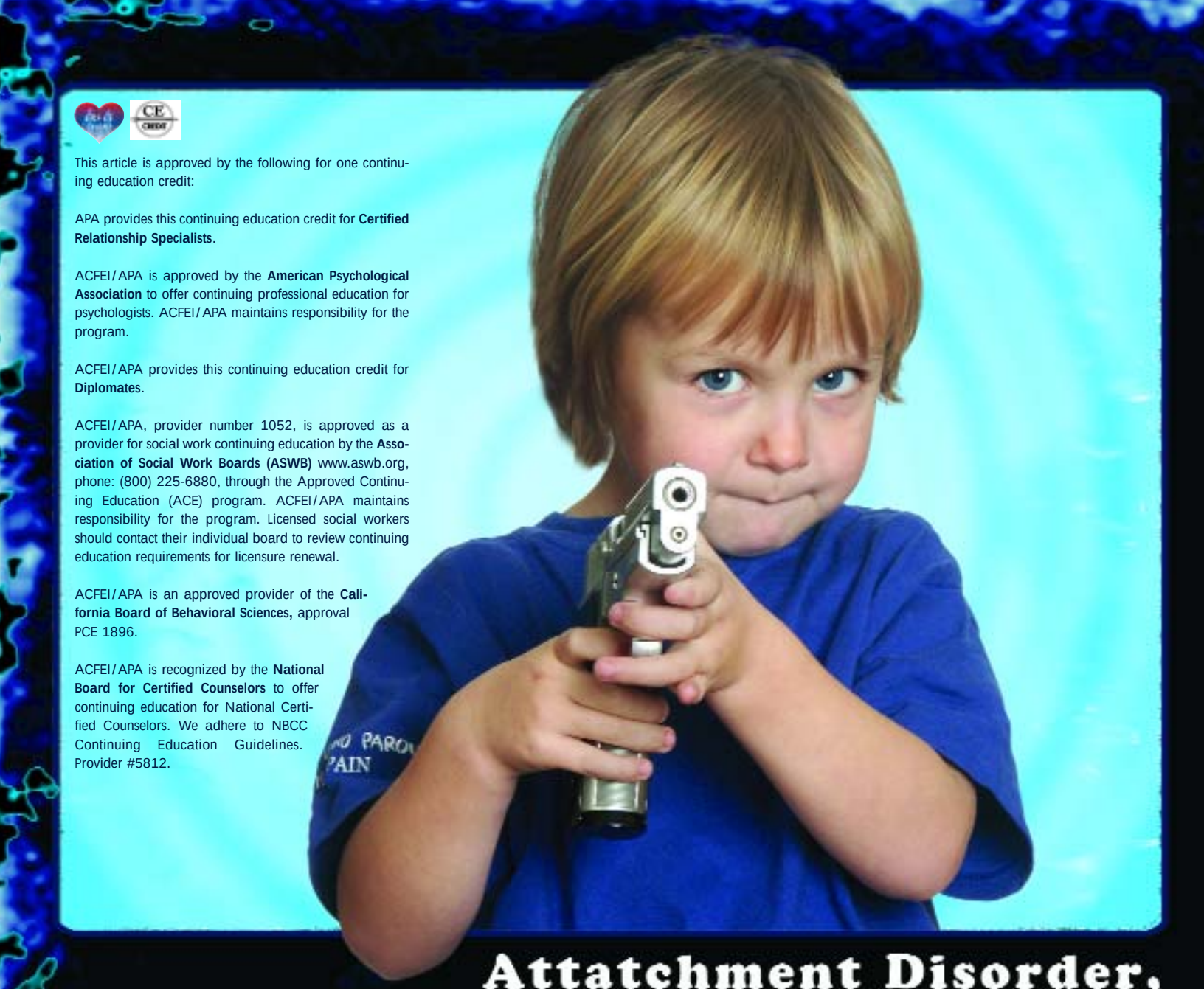

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Attatchment Disorder, Antisocial Personality, and Violence

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Key words: attachment disorder, antisocial personality, and violence

There is a serious and rapidly escalating problem throughout our society. More and more children are failing to develop secure attachments to loving and protective caregivers. These children are left without the most basic and important foundation for healthy development. They are flooding our child welfare and juvenile justice systems with an overwhelming array of problems—emotional, behavioral, social, cognitive, physical, and moral—and growing up to perpetuate the cycle with their own children.

Children with a history of severe attachment disorder develop aggressive, controlling, and conduct-disordered behaviors that contribute to the development of an antisocial personality. As early as the latency years and preadolescence, these children exhibit a lack of conscience, self-gratification at the expense of others, lack of responsibility, dishonesty, and a blatant disregard for the rules and standards of family and society. Teenage boys who have experienced attachment difficulties early in life are 3 times more likely to commit violent crimes (Raine, 1993). Disruption of attachment during the crucial first three years of life can lead to "affectionless psychopathy": the inability to form meaningful emotional relationships, coupled with chronic anger, poor impulse control, and a lack of remorse (Bowlby, 1969). These disturbing psychosocial qualities have contributed to a more violent and "heartless" character to the crimes being committed by today's youth.

We are experiencing a pace of violence among certain children that has been steadily rising for more than two decades. A small percentage of disturbed youth are committing a larger percentage of violent crimes, and at younger ages. Between 1983 and 1992, the arrest rate for girls under the age of 18 increased by 85%, while it went up by 50% for boys. The number of youths held in juvenile facilities has increased 41% in the past 10 years. More than 110,000 children under age 13 were arrested for felonies in 1994; 12,000 were arrested for crimes against people, including murder, rape, robbery, and aggravated assault (Berman et al., 1996). The vast majority of these children suffer from undiagnosed attachment disorders, have histories of abuse and neglect, lived in single-parent homes with young and highly stressed mothers, and had a parent with a criminal record (Levy & Orlans 1998). These young offenders will become the superpredators of tomorrow, and are likely to go on to commit more numerous and serious offenses.

A recent newspaper article reveals the seriousness of our current problem: "The nation's juvenile courts, long a troubled backwater of the criminal justice system, has been so overwhelmed by the increase in violent teenage crime and the breakdown of the family that judges and politicians are debating a solution that was once unthinkable—abolishing the system and trying most minors as adults" (Butterfield, 1997). The legal and child welfare systems not only find it impossible to keep up with new cases, but have difficulty monitoring and serving the children and families on their current caseloads. As many as 50% of all fatalities that are due to child abuse and neglect occur in cases that have already been brought to the attention of law enforcement and child protection agencies (Lung & Daro, 1996).

Secure and Disordered Attachment

As defined by Bowlby (1969) and Ainsworth (1973), pioneers in the study of parent-infant relationships, attachment is an enduring affective bond characterized by a tendency to seek and maintain proximity to a specific person, particularly when under stress. Thus, attachment is the deep and long-lasting emotional connection established between a child and caregiver in the first several years of life. Attachment is rooted in biology and evolution. Human infants are instinctively inclined to form attachments; infants instinctively reach out for the safety and security of a "secure base" with a reliable caregiver, and parents instinctively protect, nurture, and love their offspring. Instinctual attachment feelings and behaviors in infants and toddlers are activated by cues or signals—social releasers—from caregivers (e.g., smiles, eye contact, holding, rocking, touching, feeding). The attachment process is defined as a "mutual regulatory system," with the baby and caregiver influencing one another over time.

Secure attachment relationships serve many important functions for children developmentally:

1) They provide safety and protection for the vulnerable young via closeness to a reliable and consistent caregiver;
2) They teach basic trust and reciprocity, which serves as a template for all future relationships;
3) They facilitate healthy cognitive and social development via safe and secure exploration of the environment;
4) They promote self-control, the ability to regulate and manage impulses and emotions;
5) They lead to the formation of a healthy identity, self-worth, and autonomy;
6) They establish prosocial morality, which includes empathy, compassion, and conscience;
7) They generate positive core beliefs ("internal working models") about self, others, and life in general; and
8) They protect children against future stress and trauma by increasing resilience (Levy & Orlans, 1998).

Children who begin their lives with secure attachments fare better in all aspects of functioning as their development unfolds. Numerous longitudinal studies have demonstrated that securely attached infants and toddlers do better later in life in regards to their self-esteem, independence, relationships with parents and other authority figures, friendships, impulse control, empathy and compassion, resilience in the face of adversity, school success, and future marital and family relations (Main et al., 1985; Waters et al., 1979; Troy & Sroufe, 1987; Jacobson & Wille, 1986; Sroufe et al., 1993). Conversely, children who begin their lives with compromised and disrupted attachment are at risk for developing an array of serious problems as they grow

older. These children typically become impulsive; rage-filled; unable to give and receive love and affection; lacking in conscience, remorse, and empathy; extremely oppositional; aggressive; and violent.

The most common causes of attachment disorder are abuse, neglect, multiple out-of-home placements (e.g., moves in foster care system), and other prolonged separations from the primary attachment figure (e.g., from hospitalization, prison, postpartum depression). Some social service and mental health professionals believe that attachment disorder is rare. However, the evidence indicates otherwise. Research has shown that severe attachment disorders are created in up to 80% of the children in high-risk families. The risk factors include abuse, neglect, domestic violence, poverty, substance abuse, a history of maltreatment in the parents' childhoods, depression, and other serious psychological disorders of parents. Since there are one million substantiated cases of serious abuse and neglect in the United States each year, the statistics indicate there are approximately 800,000 children with severe attachment disorder coming to the attention of the child welfare system annually (Lyons-Ruth, 1996). Surveys indicate that the actual number of cases is 10-16 times higher (Gallup et al., 1995). Also, this does not include the thousands of children with attachment disorder adopted from other countries.

Attachment disorder affects many aspects of a child's functioning. The following are common symptoms:

• Behavior: oppositional and defiant, impulsive, destructive, dishonest (lying, stealing), aggressive and abusive, hyperactive, self-destructive, cruel to animals, fire setting.

• Emotions: intensely angry, depressed and hopeless, moody, fearful and anxious (although often hidden), irritable, inappropriate emotional reactions.

• Thoughts: negative core beliefs about self, relationships, and life in general ("negative working model"); lack of cause-and-effect thinking; problems with attention and learning.

• Relationships: lacks trust, controlling ("bossy"), manipulative, does not give or receive genuine affection and love, indiscriminately affectionate with strangers, forms unstable peer relationships, blames others for own mistakes or problems, victimizes others or is victimized.

• Physical: poor hygiene, tactilely defensive, exhibits enuresis and encopresis, accident prone, high pain tolerance, genetic predispositions (e.g., depression, hyperactivity).

• Moral/Spiritual: lack of empathy, faith, compassion, remorse, meaning, and other prosocial values; identification with evil and the dark side of life.

One of the most damaging results of abuse and neglect in children is their chronic inability to modulate emotions, behaviors, and impulses. Maltreatment affects the biological and psychological ability to self-regulate and often leads to a variety of psychosocial problems, including aggression against one's self and others (van der Kolk & Fisler, 1994). Secure attachment with a primary caregiver is critical if children are to learn self-control. "The primary function of parents can be thought of as helping children modulate their arousal by attuned and well-timed provision of playing, feeding, comforting, touching, looking, cleaning and resting—in short, by teaching them skills that will gradually help them modulate their own arousal" (van der Kolk, 1996, p. 185). Regulation of emotion and behavior is a crucial ingredient in healthy early childhood development, and it is a process that caregivers and babies accomplish together. This mutual regulatory process breaks down under conditions of anxious attachment. A depressed, substance abusing, or otherwise neglectful or abusive caregiver is not attuned to his or her infant's emotions and needs, leaving the baby without any necessary external regulatory support (Robinson & Glaves,1996).

A child's core beliefs or "internal working model" is defined, to a large extent, by the nature of his or her primary attachments. A securely attached child believes: "I am good, wanted, worthwhile, and loveable; caregivers are sensitive, caring, and trustworthy; my life is basically safe and worth living." An attachment disordered child believes: "I am bad, unwanted, worthless, and unlovable; caregivers are insensitive, threatening, and untrustworthy; my life is basically unsafe and not worth living." These latter core beliefs promote a sense of alienation from family and society, a need to control others and protect oneself at all times, and angry, vindictive, and violent behaviors.

Important prosocial values, attitudes, and behaviors are learned in the context of secure attachment relationships: empathy, caring, compassion, kindness, and morality. How does secure attachment promote the learning of empathy and the ideals of right human conduct? Empathy and morality are learned via four psychological processes: 1) modeling by parents or other attachment figures; 2) internalizing the values and behavior of parents or other attachment figures; 3) experiencing synchronicity and reciprocity in early attachment relationships; and 4) developing a positive sense of self. When the family does not promote secure attachment and appropriate socialization experiences, as is the case with abuse, neglect, or multiple out-of-home placements and caregivers, the child is at risk for developing not only conduct disorders, but also a more pervasive lack of morality.

Attachment disorder may be transmitted from generation to generation. Children lacking secure attachments commonly grow up to be parents who are also incapable of establishing this crucial foundation with their own children. Instead of following the instinct to protect, comfort, and love their children, they abuse, neglect, and abandon. There is a "pyramid effect"; with each generation there is a multifold increase in the number of attachment-disordered children. The situation has reached overwhelming proportions:

• The number of children seriously injured by maltreatment quadrupled from 1986 (140,000) to 1993 (600,000).

• Three million cases of maltreatment were investigated by Child Protective Services in 1995, and over 1 million were

confirmed as serious abuse and/or neglect, with risk for continued maltreatment. Surveys indicated the actual number of cases are 10 to 16 times higher.

• Child Protective Services are unable to handle the vast increases; only 28% of seriously maltreated children were evaluated in 1993, compared to 45% in 1986 (NCCAN, 1995; Gallup et al., 1995; Children's Defense Fund, 1997).

Violence and Children

The United States is the most violent country in the industrialized world—particularly for children. Homicide is the 11th leading cause of death for all Americans, but the 3rd leading cause of death for children between 5 and 14 (Osofsky, 1995). The homicide rate for young males is 40-times higher than the rate for the country with the lowest rate (Japan). Children and youths are victimized more than adults in every category—physical abuse, assault, bullying, rape. There was a 300% increase between 1986 and 1993 in the number of children seriously injured by maltreatment—mostly by violent parents (Children's Defense Fund, 1997).

The proliferation of violence has been likened to a national epidemic, breeding more violence at an exponential rate (Levine, 1996). Nearly 1 million teenagers are victims of violent crime annually, with African American males and those living in poverty at greatest risk. Even schools cannot provide a safe haven; 3 million crimes occur on or near school grounds each year, and 105 fatalities were reported from 1992 to 1994 (Kachur et al., 1994). One quarter of those arrested on weapons charges are juveniles (U.S. Department of Justice, 1995; cited in Levine, 1996). In a Chicago neighborhood, one-third of school-age children had witnessed a homicide and two-thirds had witnessed a serious assault (Bell & Jenkins, 1993). Thirty-two percent of Washington, D.C., children and over half of New Orleans children were victims of violence in their communities (Richters & Martinez, 1993). Children are directly exposed to family and community violence. Infants and toddlers are indirectly but profoundly exposed; they are "tuned into" their caregivers' fears and anxieties about violence, influenced by the adults' coping strategies, and restricted in their psychosocial development (Osofsky, 1994).

Children who experience and/or witness violence in their homes are seriously affected due to their literal and psychological proximity. Over 3 million children witness parental abuse each year, including physical abuse and fatal assaults. Domestic violence is associated with maltreatment of infants; mothers abused by their male partners have higher rates of child abuse. Physical abuse is the leading cause of death among children less than 1-year old (NCCAN, 1993; Strauss, 1993). Exposure to violence, including physical abuse, has severe and damaging consequences on many aspects of a child's functioning: physical, developmental, cognitive/attributional, social, emotional, behavioral, and academic (Kolko, 1996). Infants, toddlers, and older children often experience the three hallmark symptoms of post-traumatic stress disorder: reexperiencing the traumatic event, numbing of responsiveness and avoidance of reminders of the trauma, and hyperarousal (APA, 1994). Other common symptoms include sleep disturbances, night terrors, separation anxiety, fearfulness, aggressiveness, difficulty concentrating, and emotional detachment (Zeanah & Scheering, 1996).

Children are becoming more violent. Every 5 minutes a child is arrested for a violent crime. Juvenile homicide has doubled in the last decade (Children's Defense Fund, 1997). Violent crimes perpetrated by youths have recently become the focus of increased national concern and scrutiny. In an 8-month period (October 1997–May 1998), school shootings resulted in 14 killed and 49 wounded. In West Paducah, Kentucky, a 14-year-old boy sprayed bullets into a high school prayer circle, killing 3 girls and wounding 5 others. In Pearl, Mississippi, a 16-year-old stabbed and killed his mother, then shot and killed 2 schoolmates and wounded 7 other high school students. Two boys, ages 11 and 13, in Jonesboro, Arkansas, shot and killed 4 students and 1 teacher and wounded 10 others. On May 21, 1998, a 15-year-old boy killed 2 students and wounded 25 others in Springfield, Oregon, by opening fire in the school cafeteria—after he shot and killed his mother and father in their home.

This series of recent killings and injuries by angry youths mark a shift in the nature of youth violence, with incidents moving beyond one-to-one disputes into movie-style scenes of mass mayhem. In essence, there is more firepower, more victims, and an increased sense of callousness and indifference on the part of the young killers (Lewin, 1998). Children are not born violent; violence is learned and reinforced as they develop. Numerous research studies have concluded that an interaction of several factors increases the risk of violent behavior in children and adolescents (Levine, 1996; National Research Council, 1993). These are the primary factors:

• A violent environment: Human violence is largely learned. Children learn that violence is an acceptable way to solve problems by experiencing and witnessing violence (e.g., physical abuse, domestic violence). Boys who learn to be violent are more likely to be violent toward their wives and children, and to be involved in crime when they become adults (Huesmann et al., 1984).

• Habits of thought: From preschool years through adulthood, violent individuals have thought patterns and beliefs that endorse the use of violence: "aggression is a legitimate way to express feelings and solve problems; it increases self-image and feelings of power." These thought patterns are usually learned in early childhood in the family (Shure & Spivack, 1988; Slaby & Guerra, 1988).

• Family influences: Aggressive and violent children often have parents who have antisocial personalities, use harsh physical punishment, do not provide adequate supervision, and lack involvement in their children's lives. Severe family conflict and violence threatens childrens' fundamental security and leads to expectations and behaviors regarding violence (Emery & Laumann-Billings, 1998). Children who

witness violence in their homes are at high-risk for developing distress symptoms (depression, anxiety, impulsivity, sleep problems) and violent behaviors (Rosenberg & Rossman, 1990; Martinez & Richters, 1993). Three out of 4 mothers of school-age children work outside the home. Juvenile crime is most common in the hours immediately after school, due to lack of supervision. Eighth graders looking after themselves are more likely to smoke, drink, get poor grades, and use marijuana than children who have some supervision after school (Children's Defense Fund, 1997).

• Media: The average American child spends 900 hours a year in school and 1500 hours a year watching TV. By the time a child leaves elementary school he or she has seen 8,000 murders and over 100,000 other acts of violence. Forty years of research has documented that violence is learned from TV and movies. Children's TV shows contain about 20–25 violent acts per hour. Preschoolers who watch violent cartoons are more likely to hit playmates, disobey class rules, and argue than children who watch nonviolent shows. Elementary school children who watch considerable amounts of TV violence are more aggressive as teens and more likely to be arrested for criminal acts as adults. Children who watch extensive violence on TV can become less sensitive to the pain and suffering of others, more fearful in general, and more harmful to others. A primary message from TV and movies is that violence is an acceptable solution to human problems (Huston et al., 1992; NIMH, 1982).

• Guns: The widespread availability and use of guns has broadened the scope and lethality of youth violence. Firearms account for over 75% of all homicides for those 15 to 19 years old. Guns have become a staple of childhood and teenage life in many American cities. In one study, every child living in public housing in Chicago had witnessed a shooting by age 5. Every 90 minutes a child is killed by someone using a gun (Mercy & Rosenberg, 1996; Berkowitz, 1994).

• Alcohol and drugs: Drugs and alcohol have the power to disinhibit, often resulting in violent behavior. In over 60% of all homicides the perpetrator, the victim, or both had used alcohol. Violence frequently occurs among youth in places where drugs and alcohol are used (NCIPC, 1989).

• Genetic influences: There is no single "violence gene," but violence is related to traits that may be partially inherited—a difficult, fearless, and uninhibited temperament; hyperactivity; and attention problems. Temperament differences may partially explain why siblings are different and why, even in violent communities, only some youth turn to violence (National Research Council, 1993).

Attachment Disorder, Antisocial Personality, and Violence

A neglectful, abusive, or nonresponsive caregiving environment produces out-of-control, angry, depressed, and hopeless children by 2 to 3 years-of-age. Attachment disordered children have frequent and prolonged temper tantrums, are impulsive and accident prone, and desperately seek the attention not previously received. They are restless, irritable, have a brief attention span, demand instant gratification, and have little frustration tolerance by the preschool years. By age 5 they are angry, oppositional, and show a lack of enthusiasm. Their inability to control their impulses and emotions leads to aggressive acting-out and a lack of enduring and satisfying relationships with peers and others. Compared to securely attached children, attachment-disordered children are significantly more aggressive, disruptive, and antisocial.

Research has demonstrated that infants of impoverished teenage mothers, for example, are at-risk for developing severe attachment disorder ("disorganized-disoriented attachment patterns") and subsequent aggression. Sixty-two percent of these infants initiated conflict with their mothers via aggressive behavior by age 2. As toddlers, these children were aggressive, avoided contact with their mothers, and developed controlling and coercive coping strategies (Hann et al., 1991). Kindergarten children who were classified as attachment disordered in infancy were 6 times more likely to be hostile and aggressive toward peers than were those classified as secure (Lyons-Ruth et al., 1993). Findings from the Minnesota High Risk Study, which followed a large community sample of impoverished mothers and infants from birth into adolescence, documented the relationship between insecure attachment and later conduct disorders. Insecurely attached infants were more aggressive and impulsive, and had more conflict with peers and caregivers during their school years (Egeland et al., 1993; Erickson et al., 1985; Renken et al., 1989; Sroufe et al., 1990). Among high-risk families, it is clear that early disturbed-attachment patterns place children at high risk for later aggression and violent behavior.

Many of the key symptoms and traits of the adult psychopathic and antisocial personality are displayed in severely attachment-disordered children: cruelty to animals; enuresis; fire setting; predatory, vengeful, controlling, and manipulative behaviors; a lack of empathy, remorse, and conscience; pathological lying; self-gratification at other's expense; an inability to form close relationships (Hare, 1993; Yochelson & Samenow, 1976). Davis (1998) reports that serial killers seek control over others, lack a conscience, and display other typical symptoms by age 12 (enuresis, animal torture, fire setting, pathological lying, chronic daydreaming, violent fantasies). Douglas (1998) describes the adult violent psychopathic personality (e.g., sexual predator) as obsessed with manipulation, domination, and control. In essence, children with severe attachment disorders are "violent psychopaths in training."

Attachment disorder occurs on a continuum from mild to severe. Children with severe attachment disorder commonly manifest the three symptoms that are also found in the childhood histories of adult psychopaths: cruelty to animals, enuresis, and fire setting. Infamous serial murderers such as Jeffrey Dahmer, Ted Bundy, David Berkowitz ("Son of Sam"), Charles Manson, and Albert DeSalvo

("Boston Strangler") all tortured animals when they were young.

Cruelty to animals is one of the most disturbing manifestations of attachment disorder. It ranges from annoyance of family pets (e.g., tail pulling, rough play, kicking) to severe transgressions (e.g., strangulation, mutilation). These children lack the capacity to give and receive affection with pets, lack the motivation and sense of responsibility necessary to provide appropriate care, and are not able to empathize with the suffering of animals. They often delight in venting their frustrations and hostilities on helpless creatures to compensate for feelings of powerlessness and inferiority. Studies found that children who abuse animals are 5 times more likely to commit violent crimes as adults. The FBI's Behavioral Science Unit found that a majority of individuals who have committed multiple murders admitted to cruelty to animals during childhood (Cannon, 1997). Parental abuse of children was the most common etiological factor found in cruelty to animals (Tapia, 1971). Fromm (1973) noted that children who are sadistic are usually themselves the victims of cruel treatment. Showalter (1983) concluded that cruelty to animals represents a displacement of aggression from the child to a helpless animal.

Fire provides a particular appeal for some attachment-disordered children. Its attributes of power and destruction are attractive qualities to the child who is rage-filled and feels powerless. The child's fire-setting behaviors are extremely disconcerting to caregivers. The child senses this fear and apprehension, and uses this to his or her advantage in order to gain further power and control. Fire-setting behaviors vary in degree from simple fascination and/or occasional lighting of matches to more serious actions such as setting fire to a home. The more serious the nature of the premeditated fire, the more seriously disturbed the child. Society is beginning to recognize the magnitude of this problem. Juveniles now account for the majority of all arson arrests; children and teens accounted for 55% of arson arrests in 1994. One third of those arrested were under the age of 15, and 7% were under the age of 10. No other serious felony has such a high rate of juvenile involvement (Estrin, 1996).

Conclusions and Recommendations

What are the solutions to the vast problems of attachment disorder in families, the child welfare system, and society? The solutions can be found in four areas: 1) attachment-focused assessment and diagnosis; 2) specialized training and education for caregivers (Corrective Attachment Parenting); 3) treatment for children and caregivers that facilitates secure attachment (Corrective Attachment Therapy); 4) early intervention and prevention programs for high risk families (Levy & Orlans, 1998).

Attachment disorder is one of the most easily diagnosed and yet commonly misunderstood parent-child disorders. Many social service and mental health professionals, although adept at assessing behavioral and emotional disorders, are not trained in the use of an "attachment frame." Parents and other caregivers (e.g., foster parents) assume the responsibility of childrearing with challenging attachment-disordered children, often without the necessary information, training, and support. Adoptive and foster parents commonly feel frustrated, angry at the child and the "system," demoralized, disillusioned, and burned out. They require specialized parenting skills in order to be successful in their parenting roles. Traditional psychotherapeutic approaches have not been effective with severely attachment-disordered children who do not trust or form the working alliance basic to success in therapy. For over 30 years we (the authors of this article) have been developing and refining approaches for the treatment of attachment disordered children and families. We have found that effective treatment involves the following: creating secure attachment patterns; systemic, holistic, and integrative interventions; and utilizing a developmental structure (see Levy & Orlans, 1998). A significant amount of evidence accumulated over the past 25 years indicates that early intervention and prevention programs are effective for at-risk children and families (Guralnick, 1997; Ramey & Ramey, 1998). Such programs have been shown to enhance parent-children attachment, foster children's cognitive and social development, and reduce later violence.

For More Information

For more information on the issues raised in this article, see the following website: www.attachmentexperts.com.

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References

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