

**Facing the Fear of Vulnerability**

Treatment of a Child with Reactive Attachment Disorder

By

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## TABLE OF CONTENTS

INTRODUCTION .....	1
CHAPTER 1: A BRIEF HISTORY OF TRAUMA THEORY .....	6
CHAPTER 2: ATTACHMENT THEORY.....	12
A Brief History of Attachment Theory .....	12
Interaction and the Formation of Self.....	19
CHAPTER 3: REACTIVE ATTACHMENT DISORDER.....	32
CHAPTER 4: JAY’S EARLY HISTORY.....	37
No time to Bond.....	37
No One to See.....	40
CHAPTER 5: MISDIAGNOSIS, ASSESSMENT AND DIAGNOSIS .....	44
Misdiagnosis, a Common Serious Error.....	44
Genetics and Differential Diagnoses .....	46
Assessment .....	53
Diagnosis .....	57
CHAPTER 6: TREATMENT OF RAD.....	60
Discipline Techniques.....	60
Rebonding Techniques and Rage Reduction .....	64
CHAPTER 7: TRAUMA.....	74
The Lasting Effects of Trauma .....	74
Somatic Memory .....	76

Differing Approaches to Trauma .....	83
Reichian Therapy .....	92
Vulnerability and Surrender .....	97
CHAPTER 8: GROUNDWORK FOR TREATMENT .....	102
Meeting the Family .....	102
Choosing the Primary Caregiver and Support System .....	104
CHAPTER 9: JAY DETERIORATES .....	107
Getting Started .....	107
Treating Jay with Predictable Failure .....	110
CHAPTER 10: THE NEW BEGINNING OF THERAPY .....	115
But Jay Gets Worse .....	115
Just a Little Progress .....	119
CHAPTER 11: FACING RESISTANCE AND CREATING TRUST .....	123
Regressing for Fear of Intimacy and Vulnerability .....	123
Attempting Intimacy .....	124
Couchwork! Not Again! .....	128
CHAPTER 12: FACING VULNERABILITY WITH COURAGE .....	132
Jay Recovers a Memory .....	132
CHAPTER 13: THE RISE AND FALL OF THE FALSE MEMORY DEBATE .....	135
War of the Researchers .....	149
CHAPTER 14: TERMINATING WITHOUT ABANDONMENT .....	159
Our Last Session .....	160

Final Diagnosis .....	165
CHAPTER 15: CONCLUSIONS .....	169
Symptoms and Treatment .....	169
The Experiential and Preventable Cause .....	169
REFERENCES .....	176
Appendix A: “Lonely Heart” .....	189
Appendix B: “Sad” .....	190

## INTRODUCTION

The purpose of this case study dissertation is to explore the causes, symptoms and treatment of a child with Reactive Attachment Disorder. This is about a 10-year-old boy named Jay, who did not have the opportunity to bond and securely attach to his parents during the critical wiring period of the first three years of life. Not only will this paper explore the effects and symptoms this deprivation had on Jay, but it will also study the actual impact such experiences have in the brain and on the formation of personality. Included in this look into cause and effect, I will explore the beliefs through which Jay was perceived and thus treated. Finally, because it is not possible to fully understand and treat attachment trauma without also exploring trauma, in general, this papers begins with a short historical review of Trauma Theory followed by a brief history of Attachment Theory.

This paper will explore Jay's young life, showing how a lack of attachment contributed to his problems as a boy. During treatment, I learned that Jay had four other therapists in his life before the age of four, including his parents' therapists. Under their watch, Jay missed his opportunity to form a secure attachment.

My journey through the attachment and trauma research led me to discover a phenomenon: A perspective exists, supported by therapists and researchers, which commits to protecting parents at the expense of their children during the therapeutic process. Resulting from this perspective or orientation are popular theoretical and treatment approaches which seem to avoid exploring relevant childhood experiences or feelings. Where I had once naively expected that all of my field—because it was *psychology*—was seeking with me to see more clearly the needs of young children, I discovered I was wrong.

I found that one approach to assessment, by virtue of the medical model, preferred genetic explanations to asking probing questions of parents about the child's quality of life or exploring in depth the childhood of an adult patient. The traditional analytic approach assumed inborn drives and fantasies were responsible for behavior, which often precluded exploration into signs of childhood trauma, especially attachment trauma. The behavioral approach presumed that one cannot know what is inside the "black box," so there is no point in dredging up problems and making people feel bad. Cognitive theory included a goal of replacing emotionality with reasonable beliefs, choices, and actions, ignoring childhood issues and possibly having the effect of supporting a repression ethic which could serve to shield parents. Fortunately, many of these theories also have virtues which contribute dynamically to the field, as well as to Jay's treatment. No need to throw the baby out with the bathwater.

As my survey through the literature unfolded further, I discovered an ongoing theme of theoretical disagreements between theoreticians on behalf of the children and on behalf of the parents. While I am reluctant to oversimplify or exaggerate, I believe it clarifying to characterize one side of the divide as pro-parent and the other as pro-child. This theoretical division will only be addressed because it affected Jay profoundly. It appeared more and more that Jay was a victim of theoretical blindness which I could not separate from my understanding of how he came to have Reactive Attachment Disorder.

Writing my last draft, I made another discovery. There was a correlation between my awareness and anguish that Jay had not been seen and the literal goals of the pro-parent camp not to see. The pro-child camp was highly invested in observation and studies of cause and

effect. The pro-child theorists were seers. On the other hand, the pro-parent theorists could not and would not see clearly, and were actually invested, perhaps unconsciously, in presenting theories to insure blindness. It looked as if pro-parent theorists had not chosen to do the work to examine their own childhoods, and rather, were doing their parents' bidding with great social influence. It actually appeared that people in major positions of power and leadership within the field had proposed theories which protected and represented those who wished to remain blind, while misleading and harming those who depended upon them for clarity. When I reconsidered, allowing that there may be no correlation in fact between the intention behind these theories and their effect of providing parental immunity and theoretical blindness, I came across even more evidence to the contrary. As the reader shall see, clinicians, theoreticians and researchers were often quite vocal about protecting parents, and at other times so blind and illogical, it seemed that such intelligent people could only have been unconsciously protecting parents or their parents.

A word about trauma as it relates to attachment disorders. Attachment disorders are traumatic, and since they happen to an infant at a formative period of their lives when they are most vulnerable, it may be the most traumatic of traumas with the most pervasive result. In recent years, the field of trauma has done more research on how to get to buried core issues than any other field. The field of trauma acknowledges attachment as the earliest, deepest trauma and even explains that early attachment trauma is the most probable reason why one person may be more vulnerable to trauma later in life, while another securely attached person is more resilient. The field of trauma understands that in order to heal primitive core issues, therapy must go deep and include at least some recall of the trauma, if

not emotional release. Therapy must pass through defenses, denial, resistance and into repressed material which is either believed by the victim to be too terrible to remember or re-live or too dangerous to know. Unfortunately, it appears that most therapists are not sufficiently educated in either attachment or trauma theory, which is Jay's misfortune.

The reader will be introduced to Jay, as the material relevant to his experiences unfolds. The issue of vulnerability was highly relevant to Jay's world view and the healing process he needed to enter. It would be helpful, then, to offer an operant definition here of vulnerability for the purposes of understanding and treating Jay.

Jay's history with lack of attachment and trauma led him to be in a continuous state of defense. When I met him he was on guard, acting like a little man, a tough guy. Further, he believed he had to be perfect or act as perfect at all times to ward off criticism or loss. Jay believed that to be an authentic child would be too vulnerable. In order to become a "real boy" as Pinnochio's father put it, Jay would have to learn to be vulnerable in play, in school so he could learn, and while relating in the world. We may not think that these normal activities or interactions require vulnerability, but Jay did. My role was to prepare him for this level of authenticity or vulnerability on a daily basis.

As a tough little man, he was not free to know himself or to care for himself empathically either. Part of his preparation to be authentic in the world involved developing the capacity to be vulnerable on a deeper level in private moments with safe people, such as his father, his therapeutic mother, and me. It also required the capacity to revisit the sources of his inner terror and horror, so that these injuries could be healed, as well. This process

involved leading him to become vulnerable with himself, honest with himself, and true to himself for the purpose of self-awareness and self-report.

Thus, for the purposes of this paper, vulnerability is on a continuum. Sometimes it is about relating to other people in authentic ways, and sometimes it's about finding the truth in oneself to share with another safe person. As such, Jay had to also learn how to identify safe people and, at other times, to represent himself in a healthy way when someone hurt him. As the reader will see, vulnerability was Jay's biggest fear and his greatest challenge to heal. It also became the clearest evidence of his progress.

Because Jay is a male child, I have opted to use the pronoun "he" when referring to subjects and clients, in general.

## CHAPTER 1: A BRIEF HISTORY OF TRAUMA THEORY

In order to work with Jay and to understand the ramifications of his behavior and the results of our sessions, I needed to understand prevailing theory on resistance and repression of trauma, in part because Jay was very resistant to work, and he was very repressed, as we shall later see. Further, attachment trauma is a form of trauma, and I wanted to become well informed about working with victims of trauma, in general.

Sigmund Freud had pioneered in working with victims of repressed trauma, and his earlier work is well in accord with contemporary trauma theory. Thus, I began with the father of psychology to understand why Jay was so afraid to explore his earlier memories.

Freud enjoyed collaboration with his eminent friend and physiologist, Joseph Breuer, with whom he observed that under hypnosis, patients could review traumatic experiences which they had blocked from conscious awareness. According to attachment theorists Terry M. Levy and Michael Orlans, the patients of Freud and Breuer had experiences which Breuer termed “abreaction” and which Freud called “catharsis” (1998, pp. 269) with therapeutic results. Freud believed that repressing trauma affected the physiology of the body (p. 270), as current day trauma theorists also believe.

Later Freud discovered that many of these types of repressed events could be recollected through the process of “free association” (p. 269). Freud and Breuer did not question the recollections of their hysterical patients. Freud began to suggest incest and sexual abuse underlying hysterical symptoms and even wrote to his close friend and mentor, Wilhelm Fleiss, that he had reason to believe that his own father had been “perverse” (Jeffrey Moussaieff Masson, 1985, p. 264).

In early April of 1896 Freud wrote to Fleiss with excitement in anticipation of formally presenting his Seduction Theory to his colleagues (p. 179). His pro-child Seduction Theory proposed that physiological symptoms of hysterical women made sense when understood as symptoms of repressed childhood sexual abuse.

Freud was harshly rejected by his peers. He was devastated. In a letter to Fleiss, he wrote, “Word was given out to abandon me, for a void is forming all around me” (p. 185).

Six month’s after Freud’s colleagues rebuked him his father died. During the night following his father’s funeral, Freud had a dream that he read a poster which said: “One is requested to shut the eyes,” from which he inferred with remarkable pro-parent blindness that he had carried unreasonable hostility toward his father far too long (p 445).

Who requested Freud to shut the eyes? A pro-child interpretation would be: Both the Society of Physicians, Freud’s all-powerful peer group who rejected him for what he reported he saw, and his childhood father, whose secrets he kept, requested him to shut the eyes. More than one hundred years ago the field of psychology was resistant to pro-child thinking.

A little more than a year after Freud’s debut of the Seduction Theory and a year after his father died, Freud shut the eyes. He recanted the Seduction Theory in a letter to Fleiss dated September 21, 1897, but he did not begin work on a replacement theory, in part, until 1905 (Henri Ellenberger, 1970, p. 444-517). Freud developed his pro-parent theory over the next forty-plus years to explain how sexual fantasies and internal drives account for behavior. Fortunately, he preserved some important concepts useful today, such as “defense mechanisms,” “resistance,” and “repression,” which would be, of course, the repression of

sexual energy rather than abuse, turning “from the repressed to the repressing,” as Ellenberger put it (p. 517).

Geniuses are not always heroes.

Freud had many protégés. Only Reich further explored sexuality, repressed feelings, and the relationship between mind and body in healing, developing a theory that children learn to tense certain muscles in defense of intolerable or unaccepted feelings. Reich postulated that our bodies tend to hold the affect in facial expressions, body postures and personality traits, and he called the state of holding these repressed emotions “body armor.” He believed that talk therapy was insufficient for relieving these repressed emotions. It was more efficient to have the patient hitting out, screaming or crying. His concern was to release affect stored in musculature, independent of the related issues. Reich did not delve into content (Levy & Orlans, p. 270).

Reich, himself, was a victim of sexual abuse throughout his childhood, according to psychohistorian Alice Miller (1990, pp. 56-57), and he actually believed it was good for him, which Miller suggests accounted for his growing insanity. Reich believed that people must be sexually liberated to be healthy, which especially had meaning during this time period. Perhaps Reich’s flagrant drive to reenact his own trauma was interpreted by him as liberated within the context of sexually repressed culture. Toward the end of his life this theme developed even further. He struggled toward a social sexual revolution, authoring a book to that effect (1945). As his health declined his beliefs became more extreme. Or perhaps the reverse is also true, that as his beliefs became more extreme, his health declined. According to Levy and Orlans, Reich believed orgasmic energy could be measured and harnessed in his

“Orgone Box,” which could cure a wide range of psychological ailments, especially frigidity (p. 270).

Reich’s failing health and growing extremism coincided with the McCarthy Era, a time when it was forbidden to say the word “pregnant” on television. When Reich began to market the “Orgone Box” he was arrested for fraud, tried, and found guilty by default, as he refused to defend himself (*Ibid*). He then refused to obey the injunction against him, selling his Orgone Box anyway, and was imprisoned for contempt of court. He subsequently died in prison. After his death, his theories were discredited for the most part. His techniques were all but forgotten, except for a few disciples who came to modify Reich’s theory, most specifically Alexander Lowen (1975, p. 36).

Lowen didn’t write off Reich’s theories or his lessons. He had discovered Reich in the earlier years at the New School for Social Research in New York, where Reich taught Character Analysis by observation of the body and its armor. Lowen valued the perspective of careful observation of the relationship of the body to the mind (1975, pp. 13-14). Further Lowen experienced first hand Reich’s therapeutic technique of continuous deep breathing, including it’s effectiveness on him as a patient of Reich (pp. 16-25). Lowen’s work ultimately deviated from Reich in that there was less focus on sexuality, per se (pp. 35-44). Further, where Reich had used the couch, Lowen’s focus came to be the use of two main positions, one sitting and one in a standing back arch, in which patients were posed to release their pent up emotions. Lowen and Reich both used touch. Lowen’s own version became known as Bioenergetics, presented in a book by the same name (1975). His version was more respected and well-received during a more accepting time period.

In my treatment of Jay, I elected to synthesize the techniques of Reich and Lowen. Use of breath was apparently so universal it seemed to be provided by nature as a natural way to heal trauma, and it was a technique which was free of suggestion, unlike hypnosis. Like Reich, I had Jay lie on the couch. Like Lowen, I was interested in content, as Jay brought it up. Most of Jay's content was about his cravings to be mothered and his desperate fear of abandonment.

Levy and Orlans summarized The Human Potential Movement which began in the 60's and 70's as a time when psychology refocused on mind-body therapies for healing trauma. Milton Erikson's hypnosis and Gestalt Therapies developed by Fritz Perls, which included talking back to an empty chair and hitting with a baton to release anger, were introduced into the repertoire of newer therapeutic techniques. Another new technique, developed by Arthur Janov, was The Primal Scream Therapy (pp. 269-273), which utilized screaming from the deepest part of the self to purge feelings of pervasive fear.

Paul Roland was able to achieve success in 1955 working with catatonic patients by touch therapy. Another touch therapy was Rolfing, where massage was intended to press out emotions held in the muscles (*Ibid*).

Holding therapy, used by attachment therapists, has been around for a long time. It was actually used in by Ann Sullivan in healing Helen Keller. Gertrude Schwing was reportedly able to have remarkable results doing holding therapy with schizophrenic children. Robert Zaslow discovered "Holding Therapy," which he used productively with autistic children in 1966 (*Ibid*).

Today, the standing expert on Holding Therapy or Rage Reduction Therapy, as it is also called, is Forest Cline, who oversees Intermountain, a large facility in Helena, Montana. This facility is dedicated to healing children with Reactive Attachment Disorder, where many unattached children there have already tried to kill (Ken Magid, 1987, p.205). Sometimes it is hard to grasp that a young child is already hard wired for criminal behavior, and Holding Therapy looks abusive to the untrained eye, because the child screams and rages in what appears to be a desperate attempt to be free of the imposed intimacy. In a conversation with Magid, Cline answered the somewhat common criticism that Holding Therapy looks like brainwashing: “Some of these kids need their brains washed (June 6, 1986).”

## CHAPTER 2: ATTACHMENT THEORY

### A Brief History of Attachment Theory

Within the past century psychologists have been grappling with the importance of mothering and attachment in the formation of the human being.

John Watson, the father of American Behavioral Psychology, was one of the first theorists to argue that healthy child development depended more on parenting than genetics.

Watson observed that an infant would show affection for parents before they left on a vacation of three weeks, and after his parents returned, he would dismiss his parents and prefer his replacement caregiver. This, Watson deduced was because “the infant child loves anyone who strokes and feeds it” (1955, p. 73). Believing that he was reporting simply on a practical baby, Watson observed the impact of a broken attachment, misapprehending the depth of the injury to the child.

Watson believed psychology needed to further appreciate the importance of parenting. “Isn’t it just possible that almost nothing is given in heredity and that practically the whole course of development of the child is due to the way I raise it” (p. 15)? Watson didn’t discover the importance of attachment, but he did hypothesize the importance of parenting.

Watson devalued the importance of affection and attunement in healthy child development. He effectively warned parents in 1928 against too much attachment with small children. “Never hug and kiss them, never let them sit in your lap. If you must, kiss them once on the forehead when they say good night. Shake hands with them in the morning” (p. 82). Nevertheless, Watson believed more research was needed to better understand the matter. Watson asked, “Will you believe the almost astounding truth that *no well trained man*

*or woman has ever watched the complete and daily development of a single child from its birth to its third year” [Ital. his] (p. 13)?*

Harry Harlow and Bob Zimmerman proved the importance of mothering. In experiments with rhesus monkeys they showed that food wasn't everything. In fact, infant monkeys, given the choice of a soft cloth “mother” without the bottle and a wire “monkey” with the bottle, consistently drank from the wire “mother” and clung, instead, to the cloth “monkey” (1959). Babies need a soft mother.

Anna Freud acknowledged the impact of abandonment on children by relaying an observation she and her colleague made. In 1944, Burlingham and Freud published their observation from a war nursery of a two-year-old's avoidance of an attachment figure. She was a nurse who married, left for awhile, and returned. The child was “completely lost and desperate” and he “refused to look at her when she visited him a fortnight later,” observed Freud. “He turned his head to the other side when she spoke to him, but stared at the door, which had closed behind her after she left the room. In the evening, he sat up and said: ‘My very own Mary-Ann! But I don't like her’” (p. 63). Toddlers can't bear being left by their mother figure. We can infer, since the nurse was not the child's mother that this was at least a second abandonment.

Rene Spitz reported even more devastating effects on children in a foundling home of youngsters raised by overworked personnel, one of whom had to care for eight to twelve children. Spitz measured this institution against another, more adequately staffed institution. The children were compared for “development of six sectors of the personality: master of perception, of bodily functions, of social relations, of memory and imitation, of manipulative

ability and of intelligence” (1949, pp. 147-8). The children in the foundling home pursued a downward developmental trend in all aspects of development as compared to the nursery, resulting in developmental arrest or even retardation, a condition which they called marasmus. A large number of children died during the two-year period of observation (p. 150).

The children in ‘foundling homes’ continued to decline. According to Spitz, “We have here an impressive example of how the absence of one psychosocial factor, that of emotional interchange with the mother, results in a complete reversal of a developmental trend” (p. 149).

Spitz reported extreme differences between emotionally healthy environments and emotionally starved environments. “In a five years’ observation period during which we observed a total of 239 children, each for one year or more, ‘Nursery’ did not lose a single child through death. In ‘Foundling Homes’ on the other hand, 37% of children died during a two years observation period” (p. 149).

The father of Attachment Theory, John Bowlby, wrote three volumes on *Attachment, Separation* and *Loss* to introduce instinctive attachment drives and environmental adaptations as a way of interpreting behavior (1969). Bowlby confronted Sigmund Freud as he presented his theory of attachment. Bowlby said Freud did not significantly observe children or infants, and his theories and those of all psychoanalysts “work from an end-product backwards” (p. 4). Bowlby credited Freud with a theory which at one time defined “trauma in terms of causal conditions and of psychological consequences. In both respects separation from mother in the early years fits,” because it is known to “induce intense distress over a

long period” (p. 11). Bowlby noted that even though separation, separation anxiety, anxiety, loss, neurosis, sadness and mourning fit well with Freud’s thinking, only “on rare occasions does he single out an event of separation or loss in the early years as a source of trauma” (*Ibid*). In order to understand a child’s behavior, Bowlby would likely say, you must assess the quality of the child’s relationship with his mother.

Bowlby observed that theoreticians questioned whether or not instincts exist and whether instinct directs behavior by internal drives. Bowlby suggested that the human infant is born with an instinctive behavioral system which is driven internally to bond with his primary caregiver. The infant is strongly disposed to seek proximity to the mother figure by virtue of an internal control system. The continuity and quality of that attachment produces adaptive behavioral systems to mediate between the drive to attach and the quality of the mother’s availability (pp. 37-58). Says Bowlby, “The fact, moreover, that the pattern of attachment shown by a child correlates strongly with the way his mother treats him not only squares with the experience of many child psychiatrists but suggests a causal relationship of practical consequence” (p. 361). Bowlby suggested that if one looks to see a causal relationship one will see more than if one supposes the source of behavior is inborn.

In his final volume, Bowlby discusses the devastating impact *Loss, Sadness and Depression* has on a child. Adults who have had secure attachments are more able to successfully grieve, while children who suffer major losses and who are not allowed to grieve, suffer insult to their core personality and an inability to successfully rebound through the normal stages of grieving. So deep is that drive to bond, the loss of a primary caregiver is

devastating. The study of loss is not just about abandonment. It is also about whether or not someone is available after the loss to hear the child's grieving. Jay had no one for four years.

Perhaps just as devastating to the core personality as abandonment and loss is the lack of opportunity to even bond at all (1980, p. 9). "In those situations...in which a child has no single person to whom he can relate or when there is a succession of persons to whom he makes brief attachments, the outcome is different [lacking healthy adaptation].... He becomes increasingly self-centered and prone to make transient and shallow relationships with all and sundry. This condition bodes ill for his development if it becomes an established pattern" (p. 14). This was Jay. Jay had spent most of the awake hours of his life in the hands of strangers. Until Jay met his step-mother-to-be no one had understood or taken the time to understand his cries.

Bowlby represented that "those who are most stable emotionally and making the most of their own opportunities are those who have parents who "whilst always encouraging autonomy are none the less available when called upon. Unfortunately, the reverse is true" (1988, p. 12). Children of neglecting parents are less stable. As tough as Jay seemed, he was not stable. He was rigid and easy to provoke.

Mary Ainsworth, a student and subsequently a colleague of Bowlby, produced a series of experiments which led to classification of types of attachment between mother and child, demonstrating that infants with a secure base were more able to socialize, more positively outgoing and cooperative, and were more competent (1978, p. 313). On the other hand, insecurely or anxiously attached babies were less confident. Ainsworth created two categories for insecurely attached infants: avoidant and ambivalent.

Mothers of avoidantly attached infants are typically cold and rejecting, disliking neediness. Avoidantly attached infants are not affectionate and avoid contact with their mother. They appear angry with her and seem blasé when she leaves. They may become angry, aggressive and defiant as they grow older. “Avoidance short circuits direct expression of anger to the attachment figure, which might be dangerous, and it also protects the baby from reexperiencing the rebuff” (p. 320), says Ainsworth.

Mothers of ambivalently attached infants are unpredictable or chaotic, yet possibly sensitive to their child’s fear. These babies may cling and cry when she moves away or leaves, but when she approaches they may become angry at her. Ambivalent infants cried more than avoidant and securely attached babies, while their mothers were often unresponsive to crying and other signals (p. 314). “Resistant behavior is particularly conspicuous. The mixture of seeking and yet resisting contact and interaction has an unmistakably angry quality and indeed an angry tone may characterize behavior even in the preseparation episodes” (p. 62). Jay was ambivalently attached.

Mary Main produced scientific studies which revealed that avoidantly attached infants grow to become “dismissive adults,” who dismiss the importance of love and connection. They often idealize their parents, when their actual history or even memories belie such reports. They seem shallow, lacking self-reflection. They usually have an avoidantly attached child.

On the other hand, ambivalently attached infants, grow to become “preoccupied adults” who are embroiled with hurt and anger at their parents. Their speech is often incoherent and muddled. They have difficulty seeing their responsibility for their part in a

failing relationship, and they dread abandonment. They often have an ambivalently attached child.

Freud's descendant, analyst Melanie Klein, contributed to internal drive theory, didn't think secure attachment significant, and put more emphasis on "constitutional" factors such as internal drives and the death instinct. Klein believed that "the strength of the ego—reflecting the state of fusion between the two instincts—is, I believe, constitutionally determined" (1958, pp. 238-239). "Even the child who has a loving relationship with his mother has also unconsciously a terror of being devoured, torn up, and destroyed by her" (Klein, 1953, p. 227). Of course, such a belief would make it difficult to interpret or read behaviors as clues to experiences.

Klein's pro-parent view, was in conflict with Bowlby and Ainsworth's pro-child theories. Confirming the feud, Fonagy wrote "There is bad blood between psychoanalysis and attachment theory," in his preface to *Attachment Theory and Psychoanalysis* (2002). Peter Fonagy's expressed main goal is to reconcile the rift between Bowlby and traditional analysts, such as Klein, who were in large part offended by Bowlby's disregard for Internal Drive Theory as the force behind behavior. Of course, there has not been enough time to know whether he is succeeding in creating a reconciliation. If the analytic view remains pro-parent, it may not be possible.

Nevertheless, a number of wonderful pro-child analysts, including Ian Suttie, Ronald Fairbairn, Donald Winnicott, H. Guntrip, Heinz Kohut, Sandor Ferenczi and Karen Horney, returned to Freud's original pro-child position, developing it further. Any one of them would

have seen Jay clearly. They were all invested in understanding symptoms and behavior as evidence of childhood history and so, thus, observed and listened attentively and intuitively.

### Interaction and the Formation of Self

Contemporary attachment theorists have demonstrated that there is a critical wiring period for the human infant during which a secure attachment must take place, yielding an interactive relationship between the primary caregiver and the baby. Researchers and researcher-clinicians have produced ground-breaking evidence in recent years showing that children do not simply become stunted without this security and interaction, but their brain development is actually impeded.

Daniel Siegel explains that the brain organizes around emotional interactive experiences. These experience help shape mental processes, altering activity and structure between neurons, shaping circuits responsible for memory, emotion and self-awareness (1999, p. 2). How we experience emotion facilitates or inhibits our future ability to adapt to stressors (p. 4). “Our earliest experiences in life shape not only what we remember, but how we remember, . . . linking past experiences with present perceptions and anticipations of the future. Within these representational processes, generalizations or mental models of the self and the self with others are created; these form an essential scaffold in which the growing mind interacts with the world” (p. 5).

Siegel goes on to say that the repeated patterns of interaction become “remembered” and directly shape not just what children recall but how experience develops and is represented. The primary ingredient of a secure attachment is the pattern of emotional interaction and communication between the parent and the child. “This finding raises the

fundamental question of why emotion is so important for the evolving identity and functioning of a child, as well as the establishment of adult relationships” (*Ibid*). Siegel continues to say, “The capacities to sense another person’s emotions, to understand others’ minds, and even to express one’s own emotions via facial expressions and tone of voice are all mediated predominantly by the right side of the brain. In certain insecure attachment patterns, communications between parent and child may lack these aspects of emotions and mental experience” (p. 7).

Siegel makes the point that when an infant or toddler becomes distressed, an empathic parent who is attuned to the child’s experience will validate the child’s experience and suffering while confirming safety. The primary caregiver will care for the child’s feelings and the child will feel valuable, in spite of the negative experience. Such experiences lay at the foundation of a flexible, resilient child.

On the other hand, when a child suffers and the parent worries, is unresponsive, or is critical, the child cannot value his own emotional experience on his own behalf. His capacity to appreciate his own point of view becomes diminished or distorted. The child’s capacity to reference himself as the source of his experience and to respond to aversive experiences with confidence can fail to develop, as the child maintains a defensive stance against stress and even self-awareness. Thus, the child’s mental capacity to confidently understand and represent himself during emotional pain or even joy does not develop during this critical wiring period (pp. 203-204, 226-231, 236-238, 294-295).

### *Critical Wiring Period*

Allan Schore proposes that expressions of heredity in the brain's development require interactions during critical wiring periods. The mother's behavior and interaction is, in fact, the infant's primary environment "that mediates genetic differences" (1994, p. 17). The mediation normally vacillates between mother's happiness with her infant and disappointment, whether intentional or simply the result of misattunement. When disappointments are followed shortly by mother's positive response and comfort, the child learns hope and resilience. When an extended period follows mother's disappointment, which is too long for the infant to endure a negative state, the infant learns hopelessness and even shame (2003b, p. 19). To be clear, Shore warns that infants need to be comforted:

Prolonged negative states are too toxic for infants to sustain for very long, and although they possess some capacity to modulate low-intensity negative affect states, these states continue to escalate in intensity, frequency, and duration. How long the child remains in states of intense negative affect is an important factor in the etiology of a predisposition to psychopathology. Active participation in state regulation is critical to enabling the child to shift from the negative affect states of hyperaroused distress or hyperaroused deflation to a reestablished state of positive affect (2003a, p. 11).

In addition to an extensive history of misattunement in the first year, stressful socialization experiences in the second that elicit shame represent a traumatic interruption of interpersonal synchronizing processes....

If the caregiver does not participate in such a way as to reduce stress and reestablish psychological equilibrium, limbic connections in the critical stage of growth are exposed for extended periods of time to heightened levels of circulating corticosteroids and catecholamines. This toxic brain chemistry induces synapse destruction and death in ‘affective centers’ in the maturing limbic system and therefore permanent functional impairments of the direction of emotion into adaptive channels” (p. 117). Thus, the neglected and shamed toddler cannot socialize with others, and he may not develop mental capacities for channeling his emotions, including rage.

As we shall soon see, Jay did not have an empathic mother when she was with him.

When she was gone, which was most of the time, he was with strangers. After enough time with enough new people even the kindest stranger could not have been comforting. We can only surmise that Jay’s infancy was intensely stressful. He was continuously terrified of abandonment, which happened almost daily. The very person who could have comforted him to reduce his extended periods of stress was repeatedly leaving.

Siegel explains that lack of experience and attachment for the new brain “can lead to cell death in a process called ‘pruning.’ This is sometimes called the ‘use-it-or-lose-it’ principle of brain development” (p. 14). The infant is born with a genetically programmed excess of neurons, and the postnatal experiences of interaction create synaptic connections. Genes determine the brain structure and its potential for recording experience. Experience determines whether the synaptic connections are made or whether sheaths of myelin develop along the lengths of the connecting neurons to facilitate speed of conduction and

functionality. On the other hand, says Siegel, “disuse or toxic conditions, such as chronic stress” lead to pruning (p. 14).

Bruce Perry speaks of “hot spots” as the brain unfolds, during which “critical” and “sensitive” wiring are dependent upon the child’s experiences, yet invisible and difficult to identify (p. 12). He holds that critical periods require different experiences at relevant ages, which would not be significant at other ages. Insults during the intra-uterine period will not only influence the rapidly forming brain stem, but will affect the neocortical brain which builds upon it, even though the latter forms over an extended period of time. An infant in the first year of life requires touching, rocking and gazing, without which he may literally die (p. 12). In the second year the toddler requires verbal interaction, freedom to explore safely and an ongoing continuous proximity to his mother (2000, p. 9).

More primitive areas of the brain form more quickly and are more sensitive to insult and have shorter critical wiring periods. Says Perry, “Many of the organizing cues for normal limbic and neocortical organization originate in the lower brain areas. Any developmental insult can have a cascade effect on the development of all ‘downstream’ brain areas (and functions) that will receive input from the effected neural system” (*Ibid*).

The long term effects of an insult to a child depend upon what part of the brain is forming at the time, its rate of change, and what part of the brain has already been formed. The earlier and more pervasive the neglect, the more devastating are the developmental problems (p. 12). Perry says, “Lack, or disruption, of these critical cues can alter the neurodevelopmental processes of neurogenesis, migration, differentiation, [and] synaptogenesis” (p. 10). Perry further clarifies, “This is the core of a neuroarcheological

perspective on dysfunctional related adverse childhood events” (*Ibid*). These experience-dependent events of loss, threat, neglect and injury can result in “neural organization that can lead to compromised functioning throughout life” (*Ibid*). Says Perry, “A chaotic, inattentive and ignorant caregiver can produce pervasive development delay in a young child” (p. 12).

Perry produces a photograph of two three-year-olds’ brains. One is nearly half the size of the other, due to severe neglect (p. 20).

Rothchild explains that the amygdala is mature at birth, and the hippocampus matures in the second or third year of life. “Infantile experiences are processed through the amygdala on the way to storage in the cortex. The amygdala facilitates storage of the emotional and sensory content of these experiences” (2000, p. 20). Since the hippocampus is not yet fully functioning, an infant cannot retain memory in context. Memory is only held in emotion and physical sensations. While stress hormones may inhibit hippocampal activity, the amygdala remains unaffected and retains emotional memory (pp. 20-21).

Scientists have found that predisposition to psychological disturbance, including PTSD, appears in stressful events during early development. These disturbances include a failure to attach, abandonment, neglect, physical or sexual abuse or other traumatic incidents. Rothchild reports, “There is speculation that individuals who suffered early trauma and/or did not have the benefit of a healthy attachment may have limited capacity for regulating stress and making sense of traumatic experiences later in their lives...” (p. 24). These experiences may be recalled later only as highly charged bodily or emotional sensations prompted by cues similar to original injuries. At these moments they cannot control their emotions and probably their actions, as well. They are driven by their buried trauma, whether or not they

know right from wrong. Other indicators of past trauma may include freezing responses or dissociation as habitual survival responses and strategies (*Ibid*).

According to Rothchild, the higher the brain structure, the greater its malleability (p. 16), with the exception of the cerebellar vermis within the cerebellum and the hippocampus, both of which also continue to develop neurons throughout life like the cerebral cortex.

James W. Prescott describes “maternal-social deprivation,” a condition he redefined as Somatosensory Affectional Deprivation (SAD) and identified somesthetic processes (body touch) and vestibular-cerebellar processes (body movement) as the two critical emotional senses that define the sensory neuropsychological foundations for the maternal-infant affectional bonding during the earliest months of life (2000, p. 3).

Prescott designed and proposed to researcher Martin Teicher a scientific brain study of monkeys reared in isolation which resulted in documentation of structural and functional brain abnormalities in the limbic-frontal-cerebellar brain system of adult maternally-deprived monkeys. The study showed a causal relationship to the depressive and pathological violence of these mother-deprived monkeys.

Prescott states, “My reconceptualization of the maternal-social deprivation syndrome which involved cerebellar-limbic-frontal lobe brain functions” showed “that the isolation rearing of infant monkeys on a “swinging” mother surrogate (vestibular-cerebellar stimulation) prevented the development of the classic maternal-social (SAD) syndrome (*Ibid*).”

The experience of swinging or rocking was conveyed to the cerebellum and the cerebellar vermis, which modulates the brain-stem nuclei that control the production and

release of the neurotransmitters norepinephrine and dopamine (Teicher, 2002, p. 74). Like the hippocampus, this part of the brain “develops gradually and continues to create neurons after birth. It has an even higher density of receptors for stress hormones than the hippocampus, so exposure to such hormones can strongly affect its development,” explains Teicher (*Ibid*). If therapists were trained to know this, they could tell a feuding, working, drunken mother there is something she can do to compensate for her emotional unavailability which would make her child easier to care for when he is older: Rock her baby every day. If Jay had been rocked, he would have had a capacity for happiness. He would have had soothing moments to reduce the overflow of corticosteroids.

Teicher suggests further ramifications of the study: “Abnormalities in the cerebellar vermis have recently been reported to be associated with various psychiatric disorders, including manic-depressive illness, schizophrenia, autism and attention deficit/hyperactivity disorder” (p. 75).

Prescott believes that the failure to integrate pleasure, at least by rocking, into the formation of the higher brain centers associated with “consciousness” via the formation of the cerebellum “is the principal neuropsychological condition for the expression of violence, particularly sexual violence,” says Prescott. “A fractured neurobiological/ neuropsychological substrate which results from early sensory deprivation results in a ‘dissociative brain’ which translates into dissociative behaviors: depression, alienation, rage, violence and chemical dependencies to self-medicate the effects of SAD” (pp. 3-4).

New brain imaging surveys and other experiments show that child abuse or neglect and attachment trauma can cause permanent damage to the neural structure and function of

the developing brain. Teicher says that early exposure to various forms of maltreatment alter the development of the limbic system, which is a collection of interconnected brain nuclei that play a pivotal role in the regulation of emotion and memory. The two critical limbic regions are the hippocampus and the amygdala, which lie below the cortex in the temporal lobe. While the hippocampus is considered important for the storage and retrieval of verbal and emotional memories, the amygdala is considered the storage place for emotional content of feelings relating to fear condition and aggressive responses (p. 70).

Teicher and scientists under his direction showed that adult patients who had been consistently abused or neglected as children had 12% - 16% smaller hippocampuses and approximately eight to ten percent smaller amygdalas on the left side, while their right sides remained normal. There also seemed to be a “clear correspondence between the degree of reduction in hippocampus size and the severity of the patients’ dissociative symptoms” (p. 71). Ironically, maltreated children failed to display any difference in volume. Researchers hypothesize that because the hippocampus and amygdala unfold gradually, adverse affects may not be discernable at a ‘gross anatomical level’ until people get older” (p. 73). Not only is the hippocampus vulnerable to the ravages of stress, it is particularly “susceptible because it develops slowly, and is one of the few brain regions that continues to grow new neurons after birth. It has a higher density of receptors for the stress hormone cortisol than almost any other area of the brain. Exposure to stress hormones can significantly change the shape of the largest neurons in the hippocampus and can even kill them. Stress also suppresses production of the new granule cells (small neurons), which normally continue to develop after birth (p. 73). Jay needed to be rescued from his extremely stressful conditions.

Unfortunately these were conditions which would not be considered abuse or neglect.

In a presentation to the National Governors' Convention recorded on C-SPAN, Perry underscores the critical wiring period by pointing out that the brain of a child remains plastic and amenable to healing, while the brain of a 10-year-old is pretty much "cooked" (1997). Treating Reactive Attachment Disorder is a race. One of the tragedies in treating Jay was that his biological mother was uncooperative, and that slowed down treatment.

### *Impersonal Care, Day Care and the Strange Situation*

As previously cited, Mary Ainsworth tested out John Bowlby's theories on attachment and loss by setting up a famous study which she called The Strange Situation (1978). In this study, and numerous variations thereof, Ainsworth had toddlers and their mothers enter a room. A stranger (motherly figure) entered the room with them, and then the mother left the room. Toddlers were studied for their reactions as to whether they would display distress, allow the stranger to comfort them, or allow their mother to comfort them upon her return. Ainsworth recorded a variety of worried to distressed responses which she categorized (*Ibid*, 1978).

What has not been extracted from this study, it seems, is that if these children react so strongly to a short disappearance of their parent, how might they be impacted by being left in day care on a regular basis? It didn't seem to matter to Ainsworth's toddlers if the stranger in the room with them was warm, empathic and kind. Perhaps, emphasis on quality daycare misses the point. The children wanted their mothers. The children's necessary interactive conversations with their mothers could not be duplicated with a near stranger or someone

who comes and goes, and the attachment could not be continuous or secure or meaningful (1978, pp. 235-256). Babies and toddlers are monogamous, it seems.

Day care providers, if they are consistent enough, may possibly become the “mother” with whom the child spends most of his waking hours, yet who abandons the child on weekends and evenings to the extended babysitter “parent” where they sleep at “home.” Additionally, a primary attachment to a nanny may offend the part-time mother, and nannies are often replaced a few times over the course of a childhood.

According to Mary Main, when daycare providers alternate with parents and the child has too many primary caregivers, the child begins to internalize “multiple models” of the self, disturbing the child’s developing sense of identity (1995, p. 45).

In 1983, P. Schwartz demonstrated that day care begun too young can actually be harmful to infants. Of 50 infants studied, those in full-time care displayed more avoidant behavior than did either part-time care babies or the study’s control babies. Schwartz found that “more infants attending day care on a full-time basis displayed avoidance on reunion than infants cared for primarily by their mothers,” and daily separations from the mother might influence the bond with “infants who entered child care before 9 months of age” (p. 1076).

A study by Jay Belsky in 1985 observed kindergarteners and first graders where the children had been reared since three months of age in an extremely high-quality day care center at the University of North Carolina. Belsky compared these children to peers who entered the facility at a later age. He found that the children who had been put in daycare since three months of age were “more likely to use the aggressive acts of hitting, kicking, and

pushing than children in the control group. Second, they were more likely to threaten, swear, and argue. Third, they demonstrated those propensities in several school settings—the playground, the hallway, the lunchroom, and the classroom. Fourth, teachers were more likely to rate these children having aggressiveness as having a serious deficit in social behavior. Fifth, teachers viewed these children as less likely to use strategies such as walking away or discussion to avoid or extract themselves from situations that could lead to aggression” (p. 3).

In a controlled observational study of children undergoing major separations (three to twenty weeks) conducted by Christopher M. Heinicke and Ilse J. Westheimer (1965), there were not sufficient caregivers to assign to particular children. All children developed an inability to respond affectionately to their parents. In accordance with the amount of separation each child suffered, when the parents returned the children actively avoided physical contact, remained present but unresponsive and unaffectionate, or showed an apparent lack of recognition of their mothers. Symptoms developed after the reunion of anxious and clinging behavior or bouts of hostility and negativism.

There is enough evidence available to the profession that an infant cannot tolerate daycare as young, with as many changes and for such long hours as Jay had to tolerate. It is regretful that this point was not made to his parents. Jay’s father was a builder. He told me that if he’d known, even if his wife wouldn’t have made any adjustments, he would have taken his son to work with him. He would have let him sit in an infant seat and watch. He would have talked to him, and he would have carried him on his back. “If only I’d known,” said Jay’s father.



### CHAPTER 3: REACTIVE ATTACHMENT DISORDER

Ken Magid, an expert on treating attachment trauma, believes that many of the children who suffer broken attachments and lack of attachment from entering daycare too young or spending too much time away from their mother are at risk for Reactive Attachment Disorder and ultimately Antisocial Personality Disorder (1987, pp.121-138) or other severe disorders. Schizoid, Borderline, and Narcissistic personalities can also result from attachment failures, depending upon the severity of the breach or other environmental conditions complicating the insecure attachment, such as discipline techniques which are too brutal or too weak. Depending upon other environmental factors, some attachment theorists speculate insecure attachments during critical periods can lead to Asperger's Disorder, Autism, and even Schizophrenia. (Levy & Orlans, pp. 271-272; Welsh, pp. 18-20; Cline & Holding, p. 259; Karr-Morse & Wiley, pp. 80-81; Bowlby, 1988, p. 50; Siegel, 1999, pp. 20, 200 & 204; Karen, 1994, pp. 309, & 390-391; Shore, 2003, pp. 118 & 123-124)

Magid describes these children as prone to develop a criminal personality which may lead to sociopathy or psychopathology (p. 1-26). Experts on children with RAD believe observation of these behaviors and symptoms helps therapists and parents identify the adult pathology in time to intervene. They also suggest that how a child acts can foretell the adult he will become. (Magid, pp. 79-100; Stosny, 1995, pp. xi-16; Cline, 1999, pp. 35-68; Karr-Morse & Wiley, 99-124; Levy & Orlans, pp. 263-265)

Children with RAD either shrink away from others with apparent fear, or they are brazenly social. The latter type is the subject of this case study. According to the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR),

The essential feature of Reactive Attachment Disorder is markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care (Criterion A). There are two types of presentations. In the Inhibited Type, the child persistently fails to initiate and to respond to most social interactions in a developmentally appropriate way. The child shows a pattern of excessively inhibited, hypervigilant, or highly ambivalent responses (e.g., frozen watchfulness, resistance to comfort, or a mixture of approach and avoidance) (Criterion A1). In the Disinhibited Type, there is a pattern of diffuse attachments. The child exhibits indiscriminate sociability or a lack of selectivity in the choice of attachment figures (Criterion A2). (2000, pp. 127-128)

The disturbance is not caused by developmental delay, so Pervasive Developmental Disorder (Criterion B) can be ruled out, as well as Mental Retardation. RAD, by definition is “associated with grossly pathological care that may take the form of persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection,” physical needs, or “repeated changes of primary caregiver that prevent formation of stable attachments” (*Ibid*).

Magid believes that these numbers of disturbed and potentially dangerous children are increasing due in large part to daycare. Magid warns: “More and more mothers are returning to work, many just weeks after the birth of their babies. Parents need to know that this may be putting their children at risk for unattachment” (p. 4). Magid believes sociopaths, psychopaths, and antisocial personalities are difficult, if not impossible to treat,

and that the remedy is in prevention and in recognizing indicators early enough to effect healing. He believes it is essential for parents and professionals to identify a child who is unattached, so that proper treatment can be offered as soon as possible. “The older a child becomes, the more intractable he is” (p. 75).

Children who have not formed the proper attachments display a number of telling symptoms. It is important for parents experiencing difficulties with a child to recognize these symptoms. All children at one time or another display some of these characteristics, but it is the disturbed child who will continually display a number of them. Several of the symptoms are so indicative of pathology, that any child displaying these should be evaluated: preoccupation with fire, blood or gore; cruelty to others or animals; abnormalities in eye contact; lack of ability to give or receive affection without controlling it; and self-destructive behavior.

(p. 77)

Without this security and interaction, the child will grow to become an adult who will have difficulty trusting, may lack empathy, or may not form a conscience.

Lieberman and Pawl have addressed the early attachment symptoms of a child with Reactive Attachment Disorder, modifying Ainsworth’s categories into subdivisions: (1) non-attached, (2) anxious/ambivalent, or (3) disrupted attachment (1988). More recently, Mary Main added another type of disturbance in attachment, the disorganized type. (Main and Solomon, 1990) Disorganized is thought to be high risk for psychosis or psychopathology, such as “deranged” criminal behavior (Fonagy, *et al*, 2002, p. 38).

Zeanah, Mammen, and Lieberman have suggested that disorders of attachment represent profound and pervasive disturbances in the child's feelings of safety and security. They suggest five subtypes of attachment disorders, curiously disregarding the disorganized type:

- (1) Nonattached, where an attachment never developed to a preferred attachment figure.
- (2) Indiscriminate, where the child fails to check back, doesn't appear to show concern when the parent leaves the room, doesn't seek comfort from the attachment figure when frightened, may be indiscriminately friendly, reckless or even accident-prone.
- (3) Inhibited, unwilling to venture away from the attachment figure or to explore, possibly displaying excessive clinging or compulsive compliance.
- (4) Aggressive, displaying rage toward the attachment figure, as well as toward others and self.
- (5) Role-reversal, including controlling behaviors toward caregiver(s), either over-solicitous or punitive (e.g., bossy, rejecting, hostile), assuming parental roles and responsibilities (1993).

What distinguishes attachment trauma from other trauma is its impact on the core personality. Some become detached, unable to experience intimacy. Some become cunning sociopaths, lacking a conscience. Some may become fear-ridden. Some are explosive with

rage. Some become psychotic. Some adopt a personality of superiority, lacking empathy for others.

Sometimes insecure attachment results result from the most innocent reasons, such as a mother dying or a painful illness during infancy.

Some babies, particularly those who may have been ill or had other problems very early, seem to have a tendency not to bond and attach to their parents. These infants are at particular risk and would not do well under the supervision of another caregiver. Parents of infants who have avoidant behavior—poor eye contact or who seem stiff or reluctant to ‘mold’ to the adult body when held—should probably not use substitute care until these problems have been solved. (Magid, p. 130).

## CHAPTER 4: JAY'S EARLY HISTORY

### No time to Bond

Karr-Morse and Wiley propose that our first moments, days and weeks of life affect the formation of personality. “Our first experience of this life begins here on the first day. This won’t be recorded in language or be retrievable into rational thought. But the limbic brain remembers, and our body remembers. Here [in these first moments of life] is when we begin to build our model of what to expect, of who will be there, of how we will be received, of how safe it is out there, of how we can make ourselves known and be comforted” (1997, p. 87).

Jay’s mother, Terry, admitted to having only one drink a day and smoking cigarettes during her pregnancy. She had to have an emergency c-section. He was born blue and had to be “bagged and masked” to provide him sufficient oxygen to achieve normal color. Jay, a Caucasian infant, was hypersensitive and would arch his back when exposed to excessive stimulation or loud noises. He had colic and severe and chronic ear infections, sometimes requiring drainage tubes, so we can surmise that Jay was in pain during his first days, if not longer, and infants who suffer pain often have more difficulty attaching. Attachment theorists speculate the child may not trust the parent who cannot protect him (Magid, p. 130).

Jay’s parents were in couple’s counseling when he was born. Jay’s father was emotionally unavailable to Jay’s mother, and she was prone to rage. When he was seven weeks old, Jay’s parents put him into daycare so his mother could return to work. By the age of one, he had been in at least two different daycare facilities, each for 12-hour days. He had become inconsolable and had already begun to bite other children. His parents’ therapist

referred Jay's more affectionate parent, his father, to alcohol rehabilitation, where he stayed for one month to try to save the marriage, leaving Jay behind. They had "family night" at the facility, and Jay's mother refused to participate because she had found a new relationship with a man named Jackie, and wouldn't be home when Jay's father got out.

Jay's father, Ron, learned that Jackie was physically violent, and they were fighting. He had hit Jay's mother, Terry, on more than one occasion. Terry was drinking more than ever. She had physical custody of Jay most of the time, but when the child was visiting his father for sleepovers, she would occasionally call the house with slurred speech. Later she admitted she was so hung over sometimes she couldn't engage with him or care for him. Other times, after a 12-hour work day away from Jay, she would hire a babysitter so she could go out at night and "let down."

Thus, Jay's mother's "maternal instincts" were evidently unavailable to her. She could not put her child's needs above her own. Winnicott writes about temporary primary maternal preoccupation as the natural healthy "illness" of a mother of an infant, noting that some women do not have this "illness."

"I do not believe that it is possible to understand the functioning of the mother at the very beginning of the infant's life without seeing that she must be able to reach this state of heightened sensitivity, almost an illness, and to recover from it...there are certainly many women who are good mothers in every other way who are capable of a rich and fruitful life, but who are not able to achieve this "normal illness" which enables them to adapt delicately and sensitively to the infant's needs at the very beginning; or they achieve it with one child

but not with another. Such women are not able to become preoccupied with their own infant to the exclusion of other interests in the way that is normal and temporary” (1958, p. 302).

Jay’s parents continued to seek counseling separately. When Jay was about two years of age, Jay’s father met his future wife, Lacey. She experienced Jay’s behavior as pseudo-affectionate and charming. He seemed to latch on to Lacey from the beginning, perhaps showing a lack of primary attachment to his mother.

Bowlby, the founder of attachment theory, explains that readily attaching to strangers is a red flag: “There is abundant evidence that almost every child habitually prefers one person, usually his mother-figure, to whom to go when distressed but that, in her absence, he will make do with someone else, preferably someone who he knows well. On these occasions most children show a clear hierarchy of preference so that, in extremity and with no one else available, even a kindly stranger may be approached. Thus, whilst attachment behavior may in differing circumstances be shown to a variety of individuals, an enduring attachment, or attachment bond, is confined to very few. Should a child fail to show such clear discrimination, it is likely he is severely disturbed” (p.28).

Lacey told me that she helped her new boyfriend, Jay’s father, by dropping Jay off “at a lady’s house of childcare when Jay was about two years old.” He would climb upon the back of the couch in the front bay window and scream, “No!” as he watched her leave him behind. Jay was reported to bite and hurt other children at this facility--his third--and was asked to leave shortly thereafter.

When Terry’s job was switched, Jay’s daycare would change. By the time he was two, he’d been in three daycare facilities, and by three he’d been in four more daycares or

preschools due either to job changes or to Jay being asked to leave. To be clear, Jay had been in a total of seven daycare facilities by age three. By age three, he commonly called the staff and the little girls “bitches.” He was observably angry, and the terminology was available at home. His daycare providers would sometimes ask Lacey what was going on. Jay’s mother thought she was at her wit’s end with Jay’s behavior and that of her new boyfriend, as well.

“Such women,” says Winnicott, “having produced a child, but having missed the boat at the earliest stage, are faced with a task of making up for what has been missed. They have a long period in which they must closely adapt to their growing child’s needs, and it is not certain that they can succeed in mending the early distortion. Instead of taking for granted the good effect of an early and temporary preoccupation, they are caught up in the child’s need for therapy, that is to say, for a prolonged period of adaptation to need, or spoiling. They do therapy instead of being parents” (Winnicott, 1958, p. 302).

#### No One to See

Jay began therapy at about age three to cope with his aggression. This was the third therapist in his life, and to date, no therapist to the family had forewarned his parents that an infant cannot form a secure attachment with so much separation from his parents. Neither did any therapist assess that Jay suffered from RAD and needed help sooner than later.

Jay’s own therapist did not discuss with Jay’s parents any attachment concerns. Instead, she focused on the hostility between the parents, and hypothesized Jay was the symptom bearer for their ongoing unhealthy interactions. She never addressed the possibility that Jay was spending too much time in daycare or that these caregivers were rotating too

much for Jay to form attachments. She observed Jay at his daycare and told his parents that he “was aggressive and suffered from low self-esteem.”

Lacey reported to Jay’s therapist how many day cares he had attended and left. She explained that Jay worried excessively about his mother while he was with them, unable to enjoy the visit, even with reassurance that she was okay: “Who will bring her tissue if she cries? I don’t want to leave her alone.” Lacey noticed that his therapist didn’t seem to grasp the relevance of the latter. Rather, she thought it was sweet.

“She even seemed to be inappropriate,” Lacey bemoaned. “At Christmas, she gave Jay a monster robot.”

#### *Imitating the Batterer*

Ron and Lacey became engaged. When visiting them, Jay would sometimes sit and shudder, telling them about “the bad man Jackie” who “hurts mommy.” Terry broke up with Jackie, but she met yet another burly man who was also violent. Chuck was large, with many tattoos, and he frightened Jay. He went into rages and once smashed Jay’s fish tank, killing all his fish in front of him. Another time he smashed Jay’s bed. On more than a few occasions Terry fled the home with Jay. Other times the police came to their house. Jay’s mother promised Jay she would not marry Chuck. Yet, she did.

Exposure to battery affects insecurely attached children more than securely attached children. According to Donald G. Dutton, an expert on batterers, insecurely attached boys are more highly impacted by exposure to domestic violence than securely attached boys:

“The impact of abuse and dysfunction in the family goes beyond mere copying of abusive behaviors; it creates an environment for

an entire constellation of thoughts and feelings known as the abusive personality. It is only after the personality originates that culture exerts its influence, and it exerts it unevenly on secure and insecure boys” (1995, p. 121).

Jay was already angry, but now he reportedly began to imitate his step-father. His new step-father told him that the man who he believed to be his real father (and who was, in fact, his real father) was not his real father. Jay then told Ron that he was not really his dad, revealing his source of information. Jay also told his father and Lacey of times when the police would be called to their house, although he wasn’t supposed to “tell.”

Jay’s mother became pregnant again. Jay became jealous of his tiny sister and was caught pinching her more than once. Dutton further explains, “Abusiveness begins in the family of origin through the experience of shaming behaviors, direct experience of abusiveness from a parent, and insecure attachment with a mother who is herself frequently abused” (p.122).

#### *Re-Enacting Sexual Abuse*

In kindergarten, Jay was afraid of the bathroom and would try to get other kids to go in with him, yet when he was in there he would sometimes urinate or defecate on the floor. His teacher also caught him acting out sexually with another child, whose parents were called. Jay had persuaded the child that they could take turns sucking on one another’s penises. Jay began trying to give Lacey open-mouth kisses.

According to Alice Miller, such re-enactments are common ways for children and adults to express trauma nonverbally. “Even the most absurd behavior reveals its formerly

hidden logic once the traumatic experiences of childhood no longer remain shrouded in darkness” (1990a, p. 284). Jay had yet to reveal his sexual abuse. That would be his presenting complaint when I became involved.

## CHAPTER 5: MISDIAGNOSIS, ASSESSMENT AND DIAGNOSIS

### Misdiagnosis, a Common Serious Error

At age four, Jay's preschool recommended he be assessed for Attention Deficit Hyperactivity Disorder. His parents took Jay to his pediatrician, who rubber-stamped the diagnosis and prescribed Ritalin. The terminology for hyperactive disorders has recently changed. Previously, Attention Deficit Hyperactivity Disorder was distinguished from Attention Deficit Disorder by lack of hyperactivity. A child was either ADHD or ADD or ADHD, the combined type. Now the criteria have changed to Attention Deficit Hyperactivity Disorder, the Inattentive type (ADHD-I); Attention Deficit Hyperactivity Disorder, the Hyperactive-Impulsive type (ADHD-HI); and Attention Deficit Hyperactivity Disorder, the Combined type (ADHD-C). Under today's terminology, Jay probably was diagnosed with ADHD-C.

There were many symptoms reported to Jay's doctor, for which Jay was diagnosed with ADHD, within the definition of the Diagnostic and Statistical Manual, IV-Revised. He lacked both impulse control and the ability to focus. He could not sit still. He not only failed to follow the teacher's instructions, he simply refused them. He was aggressive. Thus, Jay's symptoms were more severe than what the DSM, IV-R allows for a diagnosis of ADHD. Yet many of his other RAD symptoms were not perceived or deemed to fall under the diagnosis of ADHD-C.

No differential diagnosis was initially made with Reactive Attachment Disorder, the Disinhibited type, when Jay was first taken to his pediatrician. Thus, he was not fortunate enough to be correctly diagnosed while he was still within the window of the developmental

time for creating a secure attachment. According to Terry Levy, an attachment theorist, misdiagnosis appears to be a common problem for children with RAD, who are frequently diagnosed with ADHD-C (2000, p.31).

Levy recognizes the preferred diagnosis of ADHD over RAD. He believes there are several reasons why the disease model of ADHD is a preferred diagnosis, to be presumed genetic in origin and treated with medication. Levy sums up the possible forces behind a preference for this diagnosis: Insurance companies find it costs less to medicate than to pay for psychotherapy. School boards prefer the diagnosis, because teachers seek quick relief for disruptions in their classrooms, and, as a medical problem, schools can receive increased funding for children with disabilities. “And many parents, feeling accused and frustrated, find it easier to accept the idea that their child has a permanent, genetic disease than the thought that they might have contributed to a problem that [could be] temporary and treatable” (2000, p. 31). Another reason Levy cites is, “Physicians today generally assume that medication is the first and most effective treatment for a child diagnosed as having ADHD” (*Ibid*).

Much of the literature easily available to the medical professions is apparently developed by experts who write for the pharmaceutical industries, specifically the makers of Ritalin, Novartis Pharmaceuticals, and Celltech Pharmaceuticals (Breggin, pp. 354-370; DeGrandpre, 1999, p. 18). This literature is then distributed by Children and Adults with Attention Deficit Disorder (ChADD), which is funded by Novartis. The premise of the literature is that ADHD causes the disruptive behaviors of the classroom, that these behaviors are genetically caused, and that they can be treated by medication. “Studies...have

convinced researchers that ADD is a neurobiological disorder and not caused by a chaotic home environment” (1995 ChADD Fact Sheet). As you will see, pharmaceutical experts, including Russell Barkley, Harold Kopelwitz, and Alan Zemetkin write to make the argument that disruptive childhood behavior results from ADHD and is caused by genetics.

### Genetics and Differential Diagnoses

Russell Barkley does not make any differential diagnosis between ADHD and RAD. As a matter of fact, in his book, *ADHD and the Nature of Self Control*, Barkley makes no mention whatsoever of RAD or attachment issues (1999).

Barkley asserts:

Only a treatment that can result in improvement or normalization of the underlying neuropsychological deficits behavioral inhibition is likely to result in an improvement. . . . To date, the only existing treatment that has any hope for achieving this end is stimulant medication or other psychopharmacological agents.

If one accepts that human inhibition and self-control are traits and that individual differences along those traits are largely, though not solely, genetically determined, the implications are. . . .extraordinary. From this perspective, if you fail to use your powers of self-control, others have the right to legally and morally judge you (and, by inference, the quality of your parent’s child rearing). (Barkley, 1997, pp. 318-319)

While experts on RAD, as standard practice, evaluate the impact adoption may have on attachment, especially considering the age of the child at adoption and the history of the

adopted child, Barkley, instead, uses adoption studies (without consideration of age at adoption or history) as evidence that ADHD is genetic. As we have previously seen, age matters, because there is a critical period for a child to attach, and there are devastating consequences to a child whose attachment fails or is broken during this period.

Barkley states, “Another line of evidence for genetic involvement in ADHD has emerged from studies of adopted children [which] reported higher rates of hyperactivity in the biological parents of hyperactive children than in adoptive parents of such children. [These] studies suggest that hyperactive children are more likely to resemble their biological parents than their adoptive parents in their levels of hyperactivity” (p. 38). Perhaps these comparisons were made without consideration that the biological parents were obviously experiencing different and more stressful environmental factors, since they were relinquishing a child, while adopting parents were seeking one. Barkley cites another study which “identified a strong genetic component” in adopted children with ADHD-C, since “more child pathology” shows up in adopted children. I could find no reference in Barkley’s work to imply that factors other than genetics, such as the abandonment trauma of adoption, might influence the behavior of these children.

Barkley explains aggressive behavior by subsuming it into the diagnosis of ADHD-C, the combined type, which distinguishes “peer relations and the types of emotional disturbances and psychiatric disorders found to be co-morbid with them....” [These children] are “typically rated as more aggressive, defiant, and oppositional, and are more likely to have oppositional or conduct disorder, and are more often rejected by their peers than those with ADHD-I” (p. 26).

As if unaware of the types of attachment patterns already identified and categorized by researchers, Barkley writes, “Early hyperactive-impulsive behavior is associated with a greater risk for adolescent delinquency, early substance use and abuse, and school suspensions and expulsions, particularly when hyperactive-impulsive behavior is combined with early aggressive or defiant behavior.... This implies that the ADHD-C subtype is probably far more prone to these outcomes than will be the ADHD-I (i.e., ADD-HI) subtype when the latter is eventually studied in longitudinal research” (p. 27).

Harold Koplewicz, the child psychiatrist who spoke at the first White House Conference on Mental Health in June of 1999, coined the biopsychiatric slogan “no-fault brain disease,” explaining that the emotional suffering of children has nothing to do with what they are receiving or witnessing from the adults around them. His work was both supported and applauded by the Clintons and the Gores. To underscore the theoretical position of this book, *It's Nobody's Fault*, Koplewicz has a section, entitled, “Bad Seed” (1997, pp. 234-250).

In *Toxic Psychiatry* Peter Breggin disagrees: “Ultimately, Dr. Koplewicz argued that all troubled or troublesome children are the product of defective genes. For example, again without citing a single scientific source he made yet another false claim, ‘A gene for ADHD has been identified.’...I was also shocked that anyone in the mental health field would dare to deny the mountain of clinical and research evidence that confirms the devastating effects of broken relationships and traumatic events on the emotional lives of children. In fact, there is inescapable evidence that trauma, abuse, neglect, and loss of relationship cause severe

emotional disturbances that can last a lifetime, especially when inflicted upon children and young people” (2000, p. 24).

In an interview with Robert Karen, Alan Sroufe had this to say about Koplewicz’ claim that a gene for ADHD had already been identified: “Everything’s genes these days. There have been dozens of papers saying that all this stuff is just temperament. Hell, we’ll find a gene for security of attachment any day here!” (Karen, 1998, p. 296)

### *Nature Versus Nurture*

Other scientists join in the argument that psychiatric disorders, including ADHD and RAD, result from environment rather than genetics. De Grandpre debated Stephen P. Hinshaw: ADHD: Serious Psychiatric Problem or All-American Cop-Out? (2000). Others include Leo (2000) and Galves *et.al.* (2002).

ADHD is of particular interest to Bessel van der Kolk, since it “has a high degree of cormorbidity with [Post Traumatic Stress Disorder]” (1996, p. 31). For example, Putnam found that “Recently, child researchers have begun to link histories of abuse with symptoms of attention-deficit/hyperactivity disorder (ADHD).... ADHD symptoms typically occur in 25-45% of severely maltreated children, well above the frequently reported base rate of 9% in pediatric patients.... Children with PTSD had activity profiles resembling those of children with ADHD, whereas the profiles of those without PTSD more closely resembled those of depressed children” (1997, p. 41). Van der Kolk, McFarlane, and Weisaeth complain that in none of 36 studies reviewed by Putnam “on children with ADHD did the investigators

measure past histories of trauma, comorbidity with PTSD, or the effects of the pharmacological agent studied on trauma-related symptomatology” (1996, p. 31).

Van der Kolk and McFarlane express alarm. They believe there is an enormous tendency in the field of psychiatry to ignore the impact of trauma and its level of occurrence in society. “The study of trauma and of its impact on the development of psychopathology runs the danger of becoming marginalized again” (p. 30). Van der Kolk and McFarlane suggest that our world of social Darwinism demands that victims no longer deserve rehabilitation. Rather, “the more their plight differs from our own, the more secure we can feel about the notion that bad things only happen to ‘bad’ people or to people who are somehow genetically impaired” (*Ibid*).

It appears more and more clearly that van der Kolk and leading attachment theorists hold that the behavior of children is influenced by environment as opposed to genetics. The contemporary notion that it is a combination of the two does not predominate, at least not in conventional terms. As we have seen, genetics refers only to the development of the physical self, the unfolding of the nervous system and the physical brain pushing a drive to attach. This drive, according to attachment theorists and scientists, is an inborn, biological drive or motivational system which leads a child to create a “few, selective attachments in his life” (Siegel, 2001, p. 69). Simply put, the role of genetics is to create the hardwired drive to attach. It’s the experiences which an infant and child have in life which “directly shape the organization of that system” (*Ibid*).

Siegel addresses the commonly asked question, “Well then, why do different children in the same family with the same parents turn out differently, if not due to genetics?” and

answers, “But siblings—including even identical twins, who are raised by the same parents at the same time—actually have a ‘nonshared’ environment, in that the parental behavior is not identical for each child” (1999, p. 19).

In an attempt to reconcile the disagreement between attachment theorists and geneticists, Robert Karen seeks a middle ground. He suggests that there may yet be evidence of temperament, although the need to successfully attach remains (1998, pp. 269-312).

Interesting to note, once the compromise with geneticists is made, the sacrifice of trauma theory appears to be also made. Karen represents Alice Miller’s recommendation to identify issues and release them, as an ongoing bitterness. Karen represents that Miller advocates holding on to bitterness, something I never gleaned from her writings. He attacks Miller on a personal level for pushing the issue so far:

“ ...Her message is that parents do a great deal of harm and that we, the children, must be willing to remember and embrace our rage if we are ever to be whole. ...but holding on to anger and blame is another impediment to mourning. It prevents the grown-up child from feeling the loss of what he never had... This is the ambivalent, enmeshed position, and, in adopting it, Miller, who in her old age is seething over what her mother did to her, has fallen into a writing style typical of the incoherent, muddled interview transcripts of preoccupied adults. (p. 406)

#### *Other Causes of Personality*

John Bowlby wrote in his epilogue to *Loss* that his study of attachment is at the root of his attempt to see and understand behavior in terms of experiences. Experiences which

follow attachment, such as discipline techniques and communication styles, would be additional factors:

I have concentrated on problems of aetiology and psychopathology, believing that it will only be when we have a good grasp of what the causes are of psychiatric disorder and how they operate that we shall be in a position to develop effective measures either for their treatment or for their prevention. My strategy has been to select one set of putative causal factors—the disruption or threatened disruption of an affectional bond—and to trace the consequences; and in doing so to identify so far as possible those other conditions that, occurring before, during or after the disruption, influence the consequences for better or worse.... It has been possible to indicate how certain combinations and circumstances lead to certain forms of personality disturbance. (1980, p. 441)

Siegel explains other ways in which personality forms in response to original experiences. Siegel describes “recursive” features of the brain which contribute to the appearance of inborn traits. These recursive features tend to seek and categorize experience according to the experiences they have already had. In expecting the future to look like the past, the child begins to experience what they expect to experience and evidence a personality born of anticipation. These features are in operation from birth, perhaps even pre-birth (1999, p. 12-20). Karr-Morse and Willey believe that every experience the child has in the delivery room and shortly thereafter with the parents begins the process of expectation, anticipation and self-fulfilling prophesy (1997, p. 87).

Siegel adds another experiential factor in the formation of personality, the genetically produced neuronal system, which is uniquely developed based on experience. Siegel introduced the discovery of “mirror neurons,” a neuronal system that links perception to motor action. When we face someone who acts in a given way, we have neuronal impulses to repeat the action ourselves (2002, p. 4). Thus, when a person smiles and says “Hi!” we have an impulse to smile and say “Hi!” If someone yawns, we may have an urge to yawn. If a father hits a mother in front of a child, the child may have an urge to hit, as well. If the child represses the urge, the mirror neuron may retain the drive to hit, and the child may lash out and scapegoat someone weaker when he is free from inhibition. If a child is treated with respect, perhaps the mirror neurons will create a character with a drive to treat others with respect. When a little person is treated with disregard, the mirror neurons may create a character, perhaps a drive, to treat others with disregard. These mirror neurons give the *appearance* of inborn traits from which people might say, “He’s a chip off the old block,” or “You’re just like your mother” (*Ibid*).

There seems to be a question answered by researchers, even more than it is asked: Where is the origin of childhood pathology? Some say it is in the child. Others say it is in the experience or treatment of the child. Perhaps one of these perspectives is at the heart of why Jay was misperceived and misdiagnosed.

#### Assessment

Since Jay entered life in pain with medical complications and started twelve-hour days in daycare five days per week at seven weeks of age, his history indicated he had no opportunity to form a secure attachment. He spent the majority of his waking hours in

rotating daycare facilities and with rotating caregivers and babysitters. At age one, his only affectionate parent abandoned him for one month to enter a rehabilitation facility. His mother was drunk during much of the time he spent with her. She would leave Jay to get attention elsewhere or neglect him to drink. Nevertheless, his mother was the most regular player in his life. Jay simply did not have enough interaction with her to form an interactive, relational, communicative relationship that is essential in the formation of an attachment. To reiterate what Daniel Siegel had to say: “Collaborative communication allows minds to ‘connect’ with each other during childhood. Such human connections allow for the creation of brain connections that are vital for the development of a child’s capacity for self-regulation. Studies reveal that such relationship experiences are grounded in patterns of communication” (1999, p.70).

To form a secure attachment, a child must have continuity with the primary caregiver. With little or no opportunity to form a secure attachment, and with so many breaks with his mother and father, one can only speculate as to what point or what age Jay would not have trusted anyone who was willing to commit to him. Thus, Jay suffered from Reactive Attachment Disorder of Early Childhood, not only by virtue of his experience and history, but by virtue of his symptoms.

It is not uncommon for children with RAD to attract additional trauma, such as sexual abuse, physical abuse, shame, rejection, verbal abuse or ongoing neglect. They often have to adapt to the pathology of their parents as well as endure ongoing insecurity. In this case, Jay’s mother was very needy, herself, and she twice chose to be in abusive relationships with

very angry and scary men. Jay was, therefore, exposed to other abuses, including sexual abuse by an older child.

Jay liked to play with older children to whom he looked up. He liked to play with younger children, whom he bossed around. He could not get along with children his age. With them, he was hostile, combative, and even violent. He thought nothing of hitting or biting other children, and measures to stop him did not work.

Jay's behavior became progressively more alarming from the time I met him at four until he was seven, one year after he began living exclusively with his father and Lacey. He pinched his baby sister and reportedly hit other children, sometimes with objects or weapons. He lied compulsively. He tortured his father's dog. He obsessed over the children's bathroom at school, fearing it and acting out there, re-enacting his sexual abuse with another child.

Jay had two significant sides to him. He was terrified of being alone or of being left behind, but he was a little tough guy with a highly developed false self. He was cunning with adults, flattering them and lying to see how much they would believe him, and actually conning whom he could to get what he wanted, with apparent satisfaction. Magid explains, "Even in the early years, young sociopaths contain at least two sides to their personalities. The outside, superficial mask is often a likeable character. Usually, this charming 'public side' is verbally fluent and capable of making short-term friends easily." The other side of them is terrified of being left, of having their heart broken again, and of being vulnerable (p. 11).

Jay's diagnosis was severe, and his prognosis was very poor. Fortunately, he was still young, even though he had already passed through his critical wiring period.

#### *Presenting Complaint*

I was called in by Jay's father to evaluate Jay's disclosure of sexual abuse at the age of four. Jay was very friendly with me from the moment I arrived. He did become reticent to talk, however, when we approached the subject of his disclosure to his father. Within twenty minutes he told me the same information, although probably a more abbreviated version than the one he told his father. He reported that his ten-year-old cousin had persuaded him to "suck his pee-pee" when they were both visiting their grandmother, and their mothers were with her in the other room. A report was made. His father did not want to return Jay to his mother's house, since, by virtue of neglect, Jay had been molested in her care.

#### *Presenting Behavior*

Shortly after his initial interview, Jay's mother called me and requested to see me regarding her son. I met with all of the parents. Since Jay was inclined to charm adults, his repertoire of antisocial acts was not paraded in front of me. I asked questions about Jay's history.

Jay's mother did not believe that his cousin had abused him. She did begin to speculate, however, that if Jay were abused, it would have been by her ten-year-old step-son under her own roof. I observed that Jay's behavior was pseudomature and that he would not accept affection unless he initiated it. He controlled the eye contact, as well. He would look away when parents were addressing him and regularly change the subject. When he wanted to address something which interested him, he was quite insistent and interruptive.

## Diagnosis

It was helpful to make a more accurate diagnosis by taking a full history of Jay, by having studied the literature on attachment, and by following the DSM-IV criteria with rigor for a diagnosis. Given his history and the behavior to confirm it, I was sure he suffered from Reactive Attachment Disorder and considered the sexual abuse secondary to his more serious condition. I considered that we would deal with the sexual abuse in the course of addressing his attachment disorder.

### *Initial Multiaxial Diagnosis, Ages 4-6*

Jay's initial multiaxial diagnosis was quite severe:

Axis I. 313.89 Reactive Attachment Disorder of Early Childhood: Disinhibited Type

312.81 Conduct Disorder, Severe

307.7 Encopresis Without Overflow Incontinence

V 61.21 Sexual Abuse of Child (age 4 by child age 10)

Axis II. None.

Axis III. None.

Axis IV. Biological mother was frequently unavailable, inconsistent and provocative.

Axis V.GAF 20. Capable of hurting or molesting others.

### *Differential Diagnosis*

I ruled out Attention-Deficit Hyperactivity Disorder, Hyperactive-Impulsive Type, because Jay's behaviors were willful and included destructiveness and violence and issued from a clear lack of attachment in his first few years of life.

Since aggressive behaviors typically result from RAD, theoretically I could have streamlined this diagnosis and omitted Conduct Disorder. However, for purposes of clarification, I included it. RAD spoke to the origins and issues more clearly. Conduct Disorder spoke more clearly of the severity of the behavior, especially in a child so young.

### *The Look of Reactive Attachment Disorder*

Sometimes Jay appeared to have an insecure attachment of the avoidant type. Sometimes he appeared to have an insecure attachment of the ambivalent type. At any rate, he had an attachment style which looked like a “little man” committed to being invulnerable, the disinhibited type of RAD. Further, Jay showed signs of indiscriminate attachment when I first met him. He was aggressive at school and at home, and he demonstrated significant role-reversal behavior toward his mother and others.

According to Foster Cline (1999), symptoms of character-disturbed children include several of the following:

Rejection of authority, lying, cruelty to animals and others, refusal to accept responsibility for consequences or actions, below ability school performance, lack of long-term friends, manipulative behaviors, difficulty with eye contact, stealing, refusal to follow parental guidelines, self-control problems, inability to give or receive affection, self-destructive behavior, phoniness, problems with food, superficial attraction to and friendliness with strangers, and promiscuous sexual activity, all of which were in Jay’s repertoire. RAD traits which Jay did not demonstrate were thoughts about fire, blood, or gore and substance abuse. (p. 64)

In any event, I have never understood why a therapist would not seek to understand a cause behind behavior which could lead to reversal rather than a genetic explanation. It would seem that abuse, neglect, and abandonment and failure to attach would be ruled out first, before an assumption of genetic origin would be presumed.

## CHAPTER 6: TREATMENT OF RAD

Some unattached children with RAD are possibly, if not probably, future children of hopelessness or self-destruction. Others are potential serious criminals, including rapists, child molesters, or killers. No violent criminals are securely attached, and perhaps all violent criminals have suffered a lack of attachment or severe attachment breaks (Cline, 1999, p. 69; Levy, 2000, p. 60-80; Schore, 2003a, p. 270; Magid, pp. 1-50; Barker, 2000; Prescott, 2000).

### Discipline Techniques

RAD discipline techniques require establishment of basic respect and structure. Jay's room needed to be neat, and his responsibilities had to be met without overburdening him. RAD discipline techniques are also designed to address destructiveness and abusive behavior. According to Therapeutic Parenting Specialist Nancy Thomas discipline must include personal responsibility for the child's life and choices. For every destructive act the child may be expected to work and doubly cover the cost of the destruction. Discipline must necessarily involve lessons in cause and effect (Thomas, p. 68).

When Jay acted destructively, he was required to self-reflect. Lacey usually did this with essays. She loaned me a few of her books, and in one I found a note, "Have Jay write an essay on evil." If the essay is thoughtful it is his ticket out of isolation. This is tricky, because some RAD children choose the isolation pathologically, and isolation can be harmful. For about a year, Lacey chose to keep Jay by her side at all times. When she went to the bathroom, he was expected to tap on the door until she returned, so she could be sure he didn't leave.

The child with RAD is determined to achieve and maintain power, yet cannot heal having achieved it. They presume power over adults and act “bossy.” Thus, Terry M. Levy and Michael Orlans believe it is essential to maintain therapeutic control over the child. “We began to see that a child only required a level of control equal to his level of resistance” (p. 273). Sometimes establishing control may include reminding the child that they are not the boss. In some cases, the adult may even need to ask the child, “Who’s the boss?” The adult needs to get the answer, “You are” (p. 272-273).

Establishing control includes the enforcement of consequences for bad behavior swiftly and consistently. Control requires a full repertoire of discipline techniques, born of behavioral theory, as well as healing techniques. Since attachment therapists are working with children who may become killers and rapists, most of the skills for treating and parenting a child with RAD may appear extreme and offensive to the uninitiated. Additionally, RAD therapists are working quickly with these children, as they have very little time. Finally, these children don’t respect adults who are soft, kind and respectful to them. They are looking for someone who is big enough for them and can tolerate their rage.

Cline recommends the Sixty-Second Scolding as one discipline technique, which cannot be done in anger. The child misbehaves and the adult takes her place standing over the child or perhaps gets her face close into his face, and the scolding begins immediately:

The Sixty-Second Scolding involves standing over the child and briefly intimidating and surprising the child through words and tone of voice, letting the child know in a loud and forceful way what he has done is

wrong and, in essence, for about twenty seconds, giving the child “hell and high water.” (Cline, 1999, p. 251)

The adult then drops to the floor, asking the child, who is supposedly in a state of surprise or disorientation, “Do you understand I reacted that way, because I care about you?” The scolding is over, and with resilience in mind, the child is encouraged to move forward with his day.

Cline recommends that where lying, cheating and stealing are concerned with RAD children, there will be times when the adult has to say, “I don’t believe you.” This is for two reasons: It doesn’t work to say, “I think you’re lying,” because the child can always argue and force the issue into a confrontation.” However, the adult can always explain the reason they don’t believe them. If there is no evidence, it is because of their reputation. If the child changes his reputation, people will believe him more (p. 246). With a RAD child it is better for the parent to be a disbeliever than to be the adult who the child believes he has fooled.

Cline recommends natural consequences as another form of discipline. A child, who is irresponsible with the car, won’t get car privileges. A child who can’t behave on the bus will have to walk to school. However, sometimes it’s difficult to find a natural consequence to place on the act. One innovative parent said that the child’s fighting was such a drain on the family that he would have to clean the refrigerator or do some equivalent chore every time he fought, because doing such chores “put energy back into the family” (p. 247).

Jay also needed self-discipline techniques and relationship skills to protect himself and others. If I were asking him to become more authentic, which is, from his point of view, more vulnerable, I had to give him healthy ways to protect himself. The first and most basic

lesson was to walk away from a confrontation in which he wanted to fight. I told him he could say, "I'm too angry to stand here. I'm afraid I'll hit somebody, so I'm going to walk away now." We developed other responses. We reached a point in which Jay could ask, "Why are you speaking to me that way. Did I do something to bother you?" One time Jay actually said to another child, "Why are you so mean? Were your parents mean to you?" and it broke the ice, fortunately. I told him that question could work or it could backfire, because children are often very protective of their parents.

I worked intensely with personal responsibility issues. I taught Jay again and again, that people treat people according to how they are treated. If he ever wanted to tell me how badly a friend at school treated him, I always asked, "And what did you say or do just before that happened?"

Essentially, I was trying to break through an armor which was highly developed and adult-like, so Jay could become authentic. To Jay, authenticity was extremely vulnerable, yet vulnerability was the path to his healing. Jay needed to drop his guard in order to relate and to heal, but he needed skills to protect him when threatened. Jay's first response to emotional injury was to harm or say something mean and angry, which consistently inflamed the situation.

We worked with cognitive restructuring to achieve this goal. One of the most important of these skills was assessment. Jay needed to assess with whom he would be safe, so he could be authentic. I told Jay on a number of occasions, "One of the ways to assess who is safe is if you tell them 'Ouch,' they go 'Woops.'" We talked about all the ways one could say "Ouch," and all the ways we can tell if someone is "going 'Woops.'" "Safe people

are not people who will never hurt your feelings,” I told him, “because nobody is born to think about other people’s feelings above their own. The most thoughtful, caring people are still thoughtless at some time, or they put themselves first, because they need to, and that’s OK too. What matters is whether they self-reflect after having hurt your feelings. Do they care about how you feel when you are vulnerable enough to say, ‘I feel hurt when you say that.’” Jay preferred “Ouch!” to “I feel hurt when you say that,” although he gradually began to use more vulnerable expressions.

### Rebonding Techniques and Rage Reduction

What is widely held by therapists who treat attachment trauma is that children with RAD cannot be effectively treated by normal therapy, whether with puppets, sand play, art, or talk therapy. They cannot be healed with behavioral therapy, either, although as we have seen, it’s an important adjunct. These children need to learn to attach as soon as possible. Attachment has a very early window of opportunity, and the sooner it is treated, the easier and more long-lasting is the treatment. Attachment therapists are in a hurry.

Some treatment techniques are designed to repair the child’s lack of attachment with attachment behavior. Of interesting note, the toughest little kids ultimately are soothed by regression to infancy. These re-bonding techniques include rocking the child while singing a lullaby, making eye contact, and giving a bottle. The therapeutic parent should also pet or stroke the child’s hair and skin. Other activities include brushing the child’s hair gently with a soft brush, or while a child lies in the parent’s lap, the parent doles M&Ms one at a time every time the child makes and sustains a gaze for a few seconds. The M&Ms are intended to represent the sweetness of mother’s milk. Since the eye contact occurs with difficulty, the

child does not get an excess of candy in any one session. If the child did, the child would not suffer from RAD.

### *Arguments for Holding Therapy*

Possibly the most effective technique for treating RAD children is Holding Therapy, yet it is the most controversial. It looks invasive. It involves holding an angry child against his will, though not so tight as to hurt him. There are several reasons for its effectiveness. It creates an opportunity for the child to purge his rage, “giving it” to an adult. The process does not end until the child achieves a state of surrender, where he allows an adult to be affectionate with him. This would be coercive, except for the fact that all children secretly want to surrender to an adult, their adult. Once the child gives up off-putting, controlling behavior, they are inclined to revert to infancy, so they can receive what they missed and that for which they long. Getting the child to surrender is at the root of the controversy between attachment clinicians. When a child is “threatened” with loving attachment, they initially fight against it for dear life. They will resist again and again. To quote one attachment professional parent, Nancy Thomas, “It’s as if we are asking them to walk out on the ice, when they’ve fallen through before” (1998). Further, the child doesn’t believe the parent is strong or willing enough to endure their rage (*Ibid*).

Holding Therapy works almost like an exorcism. It is also known as Rage Reduction Therapy and is one of the controversial treatments, but it’s not new. Elvis Presley and Mary Tyler Moore starred together in a movie, *Change of Habit* (Graham, 1969), in which Presley, as a local doctor, does Rage Reduction work with a selectively mute child. Many treatment modalities for RAD children border on the extreme, or at least appear to, and attract a great

deal of criticism for the way they appear to treat these poor children, especially holding them against their will.

Cline is possibly the most expert clinician on Holding Therapy according to Magid and McKelvy (p. 353) and Levy and Orlan (p. 269-271). Cline advocates holding. Holding is a profound, quick and deep process which leads to a venomous release and protracted exorcising of emotional poisons (p. 276). Following this raging catharsis is what appears to be a state of grace, or a regression into infancy, or a deep bonding process including relaxed surrender, vulnerability, and mutual gazing.

In holding, the child is held only as tightly as necessary to keep the child at hand, so the child is free enough to struggle, fight and rage. It often leaves the holder beaten and bruised. The child ultimately experiences the grown up as willing to tolerate the child's rage, strong enough to hold the child, and strong enough for the child to be a child and the grown-up to be the grown-up in charge. Some parents elect to wear protective padding or set rules, such as "no pulling hair."

Cline explains the virtues of holding therapy: "Holding therapy ends positively for the children. The children are brought through the angry, difficult feelings, and then hugged and gently rewarded for their efforts. Just as we cuddle and comfort the infant after immunizations are done, we cuddle and comfort children after a difficult holding session. And the children feel loving and loved, sometimes for the first time in their lives" (p. 260).

Cline continues: "As severely disturbed children move toward health, they can understand and accept that it was necessary for the adult to force them to accept closeness, because they were not strong enough to accept it themselves. Many children eventually feel

great affection and gratitude for the persons who rescued them from their prisons of isolation” (p. 260).

The primary goal of holding therapy is for the parent to be strong enough, compassionate enough, and safe enough to receive the child’s pent-up anger. Cline goes on to enumerate many of the additional benefits of holding treatment for children:

Direct the child’s attention; nurture him; physically contain him; promote the exploration of his feelings; confront his behavior; resolve internal conflict; enhance attachment relationships; direct interaction; encourage acceptance of the therapist’s or parent’s reality; encourage compliance; encourage a reciprocal loving response; validate their feelings; identify and appropriately express and regulate feelings; resolve early trauma; work through grief and loss issues; cognitively restructure faulty thinking patterns; learn to see the world and their place in it in more realistic terms; reshape behavior to more appropriate, socially acceptable levels; relate to others in a respectful, responsible, and reciprocal way; develop thoughtful decision-making skills; experience and accept loving and nurturing care; and increase self-control abilities. (p. 263)

There are numerous positions for holding children. One primary position is to have the child sit on the holder’s lap, facing the holder (Welch, 1988, p. 25). This, of course, is the most risky for the holder and may be best for very young children. Another is to have the child’s legs outstretched on a couch, while the holder has the child’s head in her lap, face up

on a pillow. She will have one arm behind his back, and another arm free on top to keep the child from injuring the parent or therapist, depending upon who is holding.

Martha Welch offers the following guidelines to reach a resolution: “Help your child to get in touch with his feelings; accept his feelings; get in touch with your feelings and communicate them to your child; insist on eye contact; insist on being hugged and cuddled in return; keep holding until he feels better” (pp. 239-240).

Welch advocates holding for most parents and implies that it is almost a necessary staple in the healthy family. She says, “Discovering *holding time* is like rediscovering the wheel. Once you are using it, it seems simple. In fact it is. It does take effort, but not as much effort as is demanded by the trouble you already have or will have with the everyday problems of child rearing. . . . We have been taught to accept some degree of frustration, anger, and aggression as normal in parent-child relationships. At the very least, the aggression is excessive and to a large degree unnecessary. An alternative for dramatic improvement exists. This alternative requires no financial expense, no ongoing visits to therapists, and in fact is totally under your control. *Holding time* is available to any mother who wishes to raise healthy, happy, successful children who are capable of loving others and of showing it. And in the process it will provide *you* with a more loving relationship with your children. The whole family can benefit” [Italics hers] (Welch, p. 240).

#### *Arguments against Holding Therapy*

In the case of RAD children, often the therapist does the holding. In some cases, children are sent to residential facilities, most of which are in Colorado. Children live there with professional parents like Nancy Thomas. They are held, rocked, given bottles, and they

learn to attach. In the process they are taught to behave and live cooperatively. In the end, they are sent back home or to a foster home, thereby suffering another broken heart, that is, another attachment break.

Some therapists, Cline included at one time, see their RAD patients on appointment, and in order to keep their schedule, instigate the child's rage by pinching, poking or elbowing the child to get him started. This intrusive initializing technique so outrages other therapists, including myself, that Holding Therapy, as a whole, has come under much criticism.

There are many professional parents in Colorado who help treat RAD children, some of whom have put up shingles themselves. One professional parent developed a ceremonious process of Rebirthing [not to be confused with breathwork, called "Rebirthing"] in response to a common request by RAD children, so the child could be born again to the new parent. She created an arduous tunnel through which a child would crawl, and in the end the reward was her new mommy. Unfortunately, one child died of suffocation. This tragedy tainted a lot of the progressive good work that has come out of Colorado. Holding Therapy or Rage Reduction work also came under further scrutiny. I, myself, have experienced several professionals and lay people ask if Holding Therapy could kill children, or, as one person inquired, "Is this the same therapy that was used in Colorado that killed a child?"

Beverly James (1994) is the leading critic of Holding Therapy or Rage Reduction. She says, "Several approaches have been developed that practitioners claim are the only way to cure attachment disordered children. Their methods include: prolonged restraint other than for the protection of the child; prolonged noxious stimulation; and interference with

bodily functions, such as vision and breathing” (p. 92). James goes on to say, “I believe the phrase ‘coercive techniques’ accurately describes the listed procedures.

Prolonged restraint as used by coercive therapists is unrelated to the child’s immediate behavior. The intervention is arranged by appointment, usually continues for several hours, and is often repeated daily for weeks. The child is held immobile by one to six adults who may include the parents. The clinician typically places his or her face, bearing a deliberately angry expression, within inches of the youngster, stimulating him to a high level of arousal. The youngster fights against the restraint and anger; he screams and cries.

Some practitioners also advocate prolonged noxious stimulation while the child is restrained. This includes such actions as poking the child’s ribs, continuously tapping the youngster’s chest or the bottom of his feet, tickling, pulling toes, or continuously moving the child’s head from side to side. In addition, the child’s eyes might be covered and his nose pinched for more control. The practitioner yells at him to breathe through his mouth, then covers his mouth and yells at him to breathe through his nose. (p. 93)

### *Synthesis of Holding Therapy*

James is righteously outraged by these abusive tactics. There is no need to abuse children to get them to rage while being contained. Given that RAD children demonstrate affection on their own terms when they want something, they begin to rage reflexively when

a parent tries to be warm and affectionate. Holding the child need not be abusive or coercive in any way. It need only be strong enough for the child to feel convinced he cannot get away and to feel secure as he gets out his “angries.”

I decided to employ Holding Therapy with Jay, but I made modifications. I decided I would not do the holding myself, to avoid the possibility of Jay bonding with me and then feeling abandoned again. I decided to instruct the parents how to do Holding Therapy. Many times they did Holding Therapy in my office until they were proficient as necessary.

I decided not to use Holding Therapy as a discipline technique or a time for parents to express their feelings to the child. We have already seen that the child who learns or is made to feel responsible for the parents’ feelings is at risk for a narcissistic personality adjustment (Miller, 1981, p. xix). Discipline techniques, separate from Holding Therapy, were saved for destructiveness and abusive behavior.

#### Vulnerability and Surrender

Magid speaks highly of Rage Reduction Therapy — another term for Holding Therapy — as a healing tool for children suffering from RAD. He describes the impact it has on these children without a conscience, saying, “Basically, Rage Reduction Therapy involves physical holding and control of a patient who is confronted with his death-grip resistance to accepting love and acting responsibly. The therapy contains explosive dialogue, as the psychopathic patient is encouraged to work through his unbelievable rage and anger while being forced to accept another’s total control” (p. 205).

“This holding treatment breaks down those paths of resistance and allows the unattached child to reach painful hidden emotions,” Magid explains. “Once these emotions

are released the child can go on to attach to other human beings and experience the joy of life” (p. 209). Thus, the process of holding therapy introduces the child to the rewards of vulnerability at a far greater speed than talk therapy or play therapy. Children suffering from Reactive Attachment Disorder wouldn’t choose vulnerability on their own.

Patients with disorders of attachment have a terror of being vulnerable outside therapy and inside. Harry Guntrip explains this fear of weakness without specifying a person who fears attachment: “So great is the human being’s fear of appearing weak that he will rather be bad and suffer guilt; and he will also rather go on being ill and suffering the miseries of neurosis than admit the implication of weakness,... yet the patient is in truth weak, through no fault of his own. He has been gravely damaged in infancy and childhood, he is deeply fear-ridden and his emotional ego-development has been arrested at the deepest levels [and] craves all the time for a good parent-figure with whom he can get a new start. Thus *he can neither fully accept nor fully reject the therapist, and most of his difficulties in treatment lie in his desperate need to set up and maintain some form of compromise relationship [ital. his]*” (p. 277). Yet, Guntrip stresses, there is no compromise. To feel, one must risk and become vulnerable.

It is critical that the child accept vulnerability as a lifestyle and stay vulnerable, relinquishing power or control of others. He will return again and again to wear power like a suit and to boss other children and to charm adults to control them. Repeatedly, the attachment therapist, the healing parent, and all supervisory adults in the child’s life must zero in on this impervious behavior and require the child to remove his coat of armor. He will be called away from play. He will be kept in tow at the hip. He will be asked by the

therapist or the parent, “Who is the boss of you?” To which the child must answer, humbly, “You are.”

This level of control and domination, if it seems that way, is needed. RAD children are not normal children. They are little children’s whose souls are lost, who, if left to their own devices, would be cruel and violent. They only feel childlike and safe when they know that no one will let them be the boss. The question, “Who’s the boss?” is not a question asked of normal children. They already know the answer.

## CHAPTER 7: TRAUMA

This chapter is about two types of trauma: absolute terror and dangerous knowledge. Absolute terror is born of experiences which are so frightening the person thinks they will die. Dangerous knowledge is buried truths, the content of which are so awful that the child would feel somehow in jeopardy were they to acknowledge it. Jay suffered from both types of trauma. His attachment trauma was so terrifying to him, he would sell his soul to never feel those frightening feelings again. Neither would he ever give his heart away again. Also, Jay had buried memories of meanness, which made him feel worthless. But to Jay, his worthless feelings were simply because he was worthless. He could not see that they were caused by the way his mother treated him. He believed he was bad, so he deserved to be treated badly. And he “might as well join the bad people.” Jay was a victim of trauma, as well as RAD, and it needed to be understood. Jay’s dangerous knowledge also surfaced later in treatment.

We will look at relevant brain research in order to understand these lasting effects, and we will look at techniques for treatment, because attachment trauma is trauma and can be better understood and treated by many of the techniques explored below. In the final analysis, vulnerability is necessary for the treatment of trauma in general, as well as attachment trauma.

### The Lasting Effects of Trauma

The effects of any type of trauma on a young child are lasting, as such experiences impact the development of the brain. Researcher Martin H. Teicher explains,

The left hemisphere is specialized for perceiving and expressing language, whereas the right hemisphere specializes in processing spatial information and in processing and expressing emotions, particularly negative emotions. We had wondered whether mistreated children might store their disturbing memories in the right hemisphere and whether recollecting these memories might preferentially activate the right hemisphere. (p. 73).

“To test this hypothesis, Fred Schiffer worked in my laboratory at McLean in 1995 to measure hemispheric activity in adults during recall of a neutral memory and then during recall of an upsetting early memory,” Teicher explained. Subjects with a history of abuse “appeared to use predominantly their left hemispheres when thinking about neutral memories and their right when recalling early disturbing memory. Subjects in the control group used both hemispheres for either task” (*Ibid*). This suggests a disconnect for trauma victims between their traumatic experiences and their ability to report and express the memories.

Teicher’s researchers learned that childhood trauma was associated with diminished right-left hemisphere integration. “We decided to look for some deficiency in the primary pathway for information exchanged between the two hemispheres, the corpus callosum” (pp. 73-4). Teicher and his researchers found that boys who had been abused or neglected and girls who had been sexually assaulted had significantly smaller corpus callosums than the control groups.

”Stress sculpts the brain to exhibit various antisocial, though adaptive, behaviors,” says Teicher. “Through this chain of events, violence and abuse pass from generation to generation as well as from one society to the next. Our stark conclusion is that we see the

need to do much more to ensure that child abuse does not happen in the first place, because once these key brain alterations occur, there may be no going back” (p.75).

### *Somatic Memory*

Some people process trauma in a healthy, conscious and expressive manner, while others somatize, and still others, who seem more fragile, may dissociate or develop symptoms of Post Traumatic Stress Disorder. Children who suffered a poor attachment in early years, neglect, or physical or sexual abuse are more prone to dissociation or PTSD later in their lives (Rothchild, 2000). “Babies raised by caregivers unable to meet significant portions of their needs are at risk of growing into adults who lack resilience and have trouble adapting to life’s ebbs and flows” (p. 17). The body remembers in many ways, when the brain tries to forget.

### *Dissociation*

Some researchers and theoreticians explain that victims of trauma, especially in the early years, have various defenses against remembering, most often dissociation. The actual experience of dissociation during a traumatic event predicts the development of PTSD, according to Babette Rothchild (p. 24), who believes that dissociation should be mentioned in the DSM-IVR as a symptom of PTSD; it is listed as a symptom of Acute Stress Disorder. She suggests there is a growing debate as to whether PTSD might actually be a dissociative disorder rather than an anxiety disorder (p. 5). Dissociation takes place when an event is too terrifying to face, and PTSD takes place when the event remains unprocessed and out of awareness, while symptoms remain.

Van der Kolk, McFarlane and Weisaeth believe that trauma may never be forgotten, but is held in the amygdala (1996, pp. 232-233) and manifest emotionally in the body. These hidden memories may surface under a variety of circumstances when one's guard is down, following unexpected reminders of past traumatic events, while sleeping, under the influence of drugs or alcohol, or in aging. "It is conceivable that traumatic sensations may be revived, not in the distorted fashion of ordinary recall, but as affect states, somatic sensations, or visual images (nightmares or flashbacks) that are timeless and unmodified by further experience" (p. 24). "Emotional memory may be forever," suggests researcher J. E. LeDoux (1991, p. 242).

Within the limbic system are two related areas involved in the storage of memory, the hippocampus and the amygdala. The amygdala stores highly charged memories involving terror and horror, while the hippocampus provides a context for memories, giving them a beginning, a middle, and an end. Traumatic memory is often held in the amygdala and the body without such a beginning, middle and end. Trauma commonly produces PTSD, which, according to Rothchild, results "when the ANS continues to be chronically aroused even though the threat has passed and has been survived" (p. 12).

While the body stores traumatic memory in the amygdala, the right brain, and the body, the hippocampus is suppressed by the overproduction of corticosteroids during trauma and thereafter, as the body continues to believe it remains at risk. Thus, while the trauma is remembered forever, the context of the event may be lost, sometimes temporarily, sometimes until recollection is safer, sometimes until a reminder, sometimes until a state-specific experience of fear arousal, and sometimes forever (Rothchild, pp. 15-36). The trauma victim

continues to vigilantly bare the event out of awareness as if it had no cause and as if it will never end.

Various circumstances can produce flashbacks in which the amygdala remembers, triggered by cues from the environment and/or the body. Cues from without or within can prompt a memory. A smell reminiscent of the repressed past or hyperventilating and rapid heart rate can become a cue or create state-specific remembering.

Rothchild says “Later traumatic experiences might only be remembered as highly charged emotions and body sensations,” says Rothchild. “It may be that survival mechanisms such as dissociation or freezing have become so habituated that more adaptive strategies either never develop or are eliminated from the survival repertoire” (p. 25).

One of the results of PTSD, including dissociation, is the fear of not only the trauma, itself, “but also of their own reactions to the trauma,” writes Rothchild. “Eventually a victim of PTSD can become extremely restricted, fearful to be with others or to go out of her home” (p. 14).

Some traumatized people remember the event emotionless, as if watching a video, complete with detail. PTSD persists in these cases, because they are not able to make sense of the events, and while they may not feel connected to their feelings, they still suffer from intense emotions which they cannot lay to rest.

Others feel numb in their bodies and complain of deadness in their lives, while still others remember little of the actual event, but are plagued by physical sensations which mimic the event and make no sense in present circumstances (Rothchild, p. 15).

The body stores different types of forbidden emotions in different areas of the body, correlating with the emotions repressed. For example, anger is held in the jaw, the neck and the shoulders and released by biting, yelling and fighting, if not venting. Sadness is held in the throat and released through the eyes by crying and wailing. Disgust is held in the stomach with nausea and released by vomiting, wrinkled nose, raised upper lip or turning away. Happiness is felt in the whole body, but mostly shown in brightness of eyes, in the breath, and is expressed most often by smiles and laughter. Fear is held in the stomach, and involves widening of eyes with lifted brows, trembling, racing heart, and blanching, and is expressed by fighting, fleeing, or freezing. Shame is held in the blood, and is expressed by rising heat, hiding, and an inability to make eye contact (pp. 57-58).

According to Richard P. Kluft (1997, Eds. Applebaum, Uyehara & Elin), once one part of a memory returns, as in a flashback, most, if not all of the memory may return. It may take place all at once, or gradually (p. 43).

It is important for patients to correlate the image or flashbacks with sensation, affect, behavior and meaning (p. 69). Learning to feel one's own feelings and body, express one's own feelings, find one's authentic point of view and feelings, and to correlate these forms of awareness with meaning and meaningful behavior is important to trauma work (p.102).

#### *Repression and Defensive Exclusion*

While the right brain holds and the amygdala freezes the memory of trauma, the more sophisticated neocortex excludes or denies unacceptable knowledge. They are two distinct and separate processes, which may overlap.

According to Schore, “Current neurobiology suggests that repression is a developmentally more advanced left brain defense against affects like anxiety that are represented at the cortical level of the right brain, but the earlier-appearing and more primitive dissociation is a defense against traumatic effects like terror that are stored subcortically in the right brain” (2003a, p. 246) and amygdala.

Bowlby explains, “a mechanism may exist whereby neural excitation in the slower acting system can be blocked from reaching the higher center so that the aversive and emotional components would be excluded and no pain experienced. Even so, there would often be limited awareness that in some part of the body all is not well” (1980, p. 57).

Bowlby suggests that: “He may mistakenly identify some other person (or situation) as the one (which) is eliciting his responses. He may divert his responses away from someone who is in some degree responsible for arousing them and towards some irrelevant figure, including himself. He may dwell so insistently on the details of his own reactions and sufferings that he has no time to consider what the interpersonal situation responsible for his reactions may really be” (p. 65).

Bowlby makes a distinction between material which has been repressed because it is too traumatic to remember or relive and material which is forbidden to be acknowledged. The latter coping strategy he calls “defensive exclusion.” Experiences which are defensively excluded are experiences excluded from conscious awareness, because (a) it is information which arouses attachment behavior which will become predictably unassauged or even punished; or (b) he knows it is information his parents do not want acknowledged and may lead to punishment or loss if he acknowledges it as true:

Whenever information that would normally be accepted for further processing because of its significance to the individual is subjected to defensive exclusion for prolonged periods the consequences are far-reaching. Among them, I believe, are most, perhaps all, of the very diverse array of phenomena that at one time or another have been described in the psychoanalytic literature as being defenses...

The effects of repression are regarded as being due to certain information of significance to the individual being systematically excluded from further processing. Like repression, defensive exclusion is regarded as being at the heart of psychopathology. Fragments of behaviour reveal forbidden information seeping through along with attached feelings, moods, nightmares, known in traditional analytical circles as “the dynamic unconscious and the return of the repressed.”

Should...it be a behavioural system, or set of behavioural systems, as central for personality functioning, as is the set controlling attachment behaviour, the effects are likely to be extensive... Certain forms of behavior, thought, and feeling will cease to occur or be experienced and, on the other hand, forms of behaviour, thought and feeling of some other kind will take their place. (1980, pp. 65-66)

Alice Miller suggests that the behaviors are re-enactments. She speaks of this banished knowledge prolifically. Speculating that it may begin in infancy, she says, “The only possible recourse a baby has when his screams are ignored is to repress his distress,

which is tantamount to mutilating his soul, for the result is an interference with his ability to feel, to be aware, and to remember” (1988, p. 2).

Miller believes acting out is a nonverbal expression of repressed trauma. The solution to healing this trauma is to allow a search for the truth to be safe and accepted as valid (1981, 1983, 1984, 1988 & 2001).

According to Miller, forbidden knowledge creates acting out behavior, behind which the true motives are

“the unconscious need to pass on to others the humiliation one has undergone oneself; the need to find an outlet for repressed affect; the need to possess and have at one’s disposal a vital object to manipulate; in self-defense, the need to idealize one’s childhood and one’s parents by dogmatically applying the parents’ pedagogical principles to one’s own children; fear of freedom; fear of the reappearance of what one has repressed, which one reencounters in one’s child and must try to stamp out, having killed it in oneself earlier, and revenge for the pain one has suffered.” (p. 97-98)

Thus, two phenomena are distinct one from the other, but may overlap. For example, a rape may be so traumatic that it can only be remembered outside of time or space and under the conditions of dissociation or flashbacks. And then, the memory may fully return. However, if the rapist was someone close, like one’s father, the rape may be remembered, while the rapist may not. Such knowledge might be forbidden, or defensively excluded from awareness and never remembered, even though the pain and humiliation of such subjugation will be encoded in many ways and will find some disguised way out.

As traumatic experiences become somatized when they are not remembered, repressed or defensively excluded memories must also be expressed indirectly. This expression is not a healing expression. It is a re-enactment in which the victim re-victimizes himself or becomes a perpetrator, perpetuating an on-going chain reaction of abuse and neglect. In so doing, he may accommodate the requirement to “honor” his parents and forget his own distress, thereby taking up the banner that no one else should remember anything or dishonor their parents.

Violent criminals often speak well of their parents, who were in reality brutal and cruel. (Magid, p. 69)

#### Differing Approaches to Trauma

Taking the best of most of the trauma theorists, a number of recommendations can be woven into the fabric of therapy with a RAD child.

For Alice Miller, the cause of psychopathology is the repression of trauma for the parents’ sake, so its antidote begins with the removal of sanctions against remembering and expressing buried childhood emotional pain (2001, p. ivx-xv). I found this helpful in working with Jay. I was ever reminding him that whatever he felt or wanted to say was welcomed, especially anything which he’d wanted to express before but didn’t. As much as I wanted to give him complete freedom, I walked the line to never suggest how this might sound or what he might say. I was careful not to even appear to make suggestions in this day and age (See Chapter 12).

Babette Rothchild (2000) recommends that an important aspect of treating PTSD is giving it a beginning, a middle, and an end, framing a place for traumatic events in the

hippocampus. For trauma to become resolved, it needs to find its place in the life story of the trauma victim (p. 12). A child needs to have his own story, in which he is born innocent and can triumph heroically from his hardships. I found this concept helpful, as well. It wasn't particularly a significant healing technique, but whenever Jay discussed emotional pain or memories, we framed it with what happened first and then what happened afterwards.

Van der Kolk warns therapists to prepare the client before doing trauma work. "Prior to unearthing the traumatic roots of current behavior, people need to gain reasonable control over longstanding secondary defenses" such as "alcohol, drug abuse, or resorting to violence against self or others" (1989, p. 23). Extending this concept I applied this point of view by giving Jay coping techniques for how to handle rejection in school or by friends from his block and other events where he feels at risk of being left or left out. He needed to learn the importance of personal responsibility and problem-solving skills, in order to avoid fights.

Siegel believes it is important to assess how much trauma a person has experienced, because seeking to heal one trauma may bring up more trauma than a patient can process. I heard Siegel's cautionary note, but I also heard Robert J. Neborsky's testimonial on the effectiveness of opening wounds and releasing past trauma in a safe environment.

Neborsky discusses the best techniques he's witnessed, specifically at a center which initiated patients into psycho-education, including explanations about defense techniques and "how to recognize unconscious affect present in the room" (p. 297), with an expressed goal to experience the unconscious emotion and free the patient of anxiety and defense. "The process then opens the unhealed wounds of past trauma for direct inspection by the patient

and the therapist. The underlying feelings of the original trauma are made conscious, and through the therapist's attunement and empathy, the therapeutic repair occurs" (*Ibid*).

Francine Shapiro and Louise Maxfield recommend Eye Movement Desensitization and Reprocessing (EMDR). Shapiro says she originally called it eye movement desensitization. She now would have named EMDR differently, calling it "reprocessing therapy" (2003, Solomon & Siegel, Chapter 5, p. 196). I did not try EMDR with Jay because I have no training to do so.

EMDR operates on the theory that when a trauma is not fully processed, the perceptions, thoughts and emotions involved are generally stored in the brain in a state-dependent form. The storage may thus be isolated out of context. Eye movement upon recall is used to "forge new connections between the unprocessed memory and more adaptive information that is contained in other memory networks. EMDR focuses directly on all the perceptual components of memory (imagery, cognition, affect, body sensations) and maintains these in a dynamic state" while the client is asked to focus on an eye movement task (p. 199). Reportedly research supports the effectiveness of this technique (*Ibid*).

### *Standard of Care*

Daniel Brown, Alan W. Scheflin, and D. Corydon Hammond (1998) write "In the history of the trauma field, however, there has been a long-standing controversy about the best clinical procedure to facilitate the integration of the trauma memory and the effects associated with it" (*Memory, Trauma Treatment, and the Law*, p. 447). The authors review best practices and standards of care in the courts and within the profession. They report that

emotional release from trauma has been demonstrated by research over time to be an effective therapeutic tool. Additionally, two-chair Gestalt work has been shown to be more effective than intellectual work. Yet, in both cases, the symptoms are reduced more substantially when combined with cognitive restructuring or perceptual change (p. 447).

In the more recent years emphasis has shifted from abreaction or hypnosis to re-integration. The integration model now may include cognitive therapy's BASK components (behavioral, affective, somato-sensory, and narrative knowledge). "*Emotional discharge alone has been replaced by the integration of affect and memory content as one of a number of dimensions of integration work* [Italics theirs]" (p. 449), say Brown, Schefflin, and Hammond. Van der Kolk explains, "Unfortunately, in the context of the 'false memory' controversy, and of the confusion between what constitutes a valid therapeutic and valid forensic approach, hypnosis has recently fallen into disrepute as an effective treatment of PTSD... Abreaction (the dramatic reliving of traumatic events under hypnosis), coupled with psychotherapeutic processing of the recovered material, has been used successfully with victims of child abuse and chronic PTSD" (1996, p. 548).

I have noticed when the emphasis shifts from emotional discharge to "integration" there usually is implied a goal to get emotionality under control, which may have a pro-parent result, if not goal. Contemporary trauma treatment now under the primary domain of behaviorists has produced alternative premises for the use of abreaction: The emphasis is not on catharsis, but rather on mastery. It does not emphasize memory recovery, itself. Its goal is to correct mental distortions and restructure existing memory. The primary goal of abreaction is integration, not emotional release.

With or without abreaction, both a minority of contemporary trauma experts who advocate release and the majority cognitive trauma experts who advocate mastery of emotions agree that integration “is the main goal of trauma treatment following stabilization” (p. 450).

The integration model includes the generally accepted premise of dissociated traumatic memory which is too painful to integrate into conscious awareness. While the actual memory is frozen in the amygdala, and perhaps unchanged as compared to ordinary memory over time, traumatic memory is subjected to dissociation and “various components of memory fragment, including affect, beliefs, somato-sensory dimensions and behavior associated with the traumatic experience, and each of these dimensions in turn is dissociated from each other” (p. 438).

Treatment proceeds through three main phases, also called The Phase Model, the first of which is to stabilize the patient, making him safe both within and outside treatment. The second stage is to help the patient process the overwhelming material. According to van der Kolk, “The importance of capturing the experience in its full range of representations goes beyond the person’s simply remembering and reporting the verbal schemata. Treatment must address the somatosensory, emotional, and biological, as well as the cognitive, dimensions of experience” (p. 546). The final focus of treatment is directed to helping the patient reengage in life (*Ibid*).

#### *To Go Deep or Not?*

Marion Solomon suggests concern that “focusing too much on childhood traumas can reinforce externalization, and cause projection and a sense of victimization. An adult may

have been victimized a child, but the way the person deals with his or her feelings about these issues in the here-and-now is their responsibility” (2003, p. 342). I agree with her. While I tell Jay he was born innocent, I also say he is responsible for not treating other people badly, just because he was treated badly. That kind of logic was his mother’s logic when she hurt him. I understand that he cannot yet control his rage, but he has to learn about personal responsibility theory. He has to do the work to heal, so he doesn’t pass it on.

Solomon and Siegel say that “To help traumatized individuals process their traumatic memories, it is critical that they gain enough distance from their sensory imprints and trauma-related emotions so that they can observe and analyze these sensations and emotions without becoming hyperaroused or engaging in avoidance maneuvers” (2003, p. 187). It may not be enough to make meaning of traumatic experiences. “Trauma victims need to have experiences which are directly contradictory to the emotional helplessness and physical paralysis that accompany traumatic experiences,” say Solomon and Siegel (2003, p. 188). They need emotional processing. They need safety in their lives. They also need anxiety management skills, including self-relaxation, role-playing, healthy modeling behavior by their therapist, thought-stopping techniques, and practical techniques to help them distinguish between fears from the previous event and present circumstances (p. 189).

Jay learned to consciously feel his feelings gradually through the course of therapy. He released emotions. He learned how to walk away from upsetting stimuli. He learned “strong sitting,” a form of self-soothing, like meditation. Jay and I did role-playing often, and he did so with his new mother. We often talked about how to tell the difference between how much of what he was feeling in a given moment came from now, and how much came

from his trauma. This was not only a thought stopping technique, but it helped him process more trauma and become more self-aware.

Babette Rothchild believes in addressing trauma by going into it. She suggests that if a therapist has good theory regarding trauma, technique may not be that important. Further, she believes it is often helpful to teach theory to the client (2000, p. 96).

Others recommend that the patient go through the defenses, resistance, memories and feelings in the safety of therapy, because there may be insufficient healing of trauma without catharsis (Brown, Schefflin & Hammond, p. 446).

Rothchild (2000) points out that some clients have had secure childhoods with only a single trauma and so have little difficulty in processing the event. Victims of multiple traumas, like Holocaust survivors, can recover by processing one trauma at a time, making a story of their lives. However, if a trauma victim was neglected in the earlier years, suffering a series of traumas as well, they will fall into the category of the most delicate patient. The adult patient must be safe in his life and safe enough to bond with the therapist before he can process the traumatic events which have befallen him (p. 88). Rothchild warns “decompensation can even occur” (p. 79-80). Use the body as a gauge. It is necessary to know with what type of client the therapist is dealing. Have they experienced multiple or severe traumas at an early age, or are you treating one trauma experienced later in life (p. 24)? Jay had suffered severe and protracted trauma, including high levels of stress throughout his first four years.

Did I see him as delicate? Yes and No. He was still malleable, because even though he had passed through the critical wiring period, he was still a child. Further, he had parents

in whose arms he could fall safely apart. He presented as a little tough guy. He still required swift intervention and someone stronger than him. But inside he was a delicate child who had been hurt much too much. Jay needed to become vulnerable in a context where he could receive the rewards of intimacy. If we had treated him as if he was too delicate to move as quickly as possible, however, it would have been a mistake.

Van der Kolk believes it is important that the therapist keep in mind that the purpose of treatment is to recover the memory so the patient can regain conscious control. Thus, the patient needs to learn to differentiate the present from the past, gradually coming to recognize what feelings and beliefs are being reactivated and are shaping the present moments. The only reason to uncover trauma is to gain conscious control over the unbidden reactivation of painful affect. Once the traumatic experiences have been located in time and place, a person can start making distinctions between current life stresses and past trauma and decrease the impact of the trauma on present experience. The client then realizes that the conclusions he drew as a child have retained their significance in his adult life. They will maintain control over him until he re-examines and verbalizes them. He must realize in order to escape the shackles of trauma, that *he was not responsible for what happened to him as a child or his response to it*. Now that he is an adult and he has awareness and choices, he becomes responsible for the consequences of his actions. (1989, pp. 13-14)

As we shall see, van der Kolk has a sense of urgency, but he found that the techniques available to him put his patients in a crisis if he moved too quickly. Thus, he began his search for faster therapeutic techniques for trauma victims. Reconciling Rothchild's "go

slow” with Attachment Theory’s “hurry up” is another concern in treating a RAD child.

Which approach does the RAD patient need the most: speed or caution?

### *Speed with Caution*

Van der Kolk has been seeking a form of therapy in which therapists could proceed directly to the trauma. He has embraced EMDR and openly expressed a belief that there remain undiscovered techniques for getting to trauma safely and efficiently. Biographer Mary Sykes Wylie interviews van der Kolk (2004) and describes him:

“He’s scandalized a number of cognitive-behavioral therapists and academic researchers by openly embracing EMDR, demonstrating an interest in such truly outré techniques as Thought Field Therapy, enthusiastically taking up nonstandard somatic therapies, and even sending his patients off to participate in theater groups and martial arts training. Van der Kolk’s bold criticism of the orthodoxies of psychotherapy and public advocacy of somatic approaches have, in particular outraged many.” (pp. 32-33)

Wylie says van der Kolk has become noted for his “determination to make the field viscerally understand that trauma isn’t simply a neutral mental health issue, but a profoundly moral concern.” (p. 33)

Van der Kolk openly criticizes himself for moving too quickly to process traumatic stress, creating an increase in suicide attempts. “When people get close to reexperiencing their trauma, they get so upset that they can no longer speak. It seemed to me then that we needed to find some way to access their trauma, but help them stay physiologically quiet

enough to tolerate it, so they didn't freak out or shut down in treatment. It was pretty obvious that as long as people just sat and moved their tongues around, there wasn't enough real change" (Wylie, 2004, p. 34).

### Reichian Therapy

Say Solomon and Siegel, "It is possible that some of the newer body-oriented therapies, dialectical behavior therapy, or EMDR may yield benefits that traditional insight-oriented therapies might lack" (p. 188).

According to Rothchild, "Using the body itself as a possible resource in the treatment of trauma has rarely been explored. Somatic memory has been named as a phenomena, but few scientifically supported theories and strategies for identifying it, containing it, and making use of it in the therapeutic process have emerged" (Rothchild, p. 5).

Wilhelm Reich proposed a type of therapy now known as Reichian Therapy, which unfortunately seemed to have as its objective the liberation of repressed sexuality. Reich seemed so preoccupied, perhaps obsessed, with sexuality, he may have driven his own discovery into obscurity (Reich, 1945).

Alexander Lowen did Reichian Therapy (also known as "Body Therapy," Somatic Therapy, Vivation, or Re-birthing) with Wilhelm Reich in the spring of 1942. He wrote of his experience:

I went with the naïve assumption that there was nothing wrong with me. It was to be purely a training analysis. I lay down on the bed wearing a pair of bathing trunks. Reich did not use a couch since this was a body-oriented therapy. I was ordered to bend my knees, relax, and breathe

with my mouth open and my jaw relaxed. I followed these instructions and waited to see what would happen. After some time Reich said, “Lowen you’re not breathing.” I answered, “Of course I’m breathing; otherwise I’d be dead.” He then remarked, “Your chest isn’t moving. Feel my chest.” (Abrams, ed., 1990, p. 185)

Lowen felt Reich’s chest and realized that relatively speaking, he was not breathing. He began to breathe more deeply. Twice he was facilitated into and allowed to release a deep scream. In succeeding sessions he safely experienced early memories and experiences during which he had buried his feelings, but now, reliving them, could release them (p. 187).

Ruskan borrows from Eastern philosophy and techniques of breath work, meditation, and centering, explaining how to successfully access and release negative emotions through a similar practice of breathing:

“Breathing in this manner gets the energy moving in your body. You will feel various physiological sensations as well as emotions. The first sensation is usually that it becomes difficult to keep up the fast breathing rate required for the breath to have any effect. You will feel like you have to push very hard; be careful you don’t slow down your rate to the point where the breath is ineffective. You might become sleepy and drift off, forgetting to breathe for a short period. This is not dangerous -- you will always wake up when you need more air.

“There will be other sensations such as light headedness, tingling, feelings of numbness, vibrating, or the sensation of

energy rushing through the body, or tingling in the hands and body. There may be localized specific sensations of pressure or pain, pointing to a specific memory or moment in time. These all indicate that the work is proceeding correctly.

“Negative emotions will start to come up intensely, and should be processed. You should be ready for feelings that you may never have confronted before. For all these reasons, you should be somewhat experienced in inner work before launching off into a heavy session with this breath, and you may want to have a therapist or other breathwork professional with you, such as a Rebirther or Vivation specialist. (1993, p. 239)

### *Couchwork*

I modified, simplified and evolved my own variation on Reichian Therapy/bodywork/breathwork, calling it simply “couch work.” I make my patients as comfortable as possible. My office is warm; the couch is large and soft. I have chosen to use minimal intervention, as compared to the aforementioned therapists.

My first attraction to couch work was that it allowed for regression without suggestion, because I too have come to fear being accused of planting suggestions. No hypnosis is involved. I find that my most important role is that of a witness and a coach-theoretician, who attempts to answer questions.

There seems to be a healing mechanism built into the human design, which doesn't take much involvement on the part of the therapist. I have found it takes much less intervention than other Reichian therapists (Lowen, p. 103) and fewer postural requirements

then Yoga experts and other Eastern masters require. Many of them practice extraordinary techniques and uncomfortable positioning of the student or patient. I believe all these manipulations may be intrusive and have found them unnecessary.

The process of doing couchwork is *work*. “Healing is for the fittest,” I may say to my patients. To Jay, I said often, “Healing is not for free. It’s for the brave and hard workers.” The subject is asked to breathe intensely with long deep breaths repeatedly for one half hour, more or less. This process brings up a multitude of issues akin to life itself. I have seen that people tend to do couchwork the way they do life. Dutiful people breathe with conviction. Dependent personality types breathe weakly and need to be prompted to continue. Some people want to rebel. Some can’t stand being uncomfortable. Some have difficulty with expectations or with surrender. And so on. This self-awareness is useful, in itself, and the process alone is an opportunity to correct an orientation toward life, itself.

Patients must feel safe and have a willingness to be vulnerable. Couchwork may be no more than the repeated practice of learning to face fear, practice surrender and courage, and become vulnerable. It is an opportunity to practice vulnerability in a safe environment while lying down. At the least, it creates self-awareness. It may simply be a practice of becoming familiar with one’s own coping mechanisms, of coming to know one’s own body, of looking at one’s own attitudes about surrender, patience, and expectations (Ruskan, p. 240).

After excessive breathing, the body appears to mimic the state-specific condition of a mind-body in trauma. It begins the production of symptoms which replicate sensations experienced in the trauma about to be revisited. Combining this state of alarm with a choice

to relax into the feelings and re-observe the experience in a safe environment, the patient is able to remember events which had previously been excluded from his awareness. The memories are usually produced at first in flashback form, without a context other than the way the patient feels. For example, a woman may feel her cheek hot and stinging, and then she may hear her mother's voice and see her face admonishing her, "If you cry, I'll slap you again." The pervasive theme of couchwork is buried trauma or emotions repressed for the parents' sake. The common response is catharsis and release, followed by relief (Lowen, p. 186-7; Ruskan, p 239-265).

Usually, the patient is aware of feeling younger. He may even be able to identify what age he feels and the room he's in with all its smells and artifacts. He may know if he feels alone or with someone. At this point, I ask him to begin breathing normally, allowing himself to slip into the way his body feels as fully as possible. The patient commences an adventure into himself. Couchwork requires relaxation, surrender and vulnerability. The environment provides the safety.

I have never seen a patient decompensate with this technique. Ultimately they are in control. They choose how deeply they wish to breathe and for how long. They can surrender and "go on in," or not. Most patients are curious, so they appear to be brave enough to persevere. Some are more cautious. I do often coach or coax them to go on. Finally, I think my presence makes a difference. I am there with empathy as their enlightened witness. I offer a possible emotionally corrective experience. I offer nonverbal relational containment. "Regression, even if it is of the withdrawal type, facilitates attachment to objects if the holding environment is well constructed" (Giovacchini, p. 234).

For Peter Giovacchini, patients who have suffered “from early developmental failure as a result of infantile deprivation,” regression is not “intrinsically disruptive,” and is a necessity for healing. The opportunity to regress in a “secure, containing environment can be restorative,” which can lead the patient to realize that reliving his history need not necessitate fragmentation (pp. 226-230).

### Vulnerability and Surrender

“The presence of an attachment figure provides people with the security necessary to explore their experiences” (1994b, p. 146), says van der Kolk, indicating also that the healing parent needs to be there for a child in therapy, and the therapist needs to create a bond of safety, understanding, and trust for the adult child of attachment trauma. Without safety, there can be no vulnerability.

Resistance to vulnerability is an obstacle to healing, no matter what the nature of the trauma. Surrender is a goal in itself especially for a RAD child or adult. The capacity to become intimate is terrifying to the RAD child, but it is necessary. Until a child can become vulnerable, he cannot be authentic, and he cannot be as a child and learn as a child. As an adult, he will not experience intimacy. Treatment of a child or an adult must include the provision of at least one safe and continuous person, who is capable of modeling how to choose safe and trustworthy people to be in one’s life. Van der Kolk suggests:

The success of treatment depends on the patient’s ability to tolerate intimacy—in other words, on the patient’s capacity to trust another person with his or her helplessness and pain. Independent of the trauma that brings an individual to treatment, different people have different

capacities to tolerate such intimacy. This ability is an important determinant not only of the success of treatment, but also for the individual's initial reaction to the trauma. (p. 538)

Van der Kolk surmises, "The ability to tolerate the truth of the traumatic experience involves a capacity to bear pain in the presence of another human being; this constitutes the core of mature intimacy" (p. 538).

Van der Kolk regards the lessons offered by trauma support groups as instructive to therapists. He suggests that serenity comes from learning to trust and "They promote interdependence through (re) learning to trust, and through making contact and developing interpersonal commitments" (1996, pp. 550-1), which is something most difficult for a RAD patient.

Victims of trauma who continue to avoid acknowledging their feelings will act out, reenact, re-live their trauma repeatedly (p. 11). They may even become a perpetrator to others. Van der Kolk finds that "one serious obstacle to effective treatment is that many traumatized patients will guard against confrontations which remind them of their trauma, including psychotherapeutic interventions" (p. 424).

RAD patients fear vulnerability, and present as little men and women, or little tough guys, like Jay. Jay feared ever depending upon an adult again, because that would set him up for the next traumatic abandonment. He believed weakness and vulnerability led to caring which led to abandonment, excruciating heartbreak, and possible death. Jay believed if he appeared weak, he would be injured so much that the next time he would die. So, he puffed up to look ominous to anyone who would try to get close. Further, Jay believed that if he

appeared weak, he could not be perceived as perfect enough to deserve respect. As a child with RAD, Jay had almost no self-worth, because no one wanted him, so he desperately needed respect. He imagined puffing up got him respect. Actually, adults often thought it was cute, until they experienced the meanness that came with it. Jay had learned to enjoy the feeling of power when he was a little man. His sociopathic adaptation resulted from a choice made in early childhood to protect himself and depend on no one.

Later, as adults, adult children with RAD may be perceived in therapy as extremely resistant. As we have seen in the previous chapter, they may enter what Guntrip calls a “schizoid compromise and psychotherapeutic stalemate.” That is, they may be in a hurry to heal, so they won’t have to feel pain or vulnerability anymore, but they are not willing to become vulnerable to get there, thus creating a stalemate in the therapy. For this reason alone, a therapist could never predict how long healing will take, because the time factor is set by the patient’s willingness to become vulnerable. Not treated as a person in his own right in childhood, the patient comes to “*defend* his independence and freedom of self-determination [ital. his]” (1992, p. 272), says Guntrip. He is in need of people and afraid of this need. “All through his treatment he will be torn about between his fears of isolation and his fears of emotional proximity.” Guntrip elaborates:

This constant oscillation between ‘near and far,’  
dependence and independence, trust and distrust, acceptance of and resistance  
to treatment, the need of a security-giving relationship and fear of all  
relationships as a threat to one’s separate existence as a proper person presents  
itself for analysis under a thousand forms all the way through the process of

psychotherapy. When the patient can establish a persistent compromise halfway between the two extremes, the result is ‘blocked analysis’ and therapeutic stalemate” (1962, p. 273).

Guntrip revisits Freud’s insight that every patient resists treatment, no matter how much they want to heal. Freud deemed the root of resistance to be guilt of sado-masochistic drives blocking the progress of analysis. Guntrip says, “Guilt is felt not so much over sex and aggression, as over weakness and fear [feeling] contempt and hatred for the part of his own personality which will ‘let him down,’ [that is] a fear of weakness that is the cause of ‘resistance’” (p. 276). Further clarifying, Guntrip writes:

“The fundamental conflict in human personality is not that of a sadistic if ‘moral’ super-ego attacking cannibalistic or murderous incestuous impulses. It is the desperate struggle of a person who feels at bottom to be no more than a helpless and frightened infant, dependent on other people, to compel himself to keep going ‘under his own steam’ by hating and driving his basic infantile self, which is so deeply withdrawn from all real object-relationships. It is the struggle to master and defeat chronic infantile dependent needs by internal violence, and force the outer world self to carry on in a state of maximum independence” (p. 277).

Guntrip is making the point that the patient will not heal until he makes the choice to be vulnerable. Couch work facilitates this process, especially for a child who suffers from RAD. When a child can voluntarily lie down and breathe until he experiences emotions or memories from the painful past, he is learning vulnerability. When he can choose to go into

these memories, knowing emotions won't hurt him, he is learning to process vulnerable feelings without armor. When he can make the choice to let go, rather than to defend, the child has begun dismantling his own wall.

As T. L. Cermak and S. Brown (1982) put it, "No pain is so devastating as the pain a person refuses to face, and no suffering is so lasting as suffering left unacknowledged" (1982, p. 389).

## CHAPTER 8: GROUNDWORK FOR TREATMENT

### Meeting the Family

I first met Jay at age four in a parking lot outside a parenting class I teach. Jay's father, Ron, and his girlfriend at the time, Lacey, had enrolled in the class upon her suggestion, seeking alternatives to Ritalin prescribed by Jay's pediatrician. Jay appeared to be outgoing, even cocky in the parking lot. His manner seemed pseudo-mature. He spoke to me like a little man, brandishing my name with authority. I noted that he showed no sign of distress as he was led off, and his parents went upstairs to class.

After Ron and Lacey had graduated from the class and Jay had turned five, I received a frantic phone call from Ron imploring me to come hear what his son was telling him about sex play with a boy six years older. I made a home visit, and Jay reported to me that his cousin had been asking him to "suck his pee pee in the bathroom" and he had "put his pee pee on my butt." Jay told me that his ten-year-old cousin also sucked Jay's penis. Although Jay did not name the 10-year-old step-brother with whom Jay lived, all the grown-ups wondered if he was covering for him.

Jay's father and I then went to the Sheriff's department to report the abuse, because Ron did not want to return Jay to his mother and step-father, since it was in Terry's care that the abuse had taken place. A social worker came the following day to interview Jay on his first day of school, but Jay now had little to say. Terry told the social worker that she believed her son had lied about the abuse. The Department of Children and Family Services allowed Jay to return to his mother's home.

I spoke to Jay's mother about the report by phone. I asked her why she thought Jay would make something like that up. She speculated that he might be covering up for his older step-brother. Terry went on to tell me stories about what an evil child her step-son was and how he had even struck her. She believed her husband, Chuck, didn't notice or acknowledge any problem with his son, which caused her to feel exasperated.

Terry and Chuck enrolled in the next parenting class with their new baby. The class was explicit about the importance of secure attachment and the possible impacts on a child who is insecurely attached. Terry continued to seek dialogue with me after class out of her husband's range of hearing. She continued to speculate that her step-son, instead of Jay's cousin, had molested Jay. I told her if she had any reasons other than speculation, I would call DCFS. Based upon my experiences working for DCFS, Jay then might end up in his father's custody, because DCFS would not allow him to live home if he were at risk.

As I became unavailable after class for any dialogue except questions about the course material, Jay's mother asked for another meeting with me. She wanted to tell me her step-son was now gone from their house, as they had sent him back to his mother. She wanted to know if I would treat Jay. I agreed to meet with Terry and Chuck along with Ron and Lacey to discuss Jay and possible treatment.

The meeting began with all of them asking if I would treat Jay. I took a brief history of Jay, while I had them all together. Then, I told them that I suspected that the sexual abuse might not be Jay's biggest problem. I explained what Reactive Attachment Disorder is, and that treating his attachment disorder would be the main goal of therapy, and the sexual abuse would be treated as he learned to trust and might even be a platform for creating trust. I

explained Holding Therapy, the controversies created in using it, and described my recommendations for how it should be done.

Jay's mother remained focused on the sexual abuse as the primary problem. Lacey and Ron could see that while the sexual abuse was a matter of grave concern, the attachment problem was more pressing. They also suspected that the offender might be Jay's step-brother.

I explained to them that in attachment therapy, the primary parent would always be there, and the family would be as supportive as possible. I explained Jay's limits to confidentiality, since his parents hold the privilege, unless he wants to confide abuse by a primary parent, in which case I would hold the privilege, and, as a mandated reporter, I would have to call DCFS. I told them about how I would work, including using education and recommendations for stronger discipline techniques than I taught in the parenting class. I explained that we would use healing techniques to revisit trauma, which I described to them. I told them about other techniques used to reduce rage. I explained cognitive interventions and that he would be taught basic values, such as cause and effect, personal responsibility, respect for others, and self-reflection.

#### Choosing the Primary Caregiver and Support System

I explained that Jay was unattached and he would need to learn to bond as part of the process of healing his attachment disorder. He would need a dedicated parent who could commit to him 24 hours per day, seven days a week. I explained Holding Therapy and couch work and how his parents would have to unequivocally take responsibility for his pain and behavior. They would all, especially his dedicated, primary or therapeutic parent, need to

receive his expressed anger and hurt for past injuries of abandonment without defending or retaliating, within the context of a frame. I explained that a dedicated parent would need to do Holding Therapy nearly every day, if need be, as well as bring Jay for couchwork at least one time per week. I explained that they would all have to learn to become consistent disciplinarians, using natural consequences, and that discipline would necessarily be “tough love.” They would need to back one another up. I explained that my role, to a large extent, would be to coach them, especially the therapeutic parent, and to do couch work with Jay at least once weekly. As I said this, Jay’s mother nodded, sitting beside her baby of five months. She did not seem to grasp that she could not be that person, but I knew we would have to let her try even though time was of the essence.

“You will have to give up blaming Jay’s big brother for his problems,” I reiterated, testing her defensiveness, strength and commitment to this theory and the work involved. I added: “His incest experience, however traumatic, is the least of his injuries. His greatest injury was his continuing abandonment in his first years and his lack of attachment to any of his parents. He has spent so much of his early years in day care that he never learned to bond with another human being. He needs to learn to bond before it is too late, and we’re running out of time, if we haven’t already.”

She offered a conciliatory nod of consent.

We all agreed that the task would be extremely difficult, given that she had a newborn, as well. She said that she wanted to try, and we all agreed to support her in every way possible. For the next year, Jay remained with her, but visited his dad and Lacey, who had married.



## CHAPTER 9: JAY DETERIORATES

### Getting Started

I began teaching Jay's mother about Holding Therapy in the presence of the other three parents, so that every one would understand what she had to do and be able to support her in the process. To my knowledge she tried it only once after I instructed her, and Jay told me that he could smell alcohol on her breath.

We had a number of sessions with all four parents. Jay seemed to love the attention. It seemed that everyone wanted to find out who really molested Jay, so I created a game. Each one of us would guess who molested him, and he would have to say "no" if we were wrong and "yes" if we were right. I started; then Lacey was next; Jay's father followed; and then his mom continued; and his step-father finished the first round, and we started back around again. I picked that order, so everyone would have a chance to get the idea how to play it.

My first guess was Jay's baby sister. He giggled and giggled. I said, reminding him of the game, "Is that a 'no?'" Jay said, "No is no." Then Lacey guessed it was the dog. Jay giggled again and said, "No." Then Jay's mom asked if it was his teacher, and Jay giggled some more and said, "No." Then Jay's step-father asked if it was their other dog, and then Jay looked at him, seriously and said, "No." I could tell it was time for a serious guess. I asked Jay if it was someone in either one of his homes. He said "Yes." He still seemed to like the guessing game, even though he had not wanted to disclose so far. Lacey asked if it was someone in their home. Jay said, "No." Then Jay's mother asked if it was someone in

their home, and Jay said, “Yes.” Then, Jay’s stepfather asked if it was his son. Jay said, “Yes.”

*The Perpetrator was a Friend*

Jay began to add detail about his molestation. His older step-brother had been the primary offender, but his older cousin of the same age was also involved, although not as much. He talked a lot about his step-brother. It was apparent that he admired him and was afraid of him. For a period, he spoke incessantly about this older child. He liked that we listened. I offered him a bat to get his “angries” out, and he relished the work, but it always seemed rather false.

“Jay,” I asked. “Why don’t you sound really angry at your step-brother?”

“I’m not,” he responded.

“Why not?”

“Because I like him.”

“Why do you like him when he hurt you?”

“He didn’t hurt me. He was nice to me. He’s the only friend I’ve ever had.”

“Haven’t you ever had friends at school?” I asked.

“No. Nobody likes me.”

“Why is that?” I asked.

“I don’t know. They just don’t like me.”

“That doesn’t sound true to me, Jay. People always have reasons why they don’t like people. If everybody doesn’t like you, maybe there’s something you do to push them away.”

“No, there’s nothing I do. They just don’t like me, and I don’t like them either.”

“Are you ever mean to other children?”

“Sometimes.”

“Could that be a reason children don’t like you, because you’re mean to them?”

“No,” said Jay. After that, he didn’t want to talk anymore.

“How was your step-brother nice to you?” I asked. Jay did not reply, and it was time to end. Perhaps, Jay was right and his step-brother was the first person in Jay’s young life to take time with him.

### *Injure or Feel Hurt?*

I began to have Jay do couchwork, paying him a penny a breath, because he was only four years old and not inclined to put himself through such work. In one session, while Jay was breathing, I pointed out that I saw him clenching his jaw and holding his hands in a fist.

“Jay, you need to relax, and go sweet weak,” I coached. There was no need to explain to him this terminology which I had just made up on the spot. He completely understood me. His face turned bright red, and he reared up on the couch.

“No! I will never be sweet! I will never be weak!” Jay raged, as if at me. I listened, somewhat stunned.

When Jay wound down a little, I told him that I understood that he was afraid of being weak. I asked him if he feared someone would break his heart again? I stopped Jay in his tracks, asking him this question. He looked at me like I was smarter than any adult he’d ever known.

“Do you know that?” Jay asked. “How do you know that?” Playing on my newfound mysticism, I commanded him.

“Now, you need to lie down again,” I asserted firmly. Jay lay down again. I continued, “Jay, you have a choice. If you get vulnerable and remember the things which hurt you so much and feel those feelings and cry about them, you can heal. If you don’t let yourself go into these old feelings, then you will continue to hurt other children. Then, they won’t like you.”

“No!” Jay asserted, again, still lying down. “I would rather hurt other children than feel hurt again!” I was astounded by the clarity of that moment. I saw how well he could follow my thinking and his dilemma. I was amazed that he could be so clear about this profound choice before him. I was in a deep appreciation that the crux of our problem was articulated so clearly between the two of us. I was mostly amazed by what struck me as an operative definition of evil. It came like an epiphany, even though I had already read M. Scott Peck’s *People of the Lie* (1983). I saw how we are all faced with these moments when we have to decide whether to face our own pain or difficult choice to achieve relief by hurting others. Since then, this insight expanded into another choice I’ve seen patients make, which is to pursue self-gratification rather than make a healthy or even moral choice, such as put one’s child’s needs before one’s own.

#### Treating Jay with Predictable Failure

It seemed like the therapy was progressing too slowly for attachment work. Jay’s ability to feel secure with his mother was not improving. She took frequent trips to Los Vegas, leaving Jay and the baby behind sometimes, and other times she left him in the hotel room with her restless, first-born teenage daughter by another marriage. Jay had begun to

talk to me and his father and Lacey about his mother's broken promises and that he didn't believe her anymore.

I thought from the beginning that it might be impossible for Jay's mother to do the corrective parenting and re-bonding work, given that she had a newborn and had not yet healed herself. However, there could be no suggestion that she give up her child to Lacey. It would have to be her idea. I believed that idea would come in just a matter of time, hopefully sooner than later. I explored Lacey's feelings on the matter to see if she was able or willing to give up her own hopes of having a baby, in the high probability that Jay's mom could not keep her commitment to Jay. She said she had already given it a great deal of thought, and she knew that she could, and she would.

#### *Where's Jay's Mother?*

Toward the end of the cooperative year Jay's mother left her husband, and became involved with a new man, devoting all her attention to him. She went back to work, even though we implored her to stay home with Jay and the baby. She missed appointments with Jay. Her drinking continued, and we could not be sure it was safe for Jay to ride in her car. I tried to see if there was alcohol on her breath every time they came. Even when the new boyfriend was not visiting the home, he would show up coincidentally on outings. Jay did not believe the coincidence. His lack of trust was exploding.

One day Lacey brought Jay to treatment. Jay, not quite six years of age yet, appeared arrogant and cocky. He was particularly disrespectful to me, as well as to Lacey.

"I could see you were at 12 o'clock when you walked in," I said to Jay, referring to an heuristic model I taught Jay which I call "The Power Clock," where six o'clock is humble or

vulnerable, and 12 o'clock presumes power, authority or dominance and control, resulting in entirely different and opposite attitudes or even personalities.

"Yeah, so what are you going to do about it?"

"Watch you," I said. "What are you so angry and hurt about?" I asked.

"Nothing," Jay dismissed me.

"He's really hurt," Lacey said, "because his mother told him they were going on a trip together, just the two of them. They went to Las Vegas, and she left him in a hotel room with his baby sister, and his older sister babysitting the two of them. Then, last weekend, she took him to a baseball game, and it seems they *accidentally* ran into her new boyfriend, so she invited him to join them. After that, she mostly paid attention to her boyfriend."

"Yeah, *accidentally*," Jay mimicked Lacey and his mother, simultaneously.

"It sounds like you don't believe she accidentally ran into him," I checked.

"She *planned* it."

"That's sure what it sounds like. I think you could be right," I agreed. "That's a pretty big coincidence. Did she act really surprised or pretend to be surprised?"

Jay then studied me and said, "Pretend surprised." He was now at 6 o'clock. "You think she planned it?" asked Jay, as if he was amazed someone else thought the same thing. He looked at Lacey who was smiling.

"You think she did too?" Jay asked Lacey. She nodded yes.

"I bet you really feel betrayed," I said.

"I hate her," he said. "I don't ever want to see her again. I don't ever want to talk to

her again. I hope she never calls again. Why can't you make her get out of my life?" he asked Lacey.

### *The Relinquishment*

Jay was getting worse. He was seen pinching his baby sister. He had acted out sexually with children in his kindergarten, as distinct from child's play or discovery. He was suspended from every school he entered. At this point I asked Jay's mother if she could choose between her boyfriend and Jay. She said she could not.

I asked Jay's mother if she would allow Lacey to become the primary parent so that Jay could be healed. She took some time to think about it, and finally she consented. I told her that I believed she had made a moral choice, and I admired her. I told her the story about King Solomon who mediated a dispute between two women, each insisting that they were the rightful mother of an infant. King Solomon said, "We will have to cut him in half, so that each of you can have the baby." One mother said, "Oh, no, please don't. Let her have him." With those words, King Solomon knew who was the real mother, and awarded her the baby. I told her that her choice was the choice of a real mother, given that she couldn't do what needed to be done for her child. The agreement to relinquish her parental rights was drawn up, submitted as delicately as possible, and rubber stamped in court.

At first, Jay's mother was allowed to send presents and make phone calls, but these were too disruptive because they were erratic. When too long a period went by, Jay would spin out of control. In therapy I had Jay write a letter to his mother telling her why he felt hurt that she didn't call at the time she said she would. Having taken the class, I thought she would understand, since the class talks in depth about how parents can heal mistakes they

have made by their children if they listen to their feelings. Lacey even prepared her for the letter.

However, after Jay mailed his letter, Jay's mother called one day, and Jay answered the phone. He said, hopefully and cheerfully, "Hi, mom!" She responded, "I am no longer your mother. May I speak to Lacey, please?" Jay was devastated and filled with rage for months thereafter. When holidays, such as Mother's Day and Jay's birthday came and went, Jay's mother would only sometimes acknowledge him. She was unpredictable, and Jay's behavior spiraled further out of control. He now raged daily, usually destroying what he could.

On numerous occasions, I, along with Jay's father and Lacey, explained to Jay's mother how hurtful her cutting remarks were, as well as her unpredictability. The excuses seemed endless. Finally, I explained to her that we needed to end all contact, if we were to go forward. Jay's father and Lacey spent hours on the phone with her trying to console her and trying to explain that it was only for Jay's benefit and that Lacey was not conniving to steal her child.

## CHAPTER 10: THE NEW BEGINNING OF THERAPY

### But Jay Gets Worse

When Jay was still six years old, his father gave Lacey complete rein with his son, and he agreed to support her every way he could. I, then, began to coach Lacey on how to heal Jay. Lacey made the complete commitment to Jay, readily agreeing to give up her precious hopes to have a baby. Jay would be her baby.

Shortly thereafter, Jay molested a younger child next door. I say molested because the context was not based on curiosity. It was not child's play. It was based on power, requiring three-year-old to suck his penis. Lacey began to attend school with Jay, shadowing him. Unfortunately, he focused on her to the exclusion of the teacher and still found ways to injure other children. I determined that he could no longer be trusted to play with other children, even those outside the home. He was not safe. He was very aggressive. Lacey decided to home school Jay. She taught him how to turn his feelings into a poem on the computer. She brought his first poem with them to one of their sessions (See Appendix A).

As a result of the transition, and Jay's deep, entrenching feelings of abandonment, Jay was displaying a whole new set of symptoms. Fortunately, Lacey was prepared. He now went into uncontrollable rages using foul language worse than ever, and compulsively, even needlessly, lied. He was unable to use cause and effect thinking, blaming everyone else for how they treated him, and was not able to see that he caused the way they saw him and treated him.

Jay didn't trust anyone. He didn't want to be vulnerable or let anyone be his boss. He felt driven to scapegoat others, and Lacey was his main target. In therapy, I learned that

Jay had been threatening to kill Lacey. He had been caught trying to torture their aged and infirm dog. He told Lacey that if she didn't do what he wanted, he would report her for child abuse, so I wrote her a protective letter on letterhead just in case. He acted like a little Mafioso, and his abilities to charm and manipulate continued to develop with strangers, friends and relatives. He enjoyed conning adults with cunning in Lacey's presence to see what she would do, and thus, if she disciplined him, it made her look bad.

Sometimes I was asked to make home visits because Jay was out of control. On one such day, Jay began raging when he found out he was going to see me and do couchwork. Jay broke out his windows. I arrived to hear the child say, "Be careful not to close your eyes when you sleep, Mama, because you'll wake up dead."

"You sound really angry," I said.

"Duh!" he said, with a ridiculing tone. "I hate the world and everybody in it!" he yelled, red-faced, confirming my observation. "I'm going to kill all of you!" He was still screaming and throwing things around.

"You must be terribly afraid." I whispered, using paradoxical interventions. With RAD children, it is particularly effective to interpret all their actions which are designed to be bold and protective as weak, and all their vulnerable actions as strong.

"I'm not afraid. You're afraid!" Jay yelled. "You're a fucking bitch. You're both bitches! Get away from me. Get away! Get away! Get away!" he ordered hysterically.

"People who are afraid often try to frighten other people," I whispered, moving closer. "They say things that are supposed to sound so scary."

“If you don’t do what I say, I will call Children’s Services and report both of you (the new mother and me) for child abuse,” he threatened.

“Go ahead!” I challenged him. “Nobody will believe you, because you’re lying. Smart grownups can usually tell the difference between the truth and a lie. I think the truth is you are afraid to trust grown-ups ever again, because you are afraid of being hurt again, so you want to boss them around to be safe. I wonder if you’re so mad at your birth mother right now that you hate *her*. But, she’s not here. Maybe you hate Lacey, instead, and anyone else you can scapegoat.”

“That’s right. I can’t trust any grown-ups. And, I’m not afraid of anyone,” he half-yelled.

“I’m wondering if you think you have to be tough” I inquired, “so no one can hurt you.”

“Yeah, I have to be tough. I *am* tough. I don’t have to be tough. I *am* tough.”

“Do you think all grown-ups are the same?” I inquired.

“Yeah,” he said. I knew a part of him was clear that his mother and Lacey were very different, but he was stuck.

“That’s too bad.”

“Why? What do you mean?”

“Then you’ll probably not be able to tell if a good one comes into your life.”

I recommended that Lacey remain with him in every room of the house at all times. I asked his father, in front of Jay, to board up the windows, take everything out of his bedroom, except his mattress, and let him earn his way back to a normal child’s bedroom. I told Jay

that he was going to experience what jail was like until he could learn to control his destructive choices, because jail was what would happen to him as an adult if he couldn't control his behavior. I saw that my toughness was hard for Lacey, but she accepted my recommendation. She understood how serious was Jay's behavior. Without heroic efforts on the part of caring adults, it appeared as if Jay could be on his way to becoming a killer or a rapist or both.

At the height of his worst behavior, his father took him to a local prison so Jay could see a jail. The guard at the gate said they couldn't go in, but he took the time to tell Jay some stories about what it was like inside.

Jay appeared to be headed straight for sociopathy. He had many of the traits of an adult sociopath, as described by Cleckley:

He effects a superficial charm and sophisticated insight into social appropriateness [Yes]. He is acquisitive and makes a good superficial show of material success [N/A]. He is deceitful, lying easily [Yes], and may pass 'yes/no' lie detector tests [N/A]. He likes to 'put one over' on people, to manipulate, to line up a power base, and to beat the other fellow to the punch. He loves the intellectual skill of manipulating people, especially of staying one jump ahead [Yes]. He has contempt for authority and is particularly thrilled when he can manipulate those in power [Yes]. He is bold and daring and hungers for thrills and excitement [Yes]. He has a compulsive and impulsive propensity for sexual deviancy, especially in the realm of the forbidden [Yes]. He enjoys derogating and humiliating others, and has a

propensity for violating the rights of others [Yes]. He has a guiltless insensitivity which is undaunted by danger and punishments, and rather, seeks to provoke and attract them [Yes]. He has an inability to love [Unsure], a lack of empathy [Yes, except for his biological mother], and a lack of conscience [Yes]. He is a sore loser [Yes]. He enjoys vindictive retribution, often in ways that are socially disreputable, irresponsible or even illegal [Yes] and often in ways that are socially acceptable and legal [Yes].

#### Just a Little Progress

I told Jay that I understood that he truly couldn't control his behavior yet, but that we were going to help him. I told him that if I were in his shoes, I'd be just as angry as he was, and just as terrified of becoming vulnerable. I directed Lacey to physically contain him during his rages and to whisper understanding words to him, such as: "I know you are angry," "I can handle your anger," "Tell me how bad it hurts," and "I love you, no matter what." We knew he was defying Lacey to love him, terrified that she did, and terrified that he would love her and she would leave him too. He would rather refuse to let her in.

#### *Education*

Lacey was to work with him, as I modeled during private sessions on having him express to her his hurt feelings instead of meanness. He needed to come from vulnerability. We would not respond to an adult affect. We would call it phony every time. She would always contain his rage by Holding.

He was to begin the process of learning self-awareness, and we were going to teach him theory about how he became the way he was, how his actions create more bad

experiences for him, and how to heal. Lacey continued to love him unconditionally, while accepting no bad behavior, requiring him to be as a child or remain in his room.

We gave Jay a new vocabulary for all his behaviors, thoughts and feelings. He grasped it quickly, as it vindicated him: he was not inherently bad. Rather, he was inherently good. He was relieved to hear the explanation for his mistrust, anger and bad behavior, which made him an innocent child who had been wronged. He learned terms like “scapegoating,” “surrender,” “self-awareness,” “honesty,” “authenticity,” “cause and effect,” “karma,” “bonding,” “attachment,” “Reactive Attachment Disorder,” “RAD,” “neglect,” “abuse,” “sexual abuse,” “fear of fear,” “healing,” “vulnerability,” “fear of vulnerability,” and “courage.”

One day Jay walked into therapy declaring, “I don’t want to be here.”

“That’s honest,” I said.

“I’m not honest,” he said.

“Who says so?” I inquired.

“Terry,” said Jay, apparently making the choice to call his birth mother by her first name.

“I see you decided to call your bio-mom by her first name.”

“She’s not a real mom, so she can’t be my mom.”

Nodding, but letting that one go for the time being, I asked, “Did she say you were not honest?”

“She said I’m a liar.”

“Are you?”

“Sometimes.”

“But obviously not always. I guess that means you’re a person who lies sometimes, but that doesn’t make you a liar,” I reframed for him. “You seem completely honest now.”

“She wouldn’t like this kind of honesty. I’m talking bad about her.”

“I imagine not. Can you be this honest with mom-Lacey?” Pause.

“Yes.”

### *Mother, Keep Your Power*

Sometimes there was a slight tension between Lacey and me, because I was so “hard on Jay,” and she wished we didn’t have to be. I could feel the depth of her maternal loving. The part that was hardest for her to enforce was my rule that he was not allowed to act or play like an adult. Period. Of course, she had to enforce that rule, consistently. Sometimes it seemed to her that enforcing this rule made it difficult for her to achieve the bond we were all seeking. It was not easy to stand up to Lacey and to insist we be so “hard on this child.”

One day I received a phone message from Lacey, in which she said, “I just wanted to tell you that I’ve had a revelation. I truly understand why we have to keep Jay out of power. Not only is he practicing a false self when he’s in power, but I can see that as long as he assumes an attitude of power or adulthood, he can’t learn what he needs to learn developmentally. I also see why he has to learn to be vulnerable to get there.”

### *Raging to Heal*

I continued having Jay do couchwork for a penny a breath, but this usually led to holding therapy, instead. I never had to provoke Jay in any intrusive way to get him to do holding therapy. Neither would I ever have considered it an option. It was not necessary.

There were several things which occurred naturally and which provoked his rage. First, and foremost, was couchwork. He hated couchwork.

Jay also hated affection if it wasn't on his terms. I asked Lacey to initiate affection with him sometimes, especially whisper to him that she loved him. She whispered words of understanding to him, and the second she began to touch his heart, he would flare up as if she were trying to kill him. I had to book their sessions on Sundays, so that no one else was in the therapy suite, because Jay's rages were filled with fury and volume. His voice never seemed to tire. He could go on for an hour at full volume and intensity. I didn't want to ask him to yell quietly.

## CHAPTER 11: FACING RESISTANCE AND CREATING TRUST

### Regressing for Fear of Intimacy and Vulnerability

I made a house call one day and observed that Jay spoke in a voice I'd heard before as he peered at Lacey through hateful eyes. He actually looked like a little demon. He said in a low guttural tone, "I'm going to slit your throat."

I told him to lie down and breathe. Jay refused, so Lacey and I went to hold him. He said to her, "I fucking hate you. You'll never be anybody's real mother."

I caught a glimpse of Lacey to see how she was — the woman who had given up having her own baby to heal Jay. She looked completely tuned in. I realized I was more angry at Jay for trying to hurt her than she was. A part of me thought she was a saint, and I wanted to spare her this cruelty. I wanted to throw myself in front of her to protect her from this ungrateful child. But, the look on her face reminded me that she understood the origin of his pain.

"Tell me why you feel hatred for me right now, Jay," she queried him.

He did something I've seen him do many times. He put his fingers in his ears and started making nonsense sounds, so he couldn't hear her.

I took his hands off his ears, and he spat in my face. To re-assert my power, I lifted him in the air by his feet and deposited him on the carpet. He gave me an evil look. Lacey calmly called out, "Honey, could you get Faye a damp wash cloth?" Ron appeared shortly with the wash cloth.

"Are you afraid I'm getting too close to your heart?" asked Lacey, leaning over him on the floor and zeroing in.

Jay started screaming and wiggling with his hands on his ears and his eyes squeezed shut. I just sat back and watched. I figured I could wait him out. Lacey must have decided the same thing. When he would start to fade out, she would pull him onto her lap on the floor, and he would start up again. Each time his efforts to wrestle free became weaker.

#### *Attempting Intimacy*

Finally she asked Ron if he would bring her a bottle of chocolate milk. She was able to rock him and pet him and sing to him. Jay began to whimper and cry, “I hate you, because you’re trying to touch my heart. I can’t let you.”

#### *New Clinging Behavior*

Shortly thereafter, Jay became frantic whenever Lacey would leave the room, indicating that he was starting to bond with her. As he began to trust her, he would confide in her, often crying about frightening things he remembered: the police coming to their house and then being told not to talk to them; his mother yelling mean things at his step-father; his mother throwing things; his step-father hitting her; and his step-father smashing his bed and his fish tank, while he watched all his favorite fish flounder and die on the floor amongst the glass. He told Lacey about promises to him she had broken.

#### *Hope Returns*

Keeping the faith had been difficult. Even though we knew Jay was inherently good inside and that he was not a bad seed, there were times when his father, his mother and I each went through periods of worry that he might not make it, and he would turn out to be a violent criminal. We dared on a few occasions to speculate on what that might be like for them.

Shortly after we expressed our worst fears to one another, Lacey began to report little victories. She had a ritual with him in which she would sing a lullaby to him every night, rocking him while stroking his face and hair, often giving him a bottle. One day, she heard him in his bedroom singing the very same lullaby to his teddy bear and saying sweet things to the bear which Lacey had said to him. She told me she wept with joy and relief, because she knew it was a sign. The following day, Jay wrote another poem, which she typed on the computer for him. She brought a copy for me to their next session (See Appendix B).

### *Working with Dad*

On some occasions Jay's father came to treatment with him instead of his mother. His father was excellent at filling in. However, Jay was sometimes jealous of his father. By a Freudian interpretation, I could say that Jay was experiencing a belated Oedipal stage with his father. I knew he resented anyone taking Lacey's time from him and I also knew he had anger that his father had abandoned him and failed to protect him. Lacey had not ever abandoned him. She had only arrived late in his life. Perhaps too late. We used these occasions to process Jay's anger at his father, who was completely accepting. Often Jay came with his father, because he was already showing anger at him at home.

Jay walked into one session jerking his arm away from his dad. He threw himself on the couch and folded his arms.

“So you're angry at your dad or angry at the world?” I asked.

“I'm not angry at my dad. I just hate him.”

“Why do you hate him?”

“I hate him for meeting Terry first. I hate him for choosing to marry Terry. I hate him for letting her go to work and for taking me to daycare. I hate him for not meeting Lacey first. Why couldn’t I be born from Lacey?” Jay threw himself around the room from chair to sofa to sofa to chair, weakly crying, but preferring anger.

“I’m too mad to be sad. I hate him!”

“Let’s do some rage work,” I suggested.

“I can’t. I can’t let you watch me.”

“Can you let your dad watch you?”

“Yes.”

“OK, I’ll step out, but if I don’t hear really hard work yelling, I’ll be back.” Before I left I got the padded bat and placed it in Jay’s hands. I pointed to a place on the pillow. “Do you recognize who this is?” I asked.

“Yeah, it’s my dad,” said Jay, impatiently.

I barely closed the door behind me and I heard the sound of pounding and screaming. “I hate you! I hate you! I hate you! I hate you!” I heard visceral roars, like he was tearing into the cushion.

When the sounds died down, I let myself back in. Jay had his head in his father’s lap. He was now crying. I sat down quietly. After a few minutes Jay stopped crying, looked up at me and smiled.

“Good job,” I said. “Why did you want me to leave?”

“I feel self-conscious. I don’t want to look bad in front of you.”

“That’s new,” I said.

“Yeah, I don’t want to cry in front of you either.”

“Really?” I mused.

“Yeah.”

“Is that because you’re mad at me too?” I asked.

“No. It’s because I’m *not* mad at you. I’m going to marry you when I grow up.”

“Oh, Goodness,” I said. “How sweet is that?” Taking a breath, I added, “Well, Jay, you know I’m already married. But, I certainly am complimented. I love you too.” I took another pause, and then continued. “I just want to tell you when people cry in front of me, I feel closer to them. I’m not that close to people who can’t cry in front of me or share their feelings with me. One reason I feel so close to you, is you have shared so many feelings with me.”

### *May I Call Her Mom?*

On the very next session, Jay arrived with a question. He wanted Lacey to leave the office to ask me.

“Can I call Lacey ‘Mom’?” he asked.

“Why?” I asked.

“Because Lacey is taking care of me, and it’s about time I have a safe mommy.”

“I think that would be wonderful. I think she would be so proud.”

“But my first mommy would be really angry with me, if she knew.”

“That’s a shame. She still has a lot of power, doesn’t she? Maybe we could ask her for her blessings.”

“No!” Jay snapped.

“OK, then we don’t need to tell her for now,” I said, and Jay seemed satisfied.

### Couchwork! Not Again!

Jay continued to hate couchwork. When bribing him no longer worked, we moved to philosophical issues around courage and surrender. Early on, he threw huge tantrums, for which his parents did Holding Therapy. Holding Therapy led to a “state of grace” in the end, with which it was easy to rebond with Jay.

Couchwork was a staple throughout our work. We would talk for about a half an hour, usually about important good or bad choices, leading to discussions about pride and arrogance, friends, responsibility, cause and effect, philosophies of life, trust and vulnerability. Then we would begin couchwork, which often led to a struggle. Jay’s job was to surrender each time to the task at hand. He was to surrender his ego and his defensiveness, and face his fears with courage. After his session, if he did well, he would do something prearranged he really loved or wanted to do. When he had finished his work, he would be held, stroked, petted, sung to, and understood, while he was in a vulnerable state. As he got older, there were additional rewards such as Hurricane Harbor, a movie, or going for ice cream. If he didn’t surrender, there would be no reward, and he would often be confined for a day to his room. How hard or easy it was, was up to him. He had to learn to face what was in front of him. We had to play hard ball, because we were running out of time. Hard ball worked, because he began to surrender to the couch work.

The process itself was invaluable, whether or not he had memories or catharted any buried trauma. He did have memories, however. He did release more pent up, putrefied emotion than one could ever imagine in such a small child. It might be hard to believe, but

Jay had many memories of being left in a crib, of being left in day care, of languishing in day care, and of being alone as an infant and toddler.

One day Jay came in to therapy in a chipper mood.

“Remember, we decided to start with couchwork, so you can get it over?”

“O-o-o-h-h-h, No-o-o-o,” Jay moaned. “I was hoping you’d forget. I don’t want to feel my feelings. I don’t want to breathe. I’m not going to do it.”

I responded with an educational lecture: “I don’t think that’s an option, Jay. I don’t think you want the consequences, if you don’t. Listen, I’ll explain this to you again. This is the biggest gift I have to give you. It’s the secret of life: Always do what’s in front of you to do. Don’t waste time hating it, especially if you must do it anyway to feel good about yourself. We do what is the right thing to do, so we can live with pride and self-worth. Couchwork will help you become more likeable to your friends. It will make you nicer to people. It will reduce the suffering inside you. It will help you heal. So, never waste time or life hating what you must do anyway. When you hate what you must do, you make it worse, much worse. Now, lie down and breathe.”

Jay threw himself down on the couch and started breathing like he was mad. I didn’t mind, because I didn’t care what his attitude was, if he was breathing hard. Pretty soon he started throwing himself all over the couch, tossing and turning.

“Jay, that’s enough. Lie still,” I admonished him. I didn’t care that much whether he lay still or not, if he was breathing hard, but I believed he needed to practice surrender, as much as he needed to breathe. I was not goal-oriented for the couchwork. I was goal-oriented for his practice of surrender.

After about twenty to thirty minutes of hard breathing and many admonishments to lie still and surrender as he breathed, Jay reported that he wanted to stop.

“Do you have symptoms yet?” I asked.

“Yes,” Jay said.

“OK, what are they?”

“I feel mad.”

“That’s not a symptom. That’s you mad at me and not wanting to do the work. Keep breathing.” I knew it wasn’t a symptom, because he didn’t report bodily feelings.

Jay slammed his fists beside him into the cushion and resumed breathing. After another ten minutes, Jay said, “I don’t like this feeling.”

“What feeling?”

“I feel tingling. It’s uncomfortable. I feel uncomfortable.”

“That’s good, Jay. That’s exactly what we want. You’re not in pain. You’re just uncomfortable. That means you are doing real couch work. Good for you. It needs to be stronger feelings, though. We need them to start forming strongly and clearly in certain spots in your body so that when you stop they won’t go away too quickly and you’ll have plenty of time to go on in and look at them, feeling the feelings. Give me another ten minutes breathing.”

Jay’s face turned red, and he started to cry. Apparently, he *was* ready. He turned over on his side and went into a fetal position. I didn’t say anything. I let him go. He cried for quite awhile, rocking himself. Then he put his thumb in his mouth, but his breathing

continued to stutter. Lacey and I sat quietly for about ten minutes. Finally, I asked him if he knew where he was.

Jay took his thumb out of his mouth and barely said, "In my crib. Nobody's coming to get me. I feel alone. I am so alone." Then he began to cry and stopped it with his thumb again.

"Jay, take your thumb out of your mouth, so you can cry."

Jay took his thumb out, and then we waited. He was not crying. I asked him to breathe a little more. He breathed for another two minutes and began to cry, rocking himself again. "She came and got me and then she put me back in the crib," he whimpered. "I hurt so bad. I can't take it. Why is she leaving me? Mommy! Mommy! Mommy! Come back, mommy!" He cried and rocked, while Lacey and I sat with him. As he began to stop crying, I signaled Lacey to go to him. First she put her finger in the palm of his hand. He grasped it, and then he opened his eyes, surprised.

"Oh," he said. "I forgot where I was. I thought she came back," and he choked again. "She's not coming back. You are," he said, as Lacey lifted his head, and he began to snuggle into her lap. They sat for another ten minutes, while Lacey petted his hair and skin, occasionally bending to kiss him on his forehead.

## CHAPTER 12: FACING VULNERABILITY WITH COURAGE

In our last year of work, Jay was no longer violent toward other children. He became violent toward himself. He sometimes sounded suicidal. When he would make a mistake, he would chastise himself relentlessly, and sometimes strike himself repeatedly on his head, blaming himself, saying to Lacey, “I’m worthless. I’m a loser. I’m wasting your time. I never should have been born. If I died everyone would say, ‘Thank God, Jay is dead.’” Lacey tried to understand why he was saying these things to her, and she tried to dissuade him of his thinking.

This was an alarming turn of events, and I also tried to get at the root of his thinking in therapy and to talk to him about his “shadow,” that this was a lie inside his head that came from something in his life that taught him to think and feel this way. I talked to him about how the very center of his being was holy and divine. He was born Good with a capital “G.” He was beautiful, and all these feelings were a lie inside. I wanted to help him get to the source of this lie. He persisted in his self-loathing.

### Jay Recovers a Memory

One day Jay came for couchwork, and he was highly agitated. His mother had to actually pull him into my office. He was in a self-deprecating mood and insisted he couldn’t do couchwork. He insisted he would only fail at it again. I told him, “Failure is only the refusal to try.” I told Jay to lie down and start breathing.

I had to prod Jay in the beginning. Many times, he insisted that he was too frightened to breathe anymore. He couldn’t stand the way he felt. He would wiggle and writhe all over the couch. He wouldn’t stay still. I pushed him to keep on breathing. Finally, when I

thought it was time, I said, “You can stop now. How do you feel?”

“Mmmmmm,” Jay said. He was holding his head, rocking.

“What?” I asked.

“Mmmmmmm,” Jay said, tearing up, with his lip pressed firmly together. Then, as if he could barely talk, he managed to explain in a muffled voice, “My head hurts. Something’s on my mouth. There’s a tape over my mouth. I can’t talk,” he said. “It feels like I can’t talk. I’m terrified. I want to stop. I want to scream, but I can’t.”

“Scream anyway. Imagine you can scream the tape off your mouth,” I said in one of my rare instances where I asked a patient to imagine rather than recollect, because Jay clearly need to cathart.”

Then Jay began to scream in terror. He screamed and screamed. His screams finally were broken up with reports to us.

“She’s tying me up. She’s walking around me and hitting my head with a wooden spoon.” He ducked and screamed and cried some more. Then, he sobbed, blurting out, “She’s saying, ‘You’re a cry baby. You’re worthless.’” Jay was gagging and choking on his tears, “She’s saying, ‘You’re a loser. You’re not worth my time. I never wanted you in the first place.’” Jay continued to cry a tormented cry for minutes to come.

When he wound down, Lacey joined him on the couch and pulled his big little body onto her lap and cradled him and rocked him and comforted him with sweet words of “I’m here now. Mommy’s here. I’m finally here. I’m so sorry, Jay. You never deserved to be treated that way. I’m so sorry. My sweet, sweet baby boy, I wish I could have protected you then. Mommy’s here now.”

Of course I accept that I'm a mandated reporter, and so I do what I must do. But, I must admit there are times when I wonder if it is the right thing to do, or sometimes my intuition actually tells me that it's not. Against my intuition, I reported the abuse to DCFS, because I was worried about betraying Jay's trust. He didn't want to make his mother angry. They sent someone to talk to Jay.

"I never said it," he told the social worker. According to Rolland Summit, it is not uncommon for children to recant allegations against their parents for fear of reprisal. Summit calls this The Accommodation Syndrome, which more commonly applies to sexual abuse (1994).

The social worker visited Jay's half-sister's preschool. She called to tell me that she thought the little girl's behavior was erratic, but she had nothing to go on. I got the impression Terry was never contacted. Case closed.

I was relieved, because I too had also been concerned about riling Terry. I thought she might be capable of retaliation. This didn't concern me often, but since the False Memory Syndrome movement, I believed under some circumstances it might be possible. I was treating a child who was not only estranged from his mother due to therapy, but now he had produced a memory which could be quite embarrassing to her, at the least.

## CHAPTER 13: THE RISE AND FALL OF THE FALSE MEMORY DEBATE

I didn't feel safe making the report against Terry, in part because I didn't want Jay to suffer any backlash from his biological mother. I didn't want her to go back to court, seeking custody or blaming me. I didn't want to be accused of planting Jay's memory. It seemed to me that the accusation against a therapist of planting false memories had become the practical way to defend oneself. My patient was recovering memories, and there was an actual movement educating therapists that this was impossible, and I could be accused of brain washing Jay. I could imagine it happening, and I didn't like feeling intimidated by the False Memory proponents. I looked into this issue, thinking if there wasn't much to it, I wouldn't take this tangent in my dissertation. However, there turned out to be more major material on the issue of intimidating and training therapists to be blind. Further, the issue of false memories and the issue of repression of trauma seemed inseparable.

I wondered from whence came this sudden power to redefine trauma therapy in such a pejorative way. How did these new holders of the power of definition manage their sudden appearance with such credibility and capacity to intimidate therapists, including myself?

It was in the aftermath of the McMartin Trial that the False Memory movement burst onto the legal front and into social awareness, impacting the field of psychology. Almost all of the children in the widely publicized McMartin Case of 1990 had apparently been led to falsely report trips by underground tunnel to a nearby mortuary. March 16, 1985 a group of parents had actually paid to dig up the area between the school and its property boundary, and no tunnels were found (Los Angeles Times).

In 1989 clinician Kee McFarland, the primary therapist who first interviewed the plaintiff children of the McMartin Preschool, had been publicly embarrassed in the course of the trial. She had clearly asked leading questions of the children. When the verdict came in “Not Guilty,” McFarland was thought by some to be responsible for leading the children to false memories (January 8, 1990). The verdict sent a message across the therapeutic and legal community that children could easily be led to have false memories or to lie for compliance sake. Workshops suddenly became available for interviewing children. I attended one of them, as well.

After the verdict the structure of the school was demolished, and before construction could begin on a new building, one of the children’s parents paid UCLA archeologist Gary Stickel for an archeological dig *under* the site. The commissioning parent’s older child, Joanie, now 12, gave an impeccable description of the location of the tunnels. The archeologists unearthed a trail of contrasting earth where Joanie said the tunnels would be, writes Rolland Summit, UCLA pro-parent clinician and researcher.

Beneath the floor of the exit, inside the vertical plane of the foundation, in fill undistributed by the earlier excavations, a plastic lunch bag was found bearing the date of its distribution: “DISNEY CLASS 82/83” and also printed [copyright] “1982 Walt Disney Productions.” Except for some kind of clandestine intrusion, nothing in the location could have been newer than September, 1966, when the foundation was poured. (Summit, 1994)

When the results of the dig were offered to the LA Times, the mother of Joanie was told that it was “old news.”

In the climate of the Mc Martin verdict the False Memory Foundation was founded in 1991. Its Scientific and Professional Advisory Board members advised therapists that “to treat for repressed memories without any effort at external validation is malpractice, pure and simple” (1993b, McHugh, p. 1). The FMSF further suggested a standard of care in violation of ethics codes in which the therapist of a client who recovered a memory should investigate the contents of the memory by contacting the parents and other sources of validation about the memory. They must provide comprehensive information to any clinicians working on behalf of the parents and to refuse to provide such information would be considered a lack of “good faith” (McHugh, 1993a, p. 3).

That same body holds that recovered memories are probably false and, should a therapist be a party to a recovered memory, malpractice is implicated. “Traumatic memories are memorable,” maintained James Hudson, of the Advisory Board (1995a). “People who undergo trauma remember it” (1995b). Other members of the Advisor Board include Aaron Beck, Henry Ellis, Richard Ofshe, Emily and Martin Orne, and Elizabeth Loftus.

While there is no false memory syndrome in the DSM, the courts heard arguments to its validity in case after case (Brown, Schefflin & Hammond, 1998, pp. 434, 1-55 & 578-634) presented by scientists and advocates of the False Memory Foundation, speaking as friends of the Court. Therapists were often their target of the Foundation in cases where the therapists had reported a recovered memory of child abuse, usually incest. Therapists became further intimidated (p. 2; Pope, 1998, pp. 96-97). Though protected as mandated reporters,

therapists are not protected for their assessment and treatment actions (pp. 70, 96). Referring to pressures within and without the field to overlook clues to child maltreatment, Kenneth Pope criticizes the impact such advice has had on psychotherapists. “To what degree, if at all, might therapists refrain from pursuing diagnostic leads based on presenting symptoms because of the threat of malpractice suits” (1998, p. 96)? Taking this logic further, Pope asks, “If suspecting the possibility of child abuse on the basis of such symptoms would subject them to actual or threatened malpractice suits, how, if at all, would such knowledge affect their response to the client and their consideration of whether to file a mandated report of suspected child abuse” (p. 97)?

The False Memory Syndrome was coined and developed by the False Memory Syndrome Foundation. The organization was formed by Peter and Pamela Freyd in 1991 with Ralph Underwager, director of the Institute of Psychological Therapies in Minnesota and his wife, Hollida Wakefield. The Foundation served to aid in the defense of allegations against the Freyds of sexual abuse by their daughter, trauma and memory psychologist Jennifer J. Freyd (Pope, 1988). Jennifer Freyd is a professor of psychology at the University of Oregon and now author of the theory, *Betrayal Trauma: The Logic of Forgetting Childhood Abuse* (1996).

Underwager and Wakefield were publishers of a journal for skeptics on *Child Abuse Allegations*. Underwager filed a few briefs on behalf of the FMSF to the courts, but the courts found he was not qualified to be an expert witness (State v. Swan; Timmons v. Indiana; Daubert v. Merrell Dow Pharmaceuticals, Inc.).

Freyd went public with her abuse at an August, 1993 mental health continuing

education conference in Ann Arbor, Michigan. She took this step reluctantly after numerous attempts to confront her family privately led to the formation of the FMSF as well as attempts by her parents to slander her at her workplace at the University and in the media (Whitfield, 1995, pp. 4-8). “My family of origin was troubled in many observable ways, and I refer to the things that were never ‘forgotten’ and ‘recovered,’ but to the things we all knew about.” Dr. Freyd spoke of her father’s alcoholism, the occasional open discussion of his own experiences of being sexually abused as an eleven-year-old, calling himself a ‘kept boy,’ and his entering male prostitution as an adolescent (Freyd, 1996, p. 198; Freyd, 1993).

Freyd says she wrote at age 13 in her diary, “I am caught in a web, a web of deep, deep terror.” Freyd later declared, “My parents oscillated between denying [my] symptoms and feelings to using knowledge of these same symptoms and feelings to discredit me.... My father told various people that I was brain damaged,” even though Freyd was a graduate student on a National Science Foundation fellowship, teaching at Cornell, and recipient of numerous research awards. Jennifer explained that her mother consulted with her own psychiatrist, Dr. Harold Lief, to have him speak to Jennifer. Dr. Lief, currently an advisory board member of the FMS Foundation, explained to Jennifer that he did not believe that she was abused, even though he admitted and disclosed that her father had “homeoerotic” fantasies (pp. 198-200).

Underwager filed an affidavit on behalf of members of the Children of God cult, who believe there is a holy dispensation for pedophiles tried in France in 1992 (Mike Coyle, 2004, part 2, p. 1; Whitfield, 1995, p. 7). He asserted that the accused were “not guilty of abuse on children” (Coyle, p. 1-2). Underwager reportedly told a group of British reporters in 1994

that “scientific evidence” proved 60% of all women molested as children believed the experience was “good for them” (*Ibid*). In the company of his wife, Hollida, he also disclosed in an interview to a Netherlands journal *Paidika: The Journal of Paedophilia* for pedophiles that he was himself a pedophile (Whitfield, 1995, p. 7).

Underwager resigned without explanation from the FMS Foundation shortly after a translation of the interview was released in the United States (*Ibid*). Hollida remained on the Advisory Board (FMS Newsletter, July 3, 1993). Here again, behind the influences which tell us not to see our clients clearly because we might hurt their parent’s feelings, is a force which seeks immunity for parents with the freedom to self-indulge at the expense of children. For such freedom and immunity to exist, others must close their eyes. If they do, they will not see Jay.

#### *Two Sides of Elizabeth Loftus*

Before her affiliation with the FMSF, memory researcher and court expert Elizabeth Loftus represented and produced research which supported the phenomena of repressed and recovered memories.

Memories that may cause us great unhappiness if they were brought to mind often appear to be ‘forgotten.’ However, are they really lost from memory, or are they simply temporarily repressed, as originally suggested by Freud (1922)? *Repression* is the phenomenon that prevents someone from remembering an event that can cause him pain and suffering. One way that we know that these memories are repressed and not completely lost is the method of free association and hypnosis and other special techniques used by

psychotherapists can be used to bring repressed material to mind and can help a person remember things that he has failed to remember earlier” (Loftus & Loftus, 1976. p. 82).

As recently as 1994 Loftus also directed a study which produced evidence for repressed memories. Loftus, *et al*, found 19% of a sample of sexually abused women had lost all memory of their abuse at some time in their lives, and 12% had large gaps in their memory (Loftus, Polensky & Fullilove, 1994).

Yet in 1994 Loftus and Katherine Ketcham published *The Myth of Repressed Memories* (1994), and Loftus joined the Advisory Board of the FMSF becoming their leading researcher and court expert (FMSF-FAQ, 2004). Loftus and Ketcham characterized therapists and researchers involved in the recovery of memories, or who believe that memories can be recovered, as “True Believers.” She and Ketcham identified researchers like themselves as “Skeptics” (p. 7), holding that no evidence exists as yet for the phenomenon of repressed memories. She did not mention any previous research within the field over the years, including her own study of 1994. True Believer van der Kolk remarked: “Loftus’ ‘selective attention to detail’ has been the hallmark of the so-called ‘false memory’ debate” (van der Kolk, p. 567).

Loftus and Ketcham conducted a now famous experiment, “lost in the mall,” in which they successfully implanted “an extensive autobiographical memory” by way of relatives in the memory of a young man, allegedly creating evidence that recovered memories might be implanted memories. After that, Loftus became a highly-paid expert witness for the defense, especially for parents accused of molesting their children, and against therapists who were

accused of implanting such memories (Loftus and Ketcham, 1999, p. 99). The scientist, Elizabeth Loftus, became the leader of the charge for the FMSF, testifying again and again in court on behalf of the accused and always against the victim/accuser that recovered memories can be presumed false. She testified against therapists who were being sued by the accused for having planted memories in their child's mind. Her research was being used to discredit children and protect parents with pro-parent research against children and pro-child clinical theory.

Loftus and Ketcham write:

Therapists specializing in recovered memory therapy operate in a neverland of fairy dust and mythic monsters. Woefully out of touch with modern research, engaging in 'crude psychiatric analysis,' guilty of oversimplification, overextension, and 'incestuous opinion citing,' these misguided, undertrained, and overzealous clinicians are implanting false memories in the minds of suggestible clients, making "therapeutic lifers" out of their patients and ripping families apart. (1994, p. 32)

In another quote, Loftus said,

Therapists rely on the malleability of memory to help their patients re-create or reconstruct their traumatic life histories. But what happens when both patient and therapist seek a definite answer in the indefinite past? ...Perhaps the whole idea of therapy as a vehicle for making contact with the past' deserves reconsideration. (Loftus & Ketchum, p. 267)

Loftus recommended "behavioral and pharmacological therapies that minimize the

possibility of false memories and false diagnoses... and avoid “dwelling on the misery of childhood” (1995, p 28). Loftus believes that “a competent therapist will help others support and assist the client and help the client direct feelings of gratitude toward those significant others” (1955, p. 28). Loftus would not be able to see Jay.

### *Skeptical “True Believers”*

Ethicist Kenneth Pope points out that it might not be difficult to persuade someone that they had such an experience being lost in a mall at age five, when many, if not most of us have been lost before and the thought of it isn't too alien. Given this common childhood experience, how is the determination made that the lost-in-the-mall memory is not substantially correct? Further, no one is implicated in the memory. It is a benign planted memory, for which an older member of the family claimed to be a witness. A therapist can never tell a client they were there with them and remember it well (1998, p. 81). Pezdek, Finger, & Hodge (1996, 1997) attempted the same experiment, only the suggested memory was that of a rectal enema. They had a zero percent success rate. Pope further questions the experiment, asking whether the subject was complying with social demand conditions of the research design itself (p. 81). Additionally, one might ask why scientists accepted the results of an experiment on *one* subject as meaningful.

Further, Pope asks, “If the experiment is assumed for heuristic reasons to demonstrate that an older family member can extensively rewrite a younger relative's memory in regard to trauma at which the older relative was present, why have false memory syndrome proponents presented this research as applying to the dynamics of therapy, but not to the dynamics of families, particularly parents or other relatives who might be exerting pressure on an adult to

retract reports of delayed recall” (1998, p. 82)?

Loftus and Ketcham (1994) inscribed in the beginning of their book, “Dedicated to the principles of science, which demand that any claim to ‘truth’ be accompanied by proof.”

The pro-parent authors write:

The journey to recover our lost innocence takes us deep into the land of metaphor and myth, where we encounter the divine purity of the Inner Child, the Hell of Childhood, and many other richly symbolic and profoundly imaginative archetypes. In the Myth of the Dysfunctional Family, for example, we learn that every family is dysfunctional in one way or another and that family rules and customs ‘kill the souls of human beings.’ In the Myth of Psychic Determinism we discover that our personalities, psyches, and behaviors are determined by events that occurred in our childhood. While we may think we are free to choose, the myth teaches that we are passive characters acting out a script, moved and played upon by unconscious, uncontrollable forces.

But even in this land of metaphorical excess, where Evil is personified and Innocence is inevitably perverted, there is hope of a happy ending. The Myth of Growth promises that we can ‘grow out of’ our complexes and conflicts and ‘grow into’ more mature, stable, understanding, and loving human beings. Salvation is possible—our wounds can be healed, our broken places mended, our impurities purged, our souls cleansed—through the Myth of Total Recall. Memory is imagined as a computerized process in which every action, expression, emotion, and

nuance of behavior is imprinted into the soft tissue of the mind. If we are willing to search for the Truth, we can discover it (and in the process be cured) by going back to the past, facing our demons, and reclaiming our lost innocence.

Do the myths hold up to reality? Only if reality is molded and framed to fit the myth. When we ask hard questions about these myths and challenge their metaphorical underpinnings, the uneven fit between fact and fiction is quickly revealed and the rickety theoretical structure wobbles. Does the inner child really exist? Are human beings ever wholly 'pure' or perfect? Is there such an entity as an ideal family against which dysfunction can be measured? Is our history necessarily our causation? (pp. 265-266)

Pope maintains that new research by Loftus and her colleagues does not measure up to basic scientific standards (pp. 79-80, p. 107). He cites twenty-two studies supporting the phenomenon of repressed memories. Fortunately, the debate has caused even more research, as well as higher standards for research (1998, pp. 92-93).

Pro-child trauma researchers are critiquing the pro-parent research *and* the researchers. Pro-child researcher and clinician Charles Whitfield refers to the work of Loftus, *et al*, as "false expert syndrome" (1995, pp. 214, 221, 226). Another pro-child researcher clinician, Richard Kluff (Eds. Appelbaum, Uyehara, & Elin, 1997, p. 52-53), maintains that these self-proclaimed experts have "minimal direct experience in the treatment of the traumatized or in researching the consequences of trauma." Taking another shot in the war of the researchers, Kluff continues:

Their credibility has been achieved by “depreciating and disparaging those who work with trauma and who might be understood to know something about traumatized populations.... Those who treat and study trauma themselves are mocked and derided, and are alleged to create the circumstances and conditions that they treat.

The result is the enshrinement of persons as experts on trauma whose acquaintance with the realities of work in the trauma field is vicarious and limited. Those who have never treated a trauma victim are accorded credibility when they advise clinicians how to proceed and how not to proceed....I would suggest that an alternative title might be the “false expensive expert syndrome,” referred to by the acronym “FEES.”

Many pundits who promote the false memory perspective remind me of the song, “I’m an Old Cowhand...I’m an old cowhand, from the Rio Grande...I’m a cowboy who never saw a cow, never roped a steer, ‘cause I don’t know how...Yippeekiokayay!” (p. 53)

Kluft, contributing a chapter in *Trauma and Memory: Clinical and Legal Controversies*, “The Argument for the Reality of Delayed Recall of Trauma,” writes in the same book with Loftus: “Elizabeth Loftus, Ph.D., is a brilliant researcher and scholar. She has described her own experiences of abuse and reflected upon her incomplete recollection of it. Her words are captured in a deposition cited by Whitfield. She both denies she repressed the memory of the abuse, and speaks of her uncertainty about the number of occurrences, and of her memory having taken and destroyed her recollection of her abuser” (1997, p. 50).

To reiterate, it appears that the leading court expert on false memory at one time believed at least some patients repressed trauma and repression was a psychological phenomenon, per se. She also produced research which supported evidence that victims of sexual trauma often repress their memories. She even admits under oath that she was abused, can't say how many times, but remembers enough to know she was abused. She can't say by whom. Bowlby might call such an inability to recollect "defensive exclusion," because it may be more dangerous to know who the perpetrator was than to remember the horror of what happened. Miller might observe that Loftus works so hard to prove that victims are misled to fabricate memories and accusations against perpetrators, and are not to be believed, that perhaps Loftus is attempting to exert the amount of control on others necessary to control or bury the truth in herself.

It seems interesting that she remembers bits of her own abuse, but not her perpetrator. It seems incongruent that she argues that others cannot repress and recall their traumas, even though she has repressed some of hers. Apparently, she has no intention to recall her own perpetrator, ever.

Perhaps, like Freud, and certainly others, Loftus has formed a belief to advocate and insure she will not remember. Perhaps, it is a form of acting out or a form of re-enacting her own instructions to close her eyes. Maybe she, like others in our field, is taking her childhood mandate not to see to our patients and those who depend upon us to see clearly and help them to see clearly. In *Shahzade v. Gregory* the prosecutor revealed that while Loftus had testified in 113 criminal trials, she had never testified for the prosecution (Brown, Schefflin & Corydon, 1998).

Since 1986, more than 100 appeals have been made and adjudicated regarding recovered memories. The courts were originally receptive until the False Memory avalanche of propaganda discrediting repressed memories. Fortunately, the courts have moved again in the direction of accepting the existence of repressed memories. In *Shazade v. Gregory* (1996) the courts adopted van der Kolk's nomenclature for repressed memories, "dissociative amnesia" (p. 607). True Believers or pro-child researchers and clinicians have begun to amass scientific data on repressed memories and to provide "transcripts" from other well-researched rulings. Such cases include the already mentioned *Shazade v. Gregory* ruling; *State v. Alberico* (1993) which developed an appropriate test for experts in repressed memories or dissociative amnesia (p. 606); and *State of New Hampshire v. Waters* (1995) which found that "there is no evidence to find that recovered memory is less reliable than typical memory evidence" (p. 604).

Nonetheless, many judges are still persuaded by the False Memory "researchers," possibly because they have not learned of the contrary evidence or possibly because they are predisposed to accept the pseudoscience of the false memory advocates as valid and disregard evidence provided by the trauma field.

According to Brown, Schefflin and Corydon, "The false memory controversy needs to be seen for what it is—more political than scientific, more the dissemination of propaganda than the distribution of scientific knowledge, and more the strategic use of pseudoscientific arguments as social persuasion to influence public policy and sway juries than the articulation of lasting truths about the human condition" (p. 435).

## War of the Researchers

An ongoing war of the researchers appears over time and runs through different issues. It seems that in order to understand a theory, one needs to appreciate its history, motives and its ramifications.

Whitfield traces a sociological progression of social action and backlash. He plots the formation of the Society for the Prevention of Cruelty to Animals in 1866 in the context of a history of treating children like property which led to the formation of the Society for the Prevention of Cruelty to Children in 1974. New endeavors to protect children created a climate for the work of pro-child Janet and Freud, whose patients were believed and who improved perhaps because they were believed. In April of 1896 Freud formulated and presented the Seduction Theory to his rejecting peers, in 1897 he privately retracted it to his mentor Wilhelm Fleiss, and in 1905 he formally retracted it. In its place, over a period of 40 years, Freud proposed that symptoms come from repression of internal drives and fantasies. In 1962 Kempe, *et al*, described the battered-child syndrome. In 1969 Bowlby produced his theory on Attachment. In 1980 he published Volume III on *Loss*. In 1973 laws against child abuse were enacted, and in 1977 Adult Children of Alcoholics (ACoA) was founded. In 1977 information was made public by several analysts regarding Freud's retraction of the Seduction Theory. 1978 Alice Miller began demystifying mental and emotional child abuse, while identifying a socially popular repression ethic on behalf of parents against children. In 1983 the recovery movement (including ACoA and John Bradshaw) expanded, while in 1989 the anti-recovery movement backlash began (p. 53).

The McMartin trial and its verdict of 1990 seemed to impugn the integrity of trauma therapists everywhere. In 1991 The False Memory Syndrome Foundation was formed, apparently to protect the parents of Dr. Freyd. In 1993 the FMSF began publishing and conducting seminars warning therapists not to believe recovered memories.

The immediate ramification of this debate is that professionals participating on either side are recognized, and one side is significantly resistant to considering the impact childhood has on their patients, and thus failing to see Jay's needs in his critical wiring period. The other side has sharpened its perceptions and understanding of the impact experience, especially lack of attachment, has on personality. As such, it has learned to read clues.

In terms of motives, and for the sake of simplicity, one side of this war seems to be pro-parent and the other seems to be pro-child. In this continuous battle I have noted that on one side of the adversarial dialogue there appears to be a motive to protect parents from blame for their actions and to identify the inherent constitution of the child as the source of his own problems. Without our field agreeing to see a child's needs for secure attachment, we will have more and more suffering children like Jay who grow up to be our worst nightmare, dangerous out of jail and expensive in prison. While all children could have been blessings to all of us, instead they lose their only opportunity in their one and only life to live it to the fullest. Sometimes they even become our worst nightmares which we love to blame and hate. Our field seems systematically and deliberately in denial, as it liberally presents both points of view as valid. Perhaps, someday one of these views may be seen as detrimental or even as malpractice.

### *Pro-Parent Motives*

When pro-parent arguments are made they seem illogical, compared to the attachment arguments. Robert Karen represents the pro-child/pro-parent debate thus:

If the fundamental message of attachment research is that children need to be cared for in consistent and sensitive way, that they love their parents powerfully and need to have that love returned and sustained, then the fundamental message of temperament research is that people are inherently different, that those differences need to be tolerated and respected, and that much of what we once saw as parentally induced is actually part of the nature of human differences. (p. 295)

In November 11, 1990, Karen interviewed pro-parent researcher Thomas Bouchard, who unabashedly and somewhat illogically explained his motives thus:

I think if we recognize that individuals differ from each other in these fundamental ways, we're going to have a lot more respect for one another. We know that we're physically different. We respect and understand that a kid who's only four and one-half feet tall is not going to compete with a kid who's six feet tall. Well, the same may be true for many psychological traits and characteristics. (Karen, p. 1994, p. 296)

Jerome Kagan agreed with Bouchard in an interview with Karen on December 21, 1990:

There are some people with a very short fuse. They blow up easily; it's hard to get along with them. Many people assume that it's

a function of their past and they should be able to control it. So then you get angry at these people. But if you believe that this is partly temperamental, and that their biology prepares them for this, then you become a little more forgiving.

Karen goes on to paraphrase.

Kagan also expects temperament research to take the pressure off mothers who, he believes, have got a raw deal as a result of decades of behaviorist and psychoanalytical influence. He quotes with pleasure the words of a famous scientist who suffers from terrible stage fright whenever he makes a speech. After hearing Kagan present his data, he said, “I’ve been blaming my mother for fifty years, but after hearing this, I’m going to stop.” (p. 296)

Karen, who has extensively explored the motives of geneticists, has found two main points of contention: First, attachment theory blames mothers and ignores “the fact that infants could be difficult or that there could be a poor fit. . . . and [Second], attachment theories have not been so eager to let mothers—or caregivers in general—off the hook: They want it understood that sensitive, consistent parenting is vital, and they see proclaiming that as part of their mission.” Karen goes on to say:

The blame issue is similar to the poorness-of-fit concept in that it has been highly charged politically, and the antagonists are often more concerned with the impact certain types of statements will have than whether or not they are true. Many developmentalists recognize that, of

course, parents are sometimes blamed for their children's suffering, but they believe that making an issue of it will only tend to generate guilt—and a guilty parent is more likely to do a poor job than one who had been reassured and encouraged. . . . An atmosphere of guilt is so destructive, they lean toward never saying anything, even in professional contexts, that might suggest that mothers ever behave badly. Poorness-of-fit and other temperament-based explanations are more reassuring. (p. 296-297)

According to ADHD researcher Barkley,

The weight of the research points to hereditary and neurological factors as having the lion's share of influence over the expression of this disorder [ADHD], not poor parenting, diet, or excessive television viewing. Genetic effects seem to account for as much as 80% of differences among individuals in these symptoms; the common environment accounts for very little, if any, of them. The yoke of moral indignation from others, character indictment, sinfulness, and willful neglect of social responsibilities can therefore finally be lifted from the shoulders of those with ADHD; they need bear it no longer, for it is clear now that to continue to hold such views will bespeak a stunning scientific ignorance about this disorder. (p. 349)

The common theme of the geneticists or pro-parent theorists is that it's just not nice, necessary or productive to blame mothers. Apparently some researchers spend their lives producing theory which protects mothers and parents. The motive makes sense. The logic doesn't.

Even the notions of temperament or poorness-of-fit are remarkable concepts designed to comfort the guilt of a mother who already knows she can't fully tune in, rather than teach her how to respond properly to her baby. Babies—all of them—are lovely, innocent, dependent and consolable by a consistent and attentive parent who can tune in. They are even trusting until they become fearful that they are not safe, at which point they become cranky, and not before. To presume that a baby is born difficult is to create blindness and insure a failure to see the infant's cues to his needs. Any mistrusting baby may recover from crankiness if his life becomes safe enough or the damage is not already too severe to safely remember and cathart.

Summing up the logic of pro-parent theorists covered in this paper, it is just as easy to assume that we are all different than to think we all could have had it easier and been better. Taking such reasoning to its logical conclusion, there is no need to advocate on behalf of the needs of babies, because they will turn out the way their going to turn out anyway. However neglected or abused a baby, there is no point in making a parent feel guilty. If behavior is thought to be a function of the past, then we are unreasonably expected to control it [as opposed to healing it]. If only we would accept the genetic theory, then everyone could be respected [including criminals and the mentally ill?], and no one would be blamed [including criminals?]. All would be accepted as they are. The person with the malady or difficult behaviors could be forgiven more easily, since they genetically cannot help themselves. Society would stop judging bad behavior and mothers so harshly.

The logic of the above thinking is that it is better to believe what is untrue, see what is untrue, and not see what is true, so no parent has to feel hurt or responsible for the results of

injuries to their children. The resistance is against feeling blamed for failing to act and protect. Personal responsibility is the law of the land, except for parents who are protected by an ideation of parental immunity. In protecting parents the child or even the infant is sacrificed, perhaps because the child or infant is thought to be more able to bear the burden than the fragile parent.

However, trauma therapy assumes responsibility for healing injuries, while geneticists abdicate responsibility. Actually, geneticists would, in fact, rather blame a grown child than his mother. There is little reason to believe that proponents of the “bad seed” theory have compassion for criminals. The theory which regards human beings the most is the one who looks with compassion at injured and repressed children who had to grow up. They are seen as babies who, born fragile, pristine, and dependent, grew to be adults who learned to cope with their circumstances in ways which don’t fit in society. This theory seeks to heal them, if at all possible. That is not to say that dangerous criminals should be allowed to be free, but rather, offer hope for healing and the conviction that prevention is an essential concern for our society and profession.

These pro-parent theorists have not met Jay, a real person, and have not seen first hand how much he has suffered at the hands of his biological mother and rotating caregivers. Yet, if they did meet Jay, I believe they would still protect his mother’s feelings over his, because her feelings and identity matter more to them.

I would suspect in their own homes, their mothers’ feelings have always mattered more than theirs, and they have learned that well. Further, pro-parent theorists believe they turned out just fine. I’m sure they believe they turned out so fine, in fact, there is no need to

go to therapy, especially when medical and scientific advances provide that medication is available.

Brown, Schefflin & Hammond were very disturbed by the pro-parent, skeptical professionals who represented themselves as experts to the court, including how they fought, and whether they should be fighting at all:

What Loftus is demonstrating in her popular books, and also in the courts, has to do less with scientific method and more to do with scientific discourse as a form of social influence. We find it ironic that some memory scientists have been so vehement in their accusations about undue suggestion in psychotherapy, and yet are seemingly so oblivious to the blatant social suggestion effects inherent in the very way they communicate their false memory beliefs.

It may be that some of the more prestigious outspoken scientists associated with the extreme false memory position are systematically suggesting or implanting false beliefs about false memories in the professional and lay community and in former psychotherapy patients...

*Are we to remain blind to suggestive influences inherent in laboratory research or inherent in public or forensic communication about false memory beliefs and only focus on suggestive influence in psychotherapy* [ital. theirs] (p. 434)?

Brown, Schefflin & Hammond suggest that the formation of Victims of Child Abuse Legislation (VOCAL) and FMS were a backlash against intrusion into the “sanctity of the

home” (p. 12), because parents resented having their adequacy as parents questioned.

Van der Kolk believes that the “false memory” debate illustrates that when “the discoveries of psychiatry come into conflict with society’s cherished beliefs, psychiatry has traditionally been vulnerable to giving up the pursuit of science,” (p. 568) as evidenced by Freud’s recantation and Loftus’ reversal.

Miller says:

“I officially broke away from the Swiss as well as the International Psychoanalytical Association. I was forced to take this step when I realized that psychoanalytical theory and practice obscure —i.e., render unrecognizable—the causes and consequences of child abuse, by (among other things) labeling facts as fantasies, and furthermore that such treatments can be dangerous, as in my own case, because they cement the confusion deriving from childhood instead of resolving it” (1988, pp. viii-ix).

Freud’s views reflected society then and now. When he proposed a theory of causation to his colleagues in 1896, he was rejected by his peers. Insight into the origins of patients’ behavior has not been welcome because it implicated parents. So, Freud reversed his theory and identified the causes behind disturbed behavior as inborn: internal drives and fantasies.

Before recanting his theory, he wrote to Wilhelm Fleiss, “A lecture on the etiology of hysteria at the psychiatric society was given an icy reception by the asses and a strange evaluation by Krafft-Ebing: ‘It sounds like a scientific fairy-tale.’ And this, after one has

demonstrated to them the solution of a more-than-thousand-year-old problem, a *caput Nili* [source of the Nile]! They can go to hell, euphemistically expressed” (p. 184).

In my opinion, there's no place for me to go but into the system. If not us, then who? The more teachers who can lift the veil on the War of the Researchers, researchers who represent the needs of Jay, and clinicians who can see him clearly, the safer Jay will be and the more prevention can take place. After all, what Jay needed was prevention.

## CHAPTER 14: TERMINATING WITHOUT ABANDONMENT

Recent findings from neuroscience suggest that the brain remains plastic, or open to continuing influences from the environment throughout life. “This plasticity may involve not only the creation of new synaptic connections among neurons, but also the growth of new neurons across the lifespan. The capacity for attachment classifications to change beyond the early years of life may be related to this ability of the brain to continue to grow in response to experiences across our lifetimes” (Siegel, 2001, p. 70).

Somewhere between our knowledge that Jay had missed the critical wiring period for secure attachment-- allowing his brain to prune away neurons which would never grow back--and our knowledge that the brain is plastic, was our conviction that Jay could heal. Further, we saw Jay as innocent and not to blame for his desperate and destructive attempts to cope with his despair and rage. The root cause of these states, as well as his aggressive behavior, was a lack of sufficient attachment.

Lacey home-schooled Jay until his last year of elementary school. As Jay improved, she discovered an elementary school nearby, a special school with curricula and teachers who understood RAD. Jay attended part-time in the mornings for the first half of the school year, and from January 2004 until June, he attended full-time. She anticipated the time for him to go to middle school, and she wanted it to be a success. She spent the year looking into schools all over the country. Fortunately, she found one in San Diego, and she and I both knew there was a good attachment therapist there also. It was only then I realized how fortunate we had been that she'd found a grammar school nearby.

Jay spent the summer visiting his new mother's family back East. I had been notified by Lacey that they would be moving in time for school to begin in September. She scheduled a last appointment for Jay before school started.

### Our Last Session

Jay walked into my office looking briefed and prepared. At eleven, he looked older and softer than I had remembered him. He carried the book I loaned him, *Zen Comics*, under his arm.

"I'm returning your book," he said. I felt a twinge. I can't say whether I was feeling it for him or for me. "I think I understand one of the stories, but only one," he said, sounding ashamed.

"He has felt pretty frustrated that he could only understand one," Lacey added on behalf of Jay.

"One is excellent!" I remarked. "They're like Zen Koans, Jay. It takes Zen students a long time to grasp the meaning of just one koan. You have to chew on it for a long time. I'm quite proud of you that you got one. That's really cool! It's interesting to me that you see failures rather than success. It's that same old thing, isn't it? You can't be a person learning. You can only be a person who already knows. You still think you have to be perfect, don't you? I wish we could relieve you of that. What a burden! The best part of life is the growing part, and we can't grow if we're pretending we already know."

"Yeah," Jay agreed. "I still want to be perfect, and if I'm not, I feel worthless."

"Okay, so which koan did you figure out?" I asked.

Jay showed me a story of a student preparing to receive his master for tea, trying to make the place look perfect. After the student had everything just so, he had an insight and returned to mess things up, just a little.

“Wow, Jay! What does this mean?” I asked upon looking at the page he had handed me. I looked up, and saw Jay looking at me, smiling demurely.

“Perfect is not perfect,” he said, beaming.

“How did you get so smart behind my back?” I asked of him, beaming back. I hugged him warmly. “I would like you to keep that book and call me every time you understand another story.”

“I’m so proud of your work and my journey with you.” After a pause, I moved on to our next order of business.

“OK, let’s do our last couchwork together. Are you ready?”

“No,” Jay responded, as he lay down and began to breathe without a contest. He breathed and breathed. After about twenty minutes of very hard breathing, he spoke.

“I’m afraid.”

“I understand,” I said. “What are you going to do with your fear?” I asked.

“I’m going in,” he said.

“We’re here,” I said. With that, Jay began to cry the loosest, least self-conscious, most unguarded cry I’d ever heard him cry. He sobbed and sobbed, uncontrollably for five, perhaps ten, minutes. After awhile his sobs turned to whimpers which turned to sweet, soft sniffles. Then, he lay silently for awhile. His “safe mommy” and I sat with him quietly. She began to pet him gently. After awhile he began to stir slightly.

“How bad was that?” I asked.

“It wasn’t bad,” Jay answered, somewhat lightly, as if he’d already noticed the truth of what he said.

“So your fear of being vulnerable is worse than vulnerability, itself?” I zeroed in.

“I finally see what you mean,” Jay said.

After a little while, Jay sat up to look at me. I had some parting words. “You know Jay, all the bad ways your mother treated you were never about you. They were about her and her childhood. She had a mean mommy too. And, she never had a Lacey, like you.”

“And,” Jay said, “she never had a Faye either.”

*Updates by E-mail*

I received an update from Lacey, dated October 14, 2004. At first she described how Jay was doing in school. She said he was catching up academically in school, accomplishing an “amazing” amount in math: “good for his self-esteem.” She says he’s trying very hard academically, and his teacher pushes him to do his best. He’s learning the correct way to write paragraphs, essays, and edit work properly. Then, Lacey went on to say,

His ability to self-regulate is still a struggle...his teacher seems to be trying to address his emotional and social issues as they arise, as well as do preventive teaching...she seems really attuned to what creates anxiety and stress for him...and seems to really be aware of his false self and the social self who puts on a macho bravado...he is currently reading Dr. Jekyll and Mr. Hyde at school (hmm, interesting)....

His subconscious tape of worthlessness is still stuck in him which really shows itself at any perceived threat of my attention (he thinks I am what makes him good)...you can see him start to become more anxious and hyper when he fears he will lose attention...we try to have preventive dialogues about his fears, and how to get them up and out and be in the present where he is not neglected...sometime it works, sometimes it is too late (depends how attuned I am)...his rage is still very much there...when he is stuck in this shamed place he needs to hear all the things he wanted to hear when he was an infant...I finally realized (more like understand and accepted) over the summer that my love [and his father's] and commitment to Jay has allowed him to grow and heal, and perhaps stopped him from getting worse, but it will never heal his original wound...I can never change the fact that in light of everything we have, he still aches for his first mommy...in his most difficult times, it is her mirror of him that he remembers, not how much we love him, it is her words about him and how to perceive the world he hears...I cannot be part of his subconscious tape because I wasn't there...it is my path to lead him to heal and rewrite his subconscious tapes...and help bring him into conscious awareness...

with love,

Lacey”

Then, I received another e-mail an hour and one-half later which read:

faye...are you familiar with bruce lipton's video, nature, nurture, and the power of love: conscious parenting? it is very good...it states that contrary to popular belief, genes do not control behaviors (human expression)...genes can not turn themselves on, a gene cannot express itself without the influence of the environment...genes defer to the perceived environment...he also talks about our subconscious learning period, from in-utero till age six...which stays dominant within the individual...this really relates to both Jay and myself...i was separated from my mom at age seven and was able to hold on to a strong sense of self in a more toxic environment, and use my love from her and for her as a secure base to separate my new traumatic experiences from who i was...and Jay was separated at age six, and while he is learning new perceptions, he is still traumatized by the insecurities and lack of attachment with his first mom...remember when we had that conversation about the little boy who at age six was sent away from his parents because he is thought to be the new Buddha (i don't personally agree with this) but, i know from myself that while i had tremendous grief and missed my mom everyday, i also had a strength from her which allowed me to face my new situations and not become completely broken by them...and Jay because he lacked so many experiences, feels so easily broken, even though his new environment is more secure...i also know that the age he is at now is an especially crucial time for rewiring his brain...not that it is a last chance, but adolescence provides another critical wiring period, and i see it as a huge opportunity to help him deep within his brain...

does all this writing seem too time consuming...it is quite long???

have a good day... :) Lacey

Her sweetness and strength run through this email. She's the one who gave up her precious opportunity to have a baby of her own to heal Jay, when most people were put off by him. This was the email that caused me to rearrange my dissertation and to focus intently on prevention and why Jay wasn't seen in time.

### Final Diagnosis

My diagnosis of Jay at our last appointment was thus:

#### *Multiaxial Diagnosis, Age 10*

Axis I. 313.89 Reactive Attachment Disorder of Early Childhood: Disinhibited Type

Axis II. None.

Axis III. None.

Axis IV. 90. Excellent therapeutic mother. Still longs for biological mother.

Axis V.GAF 51. Moderate to serious symptoms, depending upon the stressors of life and relationships at school.

### *Progress*

The little Mafioso I originally met was a fraud. He acted the role which he had created at a tender age to cover his consummate fear of vulnerability. He had made the choice, perhaps before he was even one year old, to never be weak or trust again, because that would bring him more unbearable pain and heartbreak, something he believed he could never survive again. Jay was so terrified of vulnerability, he'd convinced himself that he needed no one. He made the choice that he would rather dominate than be dominated. He would rather bully than face his own fear. His bravado was a sign of fear of feeling or being

hurt again, or as I put it to Jay, refusing to surrender to his real self was a sign of “cowardice and weakness.” To be strong, Jay would have to discover the courage to be soft, or “sweet weak.”

I believe it was essential to Jay’s healing that his father, step-mother and I believe he was inherently good. When he believed he was innately evil, it was critical that the three of us or the two of us remain convinced beyond any shadow of a doubt that he was, at his core, pristine, as Fairbairn would say. I believe our faith in Jay sustained him and made it easier and easier for him to become vulnerable with us. Because we had faith in him during his darkest moments, he was finally able to feel safe enough to become vulnerable enough to heal. What Jay has most successfully healed is his fear of being authentic, that is, of experiencing his feelings and expressing his needs and honest thoughts.

Jay’s recovery required heroic efforts not only on his part, but on the part of his parents. With enormous sacrifice, Jay will be at best an enlightened person who independently understands how healing works and what he has to do on his own some day, although I suspect he will be always struggling with deep emotional pain and emptiness at his core.

### *Prognosis*

I believe the stance of being ever on guard to defend himself keeps Jay’s limbic system saturated with toxic corticosteroids, which interferes with his ability to self-regulate the deep threatening emotions with which he copes on a daily basis. I have learned from writing this paper that to avoid further pruning by corticosteroids, it is critical that he keep his stress level as low as possible through adolescence. I am even contemplating

recommending medication which would decrease or absorb the corticosteroids. I also recommend meditation, and it will be important for him to continually seek humility as well as environments where he may be safe to be vulnerable.

There is no doubt that Jay's new "safe mommy" and I have helped him significantly. We can vividly imagine the potential risk he would have been to society and himself. However, having his mother's email, I am forced to face the possibility that Jay may always suffer at his core, whether he learns how to cope or not.

When I received the emails from her, I rearranged my dissertation, because it became beyond clear to me that treating attachment disorders well is not as important as preventing them.

I have great hope that the posture of vulnerability and surrender will bring Jay as much ongoing healing and peace as it already has, and I trust that the skills I taught him to protect himself will be also used better and better as he matures. I also hope that Jay will become so good at assessing safe people, that he will be able to enjoy the stance of authenticity as much as possible. As I have said, vulnerability is not only key to his healing, it is his evidence as to how healthy he has become and how safe he feels with his therapeutic mother/step-mother.

### *Prevention*

Lacey has begun graduate school to study neo-natal psychology with a goal to become involved in prevention. Lacey and Jay make public appearances together from time to time to explain attachment, RAD, and how it feels to be unattached and attaching. Their audiences include both therapists and parents.



## CHAPTER 15: CONCLUSIONS

### Symptoms and Treatment

Jay's symptoms of an attachment disorder were so pathological that they pointed to Reactive Attachment Disorder and future severe criminal behavior. I believe I have thoroughly explored and revealed the causal relationship between Jay's history and his symptoms of manipulative, violent, and dangerous behaviors which indicated a diagnosis of RAD. Further, I hope it is clear that a child diagnosed with RAD must be treated with urgency, and his treatment needs to be deep, safe, and well-informed.

A look into cutting edge trauma theory was a significant and inseparable adjunct to this case study. Additionally, the field of trauma theory is fundamentally in accord with attachment theory. Both are investigators and observers of behavior and its environmental origins.

### The Experiential and Preventable Cause

It was my goal, in part, to seek the causes behind Jay's disorder. I demonstrated that Reactive Attachment Disorder is a special type of trauma which is created in the brain resulting from a deficit of mother-infant interaction. I believe I have shown that Jay's history was sufficient to cause his resulting symptoms.

Since four therapists knew Jay during his critical wiring period of attachment and did not intervene on his behalf, I was concerned as to why Jay was not seen. Were these clinicians indicative of the greater population of psychotherapists. Was there a common failure throughout the profession to identify Reactive Attachment Disorder or its causes? Why was Jay not seen? Why was his disorder not advisedly prevented?

I saw that there had been a problem with differential diagnosis. Jay had been diagnosed with ADHD, and there were actual written materials or medical propaganda which supported this incorrect diagnosis. These materials suggest that children with ADHD, including aggressive and anti-social children, were the products of bad genes. They could not be healed, but could be medicated and controlled. Ritalin was the favored treatment, along with some behavioral modification techniques to help other members of the family cope with the child. The goal of treatment was to get behavior and feelings under control. If the cause of Jay's behavior was considered genetic and the solution was medication, nothing would be suggested to change Jay's circumstances. This perspective would allow Jay's broken attachment to continue.

I noted in this paper how the cognitive behavioral treatment modality historically supplanted abreaction with Integration Therapy when the "false memory syndrome" movement came into play. I noticed that the behaviorists, as much as they were reluctant to think in terms of genetics, had little use for exploration of childhood causes of symptoms or emotional releases of pain from past experiences, since emotions were to be mastered, rather than expressed.

I have noted in the course of writing this thesis that there has been a discord between attachment theorists and traditional analysts, the former suggesting character is made, the latter suggesting it is inborn, which would blind analysts to seeing Jay's broken attachment, allowing it to continue.

I saw that there had been a feud between trauma theorists and false memory theorists who suggested that personality is inborn, and any recovered memories of abuse must

necessarily be considered false. This would have protected Jay's biological mother, but not Jay. All his symptoms would have meant nothing.

Thus, I believe I have identified a secondary cause of Jay's Reactive Attachment Disorder: Bad theory or theory which blinds clinicians to causality. Theory which blinds us misleads us. Whether or not genetics plays a role in the formation of pathology, we need to find a way to presume genetic explanations last, after looking for experiential causes which can be treated and healed. Research with genetic explanation must be reviewed for bias. John Read, Perry, and their colleagues write that in the 1990's only .2% of the research on the causes of schizophrenia considered childhood experiences. I would therefore say that the research on schizophrenia through the '90s, at least, is invalid.

Needless to say, looking at the causes behind symptoms must include caution so that there is no tendency to find injuries where none exist. While I think it is significantly easier to ask a child to contort the truth to protect their parents than to contort the truth to make false allegations against their parents, we need to learn from Kee McFarland's bitter lessons and use memory recover techniques which are as safe and credible as possible. If we use hypnosis, the process should be videotaped, so that there can be no accusations that memories have been planted. Finally, to suspect problems in such a way as to suggest them where there are none, is just bad therapy. Curiosity and open ended questions must replace leading questions.

Parents were children too who had to grow up. To be patient-centered necessarily means that parents are not to blame for how they turned out or even for what they have done. Their behavior makes sense. Patient-centered means that the children of parents, grown or

not, have a right to their authentic point of view, their feelings, and their need to have the freedom to face their own repressed pain, which was originally denied for their parent's sake. Patient-centered therapy grants such freedom completely, so the patient can feel safe enough to explore what has always been taboo in order that they may heal. Patient-centered or pro-child therapy would seek to reverse the legacy of pro-parent theory in a way which does not forget that parents were children too. In patient-centered therapy or in pro-child theory parents and grown children often need help in breaking painful child-rearing legacies and transmissions from generation to generation, forgiving themselves for how they turned out and even for how they have treated their child thus far. Parents can make amends completely by listening to their child's feelings without defending themselves.

We, as a profession, need to know that there *is* a War of the Researchers. When I mentioned it in my last class as an explanation for a point of view being proposed, a fellow student said to me, "You sound paranoid, like you believe there is a conspiracy of researchers!" If students do not know of this issue, then they cannot see and assess clearly. The students aware of the War seem to be the ones who are in the attachment and trauma camps. Not all of them even know of the War. Most students think the different points of view are just different vantage points on the same thing, leading to different approaches toward the same end.

Students would do well to contemplate these questions: What is your theory of psychology and the causes behind behavior? Why do you believe it? What would you gain if you found out that your belief were wrong? What would you lose if you found out your belief were wrong? I would need to answer that question, too. If I found out my theory was

wrong, I would lose my faith in the resiliency of people. I would not be free to believe with conviction that if they were brave enough to go into their pain, they could heal. I would gain a greater acceptance that people are as they are, rather than feel an earnest need to heal and protect. I would not be as concerned with parenting, anymore. I would become more interested in the quick fix of medication.

As children, we were taught to honor parents. In our youngest, most fragile years, we learned to deny our inner experience, so that we would be safe at home. We developed blinders to protect our parents' feelings. We learned to place the feelings of our parents above our own, often saying what our parents wanted to hear, forgetting our own perspectives and feelings. We learned this as if it should be so, even though it cost us our authentic affectivity. We learned it so well that some of us became psychotherapists with subconscious goals to enforce the taboo against knowing ourselves or anyone knowing themselves.

Our profession is primarily responsible for removing the blinders from our theories, our researchers, our and clinicians, so that we can at least become self-aware about which theories we choose and *why*. All psychotherapists had childhoods. Those who have explored the impact their childhood had on how they turned out seem to be better therapists and theoreticians. Those students of psychology who seek to do cognitive therapy, behavioral therapy, or traditional analysis in lieu of exploring the effects their childhood had on them, will not only cheat themselves out of self-awareness, but they will not develop the ability to see anyone else more clearly.

Patients need therapists who behold them and empathize in such a way as to contemplate their history and perspective of the world, including their beliefs and reactions to their own story, their ways of coping, and their own levels of denial or self-awareness. Such a therapist is seeing, perceiving and intuiting the patient, because the therapist appreciates that the patient is exuding clues to their yet-to-be-spoken drama. If the therapist believes in genetics, stoicism, positive thinking, premature forgiveness or “integration,” [contemporary behavioral treatment of trauma] then there will be few perceived clues and little, if any, searching for the untold story.

It seems ironic to find so many forces against introspection and emotionality within the profession. It’s as if psychology itself has made a home for those who want to infiltrate the profession, advocating and preserving bad theory in service of parents, on behalf of parents-- their parents and everyone’s parents. Obviously, these endeavors are forwarded by unconscious, unexplored motives within our profession.

### *Raging for Jay*

I could not escape the problem of theory and why so many therapists in Jay’s life did not see his plight in time to make a difference. I could not escape the thought that a human soul had been allowed to permanently prune away synapses within as he shriveled in agony. I could not help from seeing again that the problems of perception are rooted in our childhoods, and if we have not risked blasphemy and challenged the taboo of putting our own needs above those of our parents, then we will be blind. We will be blind no matter how many diplomas and credentials are awarded us, no matter how many foundations recognize

us, no matter how many grants are given us, and no matter how many clients knock on our doors. We will be blind. We won't see Jay. We won't see all the Jays.

When theory directs practice to ignore symptoms or attribute them to inborn drives, the effect seems to be to protect parents from perceiving their children's needs. When theory directs practice to turn a blind eye or attribute symptoms to genetics therapists' patients are cheated out of the guidance they needed from their therapists who might otherwise have offered suggestions or warnings. What happened to Jay could have been prevented. That is a tragedy, an ongoing tragedy.

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## Appendix A: “Lonely Heart”

## Appendix B: “Sad”