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PTSD FROM EARLY CHILDHOOD TRAUMA AS A PRECURSOR TO ATTACHMENT ISSUES

By Christy Owen

Reactive Attachment Disorder (RAD) is a relatively new mental health disorder that was first included in the DSM-III in 1980. It was not studied much for the first two decades thereafter, but in the last several years RAD has "received increasing attention as a possible explanation of severe behavioral disturbances in children and adolescents" (Kemph & Voeller, 2008, p. 181). Its history is turbulent, with conflicting research about its causes, effects, treatment, and prognosis.

The diagnostic criteria for RAD have evolved and been modified in several regards over the years, culminating in the two forms of the disorder (inhibited and disinhibited) being divided into two separate and distinct disorders in the *Diagnostic and Statistical Manual of Mental Health Disorders – 5th Edition* (DSM-5; American Psychiatric Association [APA], 2013) ---RAD (inhibited) and Disinhibited Social Engagement Disorder (DSED; disinhibited). However, the diagnostic criteria for both disorders continue to be vague and incomplete.

Clinical presentation of RAD and DSED includes a number of hallmark maladaptive behaviors that are not denoted in the diagnostic manuals. More importantly, the diagnostic criteria do not reflect the true pathology of the underlying "reactive" behaviors that are manifested in clinical presentation. A number of deviant and maladaptive behaviors that are common amongst children and adolescents with RAD are not even mentioned in the diagnostic criteria. Stinehart, Scott, and Barfield (2012) plainly protest that "the inventory of symptoms associated with RAD often extends far beyond what is enumerated in the [DSM] based on anecdotal experience" (p. 359).

Despite the fact that a number of studies found that a significant portion of children with RAD exhibited both the inhibited and disinhibited traits, the APA (2013) nevertheless chose to divide RAD into two separate, distinct, and very different disorders (RAD and DSED) in the *DSM-5*, with no apparent reference to the likelihood of convergence, presumably based solely on Zeanah and Gleason's (2010) recommendation.

PREVALENCE

There is significant debate about the prevalence of RAD in either of its forms. Some resources maintain that it is "exceedingly rare" (Zeanah & Gleason, 2010, p. 31). Others report that the prevalence of RAD in a high-risk sample of maltreated children in foster care was approximately 38-40% (Lake, 2005; Smyke et al., 2012; Zeanah & Emde, 1994; Zeanah et al., 2004).

Based on the statistics provided by the U.S. Department of Health and Human Services, the actual number of afflicted children across the population could be staggering. In 2008, more than 460,000 children were reportedly placed in foster care in the United States (U.S. Department of Health and Human Services, 2009). Forty percent (40%) of that 460,000 equates to 184,000 new children that could potentially exhibit signs of RAD each year just here in the United States. As for international implications, a decade ago Hall and Geher (2003) proclaimed that approximately one percent (1%) of all children worldwide may suffer from RAD. (The same percentage, incidentally, of children diagnosed with Autism in the United States according to the

Centers for Disease Control and Prevention, n.d.) That same year, UNICEF (2003) reported that there were 2,183,635,000 children in the world, age 0-18. Accordingly, pursuant to Hall and Geher's assertion, it stands to reason that as many as 22,000,000 minor children may suffer from RAD today worldwide.

STATISTICS AND PROGNOSIS

Some clinicians have suggested that RAD "may be the first step on the developmental trajectory towards conduct disorder, which has life-long implications for the individual, family and society" (Ferguson, Follan, Macinnes, Furnivall, & Minnis, 2011, p. 107). Research also suggests that attachment disorders may ultimately evolve into personality disorders (Crawford et al., 2006) if not treated.

Statistics suggest that 11 to 36 percent of all adoptions in the United States end through disruption (i.e., before the adoption is legally finalized) or dissolution (after the adoption is legally finalized; Child Welfare Information Gateway, 2012; National Adoption, 2012). Clearly this is the single-most at-risk population for developing RAD, and yet there is no research on how RAD impacts America families who have adopted or are providing kinship care for such children. It is imperative that new research be conducted to address the unique issues that arise with this population.

STAGERRING FINANCIAL AND SOCIETAL COSTS

Combined, the states of Florida, Tennessee, and Georgia reported a total of 5,150 foster children residing in a group home or institution on 09/30/2012, at an annual cost of nearly \$200,000,000. Research is replete with studies that addressed institutionalization as a high-risk factor for development of RAD, as already noted throughout this paper. If the other 47 states have similar outlays, then the U.S. Government is currently spending more than \$3,000,000,000 a year to institutionalize foster and surrendered children, but the financial expense is just one measure to consider. The future effects of young adults released into the general population after aging-out of foster care, without learning how to connect with others socially in a meaningful and appropriate way, is too staggering to compute.

CHALLENGING THE CURRENT ETIOLOGY AND DIAGNOSTIC PROTOCOLS

As mentioned, there are a number of hallmark behaviors in clinical presentation that are not addressed in the diagnostic criteria for RAD or DSED. These include lack of conscience or empathy, destruction of property, pathological lying, extreme aggression, stealing, sexually provocative and predatory behaviors, food hoarding, feigned ignorance and story-telling (usually to manipulate others into feeling sorry for the child), preoccupation with fire, cruelty to animals, incessant chattering, and presenting as "superficially engaging and charming" (CANGRANDS, 2012, para. 4; Grcevich, 2013; Hall & Geher, 2003; Lake, 2005; Stinehart et al., 2012). As such, the diagnostic definition is almost unidentifiable or incompatible with real-life conduct manifestations of the disorders.

A careful examination of the *DSM-5* (APA, 2013), reveals that children with RAD and/or DSED diagnoses also satisfy the diagnostic criteria for Posttraumatic Stress Disorder (PTSD). In fact, in addition to the obvious history of insufficient care required for diagnoses of RAD or DSED,

the primary *DSM-5* diagnostic elements of PTSD that RAD/DSED children meet are underlined below:

- A. Exposure to actual or threatened death, serious injury, or sexual violence... (experienced, witnessed, or was confronted with the event; actual or threatened death/serious injury; response involved intense fear, helplessness, horror)
- B. Presence of ... intrusion symptoms associated with the traumatic event(s) ... (recurrent, upsetting, intrusive memories; recurrent, upsetting dreams; acting/feeling as if the event were occurring now; intense psychological or physiological distress with exposure to triggers)
- C. Persistent avoidance of stimuli associated with the traumatic event(s)... (avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event; avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories...)
- D. Negative alterations in cognitions and mood ... (persistent and exaggerated negative beliefs or expectations about oneself, others, or the world; persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/ herself or others; persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame); markedly diminished interest or participation in significant activities; feelings of detachment or estrangement from others; persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity ... (irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects; reckless or self-destructive behavior; hypervigilance; exaggerated startle response; problems with concentration; sleep disturbances). (APA, 2013, pp. 271-272)

Indeed, the behaviors noted in Criterion E are the same conduct-disorder type behaviors addressed above that manifest in clinical presentation of RAD/DSED clients (but are inexplicably not mentioned in the *DSM-5* criteria for those disorders).

INSUFFICIENT, MYOPIC RESEARCH

Clearly, PTSD more accurately depicts the pathology related to attachment issues arising from childhood abuse and neglect than RAD or DSED currently do, but there is scant empirical research on PTSD caused by early childhood trauma (i.e., abuse and/or neglect). In fact, as of 2010, only four random controlled trials were conducted worldwide with a focus on PTSD related to childhood abuse by a caregiver (Cloitre et al., 2010). Those four studies involved adult women who had a history of childhood sexual abuse (by a caregiver, parent, friend/neighbor, or stranger) prior to the age of 18. None of these studies evaluated children currently living with the ramifications of and struggling to overcome PTSD from early childhood interpersonal abuse or neglect, however. No correlations can be drawn, since the participants were all adults and they were, thus, not currently re-experiencing the trauma or then-under the care of an adult who could harm them.

All of the research that does exist fails to really hone in on the contributing factors involving the interpersonal betrayal of the child by his or her caregivers (who were supposed to

protect him or her from harm) and the fact that, by, definition, the caregivers failed to provide the child with the most basic needs (food, shelter, comfort, and safety). The underlying mechanism is that the child was harmed by someone who was supposed to care for and protect him or her, so the child is understandably afraid to trust others (especially those in caretaking roles) who might also hurt him or her. As a result, the child develops extreme defense mechanisms to safeguard himself or herself from letting others get close (Goodman, 2013; Iwaniec, 2006; Owen, 2012). These behaviors may include violence, oppositional defiance, destruction of property, even encopresis. So what the *DSM-5* calls RAD and DSED (APA, 2013)—both under the same category of trauma and related stressors as PTSD—are realistically and fundamentally, aspects of PTSD from early childhood trauma.

Unfortunately, no empirical research exists to support this contention yet. A link between dysfunctional attachment and the development of PTSD has been made, though there is insufficient data to determine exactly how this mechanism works (Benoit, Bouthillier, Moss, Rousseau, & Brunet, 2010; Busuito, Huth-Bocks, & Puro, 2014; Scott & Babcock, 2010). Thus, this author scoured the literature that is available and made as many supported correlations as possible.

The countless studies on PTSD in combat veterans and victims of natural disasters, for example, cannot shed any meaningful light on PTSD from early childhood interpersonal violence by a caregiver. Any child who endured unspeakable neglect and/or abuse in his early years by someone who was supposed to protect him, would understandably be terrified of trusting anyone lest that person harm him, too. A foster or adopted child placed with new caregivers is naturally terrified and fears future abuse. Some of the typical RAD behaviors (such as deliberate enuresis/encopresis) are designed as self-defense measures to repulse caregivers and make them back away from the child—thus insulating the child from further rejection and trauma. These children dissociate and experience PTSD flashbacks to prior abusers when a new caregiver yells at them or has angry, disapproving eyes (Owen, 2012; van der Kolk, 2005; van der Kolk, 2014; van der Kolk, Pelcovitz, Roth, & Mandel, 1996).

NEW ETIOLOGY AND TREATMENT IMPLICATIONS

The underlying issues—which are not addressed in the *DSM-5*— are a lack of trust and the fact that the child does not feel "safe" in his home environment for any multitude of reasons. The mother may be overly-soft, in which case the child perceives her as weak and unable to protect him; she may be overly-hard, in which case the child perceives her as a threat to his safety since others abused their authority over him in the past. She may be disabled, addicted to too much television, inconsistent, overwhelmed, flighty, or emotional. She may have entrusted the child to others in her absence (such as a boyfriend) who have abused or neglected the child, in which case the child blames her for failing to protect him. Regardless of the reasons --- *and some of them stem from well-meaning authoritarian parenting styles* --- the child does not feel safe and does not trust his parents to protect him, due to past trauma. This author contends that this is the core causation of RAD and the myriad of behaviors that RAD children employ to maintain control of their environment.

This etiological stance naturally leads to treatment implications. Treatment becomes systemic as well as individual. It begins with educating the parents on the child's underlying behaviors and giving them new parenting tools and techniques to help the child learn to feel safe

and trust. Unless and until interventions are sought to break cycles of abuse, neglect, apathy, and detachment, the patterns will become ingrained and cyclical.

EVIDENCE-BASED SUPPORT FROM TREATMENT PLANNERS

Treatment planners, such as the series edited by Arthur E. Jongsma, Jr. and colleagues, are compiled of evidence-based practice interventions for a myriad of mental health disorders. These resources give validity to treatment protocols and approaches. *The Adolescent Psychotherapy Treatment Planner* (Jongsma, Peterson, McInnis, & Bruce, 2014), for example, does not include any recommended treatment protocols for attachment disorders, RAD, or DSED. In addition, the section on “adoption” does not provide any meaningful interventions that would reasonably relate to a child with RAD or DSED.

There is, however, a section for PTSD, which effectively bolsters the premises of this paper. Interventions #19-24 in that section relate to training the parents on “how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions ... can be used to promote positive change” (Jongsma et al., 2014, p. 315) --- as well as “managing disruptive behavior;” and teaching “the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether their reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.”

As the case study below details, the treatment approach under the new etiology involves the whole family. The child is taught respect for authority and how to express anger appropriately (i.e., without hurting anyone or breaking anything), but 90% of the work is done with the parents (helping them understand the roots of the child’s behaviors and giving them new tools and techniques that do not elicit confrontational or oppositional responses).

CASE STUDY

Identifying Information and Reason for Referral

Jerusaleh Nickelsmith is a 10-year old Asian female who was adopted by an American couple from an orphanage in South Korea at the age of three, after her prior adoption by another couple failed and she was returned to that orphanage. She was interviewed with her family at Respite Retreat, Inc., a non-profit ministry in Georgia that wraps around adoptive families who are on the verge of dissolving a child's adoption and surrendering the child to the state's foster care system. Jerusaleh remained in residential care at Respite Retreat for nine months, while her parents received outpatient psychoeducational services and followed a rigorous visitation schedule to practice the new skills they learned, with ample opportunities to build trust.

Behavioral Observations

At intake, Jerusaleh presented as alert, coherent, and intelligible. She made good eye contact and appeared well groomed. Her speech was clear and she willingly responded to questions, although she seemed intent on maintaining control over the pace and direction of the interview by asking many questions. Some of her responses seemed very coy and deliberately vague or innocent; the interviewer felt, however, that the client cooperated with the interview

process. Jerusaleh appeared calm on the surface (when she was not trying to control the environment), with appropriate affect, but this belied her underlying hypervigilance. Her mood and speech both appeared normal and appropriate; she appeared forthright about her history to the extent that it portrayed her as a victim, but feigned ignorance about issues she needed to work on; everyone else seems to be the problem, according to her.

History of the Present Problems

Jerusaleh's behavior had escalated steadily over the past several years prior to treatment. She was violent, verbally abusive, and destructive to both property and her own body. She threw rages in which she yanked out handfuls of her own hair, bit chunks of flesh out of her arm, growled like an animal, and maliciously destroyed others' property. She would scream, unprovoked, for hours at a time without tiring or getting hoarse. She had run away twice, and threatened to climb on the roof and jump off. Her parents had not been to church or out to dinner for more than two years because of her "screamers." Jerusaleh was noticeably proud of her disturbances; she smiled openly throughout as first she, and then her parents, described these episodes. On a scale of 1 to 10, with 1 being not at all motivated and 10 being very motivated to get better so she can be released to go home, Jerusaleh reported that she is a 10—but that was because she did not believe she had anything to work on. She thought her parents needed to be "fixed," not her.

Jerusaleh's aggression, opposition, and defiance were exasperated by her narcissistic, histrionic, and borderline personality traits. Respectively, Jerusaleh satisfied all nine traits of narcissistic personality disorder, six of histrionic personality disorder, and five of borderline personality disorder. She was, of course, too young to be diagnosed with any of these, but the prevalence of these personality traits and how tightly they are woven into her schemas are worth addressing. Indeed, Jerusaleh's behaviors and responses to her parents' directives appeared to be driven significantly (if not primarily) by these narcissistic, histrionic, and/or borderline traits.

Jerusaleh lived with her adoptive parents, Azariah and Violet Nickelsmith, and their two biological sons, Camden (age 21) and Victor (age 15). Camden was in college (lived on campus, about three hours away from home) and was not available for the interview; other family members reported that he was deeply hurt by Jerusaleh's conduct and "ungratefulness." Victor was a sophomore in high school who was heavily involved in culinary arts; he seemed detached from and apathetic to Jerusaleh, and reported he did "not care" whether she remained in the family or left it. Jerusaleh's parents had been married for 23 years. They were visibly weary, dejected, defeated, and broken. They were obviously very close to dissolving this adoption and surrendering their daughter to permanent foster care or adoption by another family, and regarded this as a last ditch effort to salvage the adoption and help restore their family. They requested a period of 30 days with no contact or updates.

At the tender age of 10, Jerusaleh had not yet had any formal involvement with the criminal justice system. However, the police had been called to Jerusaleh's school and home on several occasions due to her many destructive rages and violent outbursts. Unfortunately, one officer who responded to a call placed by school administrators blithely informed the adults—in front of Jerusaleh—that she would not be arrested until the age of 14, which gave her *cart blanche* determination to destroy as much property as she wishes, knowing that her parents and other adults have no proper recourse in the law to stop her. Moreover, Jerusaleh's schemas evolved to incorporate an element of accusing adults of harming her in some regard, in an effort to get her parents in trouble. She had, for example, bitten herself to elicit bruises, then accused her mother

of hitting her (or pulled her own hair while outside alone on the deck, screaming "Ow, you're hurting me!"), and she readily admitted this.

Jerusalem did one bizarre thing during the interview. She observed a male adult go into the (unisex) bathroom, and then asked if she could go to the bathroom, and attempted to open the door while he was in there using the facilities. When he came out, she stood there, with her head cocked, and said, "I'm just a pure, innocent little girl." When asked about the incident, she said she "wanted to see something," but shut down and would not expound further. She denied that she had ever been inappropriate with her father or brothers, and suggested maybe "something happened back at the orphanage." Her mother recalled some "odd" older boy at school and an incident on a bus several years ago; none of those brought much clarity to Jerusalem's conduct or motive.

Treatment History and Family Treatment History

Jerusalem's family had sought out services from a myriad of other places over the past three years, including a week-long "intensive" by purported "attachment therapists" in Atlanta who advocate holding therapy and other fringe treatment approaches. Jerusalem's behaviors only escalated thereafter; the family had found no relief before partnering with Respite Retreat, Inc. that helped them understand the roots of Jerusalem's behaviors or issues, or how to address/respond to them appropriately. The residential treatment placement with Respite Retreat was the first (and likely only) such attempt to help resolve Jerusalem's deep-seated schemas and equip her parents with new tools and approaches. Jerusalem had never been on any medications; the family was a strong resistance to same. Violet, the adoptive mother, had a history of depression and anxiety; she currently takes Lexapro.

Relevant Medical History

Jerusalem had a brain scan after her first adoption failed in 2004, which indicated that she had a Traumatic Brain Injury. Part of her evaluation by the "attachment therapists" in Atlanta included neurofeedback brain scans, which are in her file. There is no relevant information divulged in those neurofeedback scans. Jerusalem's last physical exam was in May of 2012. She had no medical problems or prior surgeries.

Developmental History

Jerusalem's birth family history was unknown. She was reported to have been abandoned in a park in South Korea, wearing only a soiled diaper on a frigid, rainy day. She was initially adopted by a family in 2004, at the age of 2-1/2, and returned to the orphanage the following day. The Nickelsmith family adopted her nine months later, just after her 3rd birthday in 2004. She was the youngest and only daughter of three children in her adoptive family. Her brothers were both biologically related to their parents. The parents intentionally adopted a girl (Jerusalem), in order to complete their family with a daughter. Jerusalem did not speak English when she was adopted. Some of her aggression and outbursts were initially attributed to the language barrier and her adjustment to America; others to her age at the time of adoption (three). Both of these factors combined to shield or mask the severity of Jerusalem's developing schemas.

Social and Family History

Jerusalem's parents owned a very successful construction business in northwest Georgia. The father did all the bidding and client interactions; the mother handled the financial and employee hiring/training aspects of the business. Jerusalem reported her mother was "mean" and "weak," yet one who treated her (the child) "like a princess." No one could be trusted, except herself, and she felt it was her duty to let others know what she wanted, so they could serve her. When asked who she loves, she said, "Just me." When asked how she would feel if her parents were to get into a fatal car accident, she paused for a moment, then shrugged and said, "Oh well." When asked what makes her happy, she said, "Things. Candy. Pretty presents." She was intermittently hyper-focused on what was being discussed, and completely detached and disinterested in the topic at hand. It was obvious that Jerusalem had clinically significant impairment in every aspect of her life: socially, academically, and relationally.

Jerusalem reported anger and frustration that her mother, Violet, interfered with her relationship with her father, Azariah, whom she felt she had "wrapped around [her] little finger." It was clear from the outset that Jerusalem's schemas often revolved around triangulating her parents. Jerusalem's depiction of her relationship with her brothers was inconsistent with that expressed by her brother, Victor, and her parents. In her view, her brothers idolized and adored her. According to the others, neither brother could tolerate Jerusalem at all; the oldest brother was pushing his parents to officially dissolve her adoption.

Academically, Jerusalem was an inconsistent student. She was capable of excelling academically (as evidenced by a review of her academic records and schoolwork), but often deliberately chose not to apply herself because, by her own admission, she knew that irritated her mother. Jerusalem's apparent sexualized behavior as evidenced during this interview was a red flag, especially in light of mild references to an "odd" older male student at school who "liked" Jerusalem, and some incident that happened with a male student on a bus (apparently, he was bothering Jerusalem and she hit him). Her comment ("I am just a pure and innocent little girl"), however, was especially curious in light of the fact that she methodically set out to try and see an adult male's genitalia during the interview.

The Nickelsmith's reported ongoing "night terrors" that disrupted and disturbed Jerusalem's sleep, as well as the parents'. These were said to occur nightly, with loud, guttural outbursts several times a night. Jerusalem claimed not to have any recollection of them. Throughout the interview, Jerusalem was notably hypervigilant. Her eyes darted around the room; she anticipated questions and jumped to answer them before they were asked. She jumped in her seat when the phone rang, and again when the interviewer intentionally but covertly dropped a book on the floor. In those moments, her eyes registered fear. At times, Jerusalem seemed to want the attention related to her adoption to be singularly focused on her as a poor, pitiful victim of tragic events; other times, she tried to redirect the attention away from her traumatic experiences and change the subject completely.

Jerusalem had a pattern of "mommy shopping" — whereby she sought out women to befriend and then tried to manipulate them into thinking she would be happier if they would adopt her. This had happened on at least four occasions—at school, church, and even with her own adoptive maternal grandmother. When asked what words people would use to describe her, Jerusalem rattled off "sweet, pretty, princess." She could not think of any princesses who have screaming rages, but she smiled and said, "At least I get my way." The interviewer asked which princess reminds her of herself, and she said, "All of them, because they have pretty things."

Jerusaleh could not think of any hobbies she enjoyed. When asked about "friends," she initially claimed she had "lots," but then was unable to name any. Every time her face registered one thought, she would stop and her face would fall. When prodded, she admitted that no one really liked her and she had never been invited to anyone's birthday party or sleepover.

Current Situation and Functioning

In that Jerusaleh was placed in residential care following the intake interview, she was in an environment that was equipped to keep her safe from her own self-mutilation. During the interview, she appeared to be functioning at a reasonably stable level. However, the family was clearly in extreme distress, which is obviously something that had to be addressed.

Diagnostic Impressions

Pursuant to the assessments and clinical observation at intake, Jerusaleh's primary clinical diagnosis was Posttraumatic Stress Disorder 309.81 (F43.10) from her early childhood trauma and ensuing safety and trust issues related thereto. Specifically, Jerusaleh was aware that she was left alone undressed and cold "to die" in a park and that she was later abandoned by a second family; her family had talked openly about the prospect of dissolving this adoption and abandoning her a third time (Criterion A). Her behaviors evidenced "recurrent, involuntary, and intrusive distressing memories" (APA, 2013, p. 271) of her abandonment, "intense or prolonged psychological distress" (p. 271) at the reality that she had been twice abandoned and might be abandoned yet again, and "marked physiological reactions to internal or external cues that symbolize or resemble" (p. 271) her abandonment (Criterion B). Jerusaleh's "mommy-shopping" efforts appeared as her concerted effort to avoid potential abandonment in the future, by lining up a replacement family to stand in the gap (Criterion C). Jerusaleh's behaviors manifested "persistent and exaggerated negative beliefs or expectations about ... others" (APA, 2013, p. 272), "persistent, distorted cognitions" (p. 272) about her abandonment that lead her to blame others, "persistent negative emotional states" (p. 272), "feelings of detachment" (p. 272), and a "persistent inability to experience positive emotions" (p. 272) (Criterion D). She evidenced all six of the behaviors listed for Criterion E. She had been plagued by this disturbance for more than one month (Criterion F); Criteria G and H applied as well.

Jerusaleh also met the diagnostic criteria for both Reactive Attachment Disorder (inhibited) and Disinhibited Social Engagement Disorder (disinhibited), as well as Conduct Disorder, Oppositional Defiant Disorder, and Intermittent Explosive Disorder, but it was hypothesized that these were all rooted in schemas devised to modulate (or derivative of) her PTSD and thus her treatment revolved exclusively around EBP's for the PTSD. These latter five disorders were not accounted for independently in the treatment or case conceptualization plans, since they were concomitant to the PTSD. Once the PTSD resolved, the behaviors associated with the comorbidities were hypothesized to resolve as well. Building up the child's ability to trust and feel safe with her parents and home environment were paramount in resolving her issues. Since Jerusaleh's trauma occurred prior to her adoption at age 3 and continued to the present, she met the diagnostic criteria for both PTSD in children under age 6, as well as persons age 6 and older.

In addition, as noted, Jerusaleh had a repertoire of budding personality traits that require some shaping and reframing to help prevent them from turning into any of the full-blown personality disorders.

Parents' Presenting Issues Versus Genogram and Whole-family Treatment

At first glance, Azariah appeared to be intentionally and flippantly undermining Violet's authority by pampering his daughter with treats and kindness, and Violet presented as an exhausted and defeated mother whose own husband was sabotaging her authority with their daughter. The criticalness of family systems in this model with this particular family became apparent after completing a genogram, which revealed a much different "dysfunctional dance." Azariah's mother died in his arms when he was 15 and he lived independently thereafter; for all practical purposes, he was an orphan himself, with a great empathy for other orphans. Violet was the youngest of seven children, and the only daughter; for all practical purposes, she was the "baby" who took great delight in tattling on her older brothers. She would bait Azariah's compassion for their daughter, and then use it to triangulate and gain sympathy from others. Violet also conveyed a deeply rooted theme of abandonment and rejection by her own mother throughout her own early childhood. These underlying systemic issues complicated the family dynamic and proved the importance of treating the whole family, not just the reactive child, even though the diagnostic focus had been on the child alone.

Measurable Treatment Goals

During treatment, Jerusaleh learned how to be respectful toward authority and express anger appropriately (without hurting someone or breaking something); she learned the Choice-Consequence Model (CCM). A key component of CCM involves parent management training to identify the triggers and hooks Jerusaleh used to engage her parents in negative ways or manipulate situations. In the past, Jerusaleh had learned that she could forcibly gain her way through yelling, screaming, threatening physical harm to herself or others, or destroying property. The temper tantrums that worked for her at 3 and 4 years old were no longer appropriate for her at 10. Once Jerusaleh realized that she no longer has any power or control via negative schemas of screaming and violence, she began to realize that her real power was in controlling herself.

Concurrently, Jerusaleh's parents received extensive and intensive psychoeducation as to the root causes of her aggression, hostility, and power/control issues; how and why her maladaptive schemas had been successful; how to respond differently in order to disrupt those schemas; as well as delved into their own elemental family systems aspects, such as triggers of the mother's own early childhood rejection and abandonment. It was imperative that these parents viewed the problem as a broken family unit, rather than just a "sick" child ... and realized their own individual and corporate parts in the family's "dysfunctional dance."

Case Conceptualization

Jerusaleh Nickelsmith was adopted from an orphanage in South Korea by an American couple seven years ago, after a prior adoption failed. The adoptive parents had two biological sons as well, ages 15 and 18. The adopted child's aggression and violence created an unsafe living environment. She was admitted for nine months of residential treatment at Respite Retreat, a non-profit ministry in northeast Georgia. During her residential treatment, her parents received extensive and intensive psychoeducation as to the root causes of her aggression, hostility, and power/control issues.

Diagnostic Formulation

As advocated by Zayfert and Becker (2007), Jerusalem was administered the Clinician-Administered PTSD Scale for DSM-5---Child/Adolescent Version (CAPS-CA). Her scores therein confirmed that she meets the criteria for current PTSD. She did not meet the criteria for any of the associated features (i.e., shame, guilt, derealization), but her responses indicated a complete severance of conscience and attachment. She also met the diagnostic criteria for Conduct Disorder with limited prosocial emotions (e.g., lying, stealing, cruelty to animals, destruction of property), Intermittent Explosive Disorder (e.g., excessive and impulsive aggression), Oppositional Defiant Disorder (e.g., loses temper, easily annoyed, resentful, argumentative, defiant, blames others, and vindictive), Reactive Attachment Disorder (e.g., evident inhibited and emotionally withdrawn behavior toward her parents, persistent social and emotional disturbances, with a history of insufficient care in her formative years), and Disinhibited Social Engagement Disorder (e.g., as primarily evidenced by her "mommy shopping" strategies). Each of these was tied in directly to the PTSD related to her early childhood trauma and the ongoing triggers involving her perceived lack of safety and trust, or the maladaptive behaviors and schemas she developed post-adoption. Thus, it was hypothesized that resolving Jerusalem's PTSD would necessarily impact the other qualifying disorders. Once Jerusalem and her parents learned how to respond to each other in healthy ways, the trust and safety built up, and bonding ensued. A necessary element of that entailed replacing Jerusalem's negative behaviors and schemas with positive, healthy ones.

Clinical Formulation

It was obvious that Jerusalem's considerable shame about having been abandoned by her birth mother and first adoptive family, along with undisclosed physical, psychological, and possibly sexual trauma in her early childhood at the orphanage, led to her development of PTSD and a host of maladaptive schemas. Her negative thoughts, including self-blame and negative self-worth related to the traumatic events, added to her fear of attachment and her avoidance tendencies. Because traumatic things clearly happened in Jerusalem's early life, she developed deep feelings of being unsafe and mistrustful of others — especially those in a caretaking capacity. Over time, this resulted in the development of extreme ups and downs for Jerusalem's emotions; some of this appeared to be self-defense to make others back off from getting too close to her, and some of it appeared to be maladaptive ways of manipulating adults to get what she wanted. It was imperative that Jerusalem learn to recognize the antecedents that precipitated her emotional roller coaster, so that she could work towards anticipating them and proactively reign them in before they escalated. In order to overcome her PTSD and thus build attachment to others, Jerusalem first had to learn to trust and feel safe in her surroundings.

Cultural Formulation

This was a delicate matter, since Jerusalem is Asian, with Asian features, being raised by a family in which all the other non-adopted members are White. It was evident that some element of cultural confusion compounded the problems — perhaps contrived as a lack of belonging due to her obvious differences from other family members, which reinforced her "outsider" mentality and hampered her ability to feel safe and trust others. This subject was probed to ascertain whether

and how the cultural differences complicate Jerusaleh's mindset. However, Jerusaleh had clearly been acculturated fully into the middle-class American lifestyle during the seven years post-adoption.

Treatment formulation

Pursuant to the primary diagnosis of PTSD, the best treatment approach involved the use of TF-CBT, with elements of developmentally-based (Greenspan), attachment-focused (Bowlby), structural/strategic (Minuchin) and family systems (Bowen) theoretical approaches as well. Additional focus on manipulative behaviors and maladaptive schemas not necessarily related to the PTSD (but learned throughout a tenuous transition period) was also necessary, with specific psycho-education for the parents as to what role they played in their daughter's maladaptive schemas and negative responses. The treatment plan is included in Figure 1.

Figure 1

Treatment Plan
<p>Identified Problem, Treatment Goals, Objectives, and Interventions:</p> <p>Identified Problem 1: Client is hypersensitive to the criticism or disapproval of others, especially family members.</p> <p>Goal 1: Interact normally with friends and family without irrational fears or intrusive thoughts that control behavior.</p> <p>Objective 1: Client will learn and implement physical and mental calming and coping skills to manage emotional reactions related to trauma and other stressors.</p> <p>Intervention: While building rapport, counselor will teach the client skills needed to progress in therapy, including the identification and management of emotions such as anxiety, anger, and shame; use skill-building techniques such as relaxation, breathing control, coping self-statements, covert modeling, and/or role playing toward effective use of relevant skills.</p> <p>Objective 2: Client will learn and implement skills for managing relationships with friends, family, and others.</p> <p>Intervention: Counselor will teach the client interpersonal communication skills such as assertive communication, problem solving, and conflict resolution skills for mitigating and managing interpersonal conflicts; use behavioral skills training methods such as instruction, modeling, rehearsal, to develop skills and practice, review, and corrective feedback for refining and consolidation.</p> <p>Goal 2: Understand how guilt and shame drive negative schemas that adversely impact current relationships.</p> <p>Objective 1: Jerusaleh will understand how emotions become "out of control" and learn to better control emotion.</p> <p>Intervention: Counselor will provide psychoeducation regarding the bio-psycho-social-spiritual model, the balance of emotion and reason, the purpose of emotions, and teach basic skills for managing emotions, self-validation, mindfulness, acceptance, distraction, and self-soothing planning.</p>

Objective 2: Jerusaleh will reduce her stress around past traumas (assessment: graph habituation to trauma-related stimuli and memories).

Intervention: Counselor will use imaginal and *in vivo* exposure (TF-CBT for PTSD), cognitive restructuring of safety-related thoughts, as well as guilt and shame-related thoughts (once identified) (TF-CBT for PTSD)

Goal 3: Return to pre-trauma level of functioning without avoiding people, places, thoughts, or feelings associated with the traumatic event.

Objective 1: Client will identify, challenge, and replace fearful self-talk with reality-based, positive self-talk.

Intervention: Counselor will work with client to identify and explore the client's schema and self-talk that mediate her trauma-related fears; identify and challenge biases; assist her in generating appraisals that correct for the biases and build confidence

Objective 2: Client will learn and implement thought-stopping to manage intrusive unwanted thoughts.

Intervention: Counselor will teach the client thought-stopping in which she internally voices the word STOP and/or imagines something representing the concept of stopping immediately upon noticing unwanted trauma or otherwise negative unwanted thoughts.

Identified Problem 2: The family is in distress because the parents' approaches and responses to the child trigger her fear and trust issues related to her PTSD.

Goal 1: Train the child up in the ways of the Lord without inadvertently re-traumatizing her.

Objective 1: The child's parents will learn and implement Parent Management Training (PMT) skills to recognize and manage any problem behaviors of the child client.

Intervention: Counselor will use a PMT approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions can be used to promote positive change.

Objective 2: Child client and family members will gain new patterns of communication to effect positive choices.

Intervention: Counselor will teach parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior, use of clear, direct instruction, time-out, and other loss-of-privilege practices for problem behavior.

Goal 2: Reframe familial interactions in healthy ways in order to overcome PTSD trigger responses.

Objective 1: Child client and family members will verbalize an accurate understanding of PTSD and how it develops, as well as how to recognize, anticipate, and head-off triggers.

Intervention: Counselor will assign child client's parents to read psychoeducational chapters of books or treatment manuals on PTSD that explain its features and development.

Objective 2: Client will make positive choices three out of five times.

Intervention: Counselor will work with the child client and her family to implement the and Choice-Consequence Model (CCM) and devise an effective choice/consequence chart, for parents to implement consistently and immediately upon the child's action.

REFLECTION

Because there is no empirical or evidence-based treatment for RAD/DSED, many therapists do not have the critical tools and foundational understanding of the schemas and mechanisms these children use, in order to help the children and their families heal. By definition, children who have experienced interpersonal trauma by a caregiver have endured maternal privation/deprivation through adoption or foster care. Cross and Purvis (2008) methodically addressed the spiritual issues involved with this population of children in their article titled “Is maternal deprivation the root of all evil?” Using Scripture, Cross and Purvis defined the nature of evil, the nurture of evil, the roots of evil, and the pathology involved. In the end, they concluded “with some degree of certainty, that although not all maternally deprived (or psychological abandoned) individuals will become antisocial, virtually anyone wh in fact becomes antisocial will have been maternally deprived” (p. 77). Thus, it is clear that “matrnl deprivation may actually be the root of all evil” (Cross & Purvis, 2008, p. 77).

Relevance to the Church

God designed man to be in close relationship and community with Him and other men. Anything that interferes with that design creates turmoil for man (Owen, 2012; Rackley, 2007). Attachment difficulties thus have clear underlying spiritual implications. Christians have a duty to act. The Bible mandates that Christian encircle these families with prayer and compassionate support, to be used as God’s vessel to help them heal from the inside out. If Christians stand back and allow these families to fracture and fail: how will that little girl ever learn to trust and believe in God, *whom she cannot see or touch*, and who promises to love her and never leave her --- when her own adoptive parents, *whom she can see and touch*, have reneged on their promise to love her forever by surrendering her to the State or institutional care? Research has shown a direct correlation to one's detachment from others and a diminished God image (Rackley, 2007). Clearly, helping these children learn to bond with and trust other people in a meaningful way, will help them be able to bond with and trust God eventually, too.

Significance of this Research to the Christian Faith

James 1:27a declares that “religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress” (New International Version). Children who have been adopted or are being raised in kinship care due to the chronic dysfunction of their birth parents are literally or figuratively “orphans.” Children who have suffered early childhood trauma such that they later manifest the criteria of PTSD/RAD/DSED are certainly also evidencing their “distress.”

John 10:10a warns that “the thief comes only to steal and kill and destroy” (New American Standard). His primary target is the family ... and he prowls around looking for opportunities to

disrupt families. Christians need to be aware of and vigilant against the dark spiritual forces that undergird these children's behavioral and emotional disturbances (Eph. 6:10-18). Above most other disorders, the dynamic of the conflict in children with PTSD from ECT and their new caregivers has a particularly demonic element to it. Many of the night terrors, for example, include emission of a deep, guttural-growl that sounds non-human. The level of rage and cold, calculating revenge that these children can inflict (i.e. evidence of deprivation, according to Cross and Purvis, 2008) defies rational explanation. Sometimes, the harshest condemnation of these parents comes from within the church; which must be resolved.

The good news is that John 10:10 does not end with foreboding about the devil's plans and design ... it ends with hope in Jesus Christ for conquering the devil and offering us eternal life "to the full." These children and their families can and do heal completely, fully (Owen, 2012). Competent counselors in full armor who recognize a child with PTSD from ECT as rooted in fear and work to overcome the dark, spiritual influences that threaten to destroy the family, can help bring hope and healing to these families in a way that those treating for RAD/DSED cannot. There is hope and healing in Jesus Christ!

CONCLUSION AND CALL TO ACTION

Any disorder that has such vast implication for a nation (potential for 550,000 children and \$3,000,000,000 in institutional care costs each year here in America alone) warrants much more intense study than has been granted to date. This author is compelled to advocate for more studies to specifically and empirically address (a) the maladaptive behavior schemas that diagnostic criteria are silent on, (b) how the "phenomenon of shame" (Shreeve, 2012, p. 50) impacts RAD (especially as to children from disrupted or dissolved adoptions), (c) to what extent RAD and PTSD are related; and (d) to focus on the population of children who must learn to trust and bond with a new parent after the loss of one to whom they were attached (even if disorganized). Future research should also focus on children who are currently living under the care of a new caretaker, having previously been abused by a former caretaker.

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