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THErapy REVISED

Introduction

Children with attachment disorders (AD) have been notoriously challenging to treat. Traditional psychotherapy approaches have, by and large, failed to generate meaningful or lasting change in this population. In particular, individual child therapy is highly contraindicated for AD children. When attachment is the issue, it is the parent-child relationship that is really the client, not an individual. Therefore, the parent(s) should be present in the session. In addition, with only the child in the room, there is not even a quasi accurate perspective on life at home, available to the therapist. Thus, individual therapy with children with attachment difficulties usually ends up being a meandering trip through the briar patch.

Psychopharmacology can assist with portions of the total AD symptomatic picture, but has little to no direct impact on the basic attachment difficulties. Relationship is, after all, not an outcome of medication. AD children frequently have negative, unusual, or contradictory responses to a wide variety of medications. Though certainly not a formal diagnostic criterion, a history of poor, and / or contradictory responses to multiple medications should bring the possibility of Attachment Disorder to mind.

As with other kinds of childhood emotional problems, the beginnings of progress with children with AD are often accompanied by worsened behavior. With AD children, progress is particularly vulnerable to backwards lapses. Due to their vulnerabilities, children with AD may need periodic “therapeutic 5,000 mile checks” over time. Without appropriate therapeutic intervention, the most common adult outcomes for AD children are Borderline Personality Disorder, Antisocial Personality Disorder, and Bipolar Disorder.

PURPOSES OF THERAPY: The obvious overarching goal of therapy is the facilitation of an attachment relationship with the child’s parents first and foremost. However, because this is such a complex achievement, involving multiple component skills, developing these skills is an integral and ongoing part of attachment work. Work on these skills tends to proceed in a parallel fashion.

- Provide experiences of emotional safety
- Promoting integrated functioning in place of fragmentation
- Determining how the child’s IWM is constructed and teaching that to the child and parents to promote mastery vs. reactivity and allow for the beginnings of incorporating new experience
- Enhance the child’s access to her feelings
- Deepen connection to the body
- Develop the child’s affective tolerance and emotional regulatory skills, thereby lowering the need to dissociate to regulate
- Neutralize traumatic affect that may be present
- Clarify personal boundaries and respect for others’ boundaries
- Teach and develop attachment skills and prosocial skills
- Teaching specialized parenting strategies

USEFUL OFFICE EQUIPMENT: An L-shaped couch can facilitate various seating arrangements and interactions. An office chair on casters allows the therapist to quickly adjust distance / proximity. A large white board is a resource for adding the visual dimension to the verbal-auditory one. A variety of play materials can be useful as metaphorical props for the therapy, to provide some background distraction to lighten the intensity at moments, or as a reward at the end of work well done. This is not the same as nondirective play therapy which is ineffective with this population. Soft covering for at least part of the floor makes working on the floor more comfortable and softens the environment. Softer lighting, such as floor lamps vs. fluorescent ceiling lighting, is essential to establishing a softer environment that facilitates intimacy. The goal is to approach a room in a home vs. a more impersonal office context.

WRITTEN RECORDS: It is useful to keep somewhat detailed written records of sessions for two reasons. It is very important to track the specific words AD children use to describe some aspect of their inner experience, be it feelings, images, or beliefs. Their own words are the most reliable key to unlock a related inner experience. What might seem like an equivalent word or phrase to an adult, may not connect to anything internally for the child. (Example: because a child may describe some feelings as “horrible”, does not mean that “feeling bad” will connect to those feelings). This reflects the fact that the more developmentally delayed, and internally disconnected, a child is, the less is their thinking organized along the lines of word meanings. Thus, because one word connects to something does not mean another word with similar meaning will connect to anything at all. Hence it is important to have a record of the child’s own verbal keys to their inner world. The second reason for keeping a detailed record of therapy is to be able to return to topics touched on at past points. Working on things in a sequential fashion is often ineffective with AD children. A subject discussed the previous week becomes wholly inaccessible the next week, as the previous session mobilized the child’s protective system. However, coming back to that same topic a month or two or three months later can be productive. Having a detailed map of where therapy has been is obviously necessary to do this.

THE DYNAMICS OF CHANGE: (From Neurolinguistic Programming- NLP). The following are reliable markers of the presence or absence of any real intention / motivation to change and of processes that are likely to facilitate or inhibit change. The verbs being used are in the present tense- change only occurs in the present, not the past or the future. Historical searches for why things didn’t change in the past usually bear little connection to change in the present. The commitment to change is clear and specific, not vague or tentative (might, maybe, seems, seems like). Focus is placed on a clear starting point- a multi-point focus typically produces little or no change in anything. Goals are positively defined as doing something and not as not doing something. Pursuing change involves doing, vs. trying to do something. The word “try” carries an implicit expectation of failure. The word “can’t” is most often a plea to be excused from the responsibility for changing rather than a true statement of inability. When used, it should be replaced with “won’t”, particularly for AD children.

EVIDENCE BASED PRACTICE

THE NATURAL WORLD: Evidence based practice (EBP), and the research upon which it rests, has brought greater precision and efficacy to a range of clinical challenges. With continuing research in the future, it is reasonable to expect the evolution of EBP. However, EBP may never become all inclusive in its applicability. The complex and multifactorial nature of many clinical conditions effectively limits empirical research because there are so many interactive effects between all the variables operating in the natural world, that identifying cause-effect linkages becomes very difficult without distorting the real world dynamics. This is reflected in the fact the overall history

of medical research is rife with conflicting interpretations of the same findings. Given these challenges, the current reality is that the abundance of complex everyday situations that practicing clinicians face, extends well beyond the territory that has been mapped out by EBP.

“Realistically, the proportion of therapeutic decisions that need to be made without the availability of unbiased, clinically relevant, well-designed studies remains high. These decisions then default to other decision-making factors.”

David M. Gardener.

Child and Adolescent Psychopharmacology News. 14 (3) 2010.

RESEARCHERS AND CLINICIANS: The roles of researcher and therapist are fundamentally different with different spheres of operation, differing objectives, and differing uses of conceptual terminology. As with any concept, the risk is present that the conceptual frameworks of research may become a filter that obscures real world experience rather than illuminates it. This can generate semantic differences that are more academic than practical, thereby yielding questions or conclusions that may be false or unanswerable.

“Is disorganized attachment a function of dysregulation or insecurity (how distinguish)?”

“Disinhibited attachment disorder is not a syndrome characterized by attachment insecurity, but by a failure to develop committed intimate social relationships (how distinguish).”

PRACTICE WISDOM: An important concept that tends to be overlooked by EBP is that of Practice Wisdom. Practice Wisdom refers to the additional dimension of expertise that a clinician acquires by virtue of cumulative experience. It derives from having a range of direct experience with the application of theories, with clients, and with a range the use of techniques. Practice wisdom is quite possibly unquantifiable. Most simply put, Practice Wisdom affirms the adage that “Experience is the best teacher.” This dimension of clinical expertise potentially gets diminished by the rigid application of any manualized technique.

THE THERAPEUTIC RELATIONSHIP: Related to the concept of Practice Wisdom is the Therapeutic Relationship itself. The Therapeutic relationship is inherently not manualizable. The attempt to manualize it converts it from a relationship into simply another “technique”. We know from outcome research with adults, that 60% of the change is attributable to the relationship and 40% to technique (Cassidy & Shaver 2008). In addition, there are more and less effective therapists across all disciplines, independent of technique. Something else beyond technique is going on.

“When you look past therapy “brand names” and look at what effective therapists are actually doing, it turns out they are doing what psychodynamic therapists have always done: facilitating self exploration, examining emotional blind spots, and understanding relationship patterns. The more the therapists acted like psychodynamic therapists, the better the outcome. This was true regardless of the kind of therapy the therapists believed they were providing.”

-Jonathan Shedler. University of Colorado School Of Medicine. 2010.

At this point that we lack research methodologies capable of embracing the full spectrum of complex real world dynamics and situations. There is reasonable doubt that this gap will ever be fully closed as the real world just may not be fully embraceable by the scientific method. This is further complicated by the element of human perception which is reflected in medicine’s long history of differing interpretations of the same data. It seems unlikely that human perception is a manualizable phenomenon. In addition, the contribution that cumulative experience makes to a clinician’s efficacy and that the therapeutic relationship makes to the final outcome are also, most likely, beyond the reach of a manual of technique.

Adopting an absolute stance about the use of EBP places a clinician in the position of facing a percentage of therapeutic situations for which no tool will be available, and possibly undervaluing the influence of experiential expertise and the therapeutic relationship.

PRINCIPLES & GUIDELINES

PARENTS: It is almost impossible to make any impact on an AD child without responsive parents and a home life designed to foster the child's progress. The parents should be viewed as the primary sources of healing, with the therapist being a coach and consultant to them. Initially, parents need to be defined as safety resources. This is a necessary prelude to developing an attachment bond. For parents to be credible safety resources for the child they must be clearly established in the executive position (Family Therapy 101). Of necessity, this entails removing any “special role” that the child has acquired. Often, such special roles are defined on a basis of pathology or the child’s painful history. In therapy, it is prudent to watch for opportunities, such as when the child becomes anxious in the moment, to teach AD children to seek protection from their parents. Should there be any spontaneous seeking of protection from the parents by the child, that should be openly acknowledged and supported. Until a clear attachment bond is established with the primary caregiver, the other parent’s priority should be acting as a support and back-up to the primary caretaker. An additional function of parents in session is to be credible sources of information on life at home, thereby undercutting the AD child’s typical lapses in credibility.

PROJECTIVE IDENTIFICATION FOR PARENTS: Parents can be described as emotional echo chambers for their children with attachment difficulties. As emotional echo chambers, parents may well experience the feelings that truly belong to their children, but their children are not acknowledging (and may not even be consciously experiencing). Understanding this provides parents a valuable buffer against overpersonalizing their emotional reactions to their AD child. In addition, seeing themselves as emotional echo chambers gives parents important information about their child’s feelings in the moment. This empowers parents to intervene with greater precision than if they are mistaking their child’s disowned feelings for their own.

PARENTING STRATEGIES: Parents who are raising children with attachment difficulties, need specialized strategies to assist them, as much of the parenting is counterintuitive, and conventional parenting approaches are often ineffective. Teaching these strategies is an ongoing aspect of the clinician’s role. Sometimes this requires separate meetings with just parents while some of it is best done in session when the “teachable moment” appears. In this respect, it is useful to identify a hand signal the therapist can use to signal the parents that they are in need of some input from the therapist at that moment. This could be purposes of explanation or correction. Almost always, such input becomes vitally important at home. An excellent example of this is teaching parents to recognize avoidance or passive-aggressive behaviors, which can be subtle. Pointing these behaviors out when they occur helps parents hold the child accountable rather than overfunction for the child. Another example is dismissive behaviors, which package disrespect. Identifying them is important as such behaviors poison the relationship and block emotional access to the child. Should the child then make fun of the parents’ being “wrong”, that needs to be addressed immediately

THERAPISTS: Successful attachment therapy requires the therapist to be playful and supportive, yet challenging and structured. This is embodied in well-known metaphors in the attachment field of AD children needing a steel box with a velvet lining or an iron hand in a velvet glove. It is useful for attachment therapists not to take themselves too seriously. An adult who takes himself too seriously is an easy target for an AD child’s strategic behaviors. To be effective with AD children, clinicians must be able to be playful even ridiculous at times, to laugh at themselves, to acknowledge being wrong, and to acknowledge having been fooled. They should be able to share the expert role with the parents. Additionally, it can be very beneficial to the family atmosphere for therapists to draw the AD child’s anger towards them and away from the parents. This involves

being comfortable with the role of “the heavy” as AD children will often accuse therapists of brainwashing the parents. This can approach encouraging a bit of a split between the therapist and parents in the early phase of treatment.

INTERSUBJECTIVITY: A child with AD brings very powerful feelings into therapy. The therapist and parents will repeatedly be made the target of rage, terror, shame and despair. These can evoke primitive somatic responses from the therapist, and it is essential, though often quite difficult, not to personalize this. Despite such impacts, therapist must be able to co-regulate the child’s arousal state, both up and down, just as a competent primary attachment figure would do. This requires a well honed awareness of the facial expressions, gestures, and vocal qualities as well as awareness of the child’s implicit arousal levels. “Clinical efficacy with AD children is more than left hemisphere technical skill. All such technique sits atop right brain implicit skills. Over time, it is important for a clinician doing attachment work to be able to finer and finer distinctions in affective nuances, implicitly communicated.” (Allan Schore). The task of co-regulation should be transitioned to parents as efficiently as possible. It can also be effective for clinicians to share their intersubjective experience with the parents and see if it resonates with the parents' experience. Such sharing can assist with building a powerful bond between therapist and parents while also assisting the parents to put their experience at home in a clearer perspective.

INCREMENTALISM: Therapy with AD children is very much a stepwise process. Maintaining an incremental perspective serves multiple purposes: 1) it keeps the focus of therapy more closely aligned with what is currently happening, which is always where emotional access lies, 2) it facilitates more specific objectives which are easier to keep clear, 3) it allows therapy to progressively unfold out of events as they develop, 4) it reduces the chances of overwhelming, or becoming misattuned to, the AD child by looking too far ahead, 5) it keeps things at a pace that promotes internalization for the child, and 6) it models, for the parents, a realistic rate of progress.

DUAL LEVELS OF WORK: Clinical work with children with AD generally has two parallel levels, both of which are ongoing. Most simply put, these are the emotional and behavioral levels. At the emotional level, the goal is one of transformative emotional healing. At the behavioral level, the goal is one of behavioral change, in the moment, such that behavior is shifted in a more functional direction. At the emotional level, altering behavior in the short term is not a priority. In fact, the pursuit of emotional healing frequently leads to an interim behavioral deterioration. At the behavioral level, processing emotional experience is not the focus; behavioral change in the moment is. However, behavioral work frequently triggers significant affect, and this does present an opportunity to work on the emotional level. If that is going to be the choice, a clear decision should be made to shift from the behavioral track to the emotional one. This avoids an ineffective muddle of behavioral and emotional technique. Families struggling with children with AD need both emotional and behavioral tracks as components of the therapy. Parents need assistance with managing the extremes of behavior that AD children generate at home (and may never display fully in therapy). The emotional work, early on, is pretty much the exclusive province of therapy. As progress is made at the emotional level, much of the work of emotional healing can be shifted into the home context.

THERAPEUTIC INTENSITY: It is not realistic to expect a child with AD to willingly engage in therapy, to a meaningful degree, from the outset. The magnitude of their emotional challenges is simply too great. Like anyone in a similar position, they are more likely to be concerned about self-protection than self-discovery. Thus, the intensity of attachment therapy must be gauged so as to disturb the child’s self-protection system if progress is to be made. However, the intensity must also be gauged so as not to produce an overwhelming and disorganizing degree of discomfort. This will only confirm for the child that therapy is yet one more unsafe place peopled with hurtful

adults. This leaves a range of intensity that is constructive, analogous to the therapeutic dose of a medicine. Too much or too little and there are no results or negative results. This therapeutic range of intensity is, of course, highly variable from individual child to child. Thus an effective attachment therapist must be: 1) skilled at reading a child's distress and distinguishing mounting discomfort from a state of being overwhelmed, and 2) able to adjust the intensity level so as to repair a break should the child's upper threshold of distress be exceeded. This is analogous to the relational repair work that parents must do at home after a rupturing parent-child interaction occurs.

PHYSICAL PROXIMITY: As physical proximity is often closely related to emotional arousal level, adjusting the child's physical proximity to the parents and/or therapist can be an important aspect of activating and regulating the child's emotional arousal. If the child is only minimally aroused, increasing the adults' proximity can usefully activate the child's emotional arousal. On the other hand if the child is beginning to get overloaded, resulting in behavioral deterioration, having the adult or child move farther away can reduce the arousal level below the overload threshold, and allow the current interaction to proceed without any harmful disorganization occurring. However, depending on the parent-child dyad, increasing the proximity by having the parent hold the child and provide soothing comfort can also effectively lower states of overarousal. When the child is engaging in purposeful distancing behavior, decreasing the proximity by having the parent move away can make the child's apparent goal explicit. This sometimes generates a useful distress reaction in the child that sets the stage for working with the discrepancy between surface behavior and the child's real want underneath that.

INTERACTION INTENSITY: Children with AD tend to assess the threat potential of an interaction both by who initiates the interaction as well as by the nature of the interaction itself. Thus, a less intimate / affectionate response initiated by an adult is likely to be more anxiety provoking than a more intimate-appearing interaction that is initiated by the child. In general, AD children can receive significantly less affection than they can appear to offer. Thus, it is prudent for the adults, when initiating an affectionate exchange (e.g. a hug) to temper it so it matches what the child can receive at first and then gradually intensify the interactions over time to extend what the child can receive. This attunes what the adult initiates to what the child can receive at a given point in time.

GAINING ACCESS: For therapy to have lasting impact, the process must access and channel (regulate) emotional energy in the present. Children with AD tend to function as enclosed systems within themselves, with the degree of integration varying widely across children. As a system, the different parts are interconnected and thus, they influence each other in reciprocal ways. Feeling, thinking, sensation, perception and behavior all affect, and are affected by, each other. These parts can be thought of as occupying different points on a circle, and that circle encloses the AD child's emotional energy. In order to access the child's energy to power healing transformation, a doorway must be discovered. The most accessible doorway on the circle changes over time and must be discovered anew each session. Doors that were open one week are nailed shut the next. Predictability in approach almost guarantees rendering therapy a sterile enterprise sooner or later. Hence the therapist needs to be able to approach the child from different angles across time. What the therapist is searching for is evidence that emotional energy has been activated in the moment in order to fuel the therapeutic endeavor. Sometimes inquiring about feelings opens a door (affective approach). Sometimes inquiring about what the child thinks or believes opens a door (cognitive approach). Sometimes focusing on the child's behavior, in or out of therapy, opens a door (behavioral approach). Sometimes asking about physiological sensations opens a door (physiological approach). This concept of gaining access mitigates against the artificial and illusory division between emotional/relational work and cognitive/behavioral work. These areas are reciprocally related rather than being separate, either-or categories.

THE FORMATION & DECONSTRUCTION OF MEMORY: The formation of a memory is a process that occurs in stages. At first, the precursor to a memory is a fluid pattern of electrical signals that encode aspects of the situation and any accompanying feelings. However, in the presence of heightened fear states, cortisol interacts with proteins and neurotransmitters to strengthen these fluid signals and consolidate them into a cohesive, fear-inducing memory. The triggering of that memory in the future activates the feeling and returns the memory to its initial, biologically fluid instability. The memory will then reconsolidate unless something (new learning or behavior, EMDR, drugs) interferes with the reconsolidation process. Interference leads to weakening of the original memory, and potentially, its eventual disappearance. However, to effectively block reconsolidation, therapy must be precisely timed so that it occurs during or shortly after the memory has been triggered. This is a narrow window as reconsolidation takes but a few hours. This underscores the importance of gaining of emotional access in the therapy session itself in order to create the precious opportunity to begin therapeutically deconstructing the emotional pain bound up in memory. Of necessity, this creates some degree of dysregulation in the moment.

EMOTIONAL ENGAGEMENT: Maintaining an emotional engagement between the child and the adults, regardless of the behaviors put forth by the child, is an essential ingredient for therapy to be effective. Emotional engagement means that there is real emotion embedded in real time, in the interactions between the adults and the child rather than more sterile routinized or intellectualized exchanges. A major block to engagement is AD children's typically disparaging view of emotions in general, and theirs in particular. One way to learn about these attitudes is to ask the child what she thinks her parent thinks of the feeling in question. The answer, of course, is constructed out of the child's own attitude. Sustaining the emotional engagement generally requires working spontaneously with what has just occurred in the immediate moment rather than imposing a predetermined plan over an entire session. Sometimes, this engagement is at a preverbal, subconscious level. At this level, the visual and tactile modalities are often more important than the auditory / verbal one.

EMOTIONAL TOLERANCE: As AD children diligently avoid being emotionally real, when genuine emotion does surface, it can be a frightening experience. AD children need to build up a tolerance for genuine emotional experience- metaphorically, they need to build their emotional muscles. If the child does not immediately disconnect from the feeling, then the presence of real emotion represents an opportunity to work on that tolerance. The goal here is to let the feeling be present as long as possible and congratulate the child for remaining connected to the feeling and not hiding it. This is not the time to seek further explanation for the feeling or to offer reassurance. The treasure is the appearance of the feeling itself. The gift to the child is the empathic witnessing of the feeling by caring adults. It can be useful to point out to the child afterwards that nothing destructive occurred as a result of expressing some real feeling. This lays the groundwork for emotional processing via reciprocal inhibition to begin.

RECIPROCAL INHIBITION: Reciprocal inhibition refers to the pairing of an anxiety response that is connected to a disturbing memory, with some form of emotionally incompatible experience. Research has established that repeated pairings of the incompatible experience with the anxiety reaction leads to a deterioration of the connection between anxiety and the previously distressing memory, such that the memory becomes progressively less charged. Metaphorically, the original anxiety reaction is overwritten, and a new neural network is laid down. This does not happen from a distance. For reciprocal inhibition to occur, the anxiety has to be activated in the present moment and then balanced with the emotionally incompatible experience. This is a delicate balancing act, as defensive responses to the anxiety can easily block any incompatible experience.

THE NONVERBAL DIMENSION: Communications research has repeatedly found that in verbal interaction, body language carries about 50% of the message, vocal characteristics 40%, and the verbal content 10%. These results highlight the importance of tracking the nonverbal dimension, a task even more essential to working effectively with AD children. The nonverbal dimension carries most of their emotional expression, and much of that is out of their awareness and so beyond the reach of verbal report. Being aware of this dimension, in all of its richness, is a critical skill for the clinician doing attachment work. Probably the most comprehensive breakdown of the nonverbal dimension was done by the Neuro-Linguistic Programming practitioners back in the 1970's. They identified the below listed items as all capable of carrying affective information.

- Body position
- Muscular tension
- Gestures and movement of body parts
- Head tilt
- Breathing: location and rate
- Facial color, muscle tone, and jaw position
- Lips: pursed / drawn, sucked inward, corners upturned / downturned
- Voice tonality, volume, rate of speech, articulation, fluid vs. staccato, dismembered sentences
- Quality to the eyes

As AD children are so feeling-averse, it is useful to establish the principle that “mouths talk or bodies talk”. This challenges the illusion that the child is in full control of the information being conveyed. They cannot, not express their feelings. This idea typically generates considerable anxiety for an AD child. It also provides a basis for telling (gently) the child, “Your mouth says you have no feelings and your body says you do”. The therapist can then offer a guess, based on the nonverbal data, as to which feeling is present. This intervention can serve a dual purpose: 1) it can be a gateway to gaining emotional access, and 2) it can make disconnected feelings more explicit for the child.

(See Behavioral Expression Lists below)

READING THE EYES: Being able to read the appearance of an AD child's eyes can provide the therapist useful information for promoting emotional engagement. In my experience, the different looks to the eyes fall into five broad categories. 1) Clear / bright- indicates that the child is present, engaged, in a positively valenced mood and more aware of the big picture. 2) Dark- the eyes appear as if a shadow has fallen across them and this usually reflects anger, rage, or depression. 3) Empty- the eyes appear as voids, giving the impression that “no one is home”. This is the look of depletion, of giving up, and of disconnection from self and the environment. 4) Steely / piercing- the eyes appear focused outwards with an intensity that seems to “look right through” an observer. This is the gaze of hypervigilance and of focusing on individual details. It telegraphs anxiety and distrust. 5) Mirrors- The surface of the eyes appears only as a reflective surface that masks anything beneath it such that an observer is essentially, shut out. The basic message is, “I don't want you to see me.” 6) Receptive: These are the eyes of the infant just taking in or absorbing the immediate world like a sponge. This, in many ways, is the gold standard of attachment work.

SPEAKER AND LISTENER: Separate these roles clearly in therapy. The speaker is responsible for what she said, and the listener is responsible for what he heard. This is important, for how anyone hears another is more influenced by the beliefs of the listener than by the words of the speaker. Partially this is a boundary intervention and partially a management tool to keep communication from getting unproductively bogged down in a “You said / No I didn't” debate. When the listener says “You said...”, that is reframed as “What you heard...”; and the speaker does not defend against what the listener says was said. This opens the door to examine the listener's responsibility

for hearing what he did. This boundary will have to be maintained repeatedly over a course of therapy.

SOCIAL SKILL DEVELOPMENT: Given their typically uneven development, AD children usually have multiple social skill deficits, and some of their maladaptive behavior comes out of this not knowing what to do rather than emotional resistance to doing it. Therefore, a component of therapy with these children is teaching and practicing skill development. Examples of basic skill deficits frequently seen with this population are: greeting people, poor eye contact, saying thank-you, verbalizing feelings, looking at the speaker, considering the listener's perspective, accepting compliments, understanding personal space, understanding personal ownership, not interrupting, speaking respectfully, asking questions of others, making requests vs. demands, being aware of voice tone.

SPECIFIC INTERVENTIONS

BIRTH FAMILIES: For children who have been adopted or are in foster care, teaching them about the true circumstances of their birth families can promote healing in a variety of ways: 1) it can begin to resolve any loyalty conflicts that children may have, and this is essential, for loyalty conflicts are almost always impediments to future attachments, 2) similarly, it can prevent an idealization / devaluation split that would block both grieving and future attachments, 3) maybe most importantly, it gives the children permission and validation for the feelings of anger, betrayal, and sadness that are almost always present when children are not with their birth families, 4) it can prevent or help heal feelings of guilt that can be present when children have heard a variation of the "special child" adoption story, yet have their painful feelings inside rather than any sense of gratitude, 5) it opens the door to nurturing self-image which has almost always been damaged by children's self-blame for not being with their birth families, and 6) it avoids creating distrust in the adult world, as children, sooner or later, come to view more positively valenced adoption stories as just not squaring with the facts. They are then left to wonder (usually by themselves) why they are being given the positive story. This discussing of the realities of birth families, is highly charged material and should be done incrementally, over time, paying particular attention to the child's nonverbal indicators so as to avoid any states of being overwhelmed, which would block the necessary integration for healing to result.

EYE CONTACT: As long as an AD child does not have consistently good eye contact, working on eye contact should be a priority. When speaking to the child or when the child is speaking, the therapist and parents should regularly, but not always, insist on eye contact, as eye contact increases the impact of what is being said. If a verbal cue such as "look at my eyes" is not sufficient, therapist or parents can: 1) gently place their hands on either side of the child's head and turn it or, 2) tap the child lightly on the cheek or under the chin until her head is pointed towards the adult. Getting eye contact in any given situation is not one of those battles to be "won" at all costs. This sets up a likely power struggle that will only contaminate eye contact with tension and conflict. When the child is determined to avoid eye contact, it is useful to accept that while commenting on the avoidance and then moving on. Do express appreciation when eye contact is given. It is useful to describe the presence of eye contact as, "I can see you", and its absence as "hiding". Remember that extended eye contact in a relationship with a power differential (parent-child) tends to make the one with less power feel defensive.

ANGER AS THE #2 FEELING: The emotional energy of anger is first and foremost, self-protective. Anger arises protectively in response to a perceived threat, be that threat external or internal. The key point here is that anger is always the second emotion on the scene. Another more vulnerable

emotion such as anxiety or disappointment or hurt preceded the anger. Children with AD often rely on anger to manage the rest of their emotional experience. Finding their more vulnerable emotions a bit terrifying, AD children frequently convert feelings such as fear, anxiety, disappointment, sadness, embarrassment, and happiness into anger to protect themselves from these emotions. This conversion can be so rapid that the “softer” feeling is not even experienced by the child- nonetheless, it occurred. There is generally more therapeutic value in working with the softer feeling, if it can be accessed, than remaining focused on the anger. The anger can be defined as a marker or signal that another feeling occurred just prior to the anger- hence, its #2 status. The child can be invited to search for that other feeling or a guess could be offered by the therapist. This opens the door to: 1) teaching the child that he converts some of his feelings into anger, 2) that he does this so fast he may not even experience the first feeling, and 3) beginning to work on searching for the other feelings currently being converted into anger. A question that can facilitate the shift from anger to sadness is, “What will your life be like if...”

DEFENSES & IWM'S: Defenses are essentially emotional regulatory tools. IWM's serve as emotional regulatory tools on a meta-level. Other people are assigned roles within the child's psychodramatic script. Defending against this role assignment is not helpful and may well be counterproductive, as an AD child is very likely to see this as an adult effort to fool the child. This will only promote further distrust. Instead, allow the child the right to assign the adult whatever role he wishes, which is essentially an act of attunement. This, of course, is not the same as the adult actually playing that role. This sets the stage for describing the child as needing to see it that way and to keep the adult in that scripted role, regardless of what's true about the adult. This opens the “why door” and shifts the responsibility off the adult to “disprove” the role, and onto the child for constructing the role.

GIVING RESISTANCE A VOICE: Resistance takes many forms. Simply put, all resistance is born out of fear. The immediate aim of resistance in therapy is usually to escape some form of emotional experience. The larger goal is protecting oneself from what is perceived as “dangerous” emotional experience. Resistance can be conscious or unconscious. Even if it is conscious, the use of resistance, in the moment, is often not acknowledged. This is pretty much a given with children with AD. Little can be done with resistance, and the fear it points to, as long as the resistance is implicit. Simply pointing it out usually leads AD children to just intensify their resistance. It can be more effective to “give the resistance a voice”. This voice can even be given a descriptive name such as “the stop talking to stay safe part”. This voice respectfully acknowledges that the goal of the resistance is self-protection and specifies how that protection is being provided. This can lay the groundwork for identifying the specific fear that is generating the resistance in the first place. Timing should take into account that this intervention is likely to generate some dysregulation at first.

BEHAVIORAL EXPRESSION LISTS: It is very common for AD children to immediately translate feeling into behavior. Often this occurs so rapidly or has become so automatic that the child does not experience the feeling that spawns the behavior. Hence, inquiring about the feeling when the behavior appears can be futile. Here is where behavioral expression lists come into play. Child, parent, and therapist all contribute to the creation of a comprehensive list of all the different behaviors that have been observed in the presence (presumably) of a certain feeling. The list is copied, ideally by the child if willing, and taken home for display. The list is framed as a tool for learning to recognize feelings by way of the behaviors the feelings trigger. In this sense, this is fundamentally an educational endeavor to assist the AD child with affect recognition and with making connections between feelings and behavior- skills that are typically weak in AD children. A behavioral expression list is not a list of behavioral problems to be corrected. This intervention sets a context for attempting to access the underlying emotion, when these behaviors appear, in future

sessions. This second step should not be attempted at the time the list is initially constructed. The list should only be done when the emotional arousal level is in the mild to moderate range.

THE TRICK LIST: “Trick” is a useful word to use to reference AD children’s many self-protective stratagems. Trick is preferable to manipulation, dishonesty, conning, sneakiness, or lying, as it is a more “child-friendly” word that lacks the heavy-handed baggage of these other words. A useful intervention is to make a trick list for a given child. As the name implies, a trick list is a list of the child’s repertoire of self-protective strategies. Each item on the list is composed of a behavioral description followed by the word “trick”. For the child who avoids sharing information by saying “I don’t know”, this would appear on the list as the, “I don’t know trick”. This is done in the spirit of description vs. criticism and judgment. This intervention can have a bit of a playful air to it and should acknowledge the child’s creativity in devising such an array of tricks. A trick list has to be compiled over time, as the range of any single child’s tricks doesn’t all emerge at one time. Copies of the list should be made for therapy and for home. Trick lists have multiple uses. Naming and describing the tricks can partially interfere with their use. Having a list aids parents in identifying the tricks rather than simply reacting to them on the basis of their behavioral appearance. In therapy, trick lists can be used as indicators of the distrust and fear in the child that spawns the tricks in the first place. This sometimes opens a door of access to these affects. In a moment, the emergence of a trick within a session can be framed as a marker that the child’s anxiety has just increased. This can also open a door of access. Finally, the child can be taught that his use of tricks fuels his distrust of self and others. At some level, the child knows he is being tricky, and this will reinforce the expectation that others will be tricky with him. This only serves to continue to block attachment and relationships.

Once a list of tricks has been identified for a child, it is constructive to attempt to identify the target the tricks are designed to avoid (examples: sharing information, taking responsibility, directly expressing a feeling, emotional closeness, etc). This can be referenced in future sessions and may even be used on a predictive basis to predict the likelihood of tricks appearing. In challenging an AD child’s tricks, the initial level of feeling encountered is almost always frustration and annoyance. This is essentially self-protective anger (Anger as the #2 Feeling). It should not become the focus of the interaction, but should be navigated around if possible in the moment- see below.

PASSIVE AGGRESSIVE AVOIDANCE BEHAVIOR: This is more the rule than the exception with AD children in therapy, particularly early on. Sometimes it is helpful to challenge the behavior directly as being in the service of avoidance. This of course, is almost universally met with denial. Sometimes it is useful to extend the child the “benefit of the doubt” that the behavior was genuine in some way rather than avoidance. In this instance, it is important for the therapist to watch for two things: 1) demonstration of the opposite behavior, and 2) repetition of the same behavior shortly thereafter. Repetition almost always happens when the original behavior was passive-aggressive avoidance. The repetition can be pointed out, to both child and parent, as evidence that the “benefit of the doubt” was a well-intended mistake. This is helpful for holding the child accountable for having “behaviorally told on herself” with her subsequent behavior and makes it more difficult to blame the adults for an “unfair accusation”. This also models, for the parents, a useful strategy to employ at home. If more constructive behavior follows the initial “benefit of the doubt”, the therapist should acknowledge having been wrong and congratulate the child for having been honest. **EXAMPLE:** AD children often have items in their pockets to use as distractions in session. Confiscating the item is met with pleas of innocence. Soon thereafter, another item emerges.

REGRESSIVE AVOIDANCE BEHAVIOR: Though regression in service of the ego can occur, it is the exception with AD children. More typical are malignant regressions whose purpose is simply avoidance that stagnates development. A frequent tip-off to a malignant regression is the child’s

voice becoming younger, higher, sing-song. Managing these malignant regressions is an important component of therapy with AD children. Often AD children have a series of progressively more immature behaviors they engage in when anxious. They will slide down this slippery developmental slope, one behavior at a time, until they reach a point where they have escaped the imminent source of threat. Trying to eliminate all of these behaviors at once is not likely to be effective. Instead, pick the most extreme behavior, and put limits on that, and do so ahead of time, not once the regressive slide has begun. This puts a regressive floor underneath the child. This can be paired with the beginnings of teaching a relatively, more constructive alternative.

FAIRNESS / UNFAIRNESS: This subject is often raised by children with AD (and children in general) as a rationale for adults to either “do” or “not do” something. This can be effectively handled by defining “fair / unfair” as code language for one of the following: 1) “things aren’t going the way I want them to”, or 2) “I don’t want to be held responsible for my behavior”. Fairness then, is really sophisticated wording for pursuing one or both of these agendas. The most unproductive response is to engage the child in a debate about whether things were “fair” or not.

GRANDIOSITY / ENTITLEMENT: This is a very common feature of the IWM of AD children. Grandiosity can arise from a history of too many needs having being met, leading to a sense of specialness in the child. Development is blunted because of a lack of appropriate challenge, and the child learns to trade on specialness / unconditional love instead of skills. Here the child assumes boundaries will break down and the adults will give in eventually out of guilt. Adults, and particularly parents, must learn to tolerate and support the child’s struggles with fear and distress when specialness begins to fail. At the opposite extreme, grandiosity can arise from a history of insufficient meeting of the child’s needs. Here the child assumes adults won’t provide for the child’s needs. This produces a sense of unimportance, and to counter this as a matter of survival, the child develops a stance of reactive grandiosity to compensate. The child trades on a projected image of omnipotence to intimidate the adults into giving. Adults, and again parents in particular, should seek to empathize with the child’s fear and distrust without getting defensive in response to the intimidation tactics.

ARGUMENTATIVENESS: AD children (and children with AD/HD) are very skilled at assuming argumentative positions to serve multiple purposes. Parents, and therapists, frequently get caught in debating the merits of the issue as it is presented. This is unproductive 99% of the time. Instead, simply agree to disagree (an unarguable stance) with the child about the nature of reality. This saves time and prevents feeding the child’s sense of power by entering an argument the adult cannot win. Leave it open that time will tell which position is the accurate one. Keep a future eye out for events that pertain to the original issue and point out which position the events confirm as they occur.

“I DON’T KNOW” / TAKING A GUESS: “I don’t know” is a very frequent response that AD children rely on as an avoidance tool. Though well intended, adult attempts to prod the child’s thinking with suggestions, are almost always a mistake. An AD child is apt to latch onto one of these suggestions in order to escape the interaction without revealing any real information. The adult, meanwhile, may be fooled into thinking something useful was learned. A better response is to imply some disbelief in the “I don’t know” and invite the child to think harder. If this yields no result, the therapist can “take a guess”. Unlike a suggestion offered as a question, a guess is a rhetorical statement; and AD children often react to statements in moments they would just ignore a question. A further step, more challenging still, is for the therapist to take a guess and to say that absent any input from the child, the adults will consider the guess correct and will make use of it in the future when relevant. These options represent a hierarchy of increasing challenge to the AD child’s avoidance. This can also be used at home by parents.

RIBBON OF LIFE: This intervention visually lays out the important events in a child's life. In so doing, it presents multiple opportunities for gaining emotional access; and it reinforces the accurate chronology of events which can help with the temporal perception problems so frequent with AD children. A ribbon is unrolled, and one end represents birth while the other represents the present. The child is invited to pick out figures to symbolize self and significant others. The therapist, having the history, tells the story in a storyteller fashion (Once upon a time...). Events are laid out along the ribbon. Should significant figures leave the child's life, the child is asked where to place them in the room. At any point, the child may stop the story, modify the story, or share reactions to the story. The therapist should closely track the child's nonverbals as the story proceeds, and invite the child to share should something significant be observed. At the end of the story, with the child-figure in the present, the ribbon can be wrapped around this figure to powerfully represent that the child is still wrapped in the accumulated feelings of past significant events. The ribbon can be unwrapped to symbolize the opportunity of therapy. A picture of the finished Ribbon of Life can be taken and saved for further reference. This intervention can also set the stage for a subsequent close-up of a portion of the child's life in a later session. The ribbon now represents just that portion of time that is the focus and the events within it. This may draw in events that were not included initially. Again, the therapist should be closely monitoring the child's implicit affective cues.

REDOING THE SCENE: AD children often distort, ignore, or reject a wide range of input from the adult world. Sometimes they do this because the input is emotionally threatening and sometimes they simply don't know how to respond. This intervention is simultaneously aimed at addressing both of those possibilities. **Example:** A parent expresses pride in the child for having helped out a family member. The child looks blank and says nothing. The therapist can inquire how it felt to hear that, and that question is likely to be dismissed. The therapist can then "redo the scene". With older children, it can be useful to put this exercise in the context of Hollywood and the redoing of scenes in movies. The therapist gives the child a scripted line to repeat verbatim. In this case, that could be having the child tell the parent, "I like it when you are proud of me." This may meet with resistance which can be explored. If the child complies, watch the nonverbals and afterwards inquire what it was like to say the line. There are multiple points in this intervention where emotion could be accessed, and the therapist should be ready to follow an opening should it occur. At the very least, the child gets useful practice in a socially appropriate response to the parent's pride in the child and an attachment sequence between parent and child gets completed.

BODY CONNECTION: AD children are commonly disconnected from their bodies to varying degrees. This can manifest in not being able to tell the difference between different feelings or not even recognizing that they have experienced a feeling. In more severe cases, they may even be immune to physiological sensations such as hunger, tiredness, cold/warmth, and pain. AD children often breathe high in their chest and exhibit a thin, high voice. Since it is difficult to work with feelings that aren't being experienced, it may be necessary to do some work to deepen the child's bodily connection before emotional work can proceed. This can be done in many ways including use of a balance ball, standing on a dowel, breathing against applied abdominal pressure, or making growling animal noises. One variant of using a large balance ball has child lie on back on the ball with arms extended over the head. The parent (not the therapist) holds the child's arms / wrists and gently rolls the ball forward and backward (works better with younger / smaller children). This carries the added advantage of also working on trust as the children typically worry the parent will let go. Regardless of the method used, AD children often have an instinctive resistance to body work at first. That can usually be overcome by presenting the body work playfully. Activities that carry a lot of movement such as exercises or jumping on a trampoline aren't recommended as they tend to draw emotion off into the movement.

TOUCH/PHYSICAL CONTACT: Physical contact between the adults and child should be expected as an integral component of attachment work. Sometimes physical containment is required to maintain the safety of people and/or property. Often touch is necessary as a cue to focus attention, to maintain a preverbal emotional connection with a child with AD, or to expand the child's capacity for closeness previously unknown by the child. Physical contact for this purpose was originally termed holding therapy. As controversy about this method grew over the years, variations on the original name were developed. Holding therapy was once the primary methodology used to do attachment work and holding therapy and attachment therapy became practically synonymous. While well intended, I believe this was, practically speaking, simply a mistake. My clinical experience has taught me that holding work is a powerful healing intervention, and should be thought of as just that, an intervention as opposed to a mode of doing therapy. Hence, I refer to it as holding work vs. holding therapy. As an intervention, holding work may or may not be used in any given session, just like any other intervention. However, holding work is not a stat approach to be used week-in, week-out. This is a matter of practicality, not philosophy- different tools are required for different jobs at different points in time. Holding work should not be physically imposed on a child over his strong opposition. While this statement can be made on ethical grounds, I see it as common sense practicality. To impose holding work would only contaminate physical touch with conflict and tension as would occur with forced eye contact. This only countermands healing. On the other hand, to banish holding work altogether I do see as an ethical matter, for then all clients are deprived of what would be a powerful healing tool, at least for some. To preclude all physical touch, especially in cases involving abuse histories, only puts the pathology in control. What AD children need is to accumulate experiences of safe and nurturing touch, not restricted access to such experiences. With holding work as with all tools, it is not the tool itself, but the competence of the hands that use it that facilitates the outcome. Thus, the use, or not, of holding work, depends on each clinician's comfort, skill level, and value system.

PRAISE/COMPLEMENTS: AD children need clear praise and recognition for each tiny constructive step they take. However, they tend to be aversive to positive input as this clashes with self-image and generates uncomfortable emotional arousal. The typical responses are no reaction at all, dismissal of the praise, an instantaneous shift to some external topic, or acting out to try to prove that the adults are wrong. The child's rejection of praise should be acknowledged and accepted, and she should be reassured that praise from the adults is not conditional upon her acceptance of it. She should also be assured that praise will not be forced upon her nor will her enjoyment of it be demanded. In addition, the child can begin practicing the acceptance of a complement by having the child repeat the complement back, specifically, to the giver, with eye contact. Monitoring the child's voice is important for it is usually altered in some fashion to dilute the reality of what is happening. Have the child repeat the complement again using their regular voice. Watch the nonverbals closely. Inquire how it felt to do this. Usually there is a combination of some positive affect and some anxiety present. Label this a success and move on. Even when AD children begin to accept praise, they typically lose all recollection of it. This is to be expected, and so the child will need many repetitions of being acknowledged before anything will accumulate to the point of having a meaningful impact on self-image.

TRIANGULATION: Children with attachment difficulties are often highly skilled at triangulating adults as a way to regulate themselves. Most frequently, this manifests as some form of the Rescue Triangle. This is a dynamic that commonly occurs in human relationships, and it is primarily a destructive one. The Rescue Triangle has three participants. One is in the role of Victim, another is in the role of Perpetrator, and the third person arrives as the Rescuer. AD children usually place themselves in the position of Victim and then draw in two adults to be the Perpetrator and Rescuer. The roles shift over time. Nothing really changes. No healing happens. No one learns anything.

Obviously, therapists need to be highly alert themselves to not accept an invitation to step onto the Rescue Triangle. When it is the parents who have allowed themselves to be triangulated, this reliably indicates a blind spot for one or both parents that will likely require some therapeutic work to illuminate. Otherwise the Rescue Triangle will continue to reappear at home. This is therapeutic work that the attachment therapist should take on and not refer out, as referral out is likely to fragment treatment. In interfering with triangulation, the therapist effectively denies the AD child the role of Victim. In so doing, the therapist should expect an angry retaliation. This is the nature of the game at hand- any adult who refuses to support the child in the victim role, thereby becomes a perpetrator by virtue of their refusal. However, when triangulation is not blocked, its success will amplify the child's sense of being unsafe even though there may be no behavioral reaction in the moment.

AMBITENDENCY: Ambitendency is the behavioral expression of emotional ambivalence. It is a repeated occurrence in attachment work, and managing it well can yield useful results. Ambitendency can occur in states of high emotional arousal while being held, when AD children may well resist being held and attempt to squirm away. The adult, in attempting to resist the child's resistance by intensifying the physical containment, runs the risk of contaminating the experience of being held with tension and conflict. Curiously, if the adult puts the child down when the child begins to squirm, the child often runs right back to the adult from whom she was just trying to escape. This happens because the child is seeking to escape an inner emotional state by opposing the adult. If the adult then picks the child back up, the child will likely immediately attempt to get away again. If the adult then puts the child down again, the child will likely run right back, again; and so the cycle repeats. If the adult flows with this cycle and does not become stuck in either side of it, the child's arousal level tends to settle with successive repetitions of being held and put down. Metaphorically, it is like the process of a pendulum coming to settle at the perpendicular balance point. Because the adult has followed both of the child's conflicting impulses (to get away and to come close), the entire process is really a prolonged, attuned, attachment sequence.

DISTRUST OF SELF: Describe how everything the AD child does that is not real (making up answers, fake emotion, playing dumb, fake laughter, "forgetting", etc.) while intended to fool everyone else, also teaches him to be distrustful of himself. Point out how that they have been so focused on fooling others for so long that they don't recognize how much they distrust themselves. Explain how he has become so skillful at fooling himself that sometimes he really doesn't know what he is doing. Periodically reframe "I don't know" answers as "pretending not to know" and tell the child that he has been pretending not to know for so long, he can no longer tell the difference between pretending and really not knowing. Should the child disagree, just point out that time will make it clear whether he has fooled himself with his own pretending, or he really doesn't know. This approach can be supplemented by suggesting that the AD child doesn't even believe himself when he takes extreme or absolute stances. The goal here is to create a split within the AD child so he begins to question his snap judgments and strategic maneuvering. When challenging an AD child's thinking, it is helpful to tell the child up front that he probably won't believe you. This creates a paradox the child cannot escape with simplistic control maneuvers.

CORE SELF-CONSTRUCTS: Typically AD children develop core self-constructs out of their early experience. Over time, these become cornerstones of identity. An example would be, "I am helpless". These core self-constructs have associated affective states, and because these constructs become elements of identity, their influence on perception and functioning is pervasive. For AD children, these core self-constructs tend to be negatively valenced. Giving a negative self-construct a name can create some useful distance. Children have identified this technique as being helpful to them. The child can be invited to consider what they might like to do with it (getting rid of it is not

an option). It is important to monitor for the emergence of these core self-constructs in present time. (Example: If the construct is “helplessness”, imposing a consequence that the child cannot escape may well trigger it and its associated emotions). When this occurs, anger is the emotion likely to emerge first because of its self-protective aspect. However, behind the anger is the emotion truly associated with the core self-construct. Typically, this will be some variant of sadness or fear or a mixture of the two. Because they bring with them a condition of vulnerability, these emotions rarely are the first to appear. Often they never appear because the defensive anger remains intact. When these core emotions do appear, they bring with them the opportunity for healing, for the emotional energy is now present. The healing response is one of empathy for the emotion and not an altering of the situation that triggered the core self-construct in order to defuse it. The goal is to keep the emotional energy present so as to maximize its exposure to healing empathy. As the child moves through the emotional experience, and as some of the emotion is healed, some of the power of the self-construct falls away as well.

BABY STORIES: This is one tool for getting at core self-constructs. It rests on the metaphorical idea of babies “making up stories” to explain their early experience to themselves. These stories are absolute as that is how babies “think”. The stories are carried forward in time and still “live” inside the child. As a result, they block present experience. The child can be invited to take a guess at their baby story, and if they have no guess, the therapist can construct a probable one based on the available data. The layer of metaphor here serves as a buffer to maintain the child’s engagement in the process.

THE IDENTITY INTERVENTION: Our sense of identity comes from many sources. These include: our experiences; our beliefs about ourselves; our behavioral choices; and input from others, particularly parents during childhood. Once something has been incorporated into one’s sense of identity, there is great investment in maintaining it, regardless of its accuracy or inaccuracy or whether it is positive or negative. This is the case because questioning elements of identity generates an experience of, “If I’m not who I think I am, then who am I?”. This can be terrifying and far more uncomfortable than any painful feelings associated with certain elements of identity. Thus, a negative identity is likely to be defended against more positive, alternative input. Children with AD do this repeatedly. The more fragile the sense of identity is, the more adamantly it will be defended to ward off complete fragmentation. Children with AD are hallmark examples of this. Promoting healing in AD children requires working within their current sense of identity, through empathy and support for how they have arrived at their pictures of themselves and how those pictures feel. However, this is often not enough. Sometimes healing requires working from outside or beyond a child’s current sense of identity. This is the identity intervention. Here, a child’s sense of his identity is gently, but persistently, challenged. The child is taught that she has a real self that she does not know that can handle the truth. Resistance to this challenge is both predicted and accepted, given the discomfort the challenge will create. Epistemology, or the study of how do we know what we think we know, plays a role in the challenge. This involves asking a child (appropriately languaged) how does he know that what he thinks about himself, is actually true. If an answer comes, it is accepted and then subsequently called into question as a basis for defining identity. A gentle suggestion is offered that there is much more to the child than he knows. The child is granted complete freedom to throw this idea away. It can be helpful to use the metaphor of the child being a house, but living in only one room and having no idea that the other rooms even exist. It is important to repeatedly validate the child’s resistance to all this, because he doesn’t know what lies beyond his “one room”, and this “not knowing” is quite scary. The goal here is taking apart the destructive beliefs that have been woven into the child’s current identity for these beliefs will rebuff more positive alternatives. Taking the destructive beliefs apart creates an opportunity for more benign elements to be integrated. Timing is clearly a critical element here. The child must have some sense of safety in the therapeutic setting and some degree of alliance with

both parents and therapist, for this intervention initially generates an anxiety that must be weathered, with the adults' support. When the anxiety emerges, the therapeutic focus shifts from challenging the child's current identity to empathic / supportive work that assists the child to tolerate the anxiety. The first step of this affective work is often interpreting the child's immediate behavior as indicating the emergence of anxiety that the child may not have recognized. The anxiety should not be reassured away, just framed as manageable and temporary. As the anxiety subsides, the focus shifts back to the more cognitively-oriented work of opening up the child's view of self. Should more affect emerge, the focus shifts back to the affect. The identity intervention typically involves repeated alternations of affectively and cognitively oriented work.

WOUNDED CHILD WITHIN (WCW): This construct is highly related to identity and core self-constructs. One way to work with the WCW is through the use of nesting dolls. The largest doll represents the child in the present and the smallest, the WCW. The in-between dolls can represent the child in various stages of growth with the WCW having been contained in all of them. To the WCW is assigned one or more of the central fears of the child: e.g., distrust of adults. Describe the WCW as asleep most of the time, unless the fear is triggered. Then it wakes up and starts giving the big doll directions about what to do to manage the situation. The big doll always carries these out. When the fear passes, the WCW goes back to sleep until the next time.

STRATEGIC SILENCE: Children with AD sometimes attempt to control the therapeutic endeavor by becoming mute and refusing all active participation. Attempts to explore or interpret this behavior can be mistakes, for these attempts may play right into the child's hands. Therapy can get drawn off into focusing on the child's passive defiance and the attachment work evaporates as a result. Instead, an effective alternative is for the therapist to try role-playing the child and speaking what she thinks the child would be saying and then shift back into the adult role such that the therapist is carrying both sides of the conversation. Alternatively, the parent can carry half the conversation. Therapists can also role play and speak for aspects of the child such as the child's memory, body, behavior, or feelings. This can produce a denial reaction on the child's part as soon as the therapist says something which the child can't or won't accept. Engagement is re-established without ever focusing on the child's oppositional silence.

TALKING TO BODY PARTS: Instead of talking directly to the child, the therapist can address specific body parts. This can be particularly applicable when there is somatic expression of emotion occurring. Examples: 1) the child puts his hands over his eyes and the therapist asks if the hands could talk, what they would say to the eyes they are covering; 2) when exploring the child's thinking, questions can be put in terms of what the brain (rather than the child) is thinking; 3) the child uses a body part to express resistance of some form and the therapist can say, "Your arm is fighting with the grown-ups". This approach introduces a buffer of distance that can assist in freeing up a child who is anxious. It is generally more applicable to children at the younger end of the age spectrum.

BELIEF VS. TRUTH: This can be a simple, yet powerful intervention. Point out that belief and truth are not the same thing. People believe things that aren't true and disbelieve things that are all the time. If something is true, not believing it does not change its truth. If something is not true, believing it does not magically make it true. If something is familiar, that does not make it true even though its familiarity makes it "seem" true. Here is where epistemology, or the study of how do we know what we think we know is true, can be a useful tool. Even the word itself can engage the child. The child can be invited to examine the source of the negative belief. The goal is to draw out the child's thinking rather than oppose it with feedback. In the absence of any clear grounding in reality, skepticism should prevail. The therapist can always apologize later for being wrong. The

therapist should clearly establish herself on the side of truth and point out this may lead to disagreement with the child's current position. This intervention usually requires repeated use over time to keep the boundary between belief and truth distinct.

CHALLENGING BELIEFS (tiered): Rather than challenging a belief directly, which is rarely effective, invite the child to flip the belief into its opposite and then verbalize it. This is almost always met with enormous resistance which reflects the emotional investment in the belief. That resistance can be pointed out along with the suggestion that the opposite idea is an uncomfortable one- this can open the door of emotional access. Ask the child to describe how things would be if “the opposite of what you believe now is true?”. This usually meets with more resistance which can again be pointed out, thus upping the “emotional temperature”. The clinician and parent can go on to offer possibilities of how things would be if the opposite were true and look at what that experience might be like for the child, which may encounter more resistance still. Now there is a clear basis to suggest that the child needs to keep the belief for some reason, true or not, which shifts the focus from what's true about the outer world to what's true about how the child's inner world is working. This increases the chances of accessing emotion. If things remain deadlocked by resistance, the final step can be to develop an experiment to test the belief out. Ask the child to predict what else will happen if the current belief really is true. It then becomes incumbent on the adults to keep track of relevant events going forward and allow the future to “tell the story”. The therapist should state that if the future proves her wrong, she will acknowledge that and congratulate the child on being right all along. The implication here, though it should go unstated, is that the same is expected of the child if the future story goes the opposite way. The therapist and/or parent then need to bring this back up after some future data has been gathered. The parent can also make reference to the experiment, in the moment a relevant event occurs. This intervention is a good example of a tiered intervention wherein there are several linked steps which evolve successively. Each step shifts the angle of approach of the interaction and incrementally turns up the emotional intensity, which is so important in working with AD children.

ACCOUNTABILITY FOR BELIEF: Before offering an AD child love or reassurance or a complement, ask first if the child would believe it. If this is answered affirmatively, then the adult should follow through. If answered negatively, accept the child's answer, and withhold the offering. This is an implicit lesson in accountability for what is believed, or not. It also avoids giving AD children yet one more opportunity to reject caring from an adult, an opportunity they hardly need. This should be used on an intermittent basis, as it is also helpful for adults to offer positive input independent of what the child will do with it.

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