Attachment Disturbances in Traumatized Children: Assessment and Treatment
(Zeanah, 2000, 2001; Federici, 1998, 2003, 2008, 2011)

- Reactive Attachment Disorder (RAD) is a multi-complex diagnosis (not individual).
- Involves neurodevelompental, psychosocial, behavioral and family assessments.
- Never exists by itself—multiple comorbidities.
- Multiple subtypes (inhibited, indiscriminant, anxious, externalizing)

Disorders Induced By Abuse

- PTSD
- Major Depression
- Bipolar Disorder—Mood Spectrum Disorders
- Obsessive-Compulsive Disorder
- Panic Disorders and Fears
- Cognitive Deficits
- Oppositional and Defiant behaviors
- Attachment-related Disorders
- Dissociative Spectrum Disorders

Common Traits and Characteristics

- "Emotional abandonment" with anhedonia
- "Institutional/Traumatic Autistic Development"
- Regression in language and cognitive skills
- Perceptual distortions
- Pseudo-psychotic logic
- Unpredictable moods and defensiveness
- Extreme self-debasement, paranoia, mistrust
- "Sabotage" relationships out of fear of further rejection and abandonment.

Attachment Disturbance: A Continuum

- "Progression of Aggression and Detachment"
- Begins with profound neglect, deprivation, abuse, bizarre exposure in parenting, with no "retracking".
- "Imitative pattern" of pathological role models
- Cognitive and psychological confusion based on lack of infant-toddler developmental experiences.
- Sensory and cognitive disorganization
- Premature "independence and autonomy".
- Faulty attempts at survival.

- "Direct correlation" between intensity and chronicity of early childhood experiences and later cognitive-behavioral manifestations.
- Failure of historicity (i.e. child has limited sense of developmental existence).
- Chronic ambivalent attachments for survival.
- Tendency to "attach" pathologically.
- PTSD, Major Depression, Anxiety, and pseudo-psychotic and Autistic logic interfere with therapeutic attempts.
- MUST have proper assessment of "level of severity"; cognitive disorganization, and "spectrum of emotional capabilities"

The Hope Connection: A Manual for Kids under Construction

(Cross & Purvis, Texas Christian University, 2002)

1. **Core Vision: Solving Life's Problems Systematically**
   - Conceptual framework of behavioral change
   - The power of "playful interaction"
   - The "Voice": Practicing Compliance and Gaining Trust
   - Gaining Eye Contact and "Connections"
   - Finding a safe pathway to the child
   - Breaking the cycle of fear and failure
   - Expert knowledge of disorders induced by abuse
   - Praise and rewards
   - Control and Predictability
   - Recognizing "Developing Behaviors"

"Developmental Retracking": Life Values

- "Listening and Obeying"
- Making choices from Appropriate to Bizarre
- Working "with permission and supervision"
- "Respect, Responsibility and Reality" (Reality Therapy)
- Training in "Gentle and Kind Behaviors"
- **Consequences for Everything**
- Accepting "NO": An Inevitability
- "Focus and Complete My Tasks—Not Yours"
- Giving choices as a disciplinary technique

Staff—Child—Parent Interactions

- Active listening
- Encouraging developmental processes to re-emerge
- Stop negative interactions
- Shaping and reinforcing all positives
- Must be "vigilant"
- Providing safety through predictability and strength
- "Choice Theory" (Glasser, 2000)
- Practice, rehearse, script, and reinforce

Behavioral–Cognitive Interventions

- Scripted activities (Adults Only Holding Environment)
- Gaining compliance for escalating behaviors: Spectrum of Discipline)
- Teaching transitions and attachments
- Dealing with "Stranger Anxiety" (i.e. how to deal with new attachments)
- Mentors and mentoring to assist in problem-solving
- Reflecting behaviors ("Mirror Time")
- Emphasis on "comparison and contrasting" behaviors
- "Attachment Rituals" (some things must be done)

Schedules, Activities and Demands

- Pre and post instructions are mandatory
- Sensory calming and activating tasks
- Language, communication and socialization drills
- "Teaching" perceptivity and recognition of emotions
- Attack aberrant and bizarre cognitions (rational problem-solving, brain storming, cognitive restructuring)
- "Focused social-interactive training"
- Parents or authority figure interactions (supervised)
- Small group role playing
- Parental or caretaker group training

Introduction to "Level Systems"

1. Level I: Adults Only
   - 3-foot Rule
   - 24/7 supervision
   - All activities Supervised and Mandated
   - Training and Rehearsal
2. Level II: Practice for Attachment-Separation
   - Reinforcers, training, token economy, contractual
   - Continual mentoring
3. Level III: Movement Towards Autonomy
   - Must "Graduate" Levels
   - Multiple tasks and assignments
   - Must have concepts of attachments and cooperation

Recreating Parent-Child Dynamics in Traumatized and Fostered Children

- Must maintain most stable and consistent environment
- Must avoid "changes and transitions" in foster care
- Prescreening for experienced father-mother foster parenting system
- Must have "In-Home" family preservation services
- Treatment plan to supercede "Foster Care Service Plan"
- Match child with foster family
- Detailed pre and post-placement training/staffings
- Weekly review of progress via "Team Approach"

Specific Treatment Strategies: Developmental Retracking/Reconstruction

- "Regress" and move child and family unit to level of abuse-fixation
- Address and rework "Developmental Failures"
- Understand infant-toddler-childhood-adolescent developmental stages as treatment strategies
- Traumatized children appreciate and respect "slowing down" development
- Recreate humor, happiness and contentment in a safe and secure environment
- "Family-Interactive Play"

Recreating Healthy Attachments: A Systematic Approach for the Child in Care

1. **Emotional-Developmental "Matching"**
   - Continual work on physical and eye contact, body movement and posturing, enhancement of sleep/wake cycle
   - "Interactive Communication and Vocalization"
   - "Safety Companionships"
   - Praise, Reward and Reinforcers
   - Determining predictability in response
   - "Heading Off" rage and agression
   - Recognizing "Anger-Rage-Externalization" as Trauma
   - Identification of "Internalizing Behaviors" (withdrawal, crying, lethargy and depression)

Choice Theory: Making Decisions

1. "Advise and Reflect" child's choices and decisions
2. Attack irrational beliefs and cognitions
3. "Brainstorm" and create alternate solutions
4. Practice and model good and bad choices
5. "Scripting" activities to provide practice
6. Maintain "mentoring, monitoring and vigilance"
7. Practice the "attachment ritual", even if unpleasant
8. Working through developmental traumas via art therapy, sensory work, group therapy/reparenting

Management of Violence, Aggression and Resistance: Use of Paradox and Humor

- "Sequence One" Holding for violence containment and safety **(Must Have Training)**
- Avoid "Holding Therapy" which induces rage
- "Strength in Numbers" (use multiple caretakers)
- Pre-instruction, limits and early interventions
- Practicing child's potential violent outbursts BEFORE it occurs
- Teaching methods to channel violence into visualizations, verbalizations, art, and psychodrama

- "Move towards anger and violence"—traumatized children seek out strong, tolerant mentors
- Understand violence begins with frustration, depression and grief-loss patterns.
- Allow "Sequence Two Holding" for calming, soothing, and developmental attachment
- Allow personal space and venting—**DO NOT SHUT DOWN THE CHILD**
- Video tape and audiotape violent episodes
- Playback, critique, and reconstruct when **CALM** after

Reconstructing Emotional Damage: A Systematic Process

- Grief-loss issues best addressed in a family/group forum
- "Family Preservation" counseling must continue
- Safety and stability continually provided
- Avoidance of changes in placement based on behaviors
- Continual "Reparenting" with strong male-female dyad
- Parenting-Reparenting at top of hierarchy
- Teach child to maintain "childhood status"
- Stop early independence and autonomy
- Children cope when they are ready to cope

Innovative Therapies

- Family-guided play and fantasy
- Practice and rehearsal to "survive" if goal is return home
- Comparing and contrasting "good vs bad" parenting
- Develop a "picture album" of painful and positive life experiences
- Constructively criticize abuse and neglect
- Teach child to put blame where blame belongs
- Teach children "How to Excel" and supercede past traumas and abuse

The Case of Polina

- Polina is now a 15 year old, adopted Russian girl who came to her family at the age of 10 years old. She was severely physically and sexually abused, and immediately acted out following adoption. Adoptive parents drank and were physically abusive and relinquished. Polina has been in four foster placements and stands no chance for readoption. She acts out sexually, steals, and refuses to trust anyone. She is brilliant, cunning, and remains on "survival mode". She refuses any therapy and desires to return back to Russia but is refused. She is now part of the "System" and has sabotaged every placement.

Proposed vs Current Treatments

- Social service moves her from place to place based on behaviors.
- Social service desired “residential care”.
- Polina had no mentors or knowledgeable therapists
- The more changes, the worse the behaviors
- Proposed treatment was rejected by social services.
  - Move to strong/objective therapeutic foster home
  - Active family therapy and preservation services
  - Trauma and attachment work
  - Connection to older Russian children

- Five times per week individual, group and family reconstructive therapy
- Recreating traumatic developmental experiences
- “Cutting ties” with adoptive parents who had visitation
- Positive social-recreational activities under supervision
- Sex abuse counseling and training
- Strong male role model
- Regular contact with therapist whom she respected (Dr. Federici and Russian-speaking staff)
- Outdoor and recreational activities
- Refusal to accept defiance and deceit
- Reality therapy and total responsibility

Trauma and Dissociation: Stephanie

- Stephanie is now a 15 year old girl who has been in and out of foster care along with her 12 year old brother for approximately 10 years. Parents abused substances and had wild sex parties in which both children were severely physically and sexually abused and involved in pornography. Stephanie failed multiple foster placements and two attempts at adoption despite multiple therapies. Stephanie began teenage years sexually acting out and acting bizarrely, and developed clear “alters” signifying Disociative Spectrum disorder. To date, she has been unable to integrate and requires continual care.

1. **Assessment and Treatment Procedures**

- Comprehensive neuropsychological assessment
- Differential diagnosis highlighting PTSD/MPD
- Knowledge of biological “shutdown”
- Understanding “severe, ritualistic abuse”
- “Fragmentation and Dissociation”: Profound damage to self and identity
- Assessment of “uncovered” traumas (incest)
- Reduction of multi-medication interventions
- Begin course of directive, reconstructive therapy
- Change in placement to “home-based model”

- Intensive art and hypnotherapy
- Visualization and guided fantasy
- "Connection of Alters" (beginning of integration)
- Integrating trauma into personality/reality
- Expressive therapies, anger-trauma rehearsal, painful revisiting of traumatic development (with caution)
- Refuse to accept "detachment and disintegration"
- Sex education in a family context
- Group therapy for survivors of trauma
- Establishing knowledge base of trauma and current acting out and disociative behaviors

Violence and Defiance: Seth

- Seth is a 13 year old, 6 foot, 200 pound adopted youth who spent 10 years in eight foster care placements; three hospitals; multiple group homes; and was finally adopted by a family who knew nothing of his background. Seth has violent rages, aggression, and defiance without bounds. He has failed in every therapy and medication, and has had every psychiatric diagnosis. Family was ready to relinquish out of "safety fears" as he would attack them. Seth is withdrawn, nonverbal, demanding, and almost autistic-like. Every treatment provider has given up and recommended residential care.

Aggressive Reconstructive Reality

- Arranged "safety plan" for violence (police and multiple caretakers)
- Intensive 5-10 hour family intervention program
- Continual "Sequence Two" holding to enhance attachment and reduce "separateness"
- Following evaluation, utilization of all testing data into therapeutic sessions
- "Visualize and verbalize" trauma and rage
- Compartmentalize victims and perpetrators
- Use of paradox, humor with positive confrontation

- One dynamic conversation at a time (with a show of strength within the family and therapist)
- GRADUAL implementation of abuse and trauma concepts in place of aggression
- Embellishment of the "positive/survival personality" with contrast to aggressive/amoral/abused child
- Physical reinforcers for incremental change
- Mandatory "Adults Only" during trauma recovery
- Ample "Parents Only" physical activities
- Extensive role playing with "cast of characters"
- Teach concepts of "Projection and Displacement"
- Regress to "soothing-infant interactions"

Neurodevelopmental Therapy: George

- George (now 7) was abandoned at birth and in multiple placements until adopted at the age of 4 years old. George was described as being "developmentally delayed" but had no language, stereotypic movements, unbounded aggression, poor attachments, and continual academic failure and disruption. George was diagnosed with "Reactive Attachment Disorder", ADHD, Developmental Delays, and Oppositional Disorder. Brain damage/autism were found after neuropsychological testing. All previous interventions had failed, and family was unable to manage George.

Applied Behavioral Analysis with Reality

- ABA techniques (Lovaas) implemented 10-15 hours per week.
- School program for Autistic and cognitively impaired children
- Bi-monthly 5 hour family neurobehavioral therapy
- Emphasis on eye contact, self-regulation, immediacy of response to parental authority, behavior modification
- Directive role playing, rehearsal, conditioning, counter-conditioning, classical (Pavlovian) conditioning
- Parents as a "unified training unit"

- "Home Intervention Program" – Complete physical and environmental adaptations
- Eliminate all extraneous distractions
- Consistent, predictable and routine interactions
- Everything is earned, and George earns everything
- One step commands and immediate compliance
- Consistency between home and school routines and therapies (ABA as principle intervention)
- Consistent "ABA-rehearsal room" to practice skills
- All other activities monitored solely by parents
- Slow and steady "rehabilitation"

Traumatized Children In School: Education vs Escape

- Abused and neglected children seek refuge in school
- Can either over-achieve or under-achieve
- School is a place to act out traumas
- Children frequently called AD/HD or LD
- Minimal appreciation for psychological history
- "Superficial attachments" in school avoid trauma
- Teachers and peers fall prey to manipulations
- Careful observation of child reveals damage
- School is NOT the place for therapy of trauma

Constructive Special Education

- Proper Assessment leads to Proper Placement
- Avoid "Emotionally Disturbed" placement (kids with problems attach to kids with bigger problems)
- Implementation of "Individualized Educational Program" addressing cognitive needs and emotional support
- Highly structured and individualized teaching models
- Assignment of a "Mentor or Aide"
- Daily and weekly goals and objectives
- No secrets from parents
- **DO NOT EXPEL THE TRAUMATIZED CHILD**

Additional School Considerations

- Consider "Home Bound Instruction" if child becomes unmanageable in school
- Immediate implementation of Intensive Home-Based Reconstructive Therapeutic Program
- Modified academic requirements with emphasis on enhancing language and practical skills.
- Gradual "mainstreaming" back to school with strong support staff
- Extensive preparation for school return but not until Home Program completed