INTRODUCTION

Society has not yet been very successful in finding ways to prevent Attachment Disorder (AD) in general or in developing successful therapeutic methods for the individual child. If the first relations in life have gone wrong, they seem to be very difficult to remedy later in life. Attachment seems to be a “window’, wide open from birth and gradually closing more or less towards age 3.

My hope is to give the reader a realistic approach to the problem, and to lay out a broad range of theoretical and practical pathways in this challenging field. You should note the distinction in the title of *severe* Attachment Disorder: the subject is *not* children who have only experienced single traumatic life events – they have a much better prognosis – it is about children who have survived multiple traumatic events, perhaps hunger, and a persistent lack of parenting in their first years.

It is also important to understand that these children are normal children whose abnormal behavior is caused by an abnormal early environment.

In this book a lot of effort has been put into making AD behavior comprehensible and de-mystified. This is because you cannot solve a problem, unless you profoundly understand the nature of it - and AD problems have a tendency to distort our sense of proportion. A lot of everyday examples are used to illustrate symptoms, theory and practice.

If I have succeeded, the contents should not be difficult to understand, whereas working with the AD child in practice is a constant challenge to your convictions and responsibility. It is a guide trying to answer some of the common questions puzzling people working with children and juveniles suffering from Attachment Disorder (hence: AD):

- Why are there an increasing number of AD children?

- What are the causes of an AD development in children?

- How does AD show in behavior and personality?

- How do you practice treatment or therapy at different development stages during childhood?

- What can you do to prevent an AD development, or to reduce the symptoms?

- What happens to people, groups and organizations working with these children?

- How do you develop and maintain your therapeutic attitude and the structure of treatment?

First, let me give you a general introduction to the problem of AD.

WHAT IS “ATTACHMENT DISORDER’?

In the very short version Attachment Disorder (hence: AD) covers a range of behavior problems that are common in children who did not receive sufficient care during the first few years. As we

shall see, the problem of AD is a complex one, but in headlines the most important criteria will suffice:

A. Antisocial behavior throughout childhood (including preschool age):

Intimidating, violent and aggressive behavior, low ability to learn from social experience (including punishment/ restrictions). The child may have a sadistic or socially destructive intent, hurt other children or animals, display a lack of lasting shame, guilt and remorse, blaming only others when confronted. Fight/ flight/ freeze behavior (vagabonding, endless conflicts, stubbornness).

B. Uncritical attachment behavior:

The child will be charming and "trustful' towards new persons and contact persons at random. The child is unable to distinguish emotionally between familiar and non-familiar persons, is often clinging ("like tape'). The child displays immature attachment behavior (has the contact behavior pattern normal at age 6 - 12 months). The child has short and superficial contact patterns.

In both cases, the child will be disabled when trying to develop a mutual, loving, obliging relationship to others. The social competences being compromised, other aspects of life – such as playing, learning, working, mating, being a family or group member will suffer as well. Negative reactions from others (conflicts and disappointment) will disturb daily development. Therefore, the intellectual learning capacities will not be put sufficiently to use and many develop secondary problems such as criminal activity and drug abuse.

How does attachment disorder come about in general?

EARLY ATTACHMENT: A WORLDWIDE CHALLENGE

We spent several million years in refining the early mother/ child relationship – and a mere 15 years in breaking it down.

From World War II and onwards, accelerating about 1960, we started the largest social experiment ever undertaken in the western world - mothers of preschool children and babies went to work outside their homes, away from their children. This not only changed our whole culture: religious beliefs, family patterns, traditions, eating habits, number of children in a family, family income, but it also broke up the mother and child relationship into a whole new way of being attached. The conditions for learning how to become human through early childhood were turned upside down. Today, we are probably the only species of mammals where mother and baby do not stay together inseparably for at least the first two to three years after birth. Ask the gorillas or the blue whales, they will shake their heads in wonder.

In my country, it only took fifteen years (1960-75) to sweep 80% of all women out of their homes in the daytime and into factories and offices. The great stabilizers of society - the working class culture and the country life culture - disappeared almost overnight. As a cultural pivot the family was split up into members-meeting-between-other-activities. A first result, the number of children

being born at home and not in a hospital or a clinic fell from 85% in 1955 to less than 1% in 1975. The first physical contact for the baby was no longer an autonomous decision of parental judgment, but a staff decision, with the parents as spectators, sometimes from behind a glass wall. To say the least, staff decisions were not always wise, and today many adults suffer from the consequences of early separation. And so do their mothers. Enforced early separation not only produces disturbed infants, but also disturbed parents. Mothers who are physically separated from their newborns - even for very short whiles - often experience lasting intense, irrational feelings of guilt, tend to feel detached and alienated towards the baby, and feel incompetent and insecure trying to interpret the baby's signals and needs, and they become insecure when deciding how to act towards the baby. This of course will often provoke a reciprocal loop of misunderstanding and unfulfilled needs between mother and baby. Not to mention how a father, excluded from the birth experience and physical contact with the baby, should initiate any devotion to a baby arriving from hospital long after birth, deprived of the possibility of physical bonding with his child.

The next result of the changes in working patterns, and delayed some 5 years (parallel to women leaving home for work) were the exploding number of divorces, producing a new role in Danish families: the unprotected and overworked single mother. In many ways, this development became a disruption of a lot of families rather than the exciting lifestyle renewal and adequate re-orientation it was meant to be.

And finally (if you are still with me), the grandparents disappeared from the vicinity of the home, taking with them all their irritating traditional knowledge of how to cope with 8 children, incessant births, child disease and good cooking, leaving behind their bewildered offspring to become parents as best they could. Consultants, baby magazines and other substitutes replaced them. There are no longer dominant-mother-in-law jokes - she dropped the apron and went to Florida with her plastic surgeon.

Today's average parents are relatively old when the first baby arrives. They were separated from their own mother at birth, they never had to be responsible for baby sisters and brothers, they met a lot of new people early on in life, they didn't see their parents or grandparents much, and when they hold their firstborn in their arms, they don't know a thing about what to do - except being extremely ambitious on their own and on the child's behalf!

Child personality has changed. The neurotic personality (deeply attached, but caught in the age 3-5 conflict between self-realization and a strict superego) also disappeared with the dissolving family structure and moral code, and was replaced by the intelligent, spoiled, emotionally confused child, without a few solid role models, prone to following it's own mind and to be unaffected by authorities. Later to become ludo-manic, narcissistic, running for 6 hours a day, or just plain exhausted by exaggerated ambition and illusions of eternal youth.

Child psychology theory has been hesitant in adjusting to this change. In fact, our treatment philosophy, methods (such as play therapy and talking therapies) and general ideas about what children need, is still mostly directed towards neurosis problems that have become quite rare in daily practice. And sadly so, these methods in my experience are often downright anti-therapeutic when addressing severe AD problems.

Today, 80% of all Danish children age 1-3 spend most of their waking hours in a day care or in a kindergarten. These figures are, more or less, applicable to all industrialized countries. In 1948

Denmark, children's work contributed with 25% to the average family income. Now, children have become an expense, a problem and also a luxury - that's why we have so few, and so late in life. Today, the infant must, from an early age, face a more or less predictable number of adults and other children, who often are interchanged kaleidoscopically during the day. Science tells us that a newborn, with any luck, can attach to 4-5 persons before the age of 3, and still turn out as a normal, healthy adult.

How many children lost a secure attachment in the process? Still using Denmark as an example, we have a system where every new mother has several free visits from a district health nurse from birth until the child is aged 3. These nurses stated (1992) that in general 80% of all infants are feeling psychologically safe and thrive well - they cope with the many early contacts, because of a stable relation to relatively harmonious parents. So, for society in general, we haven't reached the panic level - yet. But, and that is serious enough, 15% have minor signs of deprivation, such as malnutrition (obesity, skinny, vitamin deprivation), and signs of feeling too insecure to spend their time learning, in something they could perceive as a safe environment. They have experienced too many divorces, institutions, and shifting persons to make life a happy experience. In spite of a soaring rise in school expenses, all paid by the state, 1/3 of all children who are leaving school describe themselves as losers in the system, and have a generally low self-esteem. In the last ten years, special school classes for children with socio-emotional problems have increased 300 %, according to the state office of statistics.

5% of all Danish infants show clear signs of extensive deprivation, seriously lack contact ability, suffer from the psychological consequences of violence, sexual abuse, malnutrition, etc. These children practically always grow up suffering from an array of severe personality disorders or psychosis.

We might have absorbed and adjusted better to this change in patterns of raising children, had it not happened so fast. Disrupted bonding is probably not resulting only from the nature of such changes (children in some old cultures are successfully raised in groups), but from the very speed of change, preventing the gradual adaptation to new life conditions.

Let me exemplify this by describing the experiences of the English anthropologist Turnbull: He lived with the Ik-tribe in the highlands of Uganda and found a people who stole from each other, who ignored the elderly and the children, who apparently considered cheating and deceit to be an art form. He only found one single girl who made any attempt to attach, but the parents incarcerated her considering this behavior to be highly abnormal. Eventually she died, and the parents threw the carcass out to the animals. In general, children from the age of 3 grew up in gangs without role models, and from the age of 2 were stealing food in order to survive. Well, you might say, this is somewhere far away, but Turnbull wanted to know why this culture had so many AD members. He studied their history and found that 40 years earlier this had been a much larger, kinder and very social jungle tribe. Overnight they had been deprived of their hunting grounds by the government, and with no time to adjust to a new environment in the highlands, the culture as a whole had deteriorated.

Another case: In Greenland, the Eskimo tribes had for thousands of years adjusted to a life in small hunting communities along the coast. They had rich traditions for infant care and upbringing. Among these were that in spring the whole tribe made a three-day picnic in the mountains, where those born in winter would exercise how to walk, and all attempts to stagger along were celebrated

by the members of the tribe. Around 1960, the Danish Government, by ‘persuasion,’ moved almost all natives into newly built towns. 15 years later, the next generation suffered from an enormous percentage of maladjusted, alcoholic, psychotic and identity-bereaved youngsters, with a soaring ratio of suicides. Even today, suicide is frequent in Greenland youth.

The breakdown of Communism and of society in general in Russia, Rumania and other countries has produced a host of abandoned children surviving in street gangs, and of adopted children who are frustrating countless adoptive parents who had expected that love would heal any wound, and who as a consequence have been hurt themselves. I remember a lunch break at my work in 1988 where one of the staff members uttered: ‘Let's build a new wing for Rumanian children from adoptive families’ - sadly, his doomsday vision was largely correct.

At the other end of the change/ tradition scale we find societies that have abandoned development in favor of stability and a tight network, such as the Amish of North America who with a stable lifestyle have practically no overtly AD or otherwise seriously personality disturbed members. Even those psychopaths, who according to the laws of statistics should be present are encapsulated by the overlying traditions and strong uniform social codes of everyday life.

These examples go to illustrate the idea that any very fast change in society can overrule the adaptation capacity of many families and individuals, and in some cases will result - in the next generation - in some easily recognizable physical symptoms and personality disturbances. The gap between those who adapt - thanks to stable parental care - and those who do not, is widening.

WHAT HAPPENS WHEN THEY GROW UP?

Statistics indicate that some 15 to 20 years after the abovementioned radical change in the Danish mother's workplace - that is, when the babies exposed to early random contact with persons other than the parents grew up - the following juvenile problems accelerated intensely:

- *Personality Disorders (Antisocial Personality, Borderline).*
- *Severe Identity Problems, feelings of meaninglessness and lack of lust for life.*
- *Depressive states and suicide attempts (Denmark, in spite of equalized wealth and extensive social care has one of the highest suicide rates in the world – especially young girls).*
- *Self-infliction, withdrawal or aggressive or stereotype, meaningless behavior.*
- *Addiction Problems.*
- *Altered activity levels (hyper-and hypo activity).*
- *Eating Disorders (anorexia nervosa, bulimia).*
- *Autoimmune diseases (such as certain forms of rash, arthritis and asthma)*

These symptoms have always been part of the puberty crisis - but now, more youngsters cross that line and reach a regular state of dysfunction and are in dire need of treatment.

Exactly the above-mentioned youth disorders have one striking feature in common - they are identical to the reactions of babies separated for too long from their mothers! Could it be that those who have had discrete symptoms of bereavement as infants repeat these symptoms more intensely in the next life crisis - puberty? And that this crisis, instead of leading to a transformation into adulthood, leads to a domino-effect imbalance and subsequent regression?

I think so.

IT'S NOT ONLY YOUR PROBLEM - IT'S OURS.

The increasing number of children with AD behavior patterns are only the tip of the iceberg, and I would like the troubled reader in custody of such a child to remember that you are not entirely alone and totally responsible, you are also facing a small facet of a general problem in society that should not remain hidden and private. I say this because my supervision practice has shown me that people working with these children (especially adoptive parents with no prior knowledge of AD) tend to torment themselves with blame, exhausting illusions about miracles, and feelings of anger, hopelessness and incompetence. In other words: they fall prey to the same emotional dynamics as the child in their care, and therefore are of little help to it.

It is extremely important in order to provide an efficient treatment that you see the general aspects of attachment problems and limit your efforts to something possible and not detrimental to your own health. If not, you will probably burn out and have to let go of the stable, long-term, calm and down-to-earth environment that is so important for the optimal function of these children. The child would then experience a new rejection and separation.

OUR UNCONSCIOUS BASIC CONCEPTS OF CHILDREN AND CHILDHOOD

In therapy with the AD child, the greatest hurdle is the therapist. The AD child will immediately agree to this point, and the therapist will experience it. Our usual methods fail to succeed, and this introduction is to stress that success is born out of failure.
Be patient with yourself when frustrated (from Latin, frustrare: to fool, cheat, disappoint, etc.). And be ready to re-organize your emotional, cognitive and ideological attitudes.

When speaking of the most severe form of AD leading to psychopathy in adulthood, we usually visualize either a highly intelligent, shrewd and deceitful person on Wall Street - or a bragging, muscle-wired bully who feels inclined to beat you up if you ask him for a match.
What we do not is to associate these visions with something as ‘innocent’ as childhood. Our general ideas about childhood contain an unconscious personal experience of love and care. Adult psychopaths, however, started their lives somewhere and neither love, nor care were usual ingredients of that start. Sometimes nobody gives it; sometimes the child is not able to incorporate the gift due to inborn deficits. The mother-and-child myth is an interwoven part of our religious, moral and emotional structure. As therapists we often fail to understand the negation of this structure: how can you understand a child, whose mother-and-child recollections contain e.g. being burned with cigarettes or regularly being beaten up by a hostile adult, or living for the first year isolated in an incubator, or being totally ignored? And if you could imagine this, how would that child respond to intimate contact later in life?

Especially when working with children, we tend to perceive our job as providing the love and care to a child that it was deprived of earlier.
But from a very early age (in my experience, from the age 1-3), this intention may *sometimes* prove to be a hopeless venture. When dealing with children most social workers and therapists are also motivated by a little megalomaniac who believes that everyone can become sane, loving and

trustworthy through the magic touch of a persistent therapeutic wand. If nothing else, many an ulcer stems from such deeply rooted notions, produced by our own positive experiences before the age of 3. ‘If love is not enough, we must give more’ seems to be the underlying idea. But perhaps love is not the first issue to be dealt with.

What are the elements that constitute the ability to love and experience mutual affection? Let us make a philosophical experiment:
Imagine a newborn baby having difficulties in organizing sensory input (sounds, sights, smells, touches, balance changes, etc.). If the sensory development is reduced, the child will be hindered in creating concepts to grasp the underlying meaning of all sane contact: the message that somebody loves it and wants to care for it. Many children later experiencing AD suffer from sensory deficits or sensory organization deficits in early childhood. Imagine also that this baby experiences a mother, who may love or not love her child, but she is unable to touch the child frequently in proper ways and to give it regular physical care and contact. If she does, she is not able to read the baby's signals and will over- stimulate or deprive it. Often she leaves looking after the baby to random persons such as neighbors or others, whom the baby does not know. Or you may imagine a baby lying all day in its cradle in an orphanage, only having human contact for perhaps 5 minutes a day. Imagine the father as a) absent, b) violent or in other ways dangerous to the child or c) constantly being replaced by new ‘fathers’.

Will this child be able to feel attached to anyone, or to form meaningful relationships later in life?

It is, in other terms, the hypothesis of this book that being able to love and to feel attached to others depends very much on what physical (and thereby emotional) contact you have had (and have been able to experience) early in life. The AD child has had so little contact or has been unable to experience contact to the degree where it becomes unable to form lasting mutual relationships. This is probably why normal psychotherapy (which is always based on the mutual emotional relation between client and therapist) fails with these clients.

The beginner who valiantly sets out to prove that he or she can ‘break through’ to the emotions of the child inevitably wastes much good time. The price of the defeat is hopefully a little more patience (including our humble self), a more professional attitude - and the surprising insight that not everybody feels, acts and lives as we do ourselves. Therapy with AD children is seldom a question of kissing the frog and seeing it turn into a valiant prince. It is a question of recognizing the fact that early deprivation can slow down or sometimes arrest psychological and social development in a child. However, a child arrested in early phases of development may progress more or less according to the therapeutic environment provided. Transformation is the result of developing that which is already there, and transformation is not produced by an illusive effort to shape reality according to our own scale and expectation.

In working with children it is usually evident that they grow by their own patterns in spite of our effort to change or predestine them. Working with AD children it becomes painfully clear that they only grow when the therapist is able to recognize their basic nature and to help this nature to grow slowly out of immaturity. Anyone who expects an AD child to be grateful or to confirm the professional ego by rapidly changing will become a victim of the client, and the client once again will be victimized by his or her own limitations.

‘Therapy’ comes from Greek “theraps’ meaning ‘servant’, and the professional therapist provides an environment serving the development of the child. As put by the philosopher Kierkegaard, you cannot help anyone unless you make an effort to understand how the other person sees the world. An AD child may very well see you as a naive enemy who is easily fooled by the simplest lie, who works hard instead of letting others work, who is limited by fear, conscience, love and other inferior sentiments disturbing the immediate satisfaction. He or she might not even perceive you as a person but rather as a thing like a toy or a tool, and just for fun take you apart or make funny experiments with your precious emotions: *A 12-year old boy comes into the staff room and says: ‘I've just killed Thomas!’ We rush out to save the remnants of Thomas - however, Thomas is happily painting a fence. We go back, and the boy says: ‘I didn't do anything to him - I just wanted to see how you reacted…’*

The most common initial reaction to such encounters is disgust, rage, suspicion and mindless action on behalf of the therapist. In short, a temporary regression pattern, aroused by the feeling of being threatened to the core. This feeling stems partly from reality (if you persistently annoy the psychopath with therapeutic demands for emotional response, he might fulfill your wish by doing away with you in a fit of rage). The other, more diffuse threat comes from the experience that - provoked by the client - you contain such depths of inhumanity, and that your professional or parental identity and values may be challenged in the course of the process.

In return for lost illusions of therapeutic omnipotence and the resulting hopelessness we may, through experience, get the feeling of living closer to reality, and thus be able to pose more interesting and fruitful questions. Such as: how to take responsibility for another person (and thereby for yourself), how to build a environment that makes the AD child function in a reasonably calm and stable way, and how to help a handicapped person - through recognizing the nature of the handicap instead of trying to erase it.

MY OWN CONCEPTS

For many years I have spent most of my time in a foster home with AD children, and this of course has altered my view several times. For example when a child climbed the icy roof of a 3-floor building during winter and threatened to jump in desperation. In a burst of tears he cried that his life was useless, he missed his mother, the staff members were cold, and that he wanted to die. After some hesitation I gallantly climbed out to save him - only to discover halfway that he had arranged this scene to entertain himself and 20 little companions on the ground. Beforehand, he had even made a bet with the other children as to whether he could lure me up on the roof or not! Afterwards, the little bookmaker unaffectedly collected his money from the others, while I retreated to my office wondering about the nature of AD, and how to help staff members obsessed with paranoid control aspects.

Or, walking with a six-year old little girl with curly blond hair and blue eyes, who enthusiastically informs me that: ‘I can make the new teacher change colors!’ I ask her to do so. We sit down with the teacher and the girl points to me and says: ‘That ugly man put his hand down in my panties just now!’. Our new teacher turns pink/ red, consuming this interesting piece of information. The girl smiles happily, then looks sternly at her and says: ‘I know what you did yesterday to Tommy - I could tell the grown-ups all about it!’ The now quite pale woman had forgotten to pick up a child at

the bus stop and had been too embarrassed to tell the other staff members. Thus the girl went on, and after a while she turned to me and triumphantly announced with innocent enthusiasm: ‘You see - I can make her change colors any time!’ I told the girl to stop playing with the woman and go play with her bike instead, while I assembled the teacher again. This girl is aged six, and still cannot tell a person from a thing. To her a staff member is an advanced slot machine. A week later the girl hands me a dead pet rabbit which she has just sliced into four pieces with a pair of scissors and says unaffectedly: ‘It doesn't work any more, and it bleeds all the time - can't you put it together again?’ - So much for happy childhood…

REALISM: THIS IS A HANDICAP LIKE ANY OTHER

What remains from this work is the impression of children truly handicapped - suffering from profound social and emotional immaturity to the point of blindness. Imagine yourself without the faculty of inhibition. Any feeling, whim or tendency would then be amplified in an endless loop to the point of chaos. Perhaps you have the thought that New York is a nice place, and in no time you find yourself in a bus to New York (if your attention was not attracted by something else on the way to the bus station). Or an innocent remark from someone annoys you, and you accelerate rapidly into a fit of rage. Or, the teacher has a monotonous voice, and after 2 minutes you would fall asleep. An AD child is handicapped in the sense that it has little or no ability to inhibit or modify a sensation or an impulse once it has started. It cannot contain or stabilize emotional energy for long. The consequence of this deficit is that a sense of time, space, proportions and target direction only exist at a very low level, and certainly not at the level expected by society.

Facing the dichotomy between ability and demand, the child usually copes by constructing a skilful defensive surface of imitated behavior patterns, designed to bridge the gap. In some cases, this defense is not just a part of personality; it is the total personality per se. The child learns to imitate any role, behavior pattern and emotion without any internal experience of the same. It is obsessed with controlling the perceived hostile world, as was Shakespeare’s Duke of Gloucester (who by the way ended his career as a king and a serial killer, not unlike many present rulers).

ABOUT TERMINOLOGY

‘AD’ implies some kind (however negative) of a disappointed or otherwise distorted idea in the child about attachment. In the most severe cases of AD, the child has no such concept. Let me give you an example: the abovementioned little girl. She had normal parents, but a very complicated birth, and on top of that she was born with a skin disease, preventing her from absorbing oxygen. She was placed in an incubator, where she stayed for 12 months. This was in the 70'es, and the staff did not know how important human contact is to the newborn. As a consequence, she received almost no contact during her stay. The old versions of incubators were just humming for the outside ear, but inside the noise level in some models reached a 110 DB. You can experience the equivalent of 110 DB by standing beneath a Jumbo Jet warming up.

Does this girl regard people as anything different at all from things around her? Does she hate or love anyone (nothing in her behavior indicates that)? Does she have sentimental feelings, when she hears a ventilator? This example of total deprivation is not as exotic as you may think, considering for example some of the Rumanian foster home children I have seen in a similar environment. After

leaving the incubator, she was stimulated intensely by her foster parents, and had this not happened, she would probably have appeared psychotic rather than having AD symptoms - at least she had an intellectual structuring capacity at the age of 6.

There are of course different degrees of AD: The completely unattached child, the child with paradoxical attachment, longing and hating intensely at the same time, and the insecurely attached child, suffering from low self-esteem and feeling terribly alone and abandoned. The latter cases are only on the verge of an AD diagnosis.

From the viewpoint of society, AD children do behave in an antisocial manner. From the viewpoint of a clinical psychologist, such as I their personality never matures to a point, where they can separate what is social or what is not, the severe cases are pre -social rather than consciously anti-social. 'Pre -social personality' (absence of social understanding) would be a more correct term for these children.

They must struggle to grasp the complexity of even the smallest group, and in controlling their own energy they are as helpless as a baby on a motorbike. It takes some level of maturity to be aware of (and thereby part of) oneself in a social system. When possessing normal intelligence and an immature personality, the solution for contact is often a pseudo-social surface: the client can take on any social role or behavior at random.

There are many good reasons to acquaint oneself with the nature of AD clients. One reason is that they tell us about society's diseases in general; another that our studies provide an infinite source of understanding the conditions and limitations for developing a healthy attachment throughout life.

In the text, the word 'mother' is used often, but this is really an abbreviation. In many families, the father, grandparents or other stable persons such as foster parents or day care persons successfully contribute to the mother providing a safe emotional attachment framework for the baby. 'Mother' in this text refers to a function, not necessarily to biological kinship as such. It is 'the main person responsible for the first two years of upbringing, to whom the child can become attached, often in combination with secondary role models'. It is generally believed that a baby can attach successfully to a combination of 4-5 stable persons, e.g. mother, father, day-care, a sister and a brother or any other group constellation providing 'mothering' behavior. The "mother' function is really "a small, coherent, caring, child-appraising social system'.

CONTENTS - WHAT CAN THIS BOOK GIVE YOU?

If you have an acute need of knowing what to do about a specific child, go ahead and read Part II, but please then read Part I. In the long run, a theoretical understanding will give you endurance, versatility and independence in your work.

PART I is concerned with THEORY, CAUSES and SYMPTOMS: What is the basic theory you need to know in order to read this book? What can disrupt contact between the child and the environment? What is contact, not only in the psychological sense of the word, but also in the physical stages from embryo to birth? The text follows the chronology of child development. Data from genetics, embryology, neurology and pediatrics are considered in describing causes and symptoms.

Furthermore, PART I includes a number of *checklists for symptoms of AD* at different ages. These are risk development checklists – they are not diagnostic manuals, but they may be a guideline for you, and they may help you decide if professional help is needed.

PART II describes THERAPY at different stages of development. In early phases (e.g. during pregnancy) therapy may be to keep the mother from drinking, at later stages therapy may be helping the child to build and stabilize sensory functions, and yet later to master the social environment. A child will transform in its internal organization many times during pregnancy and childhood, and for each internal state, treatment also transforms. Methods appropriate at one point of development can be useless or devastating at another.

For each developmental age of the child, you will find GOALS, METHODS and OBSTACLES (and their possible remedy) in order to facilitate your own planning of practice.

PART III suggests GUIDELINES FOR ORGANIZING THE THERAPEUTIC MILIEU. Emotional, physical and social frameworks are discussed to inspire planning of the therapeutic setting. The personal development and problems in persons working with AD problems is described as well as the common tasks of the supervisor. On the group level team development and necessary leadership for supporting the team is suggested.