RELATIONAL DISORDERS IN YOUNG ADOLESCENTS
A distinction of the problems caused by neglect and a proposed method of treatment

Summary
This study is based on experience gained in the practice of clinical psychology. In working with children and young people in whom the consequences of neglect are exhibited as problem behaviour, we observed that 'problem behaviour' assumed different forms. These differences in behaviour and the fact that the methods of treatment currently being offered are experienced as insufficient prompted us to produce this study.
In Chapter 1 of the study the differences we observed in problem behaviour are described as two distinct problems on the basis of two practical examples. These two distinct problems, which we refer to as 'attachment disorder' and 'relational disorder' are then compared and contrasted.
We describe the behaviour that characterizes each of these disorders and formulate a theory regarding the differences in terms of attachment history.
In terms of behaviour the following differences can be observed.
If a child is suffering from an attachment disorder he will fail to retain rules, show little sense of concern for the environment and will only be superficially involved in relationships. In terms of actual behaviour this will mean that the child is on relatively friendly terms with everyone, showes no specific preference for a certain adult and is indifferent towards people, clothing and objects.
The child will also show excessive behaviour in the form of demanding negative attention.
The behaviour of a child suffering from a relational disorder is typically characterized by ambivalence with regard to closeness on account of the fact that the child both desires and rejects closeness. This can be conceived of as an internal conflict which results in loneliness, depression, passivity and fear. The child suffering from a relational disorder will also exhibit excessive behaviour, although in this case the child will be inclined to accost people.
As far as the attachment history is concerned we make the following distinction: in the case of an attachment disorder the child has had no experience of attachment with a parent figure or primary caretaker. From birth onwards the child has been moved from one domestic situation to another such that there has been no continuity in the experience of the availability of a primary caretaker.
In the case of the relational disorder, the child has experienced a period of continuity and has also had some experience of a bonded relationship with a caretaker, yet this relationship has been undermined, leading to disappointment (in the traumatic sense) in relation to attachment.

Chapter 2 of the study starts out by examining whether there is any support for the distinction we make with regard to the problems caused by neglect in the relevant literature. This is also the first question to be addressed by this study.
To this end we examine the definition of neglect and the consequences of neglect during the child's upbringing.

Neglect can be defined as an act of omission by the parents and as the experience of this act of omission by the child. As far as the parents are concerned, neglect implies the failure to provide adequate care; as far as the child is concerned neglect refers to the lack of care experienced by the child and the consequences of this experience of lack.
In our own definition the child's ability to complete a particular stage of development is adopted as a criterion in defining neglect.

We propose the following definition:
'Neglect involves an attitude and behaviour on the part of parents, who, because of their lack of concern regarding the child and lack of care for the child, are not sufficiently available for the child, as a result the child is negatively affected to such an extent that he is unable to complete his developmental tasks.'
The discussion of the consequences of neglect reveals the seriousness of the problem. In listing the consequences of neglect under the various developmental categories it becomes clear that the consequences of neglect are noticeable in many categories (we mention emotional, cognitive and social development and the development of skills). There are references in the literature to the differences in terms of the consequences of neglect. Though we did not come across any explicit distinction relating to our 'attachment disorder' and 'relational disorder', the behavioural differences involved were noted. The results of the studies discussed grant sufficient room for us to be able to conclude that the distinction we make between 'attachment disorder' and 'relational disorder' is supported by the literature.

Chapter 2 of the study also discusses the second question to be addressed by the study. We wish to establish whether or not there exists between the type of problem behaviour and the attachment history of the child in question a connection which also supports the distinction we make between 'attachment disorder' and 'relational disorder'. To this end we examine the consequences of the different methods of attachment as discussed in the literature on attachment. The literature on the subject confirms that different methods of attachment result in different forms of behaviour. We then compare the behaviour and the past history of attachment disorders and relational disorders with the different methods of attachment. On the basis of this comparison we put forward the theory that a relational disorder involves resistance (ambivalence) to attachment while an attachment disorder involves the avoidance of attachment.
We found nothing in the literature to support our theory that the period during which the child is deprived of the opportunity to bond is likely to be an influential factor in the child's development. Thus we revised our theory accordingly.

The different types of behaviour related to the different methods of attachment described in the literature correspond to the different behaviour observed in what we have termed ‘attachment disorder’ and ‘relational disorder’. We now underline the difference in methods of attachment and the lack of an appropriate upbringing response, developing a working model based on these methods of attachment.

In Chapter 3 we describe the two concepts which are considered to be central to either disorder, namely ‘closeness’ and ‘self-perception’. Our aim at this stage is to gain a clearer understanding of the problem. To this end we examine the question as to whether there is a connection between these two concepts and the process of attachment. This is the third question to be addressed by this study.
For a clear definition of the concept of closeness we referred to the works of several existential philosophers: Marcel, Bollnow and Jaspers.
We define closeness as: ‘the sustained availability of a person connected to the child who guarantees the child’s safety, such that the child feels able to rely on and to trust the person in question’. We use the definition of availability as a prerequisite for trust in the sense indicated by Marcel. In this sense availability involves an element of intimacy and creates a context that enables the child to feel trust.
There is an obvious connection between closeness and attachment behaviour since attachment theory describes attachment as ‘behaviour that seeks closeness’. In the case of relational disorder, behaviour has been characterized as ambivalence with regard to closeness, namely desiring closeness and rejecting closeness.
The connection between self-perception and attachment is less clear. Bowlby's (1984) statement that the experience of attachment is a determining factor for self-esteem and self-confidence has been subject to considerable criticism. However, we note that this criticism does not refute Bowlby’s statement, it simply serves to introduce an element of differentiation, for instance: it is impossible to state categorically that the future dynamic of *all* forms of relationship is determined solely by attachment history. For example, Van IJzendoorn (1994) presents evidence based on empirical research to suggest that one’s own negative attachment history is not always repeated in the raising of children.
Thus our question as to whether there is a connection between the negative attachment history of a young person suffering from a relational disorder and negative self-perception has been answered.
We discuss the results of numerous studies that make this kind of connection.
We then go on to examine various aspects of self-image (Van der Meulen (1993), Van der Werff (1989)) with a view to gaining a clearer insight into that way in which self-image is formed and then to examine which of these aspects are affected by the problems of relational disorders.
We look at the aspect of self-esteem because self-esteem is defined as the positive or negative evaluation of one’s own person (Van der Meulen (1993)). As such self-esteem (or the lack of it) is used as a source of information not only for the development of the self-image but also for the content of the self-image.

We discuss the studies conducted by Harter (1990) and Moretti and Higgins (1990). These studies examine how self-esteem is expressed in children and young people and how self-esteem develops as the child is being brought up.
In view of the age group of the young people suffering from relational disorders, we treat self-image in adolescents as a separate issue. The research on the subject is conducted from the point of view of developmental psychology (Harter (1990); Damon and Hart (1982)). Self-esteem is then related to the developmental task.
Finally we examine what is involved in the problem of self-conception and whether this is implied in the case of a relational disorder. We discuss the self-discrepancy theory presented by Higgins, Klein and Strauman (1987) and we consider the development of Vera (our case study of relational disorder) in the light of this theory.
The chapter concludes that there is a connection between attachment history, the experience of closeness and self-image and that we have succeeded in concretizing this connection in this chapter.
In Chapter 4 we start to examine the development of possible methods of treatment by looking at the different forms of closeness a child needs to experience during the various phases of development. Each phase of development has its own form of closeness and each of these forms of closeness needs to be experienced. This is because these different forms of closeness are seen as a cumulative series of phases. In other words the form of closeness that should ideally be inherent in the first phase is carried over to the next phase of development, albeit in a different form. The child needs to experience the form of closeness normally implicit in the first phase in order to be able to assimilate the form of closeness involved in the second phase. In characterizing the various phases of development from the point of view of the forms of closeness involved, it is important to identify the method that most closely approaches the intimacy and safety required at each of the various phases.
From the point of view of the need for closeness, the baby phase is characterized by the need for a sense of physical security. During this particular phase the form of closeness is physical closeness which is communicated in caring for, nourishing and playing with the child.
During the toddler phase the sense of physical security remains and the new element of assisting and encouraging exploration is added. The child’s activities are treated with respect. During this phase the form of closeness is defined as structuring and integrating. These forms of closeness call for availability and intimacy, which if present provide the child with a sense of security.

During the primary school phase in addition to the two previous forms of closeness a third form of closeness is now introduced: the creation of periods of tranquillity. In creating moments of tranquillity during which the primary caretaker can be there for the child, a situation develops in which the child is able to stay in a certain place for a certain length of time. During such moments there is availability. This phase can be seen as an extension of the social world of the toddler and a further expansion of the social world during the years of primary school. During this phase the closeness of friends is experienced in addition to the closeness that the child experiences from its parents.
During this phase the form of closeness is defined as ‘doing things together': cycling together, playing sport together, shopping together. While the child is engaged in activities with its peers and during moments of tranquillity the parent or primary caretaker is available to assist and support the child. During this phase a kind of companionship develops - a form of closeness that the child has learnt from its friends during this phase.
During the phase of adolescence, the various forms of closeness that the child experienced during the previous phases of development are assimilated by the adolescent – he determines what form closeness is to take. The form of closeness he needs from his parents at this stage is the confirmation of his own sense of security. The adolescent relies on this kind of confirmation to develop confidence in his or her own potential. At this stage closeness can take the form of encouragement or the delegating of responsibility, but also the setting of limits.
The previous forms of closeness continue to exist into adolescence, but, as during the previous phases, they assume a different form. Chapter 4 then goes on to look at the differences between boys and girls when it comes to closeness.
Finally we look at what forms of closeness the young person suffering from a relational disorder is likely to have missed out on. In doing so we answer the fourth question addressed by this study.
Chapter 5 discusses the different methods of treatment for the two different types of disorder (the fifth question addressed by the study). In view of the fact that this study is more specifically concerned with the problem of relational disorder, the method used to treat attachment disorder is mentioned solely to give an indication of the difference between the two problems. The method used to treat children suffering from attachment disorder is known as differentiation therapy. The method used to treat young people suffering from relational disorder is known as phase therapy.

Differentiation therapy is based on the theory that the ability to differentiate precedes the ability to bond in children suffering from attachment disorder. The treatment is divided up into different phases in which the process of differentiation is developed.
Phase therapy serves to recreate the experience of the form of closeness of each phase of development. These different forms of closeness are created phase by phase. This is done subject to restriction. A few times a week the child is offered the brief opportunity to experience a certain form of closeness (for a period of 10 minutes, for example). The child is prepared for the experience during therapy sessions and supervised during the experience, but the form of closeness in question is provided by the child’s primary caretaker (foster mother, adoptive mother, group leader).
Four illustrations are given of phase therapy and a brief description is given of six treatments.

Chapter 6 examines which methods of treatment are mentioned in the literature (the sixth question addressed by the study) and investigates whether the literature supports the method of treatment developed in this study.
The chapter concludes that treatment of the problems caused by early neglect is considered to be possible and to produce results. Both the objectives and the results are evident in phase therapy, which thus endorses our method of treatment.
Phase therapy adds the experience of forms of closeness (experiences necessary for development) to the existing methods of treatment. The added result of phase therapy is that young people who once suffered from relational disorder are later able to engage in (intimate) relationships.

Chapter 7 formulates the criteria used to diagnose attachment disorder and relational disorder. These criteria can be summed up as follows:

Attachment disorder	Relational disorder
Observable behaviour	*Observable behaviour*
Limited social skills Friendly with everyone Dominant and demanding Aggressive behaviour	Limited social skills Accosting Passive and withdrawn
Expressions of fear, anger and distrust.	Expressions of fear, anger and distrust. Expression of abandonment and disappointment.
Undisciplined activities, butterfly behaviour, cursory approach to play.	Apathy with regard to activities
Creation of the problem	*Creation of the problem*
a. The environmental factor: - Series of different domestic situations from birth onwards. - Insufficient availability of the caretakers.	a. The environmental factor: - Series of different domestic situations from early youth. - Insufficient availability of the caretakers.
b. Child factor: - The methods of attachment: Avoids attachment	b. Child factor: - The methods of attachment: Ambivalence towards attachment.
Conditions which serve to perpetuate the problem behaviour	*Conditions which serve to perpetuate the problem behaviour*
a. The environmental factor: (see above)	a. The environmental factor: (see above)
b. The child factor: - Reduced ability to control impulses - Inability to retain experience - Attitude of indifference - No specific preference for a certain adult.	b. The child factor: - Nervousness - Depression - Low self-esteem - Ambivalence in seeking and rejecting closeness.

The borderline cases are then indicated together with the diagnostic criteria.
The delineation of phase therapy is discussed with a view to treating a behavioural disorder, problems with integration and mental deficiency.
Finally a broader use of phase therapy is indicated for children and young people who live in their own families but exhibit the same behavioural tendencies. These children have typically experienced a traumatic period some time during their early youth.
In Chapter 8 we discuss the merits of our study by describing and justifying the methodology adopted by the study, by indicating aspects of research that the study has omitted to cover and by subjecting the methodology to the criteria formulated by Kazdin (1997) for the treatment of behavioural disorders in children.
We conclude by making a number of recommendations for further research.