Just Go Ahead and Give Me the Chair!

No, not the electric chair! The chair! You know, the one with four sturdy legs.

Confused?

Yeah, I get that a lot myself. Let me try to, in the immortal words of that great theologian, Ricky Ricardo, *s'plain*.

The recent ATTACh conference in Charlotte was a nice reminder to me of all the tools in our toolbox on behalf of helping children with attachment issues. And with the 20th anniversary of ATTACh, we are reminded that in the *beginning* there was basically Rage Reduction Therapy. Over time, new and non-coercive treatment tools emerged. Moreover, research contributions within the field of neuroscience have identified typical brain changes that too often occur as a result of chronic early childhood trauma and maltreatment. As a result, we now have at our disposal a near panoply of ways to help youngsters with attachment disorder (AD) heal.

Which brings me back to the chair.

Amidst the currently well-stocked cupboard of attachment interventions—both direct and indirect—it is my opinion that there are four basic key components, legs of the chair, from which to choose, available for parents who courageously work day by day in the trenches with troubled youngsters.

In no particular rank order, the four legs are:

1) **Attachment/Trauma Therapy**
2) **Medications**
3) **Neurofeedback**
4) **Behavioral Parenting Intervention**

1) We all know by now that conventional "talk therapy" with our population of kiddo is a bust. Huge waste of time and money. Back in the 1980s I certainly didn't know this. Few did. It makes me cringe to reflect upon several children and families with whom I worked back then. First, I had never even heard the term *Reactive Attachment Disorder*. No professor in all of my grad school days had ever uttered the words; nor had I ever read anything about RAD. And in terms of interventions, all I knew were: 1) how to do play therapy; and 2) how to instruct Moms and Dads on parenting strategies for normally attached children. The ensuing frustration was palpable—for everyone.

Now, as far as attachment/trauma therapy for children go, therapists have an assortment of therapy *brands* from which to choose. Further, many clinicians are eclectic in their approaches, borrowing from two, three, or more brands. And families are being helped.

2) Appropriate medications constitute another leg of the chair. Here, there is the ability to assist children with comorbid (coexisting) conditions or symptoms that render AD itself extremely difficult to treat. My consistent experience has been that we do a much better job at attacking AD, once all of its common *running buddies* have been nuked. Pediatric Bipolar Disorder (PBD),

borderline psychoses, masked depression, ADHD, et al are common among the AD population. And for me, it is highly unusual to find only <u>one</u> AD running buddy. Usually there are at least two or more screeching at us. I also find it is much easier to plow away the AD running buddies than it is to directly treat the AD. But once the cronies are driven into the sea, the AD becomes much easier to attack. And appropriate/judicious medications can help with this.

I know, I know. Where do I find a psychiatrist who is AD-savvy? This of course is the biggest challenge we face, in terms of bringing Leg of the Chair #2 into play. All of us who have been a part of the mental health field for any length of time at all—as parents or clinicians—have witnessed either the frustration of <u>inappropriate meds</u> (e.g., treating a complex child with a psychostimulant), or <u>polypharmacy</u> (wherein a youngster has been placed on, say, six or more heavy hitting medicines, often with competing neurochemical interactions).

So, what is the best strategy to increase the number of AD-cognizant psychiatrists in our country? Would that I knew. Someone smarter than I will need to tackle that one.

3) Along with the *Paradigm Shift* in the field of AD treatment (i.e., assisting children by way of attunement and achieving brain self-regulation, etc—in place of coercive treatment methods), neurofeedback (NF) is the hand that fits the glove. NF, or brain-training as it's sometimes called, holds great promise. Just as medications target abnormal neurochemical shenanigans in the brain, NF targets the abnormal neuroelectrical shenanigans in the brain. Moreover, it has been my repeated experience that appropriate meds, used in conjunction with NF, work synergistically. That is, one makes the other better than either would be by itself.

As is the case with attachment/trauma therapy, NF needs a larger body of research. The bulk of NF studies rests with ADHD. In a recent study among ADHD youngsters, the investigators documented structural brain changes, as seen via neuroimaging technology, among the NF-trained group, as opposed to the non-NF-trained group. If NF can achieve structural brain enhancement among the ADHD population, then why not among the AD population? Nevertheless, we wait on conclusive research. In the meantime, we are left with a body of NF-related <u>ADHD</u> research, along with a heavy dosage of anecdotal success with AD among those of us who use NF.

4) As we all know, the lion's share of "normal" parenting strategies fall way short of the mark among youngsters with AD. Thousands of parents across the globe, who have parented both birth children as well as adoptive/maltreated children, can ably attest to this. Fortunately, the base among our ATTACh-registered clinicians is highly skilled and insightful as to how to parent the hurt child. I only wish <u>all</u> adoptive parents could attend the ATTACh conference each year to hear these persons speak and give counsel.

Again, as with all other effective services for families struggling with AD, the number of qualified/high caliber clinicians is limited. As I was perusing the other day the list of ATTACh-registered clinicians—while eating bon bons and watching soaps—there just are not that many of us. In fact, 11 states list only one, with a whopping 23 states listing <u>none</u>. Oh, and only one in the entire <u>nation</u> of Canada. We know there are more qualified AD therapists out there than that; however, if they are not on the ATTACh register, families may not find them. (If you are a qualified AD therapist who like me enjoys the occasional bon bon and soap, PLEASE register with ATTACh!)

Finally, some last words about the chair:

- **No one leg of the chair is a panacea.**
- **Every family doesn't need all four legs at any one time.**
- **Even with unlimited finances, families would implode if they tried to engage all four legs concurrently (only a finite number of hours/personal energy in the day).**
- **The goal is for each family to access whichever leg, or whichever <u>two</u> legs, are needed at a given point in time.**

As FDR might have asked: How can our field best achieve for families, one chicken (two legs) in every pot? Perhaps seven more bon bons and I'll figure this out.