SEVERE ATTACHMENT DISORDER DEVELOPMENT AND THERAPY FROM EARLY CHILDHOOD TO PUBERTY

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ABSTRACT: The diagnosis of Attachment Disorder (hence: AD) is used when the client is approximately between six and seventeen years of age. However, this "window" is rather narrow, since the causes and symptoms operate very early in life. The author gives an overview of common lifespan events based on clinical experience and studies of AD. An imaginary typical lifespan case, "Henry" is used, and for each stage of development a general description illustrates the typical traits behind the case. The second section gives examples of prevention at each developmental level of the child or youth. The focus is on the period from conception to puberty.

Key words: identity, development, vulnerability, therapeutic relationship

THE DISRUPTION OF HENRY'S SOCIETY

Henry was born into a culture undergoing rapid change. As a consequence, the rituals and roles of caretaking in his family were disrupted by industrialization before he was born: The bonds between his mother and the family broken up. Where formerly she would have learned the practice of caring for the newborn from her grandmother, her mother and other women, she was on her own during her pregnancy. At school she had been forced to speak English, which also denied her access to the "knowledge of caretaking" which had been accumulated in her native language. She did not let baby Henry sleep in a cradle, but in a bed. She did not breastfeed him, but used a bottle. She did not live in a group of women, carrying Henry in a bag on her back; she had to leave him alone, going to the factory for many hours a day. At the factory she was introduced to alcohol. Henry did not grow up according to tribal tradition; in fact he never met his father or his grandfather.

General aspects: Ancient caretaking traditions respond to the baby's survival challenges in the environment. Whenever the environment changes rapidly, the percentage of children having attachment problems tends to rise until new relevant coping traditions for care have been formed. One may study the Inuit, the Danes fifty years ago, or any other traditional society transforming rapidly: Attachment problems increase whenever the social structure is in the melting pot. For example, at present the Chinese experience massive migration from rural to urban environments and economies, which produces a host of abandoned children, adopted children, and a temporary disruption of the cultural norms of local baby-care patterns and upbringing systems. Henry was born in the midst of this turmoil; otherwise he might have been named Atassaq and have had a completely different life. Approximately 3–5% in a population have signs of severe attachment problems, but

in periods of change in society (war, famine, rapid industrialization, migration, etc.), the number increases. Most studies in failure of attachment are conducted in the wake of such changes, including John Bowlby's (Bowlby 1969, 1973, 1988) famous studies in attachment with postwar children.

Henry's Family

His father was sometimes very kind and sometimes violent towards his mother. He left for good when Henry was six months old. His mother had left home at an early age. She was in many ways still a child, although being 25 when Henry entered the world: She was unable to create a daily rhythm for herself, and emotionally she was unpredictable–she could have fits of rage at one moment and be gay and happy the next.

General aspects: The family pattern producing the AD child is a father who is (a) absent, physically or emotionally, (b) violent, and (c) a "serial father" (the mother having many short and superficial relationships with different men). The mother is not particularly young when giving birth; rather, she is emotionally unstable and has a fragile personality.

This latter characteristic can be divided into three subgroups: The mother with a disorganized or disorientated attachment pattern (and perhaps many psychopathic traits) (50%); the mother suffering from psychosis during the first years of her child's life (schizophrenia, manic-depressive, borderline, and birth psychosis) (40%); the average normal mother who either happens to be in crisis due to other events in the first years of the baby's life or whose baby is so fragile or handicapped at birth that the baby is unable to perceive the mother's attempts to make contact so that attachment does not take place in spite of her efforts (10%). Two risk groups in this category are presently growing: adopted children (only if deprived prior to adoption and usually if adopted at age 1 or > age 1), and children with extremely low birth weight (Rygaard 1998).

Henry in Mother's Womb

Henry had odds against him from the start. During pregnancy his mother was overworked and depressed from the loss of her dear ones. Her drinking was toxic to Henry's brain development and she was unable to care for herself. Henry's birth weight was low, and the birth itself very complicated. After birth he cried a lot, and she did not have much time to comfort him at her breast and have little dialogues with him (Mummy smiles, Henry smiles, Mummy looks gloomy and laughs, Henry looks gloomy and grunts). As soon as he could hold the milk bottle himself, she stopped taking him up when feeding him.

General aspects: Most (not all) children who develop AD have experienced what can be called an "insufficient pregnancy and birth." Thus, the combination of a very fragile and neurologically immature newborn can be devastating when combined with subsequent insufficient parenting. Some children develop AD merely because the parent is unable to be a good caretaker, but in most cases the baby was also fragile from the start. This results in a lack of establishing mutual feedback in

the first year of interaction, and this in turn probably results in insufficient neurological growth and in a lack of forming adequate neural networks for emotional and cognitive function and regulation.

Genetically, Henry had the misfortune of being a boy, and boys are much more vulnerable to almost any kind of disease and stress than girls. Approximately 75% of all children who develop AD will be boys (Schulsinger 1972, McCord 1982).

Baby Henry

When Baby Henry's mother cuddled him, she often scared him for fun beyond the limits of panic, not being very sensitive to his mood. Sometimes she was loving and kind; sometimes she had sudden fits of rage and yelled at him or shook him, or left him alone if she became engaged in something else. She had a habit of starting to nurse him, and then abruptly put him aside in the midst of all. If he cried or screamed, she would become very excited and scold him for not liking her as if a baby six months old could have intentions behind his actions. Henry often had stomach problems and colic, he didn't gain weight and height as well as he should, he didn't sleep well, and he often had fever. When a health nurse examined him at 9 months, his head circumference was small for his age; he was unable to lift his head when lying on the back or stomach, and his muscle tonus was low. She could not make eye contact with him. Consequently he was admitted to a hospital for a month, and a lot of different persons nursed him during the day.

General aspects: Henry's mother displayed many behaviour traits of the attachment pattern "Disorganized or disoriented," typical for mothers who were severely deprived in their own childhood. This attachment pattern is linked to the development of personality disorder later in life. Already at age 1 there was a 70% chance that Henry would have an identical pattern in adulthood (Shaver & Cassidy 1999).

Neurologically speaking, Henry's brain was already far behind:

His brain stem was unable to produce the level of brain activity required because his mother did not touch him or give him vestibular stimulation (which will normally increase brain stem activity and stabilize it at approximately 9 months). This means that his nervous system activity remained as unstable and low as in a newborn: pulse, breath, temperature regulation, regulation of sleeping, waking, and attention rhythms. Appetite and digestion patterns remained unstable, and this severe condition could quickly become chronic. Also, the brain stem is responsible for growth hormone production, and the lack of stimulation results in a lack of growth (psychosocial dwarfism) and a reduced head circumference.

His "emotional brain" was not being properly programmed. The neurological network that should have helped him calm down from states of panic and anxiety developed especially from age 10 to 18 months, and the creation of this network depended heavily on his mother's ability to soothe her child and help the child regulate the intensity of emotions. Henry's prefrontal cortex was not learning to control his "panic center," the Amygdala, when he became excited or scared. This would predict perhaps lifelong problems with emotional regulation. He could be-

come "a victim of his feelings" later in life, unable to calm down or level his emotional reactions.

His brain would normally produce an entire internal "broadcasting network" from birth to age 2, with an abundant number of possible dendrite connections far exceeding what a person ever needs in life. From age 2 to puberty, much used connections would be stronger, and not used connections would deteriorate–the brain specializes. In Henry's case, the lack of early physical stimulation would result in a 20% brain weight reduction at age 2, and the "internal network" base for further development would be of much poorer quality (Struble 1978, Siegle 1999).

As Henry left babyhood, the low level of brain activity would probably cause a shift into hyperactive, aimless, and restless activity because his frontal lobes were not active enough to dominate the rest of the brain. If the lack of stimulation had been very serious, he could have developed "institutional autism," being passive and without any wish for contact with others. At 20 months, it was about the last call for changing Henry's disorganized attachment pattern into a healthier one (Ackerman & Dozier 2005).

Toddler Henry

At age 3, Henry's mother gave up, and Henry was placed in a foster care family. His new "family" was doing a great job, but Henry's behaviour was unfamiliar and confusing to them. Henry had no sense of limits, moral or physical. At one moment he could play with the family's daughter, age two, the next he would try to strangle her. He created many fight/flight situations when the foster parents set limits or made demands. At the dinner table he sometimes refused to eat, sometimes ate until he vomited. He did not cry when he fell, he refused to have physical contact or be cuddled; he took a long time falling to sleep and often got up in the middle of the night. His dreams and fantasies were populated with volcanoes, dismembered animals, and omnipotent villains. If given an instruction, he was able to repeat it by memory, but immediately forgot it as soon as the adult was out of sight. The foster parents had the notion that he either regarded them as enemies (he called his foster mother "the dragon"), or did not need them at all–he seemed indifferent to contact and care. In the kindergarten the other children admired him for his "bravery" (he did not mind jumping from a roof to the ground), and at the same time feared him for his violent temper tantrums. He contacted anybody new in a very irresistible manner, and the foster parents felt misunderstood by their usual environment, who found him to be a nice, intelligent and charming boy. He quickly made acquaintances, but no close friendships developed from them. After one year of heroic effort, the foster family gave up when Henry pushed their daughter down the stairs and her arm was broken. Confronted with his actions, Henry's only comment was: "She stood where I wanted to walk–why did she do that? Should we play again, I'd like that."

General aspects: The problem of attachment usually calls for social attention from age 2 and onwards. It then becomes clear that emotionally and socially the child develops only at a very slow rate, whereas motor and "intelligence" skills may

be relatively unaffected (Rygaard 1998). This contradiction in skills often leads to a too optimistic first-meeting view of the child, based on the child's positive appearance and apparent capacities. However, those who know the child in longer and more intimate relations find out that the child is imitating the behaviour of others without any understanding of the meaning or intention in that behaviour. Also, the defence mechanisms in the child are activated by intimate situations that would normally make the child feel safe and loved. These are fight, flight, or freeze patterns, such as vagabonding, attempting to control others–including role reversal in the family, splitting and extremely ambivalent relations–trying to approach and avoid the adult at the same time. The child will function poorly in socially complex situations (many people, more than one task at a time, new environments, or new topics), and will try to avoid demands or any change in the environment (such as new kinds of food).

Henry at School

Henry's social worker noticed that her hair was turning grey as his case grew heavier. At 7 he was placed in another foster home with more experienced foster parents who got regular supervision, and things seemed to be all right.

Henry started in the local countryside school in a positive manner, but after awhile there were a number of incidents in his disfavour. His teacher was an experienced woman, and her 6-month report was very clear and matter of fact:

> "Henry is a very bright and charming little boy, somewhat small for his age. He is able to learn very quickly by heart, but easily forgets what we just talked about. In class, we have had some rather severe conflicts but Henry has found out that I am the leader, and he now obeys somewhat reluctantly. He responds positively to clear and short instructions directed towards him only, but he is still unable to attend to a general message to class. In fact he often tries to do what I ask him to do, but he is not able to concentrate and is distracted by what goes on around him, and he is often bored, restless and impatient. He is able to learn quite a lot by copying and repetition, but he has a very concrete way of thinking and does not always grasp the deeper meaning of the issue or text in question. In class he is fairly calm as long as he has my undivided attention, but any new event or unstructured situation turns him upside down, so he still is in conflict outside lessons. He has to be prepared many times each day for what is happening and will happen in the next few minutes. His learning depends on my breaking down any subject into little bits which can be learned by heart, one by one. Outside class he now has an "attachment person" who helps him socialize in an acceptable manner."

General aspects: Being more or less intelligent, the resources for learning are often not unfolded in the AD child because of social problems and conflicts overshadowing the learning process.

The basic learning problems in AD children all have to do with a failure in the first learning process: perceiving the caregiver as a stable emotional entity. These learning problems (emotional at first, cognitive later) stem from a lack of the first meaningful exercise in a secure relation:

- concentration (caregiver responds to contact and prolongs contact)
- perception of figure and background (caregiver is the emotional "figure")
- proportion (caregiver responds to different events)
- recognition (caregiver is the same in varying situations)
- graduation (caregiver is empathic and varies stimulation)
- frustration (caregiver provides safety when situation is uncomfortable)
- mutual attention (caregiver is attentive and rewards attention)
- motivation (copies caregiver's emotional states, such as joy)

In other words, object constancy–learned in interaction with the first object/caregiver–is the prerequisite for a coherent and stable perception of the emotional, physical, and social world around us (Blatt 1988).

Henry the Perpetual Teenager

After some rather good years in the foster family Henry entered puberty. He was suddenly caught outside school hours for shoplifting, and the family discovered that this had been going on for a year. There was also some drug abuse. When confronted, Henry's strategy was denial and varying fantastic stories about what happened. He was increasingly angry with his foster parents and refered any problem to their having let him down and not trusting him. In any incident he invariably blamed others and was unable to see how he himself influences the situation. There were a number of physical conflicts in which the foster parents had to hold him physically in order to avoid his aggression.

His foster mother was beginning to fear him, and while he still sought comfort like a child he was also looking for weaknesses and feelings of guilt he could awake in them. After one conflict, he tried to set the house on fire and ran away. He was found some weeks later in a gang of much older youngsters and was brought home by the police. After a calm period, the foster parents were called up by a parent from school because Henry had been sexually aggressive towards a girl of 8, and Henry was expelled. At 15 he ran away for good without notice, and sometimes surfaced in different court rooms and juvenile institutions.

General aspects: If treated, the AD child will often have a calm period from the start of school to the start of puberty. Depending on the intensity of the puberty turmoil and the tolerance in the environment, the course of events can be a criminal

career (usually fraud, impulsive and aggressive actions, and sexual offences due to a low ability to discriminate between appropriate and inappropriate partners), especially if drugs are involved–or if protected and being followed up intensely, a more restricted life with reasonable demands can give a positive outcome. At age 25 the AD child will often demonstrate the emotional maturity level of age 12-14.

Henry Grows Up

Even though Henry was no longer criminal at 29, he had a number of problematic behaviours. He often changed jobs, last names, partners, and residences. He was restless and easily bored with routine. He did not have a realistic view of himself, and he often looked for leadership or expert jobs. He was often hired at first glance because he was able to imitate any role in a superficial manner, but also fired within a short time. He liked "getting married" and had produced numerous offspring and disappointed ex-wives in different cities. If he stayed too long with a partner and got emotionally involved, he sometimes became violent and vengeful. At 35 he seemed to calm down somewhat. He has a relationship for some years and a regular job.

General aspects: When tested in youth and again at age 40-45, the AD person's number of psychopathic traits decrease with age. This is probably due to a "late maturation" of emotional and social function (apart from the mere exhaustion from a very turbulent and exposed life). These traits according to Robert D. Hare's Psychopathy Checklist (Hare 1985) include the following:

- Impulsivity
- Superficial and short contacts
- "Charming" behaviour
- Grandiose self-esteem
- Restlessness
- Lies that are "without reason"
- Lack of guilt and responsibility
- Parasitic lifestyle
- Lack of empathy

Depending on how and when interventions are made, they may prevent an AD development or reduce the symptoms considerably. Early intervention is most effective. Unfortunately, the behavioural consequences of deprivation and disorganized attachment only draw attention and concern from age 3 and onwards, thus producing a lot of practices aimed at treating symptoms that have already become chronic.

POSSIBLE INTERVENTIONS FROM PREGNANCY TO ADULTHOOD

Prebirth Interventions

The first intervention requires a general mapping process in social welfare systems:

Can we point out families whose behaviour makes it likely that the child will develop disorganized or disoriented attachment?

1. Families with a tradition for criminal behaviour, maltreatment, and neglect of children.
2. If substance abuse (alcohol, drugs) also runs in the family, this increases the risk.
3. The mother is not necessarily young, but she has a destabilized personality (due to her own record of early deprivation or maltreatment or due to psychosis when the child is in the most basic phase of attachment age 0 to age 2). The father is physically or spiritually absent, or violent.
4. Anorectic mothers are at risk of harming the foetus due to malnutrition and problems with attachment after birth.
5. Severely mentally retarded parents.
6. The birth weight of the child is very low or these are severe birth complications.

These families or mothers to be will often already be known in social security and other systems.

Can we direct an intervention program towards these families or mothers at the onset of pregnancy?

One intervention is to offer mothers-at-risk a special birth preparation program (Lier 1995). In Denmark (5 million population) there are currently 48 local programs aimed at mothers-at-risk after many years of focusing on older children.

The general idea of these programs is to give the mother a few stable contact persons who act as parental figures, helping her cope with daily practical problems, containing and moulding her expectations for motherhood, and helping her reduce eventual abuse problems in order to improve the foetal environment. In the study by Lier at Bispebjerg hospital, mothers admitted to such a program produced babies with normal birth weight and a frequency of birth complications not exceeding that of the population in general. Mothers not included demonstrated a reduced birth weight (by 300 grams) and a high frequency of severe complications (50% of births in sample).

Another program from a small county may be of interest: A health nurse, a psychologist, a social worker, and a nursery worker work in a team. When a pregnant at-risk mother's name is referred to the team, she immediately has

an informal visit from a team member, who becomes her contact person. She is encouraged to work at a special day care centre for children at risk, where the team is also situated. Here, she is supported by the team who is responsible for her work situation and social welfare benefits; she will "work" in a special day care unit and learn the basics of baby care. She is offered therapy, and after birth she will be nursing her own child in the day care centre under staff supervision.

The general idea of this intervention is that the team acts as a "parental substitute," partly administrating all public aspects (social security, working market, hospital contact, etc.) of the mother's situation.

The goal of the team is to support the mother and baby until the child is age 2 (and a healthy attachment process has been started between them). In severe cases, the team helps the mother place the child in a foster family or helps her after mandatory placement in custody of her child. The baby may also be placed in a private day care setting where the day care person has no more than two children and receives supervision at the day care centre.

A simpler model is in a county that has a number of specially educated day care mothers who work only with one or two children at a time. Their job is to be the main attachment figure for the babies, and the biological mother is encouraged to let her baby stay with the day care mother for most of the day.

The main idea of all these programs is to provide the mother with a "parental" figure–or a "safe base"–during pregnancy and birth, and to provide practical knowledge and substitute caretakers in the first period of attachment.

Interventions for Mother or Caretaker and Baby Relations

In the intervention programs described, an understanding of healthy neurological development is embedded since a number of studies have demonstrated the close relation between caretaking behaviour and brain development in the baby.

Stimulation of the skin and the vestibular sense (rocking, turning, rolling, etc.) seem to have a major influence on the smooth regulation of the general activity level in the baby brain and thus both on brain growth and the gradual stabilization of brain function. Consequently, a common problem in AD children is hypo- or hyperactivity. The regulating activity is mediated by the reticular activation system, which–in order to function properly in the baby–can be activated only by frequent touch (skin, mouth, and tongue) and movement.

A number of caretaker behaviours become important:

1. Frequently carry the baby on the body.
2. Feed the baby in the breastfeeding position on the arm and spend a lot of time on this.
3. With young fragile babies, a wet nurse can be a good idea.
4. Use baby massage.
5. Exercise eye contact only when the baby is touched at the same time. Touch helps the baby focus and have eye contact.

6. Use a cradle or a hammock for sleeping, never a bed.
7. Let the baby rest on a lambskin or on terry cloth.

Deprived babies quickly adapt to understimulation and avoid normal levels of stimulation and stay under stimulated. Therefore, one should gradually stimulate the baby for short periods of time. Sensory Integration Therapy (Jean Ayres) is designed to teach children how to process rising increasing levels of stimulation.

The Marte Meo program from Holland consists of video feedback sessions for mothers at risk and their babies. Mother and baby are videotaped, and the supervisor gives feedback supporting relevant maternal caretaking behaviour. The general idea of the program is to give only positive feedback whenever the mother displays relevant caretaking behaviour (see: *www.martemeo.com*).

Interventions for the Preschool Child

The abovementioned stimulation methods should be put to use even with toddlers and up to age 6, but they will be most efficient at an early age.

With AD preschool children, the emotional and social capacities are comparable to those of a much younger child. Those working with them or caring for them should consider the following:

1. When planning social and emotional demands and caretaker behaviour, divide the child's age by 2 or 3 (to match the developmental age of the child).
2. Do not focus on emotions, reasoning, and motivating. Demonstrate the behaviour you want in simple, short sequences and let the child learn them by imitating you instantly (that's how babies learn from their mothers). Don't expect the child to understand the meaning of actions.
3. Keep the child in a "mother and child" circle wherever you go. That is, the child is followed and helped as closely as a mother would follow her baby. All other social contacts should be planned and supported by the caretaker. AD children are vulnerable to new contacts and large groups.
4. Take responsibility for all negative outcomes of social interaction (wouldn't you do that with a 1 year old?)

As the reader will remember, Henry was placed in a foster care family. Since AD child behaviour is disorganized and a very stressing factor in family life, the following criteria for placement have proven valuable:

1. Foster parents should be experienced, that is, not too young. If they have children, the youngest child should be at least 5 years older than the AD child placed in the family.
2. Foster parents should have a stable life without too many new activities and new social contacts. They should be chosen for patience, endurance, and stability.

3. Relations to neighbours, school, and day care should be positive before placement, since these relations will be stressed by the child's behaviour.

4. Authorities responsible for placement should provide regular supervision.

Mary Dozier of Delaware University has made some very interesting field studies in foster family placement. Some of her most important findings include the following:

1. If children are placed in foster care before age of 20 months, most will adapt to the attachment pattern of the foster mother. If placed later, they will probably maintain the attachment pattern acquired from previous caretaker(s) or parent(s).

2. If the foster mother has a secure and autonomous attachment pattern, the young child placed will adapt to that pattern. If the foster mother has one of the three other attachment patterns (avoidant, ambivalent, or disorganized), most children will end up having a disorganized pattern.

3. Foster parents can learn the behaviours associated with secure and autonomous attachment.

Other results produced by Femmie Juffer of Leiden University, The Netherlands, studying adopted children (Juffer 2005) indicate if adoptive parents have a number of consultations with an advisor about common attachment problems for one year after adoption, more children will display a secure and autonomous attachment, compared to a control group of nonadvised adoptive parents. The same probably goes for foster parents. It is just as important to attachment outcome to "care for the caretakers" as it is to care for the AD child.

Interventions for the School Child

The interventions recommended here focus on school work settings, due to the author's experience. The age period of 5 to 12 years is often reasonably calm, and the child often has unused intellectual reserves that are overshadowed by social conflicts. However, the thoughts presented refer to learning processes in general.

To identify the nature of learning problems in AD children, the most relevant cause is the lack of early organized communication patterns between the baby and the caretaker. This prevents the creation of a clear internal representation of the mother, in some theories referred to as "internal working model," and in others as "the object relation." Early disorganized interplay probably prevents an ordered experience, not only of the first caretaker, but also of all later persons or objects, and matters. Subsequent learning problems are caused by a poor quality of the following:

- concentration
- perceiving figure or background
- proportion

- recognition
- graduation
- frustration
- mutual attention
- motivation

These problems appear both in the social relation with the teacher and peers, and cognitively when working with the understanding of subject matter, such as figures, letters, grammar, ideas, and symbols.

Interventions should be designed to support these functions as much as possible, and they should also be the underlying target of exercise in all situations. For example, the duration of concentration can be the teacher's focus in any activity or learning process.

The teacher should regard his or her person more as the "parental object" than as "the teacher," and think in terms of a given number of "parent-child relations" rather than addressing the group of children in general. In other words, most of the communication should be between teacher and pupil and not between teacher and group. Only when each child has been in this relation for a year or so can the teacher start activities and instructions on a group level.

As a "parental object," the teacher should be aware that he or she influences the child's behaviour only when being present and visible to the child. As soon as the teacher is not present, there will be little or no retention of the teacher's opinions, instructions, etc. In short "you exist only when you are in the presence of the child." For this reason instructions or dialogues about what the child must remember later should be omitted, and only the present tense and the immediate future should be used.

The class room environment should be designed to help the child focus relevantly and not be disturbed, that is, all children face the teacher, and if a child is easily distracted, a sound isolating "wall" can separate the children so that a child can see only the teacher.

Concerning the arrangement of learning matter "peeling the onion" is relevant. This means that the teacher initially observes the faculties of the child and makes demands only when he or she is absolutely certain that the child can already perform the task in question. Even then, there will probably be a number of conflicts, because the child perceives the teacher as "the hostile parent" from the original experience of the parent, and this evokes also the aggressive, disorganized, or avoidant reactions from this early period. Only when these conflicts have been contained and calmly resolved by the teacher will the child be able to work. It is difficult to be a safe authority without being authoritarian, and this usually takes some years of practice.

What makes teaching AD children difficult is not only that the internal working model of the child may be imprecise or blurred, but also early adverse experiences

will load the child's view of the teacher with negative and hostile feelings, and many defensive mechanisms will blur the communication when the child tries to avoid or disrupt communication. Thus, a calm teaching process in itself is the ultimate goal, and what is required is that the teacher learns to be a "container for negative projections" (that is to know that the child's problems stem from early life and are not really statements to be taken personal) and also learns to be a good "rodeo cowboy" (that is, the child will often try to create a secure base by role reversal or by taking control of the environment).

It is equally important to understand that the teacher's efforts to explain or convey the deeper meaning or essence of a subject can be an insurmountable challenge for the child. Instead, the logics of a task should be translated into a set of behaviours and rituals which the child can simply imitate–the "why" should always be replaced with the "how" demonstration (Rygaard 2006).

Interventions in Youth

This presentation has focused on early childhood and school years, and youth has been described in many other places. There are so many intervention programs that it is impossible to give a complete description. In general, programs based on cognitive or behavioural therapies are popular in these years. Without any evidence, it is my experience that these programs work well with many "light" youth criminals, but as with all other methods, they have only a temporary effect on youngsters with many psychopathic traits. In these cases, an intense permanent follow-up and control procedure is necessary. In a Danish facility for psychopathic criminals (Herstedvester), a permanent follow-up is combined with reincarceration without time limit if a parole is violated. The next parole then depends solely on the estimate of prison staff. This method seems to have some effect in the most difficult cases.

CONCLUSIONS

What has amazed me mostly in working with AD children is the fact that the causes seem to operate from pregnancy to age 2, while treatment usually starts when the social symptoms start to become increasingly manifest: from age 2-3 an onwards. Due to the late start of treatment, the prognosis is not very positive. This calls for the development of intervention programmes early in life.

Milieu therapy, in my experience, is a useful method in providing the secure base to extremely insecure and aggressive children. The two most important goals in this are to monitor the environment at all times (which can usually be obtained at least until puberty even in severe cases), and to provide supervision for those who work with the children in order to avoid regression under the pressure of the child's behaviour problems.

Source

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Literature

Here is a list of literature from *Severe Attachment Disorder in Childhood* is presented in its full length. The studies referred to in the above text are included here. The references in this paper to Ackerman (2005) and Juffer (2005) are not included in the book.

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