental authority for they imply that the authority rests on the explanation rather than on the parent’s role. Discipline is best carried out in a matter-of-fact manner, in the style of: “Nothing personal- it’s just business”. Disciplinary interventions should not be emotionally driven. Emotionally charged behavioral interventions tend to be ineffective because they increase the child’s sense of being unsafe, and the child is apt to counter by repeating behaviors she knows will upset her parents.

   Consequences : When imposing what would typically be time-limited consequences, don’t automatically give the AD child a definite amount of time that the consequence will last. Instead of making the consequence end after a certain amount of time has passed, base its ending on a behavioral change criteria. The consequence ends when the child changes the behavior that led to the consequence in the first place. That change should have occurred not just once or twice, but often enough and long enough that the parents have begun to expect it. This puts the responsibility for the consequence ending, totally on the child.

6. Consequences / Empathy : When imposing a consequence as part of discipline, offer emotional support (empathy) for the hardship that the consequence will cause the AD child. Communicate your understanding that being disciplined probably feels like humiliation and this will lead your child to want to misbehave. Nonetheless, you expect that she will make a good choice even though she does not want to. This both preserves attachment while maintaining discipline. Let go of any anger that remains after imposing a consequence or you run the risk of sabotaging the effect of the consequence.

7. Information : It is fine to withhold information from AD children, even information they directly ask for, when parents have a sense that that information will somehow be misused. It is instructive to tell your child that you are not providing the information requested because her past behavior (you are teaching connected thinking by doing this) has shown you that she is most likely to use the information poorly.

8. Giving / Receiving & Guilt : Avoid giving an AD child much more than she can give back. Doing so reliably stirs a sense of guilt in the child as not deserving what has been given to her. Guilt in AD children practically guarantees behavioral deterioration soon afterwards. It is for this reason that gifts at birthdays and holidays should be moderate in amount.

9. Emotional contagion : Emotions can be passed from one person to another much like colds. This is emotional contagion. It is driven partly by rapid nonverbal mimicry, particularly of other's facial expressions, and the associated internal sensations. This phenomenon occurs in infants only a few days old. Once people start mimicking facial stimuli, they often rapidly experience the emotions that are connected to these stimuli. Hence, it is important for parents to monitor their facial expressions when interacting with their AD child so their expressions don't act as a source of unhelpful emotional contagion.

10. Appreciation / Praise : After an AD child reluctantly makes a cooperative choice, appreciation is often a better parental response than praise. Appreciation puts parent and child on the same level for that interaction. Praise, on the other hand, can suggest that the one offering the praise (parent) is the more powerful one, and therefore able to pass judgment on the less powerful one (child). Praise is, after all, every bit as much a judgment as is criticism. Praise can run the risk of the child feeling the parent is rubbing his face in "the parent having won". This can generate anger which may undo the cooperative decision right then, or may fuel oppositional behavior in the future. Appreciation can avoid those risks and can strengthen the parent-child relationship.

11. Advice : Never offer an AD child help or advice without first asking the child if he wants it. This question forces the AD child to take some responsibility for stating what he wants in order to get it - this is priceless practice. Additionally, it helps parents avoid the frustration of offering advice only to have it rejected out-of-hand because the child wasn't interested in solving the problem in the first place. If the child says he does not want advice or assistance, do not offer it anyway. Just drop the subject and move on. This holds the child accountable for his negative answer. When the child gives parents orders, as AD children do, politely inform him that you did not ask for his advice and when you do want it, you will be sure to ask him ahead of time. This can work better than reprimanding the child for being rude or disrespectful.

12. Unpredictability : An unpredictable range of parental responses and consequences is useful to keep the AD child a bit off balance. This sounds counterintuitive because safety is so linked up with consistency in the common sense parenting world. AD children see consistency, not so much as indicating safety, but as making it easier to strategically protect themselves because they can reliably predict what the adults are going to do. So, the element of surprise is a powerful tool for parents of AD children because being surprised interferes with AD children's efforts to strategically maneuver. In addition to unpredictability, being vague at times is also useful because AD children tend to scan situations very quickly in order to try to figure them out. Parents being vague blocks this "hypervigilant radar" and this again can disrupt efforts at control. Parenting strategies also need to be switched over time, particularly if they are being successful, so as not to wear a strategy out by making it too predictable or routine.

SPECIFIC INTERVENTIONS

1. Attention : Since attention activates thoughts, feelings, and behavior, a useful question to ask your child from time to time is, "What are you paying attention to that is leading to this behavior ?".

2. Distrust of self : Describe how everything the AD child does that is not real (making up answers, fake emotion, playing dumb, fake laughter, "forgetting", etc.) teaches him to be distrustful of himself while he thinks he is fooling everyone else. Point out how he will tell himself it is other people he can't trust while he remains unaware of his extensive distrust of himself. Explain how he has become so skillful at fooling himself that sometimes he really doesn't know what he is doing. Reframe "I don't know" answers as "pretending not to know" and tell the child that he has been pretending not to know for so long, he can no longer tell the

difference between pretending and really not knowing. Should the child disagree, just point out that time will make it clear whether he has fooled himself with his own pretending, or he really doesn't know. This approach can be supplemented by suggesting that the AD child doesn't even believe himself when he takes extreme or absolute stances. The goal here is to create a split within the AD child so he begins to question his snap judgments and strategic maneuvering. When challenging an AD child's thinking, it is helpful to tell the child up front that he probably won't believe you. This creates a paradox the child cannot escape with simplistic control maneuvers.

3. Belief vs. truth : Explaining the difference between belief and truth is useful. The central ideas are that people frequently believe things that aren't true and disbelieve things that are true. What someone believes and what is true don't necessarily have anything to do with each other. This then becomes the basis for suggesting that the AD child may be fooling herself into thinking that some things are true just because she believes them. This can further promote some self-reflection on the child's part.

4. Forgetfulness : Forgetfulness should never be accepted as a valid reason for avoiding responsibilities or consequences. Instead, forgetfulness is framed as an intentional choice and the AD child has taught her brain to forget things she doesn't want to remember. The solution that is presented to the child in this situation is to sharpen her memory in the future or find a way to help herself remember. The child is held accountable for the act of remembering.

5. Victimhood & Responsibility : When self-pity, which usually takes the form of blaming others, while playing "victim", is used by the AD child to try to get parents to lower their expectations, parents should simply tell the child that he is choosing to feel sorry for himself and that is an easy out which the parents will not support. Empathy is the last thing to offer the AD child in such situations- that would essentially be enabling. Instead, the goal is to use the situation to promote personal responsibility for the AD child. Holding a child accountable often involves making restitution to the person negatively impacted by the child's behavior- this is action and not simply a "pro forma" verbal apology. As part of role modeling responsibility, avoid the phrase, "You made me feel…". This is a terrible phrase and one that is fundamentally inaccurate. It assigns responsibility for the speaker's feelings to the other person, leaving the speaker in the role of "victim" and demonstrating the opposite of responsibility. If you are not responsible for your feelings, your child will not learn to be responsible for his.

6. Promises : When accepting a promise from an AD child, remind her that should she choose to break it, she will really hurt herself because she won't be able to use promises in the future as a way to obtain something she wants from her parents. She will then have the added burden of having to figure out how she can earn the adults' trust back. Never accept a promise from an AD child who already has a track record of broken promises that has not been corrected sufficiently to have earned trust back.

7. Demandingness : AD children can be demanding, and often so. Occasionally ask your child, when she makes a demand, "What is in it for me?". This can be an effective reminder that relationships are reciprocal.

8. Cross-talking : If there are two adults available, cross-talking is a useful technique. Here, the adults talk to each other, with the child present, in order to convey information they want the child to hear. This makes it more difficult for the child to mount an argumentative response. The adults might simply be hypothesizing about what may possibly be going on with the child. Cross-talking should be kept fairly short or the AD child may tune it out.

9. Unresponsiveness : When attempting to talk with an AD child who is not responding at all, one can try role-playing the child and speaking what you think the child would be saying and then shift back into the adult role such that you are carrying both sides of the conversation. AD children often respond to this. This needs be done in a matter-of-fact and not teasing way.

10. Unintelligible speech : AD children frequently speak so that what they say cannot be clearly understood. Sometimes they mutter. Sometimes they speak very softly. Sometimes they make up words. Sometimes they scramble the order of words in a sentence. Sometimes they leave words out. While some AD children do have language disabilities, the majority of unintelligible speech used by AD children is a purposeful strategy. Like lying, unintelligible speech is another way to keep parents in the position of "not knowing and trying to find out". Thus, if asked to repeat what was said unclearly, the AD child is likely to say it unclearly again, or refuse to repeat it, or blame the parents for not listening, or tell the parents that they had their chance and blew it. This follow-up frustrating of the parents only adds to the child's unhelpful sense of power. Therefore, assume that if it was said unclearly, it wasn't important, and move right on as if your child never spoke. If she later says that she already told you something, just tell her it didn't get through. Then instruct your child that, in the future, when she has something that she wants you to know, to check with you when she tells you to make sure that you understood. If she doesn't double-check with you, then she runs the risk that you don't know what she wants you to know. This shifts the responsibility for communicating clearly onto the child.

11. Questions parents should avoid asking your AD child:

    1)" Did you…?"- the answer will most likely be "no".

    2)" Why did you…?"- the answer will likely be made up or "I don't know."

    3)" Do you remember…?"- the answer will be "no".

    4)" What did you say?"- see unintelligible speech.

Questions to ask:

How…?, How is it that…?, How does it happen that…?, What…? What happened ? Should a question be asked that goes unanswered, it can be useful to tell the AD child that if he doesn't answer, you will make up the answer for him and count that as his answer and use it as the basis for any related decision you might have to make.

1. "Why" questions : "Why?" questions from AD children are almost always maneuvers to undercut parental authority by getting information the child can use to argue that the parents position is illegitimate. "Why?" questions are also usually false questions in that the child already knows the answer. The best responses to "Why?" questions are to either: 1) point out that the child already knows the answer, 2) ask the child to tell you the answer to his own question; or 3) a tongue-in-cheek, but not sarcastic, answer: (Example: child asks why he has to sit and eat dinner with the family- parent replies that it helps his body digest food to eat with other people and talk). Probably the least useful thing a parent can do with a "Why?" question is to take it as legitimate and to provide a meaningful answer.

2. Forced Choice : With this strategy, parents give the AD child two choices, both of which are agreeable outcomes to the parents. Example: choice one: go to bed on time tonight and you get
   to stay up until your regular bedtime tomorrow night; choice two: for each minute you are late getting in bed tonight, five minutes will be taken off your bedtime tomorrow night. The parents then step back and allow the child's behavior to "tell the tale" of what will happen. The fact that both outcomes stem directly from the child's behavior teaches the concepts of both choice and cause-effect and makes it more difficult for the child to frame the outcome as resulting from the parents' just being "mean".

3. Overpractice : After a child breaks or “forgets” a rule, she must practice following the rule. Example: Child orders parents around rather than making requests. Rather than correct the child and then grant the request after it is phrased respectfully, the parent has the child approach the parent several times in a row, repeating the same request each time. It might then be honored after 3-4 practice rounds. The whole exercise is defined as practicing the “skill of making requests” since the earlier behavior indicated that the child did not how to do this properly.

4. Something Will Happen (unpredictability): Rather than confronting the AD child with a specific consequence in the moment, it can be very effective to say something like: “You can make that choice. I don't think it's a good move and something will happen.” Parents must be ready to follow through in some specific way should the child make the poor choice. However, the follow through can come several days later. That intervening period of waiting for the other shoe to drop can have significant impact on the AD child (though not the first time around). At the time of imposing the consequence, reference the prior warning that “something will happen” and identify that this is that something to insure your child gets the connection.

5. Planned Regressions : This involves setting aside specific time periods during which the child is allowed to regress to whatever age he would like to be. This is set up as a special game or play-time between parent and child. As part of these planned regressions, the parents actually handle the child as if he *were* the younger age he's pretending to be. One common technique is feeding the child with a baby bottle. Such planned time for “backing up” can help AD children pick up missed developmental pieces. This approach generally works better the younger the child is, but can be effective even with early adolescents. It should be done without a sibling audience.

6. Rejecting the family : When an AD child voices a wish to not be part of the family, periodically removing the child from some or all of normal family routines can be more useful than trying to include the child, who then may ruin whatever is happening for everyone. Then, instead of the family experiencing activities being sabotaged, the child experiences the natural consequences of his wish not to be involved. Physical removal, while possibly seeming a bit “harsh” at first, serves to make the child's wish very concrete so he can really experience it. This can lead the child to begin to rethink his choices.

7. Paradoxical Interventions : Precisely because they are nonlinear and illogical and therefore are not undercut by direct oppositionalism, paradoxical interventions can be very effective with AD children. Two examples are:

   ❣ Humorous, but not mocking agreement with the child's critical views of the family. Example: Openly agreeing that the child has gotten a raw deal in having to live with such a stupid and boring family and she should be upset.

   ❣ Predicting and implicitly giving permission for limited misbehavior. Example: I know that you are probably going to argue, complain, be rude, get silly, whine, ignore me, and have a tantrum about_____. Would you tell me how much time you need for your tantrum ?”

8. Accessing Anger : (This intervention should NOT be used with children prone to angry outbursts, tantrums, aggression, etc. It can be useful for children who express their anger indirectly through passive-aggressive or nuisance behaviors or are inordinately fearful of anger). Anger is essential to the defining and maintaining of appropriate boundaries between oneself and the world. AD children who cannot access their anger and use it as a boundary tool, tend to perceive the world as a chronic invasive threat and themselves as relatively helpless. This intervention can help address these factors. 1) Parent and child sit three feet apart, facing each other. 2) Each person picks an angry phrase to use that is agreeable to both. Over time, the phrases used by the child should move towards ones that are more

uncomfortable to say. 3) Decide on the voice volume both parent and child will use. Over time, this should get progressively louder. 4) Agree on a length of time from ten to thirty seconds. Use a timer to monitor. 5) Both parent and child begin saying their phrases at the same time at the agreed upon voice level. There is no listening involved. 6) Discuss the experience briefly afterwards as needed. This exercise is done only once in any given day. It can be practiced regularly, though not necessarily daily, until the most uncomfortable phrases can be repeated, with an elevated voice, for a full 30 seconds.

9. Tantrums / Meltdowns : Different children require differing approaches in order to come out of a tantrum. Some children will need direct confrontation, others will need a warm and supportive approach including affectionate holding, while still others will need to be left alone for a while as their psychological boundaries are weakened during an outburst. A mismatch will produce escalating panic and prolong the tantrum.

10. Point plans : Point plans come in many varieties that differ in multiple ways. One of the ways they differ is the time period of their cycling: hourly, daily, weekly, or monthly. For AD children, given their difficulties with temporal perception, daily-based plans are the best choice. A daily plan provides practice at learning to make connections across a 24-hour time period and it can contribute to safety by emphasizing the 24-hour rhythm of family life. One way to structure a daily plan is that each day's privileges must be earned by meeting certain behavioral criteria the day before. Things that may have been givens, such as free time, can be redefined as privileges and incorporated into such a plan. If the criteria aren't met, the relevant privileges are lost for the next day, but the the next day also brings another opportunity to earn them anew.

11. Orphanage behavior : When AD children have spent time in an orphanage, they frequently pick up behaviors that were useful in that context such as hoarding, stealing, lying, setting others up, physical aggression, and poor hygiene. When these behaviors show up in the family, label them "orphanage behavior" and define them as reflecting the child's difficulty in perceiving changes across time. Therefore they are acting as if they are still "then and there" rather than "here and now". The expectation is that they will learn to tell the difference between "then" and "now" and drop the behaviors that belong to "then". In addition to impacting behavior, this intervention simultaneously helps improve temporal perception.

12. Problematic Situations : With situations wherein there have been problems, before re-entering the situation, review what happened the previous time and explain what is expected this time. Get a firm commitment from the child to follow the expectations. The commitment takes the form of repeating back to you the expectations, not just a single-word answer. If your child won't do this or does it incorrectly on purpose, don't take her back into the situation. That simply invites history to repeat itself.

PROMOTING ATTACHMENT IN VERY YOUNG CHILDREN: AGES 0 - 5

Regardless of the child's age, it is optimal if one parent is home full-time for the first six months post-adoption, and there are no separations longer than a weekend during the first year. If there are still significant problems after the initial six months, that is a reliable indicator that professional help should be sought.

0 - 6 Months : Maximize physical contact with your infant during feeding, changing, bathing and by obtaining a front mounting pack for carrying. Rocking, stroking and lots of infant massages can help as well. Maximize face-to-face communication. Seek to match your child's facial expressions and vocal qualities to promote bonding. Observe whether your infant responds to one sensory modality more than another. If so, draw on that sense more when interacting. Identify which sounds, types of

touch, rhythms, positions, sights, and smells your infant enjoys. Pair these up with things that cause a startle reaction to lower anxiety. If your infant is primarily a self-soother, imitate his soothing activities (e.g., rocking) and add an additional element such as singing or comforting touch. Allow your infant to look away as this is often in the service of self-regulation and don't force excessive eye contact. Sleep with the baby in your bed or next to it in the with crib with the side rail down.

6 -10 months : Maintain a consistent routine to promote physiological regulation. Allow your infant her full range of feelings. Crying now may just signal a feeling and not a call for help. This kind of cry need not be immediately soothed, but attachment can be promoted by staying with your infant while she's distressed, for your physical presence validates her feeling. Attachment problems make an infant prone to backslide or regress developmentally. Allow some degree of this. Interacting with your infant at a temporarily regressed level can help fill in any earlier gaps in the attachment process. Imitate any constructive self-soothing behaviors to reinforce them. If you adopt an infant at this age, transfer as many elements from the previous placement as possible, into your home. If your infant attached to his previous caretaker, expect a grief reaction. This can sound like a more despairing cry than other infant cries. Offer physical comfort, but know that this grief can be inconsolable. If your infant doesn't relax, then remain with him so that his grief becomes part of his relationship with you. This will facilitate bonding and attachment.

10 - 18 months : Many of the techniques for younger infants also apply now. Allowing regression, and interacting with your infant while she is regressed can become more important, as a method of filling in the previous attachment gaps, as the child gets older. If your child moves away from you to explore, but does not return to check in, you can encourage checking-in by placing some favorite objects near you after she has moved away and calling her attention to them. Praise your child for returning.

15 - 24 months : When your child's wooing becomes coercion, limit the attention available and redirect your toddler to another activity. Firm limits are important to complete the bonding cycle of trusting limits. If this isn't done, there is a risk of unraveling the attachment gains made to this point. Overindulgence, though well intended, will bear no good fruit. Watch for opportunities to use language to assist your child to understand and express feelings and ideas. To the degree things can be expressed verbally, they won't be acted out behaviorally.

If you adopt a child of this age, record all the details of placement day and of the previous caretakers. Maintain contact with those caregivers, including visits, and later phone calls and cards. The frequency of contact should lessen over time. Allow open discussion about previous caretakers. This will facilitate the transfer of bonding and attachment from them to you.

24 - 36 months : Regressions are likely during this period as well if attachment is poor. Allowing for these and interacting with your toddler during them can strengthen weak spots from previous stages. Guard against any temptations to be overprotective as this will interfere with resolving separation anxiety. Build in planned absences as they can facilitate the resolution of separation anxiety. Keep expectations realistic. This is particularly important for parents who adopt a two - three-year-old. Unrealistic expectations will block attachment from developing by creating a preponderance of disappointment.

3-5 Years : The weak reality testing characteristic of this age (egocentrism and magical thinking) makes the use of the word "real", very tricky. It will probably get interpreted as real vs. pretend or fake and this can complicate attachment and identity. Therefore, avoid this word and use functionally descriptive labels such as "birth parents" or "the parents who are raising you". Avoid the use of "forever parents"; it is too abstract. If you have the information, making the birth mother concrete with photos, her name, and telling stories of the child's pre-adoptive life, based on information that you do have, can reduce the distraction that comes from not knowing. It is useful to point out likenesses between your adopted child and the rest of the family (appearance, qualities, activities, interests, foods liked or disliked, etc.) in order to nourish belonging. By age 3.6, children understand that different skin tones are differentially valued in society. Don't deny this but instead, point out that it is

not true within the family. Explain it as others'deficit and not the child's. Make up stories, with your adoptive child as a central figure, of your family's life in the near and more distant future to nurture a sense of belonging going forward.

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