

CLINICAL EDITOR: The author encourages readers to be thoughtful about our therapeutic relationships with children who see and react to the world as a dangerous and aggressive place.

A Therapeutic Response to Youth Hate Crime Offenders and their Broken Attachments

By Tamberly Mott LMFT



According to the newspaper headlines and nightly television news, there is a great deal of “youthful” hate being threatened and played out on playgrounds and streets, and it can often be deadly! Nevertheless, not all violent behavior is acted out with guns and physical violence; notice how the internet has also become a risky place for youth. Research literature indicates bullying, name-calling, and other negative or bias motivated communication is prevalent among juveniles, and may strongly impact the way youth relate to peers, as well as the rest of society (Norman & Galvin, 2006). According to the Surgeon General’s report on Youth Violence (US Dept of Health & Human Services, 2001), this is not merely a problem of the large cities, or the isolated rural regions, or any single segment of our society, it is a national problem. As mental health professionals providing services for youth and their families, we must ask ourselves where does this problem begin; what causes youth to become victimizers; and more importantly, how should we respond to this problem?

Just Teasing?

Contrary to the popular playground rhyme, verbal-violence is harmful (Norman & Galvin, 2006) and names do hurt. Name-calling and bullying represent a special class of violence that includes acts of hostility towards an individual or group, primarily utilizing language. Whether there are acts of teasing about clothing or appearance, mocking peers with disrespectful labels, or more severe threats to inflict bodily harm, we see that children’s antagonistic behavior is generally expressed in verbal form (Dennis, 1999). Other researchers report that younger children experience name calling more often than older children and middle school students experience name calling behavior at a rate of twice that of high school students (Whitney and Smith, 1993). Dennis (1999) additionally noted that among racial minority children, when compared to racial majority children, minority children report higher rates of name calling related to their race. Name calling is in effect bullying. Furthermore, it has been found that children who experience name calling are more likely to have more negative beliefs about their peers, creating an aggressive cycle (1999). Clearly, the need for therapeutic psychosocial development among today’s youth is a growing one.

Bullying and Hate Crime

Violent communication, associated with hate or bias motivated crimes, have garnered national media attention, and bullying has been correlated to these acts, but research has only begun to study the dynamics that motivate hate-aggression, especially as it relates to children. When a child is exposed, repeatedly and over time, to negative actions on the part of one or more other children, he or she is a victim of bullying (Olweus, 1993). The organization Partners Against Hate (2001) report that 160,000 children miss school every day for fear of being bullied. Bullying is a problem in both America’s schools, as well as in other countries; Ireland estimates up to 49.8% of school age children experience bullying (Dake, Price & Telljohann, 2003). As a professional who has provided school-based therapeutic services, I have worked with hundreds of kids who have been victimized by bullies. Batsche and Knoff (1994) tell us that as many as 20% of all children are bullied during their school years, although my experience tells me those numbers may be far below the actual number of victims, especially in the middle schools. A relationship also exists between bullying behavior and issues such as academic achievement, absenteeism, and ADHD (Dake, et al, 2003), leaving us to imagine how much bullying impacts a child’s health and development.

Furthermore, there is a correlation between bullying and hate-crime. Hate crimes are about the conveyance of messages (Steinberg, Brooks & Remtulla, 2003). Anderson, Dyson and Brooks (2002) inform us that hate or bias crimes have been defined as actions where the defendant’s conduct was motivated by hatred, bias, or prejudice directed toward an individual or group, solely because of perceived race, religion, national origin, ethnicity, gender, or sexual orientation. Sadly, among hate crime offenders, young people appear to be disproportionately represented (Steinberg, et al, 2003). Steinberg, et al, further argue that schools appear to provide fertile ground for violent bigotry (2003). Additionally, McDevitt, Levin and Bennett (2002) suggest that juveniles commit approximately 70% of all hate crimes. While it seems clear that the youth who bully or who perpetuate hate crimes are acting out on prejudicial beliefs and emotions concerning other youth who are perceived as different, it is less clear how they have become victimizers and why the numbers are so staggering.

“160,000 children miss school every day for fear of being bullied.” (Partners Against Hate, 2001)



The Complexity of Hate & Attachment

It is acutely evident that we cannot ignore this problem. Moreover, we must respond effectively and with the most felicitous of interventions; and who is better equipped than a play therapist? Chronic violence (verbal or otherwise) does not just occur without context; it develops in childhood and typically progresses through adulthood. Because no one theory can fully describe the dynamics related to malicious anti-social behavior, it is essential that professionals maintain an eclectic knowledge base on the issues and best practices. The variables to consider include psychological, economics, social environment, biological, and developmental risk factors; these and perhaps others, not yet understood, are intertwined in a complex relationship that can generate violent behavior. Steinberg, et al, (2003) reviewing Beck's cognitive theory, suggests that thinking guides behavior and violent-prone individuals have a basic flaw in perceiving social interactions, resulting in the development of clusters of antisocial concepts and beliefs. Perhaps there is more to the story.

Thompson (2002) discusses the clinical perceptions of attachment disorder as theorized by John Bowlby, suggesting that attachment levels may be a viable means of determining appropriate types of rehabilitative interventions for juvenile offenders. The attachment experience, which includes affective, biological, and cognitive determinants, creates an internal working model that serves as the basis for all other relationships (2002). It is easy to imagine that the attachment process for many children has been impaired; meaning, the primary bonding to a mother or to the primary caregiver—a mother substitute, has been interrupted or worse, has influenced the development of antisocial behaviors in the child. My own counseling work with children and families, as well as my

experience as a therapeutic foster parent, has provided me with rich, albeit anecdotal evidence to see that this can be true. I have witnessed many children passing through the various phases of reactions to unstable attachments, including sadness, anger, and despair. Ultimately, the failure to develop a sufficient internal experience of attachment serves to encourage and maintain antisocial behavior (2002).

In a study looking at the correlations among individual violence, psychiatric disorders, attachment disorders, childhood trauma and a history of family violence, Seifert (2003) found 83% of the violent youth had attachment disorder and 92% of that group had other psychiatric problems. In another relevant study of 6-9th grade students characterized as bullies, as many as 60% had at least one criminal conviction by age 24 (Olweus, 1993). Attachment disorder has been recognized in research as the basis for various conduct and personality disorders including antisocial personality disorder, narcissistic personality disorder, and borderline personality disorder (Lyons-Ruth, 1996, Finzi, et al, 2000, & Zeanah, et al, 2004).

Appropriate interventions and/or treatment for children who have difficulty in forming respectful, loving, lasting relationships, will change the future of the child and his/her caregivers, in addition to protecting the child-filled playgrounds and schools where much of the violence takes place. With our help, caregivers can learn techniques for coping with their child and repairing the attachment with the help of professional treatment. Play therapy can be helpful for children who have skewed perceptions of the world, particularly Thematic Play Therapy (Kaduson, et al, 1997). Additionally, Olweus (1993) offers interventions with components for the individual and the school environment. Early treatment and a healthy dose of patience and nurturance can repair attachment. A youth caught in the web of bullying and behaviors characteristic of attachment



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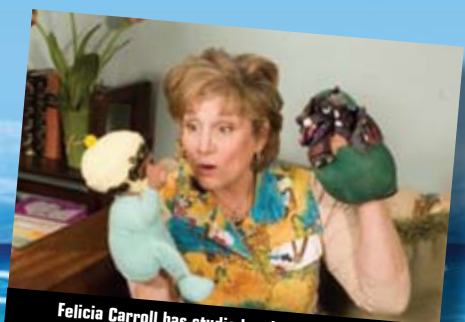
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disorder will need a long-term relationship(s) with supportive, pro-social person(s) who will expect good boundaries and will not accept criminal behavior (Seifert, 2003). Finally, in our role as mental health professionals, play therapists in particular, we can work to change the tide of prejudiced violent youth by giving these children and their caregivers rewarding interactions that can modify and restore healthy internal models, and can create more respect and caring for everyone.

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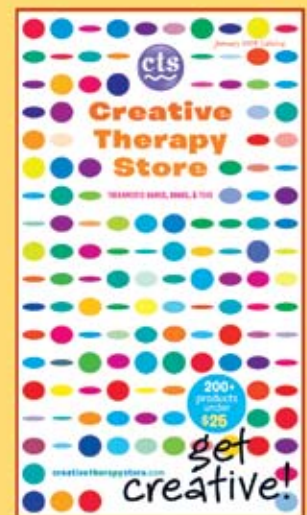
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