

RELATING TO THE CLIENT WHO CAN'T RELATE - A SHORT INTRODUCTION TO ATTACHMENT DISORDER IN CLINICAL PRACTICE

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INTRODUCTION

The therapeutic alliance with the client is a pivot in psychotherapy. The nature of this alliance depends very much on the early experiences with others: parents, peers, important persons in life prior to therapy. The attitudes of both parties are modelled over these experiences, and the therapist is responsible of being aware of emotional transference of earlier attachments from the client, and of his or her own counter-transferences towards the client. Even therapies based on a cognitive relation (as opposed to a long-term emotional relation) presuppose the existence of a client – therapist relation where the client is willing to cooperate with the therapist. The alliance is at the same time the problem and the challenging possibility for therapy.

This paper addresses the question of how to manage the therapeutic relation with clients who have had devastating early experiences with others, or have been exposed to severe early deprivation. In short, clients who lack the ability to relate in a deeper sense with the therapist, or clients who have extremely negative and hostile (often paranoid) attitudes towards the therapist.

In the Western countries, probably 3-5 % of the population has experienced early deprivation, maltreatment or early sexual abuse. In the world as such, there were 147 million children in orphanages in Asia, Africa and South America in 2003, according to UN figures (Unicef 2004). Even though the group exposed to severe early loss is large, only few enter therapy later in life. Poverty is one reason, another reason is that these clients often do not experience themselves as having a problem; they are referred to therapy because their behaviour disturbs others. Thus, their motivation is often very limited if existing at all.

Another group of potential clients are upper class persons who have been cared for by a number of nannies from birth, and who have received very little early care from their parents, while they at the same time have been very spoiled and experienced no limits. These persons often move to the top of society and become leaders of organizations, but thanks to their social position they are able to avoid any legal or therapeutic initiatives.

An example of clients referred by others: adopted children, who have been exposed to deprivation before adoption in the first years of life. These children pose a problem to parents who are able to pay for therapy, and who are very disturbed because the child is often aggressive, socially ignorant, and unable to form an emotional relation with their new parents.

Other clients are often juvenile delinquents, who are referred to therapy by the legal system while being incarcerated. Also, adult psychopaths can sometimes enter therapy trying to avoid more severe consequences of their acts.

In general the therapist should be aware that the Attachment Disorder (hereafter “AD” client) is not internally motivated for treatment, but will be referred by others who experience the social behaviour of the client as disturbing, incomprehensible or harmful.

Note: This chapter is a short introduction to the therapeutic implications of seeing the client from an attachment theory point of view. The interested reader is referred to: Rygaard, N.P.: Severe Attachment Disorder in Childhood, Fioriti 2007.

EARLY ATTACHMENT AND THE THERAPEUTIC RELATION

Following the hypothesis that early relations form the basis of the therapeutic relation, it is important to explore the early formation of social relations. This path has been explored by Bowlby and subsequent studies by means of the concept of “attachment”.

In brief, the theory of attachment was developed from 1950 by John Bowlby (Bowlby 1969, 1973, 1988). Bowlby suggested early attachment (0 -3 years) as an inborn behavior program in primates and especially humans. Bowlby’s main idea was that the attachment behavioral system had evolved in mammals to increase the likelihood of the infant’s protection and survival. This protection is mainly based on physical closeness and contact between mother and baby in the first few years. If proximity is disturbed or hindered, a number of characteristic behaviors appear in both parent and baby, such as crying, searching for the other, mourning, etc.

The system is thus activated by separation, and seems to be stabilized already at age one.

In “The Strange Situation Test”, Mary Ainsworth detected three characteristic reaction patterns (or strategies for proximity) when the mother left the room. Later a fourth pattern was detected. During this simple and ingeniously designed test, the mother and her 1-year old child are introduced to a lab room with interesting toys, the mother leaves the room twice for three minutes during the test, and the child’s reaction at separation and reunion is observed. These patterns seen at age one persist into adulthood for 70 % of the children, and they seem to be passed on from one generation to the next by the caretaker’s attachment behavior.

The four patterns are:

Secure/ autonomous.

The child reacts when the mother leaves, but explores the room after a while. When the mother returns the child seeks contact again and is soothed, and quickly starts exploring the room again. There is closeness and mutual joy in contact between mother and baby.

Avoidant.

The child apparently does not react to the absence of the mother and is consumed with handling the objects in the room. When the mother returns she also directs her interests towards the objects rather than the child. Studies demonstrate that the child is in fact very stressed by the absence and that this stress persists longer than in the secure child. The child seems to know that showing the

appropriate feelings of separation may lead to rejection, and therefore controls the expression of these feelings. A lot of energy is used to suppress the natural attachment reactions.

Ambivalent.

The child clings to the mother and at the same time can show anger or controlling behavior even before the mother leaves the room. The child does not explore the room but is preoccupied with the mother's absence, and does not resume playing activity after the mother returns. It seems to try to reassure itself of a proximity of which it is insecure. The attachment system is hyper-activated, leaving no room for the fulfilment of other needs.

Disorganized/ disoriented.

The child's behavior contains elements from one of the previous patterns, but the child doesn't respond to separation and reunion in any coherent pattern. It may "freeze" in a stiffened position, throw itself on the floor, cling to the mother and at the same time turn his face away from her, etc. This pattern has been found to be related with later personality disturbances and other problems. Approximately 15 % of all 1 year old children display the disorganized pattern. Some (but not all) of these children later develop attachment disorder.

It is remarkable that only the secure/ autonomous attachment allows the child to explore and engage itself in the environment most of the time. The three alternative patterns consume the child's attention and energy so much, that exploration and development is put aside in the attempt to recreate the secure base. As said by the Greek philosopher Archimedes: "Give me a place to stand, and I will move the Earth". A secure first relationship is the standpoint and prerequisite for experiencing life and development. Only if the child feels safe, attachment behavior is diminished and followed by exploratory behavior, which is so vital for engaging in play and learning activities, be they social or cognitive.

ATTACHMENT PATTERNS IN THE THERAPEUTIC RELATION

From the above paragraphs it is logical to understand the therapeutic alliance as interplay between the attachment pattern of the client and that of the therapist. In this brief summary, I give my personal interpretation of what I have seen in clinical practice to illustrate this line of thinking.

The Securely Attached Client

The client with a secure/ autonomous attachment pattern will usually enter therapy due to external stress, sudden life changes such as divorce, lethal disease or accidents, or a wish to explore or understand life events.

The client will have a realistic approach to therapy and the possible outcome, and will be able to cooperate with the therapist in a trustful manner. The client will be willing to explore his or her own past and present relations and reactions, and will have an appropriate critical sense towards the therapeutic process. Life events and relations are easily recalled and described in a realistic manner.

Emotional behavior will be adequate. The client will reflect much on the personal motives of self and others. The aim of therapy will often be to overcome stressful events and reorganize after a temporary crisis.

The Avoidant Client

The avoidant client will be very matter of fact and have considerable problems talking about emotional issues and memories, close personal relations and in expressing emotions. The client will often be aware of this problem. Often the client will idealize past relations, while repressing difficult early memories. The client will ignore severe experiences of loss.

The general impression will be a client who is tense and who often presents problems as causing stress, and be unable to rest in the moment, endure silence and cope with the uncertainties of therapy. The aim of therapy will often be to work through negative life experiences and reduce the fear of being close to the therapist/ others in general. During therapy, the client will often “forget” sessions or themes, or stop therapy if emotionally challenged.

The Ambivalent (Preoccupied) Client

The ambivalent client will be very demanding, and often be overly occupied with how the therapist perceives him or her instead of concentrating on personal issues. The client will have problems with low self-esteem, and try to please the therapist in a dependent-aggressive pattern. The client will be vague and unclear in describing emotional issues, will have problems “getting to the point”, and will often generalize problems to the point of meaninglessness. The client will often have vivid anger towards important persons in life, and feel abandoned and defeated by others. In conversation the client will often be disturbed by unresolved emotional conflicts and will lose the sense of proportion and direction. Thus, the structure of time and issues will represent a major problem to the therapist.

The Disorganized Client

The disorganized client will often interrupt a conversation abruptly, or have many sudden changes in focus. The client will perceive self and others very negatively and will not trust the intentions of the therapist. The client will project intensely and see the world/ others as the cause for any problem. The client will confuse self and others, and be poorly oriented in time and space, such as describing deceased people as if they were still alive (“She is...” about a dead person). The client will often initially identify completely with the therapist and apply the same manners and values, and the potential for therapy will often be overestimated in the initial phase, especially if the client is intelligent. However, the therapist will eventually understand that this identification only lasts as long as the therapeutic session and is not transferred to other situations.

Another variant of the disorganized client is the chronically negative, hostile and paranoid client who perceives the therapist as an enemy who should be controlled or destroyed, either intellectually (“hide and seek” games with the therapist) emotionally (devalue the personality of the therapist), sexually or physically (intimidating behavior). The client seems to perceive the environment in general as a potential danger and will do anything to obtain control.

The major problem of the therapist will be to maintain his or her feeling of proportions, personal value and to work on aggressive counter-transferences.

These attachment patterns will interact with that of the therapist in various ways. Some studies suggest (only concerning the first three patterns) that the outcome of therapy is best when the therapist has a pattern that differs from that of the client, which brings other viewpoints and life strategies into therapy than identical patterns do.

Approximately one third of clients with a disorganized attachment pattern have so chronic problems that they fulfill the criteria for the childhood diagnosis of Reactive Attachment Disorder (hereafter "AD"). The following text will concentrate on these clients.

ATTACHMENT DISORDER DEVELOPING OVER THE LIFESPAN

It is a major problem in studying AD that the lifespan development of the syndrome has been poorly mapped. Consequently, exactly what early stress leads to attachment disorder or even psychopathy is much discussed. There are only few studies of how early conditions can lead to the behavior described as AD syndrome, and this diagnosis is not used before age six. And there are only few studies describing when and if AD in childhood will also lead to psychopathy in adulthood.

Also, different disciplines have different causality paths in understanding disorganized and antisocial behavior (genetics, neurology, personality theories, social theories).

Genetic theories concentrate on the fact that some families have more schizophrenic and psychopathic members than others. Other lines in genetics concentrate on chemical imbalances in the brain, leading to problems in impulse control. Other lines again see antisocial behavior as a variant on the autism spectrum.

Neurological theories concentrate on brain deficits leading to antisocial behavior. The causes may be deficits developed in pregnancy or as a result of a lack of proper nutrition and care early in life. One branch (Schoore) studies early brain development as depending on maternal care, especially that the brain must learn to control emotion by external care and soothing from the caretaker.

Personality theory focuses on the early structuring of personality through the first relations with the caretaker (object relations theories).

Social psychology theories see antisocial behavior as the development of a social role in a group or a culture.

In this text only a probable overview of life development can be attempted.

In clinical experience, a child diagnosed with AD in school age will often have a variant of the following background events (this list is based on a study by the author (Rygaard 1988):

Problems during pregnancy, such as malnutrition, intoxication (maternal drug/ alcohol abuse), lack of oxygen, or brain damage.

Problems in the birth process: such as premature birth, small for age, brain damage due to complicated birth, low Apgar values, low birth weight.

Deprivation (as seen in some orphanages). A lack of consistent, sensitive care due to parental incapability (such as disorganized attachment patterns in the parents) in the first two years of life.

In clinical practice it is most interesting to study the client's life prior to age three, as the capability for attachment is founded during this period. Very often a combination of a neurologically fragile child and incompetent parenting is seen.

If this background is present and the child/ young person has the following symptoms from age six, the diagnosis can be made:

Reactive Attachment Disorder of Infancy or Early Childhood

- Beginning before age 5 and occurring in most situations, the patient's social relatedness is markedly disturbed and developmentally inappropriate. This is shown by *either* of:
 - Inhibitions. In most social situations, the child doesn't interact in a socially appropriate way. This is shown by responses that are excessively inhibited, hypervigilant or ambivalent and contradictory. For example, the child responds to caregivers with frozen watchfulness or mixed approach-avoidance and resistance to comforting.
 - Disinhibitions. The child's attachments are diffuse, as shown by indiscriminate sociability with inability to form appropriate selective attachments. For example, the child is overly familiar with strangers or lacks selectivity in choosing attachment figures.
- This behavior is not explained solely by a developmental delay (such as Mental Retardation) and it does not fulfill criteria for Pervasive Developmental Disorder.
- Evidence of persistent pathogenic care is shown by one or more of:
 - The caregiver neglects the child's basic emotional needs for affection, comfort and stimulation.
 - The caregiver neglects the child's basic physical needs.
 - Stable attachments cannot form because of repeated changes of caregiver (such as frequent changes of foster care).
 - It appears that the pathogenic care just described has caused the disturbed behavior (for example, the behavior began after the pathogenic behavior).

Specify type, based on predominant clinical presentation:

- Inhibited Type. Failure to interact predominates.
- Disinhibited Type. Indiscriminate sociability predominates.

DSM-IV 313.89

-- American Psychiatric Association DSM-IV Sourcebook, Volume III

In the following, I shall focus on the understanding of this behaviour as a function of early personality development. In therapeutic settings, the concept of personality is more meaningful and useful than for example neurological or genetic working models. Personality can be defined as a set of internal functions that allow the individual to function in a stable way and relate to others in social contexts.

PERSONALITY DEVELOPMENT: THE OBJECT RELATIONSHIP IS THE KEY TO THE WORLD. ACHIEVING OBJECT CONSTANCY

The following paragraphs are further developments of the inspiring papers by S. Blatt of Yale University (Blatt 1988) who has studied childhood causes of personality disorders. His interest is the notion that cognitive development depends on emotional roots, created in the first relationship to an object, the mother/ caretaker. We learn in a deeper sense *by heart*, i.e. the first emotional structures form the base of psychological functioning in general.

Normal sensory - motor development in a secure relationship will produce the unfolding of general psychological functions. Personality function is intimately connected with early concrete experiences of contact. The AD child is unable to form effective mutual relationships - because it can't clearly perceive (a sensory ability) and can't adequately respond (a complex motor activity).

From birth and on, the mother-child relationship is a protected area where the two constantly give each other feedback and attune with each other. In this protected world, stable concepts of the mother are formed. This is initially an emotional process which then develops into cognitive skills.

We receive millions of stimuli each second. How do we discern the important from the unimportant ones? Of course, we learn this by having an emotional center right in front of our eyes for the first year of life. This adds emotional "gravity" to some information and less to some. This is how we basically learn "how to learn". In the first years of constant communication with the caretakers, we constantly receive help to:

- *conceptualize*
- *focus*
- *recognize*
- *learn from experience*
- *concentrate*
- *communicate*
- *respond*
- *engage emotionally*
- *endure frustration*
- *build an emotional "working model of what a person is"*

These are basic skills for building stable concepts and a stable personality. AD children can be very intelligent or not, but these poorly developed skills will always be their Achilles heel. If you can only concentrate for a minute, don't know where to focus and how to maintain focus. If you are unable to recognize a situation, if you can't respond adequately, if you are only motivated for a short while, if you give up as soon as something is difficult, how can you learn in a deeper and more profound sense?

If you look at the normal child, having received proper early feedback, the baby can look at the mother for a few seconds, but her tireless response will create still longer periods of concentration. At age one the child can concentrate looking at her for perhaps a few minutes. At age three it can play with the same toy for perhaps fifteen minutes, in school it can concentrate on a book or play with a friend for half an hour, as a teenager it can keep a partner for several months.

The cornerstone of a simple function such as concentration has been stabilized in the first relationship with the caretaker and the function is then a general key to an ordered and sensible contact with the environment in general.

THE FIRST STAGES IN ACHIEVING OBJECT CONSTANCY

Object constancy means that emotions endure for longer periods. Stable emotions allow the baby to have stable intentions and ideas about what is important (internal concepts and goals). Stable ideas and concepts will produce stable, intentional behavior. Thanks to this development, the toddler can ignore random events in the present environment and stick to intention.

Basic object constancy develops particularly during the first three years of life. It passes through a number of developmental stages; the first two are most relevant for understanding severe AD.

STAGE I AND II: BASIC ATTACHMENT AND BASIC ANXIETY MANAGEMENT

Evocative constancy (0-6 months). Basic attachment.

Emotions are still evoked more by the presence of the mother. She becomes the emotional “figure”, everything else becomes “background”. Since perception is not very precise, the “mother” is not necessarily a certain person, but someone who communicates in the same caretaking way. The object relationship is being formed as a specific set of emotional reactions when the caretaker is near.

Border constancy (6-12 months). Anxiety management.

Now perception is more developed, the baby can separate “known” and “unknown” people, and remember the mother even though she leaves the room for a short while. Consequently, fear of strangers and fear of separation enter life. Emotions are insecure when new people are introduced or when familiar people leave.

Learning to perceive and focus on the mother helps the child organize tools for perceiving all future objects and people in the environment. The child will at first learn to separate the maternal gestalt from the background. A little later, he/ she will be able to perceive and concentrate on environmental objects all together (like a rattle), since she has now obtained borders - and figure/background constancy. The child examines the different aspects of the mother (eyes, mouth, hair, smell, movements, etc.) and learns to recognize them. She is now able to know whether she is held by her mother or by someone unknown. Consequently she reacts with fear and tears to

separation and strange people. A little later in development she will prefer well-known objects to unknown and have a need for repetition and recognizable surroundings. She now has constancy of recognition. In this phase the threat to the baby is the horrible fear when discovering for the first time that mother can 'disappear', and the baby can feel totally abandoned. This is something experienced by any toddler when being put to bed, but she will learn to control the fear if the parents can be empathic and make daily separations a gradual process, and not a traumatizing experience.

Again, perceiving the world depends on learning to perceive the mother in an organized way.

The creation of constancy is primarily an emotional process motivated by the mother (the object), and then unfolds as a cognitive ability, which is used to perceive *all* objects in the world.

Children who have not had qualified contact at these two initial stages will be poorly able to form meaningful emotional and conceptual working models of "the other" and personal relationships and they will frequently be diagnosed AD later in life.

AN EXAMPLE: POOR BASIC ATTACHMENT

When deprived in the first stage, the later child/ adult person will become schizoid and psychotically disorganized when frustrated, especially when close emotional contact is offered or and borders and limits are not clear.

The child will have little sense of borders between itself and the surroundings, be unable to organize impressions, and will often become symbiotic with the environment.

He/ she will not attach to you at all and only be aware of your existence when you are present, and will often only respond to direct touch. The child will have practically no self-awareness. The child will display many emotional reactions, but only from moment to moment.

We received Ann at age 11 from a foster family. The emotional contact had been stressed and the parents tried to evoke love, guilt and attachment. They tried to 'get as close to her as possible'. The fragile girl had reacted with psychotic episodes; setting the house on fire, screaming for hours, performing bizarre rituals, making strange noises, etc. We created a kind and invariable regime, telling her exactly what she should do and when, we preferred rules to emotional motivation. After a week she had improved and become a functioning AD girl. Now Ann was able to attend our on-site school, and only had short, non-involving, practical relationships. Towards strangers she was very charming and contacted anyone indiscriminately.

Ann had been abandoned by her mother immediately after birth. Her history was unknown until she was delivered to an orphanage at age two and placed with foster parents.

Another example:

James is twelve years old. His complexion is pale; his eyes are cold and observing.

He does not express emotion except when unpredictably enraged. In tests he is highly intelligent, yet when he experiences contact his behavior seems appropriate for a baby. This is a passage he wrote, describing a situation on the playground, "We were on the playground and then Brian took Thomas' skateboard and ran off and then I took it and ran away and then Thomas hit me with a shoe and then I took Brian's books and then Thomas took a shoe and went after Brian and then I

told Thomas I would take it from him and, but then he said he would throw it on me and then Brian told me to come over and then I did that and then I took a stone and hit Thomas and then the teacher came over'.

Clearly, this boy only experiences the moment-to-moment, and is unable to remember or anticipate other situations. The episode resulted in a skull fracture when he 'took a stone and hit Thomas'. James' mother, and later his stepmother were both strangled by his father before he was 2 years old.

AN EXAMPLE: PARADOXICAL ATTACHMENT AND POOR ANXIETY MANAGEMENT

If deprived mostly in the second phase, attachment will form during multiple states of panic anxiety (if the parents are violent, unpredictable, sexual abusers, neglecting). On one hand the child will be totally dependent for care; on the other hand the parent will represent a threat by being too violent or otherwise disrespectful of boundaries and limits. Any contact will therefore become very ambivalent. The sense of borders (you/ me) will be compromised. Consequently, the child will often become paranoid (believe that its own hostility is coming from the outside). The only safe relationship will be to hate the object; this assures contact and distance at the same time.

The child will project unbearable hostile and depressed feelings onto others and experience these feelings as being directed towards itself, 'I know you hate me - you're only 'kind' because you are too weak, and such a coward that you can't even scold me!' When offered contact he will alternate between searching for contact in an obsessive way, only to reject or destroy the contacting person in a split second. He will hate anyone who attempts intimacy. Intimate contact elicits withdrawal/ rejection. He will persistently adhere to details or arguments that are not part of a meaningful whole. He will ritualize stereotypical meaningless behavior. The child will enjoy 'trapping' or deceiving you or, entangle you in endless discussions about your reasonable demands. He will chronically perceive you as hostile. The child will not be able to remember you or your directions for any length of time. The child will alternate between defining itself in extremely negative or omnipotent terms ('balloon ego').

The primary defense mechanism of this stage is 'splitting'. Any experience or emotion will be intense and will mobilize counter-emotions which will be difficult to endure. The child is vulnerable to complexity and border phenomena (is this 'me' or 'the other'?), and reacts by reducing the difficult graduations by dividing everything into antagonistic pairs, such as good/bad, strong/weak, me/others, mine/yours.

Jealousy can be a predominant emotion, caused by the perceived danger of a possible loss if the "mother's" attention disappears. The children trapped in this phase often perceive you as alternatively totally nice or totally evil depending on the situation. They can't unite these two perceptions into one, a realistic idea about you as a person having both qualities at the same time. They often develop sadistic and hyper controlling contact patterns and have difficulty recognizing strong emotions as their own. One variant of this pattern is the 'Münchhausen by Proxy' syndrome, where mothers project their chaos and pain onto the baby, repeatedly hurting it (in accordance with their own unconscious experience of pain), and insisting that something is wrong with the baby, taking him to numerous hospitals. If the mother is suicidal, she may kill the baby. She will

experience herself as being free of pain and symptoms by projecting them onto the child (projective identification).

Charles (ten years old) arrived (after attending numerous schools and institutions) at our institution during a lunch break. He stands seething with anger and suddenly yells at me: "You can't force me to eat, fuck you!" I answer, "Charles, nobody will force you to eat... if you want to eat, there is food on the table. After one o'clock, the food will be taken away", and he replies, "You idiot, you can't force me not to eat either!"

One minute he is extremely compulsive and everything must be in its proper place. The next minute he will destroy his room, his belongings, or start a fight. In class, he is met by his new teacher, Iris. At their first meeting, she kindly says to him: "Hello, Charles – could we write a list about why you will hate me today?" They do this and create a 15 item list. Next, Iris asks him to list how he will sabotage the school lessons; this adds up to 12 strategies. Next, Iris says, "Well, let's start then, shall we?" For over a year, Charles faithfully reproduces the two original lists. Iris is always kind, she never gives in, she never scolds him and she takes any decision needed. After the first year, Charles has accepted the inevitable; Iris is much stronger than Charles (proved through many tests on his behalf) and virtually impossible to provoke. He is now able to work during class and rises quickly to a cognitive level appropriate for his age. He is enrolled in a normal public school while continuing to stay with us.

Another example:

Frederick is nine years old. His mother suffered from a perinatal psychosis and experienced intense feelings of guilt from this. Consequently she still tries to treat him as a baby in a symbiotic style. When he arrives at our institution he has never tried to dress himself. She anticipates all of his "needs" and cannot separate from him. She is very confused whenever he shows the slightest sign of frustration. When asked to "draw a person", he paints his mother so large that her figure completely covers the paper. In the corners he draws knives, saws, etc. Apparently his conduct is impeccable, but eventually girls in the unit begin to experience "accidents". After a while he tries to involve the other children in his plan to murder the kindest staff member (i.e. the most dangerous person to him). The treatment is often disrupted by his mother who keeps him home after weekends. She says she "is unable to live without him". After one year he is so overtly aggressive that he must be placed in a foster home with one experienced single male staff member. However, his mother takes him back home, and two years later he has stabbed a "girlfriend".

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Children who remain in these two first phases do not experience and resolve internal conflicts sufficiently. In the terms of Freud they have not succeeded in building an effective, flexible super ego function. Lacking this skill for social adjustment, they have so many more *social* conflicts. Internal conflict resolution is not an option. Instead, any frustration is attempted to be resolved by an effort to change the environment, not the child's own behavior. Everything is "your fault", because the child is only vaguely aware that it can be the cause of any conflict.

Children who remain at these levels of constancy development will usually meet the criteria for "Attachment Disorder".

If the child is disturbed in the third and fourth phases, we are in more familiar territory regarding therapeutic methods and frames of understanding the client.

STAGE 3 AND 4: BASIC INTERNALIZATION OF THE PARENT AND BASIC SOCIAL CONSTANCY

Internalization constancy and identity (12-36 months).

The toddler effectively internalizes the emotions and moral attitudes of the parents. The child becomes aware of itself as a separate person and creates situations to grasp ‘my impact on the environment’. Now the resolution of internal conflict, my needs/parental wishes, gradually becomes possible, and the child experiments with ways to fulfill both. Unresolved internal conflicts will produce feelings of guilt. The absence periods of loved objects are coped with by repression; in order to be able to function without grief, the child can to some extent repress the temporary loss of the object by emotionally ‘forgetting’ the person until he or she reappears.

Social role constancy (36 months – 6 years)

The preschool child experiments with relationships to other children and adults, creating an independent social identity. Depending on the coherence of feedback, the child will realize that different groups have different rules and demands for behavior. The child compares itself with others and finds a position in social hierarchies. A social self is created along with a set of personal characteristics (e.g. ‘I am good at basketball’).

CONSTANCY OF THE SELF AND TRAUMATIC SEPARATION EXPERIENCES

Traumatic separation experiences in the third phase where the toddler learns to remember the mother when she is not present, can produce a deeply insecure child searching for safety, avoiding responsibility and lacking curiosity and courage to meet challenge. Emotionally, the traumatized child interprets even minor necessary separations as rejections (“I am not worthy of love’). Initially the child will idealize you or be submissive when offered contact in order to prevent an anticipated rejection, and be very vulnerable to demands. He will reject you at the slightest disappointment, be possessive and jealous towards your other contacts, and remind you frequently that you put him down. The child will often start minor conflicts with you in order to reaffirm itself and to test the relationship. The child will describe itself as abandoned, sad, alone, missing someone, being without value, useless, and depressed. In severe cases the child can be suicidal.

He may have aggressive fantasies about an adult, but will usually be timid and never carry out what he threatens to do. The child will be dependent and resort to dependent regression if you are kind. He will often be narcissistic, constantly seeking positive feedback and reassurance in a compulsive manner. The child may remember its parents and will have loyalty problems towards parents when feeling attracted to the care of a therapist.

One defense/survival mechanism in this phase is creating 'the blind spot', repressive denial. The toddler survives separation periods by eradicating the memory of the mother from conscience. If you have been away from your child for too long in this phase, you will probably be ignored on your return. False cynicism, ignoring a loss like 'who cares if you come and go - love me or not - I don't love anyone' is a common reaction. The need for soothing the effect of painful, traumatic separation experiences and the loss of self-value will often produce an adult alcoholic or drug abuser. When treating addiction problems, denial and guilt is always the primary problem because these were the client's only successful survival strategies in childhood.

If deprived in the fourth phase, the child will often have a negative personal and social self-concept and have difficulty finding an adequate social role and identity. He will respond to care and involvement by quite quickly catching up with normal development. The child will be afraid of losing you, or afraid of your anger and sometimes punish itself. It will have illusions and dreams about redemption and reunion. It will sometimes display false cynicism as a protection against the disappointments of becoming involved.

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With these children (stage 3 and 4), we are talking about attachment *problems or trauma*, not about severe AD. They are accessible to therapy and personal involvement because they have developed to a constancy stage where they can transfer their emotional involvement to other people thus allowing others to be compensating parental figures. They can stay in and overcome their fear of engaging in a relationship (albeit have many defenses and second thoughts). This makes them accessible to involvement, play therapy and psychotherapy. These children are very much aware of having personal problems and in the long run are able to accept help and comfort and attach to therapists or foster parents. This is because they have developed a superego in the attachment process. They will be prone to excessive internal (neurotic) conflict due to a low self-esteem, in contrast to the AD child only having social conflicts. They also develop meaningful compensations for their fear of being unloved and later in life often produce staggering achievements in different disciplines (sports, science, etc.).

They are developed to a point beyond the scope of this text.

EMOTIONAL AND COGNITIVE DEFICITS WHEN ARRESTED IN STAGE 1 AND 2

There are six characteristics in the arrested cognitive and emotional personality organization of the AD child that can be related to Blatt's model of the interwoven emotional and cognitive development. These characteristics are general problems that all children have at an early age while organizing a system of conceptualization. In the AD child however, they persist to a degree hindering social function. You should understand these characteristics in a broad sense, applying them not only to cognitive, but also emotional functioning since their roots originate in early attachment. A low ability to discriminate is their common denominator:

CHECKLIST FOR THE AD PERSONALITY FUNCTION FROM PRESCHOOLER TO JUVENILE:

(Normal early childhood problems that persist in the AD child)

1. Sense of proportion in time, space and emotion

The child is unable to anticipate dangerous situations and decide whether an event or action is a minor event or a serious violation. The emotional reaction is the same, whether a subject is important to the caretaker or not, whether the child is hurting or killing someone or just spills milk from a cup, etc. The emotional deficit will often result in cognitive problems; a child may jump from a fence or from the top of a tree, because he lacks the ability to recognize the difference between 6 inches and 60 feet. The effective time span is short; he can remember and pursue an intention for only a few seconds or minutes.

2. Discerning reality as opposed to internal fantasies/ wishes

The child is unable to judge or to be aware of whether a feeling, idea or thought comes from within itself or from the surrounding environment. The child has a very rudimentary reality base. Random movement from truth to lie deludes itself and others. Major problems are ignored; minor problems are regarded as disasters. The child only vaguely senses whether something was experienced by itself or by others.

3. Conceptualization of the whole, elements of the whole, and their relationship

The child can only do one thing at a time, and can barely see the context, how the single action fits into the whole. When concerned with the whole, details or important elements are ignored, forgotten or blocked out of conscience. Self-esteem moves from 'Superman' to 'nobody' often and quickly ('balloon - ego'). Emotions are absolute, not relative (no doubt, second thought, guilt, anticipated fear, looking forward to something, etc.).

4. Figure and background

The child can't concentrate on any figure or feeling for very long, doesn't search for different aspects in the same object, but has a one-dimensional perception. The child shifts attention to any new, moving, spectacular or noisy object or person. It has poor recollection of feelings or events. He does not have a personal point of view but, like a sponge, absorbs anything and imitates it back.

5. Discrimination

The child reacts with fight/flight/ freeze whenever the external structure is not absolute, simple and detailed.

He prefers one-step directions and is confused by choices, responsibility and decision making. The child does not know one adult from another; remember names, faces, shared emotions or events. Can't estimate distance, height, speed, time, space very well, or recall emotional details about a person.

6. Reorganization

When the normal child has gained control over many elements and simultaneous processes, he is able to 'juggle' elements, e.g., count backwards, see an event from more than one side and understand another person's point of view. He or she can reorganize elements into a new whole, can plan and be flexible even during changes in the environment. The AD child will be rigid and inflexible, unable to cope with change, unable to have multiple viewpoints and not be able to see things 'from your side'. He will have perfected a few primitive behavior strategies and will use them repeatedly to solve any problem, even when they fail to obtain the goal or produce the desired outcome. This child will often have perfected behavior patterns in known situations with only a few variables. Increasing complexity in a task will result in quickly rising ratios of failure. The child is a

virtuoso when juggling one element and an amateur with two. It will function much better when alone with an adult than in larger groups since it can still only cope with a mother/ baby relationship.

AD AND THE THERAPEUTIC SETTING

From this point of view, it is obvious that treatment can't be limited to therapeutic sessions. Therapy must be inherent in the general environment of the client. A large part of the therapeutic work is therefore to work with those in custody of the child, be it adoptive or foster parents or the institution. The therapist must aim to create understanding of the AD syndrome in all persons who are in custody of the child, giving a balanced view of the child's possibilities and limitations.

If the child is under five years, regression therapy should be recommended, aiming towards a re-establishment of the potentials for attachment. If the child is older, therapy should be directed towards creating a stable and safe environment for the child (Milieu Therapy).

In the final paragraphs, I shall try to describe the very difficult process that the therapist will go through when encountering clients with reduced potential for entering a productive social relation, and what I see as the role of the supervisor.

DEVELOPMENTAL PHASES OF THE INDIVIDUAL AD WORKER AND OBJECTIVES FOR THE SUPERVISION PROCESS

Based on my experiences in supervising people of various professions and family members, there seems to be some common traits in the personal development of those who stick to the task long enough to be transformed by it. Usually the personal development process will take 2-5 years. Some characteristics of the personal maturation process are described below.

STATE OF THE MAGIC WAND

You meet the child without having previous experience of AD. The reactions to the child's problems are: to reinforce your normal social contact strategies behavior and your knowledge about normal personality and attachment development. You do the natural thing: you try to make a deeper contact.

This very natural impulse challenges the low emotional capacities of the AD child, eliciting fight/ flight or manipulation or withdrawal from the child. In this phase denial of the child's problem, finding excuses in other circumstances (his parents are SO bad!), or fantasies of personal therapeutic omnipotence are common. Such as: "I'm the only one who understands him, nobody else does! I'll get behind his shell to his heart with *my* method", etc.

Your general working model of "the other person" is crumbling and your self-concept is threatened. In normal social relationships, we uphold our self and identity helped by normal feedback, and when we get confusing feedback from a person, our sense of self is disturbed.

This state can last for years if your capacity for emotional involvement or professional orientation is a strong part of your identity.

You cope with (or get surprised by) single incidents and contacts. Old personal attachment trauma may be the drive of your efforts, and consequently the healing of the child becomes your “life or death’ project, since it is really an effort also to heal your own early experiences. You see yourself-in-the-child, and not the child as it is. The child quickly realizes that it can control you by responding to - or denying response to - your narcissistic need for external reconfirmation and success.

OBJECTIVES FOR THE SUPERVISOR

If you are a supervisor for a primary contact person in this state it is necessary to show full acceptance of the “working model’ of that person and pay respect to a life strategy which has worked out so far. You may enter a mapping process of the early experiences and how the persons own working model was created. The supervisee can make a diary concerning the outcome of various contacts during the day with the child.

The supervisee will often be very projective, i.e. almost obsessed with what the child is doing, thinking and feeling – and not very aware about what he or she herself is doing, feeling or thinking as a professional. You may gently turn the persons attention to a regular observation of his or her own reactions, and try to stretch the persons time perspective by pointing out patterns in the child’s and the supervisees contact .

You may point out that it is natural to experience anxiety when your basic notions are at stake. As a defense mechanism, the supervisee will often feel that “You don’t understand this child/ don’t see his capacities’, which means “I’m afraid that you don’t understand me’. The supervisee can alternate between helplessness “Tell me what to do, you’re the expert’ and rejection of the supervisor “You told me to do this or that, and it doesn’t work at all – you’re the one who is incompetent!’.

At this time, you should provide a secure and accepting environment for the supervisee who will be very vulnerable in the transformation process of revising basic notions and self-concepts.

STATE OF REALITY DEPRESSION

You begin to think that all your efforts are in vain. In fact, whatever you try only seems to make things worse. You take over the defense mechanisms of the child without knowing that it is happening (denial, rejection, splitting, projective identification, low self-esteem, incompetence, abandonment, etc.). This may be detrimental to your social relations (colleagues, family, others in care of the child, spouse, etc.), and you may become over-responsible, suspicious, reject external support and care, have numerous conflicts because you feel let down and misunderstood by others. Your negative feeling towards the child may be projected towards others in order to maintain the relation to the child. Various camouflages are used to avoid the basic feeling of self-pity and abandonment.

This is a crossway where some give up in order not to break down. That's OK. The child will not profit from seeing you go down. Just remember to tell the child that "I am not strong enough to be your parent/ therapist, and I will find someone who is". Don't use the child's behavior in that explanation.

One variant of feeling incompetent is the fantasy "There must be some therapeutic God out there who can heal him when I fail", and a quest for the miracle starts. In this phase you are an easy victim for illusionists who are after your money or your admiration and dependency – or both. And of course, there are some who just want to offer their professional help.

Those able to endure this frustrating period have begun realizing the true capacities of the child and succeed in separating their own emotional needs from those of the child. You start foreseeing the child's pattern in contact rather than feeling 3 steps behind, and you may live through the grief of realizing the child's handicaps in a process of active resignation. This means on the other hand that the real capacities and useful working points will stand out clearly – how you can help the child develop on its own terms in some areas.

OBJECTIVES FOR THE SUPERVISOR

Here you must help the person make a realistic evaluation of whether he or she is able to work with AD children, and eventually explore how the person can use capacities elsewhere. You should plan a thorough evaluation process in order to avoid a sudden desperate decision followed by guilt and inferiority feelings. If the person is an adoptive parent or foster family member, the issue may be the child's placement in an institution in order to save the family as such, or marital conflict issues triggered by the behavior of the AD child.

In the resignation process of the supervisee, your authority will often be challenged, and the person may look for other authorities presenting more optimistic prospects. At the same time, the supervisee should be made aware that he or she is beginning to develop professional views and the ability to master many situations with the child. You should guide the person into summing up where basic notions of personality have changed, how the person has become able to foresee the outcome of different interactions with the child (what works and what doesn't), and how the separation process ("The child and I are two different persons") causes both relief and sadness.

GAINING AUTHORITY AND INTERNAL REORGANIZATION

You start understanding the child and to be with it without identifying emotionally with it. You are able to tolerate the slow development of the child and respect it.

Consequently you are of value because you become a stabilizing factor. You easily recognize who in the environment are of value to the child and who are too immature. You start studying AD as a subject in general and gain knowledge. You dare follow your intuition. You realize that you have changed as a person, and probably your social network as well has been altered. You work systematically and use your experiences to improve your efforts, and you operate with a longer time horizon.

The quality and outcome of this personal development process of course depends on your access to a social network, supervision and dialogue on the way. However, the time needed will not be changed much. Personal professional development just takes time and working experience.

OBJECTIVES FOR THE SUPERVISOR

Due to the former maturation process of the supervisee, you are now at liberty to focus directly on professional development without being disturbed by basic emotional conflicts. You may help the person develop his or her professional and emotional style, explore aspects of therapy and find the personal integration of different theoretical and practical methods. It can be a good idea to let the person sum up experiences in writing and present them in a professional forum. You should acknowledge the supervisee's competences and help the person detach from you by encouraging his or her own professional judgment without your comments.

In the adoptive/ foster family, you may support the creation of "our history as an adoptive/ foster family'. What happened in the family before we met the child, what happened to us just after meeting the child, and how did roles, network and personal values change in the process? Who are we today, and what did we learn about attachment and social interaction? In these sessions, siblings should participate, and special attention should be paid to help them express how living with an AD sibling has affected their lives, and what coping strategies they have developed.

CONCLUSION

Working with AD children and youth is a challenging task for the therapist, and the understanding of this syndrome is a challenge for further scientific studies. I hope to have given the reader a short introduction to my experiences with AD clients.

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