

**ATTACHMENT PROBLEMS**

***and***

**CONDUCT DISORDERS**

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# **THE ATTACHMENT PROCESS**

# ATTACHMENT

ATTACHMENT BETWEEN A CHILD AND HIS/HER PARENT(S) IS A RECIPROCAL, PROFOUND EMOTIONAL AND PHYSICAL RELATIONSHIP WHICH SETS THE STAGE FOR ALL FUTURE, INTIMATE, TRUSTING RELATIONSHIPS. UNDER OPTIMAL CONDITIONS IT IS A NATURAL OCCURRENCE WHICH IS GENETICALLY PROGRAMMED AND ENSURES THE SURVIVAL OF THE SPECIES. IT IS FOUND NOT ONLY IN HUMANS BUT ALSO IN THE ANIMAL KINGDOM. ATTACHMENT ENSURES THAT WHEN A VULNERABLE BEING EXPERIENCES TENSION CAUSED BY NEED OR FEAR THAT IT WILL SEEK THE PHYSICAL PROXIMITY AND COMFORT OF ITS ATTACHMENT FIGURE. IT DEVELOPS AS A RESULT OF PREDICTABLE AND RELIABLE RESPONSES FROM PARENT FIGURES WHICH PROVIDE AT LEAST REASONABLE SATISFACTION FROM THE TENSION CREATED BY THE NEED.

(Bowlby)

## **Setting the Stage for Bonding**

The stage is set for bonding between parents and child during the period between the child's conception and birth, called the prenatal period.

During this period, parents begin to develop images of what the unborn child will be like.

They form expectations and hopes for their child, for themselves as parent(s), and for their relationship with their child.

The relationship between the child's parents during pregnancy also affects the bonding that will occur with the child.

The kind of parenting the parents themselves received strongly influences the kinds of images that they will develop of their child and of themselves as parents.

The characteristics of the infant **in utero** and the way the mother perceives them affects the bonds that will develop.

## **Claiming process**

Direct bonding between mother and child begins during the very first moments of the child's life.

During the first hour of an infant's life s/he is wide awake and eyes are wide open (Desmond). After this, the infant falls into a deep sleep.

Most mothers use their first contact with the child to **explore** him/her, to count fingers and toes, and to check whether s/he is physically "normal".

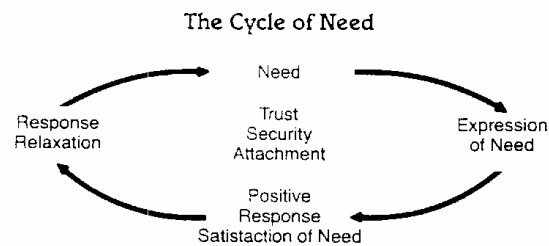
When a newborn infant is held horizontally, s/he reflexively turns the head toward the person who is holding him/her. The mother is pleased when the infant looks at her. She tends to gently caress the child.

During this exploring the mother is consciously and unconsciously looking for ways to tell her child from others.

When the mother doesn't take an active part in this claiming process the family is at high risk for severe parent-child difficulties.

## THE ATTACHMENT CYCLE

Attachments are reciprocal and frequently cyclical interactions that can be observed in the relationship that develops between parent and child. For example, a cycle of need is initiated by the infant when they express hunger by fussing or crying. If the parent then responds to the need by picking up the child while fixing the bottle, by holding the child while warming the bottle, and by continuing to hold, stroke and talk to the baby during feeding, the cycle will continue as the baby responds by relaxing, smiling and cuddling into the parent's arms or body. The experience should be pleasurable for both. This mutual pleasure helps insure that the next time a need occurs the parent(s) will most likely respond in the same positive way.



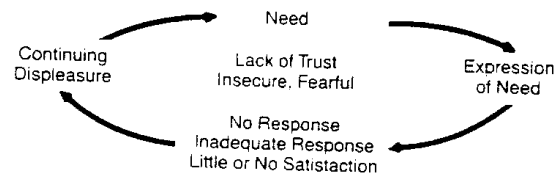
After the cycle has been successfully completed several times, the child will develop a **sense** of security and trust and will become positively **attached** to the person completing the cycle. Positive responses are required from both the child and the parent for both to attain satisfaction.

### Results of successful completion of these cycles:

- \* children develop a feeling of self-worth
  - \* children develop confidence in themselves
  - \* children develop a strong sense of identify
  - \* children develop trust in relationships
  - \* a sense of responsibility for maintaining connections develops
  - \* children learn to acknowledge their role in consequences
-

Unfortunately, many children have not had many of their needs met. The cycle may not have been successfully completed a sufficient number of times for the child to expect positive interventions in response to expression of need.

In some families in which abuse or neglect has occurred, the child might have been ignored when hungry, or may have been slapped, or may have been given an inadequate substitute for milk.



**Results of unsuccessful completion of attachment cycle:**

- \* lack of trust in others to meet needs
  - \* little security (endures a great deal of fear and worry: wonder who will take care of them; fear they cannot meet their own needs; may fear that their survival is threatened)
  - \* lack of attachment
  - \* difficulty accepting responsibility for actions (exhibit delays in conscience development; have difficulty telling right from wrong)
  - \* blaming environment and circumstances for outcomes
  - \* experience chronic anxiety
  - \* may exhibit symptoms similar to those of children with minimal brain dysfunction (hyperactive; easily distracted; impulsive; subject to extremes of emotions; learning disabilities)
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## ATTACHMENT: SUMMARY

**Attachment** - Initiated by a set of organized behaviors on the part of the child designed to regulate the proximity of the primary caregiver.

**Function of attachment** - Protection/survival

Attachment behaviors serve an evolutionary function through maximizing the likelihood of survival by keeping the parent/caregiver nearby for protection and nurturance (physical and emotional).

**Caregiver response** - determines the internal representational models for the child for such issues as trust, self-worth, etc. The child develops "expectations" of others based on his/her earliest experiences.

Early attachment experiences serve as a **prototype** (model/pattern) for relationships. The infant draws conclusions about the way people relate based on their caregiver's responses to behaviors designed to seek attachment. These conclusions become part of the infant's **internal working model**, and s/he then uses this belief system to interpret the actions of others and to mediate his/her behaviors.

Subsequent behaviors are designed to prove the internal theory. Thus, the beliefs in the internal working model often become **self-confirming** and attachment patterns are self-perpetuating.

Adults **do not** form attachment bonds **to** their children! (...except in rare and unhealthy cases.)

Adults form affectional **bonds** with their children.

It is inappropriate for adults to look to their children to be their "attachment figure(s)!"

# CAUSES OF ATTACHMENT DISORDER

- **PARENTAL/CAREGIVER CONTRIBUTIONS**

- Abuse and neglect
- Depression
- Psychological disorders
- Substance abuse

- **CHILD CONTRIBUTIONS**

- Difficult temperament
- Pre-maturity
- Fetal alcohol syndrome

- **ENVIRONMENTAL CONTRIBUTIONS**

- Poverty (long work hours)
- Stressful and violent home
- Stressful and violent community

- **"SYSTEM" CONTRIBUTIONS**

- Multiple out-of-home placements

- **PROLONGED SEPARATIONS FROM THE PRIMARY ATTACHMENT FIGURE**

- Hospitalization
- Prison
- Postpartum depression

- **INTERGENERATIONAL TRANSMISSION**

Sometimes referred to as the "pyramid effect". Children with disordered attachments commonly grow up to be parents who are not able to create a secure foundation with their own children. Instead of following the instinct to protect, comfort, and love their children, they abuse, neglect, and abandon.

With each generation there is a multifold increase in the number of children with attachment disorder (Levy, 2000).



# **ASSESSMENT**

# ATTACHMENT PATHWAYS

## **Secure Attachment**

The child with a secure attachment has an internal working model of a parent or caregiver who will provide protection, comfort and nurturing. The relationship between the parent and child is intimate, reciprocal and unique. The physical proximity of the parent is reassuring to the child. The child uses the parent as a secure base from which s/he explores his/her universe. The process of exploration assists in the development of competence and mastery. When the exploration becomes too stressful, the child returns to the secure base of the parent.

## **Anxious Attachment**

The child with an anxious attachment clings to the parent or caregiver, too fearful to risk the separation inherent in exploration. The child has no internal working model of a parent available or willing to provide protection, comfort or nurturing, and the drive to maintain physical proximity is intense. Exploration and play are constricted as are the development of curiosity, competence and mastery. Continual seeking of the parents and the ongoing wish for comfort and care are coupled with fear and anxiety regarding this relationship.

## **Impaired Attachment**

This child has no history or memory of an available attachment figure. S/he has no sense that anyone will provide protection, comfort or nurturing. The child seeks and demands possessions rather than relationships and intimacy. S/he may actively reject care-giving overtures from parent figures. Positive and negative attention are neither distinguished nor valued. Displays of affection are shallow. Exploration and play are fleeting, random and without pleasure. Separation from parent figures causes little distress or response. The child enters new situations with little overt tension. S/he appears to have -given up on the notion of emotional reciprocity.

### **Features of impaired attachment:**

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### **Disorganized-Disoriented Attachment**

These children are seen to be at most risk for developing severe problems with aggression. Disorganized attachment refers to a lack of, or collapse of, a consistent or organized strategy to respond to the need for comfort and security when under stress (Main & Solomon, 1990). Disorganized infant attachment has been found to be associated with unresolved loss, fear, and trauma of the parent(s). Mothers of disorganized infants typically have histories of family violence and abuse, rather than neglect alone (Lyons-Ruth, Alpern, & Repacholi, 1993). These mothers are "out of sync" with their babies, displaying confusing and mixed messages (e.g. extend arms toward infant while backing away) and inappropriate responses to their infant's cues (e.g. laugh when baby is in distress). These mothers show high levels of negative and downcast affect to their babies and low levels of tenderness and affection (DeMulder & Radke-Yarrow, 1991). Thus, disorganized attachment is transmitted intergenerationally: parents raised in violent, frightening, and maltreating families transmit their fear and unresolved losses to their children through insensitive or abusive care, depression, and lack of love and affection. **The infant is placed in an unresolvable paradox: closeness to the parent both increases the infant's fear and, simultaneously, need for soothing contact. Closeness and contact with the parent triggers fear rather than safety or comfort** (Lyons-Ruth, 1996; Main & Hesse, 1990).

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"These are the children of rage  
and rebellion who are forever  
biting the hand that didn't feed  
them.

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(Brendtro and Long)

## **SPECIFIC BEHAVIORS OF CHILDREN WHO LACK ATTACHMENT**

Specific behaviors exhibited by children who lack attachments are similar to those found in children who do not trust others. Some of the behaviors that will be described not only reflect lack of attachment but also the efforts of children to keep adults at a distance.

The following behaviors may be a result of lack of attachment, child abuse or neglect, effects of the trauma of separation, or a combination of all three factors influencing the child's behavior:

### **Lack of reciprocity**

Children do not seem genuine in their expression of affection. Others may feel that they give and give to the child without it seeming to matter. Children who do not experience a healthy give and take in their first relationship(s) may not be able to experience it in others. Often avoid reciprocal smiling response.

### **Aggressive Behaviors**

These behaviors may be designed to keep adults and others at a distance. If children continually have tantrums, adults may lessen demands. Aggressive behaviors may also reflect what the child has learned from the parents. It may also be a response to the inability to handle fears, frustration or anger. These behaviors may be a way to assert control over a world that is unpredictable. It may be a way of working through the anger of being separated from their parents.

### **Control Battles**

Lack of trust in others may indicate that the child needs and wants control and fears dependence. Anxiety felt by the child may make it difficult for them to comprehend limits and to abide by them. For the child who has been abused, especially if the abuse is erratic or inconsistent, a need to control the environment will develop in the child. The power struggles characteristic in abusive families and the child's lack of power may contribute to the child's need to win control issues. Although attempting to exert control, these children may feel they have little power over the events in their life. Mutual dependence indicates a willingness to trust and these children may lack the ability to enter into a trusting relationship. For the child who is grieving the loss of parents these battles may be a way to regain control of some aspect of their life.

## **Chronic Anxiety**

Children who do not feel secure about being cared for and who do not feel worthwhile will exhibit a great deal of anxiety. The child who lives in an abusive, unpredictable household will also be anxious and fearful. Children who experience traumatic losses, including moves without preparation, will also display a high level of fear. The chronically anxious child is often fearful and clinging. These children frequently have night terrors and may perseverate about their worries. Such children may become overly dependent on others. They may try very hard to please, and this behavior may be interpreted as insincere. If children cannot follow through on commitments that were made to win acceptance, their gestures may be dismissed.

## **Delayed Conscience Development**

Children with this need may not have been helped to learn right from wrong. They may justify their behavior in terms of survival or self-preservation. They may believe that they are just treating others the way they have been treated. They may have a difficult time discriminating between fantasy and reality; lies may become new versions of the truth. Such children often demonstrate little or no remorse or anxiety when caught, and may deny misbehavior in the face of the evidence. Children with delayed conscience development may perceive that trust and truth are not valued or important. Lying, stealing, and destructive behaviors may also be expressions of anger. Children who display this behavior may believe that they cannot get their needs met through legitimate means, so they must resort to manipulation, dishonesty or devious behavior. A combination of survivor's and victim's mentality directs and justifies the actions of these children. They may believe that whatever they have to do to survive is okay. They also may justify actions based on their belief that they are only doing what was done to them.

## **Indiscriminate Affection**

Children who display this behavior may hug, kiss and demonstrate affection to people who are virtual or complete strangers. These displays of affection may have a seductive quality about them. The intent of such behavior may be to prove that no one adult is more important than any other, or that people are interchangeable. Children who are sexually abused often acquire such behavior following its reward and reinforcement by the abuser. Children who are indiscriminately affectionate may go off with strangers or may allow adults to take advantage of their displays of affection. These children may have a strong need to please everyone.

**Lack of Self-Awareness**

Children who display this behavior may be unaware of their own bodies, as well as their physical and emotional needs. They may either gorge on food or water, or they may ignore the signals that they are hungry. These children may wet the bed because they do not pay attention to the discomforts of their own bodies. They may be unresponsive to pain and to extremes in temperature. Such behaviors may also develop in children whose parents did not meet their needs in infancy. Sometimes in situations of abuse or neglect, parents meet their children's needs intermittently or only when convenient for the adult; therefore, such children often do not recognize their own needs. These children do not learn the basic pattern of cause and effect and do not learn to anticipate relief following feelings of discomfort. Their expression of needs may be confusing to them and the adults that care for them because they have learned to suppress or ignore normal needs such as hunger or pain.

**Primary Process Lying**

Child gives presentation of wishes as facts regardless of contradictory evidence or confrontation.

**Over-Competency**

Children exhibiting this behavior seem to prefer to take care of themselves and don't need the care of parents. They frequently attempt tasks beyond what would normally be expected for their age level. Although this behavior may seem desirable, it creates barriers to closeness and to a positive relationship with parents or other adults. This self-parenting child does not provide a parental role to the parent. This child frequently assumes the parental role over the parent and may also take on the responsibility for younger children in the household. This behavior may also be seen in children who are resisting giving up their attachment to parents subsequent to a move. For the foster or adoptive parent who desires the parenting role, it may be difficult to cope with the rejection of positive interaction and efforts to meet the child's needs.

**Impulse Ridden**

Unable to tolerate any delay in gratification

**Fearful or uninterested in the future**

## **Dissociative Reactions**

In some children, a literal blanking out to escape from moments of overwhelming pain or terror.

## **Poor Eye Contact**

Eye contact is one of the first signs of attachment between parent and child. Initially, infants focus on the face and eyes of the parents. The eyes seem to be a central focal point. Some children in foster care are surprised that adults want to have eye contact and may feel self-conscious about face-to-face contact.

In abusive situations in which there has been a struggle for control, the child may have been discouraged from making eye contact. In a household with family violence or an emotionally disturbed parent, the child may have tried to avoid notice or may have feared that eye contact would be interpreted as challenging behavior.

In some cultures, lack of eye contact may not indicate a lack of attachment but it is a sign of respect for the child to avoid direct contact with the parent's eyes, especially when the child is being disciplined.

The sidelong glance used by some children to check out their world is characteristic of those who have undergone abuse. The lack of direct eye contact may limit attempts to initiate positive interactions and might also be interpreted by adults as sneaky.

## **The Two-and-Twenty Syndrome**

Vera Fahlberg describes this syndrome as evidenced in certain children who at times appear too old for their ages and at other times act too young or immature. These children prefer to interact with older children and to become involved in their activities. When they are placed with younger children, they want to be in charge. These children do not easily accept restrictions on their behaviors and attempt to be as independent as possible. Children who exhibit this syndrome in conjunction with over-competency tend to appear more mature than they actually are. They may be accorded privileges or be given greater responsibilities than other children their age. Parents may also have higher expectations for these children and may refrain from involving them in activities usual for a child of their age. When limits are set on their behaviors, these children may revert to temper tantrums and other behaviors expected of much younger children.



## **Profound Sense of Worthlessness**

### **Withdrawal**

Some children withdraw physically whereas others seem to put up a shield around themselves. Other children may withdraw in a way that resembles fear. Such children may cringe or try to avoid physical closeness - behaviors that may have been learned as a way to keep adults at a distance or as a response to physical abuse. Children who have not had satisfying relationships with adults are often reticent about forming attachments.

### **Self Destructive Behaviors**

### **Poor social relationships**

Having received little love they have trouble giving it. They often continue in their "babyish" ways, acting self-centered and impulsive.

## ATTACHMENT DISORDERS AND CONDUCT DISORDER

Children with a history of severe attachment disorder develop aggressive, controlling, and conduct disordered behaviors, which contribute to the development of an "**anti-social personality**" (Levy and Orlans, 2000).

As early as the latency years and preadolescence, these children exhibit:

- A lack of conscience
- Self-gratification at the expense of others
- Lack of responsibility
- Dishonesty
- A blatant disregard for the rules and standards of family and society

(Levy and Orlans)

Teenage boys who have experienced attachment difficulties early in life are three times more likely to commit violent crimes (Raine, 1993).

Disruption of attachment during the crucial first 3 years of life can lead to

- "affectionless psychopathy"
- the inability to form meaningful emotional relationships
- chronic anger
- poor impulse control
- lack of remorse

(Bowlby, 1969)

Important prosocial values, attitudes, and behaviors are learned in the context of secure attachment relationships via four psychological processes:

- **Modeling** by parents or other attachment figures
- **Internalizing** the values and behavior of parents or other attachment figures
- **Experiencing synchronicity and reciprocity** in early attachment relationships
- **Developing a positive sense of self.**

# CONDUCT DISORDERS

## DIAGNOSIS

The term "conduct disorders" is used to represent a broad range of "acting out" behaviors, ranging from annoying but relatively minor behaviors such as yelling, whining, and temper tantrums to aggression, physical destructiveness, and stealing.

The DSM describes the "essential feature" of Conduct Disorder as: "a persistent pattern of conduct in which the basic right of others and major age-appropriate societal norms or rules are violated".

Behaviors described in the DSM include: running away from home overnight, lying; setting fires; being truant from school; breaking into someone else's house, building, or car; deliberate destruction of others' property; physical cruelty to animals; forcing someone into sexual activity; using a weapon in more than one fight; initiating physical fights; stealing with confrontation; physical cruelty to people.

Short and Shapiro (1993) define conduct disorder as "a class of chronic, severe anti-social behaviors that typically begin in early childhood and extend into adulthood. They give as examples of such "acting out" behaviors: aggression, lying, stealing, manipulation and callousness.

Children displaying such behaviors have been labeled "oppositional", "antisocial", "socially aggressive", and "conduct disordered" by various authors.

Boys are consistently diagnosed as conduct-disordered more frequently than girls, regardless of age or sample studied (Wells & Forehand, 1985).

Most behavioral specialists agree that the term "conduct disorder" is used to refer to a constellation of behaviors. Typically, these behaviors do not occur in isolation, but as a complex, or "class".

## **BIOLOGY: Conduct Disorder**

Research has been focusing on which groups of "anti-social" youth - prone to fighting, thievery, rudeness, etc. - will continue their "antisocial trajectory", becoming full-fledged criminals, and which will become more law-abiding adults.

Psychologist Dr. Adrian Raine is finding that the nervous system has a part to play in the outcome.

Some who engage in criminal behavior seem to have lower physiological arousal levels than the rest of the general population. Their hearts beat less rapidly, their slow brain waves are more pronounced. To compensate for their under-responsive nervous system, some researchers now think that such folks are more likely to engage in sensation-seeking activities. Crime is among such behaviors.

Based on a study of Anti-social youth in Britain, researchers found that those who are more nervous were more likely to cease their anti-social behavior. Crime desistors actually had higher than normal arousal levels (American Journal of Psychiatry, vol. 152, No. 11). Those whose brains overact to stimuli find a life of crime too stressful.

Raine (Psychology Today, May/June, 1996) suggests that if one is anxious and fearful it is more likely that they will think about the consequences of their actions.

A suggestion, based on this research, was to incorporate biofeedback training, which can alter arousal levels, into treatment of anti-social youth.

## **Biology: New Research**

Studies by T. Moffitt and A. Caspi (2003)

Researchers tested several hundred male children for differences in a particular gene called **monoamine oxidase A (MAOA)** and compared these differences with differences in upbringing. They divided the young men into two groups: those with high-activity MAOA genes and those with low activity MAOA genes.

Results indicated that the men with high-activity MAOA genes were virtually immune to the effects of maltreatment and did not get into trouble even if they had been maltreated. Those with low-active genes were much more antisocial in their behavior if maltreated and committed four times more rapes, robberies, and assaults.

Another study of a large Dutch family with a history of criminality over several generations found the MAOA gene was “broken altogether” in the criminal family members, but not in their law-abiding relatives.

The MAOA gene is on the X-chromosome, of which males have only one copy. Women have two copies and are correspondingly less vulnerable to the effect of the low-active gene, because most of them possess at least one version of the high-active gene as well. The girls in studies who have two low-active genes were significantly more likely to be diagnosed with **conduct disorder** as adolescents if they had been maltreated as children.

Thus, a “bad” genotype is not a sentence for ill effects, unless a maltreating environment is also present. It seems, as well, that a poor childhood is less likely to produce ill effects unless the “bad” genotype is also present.

At issue is whether drugs for mental conditions that alter monoamine oxidase activity would be helpful.

# CHARACTERISTICS OF CONDUCT DISORDERED YOUTH

(Mitchell Beck)

- Justify their aggressive behaviors
- Not motivated to change their behavior
- Minimize their problems
- Blame others
- Sincerely believe their behavior is appropriate, and that nothing is wrong with them.
- Have usual perceptions that could be characterized as "I'll take care of myself", and, "It's not my problem".
- Are comfortable with their hurtful behaviors
- Show no apparent remorse or guilt, and may actually play the role of victim after an attack on another.
- Defend what they do as "less" than they could: "I was just protecting myself and if I had really wanted to that other person would be a bloody mess....today was his lucky day because I held back".
- Build a "reputation" based on their anti-social behavior

## CONDUCT DISORDERS: PROGNOSIS

Children with severe conduct disorders are likely to exhibit similar patterns of behavior into adulthood if left untreated, and they have an increased likelihood of engaging in delinquent and criminal behavior. In a review of studies assessing the stability of antisocial behavior, Loeber (1982) concluded that conduct-disordered children whose antisocial behavior had an earlier onset, was manifested in more than one setting, occurred at higher rates, and/or was manifested in several forms were at greatest risk for continued performance of these behaviors.

In a review of 23 follow-up studies, Robins (1970) reported that approximately 40% of conduct-disordered children were diagnosed as having an antisocial or sociopathic personality disturbance as adults, compared to 10% of the adults who had not been thus diagnosed as children.

Treating conduct disordered children can be a frustrating experience for mental health professionals as "these juveniles display many faces to those in positions of authority" (Chescheir and Schulz, 1989). These authors go on to state that conduct disordered children seem to lack the ability to care about other people, which makes them unreceptive to most traditional therapies.

Although various studies outline a plethora of treatments regarding conduct disorder, outcome reports indicate that most interventions are only minimally effective (Kazdin, 1987; Short and Shapiro, 1993).

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Dodge (1993) and Kazdin (1993) indicate that most treatments for conduct disorder provide short-term symptomatic relief through environmental intervention, and that the positive behavior changes disappear over time!

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# **TREATMENT INTERVENTIONS**



## **TREATMENTS FOR CONDUCT DISORDER**

Our current “quick fix” managed care climate, providing limited time and resources for dealing with profound, deep seated, life-long depression, is failing to remediate the problems for both the sufferer and those living with them.

Short-term symptomatic treatments (such as drug therapy, incarceration, brief therapy) which fail to address the root causes of aberrant behavior are not producing those substantial changes needed for real personality growth.

While interventions may induce more subdued behavior for a time, long-term change does not occur.

## **INTERVENTIONS THAT WORK**

The research shows that there are three combined components needed for successful treatment (Lavin, 1998; 1996; Ford, 1996; Izzo & Ross, 1990; Garrett, 1985).

The three components are:

- Forming a relationship with at least one caring adult
- A change in the child’s thinking about him/her self, other people, and life itself. He must learn to specifically use words and language mediators to modify his/her unhealthy views, and to control emotions. S/he must learn to “talk to himself” to keep cool and to make smart choices.
- A change from antisocial to pro-social behavior is essential. S/he must learn those skills needed to participate effectively in mainstream society.

## **SPECIAL NEEDS OF CHILDREN WHO LACK ATTACHMENT**

Some of the following needs may be displayed by children who have not formed healthy attachments:

The need to develop a conscience and an ability to:

- understand consequences of their actions and not project blame on others;
- understand effects of their actions on others and be able to feel and express remorse; and
- demonstrate understanding and remorse concerning the breaking of laws or rules.

The need to develop impulse control and to be able to:

- learn to depend on self rather than others to control behavior;
- gain foresight in understanding consequences of actions; and
- increase attention span.

The need to develop self-esteem and to:

- gain satisfaction from tasks well done;
- feel more capable of accomplishing tasks;
- feel deserving of praise, rewards and positive outcomes in life;
- feel in control and capable of change;
- feel lovable and valued;
- feel capable and deserving of having fun; and
- be able to identify self-worth, boundaries and values.

The need to develop better interpersonal interactions and to:

- gain trust in others;
- provide affection with meaning;
- be independent without hostility and be able to share mutual dependence;
- be able to let go of control in some situations;
- become more socially mature; and
- respond positively to the initiatives of others.

The need to understand and develop emotions to be able to:

- recognize their own feelings;
- understand their own feelings;
- express feelings in non-harmful ways, especially anger, sadness and frustrations; and
- recognize feelings in others.

The need to improve cognitive skills in areas such as:

- understanding cause and effect;
- developing logical thinking;
- developing clear thought processes;
- thinking ahead and associating actions with consequences;
- gaining a realistic sense of time; and
- abstract thinking.

The need to improve physical development:

- in auditory processing;
- in ability to express self verbally;
- in gross motor coordination;
- in fine motor skills;
- in personal social development; and
- to be more consistent with chronological age.

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# TREATMENT AREAS

(Beverly James)

- **EDUCATION**

Child and family understand what happened through teaching, modeling and practicing behavior, emotional responsibilities. Realities and myths about related matters are addressed which may include issues such as adoption, hospitals, death, courts, prison, and sexuality.

- **DEVELOPING SELF-IDENTITY**

Child guided in recognition of adaptive survival behavior that inhibited the development, awareness, or expression of an authentic self. Disowned aspects of self are identified and integrated.

- **AFFECT TOLERANCE AND MODULATION**

Ability to experience and express authentic emotions. Through self-soothing, structuring, creative play and metaphor, the child “tries on” and practices a wide range of emotions.

- **RELATIONSHIP BUILDING**

Child learns to experience trust and safety in relationship with an adult. Family and child are guided in identification of their “family culture” of values, rules, and rituals to enhance family cohesiveness.

- **MASTERING BEHAVIOR**

Child utilizes treatment team to assist him/her in understanding and controlling dysfunctional behavior. Caregivers are assisted in understanding the function and meaning of the child's dysfunctional behavior, and guided in maintaining control, clarity, limit setting, and consistency.

- **PHYSICAL MASTERY**

Through movement, sound, and sensory exercises the child safely learns to "own" his/her body and sensory experiences, and is able to understand and respect personal boundaries.

Advanced issues, following the development of a secure relationship with both the treatment person and the present caregivers:

- **EXPLORING AND MASTERING TRAUMA**

Child and family explore the realities of the trauma-attachment experience. They accept and own what happened without maximizing or minimizing the impact on their lives.

- **MOURNING LOSSES**

Child and family process their experience of loss through recognition, protest, internalization, saying goodbye and commemorating their experience.

- **CONSOLIDATION**

Clinician, child and family review gains, celebrate growth, and explore possible issues that may arise in the future.

## TEACHING CAREGIVERS TO BOND AND FACILITATE ATTACHMENT

The **caregiver**, or parenting person, is the one who provides on-going care. The caregiver may be the child's biological parent(s), an older sibling, a grandparent, a foster or adoptive parent, a childcare worker, or someone else.

The **mission** of the primary attachment person is threefold, and each mission bears its own message:

- \* As **PROTECTOR**: “Everything will be OK. I’ll take care of you, set limits, and keep you safe.”
  
- \* As **PROVIDER**: “I’m the source of food, love, shelter, excitement, soothing, and play”.
  
- \* As **GUIDE**: “This is who you are and who I am. This is how the world works”.

(James)

(\*Note: Parents can be urged to use support systems within their culture to enhance their strengths in parenting. For example, studies have found that immigrant mothers valued the traditional “comadre” role –female peer who acts as confidante and provides emotional and practical support – and “madrina” role – a woman selected by the parents as the ‘co-mother’ of the infant and who is willing to share in the responsibility of looking after the child.) (Lieberman, *Zero to Three*, 1990, 8-11)

# ***Rapprochement***

To bring near

To bring together



*He drew a circle to shut me out.*

*Heretic rebel, a thing to flout.*

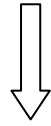
*But love and I had the wit to win.*

*We drew a circle that took him in.*

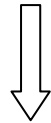
# **WORKING WITH COGNITIVE PROBLEMS**

# Thoughts-Feelings-Behavior

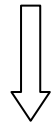
EVENT



SELF-TALK



FEELINGS



BEHAVIOR



CONSEQUENCES

# **UNDERSTANDING CONSEQUENCES**

MISBEHAVIOR IS NOTHING  
MORE THAN A NEON LIGHT  
FLASHING-

***“I need help!  
I need help!”***

NOT ENOUGH PEOPLE SEE THE  
LIGHTS!

(“The Gus Chronicles”)

*Behavior  
is not  
Diagnostic*

# COMMON BEHAVIORS OF CHILDREN/YOUTH WITH CONDUCT DISORDERS

(Listed in Psychology Textbook)

- \* AGGRESSIVE ASSAULTS
- \* VANDALISM
- \* STEALING
- \* LYING
- \* TRUANCY
- \* RUNNING AWAY
- \* FIRESETTING
- \* ROBBERY
- \* CRUELTY TO ANIMALS
- \* SEXUAL COERCION
- \* CRUELTY TO PEOPLE
- \* WEAPON USE

*To ponder: Which of these behaviors is also common for abused children?*

# OVERT AND COVERT SUBTYPES OF CONDUCT-DISORDERED BEHAVIORS

(R. Loeber and K.B. Schmalzing)

## Overt

Disobedient  
Sassy  
Blames others  
Brags  
Shows off  
Irritable, cruel, fights  
Loud, threatens  
Temper tantrums  
Attacks people  
Jealous  
Sulks  
Impulsive  
Argues  
Poor peer relations  
Teases  
Demanding  
Stubborn  
Moody  
Screams  
Hyperactive

## Covert

Disobedient  
Negative  
Lies  
Destructive  
Steals  
Sets fires  
Bad companions  
Runs away  
Truant  
In a gang  
Alcohol/drug abuse



## **BEHAVIOR INTERVENTION WITH CHILDREN/YOUTH**

WHEN CONFRONTED WITH UNACCEPTABLE BEHAVIOR PRESENTED BY CHILDREN/YOUTH, ADULTS MUST CHOOSE THEIR RESPONSE FROM AVAILABLE OPTIONS:

- **IGNORE THE BEHAVIOR**
- **PUNISH THE CHILD/YOUTH FOR THE BEHAVIOR**
- **ATTEMPT TO TEACH NEW BEHAVIOR ("DISCIPLINE")**
- **PROVIDE PROTECTION FROM THE BEHAVIOR**

# DISCIPLINE VS. PUNISHMENT

## CLARIFYING TERMS

**PUNISH:** To hurt/harm; to cause pain, loss or suffering; to treat harshly  
To penalize

**DISCIPLINE:** To teach

**CONSEQUENCE:** That which (naturally) follows from a preceding action

**CONSISTENT:** Does **not** mean “the same as”

Conforming to a set of principles; harmonious

Agreement between acts and statements

Logical connection between

## **DISCIPLINE CONCEPTS**

An “approach” rather than a set of “techniques”

Knowing how to think about behavior, and about the goals of intervention, is as important as knowing what to do.

### **What’s the point?: Intention of the Intervention**

What do I want the child/client to learn?

What might I teach from what I do?

What will my/the child/client learn about me?

What will my/the child/client learn about the world?

Will I change, or re-confirm, his/her view of how things work?

### **Understanding Behavior: Separating motive from action**

All behavior is purposeful

What meaning does a behavior have to the child/youth/client?

## "SYMPTOM ESTRANGEMENT INTERVENTION"

The goal of a Symptom Estrangement Intervention is to help a conduct disordered youth become uncomfortable with his/her "symptoms" and divorce himself or herself from these self-defeating behaviors.

This is a particularly difficult intervention because of the tendency of helping adults to become counter-aggressive.

According to Long and Fecser (1997) the goal is to "drop the pebble of a new idea in the youth's stagnant pool of thought, in order to create cognitive dissonance".

Goals are accomplished by benignly creating some ambivalence and anxiety in youth about their belief that it is okay to take the law into their own hands. If they convince themselves it's okay, they can be cruel, hurt others, commit criminal acts, etc. without feeling guilty.

The adult's strategy must be to expose this self-deception slowly, while still maintaining a caring relationship. For this to occur, the adult must be skilled in benign confrontational strategies, such as the following:

1. Ask questions, don't make statements. Questions put the responsibility onto the young person and are less likely to escalate conflict, whereas judgmental statements usually are seen as a direct challenge.
2. Establish a time line that is accurate from the student's point of view.
3. Acknowledge the legitimacy of the youth's feelings but not the behavior.
4. Affirm the youth's pride and intelligence, when appropriate.
5. Identify his or her cognitive distortions that are used to justify aggressive behavior.
6. Ask him or her why he or she is bringing the "law of the street" into the present setting.
7. Emphasize that the youth is too smart to trick him or herself into believing that it is OK to assault or hurt someone and then say it was the other person's fault.
8. Summarize by highlighting the student's self-defeating behavior and your plan for helping him or her to think clearly and develop more effective coping strategies.

## PROBLEM SOLVING SHEET

STOP            What was the problem?

LOOK  
LISTEN            Who else is involved?

THINK            What can I do?                            What will happen?

- 1.
- 2.
- 3.

THINK            Which one should I choose?

DO                If I have the problem again what will I do?

What is **MY PLAN**?

**IDENTIFYING, MANAGING,  
AND  
EXPRESSING FEELINGS**

*The dismissal of the sentience (capacity for sensation or feeling) of the baby is a major obstacle to the curtailment of violence. As long as sensitive attention is denied to the fetus, the newborn, and the toddler, we need not look very far to observe rage in the making”.*

(R. Karr-Morse: M. Wiley (Ghosts from the Nursery, 1997)

## **DEVELOPING EMPATHY and MORALITY**

In order to have a healthy conscience, a young person has to have empathy.

Empathy can be viewed as the vicarious arousal to the pain and hurts of others.

It's the response one has inside after seeing another person who is hurting.

If you think of a flower as the moral life, the foundational soil that nurtures the flower is empathy.

You can't be a moral person without being empathic.

(Shelton, 1995).



# HOW DO YOU FEEL TODAY?



*Unfocused, unexamined  
anger takes on a life of its  
own.*

*It expands and is  
boundless.*

*(Angela Cowser)*

## MODALITIES FOR EXPRESSING FEELINGS

Emotions can be represented through all modalities:

- \* A picture
- \* Songs
- \* Color
- \* Movement
- \* Shape
- \* Sound
- \* Voice
- \* Smell
- \* Taste
- \* Ways of being touched (human or “comfort wrap” with a blanket)

**CHRONIC ANGER  
IS LIKE DRINKING  
POISON HOPING  
SOMEONE ELSE  
WILL DIE!**

# Final Thought

Of the seven deadly sins, anger is possibly the most fun.

To lick your wounds, to smack your lips over grievances long past, to roll over your tongue the prospect of bitter confrontations still to come, to savor to the last toothsome morsel both the pain you are given and the pain you are giving back - in many ways it is a feast fit for a king.

The chief drawback is that what you are wolfing down is yourself.

The skeleton at the feast is you.

REDUCING  
Power/Control  
Struggles

## **DEALING WITH POWER/CONTROL ISSUES**

### **1. PERSONALIZE EXPECTATIONS**

- it's more honest
- it's harder to "fight" with a person than with a "rule"
- enables use of our relationships

### **2. STATE YOUR EXPECTATION (request, demand, rule) ONLY ONCE!**

### **3. FOLLOW UP ONLY WITH QUESTIONS.**

- Is this unreasonable?
- Do you understand the instruction and the reason?
- Why are you having trouble?
- What can/should I do to help?

### **4. KEEP THE FOCUS ON THE CLIENT'S/YOUNG PERSONS' DIFFICULTY WITH SELF CONTROL**

- Getting into power/control makes it **our** problem!
- Issue is not why or whether I can or can't "make you do it", but why you won't or can't.

### **5. BE WATCHFUL OF LANGUAGE.**

- Avoid: "yes you will"; "you need to", etc.
- Those statements aren't usually true!
- Such statements work against empowerment and self esteem.

## 6. **ALLOW THE CHILD/YOUTH TO SAVE FACE.**

- Be aware of his/her position in the peer group.
- Allow changing of behavior without feeling coerced or having to "give in".

## 7. **REMAIN AWARE OF YOUR OWN INTERNAL PROCESS.**

- This allows us to be in control of ourselves and our responses.
- This keeps the "real" issue(s) more clear.

### **Concluding Thoughts**

Some positive outcomes resulting from reduced power-control struggles between adults and children/youth include:

- taking the fear out of "challenges" (for both kids and staff)
- having an "approach" for dealing with these situations that is therapeutic for the child and reframing the situation removes the "challenge"
- keeping relationships and relating more positive
- keeping problems in the appropriate place
- changing skepticism to confidence
- enhancing the self esteem of both workers and youngsters
- providing true "discipline" (teaching and learning)

### **Notes:**

- this approach will only be adopted when staff share a positive view of kids (human nature)
- this approach will only be adopted when staff share a common view of "treatment"
- this approach has the potential to re-structure relationships between kids and staff, staff and staff, and peers
- this approach is stress reducing for both clients and staff



# **SOCIAL SKILLS TRAINING**

## SAMPLE SKILLS

Communication  
(Listening, Conversation)

Getting along with others  
(Joining in, apologizing, being a good sport, making friends)

Problem-solving  
(Dealing with teasing; coping with someone else's anger, keeping out of fights)

Presentation skills  
(Eye contact; body language, etc.)

Assertiveness skills

Manners  
(Telephone, table, control of body noises)

Dress and hygiene

Respecting "authority"

Getting attention

Disagreeing

Waiting

Using furniture

Accepting compliments

# ACTIVITIES AND VENUES FOR TEACHING SOCIAL SKILLS

Sports activities

Board games

Leisure time activities  
(hiking, fishing, etc.)

Day camps

Recreation programs

Hobbies

Shopping trips

Visits to families

School activities

Organized groups  
(Boy/girl scouts, etc.)

Hosting parties

*Nobody makes a greater  
mistake than s/he who did  
nothing because s/he could  
do only a little.*

(Edmund Burke)