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

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

ANXIOUS ATTACHMENT DISORDER

**PRIMARY EMOTION:** The primary emotion Anxious AD (AxAD) children feel is anxiety and their anxiety is usually connected to abandonment in some form- e.g., parents will leave or eject the child from the family or totally ignore the AxAD child in favor of a preferred sibling. However, there is a deeper terror lurking in AxAD children: psychologically, “no one is home”. They have a terrifying inner emptiness and a sense of no existence of their own. They are working very hard, all the time, to protect themselves from abandonment and from experiencing their internal sense of non-existence. One way AxAD children do this is to appear to emotionally relate to others, and thus, they can exhibit what looks like attachment behaviors. In the absence of needing relief from their anxiety, AxAD children can be indifferent to, or rejecting of, interaction.

**THE TERROR OF NON-EXISTENCE:** AxAD children carry an inner emptiness that they experience as a sense of not really existing. Obviously, this is terrifying. Attention from others functions almost like a prop to confirm their very existence. The quality of the attention is of secondary importance. When attention is insufficient, AxAD children feel like they are fading away, becoming “ghostlike”. AxAD children will seek emotional or physical closeness, but as “valium” to quiet their inner terror, rather than as a desire for closeness per se. When not motivated to be charming, AxAD children are likely to revert to whining or complaining about a variety of things, or engaging in baby talk for the attention drawing effects. In quieter or calmer moments, AxAD children are likely to raise their activity level so that they behaviorally avoid their terror within. This often takes the form of non-stop talking or asking of meaningless questions. This has much of the appearance of AD/HD and can lead to such a partial misdiagnosis.

**PRIMARY BEHAVIOR:** The primary behavioral strategy AxAD children rely on could be termed “impression management”. AxAD children are generally skilled at presenting a charming façade. These children work diligently to “manage” the adults’ liking of them. In addition to their charm, AxAD children lie a high percentage of the time. They almost always lie about their feelings, and
AxAD children never acknowledge having lied—they are proficient at lying about lying. Usually, anything AxAD children are genuinely worried about will be dismissed with indifference. They can invent compelling tales of abuse at the hands of parents or other adults. AxAD children rarely express thoughts that are truly “their own”. The demand to be “real” frightens them. They devote their hypervigilance skills to determining what others want from them. They are very skilled at eliciting clues from the environment; and often ask, “What do you want me to say?” or may just wait in silence for the adult to offer a prompt. Answers are then crafted around these clues. Such answers can sound insightful, but are typically meaningless. Most appearances of emotional expression are “constructed”. They like the adults being confused about them. It is very easy to underestimate AxAD children’s ability to evade real feeling. They almost always deceive adults outside the home. Their behavior can vary dramatically depending upon with whom they’re interacting. AxAD children often do well in school because they see that as a way to get the teacher to like them.

**INTRUSIVENESS:** AxAD children can be very intrusive, conversationally and spatially. When they try to get physically close, they often end up hurting the other person in some small way. Verbally, this can manifest as constantly interrupting a conversation they are not an immediate part of, for this being “left out” begins to stir their anxiety. While their intrusive behavior can be quite irritating, it is generally not motivated by a wish to create distance; but by a wish to be part of things and escape their anxiety. The interrupting can become so frequent that AxAd children sometimes should be told to put their hands over their mouths as a tactile cue to control the impulse.

**PEER FRIENDSHIPS:** AxAD children are motivated to seek peer friendships and will report having numerous friends regardless of the true circumstances. Their friendship skills can involve their “impression management” tools or becoming like who they are with in the moment (“as if”). In addition, they may try to buy friends with gifts that are often stolen or bought with stolen money. By adolescence, if prior therapeutic progress has not been made, AxAD girls are vulnerable to substituting sexual promiscuity for friendship; and both genders are vulnerable to substance use to medicate their terror and anxiety.

**THERAPY:** Because AxAD children are rarely openly defiant or irritatingly passive-aggressive, they can appear to be making progress when, in fact, little of significance is occurring. They can convincingly lapse into tears or “constructed anxiety”, in an effort to influence the therapist and parents to not challenge them so much. The key to making therapeutic progress with AxAD children is getting access to something, anything, that is real and following that thread to open up their terror that they do not really exist. This can require the therapist to be vigilant, even skeptical, to a degree that might be uncomfortable. It can also require being repeatedly, though gently challenging, and expecting more from the child. Empathy / support offered too soon will likely be empathy for a “constructed presentation” and this will put the therapeutic journey in reverse.

**AVOIDANT ATTACHMENT DISORDER**

**PRIMARY EMOTION:** The predominant emotion in Avoidant AD (AvAD) children is sadness which is related to a significant sense of emptiness / loneliness. However, the world sees little or none of their sadness or loneliness. AvAD children believe their sadness is infinite, and should they lapse into it, they see no exit. Hence, they go to extraordinary lengths to avoid any expression of it, and usually effectively shield themselves from even recognizing their sadness. Their internal shields work so well that they often truly do not think they are sad. What AvAD children do feel is an
anxious edge in quieter moments. They rarely relax, lest their sadness “creep up” on them. Their hypervigilance is aimed at deflecting anything that might activate their sadness. As physical and emotional closeness carries a high potential for triggering their sadness, AvAD children avoid closeness. They can readily perceive adult efforts to promote closeness as malicious. Attitudinally, AvAD children are contemptuous of sadness— they define it as the “stuff of sissies”. A goodly percentage of these children lie somewhere along the spectrum of depressive disorders.

**PRIMARY BEHAVIOR:** The predominant behavioral strategy utilized by AvAD children is passive-aggressive behavior. Various behaviors are employed for their nuisance effect in order to pollute the air with tension, which minimizes chances of their sadness being awakened. Tasks are commonly done quite slowly, including ones they may want to do, to generate frustration in others, which again, buffers any sadness. Promises made are usually broken for the same reason. The speech of AvAD children is sprinkled with unintelligible muttering which is yet another passive-aggressive variant to create irritation and block sadness. AvAD children do not engage in incessant chattering, and when they do, that can indicate that their sadness has been stirred.

**PHYSICAL CONTACT:** Given their dislike of physical contact, AvAD children stiffen up when touched. Hugging them is like hugging a board. As touch taps their sadness, AvAD children, when touched, may well: 1) complain of being hurt or hot, 2) say they don’t feel well, 3) insist that the touch is making them itch and they must scratch, 4) flinch, twitch, fidget, or pull away, or 5) engage in some bodily preoccupation, all in an effort to disrupt the physical closeness and distract themselves from any emergent sadness. Attempts to impose physical closeness may be met with direct physical aggression, to recreate some distance. The one context in which AvAD children do allow closeness is when they are sick or injured. They often express somatic complaints and tend to habitually overreact to minor cuts or discomforts. It is as if the somatic distress provides a justification for the closeness that strips the closeness of all emotional meaning, thereby making it acceptable.

**INTERPERSONAL WORLD:** AvAD children can demonstrate chronic avoidance of contact with others. Though they usually claim to have friends, AvAD children typically don’t take initiative socially, don’t respond to others’ initiative, and may actively or passively push others away. If they have any companions, they tend to be a few years younger. If not left alone enough, they can become openly angry. AvAD children present themselves as omnipotent and without need for others and as a result can come across as quite condescending.

**THERAPY:** Accessing their sadness is the linchpin of successful therapy with AvAD children. Absent this, therapist and parents are left forever trying to manage the many forms of passive aggressive behavior that any AvAD child will present. Behavioral treatment is practically a guaranteed failure. In terms of accessing sadness, physical holding is frequently necessary to create a sufficient intensity to have any therapeutic impact. When the breakthrough comes, AvAD children can feel suicidal for a period of time. It can be useful to remind them that they were alone initially when they experienced their sadness, but there are others present to help them now.

**AMBIVALENT ATTACHMENT DISORDER**

**PRIMARY EMOTION:** The primary emotion in children with Ambivalent Attachment Disorder (AmAD) is anger and rage. These children are openly angry, attitudinally, verbally, and behaviorally, much of the time. This is the subtype most interested in fire, gore, and death and least developed in terms of conscience and values.
**PRIMARY BEHAVIOR:** The primary behavior of children with AmAD is direct aggression. These children are not passive aggressive but overtly oppositional and demanding. If manipulation does not obtain them what they want, AmAD children are willing to become aggressive. They are willing to destroy their own and others’ property and carry the potential to hurt animals and other children. AmAD children usually understand the impact of their behavior on others and are simply indifferent. With adults they are quite likely to be verbally threatening, but the actual use of aggression depends upon their appraisal of the likelihood that they will get hurt. AmAD children derive excitement from risk-taking behavior and commonly do not understand the inherent danger involved. They are frequently partially misdiagnosed as Oppositional Defiant Disorder or Conduct Disorder.

**INTERPERSONAL WORLD:** The IWM of AmAD children is based on a scarcity model. Therefore what is wanted should be taken, as it is not going to be given by anyone. Other people are primarily resources to be exploited, and their feelings or needs are irrelevant. Having to hurt someone to get what is wanted is likely to be viewed simply as “the cost of doing business”, and the other person is apt to be seen as having deserved being hurt for having been in the way. AmAD children are almost wholly incapable of truly giving or receiving affection. With touch, rather than withdraw from it, AmAD children are more likely to treat it as meaningless. They are comfortable explicitly telling others to get away from them. At the extreme, these children derive some measure of enjoyment out of causing distress for others. With peers, AmAD children can make friends, but “friendships” are extremely short-lived due to the hurt the peers experience. Untreated, AmAD children carry sociopathic or psychopathic potential. Expectably, many of them have a history of multiple placements, and a significant percentage live outside of family contexts.

**SCHOOL:** AmAD children can get suspended as early as preschool because of their destructive behavior. They tend to be deliberate academic underachievers, based on the principle that the lower the expectations, the less you have to do. A good number of them are are given IEP’s and placed in specialized programs of some form as a result of their chronic underachievement. Their behavior tends to be equally problematic at home and school.

**NEUROLOGICALLY DISORGANIZED ATTACHMENT DISORDER**

**PRIMARY EMOTION:** The primary emotion of children with Neurologically Disorganized Attachment Disorder (NDAD) is chaotic anxiety. The overwhelming, chaotic anxiety can lead to significantly disordered thinking that can regress to a psychotic level at times. Associations can be highly illogical such that no thread can be followed. Speech is frequently tangential and sprinkled with neologisms and distorted syntax which go unrecognized by the child.

**NEUROLOGY:** There is almost always some degree of neurological impairment present in NDAD. In this category, the attachment difficulties can truly be viewed as secondary to the neurological factor rather than as primary, as is the case with the other three categories of AD. Some of the pathways to the neurological impairment are: IUE to alcohol and/or other substances, extremely poor prenatal nutrition, significant prematurity, grossly neglectful / abusive postnatal care, untreated postnatal injuries / illnesses, and genetic inheritance. Their neurological vulnerability leaves NDAD children susceptible to simultaneous, multi-systemic dysregulation. Auditory hallucinations are not uncommon, and when NDAD children look like they are dissociating, they can be listening to internal voices. These voices can communicate bizarre content which can influence behavior. Voices should be inquired about over time, as NDAD children deny their presence at first and may do so for a while. Learning difficulties are a common byproduct of the neurological damage.
**PRIMARY BEHAVIOR:** The primary behavior NDAD children exhibit can best be described as a mix of unpredictable, perseverative, bizarre at times, and often wholly unrelated to the situation at hand. Problematic behaviors frequently shift in form, leaving the relevant adults feeling they are forever chasing new problems. NDAD children usually feel remorse about their behavior afterwards, but because the behavior is driven by neurological fragility and the chaotic anxiety, remorse does not, by itself, effect future change.

**INTERPERSONAL WORLD:** NDAD children are often expressive of closeness, both verbally and physically. They tend to be excessively friendly with strangers, but they usually do so in a syrupy manner that is ineffectual. NDAD children are generally oblivious of boundaries and personal space and are intrusive as a result. This often leaves them socially isolated as invading personal space is the single biggest mistake in the social world of children.

**THERAPY:** Due to their neurological impairment, a high percentage of NDAD children can benefit from antipsychotic medication which can be thought of as “glue” for their vulnerable nervous systems. The overriding priority with NDAD children is to work towards minimizing the incidence of systemic dysregulation. Longer periods between “meltdowns” allow the child’s nervous system to settle some which can deaden its hair trigger a bit. In addition, fewer meltdowns can create enough of a contrast that the child can begin to develop an internal sense of the difference between chaos and calm. This is exceedingly difficult to do while meltdowns are regular occurrences.

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