

Behavior, for the most part, is not random. It is driven by forces, both in children and adults, often outside of their control. What forms those automatic responses? What is involved in changing them?

Children Behave the Way They Behave
Because They Think the Way They Think
by Deborah Hage

Few parents consequence or discipline their child if the child gets diabetes. Why? Because they recognize the child's disease is outside of the child's control. The child did not choose to get sick and would get well in a minute if he could. Consequencing the child, sending the child to his room, making him apologize, imposing some sort of disciplinary measure, paying the parent back, or withholding permission for the child to attend a birthday party, will not make the child better. It will make the child worse by adding insult to injury. The child's sense of self will suffer. A rift in the parent-child relationship will be created. It will be even harder for the child to marshal his internal resolve to get well. And, the resulting stress and tension will contribute to the progress of the disease as the body's energy will be diverted from healing the physical trauma to healing the added burden of emotional trauma.

If the parents believe the child's behavior is willful then it is easier for them to become angry or punitive. The child is told to take care of his toys, to not break them or be destructive. In a fit of anger the child throws the toy, ruining it. For many parents the obvious choice is to consequence the child, perhaps take other toys away. In the process the parent may get angry the child broke something lovingly given to them by the grandparents for Christmas. Impatiently the parent may harshly yell, "Why do you always break things? Why can't you be careful? What is the point of ever giving you anything nice when you always destroy it? Don't you like nice things? Well, I am not getting you anything else until this behavior stops!" The child might be spanked in an effort to reinforce the wrongness of the child's actions and hopefully make him think twice the next time he feels like throwing a toy.

What is the difference between the parent reacting with kindness and compassion with a child whose body is out of control due to diabetes and anger and impatience for breaking a toy with a child whose body is out of control due to brain malfunction? The attitude of the parents! Getting diabetes and breaking a toy are both events to be avoided. And, if the whole truth were explored, the negative impact on the parents when a child has diabetes is a million-fold worse than if a child breaks a toy. Yet, one event the parent can handle with grace and other the parent becomes harsh and punitive.

When a child hits another child on the playground is it willfulness, a conscious choice to be mean? Or is there the possibility the child striking out is as much the victim of brain damage which has destroyed important aspects of his brain's function as the child with diabetes is a victim of liver damage which has destroyed important aspects of the body's function? His emotions and behaviors may be as much out of his control as another child's diabetes is.

What we know about ourselves as parents and as human beings is if we believe a negative occurrence is accidental then we are more able to accept it with grace and good humor. However, when we believe something is deliberately hurtful, we are less kind and understanding. If, after ordering a hamburger, the waiter brings us a cheeseburger, we can choose to soften as we look around the restaurant and see it is extremely busy and so many orders so fast would be difficult to keep straight. We would then react by gently pointing out the order was wrong or go ahead and eat the hamburger rationalizing that it didn't make much difference anyway. On the other hand, we could choose to believe the waiter is incompetent and uncaring and lacking in respect for us as paying customers. At which point we could react to the perceived slight by saying something rude or disrespectful, or not leaving a tip, when the only infraction was that he did not bring us the kind of hamburger we ordered. Either way, the bulk of processing the event occurred entirely in our head.

What we chose to do would depend entirely on our interpretation of the situation.

Children are no different. The way they react to different situations is determined by what they believe about the situation. What they believe about a situation is often determined less by the immediate situation than it is by their understanding of life and people and events in general.

In this regard they, again, are no different than adults. It is a truism we are never angry at what we think we are. Our boss is unappreciative at work or gives us an unwelcome task and we go home and lash out at our spouse over something we ordinarily would have taken in stride. There was a precedent to our angry action, which had nothing to do with the immediate situation at hand. We can trace our unreasonable response back to what happened at work. Children do not have the cognitive ability to trace back their angry or unpredictable behaviors to events which occurred in the womb or during their early years of life. Nonetheless, those events were the precursor to their current behavior and shaped the thought processes which drive their present actions.

Children behave the way they behave because they think the way they think.

Before parents can effectively intervene to stop a negative behavior it is important to understand what the child is believing and why. Without knowing what the child is thinking that makes their negative behavior rational and sensible to him it will be difficult, if not impossible to redirect or curtail it with optimum results. A good therapist can, by using paradoxical and other techniques, stop most undesirable behaviors. The problem is that stopping the behavior without dealing with the underlying motivation for the behavior has the potential to simply drive the thoughts and feelings to surface in other, often less benign ways.

For example, it is possible to stop a child from wetting the bed by consequencing, using an alarm system, depriving the child of liquid before bedtime, etc. However, if wetting the bed is symptomatic of a larger issue, perhaps unresolved fear and anxiety due to previous sexual victimization, then eliminating the bed wetting is counterproductive. Wetting the bed may just be the diagnostic behavior telling us the child is frightened of being sexually molested. The child may be wetting the bed in an attempt to make the environment so unacceptable that no adult would find it or him attractive in the middle of the night. He has not learned to trust that in this house in this bedroom no one would enter his room and molest him. No matter how many years he has been in the home he may not have internalized a measure of safety. It might be a leftover, possibly habitual, non-verbal, protective mechanism. If he is not allowed to wet the bed then he must act out his non-verbalized, unresolved fear in other ways. He must find other ways to protect himself or exert a sense of power and control. Since he has not been able to verbalize his high state of anxiety he might feel forced to communicate it in other non-verbal ways, such as starting fires, striking out at other children, destroying property, and/or developing poor hygiene habits. What started out as a benign, victimless behavior, that is wetting the bed, is now overt aggression which could become dangerous.

Far better to discover what is driving the wetting the bed behavior and deal with that directly. Then as the cause of the problem, in this case fear of being molested and basic safety concerns, are addressed, the behavior stops of its own accord. Wetting the bed is then the means to tell whether or not the child's emotional issues and distorted thought processes are being addressed. As long as wetting the bed continues then the child is still fearful. Eliminating wetting the bed prematurely robs adults of the single most useful diagnostic tool to let them know the internal state of the child's affairs.

Therapists, parents and teachers must be very careful about eliminating a behavior that the child finds useful without dealing with the underlying causes of the behavior. The child is much more apt to achieve some level of emotional and behavioral stability if the cause of the behavior is determined and addressed and the behavior gradually lessens of its own accord as it becomes less and less useful to the child.

Since children behave the way they behave because they think the way they think then it behooves parents and the therapeutic community to determine what the child is thinking and how and where they learned to think that way before stepping in and making changes in the child's behavior which may or may not be ultimately useful.

Three Key Factors in Brain, and therefore, Personality Development

The keys to unlocking a child's thought processes and thus helping the child change those behaviors which do not contribute to personal or societal happiness are found in the principles of personality development. Personality development has three major components: Genetics, In uterine experience, and First two years of life. These three factors have the most influence in determining how the child is going to think about life, his place in it, whether or not others can be trusted, whether or not the world is a caring place, etc. What happens in these three arenas, in short, contributes heavily to how a child thinks, and how a child thinks is going to determine how the child behaves.

Genetics

People have long known that a child's appearance is based in large part on the appearance of his parents. Not always, but frequently enough for a pattern to be discerned, parents with blond hair have children with blond hair. Along the same lines it is understood that certain talents and abilities have a genetic predisposition. Parents with athletic or musical ability tend to have children with a higher than average chance of being athletic or musical. The research connecting intelligent parents with intelligent children is extensive to the point where the IQ of the parents is considered a fair predictor of the potential IQ of the child. There are always exceptions to the rule, of course. This is why it is considered a genetic predisposition, not a hard corollary. Genetic predispositions are not just connected to superficial traits or readily discernible qualities. Genetic predisposition goes much deeper than that. Genetics affect neurotransmitter levels and brain wiring for mood or thought processes. This innate makeup is going to affect how we react to our environment and how we respond to life's events. Personality development is not the product of either nature or nurture; it is a complex combination of both. Nurture can affect the direction of nature, but must work within its parameters.

Much can be done with that genetic predisposition. Athletic parents could let their child watch huge amounts of television so the child's genetically endowed athletic gift is squandered. Conversely, average parents could stimulate and arouse their child's modest intellectual endowment to higher than expected achievements.

More recently research is demonstrating that not only are appearance, talents and abilities genetically predisposed, but personality traits are linked to genetics as well. The shy child is more than likely to have shy parents. The outgoing, effervescent, take charge child is more than likely to have a parent with an extroverted personality. Hereditary links have also been made to personality traits such as leadership, vulnerability to stress, imagination, obsessional behaviors, susceptibility to addictions, excitability, friendliness, anxiety level, curiosity, flexibility, aggression, temperament, mental illness, mood disorders, resilience, and emotionality - to name just a few. On the negative side, alcoholic parents tend to have children with a higher than average predisposition to alcoholism. Angry or anxious parents have higher levels of cortisol in their brain systems which they pass to their children who then have a tendency to become angry or anxious more readily than other children. The way the child is raised to deal with these predispositions can have an enormous affect on the way the traits play themselves out in the child's life, but they cannot be eliminated.

Additionally, the way a child is treated by the parents is directly affected by the personality predisposition of the child. An infant both controls and is controlled by the parent interactions and events in their formative years. The even tempered infant is more apt to arouse positive emotions and interactions on the part of the parent than the child who is anxious and difficult to soothe. The extroverted infant may need far more interaction than some parents may wish to provide so may feel thwarted by parents who become impatient at the high level of relationship demands. The shy child may appear to be distant to parents who want more interaction. Parents must learn to adapt to the individual characteristics of the child while the child must learn to adapt to the characteristics of the parenting style.

In both of the above cases there is a high possibility the parents will have some clue to what a child will like and not like based on what they themselves liked and disliked as children. Children who have entered a family through adoption and foster care present more complex, genetically predisposed, personality issues to parents. Adults can surmise that children who have been placed for adoption as infants possibly have a genetic predisposition to a variety of personality traits by virtue of the circumstances surrounding their conception and relinquishment. The birth parents may lack a highly developed sense of cause and effect thinking, otherwise they would not have

engaged in sex with so little thought to the pregnancy which could possibly ensue. They may lack a sense of delayed gratification. They wanted to engage in sex immediately, without wanting to take the time to put in place measures which would prevent a pregnancy. They could possibly be characterized as compulsive or impulsive. It cannot be then surprising that so many adoptees with behavioral issues are impulsive, compulsive, lack cause and effect thinking and lack the ability to delay gratification. There is possibly a genetic component operating. Interesting to note that the very opposite qualities are found in adoptive parents who tend to be able to delay gratification, have excellent cause and effect thinking skills and are not particularly impulsive or compulsive.

Children who are placed when they are older, after going through the foster care system, also have the possibility of further genetic complications which need to be considered. A child who is placed in foster care is generally there due to abuse and/or neglect on the part of the birth parents. What kind of a parent would abuse or neglect their child? What qualities would a parent have to have which would make it OK to have sex with their child, not feed their child, beat their child, leave their child unattended while they went to a bar, or not change their child's diaper as necessary? A thought disordered and/or mood disordered parent! Someone who is not reality based would see having sex with their child as being a perfectly acceptable function of child rearing. Someone who would beat a child has a thought or mood disorder as beating a child is not rational and is not a sign of being emotionally and behaviorally in control. They may very well have been treated in the same way by their parents, which is not to make an excuse for it, but which is indicative that the thought and mood disorders possibly present may go back more than one generation. Parents who are rational and emotionally stable are more able to be effective and nurturing parents. Their children do not enter foster care because they have better coping mechanisms. Those who abuse/neglect their children due to their own inability to maintain rationality and emotional stability tend to lose custody of them, which puts the children in the foster and adoptive pipeline.

Adoptive parents tend to be exactly the opposite of people who have a thought or mood disorder. They tend to be very rational, thoughtful, behaviorally under control, people with sunny, even dispositions. No wonder Dr. Foster Cline once said, "We have pit bulls being adopted by collies."

The foster care system is filled with children who have a wide variety of thought and/or mood disorders. Having a working knowledge of genetic predisposition tells us we should not be surprised.

The In Uterine Experience

The second occurring factor, after genetics is taken into account, which contributes heavily to brain development and therefore personality development is the In Uterine Experience. Numerous factors contribute to a healthy pregnancy. The mother's access to prenatal care, nutrition, exercise, appropriate living conditions and sleep help determine the course of the pregnancy and the emotional and physical well being of the child within her. Additionally, her emotional state, her attitude toward the pregnancy, the amount of support she has, the presence or absence of drugs, the number of children she is carrying all have the potential to affect the child positively or negatively as well. The unborn child is not an insensate mass of cells waiting to become a person after birth. The unborn child is learning to feel and think and is exquisitely tuned in to and affected by the environment the mother is providing.

A study done by Dr. Mark Lieberman, addressing the effects on the fetus when a mother smokes had surprising results. The researchers initially discovered that every time the pregnant mother smoked the resulting poisonous gases entering the fetus caused the fetus to try to "hold its breath" and would curl up tightly into a ball, as a means of protecting itself from the pain of the fumes. The mother would know when she stopped smoking but the fetus did not know so would remain in this highly agitated state after the smoke disappeared. Researchers then discovered the child would also become agitated, with an elevated heart rate and a constricted posture, each time the mother thought about having a cigarette. Before the mother even put the cigarette to her lips and inhaled the smoke which actually caused the drop in the oxygen supply, the release of the cortisol in the mother's system prior to her lighting up a cigarette to calm herself down flooded the child with cortisol. He entered a chronic state of fear never knowing when the unpleasant sensation of oxygen deprivation may occur or how painful it would be when it did. This repeated cycle creates a deep seated, conditioned anxiety which will not be able to be traced to any event which occurs during the child's lifetime or which would be etched in a conscious memory. Yet the child's birth weight will

tend to be lower as he repeatedly interrupted the intake of nutrients in order to avoid the smoke. Additionally, the infants of women who smoke tend to be born slightly prematurely as the child makes an early effort to escape a toxic environment. The child has developed a tendency to be anxious before even being born.

On the positive side research has also shown that the fetus responds to the sound of his mother's voice while in the womb. When the mother was loud and anxious the fetus became agitated. When the mother spoke lovingly and soothingly the fetus responded by relaxing. The response was not to the words, but to the tone of the voice. The sense of hearing and the emotional connections which are made due to sound was demonstrated when the womb was subjected to Vivaldi and the fetus settled and became quiet. When Beethoven was played the child became aroused and kicked vigorously. In follow up studies, those children who were the most active in the womb were notably more anxious and difficult to soothe as toddlers.

The rationale for the fetal response is clear. When people become anxious for any reason the body responds by releasing a chemical which puts the body on a high alert status, watching for danger. The body switches into a survival mode, a high alert status. The pupils dilate, the heart rate increases, the skin becomes clammy, all as a result of the chemical rush preparatory to "flight, fight or freeze." When a woman is pregnant the chemical rush is not just experienced by her. It is also experienced by her infant within. When she becomes agitated for whatever reason and experiences the rush of the neurotransmitter cortisol, the fetus gets the same rush. She then evaluates the danger or gets past the experience and as her system no longer needs the cortisol to keep her in a high state of arousal necessary for survival she calms down. The fetus, however, does not have access to her rationale for calmness and stays in a state of anxious alertness long after she has calmed down. This cortisol rush wires the developing brain to be comfortable at a higher state of anxiety and arousal than others without the experience. The increased level of cortisol becomes part of the "comfort zone" of the developing child. After the child is born parents will often comment that just when everything is peaceful and calm in the home the child with just this type of in uterine experience becomes so uncomfortable that he needs to do something, anything to cause an upset. He will throw something, say something mean, become angry at some perceived slight in order to get a reaction from someone. As soon as the adult or another child in the environment begins to scream or angrily react the child appears to calm down, even can be seen to smile. The child has used others to create a cortisol rush in himself. His brain has then entered its "comfort zone" which, rather than making him feel worse as would be expected, makes him feel better, more comfortable.

A young woman brought her four year old son to me for evaluation and treatment. His behavior was inexplicable to her as he had never been abused or neglected yet he was totally non-compliant and oppositional and defiant. He rejected her and would never let her caress him or feed him. She had had to prop a bottle for him at a very young age as he refused to nurse or take a bottle from her. He avoided all eye contact. During the assessment I took a detailed history of his mother's genetic background and the course of the pregnancy. She revealed that numerous members of her family had mood disorders, ranging from depression to bipolar. Two relatives had committed suicide, another sign of possible mood and thought disorders being genetically present. She had not wanted to be pregnant and her boyfriend wanted her to have an abortion. Her parents wanted her to have an abortion. She would get close to scheduling one and then would back out. Then she would be angry at herself for not getting one and lament the growing life inside of her. She waffled back and forth, wanting an abortion, not wanting one, being angry at being pregnant, being OK with being pregnant until the time passed where she could legally obtain an abortion. At that time she became really angry as she felt trapped and regretted bitterly not having an abortion while she had the chance. The little boy was born and she immediately was flooded with a sense of joy and wonder at the precious child. She was sorry that she had not wanted him and did everything she could to hold him and caress him. He would have none of it. They struggled with their relationship for four years before seeing me.

We began by acknowledging with him his mistrust of her and how hard he worked to keep her distant. I took him in my lap and talked to him about being a baby inside of a mother. I asked him what the baby did when mom walked and he replied that the baby walked too. I asked him what the baby ate when the mom ate a hamburger and he replied that the baby ate a hamburger too. I asked what the baby was feeling when the mom was happy and he said the baby was happy too. Then I did a guided imagery with him taking him back into the womb, how dark and small it was. I covered his eyes with one hand to simulate the darkness and to suggest to him to look inside instead

of outside. We talked about the various things his mom did while she was pregnant with him and what he was doing at the same time. Finally I asked him what he was feeling while he was inside his mommy's tummy and he began to wail like a banshee. He screamed and screamed while writhing on my lap, "I'm scared. I'm dying. Help. Someone help me!" Mom fell apart. She was devastated and began to sob along with him. She had no idea her thoughts of killing her son for nine months had left him with feelings of being so frightened and anxious in her presence that he did not trust her to keep him safe and did not want to be around her.

This is a clear example of in uterine trauma. Lesser experiences can also be problematic for brain development. Any stress, particularly when it is chronic, that the mother experiences during her pregnancy can have an effect. She is abused. She has no job, no place to live, doesn't know where her next meal is coming from. Her mother dies. She has to move out of her home. All have the potential to flood her with cortisol from which the baby cannot escape.

The younger the age at which trauma occurs the deeper the impact it has. To illustrate, an adult who has lived for thirty years in relative safety and calm is in a car accident, hurricane or experiences other trauma. That trauma, that Post Traumatic Stress Disorder experience, is layered on top of a lifetime of brain development and personality development during which the adult has learned that the world is a safe place and people can be trusted. The adult experiences the trauma, the brain compares it to previous overall positive experiences and determines that the one trauma is not going to irrevocably change the course of events for him. The world is still basically a pretty safe place and most people can still be trusted. He might take more precautions and might get a panic attack when placed under similar circumstances to the trauma, but for the most part can function normally afterwards. The event is layered on top of positive events. The key is that he has the capacity to compare the trauma to a life long set of experiences so the one traumatic event does not become the primary determiner of future actions, thoughts and belief systems.

The younger the child, the more impressionable the brain and so the more impact any one single trauma can have on its development. The child does not have a lifetime of positive experiences to see that overall the world is a safe place and overall people can be trusted. The small child, the in uterine fetus, who experiences trauma sees the world first and foremost through the looking glass of that trauma.

That trauma may be innocuous to the outsider, but to the fetus is critical. Typical of birth mothers who relinquish their infant, is an instability of mood. They are upset they are pregnant, they contemplate abortion, they decide against it, they continue to be anxious about their decision to relinquish. The living state of women who are unexpectedly pregnant is often unstable. She typically does not have a wide support system. Her diet may be poor. She may be unemployed. All of these and other anxiety producing experiences during the pregnancy have the potential to negatively affect the child's emotional well being and brain development.

Studies of children exposed to a high level of anxiety in uterine found that they were colicky and difficult to soothe as infants. Their higher level of anxiety made it more difficult for them to settle and be calmed by their parents. As toddlers their anxiety made them more problematic play mates and less cooperative with the parents and caregivers. By kindergarten there was a marked increase in aggression among those children who experienced anxiety fraught pregnancies.

In my experience some of the most emotionally and behaviorally problematic children have histories of in uterine trauma. When coupled with a familial predisposition to a thought disorder, mood disorder or both the far-reaching repercussions can last throughout a person's life and profoundly affect brain and personality development.

The First Two Years of Life

After genetics and the in uterine experience are taken into consideration the next major formulator of brain and personality development is the first two years of life. During the first two years of life the brain continues its wiring process and the paths laid down by genetics and reinforced by the in uterine experience become more entrenched. It is during this period of time that explosive growth occurs. The direction that growth takes is determined in large degree by the mother and child interactions. The temperament of the child affects the way the mother responds to the baby's cries and the temperament and interest of the mother affects the way the baby seeks her out and creates a

bond with her.

In a healthy turn of the attachment/trust cycle the newborn begins to cry, signaling nonverbally that he has a need. Whether the need is for warmth, food, touch, stimulation, or diaper change the child initially cries to alert the mother that he is uncomfortable. Because he is too small he is not capable of sitting up in his crib and asking verbally for the mother's attention. Instead, he cries. The state of anxiety releases cortisol in the infant's system. Mother, if she is at all responsive, attends to his need by entering into his space with those interactions which soothe him, releasing serotonin. Thus the first task of the mother is to teach her child to stabilize his mood. He becomes aroused due to some need and mother soothes him. His brain releases cortisol and her interactions of touch, eye contact, smiles, food, and movement release the calming serotonin. The infant learns that he can cry and let his mother know he needs something and she will respond positively. He therefore begins to trust his mother to meet his needs and realizes that he is a worthwhile being. The next time he has a need he is then able to cry, alert his mother to his needs, she will come and take care of him, he will be soothed and trust that the next time he has a need he can cry. The cycle then turns around and around every time the child gets hungry or cold or senses any other discomfort. Behavior thus becomes biologically wired into the brain. According to Erickson the goal of the newborn is the development of trust. This occurs as the mother predictably attends to his cries drawing attention to his needs.

When the turn of the attachment cycle is not healthy, the infant cries and no one comes, or comes unpredictably. The infant cries and when no one comes the child does not get the soothing actions of eye contact, touch, movement, smiles and food. The sense of trust which comes from knowing that he is valued, the world is a safe, caring place and others will respond to his cries for help does not develop. Instead, he cries, no one comes, he continues to cry and no one comes. He learns the world is not a safe, caring place and that if he has a need he will have to take care of it himself. Instead of learning to turn to others for help the infant learns to look to himself and begins the process of developing self parenting skills. The tragedy is that then when the child is placed in a caring, responsive environment he has already developed the capacity to take care of himself and is no longer willing to turn control of his life and survival over to someone else.

Redirecting the child who has learned to self parent due to institutionalization or abuse and neglect takes very specific measures on the part of the mother. Her attention needs to be around very specific actions. It is not enough for the mother to go to the crying infant's side, look down, and say, "I love you" and walk away. If the mother does not follow through on specific actions the child will not feel loved and will not develop trust that they are worthwhile, the world is a safe place, and they can depend on others to help them. Those actions make the concept of love a series of actions rather than a feeling.

Love

We like to believe love is an emotion which descends upon people in some incomprehensible way. The euphoric mood is due to some mysterious connection associated with the one we love. The truth, however, is not nearly so romantic. There is nothing particularly mystical about how love develops. Love develops due to the release in the brain of pleasure causing endorphins. The mechanism for releasing the endorphins can be put in place by anyone who chooses to put the effort into it. Much like runners know they will reach a "high" if they run far enough and fast enough, lovers know if they tickle their loved one's ear and whisper sweet nothings they can expect some sort of aroused reaction. The emotion we call love, is the result of very specific actions.

The task for parents is to figure out what actions on their part release the endorphins in their child's system, enabling the child to connect pleasure with their parents. They are not hard to discover if parents can remember when they first "fell in love". If that time can't be remembered go to any high school and watch the adolescents in the halls and classrooms. The same elements present in the flirtation and courtship dance need to be injected into the parent-child dance if the two are to "fall in love". Those elements are reciprocal eye contact, touch, sweet food, movement and smiles.

Eyes have been called the window of the soul, as it is through them we make our deepest connections. It would be

very difficult to fall in love with someone who avoids eye contact. When people talk to each other it is extremely helpful if they are looking at each other as then deeper, more meaningful interactions occur. One of the first games universally played with infants around the world is "Peek a boo". The baby looks expectantly in the direction of mother's face and squeals with delight when eye contact occurs. Reciprocal eye contact is therefore a pivotal part of making a connection. The more traumatized the child the more the eye contact must be deliberately, playfully created.

The largest organ of the body is the skin. When people are stroked and massaged they are flooded with feelings of good will. Animals are tamed by petting them. Tamed animals are better equipped to respond to their master's voice, stay where they are put and come when they are called. Touched animals develop larger brains and are physically larger and more agile. Children who are touched and caressed in non-sexual ways are soothed and comforted by the presence of their parents. They become responsive to their parent's directives and wishes. In essence, they become "tame".

Food is another pivotal component of arousing the feeling called "love". Not just any food, however, will do. Lovers do not send each other carrots on Valentine's Day. The food of choice is chocolate, though any sugar will serve the purpose of arousing in a child a feeling of good will, which then transfers to the parent giving them the treat. Breast milk and baby formulas have a specific sugar content for a reason.

The inner ears contain tiny hairs which, when stimulated appropriately, can cause a pleasurable shiver to run up and down the spine. Infants are affected by rocking, adolescents by amusement parks. Adults jump out of planes and participate in extreme sports, anything to arouse that shiver of excitement, which keeps them coming back again and again to re-arouse the senses. Rocking infants serves the same purpose.

The last interaction which causes endorphins to flood the system is smiling. The very act of lifting the corners of the mouth lifts the spirit. Smiles engage strangers and make them friendly. Teachers smile at the class when giving an instruction. When members of the class smiles back then the teacher knows a non verbal contract has been reached. Smiling into a child's face lights the child up from the inside out.

The process of getting a child to attach to any parent, especially new parents is, therefore, enhanced by incorporating eye contact, touch, sugar and movement in such a way that the child's awareness is heightened and the pleasurable feelings which result are connected to the parent. Any activity between the parent and child which is on the parent's terms and involves these elements in a fun way will be bonding. Swinging a child, playing horsey, playing tag, water games, wrestling, dressing a child silly all are ways to help the child feel pleasure in the parent's presence. Activities are limited only by the parent's imagination. Theraplay interactions, developed by Jernberg, have been proven to create a loving relationship between parent and child as they are based on deliberate activities to engage the child and parent in joyful interactions.

If a child avoids eye contact, it can be overcome by playing peek-a-boo with M&Ms. Every time the child makes eye contact a piece of candy is popped into the mouth so the sweetness is associated with the parents and the resistance to making eye contact is overcome in a fun way. Key is having the sweets pass directly from the parent's hand to the child's mouth. If the child feeds himself/herself the impact is minimized.

When a child is resistant to being touched, the parent needs to touch lightly and frequently until the resistance is decreased. Brushing a child's hair, quick hugs, light tickles, neck and back rubs, foot massage, rubbing lotion into the child's hands, helping the child dress, tying the child's shoes, This Little Pig, listen to the heartbeat, patty cake, patty cake with feet, wheelbarrow, thumb wrestling, fingernail polish, counting body parts, rubbing noses, face painting, feeling muscles, etc, all are quick, fun ways to get close to a child without activating resistance. Many children arrive in the adoptive home scared and angry. Diffusing those feelings is important if attachment is

to occur. Telling children in words they are safe and loved does not penetrate the armor of defenses with children who have heard it all before. It is not telling a child he or she is loved which will have the most impact. It is acting it out in joyous, yet intrusive ways, which will help parents get through the wall surrounding injured hearts.

The estimated time line for deep seated personality change which enables a child to move from being angry, scared, defensive, and untrusting to a child who is able to be cooperative and caring is one month for every year of life if the trauma is less severe (the brain damage is less pervasive) and two months for every year of life if the trauma is severe (the brain damage is more pervasive). Forcing a child into superficial compliance is not the goal. That can be achieved readily if the consequences imposed are high enough. The goal, rather, is to change the way the child's brain operates. What is needed is healing the pathways of the brain scarred by fear and anger and helping the child find other, healthier ways of making decisions and interacting with the world. The goal is the child's happiness, not ego gratification of the adults. In order to do that the child must become less guarded, more trusting. The child must believe the world is a safe place, people do care about him and he is a worthwhile individual. Recognizing that distorted behavior is the result of distorted brain development is key. Understanding what behaviors and thought processes are the result of brain damage is the first step.