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FREQUENCY OF RAD DIAGNOSIS AND ATTACHMENT DISORDER IN
COMMUNITY MENTAL HEALTH AGENCY CLIENTS

By

Paula S. Morgan
B. S., Eastern Kentucky University, 1982
M.Ed., University of Maryland, 1992

A Dissertation
Submitted to the Faculty of the
Graduate School of the University of Louisville
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for the Degree of

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Department of Counseling Psychology
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A Dissertation Approved on

October 27, 2003

By the following Dissertation Committee:

-
- Dissertation Director
-
-
-
-
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ABSTRACT

FREQUENCY OF REACTIVE ATTACHMENT DISORDER DIAGNOSIS AND ATTACHMENT DISORDER IN COMMUNITY MENTAL HEALTH AGENCY CLIENTS

Paula S. Morgan

May 8, 2004

Attachment Disorder (AD) in children has been characterized by particularly alarming behaviors, yet the identification of this disorder for clinicians in community mental health agencies is problematic. The only available diagnosis that addresses attachment problems is the DSM-IV diagnosis of Reactive Attachment Disorder (RAD), a diagnosis that does not include the more severely disturbed behaviors that have been associated with attachment-disordered children.

This dissertation examined the frequency with which CMHA child clients were diagnosed with RAD, as well as the actual occurrence of attachment problems and Attachment Disorder as measured by the Randolph Attachment Disorder Questionnaire (RADQ). The Personality Inventory for Children, Second Edition (PIC-2) was used as another measure to explore behavior problems in this population. Results of this study indicated that less than one percent of 662 CMHA child clients had received a diagnosis of RAD. However, a total of 41% of participants in the study had attachment problems (23% with AD) as measured by the RADQ. Additional study results indicated that there

was no significant difference in RADQ scores between children currently living with their birth parents and those living in other arrangements. However, as the number of caregivers for children increased, so did RADQ scores, indicating there was an increase in attachment-disordered behavior problems. Significant correlations were found between the RADQ scores and the PIC-2 scales of Delinquency, Cognitive Impairment, Impulsivity/Distractibility, Reality Distortion, Psychological Discomfort, and Social Skills Deficits. No relationship was found between RADQ scores and the PIC-2 scale scores of Family Dysfunction, Somatic Concerns, and Social Withdrawal.

Interviews of CMHA clinicians revealed confusion and concern regarding the DSM-IV diagnosis of Reactive Attachment Disorder and what specialists in the field refer to as Attachment Disorder. Most of the clinicians reported having had very little exposure to this diagnosis in their graduate schools' programs, and seldom assigned a diagnosis of RAD due to confusion over the criteria and concern over treatment issues.

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CHAPTER I

INTRODUCTION

From the first moments of life, a bond is established between a child and caregiver that profoundly influences every component of that child's life - mind, body, emotions, behaviors, relationships, and value system. This connection, or attachment, is deeply rooted in evolution, as babies instinctively reach for the safety of their caregivers and parents instinctively nurture and protect their children. Humans have a biological tendency to form attachments because they help guarantee survival. John Bowlby (1958, 1979, 1988) considered to be the founder of attachment theory, concludes there is an innate need for social interaction, which over times becomes focused on one primary caregiver.

Babies' attachment needs are best satisfied by being in close proximity and having physical contact with their primary caregivers. They signal their need for contact by crying, smiling, and reaching for their caregiver, and the way in which significant others respond to these signals determines the strength and quality of the attachment. During the first few months of life, infants' attachment behaviors appear to be indiscriminant but by four or five months old, these behaviors are directed towards the caregiver. A healthy attachment develops when the caregiver is attuned to the needs of the child and responds consistently and appropriately the majority of the time.

Attachment is the basis for a reciprocal, life long relationship and is the template from which humans learn the following critical functions:

- Basic trust and reciprocity
- Ability to explore the environment with feelings of security
- Ability to self-regulate and manage emotions
- Development of a sense of competency and self-worth
- Establishment of a prosocial, empathic, moral framework
- Establishment of a core belief system
- Defense against stress and trauma; resourcefulness and resiliency (Levy & Orlans, 1995, 1998).

Children who start their lives with a secure attachment to their primary caregiver function better in all aspects of development. They have positive relationships with their parents, show more trust in others, are more autonomous and independent, and have respect for authority. Securely-attached children have higher self-esteem, better impulse control, and display more empathy and compassion for others. They tend to be good-natured, curious, optimistic, and accepting of people. A secure attachment is a protective factor against devastating harm and stressful life events. Unfortunately for some children, secure attachments are not always formed.

There are several factors that can prevent or disrupt a healthy attachment with the primary caregiver. One factor is a separation of any kind, such as separations due to parental hospitalization or death, serious illness and hospitalization of the child, or parental incarceration. However, disruptions in attachment have also been found to be the result of neglect or abuse by the primary caregiver. The development of insecure

attachments and the resulting behaviors in abused or neglected children places these children at even greater risk for further attachment disruptions with other caregivers. Multiple home placements often occur because the behaviors these children develop as survival mechanisms are more severe and difficult to deal with than that which most foster caregivers are prepared. Thus, these insecurely-attached children tend to be moved from one foster home to another, developing few, if any, long term, healthy relationships.

Behaviors Associated with Attachment-Disordered Children

When mothers (or primary caretakers) cannot or do not respond to the needs of their children, their children do not develop faith that the world is a safe place. These children then begin to develop an internal working model that the world is dangerous, people cannot be trusted, and they must do whatever they can to “survive.” Disrupted attachment during the 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; Levy, 2000). As with most psychological realities, attachment problems run on a continuum and differ in quality. Generally, problems with attachment are characterized by difficulty in forming a normal relationship with others, creating a significant impairment in social and emotional development. This impairment may be manifested by highly ambivalent and contradictory responses to social interactions such as indiscriminant sociability with others or excessive hypervigilance.

Many clinicians are concerned however, that in addition to impairments in social relatedness, Attachment Disorder (AD) has been characterized by more severe behaviors and pervasive characterological problems described below:

Attachment-disordered children are often self destructive, may self-mutilate, make suicidal gestures, and have other self-defeating behaviors. They destroy the property of others, their own material possessions, or both. They are often impulsive and physically aggressive with other children and adults. Aggression can be overt, such as acts of physical violence, or passive-aggressive, such as manipulative and surreptitious behaviors. Sadistic cruelty to animals, often secretive, is common. Stealing is typical, including theft outside and inside the home. Lying is of a pathological nature; they remain deceitful regardless of concrete evidence to the contrary.

A preoccupation with fire, gore, and blood sometimes occurs, and they tend to establish an affiliation with evil and the dark side of life. They can be ingenious, devious and “phony,” giving the appearance of sincerity but with ulterior and self-serving motives. For example, helping professionals often assume the child’s seemingly cooperative responses are sincere, when in reality, behavior is manipulative and controlling. Problems regarding food and eating patterns are common, such as hoarding and gorging, and usually reflect control and power struggles.

Children who have been sexually abused may manifest inappropriate sexual behavior, attitudes and concerns, such as victimizing others, excessive masturbation, and sexual seduction. Sleep disturbances include recurrent nightmares, night terrors and disturbed sleep patterns, including wandering at night. Enuresis and encopresis are typical manifestations of anger, aggression and

control issues; these children may soil in closets, clothes, and heating vents.

Extreme defiant and oppositional behaviors include refusal to comply with authority, demanding and intrusive social styles, persistent nonsense questions and incessant chatter (McKelvey, 1995, p. 42).

Children with Attachment Disorder lack both remorse for their own behaviors and compassion towards others (Lynam, 1996); they can also be sadistically cruel towards animals and humans (Levy & Orlans, 1998; Lynam, 1996; Rosenstein & Horowitz, 1996). These sociopathic behaviors may continue into adulthood if left untreated (Hughes, personal communication, July 25, 2001; Levy, 2000; Reber, 1996; Shore, 1994) where they are at risk to develop antisocial, narcissistic, avoidant or borderline personality disorders as adults (Hughes, D., personal communication, July 25, 2001; Shore, 1994). Attachment-disordered children may grow into attachment-disordered adults who are unable to form meaningful emotional relationships with their own children, thus perpetuating the disorder.

Diagnostic Difficulties with Reactive Attachment Disorder

Over fifty years ago, John Bowlby and Mary Salter Ainsworth began the groundbreaking work on attachment theory, styles and classifications. Ainsworth, Blehar, and Wall (1978) studied infants in their first year of life and emphasized the importance of infants' behaviors when they were exposed to separations from their mothers, as well as the mothers' attachment behaviors towards their infants. They identified three primary attachment styles: secure, anxious-avoidant, and anxious-ambivalent. A fourth attachment style was later identified by Main and Solomon (1990) and referred to as disorganized-disoriented attachment. In 1979, Foster Cline first coined

the term “Attachment Disorder” and noted that severely disturbed and aggressive behaviors were associated with certain insecure attachment styles (Cline, 1979).

It wasn't until 1980 however, that the diagnosis of Reactive Attachment Disorder (RAD) first entered the third edition of the Diagnostic and Statistical Manual (DSM-III), the primary tool used to diagnose mental disorders. At that time the criteria for a disorder in attachment focused primarily on disturbed infant behaviors. In 1987, the DSM III-R moved the age of the RAD diagnosis to include children up to age five, again with the primary symptom being a disturbance in social interactions. The current Diagnostic and Statistical Manual, Fourth Edition, Revised (DSM-IV-R) refers to the disorder as Reactive Attachment Disorder of Early Infancy and Childhood.

The criteria for a diagnosis of RAD focuses on “markedly disturbed and developmentally inappropriate social relatedness in most contexts,” and “diffuse attachments as manifested by indiscriminant sociability with marked inability to exhibit appropriate selective attachments” (APA, DSM-IV, 1994, p. 116). In order to receive this diagnosis, the child must also have experienced pathogenic care in the form of either persistent disregard of the child's basic emotional needs and/or physical needs or repeated changes of primary caregiver that prevent formation of stable attachments (e.g. frequent changes in foster care). This pathogenic care is assumed to be the main contributor to the disturbance in social relations.

None of the disturbed behaviors that therapists in the field were seeing with these children were made a part of the DSM-IV criteria for this diagnosis. “The DSM-IV as it is currently written is a disservice to these [attachment-disordered] children, the parents who raise them, and the professionals who treat them. The limited criteria and selection

for diagnosis actively inhibits professionals from accurately assessing, diagnosing, and effectively treating these children” (McKelvey, 1995, p. 69). Therein lies the problem that this study addressed. Children with severe behaviors, such as fire setting or cruelty to animals, have been commonly diagnosed as oppositional/defiant or conduct-disordered, and the possible underlying attachment problems have not been recognized and treated. Without identification of the etiology of the behavior problems, the problems may persist and worsen over time.

According to Anderson (1990), the behavioral symptomatology of the attachment-disordered child usually falls into the following diagnostic classifications:

- Conduct Disorder, unsocialized, aggressive
- Oppositional Defiant Disorder
- Schizoid Disorder
- Narcissistic Personality Disorder
- Histrionic Personality Disorder
- Borderline Personality Disorder (mostly girls)
- Attention Deficit Disorder (Anderson, 1990, p. 88).

Furthermore, Reactive Attachment Disorder (RAD) is the formal diagnosis found in the DSM-IV, while “Attachment Disorder” (AD) is a disorder not listed in the DSM-IV. AD is a term used by specialists in the field that includes the symptoms of RAD, but also encompasses the more severe behaviors that have been associated with attachment problems. Attachment specialists believe RAD and AD to be two different disorders. Randolph (2000) considers that children with AD must meet the diagnostic criteria for both Reactive Attachment Disorder *and* either Conduct Disorder (CD) or Oppositional-

Defiant Disorder (ODD). However, AD has not yet been formally recognized in the DSM-IV, as there remains a lag in the validation of diagnostic criteria for clinical disorders in infancy and childhood, particularly those involving primary relationships from a developmental perspective (Carmen & Huffman, 1996; Lyons-Ruth, 1996).

Neglect as a Criteria for Reactive Attachment Disorder

Alternately, an attachment problem may be missed completely for children still living with their biological parents. The issue of neglect as a risk factor for development of attachment problems needs to be examined more closely. Neglect of the child's emotional and psychological needs may result from mental illness in the primary caregiver, dysfunctional family dynamics, past traumatic events, or unresolved grief of either caregiver or child (Bowlby, 1979). In some cases, neglect may be difficult to recognize and as a result, attachment issues may be overlooked. Dysfunctional family dynamics, for instance, are not easily measurable or observable, and as a consequence, might evade the attention of social service agencies that typically intervene in reports of physical or sexual abuse of a child. In cases in which any of these factors have played a role, professionals, parents, and the community in general may be unaware that a crucial factor in their child's problems is an attachment issue, particularly if the child has never been removed from the home (Randolph, 2000).

Therapists who are unaware that the severe behaviors described previously have been associated with attachment problems may be underdiagnosing Reactive Attachment Disorder in their clients and assigning diagnoses which do not address fundamental attachment issues. "It has been our experience that many of the older children we see in the child welfare system who have been given diagnoses such as Attention Deficit

Hyperactivity Disorder, Conduct Disorder, and Oppositional Defiant Disorder often have undiagnosed attachment issues as the foundation of these behaviors” (Levy, 2000, p. 151). Without a case conceptualization incorporating an accurate diagnosis of Attachment Disorder, the attachment problem may go untreated, and over time the behaviors may remain or likely worsen.

Diagnostic Difficulties in Community Mental Health Agencies (CMHA)

It is unclear what the prevalence rate of attachment problems is in either a clinical or non-clinical population. The DSM-IV notes, “epidemiological data are limited, but Reactive Attachment Disorder appears to be very uncommon” (APA, DSM-IV, 1994, p. 117). The presence of attachment problems may in fact be uncommon, or it may simply be unrecognized. Clinicians in Community Mental Health Agencies often have difficulty recognizing and accurately diagnosing attachment problems in their clients for a variety of reasons.

First, therapists who work in CMHA outpatient settings vary in terms of their clinical background and expertise in recognizing and treating the specialized needs of attachment-disordered children. CMHAs sometimes hire graduates of programs that focus primarily on research, community intervention or social policies rather than direct clinical practice. Other programs such as expressive therapy, marriage and family therapy may lack comprehensive education regarding the nature and symptomology of various diagnoses, particularly those for children. Some programs may discuss children’s behavior and mood problems in the context of a child development class, but usually will not go beyond using part of a class period to discuss attachment theory and related

diagnoses. Furthermore, child development classes are often offered as electives rather than as a mandated part of a graduate program.

In addition to graduate programs inadequately addressing the diagnosis and treatment of attachment problems, instruments designed to assess the attachment relationship and associated behaviors are usually not a part of the initial evaluation of CMHA clients. Few such instruments are currently available, and those that can be obtained are rarely used in outpatient settings. Some of the instruments that measure attachment behavior have been developed for research purposes and are used in laboratory settings. Other attachment measures have been in use in attachment treatment centers where the relationship problem has already been acknowledged and is being addressed.

Many disorders are not easily recognized because their prevalence rate is low. However, the difficulty CMHA clinicians have with diagnosing RAD may have nothing to do with the rarity of this disorder but rather with the identification of it. The primary tool many CMHAs use to diagnose a child with an attachment problem is the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV). CMHA clinicians generally give clients a diagnosis from the DSM-IV on the day of the initial intake session and will re-examine the diagnoses annually or as new information is obtained about the client. However, as discussed previously, the RAD diagnosis from the DSM-IV is problematic because it is often difficult for caregivers to recognize and report (and for clinicians to assess) “markedly disturbed and developmentally inappropriate social relatedness” in the intake session. Caregivers generally do not bring their child into treatment with a problem of “he’s hypervigilant,” or “she’s too friendly with strangers.” What they do

bring their child in for, though, are the severe behaviors that have been associated with attachment problems, behaviors that are not addressed in the DSM-IV's description of Reactive Attachment Disorder. Finally, the CMHAs that employ these therapists may be unaware of the need for specialized treatment for attachment-disordered children. Since neither Reactive Attachment Disorder nor Attachment Disorder appear to be well recognized, it is not a focus for specialized treatment or training unless clinicians seek it out themselves.

Given that the DSM-IV is the primary tool for diagnosing Reactive Attachment Disorder in community mental health agencies, it is likely that only children with obvious attachment disruptions will be identified. Children with a history of physical or sexual abuse may be more likely to receive the RAD diagnosis, as criteria C "pathogenic care" may be used as the primary "red flag." Out-of-home placements can be another diagnostic red flag for clinicians, indicating that the neglect or abuse was severe enough that the child had to be removed from the birth parents. However, use of these two indicators alone could lead to overdiagnosing RAD. Some of these children may in fact not have problems in their attachment relationship, but may actually have a mood disorder or other neurological functioning disorders. The focus of treatment might then be misdirected to attachment, missing the more influential disorder. Alternately, needing to have substantiated abuse or neglect as a criterion for a diagnosis of RAD could also deter clinicians from identifying attachment problems in their clients.

Assessment Tools for Attachment Problems in CMHAs

Assessing attachment problems has historically focused on the infant-caregiver relationship, primarily through the Strange Situation paradigm. The Strange Situation

was designed to induce stress for the infant after a brief separation from the primary caregiver, and then measure the infant's sense of security upon the return of the caregiver. Measuring attachment relationships by similar laboratory designs for older, school aged children does not appear to be a viable or practical gauge. Consequently, the primary focus for measuring attachment problems has been on examining current behaviors of the child; behaviors that may (or may not) be a reflection of the attachment relationship between the child and caregiver.

Typically, specialists in Attachment Disorder already have on hand a great deal of information to assess and treat the child, as the child has usually seen several treatment providers before being referred to an attachment specialist. This information generally includes a thorough assessment of the child's social and behavioral history, a psychological and psychiatric evaluation, medical and psychotropic drug history, a family assessment (which includes a psychological evaluation of the caregivers), and a review of prior treatment. In addition to these sources of information, specialists have utilized a variety of instruments to diagnose and treat Attachment Disorder in older children. Several of the instruments in use today are the Attachment Disorder Symptom Checklist (ADSC), (Attachment Center at Evergreen, 1995), the Cline/Helding Adopted & Foster Child Assessment (CHAFCA) (Cline & Helding, 1998), and the Randolph Attachment Disorder Questionnaire (RADQ) (Randolph, 2000). These instruments will be discussed in Chapter II.

Improving Assessment at Community Mental Health Agencies

Community Mental Health Agencies provide outpatient treatment and are often the first to see children brought for mental health services, long before they are referred

for more intensive services. Generally, a client may be seen for months or even years in an outpatient setting before the family must consider the need for treatment in a psychiatric hospital. If the child still has difficulties and cannot be maintained any longer in the home, the family or state agency will consider placement in a residential treatment facility. As a result of this sequential, gatekeeper approach, it is likely that CMHAs may be the earliest agencies to come in contact with a child with an attachment problem. Nevertheless, attachment disorders may go undetected in community mental health agencies because not all CMHA biopsychosocial assessment forms include the developmental history of the child or one that assesses for the presence of specific childhood disorders. A typical CMHA biopsychosocial assessment form examines many areas, but because of limited time and space, generally none in depth. Upon intake, clinicians are required to review homicidal or suicidal thoughts, feelings, or behaviors. They must also ascertain whether the following areas are within normal limits: mood, behavior, and neurological, cognitive, and somatic functioning. Components of the biopsychosocial assessment that may be more fully addressed include family, spiritual, financial, educational/occupational, legal, and housing. However, it is up to the individual therapist to ask for further information that she or he thinks is important enough to clarify about any particular area, forming the basis for a diagnostic impression.

Some of the currently used CMHA biopsychosocial assessment forms may not ask in depth about the early development of the child, the number of caregivers, or the relationship history of the child's birth parents (or even the foster/adoptive parents). This information could help identify certain risk factors that have been found to be associated with Attachment Disorder. Some CMHA forms do not ask if the parent had spent time as

a child in foster care or in other out-of-home placements, indicating the possibility that the adult caregiver may have attachment problems as well. Although knowledge about these factors might be acquired over the course of treatment, they are not routinely assessed at the intake session as possible risk factors for attachment problems.

Consequently, many children might be suffering from an attachment problem that has gone unrecognized because such factors were not associated with their severe behavior problems. Even when therapists inquire about these risk factors, this information is often unavailable, such as when a state agency has custody of a child who arrived with little or no information about the birth parents or the child's early years. The state also may not have given such information to the foster/adoptive parents who brought the child in for treatment. Given the complexity of the criteria for RAD and the wide variety of symptomology of Attachment Disorder, it is understandable if few children actually receive a diagnosis addressing their attachment problems.

Summary

In order to fully address the assessment problems facing clinicians with attachment-disordered clients, discussion must begin with examining the diagnostic criteria of Reactive Attachment Disorder in the DSM-IV, a discussion that is beyond the scope of this study. However, a preliminary approach to this problem that this study addressed is the issue of poor identification of attachment problems in Community Mental Health Agencies. As discussed previously, the diagnostic criteria of RAD is felt to be confusing because social inappropriateness is difficult to recognize, and the diagnosis of RAD requires the presence of pathogenic care, a criteria that is sometimes difficult to document without court or child protective services involvement. Finally, the

criteria for RAD lacks the severe behavioral symptomology associated with attachment-disordered clients.

This study begins with a discussion on the theory and development of attachment, effects and types of insecure attachments, and available attachment instruments. The study itself took place in a community mental health agency in a large, urban city in central United States. Caregivers of child clients who had been brought to this CMHA were asked to participate in the study by completing two behavioral assessment instruments, the Randolph Attachment Disorder Questionnaire (RADQ) (Randolph, 2000) and the Personality Inventory for Children, Second Edition (PIC-2) (Lachar & Gruber, 2001). Caregivers were also asked to complete a demographic sheet about their child.

The first research question for this study addressed the number of CMHA clients who had actually received a diagnosis of Reactive Attachment Disorder by their assigned therapists. The researcher then used the Randolph Attachment Disorder Questionnaire to examine the actual frequency of CMHA clients who presented with attachment problems and Attachment Disorder as measured by the RADQ. Other variables that were examined were the child's current living arrangement in relation to RADQ scores, the number of different caregivers with whom the child had lived in relation to RADQ scores, and the relationship between RADQ scores and PIC-2 scale scores. A final part of this study involved interviews with CMHA clinicians from three different outpatient offices to assess their perceptions and concerns about the RAD diagnosis. CMHA clinicians were also asked to talk about behaviors associated with attachment problems, where they learned their information, and how they conceptualized treatment for their

clients with attachment problems.

Children with severely disturbed behaviors are usually diagnosed as oppositional/defiant, conduct-disordered, or bipolar, and the possibility of attachment-related etiology may go undetected. Without treatment, the problems may persist and worsen over time. CMHAs may be the earliest agencies to come in contact with a child with an attachment problem and therefore, the need for educating CMHA clinicians about this diagnosis is essential. Results of this study have the potential to heighten awareness of the possibility of underlying attachment problems in child clients so that CMHAs may provide appropriate mental health services for these children and their families.

CHAPTER II

REVIEW OF THE LITERATURE

Theory and Development of Attachment

Attachment theory hypothesizes that an individual's capacity to form meaningful, personal relationships has its roots in early parent-child bonding. A mother's bond with her child often starts the moment she discovers she is expecting a child. Immediately after birth, most mothers experience intense feelings of love for their babies, and a desire to care for and protect them. Infants respond to the bonding behaviors of their mother or caregiver by seeking eye contact, smiling, crying for and reaching towards their caregivers. By eight months of age they actively seek them out, and show distinct preference for that person above all others. The attachment bond however, reflects only one component of the mother/child relationship, the aspect that deals with behaviors related to the child's protection and security in times of stress. The purpose of the infant's attachment behaviors is to regain a sense of protection by being in close physical contact with the primary caregiver. Once infants feel this sense of safety, they begin to use their caregiver as a basis to explore their world. Mahler, Pine, and Bergman (1975) described this as "emotional refueling," where the toddler discovers the new person or object, and then returns to his/her mother or caregiver for security and confidence while

exploring the new situation. Most children learn through this “safe base” that they are important and that their world is a safe place to be.

Like all enduring relationships, the relationship between mother and child develops gradually and strengthens over time. Infants and their principal caretakers typically develop a close bond during the first year of life, such that by the second year of life, children become upset when they are separated from their primary caregivers. However, the clinical importance of these bonds was not fully appreciated until John Bowlby introduced the concept of *attachment* in a report on the effects of maternal deprivation (Bowlby, 1951). Bowlby’s work over the past several decades is considered by many to be the foundation of our understanding of the nature and importance of attachment in the lives of human beings. Bowlby (1969) concluded that the pattern of an infant’s early attachment to his or her parents forms the basis for all later social relationships.

Types of Insecure Attachments

Early studies on interactions between the caregiver and child by Bowlby (1940; 1958; 1969; 1979) and Ainsworth (1962) demonstrate that if the parent/child bond is damaged in some way, the child’s capacity to form healthy relationships later on in life may be impaired. Stams, Juffer, and van IJzendoorn (2002) also found that early mother-infant interactions predicted later socioemotional and cognitive development. In the first several decades of attachment research, several types of attachment patterns were discovered to be related to differences in maternal caregiving behavior. Secure, avoidant, and ambivalent attachment patterns of infant behavior were initially identified. Later, a fourth type, disorganized-attachment, was recognized (Main & Solomon, 1990). A meta-

analysis of attachment studies by van IJzendoorn (1995) indicated that in the general population, 55% showed secure attachments, 23% exhibited avoidant-attachments, 8% exhibited ambivalent-attachments, and 15% showed the presence of a disorganized-attachment. Infants identified as secure had mothers who were emotionally sensitive, accessible, and responsive. Secure children were rated as having positive relationships with their parents and peers, showed more trust in others, were more autonomous and independent, and had higher self-esteem (Bretherton, 1985; Levy & Orlans, 1995; 1998).

Avoidant-Attachment Organization

Children with an avoidant-attachment organization have consistently experienced rejection and insensitivity from adults (Ainsworth, Blehar, Waters, & Wall, 1978). “An insensitive mother will often not notice her baby’s signals, will misinterpret them when she does notice them, and will then respond tardily, inappropriately, or not at all” (Bowlby, 1979, p. 113). Since children with an avoidant-attachment organization have experienced and therefore expect rejection, they tend to turn away rather than seek comfort from others, and to act in an antagonistic fashion before the adult has an opportunity to be rejecting. Or they may just avoid the adult to avoid being rejected. Numerous studies have documented the relationship between mothers’ suppressed anger, lack of tenderness in touching and holding, insensitive intrusiveness, rejection of attachment behavior, and infants’ avoidant behaviors (Belsky, Rovine, & Taylor, 1984; Grossman, Grossman, Spangler, Suess, & Unzner, 1985; Lyons-Ruth, Connell, Zoll, & Stahl, 1987; Main, Tomasini, & Tolan, 1979; Matas, Arend, & Sroufe, 1978).

The Minnesota High Risk Study conducted by Egeland and Sroufe (1981) followed a large community sample of impoverished mothers and infants from birth to

adolescence. One of the results they found was that an avoidant-attachment pattern in infancy predicted both aggression and passive withdrawal. Other studies have also found that children with avoidant-attachment histories were rated higher in passive withdrawal, aggression, and hostility (Cassidy & Berlin, 1994; Lyons-Ruth, Alpern, & Repacholi, 1993; Renken, Egeland, Marvinney, Mangelsdorf, & Sroufe, et al., 1989; Sroufe, 1983; Sroufe, Egeland, & Kretzer, 1990). Research has documented longitudinal relations between avoidant-attachment organization in infancy and angry, noncompliant behavior towards parents and peers in the preschool period (Ainsworth, et al., 1978; Erikson, Sroufe, & Egeland, 1985; Fagot & Kavanagh, 1990; Matas, et al., 1978). This relationship was found primarily for children in high-risk family settings (Bates, Bayles, Bennett, Ridge, & Brown, 1991; Fagot & Kavanagh, 1990; Goldberg, Perrotta, Minde, & Corter, 1986).

Ambivalent-Attachment Organization

Children whose experiences with the attachment figure have been inconsistent and thus confusing may have an ambivalent (also called ambivalent/resistant) attachment with the caregiver (Cassidy & Berlin, 1994). Ambivalent-attachment children tend to be dependent and hard to comfort. They may appear to seek comfort, and then reject the adult's attempts to provide it, appearing both "clingy" and difficult. Children with ambivalent-attachment organizations are rated as having behavior problems associated with moodiness and depression (Cassidy & Berlin, 1994; Egeland & Sroufe, 1981; Renken, et al., 1989; Sroufe, 1983; Sroufe, et al., 1990). Teachers see these children as immature and unlikely to explore the school environment or relationships with peers (Howes & Ritchie, 1999). Ambivalent-attachment patterns are found less frequently and

have not been related to aggressive behavior disorders (Lyons-Ruth, 1996).

Disorganized-Attachment Organization

Disorganized-attachment organizations have been found to be associated with individuals who have experienced severe abuse or severe neglect. Children whose prior experiences suggest that adults cannot be trusted to care for or help them will often act towards others as if they too cannot be trusted (Sroufe, 1983). These children's past experiences with attachment figures leave them with no consistent methods for seeking comfort or security. Lyons-Ruth, Bronfman, and Patterson (1994) found that mothers whose infants displayed disorganized-attachment strategies exhibited double-bind communication to their infants (extending their arms toward the infant while backing away, laughing when the infant was distressed). One of Main and Hesse's (1990) hypotheses about disorganized attachments is that parental frightened and frightening behavior puts infants in an unresolvable paradox because the parent's presence would both heighten an infant's fear, and yet the need for soothing contact from that same parent makes such contact fear-arousing rather than comforting (Lyons-Ruth, 1996).

Children with disorganized-attachments have behaviors that include apprehension, helplessness, depression, unexpected alternations of approach and avoidance towards the attachment figure and prolonged freezing, with aspects of the three organized strategies mixed in unpredictable ways (Main & Solomon, 1990). They are fearful of their attachment figures and they exhibit hostile, aggressive behavior problems (Greenberg, Speltz, & Jakir, 1984; Hann, Castino, Jarosinski, & Britton, 1991; Lyons-Ruth, et al., 1993). Disorganized-attachment behaviors have predicted aggression in school-age children with other family factors controlled (Lyons-Ruth, 1996).

As disorganized-attachment toddlers reach elementary school age, their apprehension, conflict, and helplessness gives way to various forms of controlling, directive, or coercive behaviors, though conflict behaviors remain more prevalent (Cicchetti & Barnett, 1991). According to McKelvey (1995) and Levy (2000), children with disorganized-attachment organizations in latency age and adolescence exhibit a lack of conscience, self-gratification at the expense of others, a lack of responsibility, dishonesty, and blatant disregard for the rules and standards of family and society. Disorganized-attachment is considered to be one of the most severe kinds of child psychopathology.

Risk Factors that Affect Attachment

It is unlikely that there is a single cause for most disorders, even in the cases where there are clearly biological, neurological or genetic components. Different combinations of risk factors may or may not lead to the same disorder (Cicchetti & Rogosh, 1997). The effect of these risk factors however, will depend on its timing and influence in various developmental periods, as well as its relation to other risk factors (Bowlby, 1979; Greenberg, Speltz, & DeKlyen, 1993). There appears to be a nonlinear relationship between risk factors and outcomes, and a rapidly increasing rate of Attachment Disorder with additional risk factors (Rutter, 1979; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987).

To understand the development of any mental illness in children, the context in which it occurs must first be considered. When an environment is particularly unhealthy, the behavior a child adopts to get his or her needs met may be characterized as an adaptive response, even if the behavior would be considered pathological in other

settings. For instance, disinhibited behavior for children in a Guatemalan orphanage served as a way for them to get their need for attention and stimulation met; however, this disinhibited behavior was maladaptive once they left the orphanage (Minnis, 2001). Additionally, a behavior that may be quite normal at one age can be an important indicator of mental illness at another age, as normal and abnormal developmental processes are often separated only by differences of degree or maturational change (National Institute of Mental Health (NIMH), 2002). Finally, there are sensitive phases, periods of development in which stressors can have an adverse affect, depending upon the age at which the stressors occur. The risk factors that affect the attachment relationship are typically grouped into three categories: child contributions, parental/caregiver contributions, and environmental contributions.

Risk Factors Associated with the Child

Biological/neurological contributions. Biological abnormalities of the central nervous system which influence thought processes, emotions, and behavior have an affect on attachment. These abnormalities can be caused by injury, infection, poor nutrition, or exposure to prenatal drugs, alcohol or other toxins (National Institute of Mental Health (NIMH); 1998). Neurological factors that can contribute to difficulties in attachment are mental retardation, autism, communication disorder, physical abnormalities, prematurity, birth-related complications, failure to thrive, persistent colic, problematic feeding interactions, sensory loss, and prolonged medical illness (Chess & Thomas, 1996; Coolbear & Benoit, 1999; Minde, 1999; Richters & Volkmar, 1994; 1996; Shin, Lee, Min, & Emed, 1999). Other conditions which may be overlooked, such as severe chronic pain for the infant, starting day care prior to four weeks of age, and having two or more

changes in caregiver or day care provider, have been correlated with attachment problems (Bowlby, 1979; Randolph, 2000).

Infants not only come into the world with neurological contributions that may affect their ability to attach with their caregivers, but likewise are neurologically affected by disruptions in attachment. Such disruptions influence the pruning of specific neurologic pathways, specifically those that regulate affect and emotions (Bremner, et al., 1993; Bremner, Krystal, Charney, & Southwick, 1996; Ito, et al., 1993; Ito, Teicher, Glod, & Ackerman, 1998). A study by Benedict (1999) found significant differences in the neurological functioning between children who had been diagnosed with Reactive Attachment Disorder as compared to those who were identified as securely attached to their primary caregiver (Benedict, 1999). Maltreated infants were found to be more developmentally disabled than those whose maltreatment occurred later in childhood (Erickson, Egeland, & Pianta, 1989). They also scored lower on measures of IQ and had less ability to engage in age-appropriate play at three years of age (Gowan, 1993).

Temperament. Children are not simply recipients of environmental contributions. Their temperament determines the style in which they interact with the world and others around them. Temperament is defined as the variety of traits with which each child is born and can be distinguished by differences in activity, irritability, and responsiveness. Although there is some continuity in temperament and it is somewhat correlated to later personality and adjustment (Chess & Thomas, 1984; Mitchell, 1993; Plomin, 1986), temperament is often modified during development, particularly by the interaction with the caregiver (Kagan, 1984; 1989). In terms of temperament related to attachment difficulties, various measures of temperament have predicted distress to separation,

though not all children are equally reactive to the caregiving experience (Belsky & Rovine, 1987; Belsky, Campbell, Cohn, & Moore, 1996; Vaughn, Lefever, Seifer, & Barglow, 1989). A difficult, fearless and uninhibited temperament, hyperactivity and attention problems have been correlated with attachment problems (Bremner, et al., 1993; 1996; Ito, et al., 1993; Ito, et al., 1998).

Risk Factors of the Caregiver

Loss of a parent. Perhaps one of the most damaging “contributions” to insecure attachments is loss of the parent or caregiver through death. Melanie Klein reported that infants and young children mourn and go through phases of depression, and their modes of responding at such times determine the way they will respond to further loss in later life (Klein, 1935; 1940). Bowlby also believed that the most significant person that can be lost is the mother herself (and sometimes the father). “The loss of a parent gives rise not only to primary separation anxiety and grief but to processes in mourning, in which aggression, the function of which is to achieve reunion, plays a major part” (Bowlby, 1979, p. 63).

Other losses for the child occur through prolonged or repeated separations from the primary attachment figure for reasons such as postpartum depression, hospitalization, or incarceration. Bowlby found that separation from the primary caregiver during childhood consistently preceded delinquency and psychopathic personality (Bowlby, 1979). Of the seventy-six male inmates at a special hospital for aggressive psychopaths, 65% of them had had an absence of their mother or father before the tenth birthday (Craft, Stephenson, & Granger, 1964). In a sample of 157 adolescent offenders, psychopathic offenders were separated at an earlier age both from their biological

mothers and their biological fathers as compared to nonpsychopathic offenders (Forth & Mallioux, 2000). Other findings regarding absence of caregivers for psychopaths were found by Earle and Earle (1961), Naess (1962) Greer (1964), and Brown and Epps (1966).

Abusive caregivers. A particularly serious risk factor for disorganized and other anxious attachments is the abuse parents inflict on their own children. Parents are responsible for committing 60 percent of all crimes against children, stepparents and parents' boyfriends and girlfriends account for another 19 percent (U S Department of Justice, FBI Report, 2002). Parents who have antisocial personalities, who use harsh physical punishment, and who do not provide adequate supervision often have aggressive and violent children, as severe family conflict and violence leads to expectations and behaviors regarding violence (Carlson, 1998; Main & Hesse, 1990; Radke-Yarrow, Cummings Kucznski, & Chapman, 1985; Zeanah, Danis, Hirsheberg, Benoit, Miller, & Heller, 1999). The relation between harsh and ineffective parental discipline and aggressive behavior problems has consistently been documented (Loeber & Dishion, 1983). This association has been reported in children as early as 2 and 3 years of age (Campbell, 1991) and has been highlighted in most theories in the etiology of conduct disorder (Patterson & Bank, 1989).

Not all children who have been subjected to abusive caregiving develop attachment problems. Several factors can alter the course of the development of attachment difficulties in abusive homes. One factor is the severity, pervasiveness and duration of the abuse, and at what period of development for the child the abuse occurred. If the maltreatment occurred during the first two years of life, attachment abilities will be

more severely impaired than if maltreatment began when the child was older. Equally important is whether there has been another caregiver (grandparent, older sibling) who has provided a healthy attachment relationship over time for the child (Hughes, 1997). However, children who have been abused, neglected, or who experience and/or witness violence in their families are at high risk for manifesting all forms of insecure attachments (ambivalent/resistant, avoidant, and disorganized) with their primary caregiver (Carlson, 1998; Cicchetti, 1989; Main & Hesse, 1990; Main & Solomon, 1990; Radke-Yarrow, et al., 1985; Zeanah, et al., 1999).

Neglectful caregivers. Some infants who experience severe neglect in early life may develop mentally and emotionally without lasting consequences, for example, if depressed or substance-abusing mothers recover quickly and fully, or if they are adopted and their adoptive parents provide sensitive, stable, and enriching care (Dennis, 1973; Downey & Coyne, 1990; Koluchova, 1972). Unfortunately, however, neglect in early childhood is frequently the antecedent of later neglect. Exposure to deprivation, insensitive care, lack of affection, and low levels of stimulation over long periods of time are all likely to severely compromise later adjustment (Dennis, 1973). On the basis of his experience with disturbed children, Bowlby states,

In many of the cases in which there has been no occurrence of actual separation in space of child from parent, there is often evidence that there has nonetheless been separation of another and more or less serious kind, . . . rejection, or loss of a parent to love and to attach himself to (Bowlby, 1979, p. 64).

Bowlby delineated the following typical patterns of pathogenic parenting that lead to insecure attachments:

1. One or both parents being persistently unresponsive to the child's caretaking behavior and/or actively disparaging and rejecting him;
2. discontinuities of parenting, occurring more or less frequently, including periods in hospital or institution;
3. persistent threats by parents not to love a child, used as a means of controlling him;
4. threats by parents to abandon the family, used either as a method of disciplining the child or as a way of coercing a spouse;
5. threats by one parent either to desert or even kill the other or else to commit suicide (each of them more common than supposed)
6. inducing a child to feel guilty by claiming that his behavior is or will be responsible for the parent's illness or death,
7. a parent, usually mother, exerting pressure on the child to act as an attachment figure for her, thus inverting the normal relationship (Bowlby, 1979, p. 137).

Such pathogenic parenting is difficult to document, as the caregiving figure will likely omit, distort, minimize, or falsify such information given in an assessment. It would not be unusual for professionals to be unaware that a crucial factor in their client's behavior problems has been pathogenic parenting, particularly if the child is still living with the birth parents. Such neglected children are at high risk for manifesting all three forms of insecure attachments (Cicchetti, 1989; Carlson, 1998; Main & Hesse, 1990; Radke-Yarrow, et al., 1985; Zeanah, et al., 1999).

A variety of studies indicate that insecure attachments is more likely the product of maternal problems such as depression and substance abuse rather than of individual differences in the child (Hay, Zahn-Waxler, Cummings, Iannotti, 1992; Lyons-Ruth, 1996; van IJzendoorn, Goldberg, Kroonenberg, & Frenkel, 1992; Zahn-Waxler, Iannotti, Cummings, & Denham, 1990). In addition to depression and substance abuse, other forms of parental mental illness such as bipolar disorder and schizophrenia are related to children's attachment disturbances. Additional caregiver risk factors for insecure attachments include the following: parental psychopathology or criminality, severe parental discord, family history of violence, overcrowding or large family size, previous psychiatric hospitalization, sibling history of institutionalization or foster care placement, low IQ in the caregiver, multiple caregivers, poor parental support, poor parenting skills, and a history of early separation, abuse or loss in the caregiver's life (Belsky et al., 1996; Lyons-Ruth, Repacholi, McLeod, & Silva, 1991; Rutter, 1979).

Risk Factors of the Environment

There are several important environmental factors that have an impact on the child/parent attachment relationship. Social problems that have increased in recent years such as poverty, family separations, teenage mothers, single parenting, and foreign adoptions may have increased the frequency of attachment disturbances (DeAngelis, 1997). As discussed earlier, the Minnesota High Risk Study documented risk factors such as an impoverished social environment and a higher rate of violence in the community that were related to both insecure attachments and behavior problems (Erikson, et al., 1985; Sroufe, 1983; Troy & Sroufe, 1987; Renken, et al., 1989; Sroufe, 1990; Sroufe, et al., 1990; Urban, Carlson, Egeland, & Sroufe, 1991).

Risk factors from the comprehensive community mental health services program evaluation. Perhaps one of the largest studies that examined risk factors in children ages 5 to 18 who were receiving services from community mental health agencies was the demonstration project supported by the Comprehensive Community Mental Health Services for Children and Their Families Program (Annual Report to Congress, 1999).

The project collected descriptive and diagnostic data (described elsewhere in this study) and risk factors on 40,029 children from 1993 – 1994, and then again in 1997. Of the children in this program who were receiving services from community mental health agencies, 53% lived in single-parent homes. At the time of the study, only 24 percent of all children in the United States had been residing in single-parent families. The majority of families in the community mental health programs were poor, and mother-maintained households had the highest poverty rates. Sixty-one percent of the children's families reported incomes below \$15,000, compared to approximately 20 percent of all children under age 18 who lived in poverty for the general population at the time (U.S. Census Bureau, 1994).

Seventy nine percent of the families in the Comprehensive Community Mental Health Services program reported the presence of one or more of these risk factors: physical abuse, sexual abuse, family violence, drug/alcohol abuse; and a family history of mental illness. Another 39 percent reported three or more risk factors, indicating high rates of multiple family risk factors for children brought to therapy. The highest reported risk factors were history of substance abuse (62 percent), history of violence (54 percent), and history of mental illness (45 percent). In summary, children with serious emotional disturbance who presented at community mental health agencies for services were

disproportionally poor, male, in living situations other than two-parent homes, and living with the presence of some form of abuse or violence, or a family history of mental illness or family drug/alcohol problem (Annual Report to Congress, 1999).

Community violence. One significant risk factor to the child/parent attachment relationship is the increase in children's exposure to violence through their own families, the media, and through the community. According to Levy and Orlans (2000), the average American child spends 900 hours a year in school and 1500 hours a year watching television, and by the time a child leaves elementary school, that child has seen 8,000 murders and over 100,000 other acts of violence on television. In a study on clinical characteristics of children diagnosed with Reactive Attachment Disorder, over-exposure to television viewing was associated with maternal depression and child neglect (Mukaddes, Bilge, Alyanak, & Kora, 2000). Children who watched substantial TV violence and who were neglected appeared to be more aggressive as teens and more likely to be arrested for criminal acts as adults (Levy & Orlans, 2000).

Low-income mothers with a history of serious partner violence were more likely to have infants with disorganized-attachment (Zeanah, et al., 1999). Time after time children who have witnessed physical abuse in the home have been observed to have the following behaviors: fearfulness, hypervigilance, anxiety, indiscriminate sociability, identification with the aggressor, parentified behaviors, and aggression (Victim Services, 1997). Jaffe (1991) reported that boys who witnessed domestic violence were more likely to run away, report suicidal thoughts, and four times more likely to be physically abusive in their dating relationships than boys who did not witness domestic violence.

Violent juveniles. Teenage boys who have experienced attachment difficulties early in life are three times more likely to commit violent crimes and to acquire behaviors that contribute to the development of an antisocial personality (Fonagy, et al., 1996). The number of children with these severe personality traits seems to be increasing, as noted by the fact that violent crime among juveniles has quadrupled since 1975 (Berman, Kurtines, Silverman, & Serafini, 1996). Overall, arrest rates of youths for violent offenses grew by about 70 percent between 1983 and 1993/1994 (Snyder & Sickmund, 1999). More than 110,000 children under the age of 13 were arrested for felonies in 1994; 12,000 were crimes against people, including murder, rape, robbery, and aggravated assault (Berman, et al., 1996). The decade-long upsurge in homicides was tied to an increased use of firearms in the commission of crimes (Snyder & Sickmund, 1999). Arrest rates for violent crimes by youths between the ages of 10 and 17 then declined until 1999, when the, arrests of young people for all crimes totaled 2.4 million, with 104,000 arrests for violent crimes (Snyder, unpublished). Self-reported violent offending showed no decline at all (Snyder, unpublished).

According to preliminary data released by the Federal Bureau of Investigation's Uniform Crime Reporting Program, forty percent of the offenders who victimized children under age six were juveniles themselves (U S Department of Justice, FBI Report, 2002). Youths have been found to be the victims in about 27 percent of homicides committed by other youths (Snyder & Sickmund, 1999). Between 1994 and 1999, 220 violent events in schools resulted in 253 deaths. Among the 279 known perpetrators, 103 (36.9%) were students (Anderson et al., 2001). According to Lewin (1988), the vast majority of these young offenders had histories of abuse and neglect,

lived in single-parent homes with young and highly stressed caregivers, and had parents with criminal records. Levy and Orlans (1998) believe that most of these children suffered from undiagnosed and untreated Attachment Disorder.

Foster Care and Adoption Issues

Foster and adopted children have experienced significant disruptions in attachment and bonding, particularly those children who have had a large number of alternative placements. Children who experienced early institutionalization or multiple placements outside the home may not have had opportunities to build strong and mutual attachments in a reciprocating relationship with a caregiver. Some researchers have found that these children are at greater risk for developing psychosocial disorders, and in particular, problems developing healthy attachments to others (Bowlby, 1988; Hughes, 1997; Fanshel & Shin, 1978), leading to more mental health contacts (Brand & Brinich, 1999; Leslie, et al., 2000). Children in foster care showed more developmental delays (Horwitz, Simms, & Farrington, 1994) and older foster children were least likely to achieve placement stability (Barber, Delfabbro, & Cooper, 2001).

McIntyre and Keesler (1986) conducted a study using the Child Behavior Checklist (CBCL) in order to determine the proportions of foster care children who exhibited clinical psychological disorders. The population they studied consisted of 158 foster children who had been in foster care from 3 months to 17 years ($M = 4.0$ years in foster care) and who ranged in ages from 4 to 18 years. Nearly one half of the foster children in the McIntyre and Keesler (1986) study, regardless of sex or age group, displayed evidence of psychological disorder on the Child Behavior Checklist. McIntyre and Keesler (1986) further determined that foster children were 8.7 times more likely

than home-reared children to manifest psychopathology. Fanshel and Shin (1978) conducted a 5-year longitudinal study in New York of 624 foster children. They classified 24% of the children in this study as abnormal, a percentage that was considered by Marcus (1990) and McIntyre and Keesler (1986) to be an underestimate because Fanshel and Shin excluded children who were placed in treatment settings. Other studies have also found that foster children had more problems than home-reared children (Hochstadt, Jaudes, Zimo, & Schachter, 1987; Marcus, 1991).

Adopted adolescents were found to be at higher risk for poor school achievement and school problems, substance use, poor psychological and physical health, fighting, and lying to parents (Miller, Fan, Christensen, 2000; Zeanah, 2000). In one study assessing attachment-disordered behavior of adopted Romanian children, analyses revealed the Romanian children displayed significantly more indiscriminately friendly behavior (Chisholm, 1998). Other researchers have found a correlation between attachment-disordered behaviors and conduct problems (O'Connor & Rutter, 2000). In the most recent edition of the Child Psychotherapy Treatment Planner, the unattached child is defined as one who was "brought into the family through adoption after coming from an abusive or neglectful biological family" (Jongsma, Peterson, McGinnis, 2000, p. 54).

Adopted children have been found twice as likely to display behavior problems later in life and two to three times more likely to develop conduct disorders than their nonadopted peers (Levy, 2000; Sullivan, Wells, & Bushness, 1995). They were also about twice as likely as nonadoptees to have received counseling (Miller, Fan, Grotevant, 2000; Brand & Brinich, 1999). Adopted children at genetic risk for antisocial behavior

were consistently more likely to receive negative parenting from their adoptive parents (O'Connor, Deater-Deckard, Fulker, Rutter, & Plomin, 1998).

While only two percent of children in the United States are adopted, Zeanah (2000) found that one third of all of the children in residential treatment programs had been previously adopted. A higher proportion of adopted children had been admitted to a psychiatric hospital inpatient unit and had significantly lengthier hospital stays than nonadoptees (Dickson, Heffron, & Parker, 1990). In a five-year follow up study of adopted children, significantly more adoptees were not living with their adoptive families (Kotsopoulos, Walker, Copping, Cote, & Stavrakaki, 1993). Sachs (1990) found that many of the children being returned had not successfully bonded with the primary caregiver or any caregiver previous to the adoptive parents. These children seemed to lack the skills or the desire to bond with their adoptive parents (Parker, Kandis-Cooke, & Forrest, 1993). Overall, studies indicate poorer adoptee adjustment compared to nonadoptees (Sharma, McGue, & Benson, 1998; Berg-Kelly & Eriksson, 1997; Howe, 1997; Jerome, 1993; Lipman, Offord, Boyle, & Racine, 1993; Lipman, Offord, Racine, & Boyle, 1992; Andresen, 1992; Verhulst, Althaus, & Versluis-den Bieman, 1990b; Verhulst, Versluis-den Bieman, van der Ende, Berden, & Sanders-Woudstra, 1990).

RAD Criteria in the Diagnostic and Statistical Manual-Fourth Edition, Revised

An atmosphere of violence, severe abuse or neglect, and repeatedly changing a child's primary caregiver have deleterious effects on children. Such pathogenic environments can lead to problems in the attachment relationship and consequently, to the development of severely disturbed behaviors. Clinicians are required to first address behavior problems by an accurate diagnosis. The primary tool many CMHA clinicians

use to diagnose a child is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). The DSM-IV refers to the disorder addressing the attachment relationship as Reactive Attachment Disorder of Early Infancy and Childhood (RAD) and gives the following description:

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts beginning before age 5 years, as evidenced by either (1) or (2):

- (1) Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions as manifested by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting or may exhibit frozen watchfulness)
- (2) Diffuse attachments as manifested by indiscriminant sociability with marked inability to exhibit appropriate selective attachments (e.g. excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures).

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet the criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

- (1) Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection.
- (2) Persistent disregard of the child's basic physical needs.

- (3) Repeated changes of primary caregiver that prevent formation of stable attachments (e.g. frequent changes in foster care).

There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., that disturbance in Criterion A began following pathogenic care in Criterion C) (DSM-IV, 1994, p. 116).

Criticisms Pertaining to the Diagnosis of Reactive Attachment Disorder

Several important criticisms have been presented about the DSM-IV criteria for a diagnosis of Reactive Attachment Disorder (RAD). First is the issue of whether guardians and clinicians are able to recognize Criteria A (1) “excessively inhibited social responses” or Criteria A (2) “diffuse attachments.” Clinicians must be able to differentiate excessive inhibition and diffuse attachments from normal, developmental social behavior, and take both the temperament of the child into consideration as well as the context and developmental period in which the behavior occurs. In order to alert the clinician to the problem, caregivers must also be able to differentiate these behaviors from what is expected from their children at that point in his/her development. In addition to recognizing the symptoms of RAD, another problem that is evident with this diagnosis is that the presumed etiology stems from the pathogenic attachment/caregiver relationship. However, the focus of the RAD diagnosis is centered on the child’s social behaviors with different individuals and in different contexts (Richters & Volkmar, 1996; Lieberman & Zeanah, 1995),

An added criticism has been the issue of whether children are being over-diagnosed with RAD because of a historical event alone such as being the victim of abuse or neglect. Regardless of any possible underlying neurological etiology, children with a

history of maltreatment may be more likely to receive a diagnosis of RAD because the behavior problems seen in abused children are presumed to stem from the maladaptive relationships they have had with their caregivers. Some researchers have found it concerning that children with a documented abuse history and who exhibit a multitude of behavior problems are being given this diagnosis when some of the behaviors might more appropriately be indicative of other disorders that may not involve core disruptions in attachment (Richters & Volkmar, 1996, Hanson & Spratt, 2000). It is also possible for Attachment Disorder to develop in an unhealthy relationship that is not characterized by severe physical abuse (Rutter, 1997), and may be present in cases in which the abuse or neglect was never substantiated. Consequently, the inclusion of pathogenic care as a criterion remains a matter of confusion and concern.

Differential Diagnostic Problems

A considerable dilemma is the differential diagnostic problem in that many of the behaviors seen with attachment-disordered children fit several different diagnoses. Alston (2000) suggests that Reactive Attachment Disorder may be Post Traumatic Stress Disorder (PTSD) in infancy, as children with symptoms of PTSD typically display aggressive and violent behaviors with both a biological and emotional basis. Children who have Attention Deficit Hyperactivity Disorder (ADHD) and who experience maltreatment and instability in their families often develop and are diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (Barkley, 1990). In a statewide sample of adopted youth, symptomology of both ODD and ADHD was associated with histories of pre-adoption abuse/neglect, later age of adoption, and multiple foster homes prior to adoption ((Alston, 2000; Barkley, 1990; Simmel, Brooks,

Barth, & Hinshaw, 2001). None of these diagnoses address the possibility that the underlying etiology of the disturbed behaviors is a problem with the attachment relationship.

Perhaps because of the confusion regarding diagnostic criteria, some specialists in the field of attachment have used the term Attachment Disorder (AD), rather than Reactive Attachment Disorder (RAD), because RAD does not include the severely disturbed behaviors that are seen with these children. “Attachment Disorder is a diagnosis that is not in the DSM-IV yet,” states Randolph (2000, p. 2). “It is understood to include *both* symptomology of RAD and behaviors associated with a variety of other psychiatric disorders, such as ADHD, ODD, CD, Bipolar I or Bipolar II Disorder, Psychotic Disorder Not Otherwise Specified, (PDNOS), Major Depression, Intermittent Explosive Disorder, and PTSD” (Randolph, 2000, p. 2).

Education and Training of CMHA Mental Health Professionals

Several mental health graduate programs with an array of subspecialties and concentrations are located in the state where this study took place. One of them, the social work graduate school, trains their students to respond to problems such as social injustice, slum housing, child abuse, unemployment, poverty, and individual and family stress. Although social work graduates can and often do provide direct therapy, they are also trained in administration, social planning and policy analysis. Within the social work graduate program are subspecialties such as School Social Work, Marriage and Family Therapy, International Social Work, Social Work and the Law, and Social Work and Divinity.

The field of psychology, on the other hand, primarily has two “cultures,” scientific and humanistic (Ellis, 1992). Ellis reports that it is training in research skills and basic science areas that set practitioner psychologists apart from other professionals such as social workers and counselors. Within the field of psychology in this urban area a graduate student can choose to specialize in Clinical Psychology, Experimental Psychology, Counseling Psychology, College Student Personnel, Expressive (Art) Therapy, or School Counseling. The curriculum for all fields of psychology covers six competency areas: Relationship (Interpersonal), Assessment, Intervention, Research/Evaluation, Consultation/Teaching and Management/Supervision (Bourg, Bent, McHolland, & Stricker, 1989).

Most of the graduate programs first train their students as general practitioners, then as specialists. Although child-clinical programs generally require more course work in psychopathology and more supervised experience (Minke & Brown, 1996), no designated child track currently exists in the state’s programs where this study took place. Nevertheless, all graduates of the above mentioned programs are expected to have attained a broad, basic knowledge of their field regardless of their individual specialty, and must pass a licensing exam in order to practice. As a final note, graduate schools teach from the Diagnostic and Statistical Manual. Given the fact that the criteria for RAD are difficult to recognize as well as unclear, teaching students to identify symptoms of an attachment problem is a difficult undertaking for graduate programs.

Frequency of Reactive Attachment Disorder in Community Mental Health Agencies

Although there are an estimated 4.5 to 6.3 million children in the United States who have a serious emotional disturbance (Friedman, Katz-Leavy, Manderscheid, &

Sondheimer, 1998), there is relatively scant empirical investigation into the frequency of Attachment Disorders in community mental health agencies. The prevalence data for AD appears to be unclear and inconsistent. Reber (1996) suggested that this disorder is fairly common, citing a study that claims one million children with AD live in New York City alone. The National Institute of Mental Health (NIMH) conducted a study on the frequency of various childhood mental disorders. In the context of discussing attachment theory and development, Bowlby was mentioned as one of the first theorists in attachment. However, Reactive Attachment Disorder was not listed as a diagnosis in the report (NIMH, 2002).

The report lists the following childhood disorders: anxiety (13%), mood disorders (6.2%), disruptive disorders (10.3%), substance use disorders (2.0%), and any disorder (20.9%) (Shaffer, et al., 1996). Autism, obsessive-compulsive disorder and eating disorders are noted in this report for being rare yet still are a focus of clinical attention; however Reactive Attachment Disorder was not mentioned. The closest diagnosis and description of behaviors associated with attachment-disorder in the NIMH report is Conduct Disorder (CD). NIMH lists the following behaviors for CD: vandalism, theft, fire setting, truancy, precocious sexual activity, poor school achievement, substance abuse, aggression and cruelty to animals and people. The presumed etiology of Conduct Disorder, described below, appears to be similar to what specialists in the field have found for Attachment Disorder.

The etiology of conduct disorder is not fully known. Studies of twins and adopted children suggest that conduct disorder has both biological (including genetic) and psychological components (Hendren & Mullen, 1997). Social risk factors for

conduct disorder include early maternal rejection, separation from parents with no adequate alternative caregiver available, early institutionalization, family neglect, abuse, or violence, parent's psychiatric illness, parental marital discord, large family size, crowding and poverty (Loeber & Stouthamer-Loeber, 1986). These factors are thought to lead to a lack of attachment to the parents or to the family unit and eventually to lack of regard for the rules and rewards of society (Sampson & Laub, 1993) (NIMH, 2002).

Although it is likely that increases in social problems such as family separations, abuse and neglect, single parenting, and foreign adoptions increase the frequency of attachment problems (DeAngelis, 1997); the absence of epidemiological studies makes it difficult to estimate the exact prevalence. Also, since a certain percentage of maltreated children do not show no signs of stress or behaviors problems as a consequence of their abuse, reliance on rates of child abuse/neglect or problem behaviors should not serve as a benchmark for estimates of Attachment Disorder (Kendall-Tackett, Williams & Finkelhor, 1993).

Frequency of Other Childhood Disorders in Community Mental Health Agencies

As discussed earlier, the Comprehensive Community Mental Health Services for Children and Their Families Program (Annual Report to Congress, 1999) collected frequency and descriptive data as well as tracked treatment effectiveness outcomes from 1993-1994 on 40,029 children. Descriptive data indicated that the children's average age was 12.2 years, and almost two-thirds of the children brought for treatment were boys. Among the children, 55 percent were Caucasian, 15 percent were African-American, 25 percent were Hispanic, and 5 percent were of other ethnicities. Twenty four percent lived

in two-parent homes, 45% lived in one-parent homes, 7 percent lived with a guardian, 10 percent were wards of the state, and 4 percent were in other living situations.

Although 79% of the families in the Comprehensive Community Mental Health Services Program reported the presence of one or more risk factors for attachment problems, Reactive Attachment Disorder was not listed in their diagnostic categories. The program found the following diagnoses based on criteria from the DSM-IV: Of the 29,945 children in the descriptive study sample who were assigned a primary diagnosis, 29.8 % displayed conduct-related disorders and 13.5 % were diagnosed with attention deficit/hyperactivity disorder. Over 26 % were diagnosed with depression, and approximately 8 % with an anxiety disorder, and 6 % with an adjustment disorder. The remaining primary diagnostic categories (assigned to 15 percent of the sample) included, but were not limited to, substance abuse, eating, somatic, and speech disorders, as well as enuresis, encopresis, abuse/neglect, personality disorders, and learning disabilities. Reactive Attachment Disorder was not listed as a diagnosis (Annual Report to Congress, 1999).

Attachment Disorder Assessment Systems and Instruments

Since the development of Ainsworth's unique approach (the Strange Situation) for classifying attachment behaviors, other systems have been developed that also rely on separation and reunion episodes between the child and primary caregiver. These classification systems place the emphasis on the child's response to stress induced by a separation, and then measure maternal availability and responsiveness. There are several of these classification procedures available for the period of infancy through age seven: the Cassidy-Marvin System (Cassidy & Marvin, 1987; 1990; 1991; 1992), the Preschool

Assessment of Attachment (PAA) (Crittenden, 1992b; 1994), and an alternative measure of security, the Attachment Q-Sort (Waters, 1995). In these systems, attachment groups are distinguished by identifying the communicative or defensive goals that underlie attachment patterns. They are described only briefly here because they deal primarily with the assessment of attachment organizations in children under the age of seven and through home or school observations of separation/reunion behaviors.

Cassidy-Marvin System

The Cassidy-Marvin System (Cassidy & Marvin, 1987; 1990; 1991; 1992) was designed to classify preschool-aged children into five groups (secure, avoidant, ambivalent, controlling/disorganized, and insecure/other) based on a separation/reunion scenario. Classification with the Cassidy-Marvin system significantly predicted secure versus insecure classifications with Bretherton's doll play attachment representations (Bretherton et al., 1990), as well as predicted qualities of attachment representations in the Separation Anxiety Test (SAT; Shouldice & Stevenson-Hinde, 1992).

The Preschool Assessment of Attachment (PAA)

The Preschool Assessment of Attachment (PAA) (Crittenden, 1992b; 1994) provides guidelines for six major classification groups as follows: secure, defended, coercive, defended/coercive, anxious/depressed and insecure/other. Each classification group includes a set of subgroups that include typologies that expand upon infant classifications by integrating a maturational developmental perspective on preschooler behavior into the system.

Main-Cassidy Attachment Classification for Kindergarten-Age Children

The Main-Cassidy Attachment Classification for Kindergarten-age Children (Main & Cassidy, 1988) was developed on a sample of 33 children whose infant attachment classifications were known. Classification was based on a child's behavior during the first 3 or 5 minutes of reunion with the parent following a one-hour separation. Reliability has ranged from 70 – 82% and stability of classification was 62%, due to changes in the controlling group. Its relation to other measures was high (Jacobsen, Edelstein, & Hofmann, 1994; Jacobsen & Hofmann, in press).

The Attachment Q-Sort (AQS)

The Attachment Q-Sort (AQS) was developed by Waters (1987, 1995, Waters & Deane, 1985) to assess the quality of a child's secure-base behavior in the home by providing a practical alternative to Ainsworth's home observation narratives. The Q set for the AQS consists of 90 items designed to tap a range of dimensions believed to reflect either the secure base phenomenon or behavior associated with it in children ages 1 to 5. These items are sorted into one of nine piles according to whether the item is considered characteristic or uncharacteristic of a child's behavior. Sorts can be completed by trained observers or by parents, and should be based on two to three visits in the home for a total of 2 – 6 hours of observation. AQS data can be analyzed in terms of individual items or summary scales.

All of the above assessment systems examine attachment behaviors in relation to the parent-child attachment relationship and rely primarily on the brief separation and reunion episodes of the strange situation. Most of these classification systems are carried out in a laboratory type setting or by observers in the home, and examine the child's

response to the stress induced by the separation. However, it is much more difficult for scientific observers to perceive underlying attachment organizations as children get older, because situations that strongly activate attachment are very rarely observed in the home, and fewer situations are perceived as threatening. The cognitive awareness of the older child about the caregiver's proximity (rather than the actual presence) is usually enough to diminish attachment behavior. Therefore, different or additional measures are needed to measure the attachment relationship and consequent problems in older children.

Typically, specialists in attachment utilize a great deal of information to diagnose and treat an attachment-disordered child, although many times the child being brought for treatment already has been given a diagnosis of Reactive Attachment Disorder, oftentimes comorbid with other diagnoses. The information they use includes a thorough assessment of the child's social and behavioral history, psychological testing, medical and psychotropic drug history, a family assessment (which includes a psychological evaluation of the caregivers), a review of prior treatment, and a psychiatric evaluation. In addition to these sources of information, researchers have developed and used several instruments that specifically address issues and behaviors associated with attachment-disordered children. Some of these instruments are discussed below.

Cline/Helding Adopted & Foster Child Assessment (CHAFCA)

One instrument that is available to assist in recognizing possible problems in attachment is the Cline/Helding Adopted & Foster Child Assessment (CHAFCA) (Cline & Helding, 1998). The CHAFCA was designed for use as an assessment tool for adoptive and foster families to evaluate the goodness of fit issues for adoptive placement, for post-placement evaluation of problems, and as an intake tool for therapists and

caseworkers. The CHAFCA is a survey of behaviors and the child's history. According to the authors, it does not draw diagnostic inferences from answers, but rather seeks in a variety of ways to find out how the child behaves.

Questions on the CHAFCA are sorted into thirteen different subtests such as, Emotional Health, Reactive Attachment Disorder, Oppositional Defiant Disorder with Subtest for Passive Aggressive Oppositional Defiant Disorder, Attention Deficit Disorder (ADD) with Subtest for Attention Deficit Disorder with Hyperactivity (ADHD), Conflict and/or Depression, Neurological Disorder, Learning Disabilities and Developmental Delay, Sensory Integrative Dysfunction (SID), Sexual Abuse, Predictors of Violent, Dangerous, or Aggressive Behavior, Fetal Alcohol Syndrome (FAS, FAE), Giftedness, Substance Abuse, and Post-Traumatic Stress Disorder (PTSD). The higher the score on a particular subtest of the CHAFCA, the more likely it is that the child has a history of that problem.

Although the CHAFCA appears comprehensive in its coverage of most childhood diagnostic categories, there does not appear to be any validation studies for the CHAFCA at this time. Cline and Holding report that preliminary findings in a controlled study, currently underway, demonstrate CHAFCA's efficiency and validate its accuracy (Cline & Holding, 1998). The results of these studies will be published on their website, as they become available.

Attachment Disorder Assessment Scale (ADAS)

The Attachment Disorder Assessment Scale (ADAS) is an instrument that measures the degree of Attachment Disorder experienced by children ages 3 to 13. Research by Fairchild-Kienlen (2002) with children in the foster care system suggests

that the ADAS needs further refinement to strengthen validity, but that it does exhibit the ability to differentiate between selected mental health diagnoses.

Adult Attachment Interview (AAI)

Studies have repeatedly shown a relationship between responsive caregiving and secure infant behavior, as adult attachment influences parenting and thereby attachment security in the child (van IJzendoorn, 1995). A measurement of the caregiver's attachment style is likely to be very valuable in assessing attachment issues with older, school age children. Certain behavior problems of the child, in concordance with maternal classifications may yield a more precise measure of an attachment problem. One instrument that addresses the attachment classification of the caregiver is the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1996). A meta-analysis of 18 studies of the AAI investigating the correspondence between infant attachment patterns and maternal interview classifications yielded a significant three-category agreement rate of 70%, even when maternal interviews were carried out before the birth of the infant (van IJzendoorn, 1995).

Attachment Disorder Symptom Checklist (ADSC)

The Attachment Disorder Symptom Checklist (ADSC) (Attachment Center at Evergreen, Colorado) is a Likert-type questionnaire developed over twenty years ago by the ACE staff to treat severely disturbed and unattached children. Caregivers choose ratings of *never*, *moderate*, or *severe* for a list of 19 symptoms that have been associated with attachment-disordered children. The clinician and caregiver then use the Attachment Disorder Symptom Checklist to determine which symptoms need to be

immediately addressed in treatment. The items on the checklist which address

Attachment Disorder symptoms are:

- (a) Superficially engaging and charming,
- (b) Lack of eye contact on parental terms,
- (c) Indiscriminately affectionate with strangers,
- (d) Not affectionate on parents' terms,
- (e) Destructive to self, others, and possessions,
- (f) Cruelty to animals,
- (g) Lying about the obvious,
- (h) Stealing,
- (i) No impulse control,
- (j) Learning lags,
- (k) Lack of cause and effect thinking,
- (l) Lack of conscience,
- (m) Abnormal eating habits,
- (n) Poor peer relationships,
- (o) Preoccupation with fire,
- (p) Preoccupation with blood and gore,
- (q) Persistent nonsense questions and incessant chatter,
- (r) Inappropriately demanding and clingy,
- (s) Abnormal speech patterns.

Although the ADSC has been used to diagnose a child with Attachment Disorder, it is used primarily to identify the type and severity of their problems in order to develop

an effective treatment plan. The ADSC has widespread use and general acceptance; however, there are no validity or reliability studies of this instrument either in the research literature or at the therapy sites that utilize it (Worrell, 1999).

The Randolph Attachment Disorder Questionnaire (RADQ)

The Randolph Attachment Disorder Questionnaire (RADQ) was based on the symptoms from the Attachment Disorder Symptom Checklist. The symptoms of the ADSC have been observed by clinicians to distinguish children with AD from children with other psychiatric disorders, and so were presumed to represent a solid basis for the RADQ items. The RADQ was developed to ascertain the presence of Attachment Disorder, a diagnosis that Randolph feels includes the symptomology of RAD as well as the severely disturbed behaviors that specialists in the field have seen with these children. Because the behavior problems of children with Attachment Disorder often appears similar to (and is misdiagnosed as) Conduct Disorder, Oppositional Defiant Disorder, and/or Attention Deficit Hyperactivity Disorder, Randolph felt it was important to distinguish those children who actually have underlying attachment problems. The RADQ is a 30-item parent report checklist of symptoms ranging from rarely (1) to *usually* (5). The final score is used to determine the presence of attachment problems (50 – 64) or a diagnosis of Attachment Disorder (65 +).

Diagnostic criteria that forms the basis of the RADQ items are as follows:

- 1) There is a history of events during the first two years of life that are consistent with causing severe attachment disruptions (severe maltreatment, severe chronic pain for the infant, maternal depression, illness, or attachment problems, living in a foreign

orphanage, starting day care prior to 4 weeks of age; or having two or more changes in caregiver or day care provider).

- 2) Eight or more of the following symptoms are present 80% of the time or more:
 - a) acts cute and charms others to get what he/she wants (manipulates others)
 - b) is unable to make eye contact when adults want him/her to
 - c) pushes away closeness and comfort unless he/she wants something
 - d) has a tremendous need to have control over everything, becoming very angry if things don't go his/her way
 - e) deliberately breaks or ruins things
 - f) does very dangerous things, with no regard for the consequences of his/her actions
 - g) is extremely demanding
 - h) is a pathological liar (lies when it would be easier to tell the truth, or when the lie flies in the face of reality)
 - i) hoards and sneaks food, eats non-food items or baking ingredients
 - j) can't keep friends for more than a week because of bossy and manipulative behaviors
 - k) chatters non-stop, asks repeated nonsense questions, and/or mutters
 - l) teases, hurts, and/or is cruel to animals.
- 3) At least eight of these symptoms are present 80% of the time or more prior to age six
- 4) The child meets the diagnostic criteria for both Reactive Attachment Disorder and either Conduct Disorder or Oppositional Defiant Disorder (ODD), and has at least seven of the diagnostic criteria for ODD, or at least 5 of the symptoms of CD

5) This disorder is not caused by intellectual impairment or other Pervasive Developmental Disorders (Randolph, 2000, p. 5).

The RADQ has been used by specialists in private practice and at attachment treatment centers to assess and treat attachment-disordered children. Validity and reliability studies are described in chapter three. The RADQ has also been used in a validation study of another attachment assessment instrument called the Biopsychosocial Attachment Types (BAT) (Ogilvie, 2000). However, as yet there are no studies using the RADQ as an assessment tool for use in community mental health agencies.

Summary

Extensive research over the last several decades has shown that an individual's capacity to form healthy relationships later in life may be compromised if the early parent/child bond is damaged in some way. Such harm can result in avoidant, ambivalent or disorganized attachment organizations, and particularly severe damage can result in Attachment Disorder. In addition to relationship problems, Attachment Disorder is believed to encompass serious psychopathic behaviors such as self-gratification at the expense of others, pathological lying, theft, fire-setting, substance abuse, aggression, cruelty to animals and people, and a general lack of conscience and disregard for the rules of society (McKelvey, 1995; Levy, 2000).

Studies have revealed a correlation between attachment disruptions and these severely disturbed behaviors (O'Connor & Rutter, 2000). The number of children with this disorder may be increasing, as violent offenses by youths grew by about 70 percent between 1983 and 1993/1994 (Snyder & Sickmund, 1999). As discussed earlier, foster and adopted children are at greater risk for developing behavior problems related to

attachment (Bowlby, 1988; Fanshel & Shin, 1978; Hughes, 1997), as adopted children have been found to develop conduct disorders and display problems later in life (Levy, 2000, Sullivan, Wells, & Bushness, 1995).

Children who are more likely to develop Attachment Disorder are those with risk factors that cover all domains (biology/neurology of the child, parents/caregiver, and environment). Poor maternal nutrition, exposure to infections, drugs and alcohol, mental retardation, physical abnormalities, and prematurity are risk factors that can affect a child's ability to attach to the caregiver, as well as factors such as prolonged medical illness or having two or more changes in caregivers (Chess & Thomas, 1996; Coolbear & Benoit, 1999; Minde, 1999; Richters & Volkmar, 1994; 1996; Shin et al., 1999; Bowlby, 1979; Randolph, 2000).

Parental contributions to disturbances in attachment include psychopathology, mental illness, and substance abuse (van IJzendoorn et al., 1992; Zahn-Waxler et al., 1990; Hay et al., 1992, Lyons-Ruth, 1996). Other caregiver risk factors include maternal youth, single parenthood, poor parenting skills, low IQ, and a history of abuse or loss in the caregiver's life. Neglect, particularly in the form of pathogenic parenting, is highly correlated, and physical and sexual abuse of the child is perhaps the most serious risk factor for Attachment Disorder. The relation between abuse, aggressive behavior problems, and attachment difficulties has consistently been documented (Loeber & Dishion, 1983). Environmental factors that have an effect on the attachment relationship are the combination of some or all of these risk factors: poverty, large family size, severe parental discord and domestic violence, and an increase in violence in the community (Rutter, 1979; Belsky et al., 1996; Lyons-Ruth, Repacholi, McLeod, & Silva, 1991;

Erikson et al., 1985; Sroufe, 1983; Troy & Sroufe, 1987; Renken et al., 1989; Sroufe, 1990; Sroufe, Egeland, & Kreutzer, 1990; Urban et al., 1991).

Statement of the Problem

It is likely that community mental health agencies may be the first resource to come in contact with a child with an undetected attachment problem, as outpatient services are an initial choice of treatment for a behavioral difficulty. CMHAs generally require clinicians to give their clients a DSM-IV diagnosis on the initial intake session; therefore, early recognition that some behavior problems may stem from attachment issues is critical. Nevertheless, this issue remains problematic for CMHA clinicians. Despite the serious nature of attachment-disordered behaviors, the only available diagnosis that addresses this problem is Reactive Attachment Disorder. However, RAD simply addresses the problem of social relatedness, and the criteria of excessive inhibition or indiscriminant sociability are difficult for clinicians to assess in session. Additionally, for many CMHAs, if abuse and/or neglect have not been substantiated by child protective services, it cannot be a part of a diagnosis. Consequently, the inclusion of pathogenic care as a criterion for RAD may actually inhibit clinicians from assigning this diagnosis to their clients, rather than lead to overdiagnosing, a concern that was raised by Hanson and Spratt (2000).

Particularly troublesome is that fact that the DSM-IV criterion for RAD does not address the severe behaviors that generally bring the attachment-disordered child into treatment. Since these behaviors fit several different disorders, there is considerable disagreement over what an appropriate diagnosis might be. This often leads clinicians to choose diagnoses that do not address the underlying etiology of the disturbed behaviors

(an insecure attachment to the caregiver). Without addressing the etiology of the behaviors, the problem remains and worsens over time.

Reactive Attachment Disorder, as it is currently conceptualized, does not seem to be a particularly clear or coherent diagnostic entity and there is substantial disagreement over what this diagnosis actually entails. The DSM-IV's description of RAD is inadequate for CMHAs, and appears to prohibit professionals from accurately assessing and consequently treating attachment-disordered children (Watkins, 1995). At this time, there is no standardized or even widely accepted protocol used to validate this diagnosis. Consequently, many CMHAs do not have a screener or assessment tool that specifically looks at problems stemming from a disturbance in the attachment relationship.

CMHAs are not alone in facing the difficulty of recognition of attachment problems, as neither the National Institute of Mental Health nor the extensive study completed by the Comprehensive Community Mental Health Services Program on nearly 30,000 children listed Reactive Attachment Disorder as a diagnosis. Consequently, the frequency of attachment problems in the clients who are brought to community mental health agencies appears to be unknown.

Research Questions/ Hypotheses

Research question 1. To address this problem, the researcher began by asking the first question for this study: What percent of child clients seen in one office of a Community Mental Health Agency actually received a DSM-IV diagnosis of Reactive Attachment Disorder? As with any diagnosis, it was assumed that the number of individuals without the problem was greater than the number with the disorder. According to the DSM-IV, "RAD appears to be very uncommon" (APA, DSM-IV, p.

117, 1994). Since it is still unclear what the prevalence of Reactive Attachment Disorder is in either a clinical or non-clinical population, the ability to guess at the prevalence of this disorder in this CMHA was limited. Moreover, due to the complex nature of the criteria for this diagnosis and the differential diagnostic problem, it was also assumed that CMHA clinicians might refrain from assigning a RAD diagnosis to their clients at either the intake session or later, even when seen over a long period of time. Therefore, the first hypothesis for this study was that less than five percent of CMHA clients had received a diagnosis of Reactive Attachment Disorder.

Research question 2. The second research question examined the actual occurrence of attachment problems by asking: What percent of CMHA child clients met the criteria for attachment problems as measured by the Randolph Attachment Disorder Questionnaire (RADQ)? The RADQ was chosen because of the validity and reliability studies to support its use as a tool for assessing attachment-related behaviors. Also, as a parent report form, it was relatively easy for caregivers to complete while their child was in session with the therapist. Again, the absence of epidemiological studies in community mental health agencies made it difficult to not just hypothesize an estimate of the RAD diagnosis, but to hypothesize the frequency of attachment problems. Since much of the data on attachment has focused on children who have experienced disruptions in their caregiver situation, this study used the foster care population as a comparison.

Several studies have examined the emotional and physical health status of foster children and have found incident rates of psychological and behavioral problems in 37% (Schor, 1982), 39% (Moffatt et al., 1985; Hochstadt et al., 1987), and 78% (Frank, 1980).

This suggests that the presence of attachment problems was likely significantly higher than the prevalence rate of Reactive Attachment Disorder, and at a minimum, 30% in the foster care population. Given that only a small percentage of CMHA clients were in foster care at the time of the study, it was assumed that the number of CMHA child clients with attachment problems was less than the number of behavior-disordered children in foster care (37%, 39%, and 78%), but greater than the number diagnosed with Reactive Attachment Disorder. Therefore, hypothesis two declared that less than 30% of CMHA clients would be identified as having attachment problems (RADQ scores between 50 – 64).

Research question 3. A third research question asked in this study was: What percent of CMHA child clients met the criteria for Attachment Disorder as measured by the RADQ? Attachment-disordered children are conceptualized by specialists in the field as clients who meet the criteria for a RAD diagnosis and have the majority of symptoms of either Oppositional Defiant Disorder or Conduct Disorder. Earlier, research question one hypothesized that clients who had received a diagnosis of RAD were less than 5%; therefore, it was conceivable that the number of clients who met the criteria for Attachment Disorder (RAD plus ODD or CD) as measured by the RADQ would be even less. As a result, the third hypothesis stated: less than 2% of CMHA clients would receive scores of 65 and above on the RADQ, indicating the likely presence of Attachment Disorder.

Research question 4. The fourth research question asked: What was the relationship between RADQ scores and the number of caregivers? As reviewed in the literature, it is generally believed that attachment problems are related to the number of

disruptions from living situations that children have experienced, resulting in an increase in caregivers. The hypothesis for this question speculated that scores on the RADQ would be positively related to the number of different caregivers with which the child had lived. That is, as the number of caregivers increased, RADQ scores would also increase.

Research question 5. One general assumption regarding the attachment relationship is that children who are still living with their primary caregiver (generally the birth mother) in all likelihood do not have attachment problems, since they have not experienced disruption from their birth parent. Out- of-home placements typically have been a red flag for clinicians in determining a diagnosis of RAD. However, an area not easily addressed in assessing for attachment problems is the issue of neglect in the form of pathological parenting. As discussed earlier, pathological parenting may be difficult to recognize and substantiate, yet may have been a factor in some of the cases of CMHA clients living with a birth parent. Therefore, the fifth research question asked: What was the relationship between RADQ scores and the clients' current living arrangement? The hypothesis for this question stated that there would be no significant difference in RADQ scores between clients living with a birth parent(s) and those who are no longer living with their birth parents.

Research question 6. The sixth research question in this study asked: What was the relationship between RADQ scores and scores on the Personality Inventory for Children-Second Edition. Each scale on the PIC-2 provides a description of the behaviors and personality characteristics associated with high scores on that scale, descriptions of attachment-disordered children. Given that the author of the RADQ conceptualizes AD as a disorder that includes both RAD and Oppositional Defiant

Disorder or Conduct Disorder, it was hypothesized that there would be a high correlation between the RADQ scores and scales measuring delinquency, oppositionality, and impulsivity. For instance, children with high scores on the PIC-2 scale of Impulsivity/Distractibility are described (in part) as disruptive, seeking excessive attention, manipulative, uncooperative, disobedient, defiant, and assaultive. Additionally, the PIC-2 Delinquency scale has been most often associated with the diagnosis of Conduct Disorder, and individuals who score high on the Delinquency scale appear similar to attachment-disordered children. They are described as complaining, argumentative, often in trouble, and having relationships with their parents that are characterized by anger and poor communication. They may fight, steal, lie, run away, abuse drugs, belong to gangs, and spend time with friends who also get into trouble. The PIC-2 was also used because of its validity scales in order to eliminate invalid response sets from the study.

Research question 7. The seventh and final research question in this study addressed CMHA clinicians' awareness of issues in the area of attachment. CMHA clinicians were asked the following five questions in the interviews:

- 7a. What do you know about the etiology of attachment issues?
- 7b. What do you know about the diagnosis of Reactive Attachment Disorder (RAD)?
- 7c. Where did you learn about these issues?
- 7d. What do you know about Attachment Disorder (AD) and the difference between AD and RAD?
- 7e. What treatment would you provide for clients with attachment problems?

In summary, this study addressed the following research questions:

1. What percent of child clients seen in one office of a Community Mental Health Agency actually received a DSM-IV diagnosis of Reactive Attachment Disorder?
2. What percent of CMHA child clients met the criteria for attachment problems as measured by the Randolph Attachment Disorder Questionnaire (RADQ)?
3. What percent of CMHA child clients met the criteria for Attachment Disorder as measured by the RADQ?
4. What was the relationship between RADQ scores and the number of caregivers?
5. What was the relationship between RADQ scores and the client's current living arrangement?
6. What was the relationship between RADQ scores and the PIC-2 scales?
- 7a. What do CMHA clinicians know about the etiology of attachment issues?
- 7b. What do CMHA clinicians know about the diagnosis of Reactive Attachment Disorder (RAD)?
- 7c. Where did CMHA clinicians learn about these issues?
- 7d. What do CMHA clinicians know about Attachment Disorder (AD) and the difference between AD and RAD?
- 7e. What treatment would CMHA clinicians provide for clients with attachment problems?

Results of these research questions are discussed in Chapter IV.

CHAPTER III

METHOD

Introduction

This study addressed a problem with several components: identification of clients in a community mental health agency with attachment problems as defined by Randolph (2000) and then measuring the frequency with which this particular problem occurs. By the time many attachment problems are recognized for what they are, the behaviors of these children are so severe that they need care in a residential treatment facility. If therapists recognize early in treatment that the attachment relationship may be the core issue, work could begin much earlier and give the child a better prognosis. Without recognition of the issues involved, treatment often continues with little impact on the severely disturbed behaviors.

Nevertheless, assessing behaviors of children that stem from unhealthy, early relationships is complex, open to interpretations on many levels, and a difficult task at best. Making this even more difficult for clinicians is the attempt to differentiate one particular disorder from another, when symptoms of Attachment Disorder are also the symptoms of several other disorders as well. Despite the fact that most CMHA clinicians work on specialized teams, they are still required to be multi-taskers when it comes to knowing about a wide variety of clinical syndromes (anxiety, depression, psychosis, neurological and biological problems, etc.) and to be knowledgeable about treating these

problems in a diverse client population. Therefore, the potential for not identifying an Attachment Disorder is high, and frequent misdiagnosis is understandable.

This concern required finding an assessment tool that measures behaviors resulting from the parent/child attachment relationship, and then using this instrument to measure the frequency with which this problem was occurring in clients of outpatient therapists. It also required determining whether clinicians were having difficulty recognizing this disorder and why. In order to examine these matters, the researcher relied on procedures that included quantitative data (both descriptive and analytic), and one qualitative component that was aimed at enhancing the understanding of the quantitative information.

Clinician Participation

The specific community mental health agency that provided the participants for this study is located in the central part of the United States. This agency covers the mental health needs of residents in one predominantly urban county and several rural counties in the state. In 2002, over 1300 employees in this CMHA provided a wide variety of services, ranging from outpatient treatment, crisis intervention, drug and alcohol services, and residential living facilities. The researcher conducted this study at one of the sites in the urban county of this CMHA called the Central Office, a site that typically sees hundreds of child and adult clients throughout the year and provides a variety of services.

Of the 19 child clinicians who worked in the Central Office of the CMHA, 16 contributed clients for the study, as did one clinician who worked in Acute Services, another office in the agency. These therapists agreed to ask caregivers to complete test

packets, and by clinicians' report, most caregivers who were asked to participate in the study did complete the packets with the testing instruments. Although the researcher estimated that each clinician would provide an equal number of participants for the study, sample selection did not turn out to be random as intended. Some clinicians asked the majority of their parent/caregivers, while other clinicians provided only one or two clients for this research. By the study's conclusion, 100 caregivers of child clients had completed all three instruments.

Study Participants

Outpatient Therapy Teams

The children who were part of this study had all been referred for outpatient therapy for a variety of emotional and behavioral problems. Referrals for treatment came from the child's parent/caregiver, the child's school, the court system, Child Protective Services, Department of Community-Based Services, and several local psychiatric hospitals. The three outpatient child teams in the Central Office and Acute Services described below provided clients for this study.

Behavioral Health. The majority of participants in the study (N = 74) were clients of therapists assigned to the Behavioral Health team. Clinicians on this team provide individual, family and group therapy for behavior problems related to neglect and unsubstantiated cases of abuse, as well as serious life issues due to death, divorce, or a change in circumstances. Services of this team also include educational programs and consultation and referral to other service providers.

Family Connections. The number of participants that came from the Family Connections team was 16. This child therapy team provides a wide range of outpatient

mental health services for children and adolescents with severe emotional disabilities (SED). The focus of this team is to improve behavioral and emotional functioning of these children, provide support for the family, and maintain the children in the community. Services include individual, group and family counseling, as well as anger management and adoption counseling for children and adoptive parents.

Transitions. A third team, Transitions, provided 8 clients for this study. This treatment team provides a comprehensive array of mental health services for victims and perpetrators of spouse abuse, sexual abuse, and familial child abuse. Transitions services include evaluation; individual, group and family therapy; support groups; and consultation and education with other providers and community groups. Eligible clients are victims/perpetrators of abuse for which abuse is the focus of treatment, or individuals who have been court-ordered for family violence treatment. Admission criteria for children on the Transitions team include:

- Juvenile sexual offenders — a minor who has been adjudicated or admits to having committed a sexually deviant act.
- Child victim of sexual/physical abuse — substantiated report or disclosure by the state, community or family of child sexual or physical abuse or sexually reactive behavior.
- Child witness to family violence — substantiated report by the state of community or family of child witness to family violence.

Acute Services. The fourth team in this study, Acute Services, provided 2 participants. This program helps children who are in acute psychiatric or emotional distress remain in their homes and communities, or enter the hospital when necessary. Services include

statewide, around-the-clock access to and assessment by crisis intervention/planning counselors; short-term, intensive family and individual therapy; in-home crisis services; immediate access to child psychiatric services and access to residential crisis services. If necessary, a child may be admitted to the Crisis Stabilization Unit. This unit is the region's only temporary, short-term (4-7 days) 24-hour alternative to hospitalization for children/adolescents ages 3-18 who are in emotional or behavioral crisis. Clinicians strive to reduce and stabilize acute psychiatric symptoms, and divert children from psychiatric hospitalization so they can return to their homes and function independently.

Instruments

Three instruments were used in this study to answer the research questions: a demographic sheet developed by the researcher, the Randolph Attachment Disorder Questionnaire (RADQ) (Randolph, 2000), and the Personality Inventory for Children-Second Edition (PIC-2) (Lachar & Gruber 2001). These three tools are described below.

Demographic Sheet

The demographic sheet (Appendix A), which was developed for this study, was a one-page item that the clinician and caregiver filled in together prior to the caregiver completing the other two testing instruments. Most caregivers took approximately five minutes to complete the demographic sheet and sign the consent form. The demographic sheet requested general information about the child (name, age, ethnicity, diagnosis, and presence of behavior problems before age five). It also asked participants to report on whether the child had ever had previous mental health treatment, whether treatment had been continuous or intermittent, and the number of months (or years) in treatment for the

child. Caregivers were also asked about the current living arrangement for the child and the number of different caregivers the child had lived with up to that point.

It should be noted that the demographic sheet relied on the caregivers' memories about items such as early behavior problems, previous mental health treatment, and the number of different caregivers their child had lived with over the years. Relying on memory leaves some information in this study open to inaccuracy, and possible misrepresentation. The impact of the accuracy of this parent report demographic sheet on the study's results is unknown. However, the validity scales on the PIC-2 were used to eliminate response sets from this study that appeared invalid due to exaggeration, dissimulation, or minimization of problems.

The Randolph Attachment Disorder Questionnaire

The instrument that was used to assess for the presence of attachment-disordered behaviors was the Randolph Attachment Disorder Questionnaire (RADQ) (Randolph, 2000). The RADQ is a 30-item, parent-report frequency checklist of various problems that the child's caregiver has observed throughout the preceding two years. Responses on the RADQ range from 1 (*rarely*) to 5 (*usually*) and are summed up and calculated to give a total score. RADQ statements address known attachment behaviors such as "my child has trouble making eye contact when adults want him/her to," and "my child pushes me away or becomes stiff when I try to hug him/her, unless he/she wants something from me," and "my child acts overly cute and charms others to get them to do what he/she wants." The RADQ also addresses other behaviors associated with attachment-disordered children with statements such as: "my child steals . . . my child doesn't seem to feel age-appropriate guilt for his /her actions. . . my child likes to sneak things without

permission, even though he/she could have them if he/she had asked . . . my child is a pathological liar . . . my child sneaks or hoards food, or has other unusual eating habits . . . my child teases, hurts, or is cruel to animals,” and finally, “my child has set fires or is preoccupied with fire” (RADQ Answer Sheet, Randolph, 2000).

According to the RADQ manual, a score between 50 – 64 indicates the likely presence of attachment problems, and a score of 65 and above indicates the possible presence of Attachment Disorder (AD) as conceptualized by Randolph (2000). The RADQ took the participants an average of ten minutes to complete, and the majority of RADQs were completed the day the caregiver received the test packet. All RADQ response sheets were thoroughly reviewed with the parents/caregivers to insure that they completed them correctly and responded to all items.

Reliability of the RADQ. The reliability of the RADQ was established using two different techniques, test-retest reliability and internal consistency. The test-retest technique was conducted by having a group of 40 parents of children with Attachment Disorder (AD) and 30 parents of children with no history of psychotherapy (NO) complete the RADQ on two different occasions, each six weeks apart. The AD children had been diagnosed with information from the child’s social and behavioral history, psychological testing, medical and psychotropic drug history, review of prior treatment, and a psychiatric evaluation. This technique yielded test-retest correlation coefficients of .82 for the AD group and .85 for the NO group. These coefficients were within the acceptable range to establish test-retest reliability for the RADQ (Randolph, 2000).

Internal consistency (Kronbach’s alpha) was measured using the odd-even technique whereby the scores of all of the odd items were correlated with the scores of all

the even items of the RADQ. This technique was used with a group of 80 AD subjects, and a group of 35 MAL (Maltreatment history but not AD) subjects. Kronbach's alpha for the AD group was .84 and .81 for the MAL group, indicating internal consistency for the RADQ.

Validity of the RADQ. Validity for the RADQ was established using several techniques, item validity, criterion-referenced validity, construct validity, content validity, and predictive validity. Item validity was established by basing each item on a symptom from the Attachment Disorder Symptom Checklist (ADSC) (described fully in chapter II) which has been used by the Attachment Center at Evergreen (ACE) (ACE, 1995) for over 20 years to diagnose AD. The symptoms of the ADSC have been observed by clinicians to distinguish children with AD from children with other psychiatric disorders, and so were presumed to represent a solid basis for the RADQ items.

The basis for criterion-referenced validity has been discussed above in terms of the total score and item analyses that were conducted by comparing the scores of children known to have a certain criterion (in this case, AD) with children known not to have AD (this was determined based upon history and problem behaviors). Almost all of the RADQ items significantly distinguished between subject groups, except that item 30 (history of abuse or neglect) did not distinguish AD from MAL subjects, and three items did not distinguish AD from DBD (Disruptive Behavior Disorder) subjects. Such findings established the presence of criterion-referenced validity in that the RADQ was able to distinguish children in one diagnostic category from another diagnostic category.

Construct validity was established by examining whether or not the RADQ measured theoretical constructs measured by other frequently used tests whose reliability and validity has already been established. For this purpose the RADQ was correlated with the scales of three other tests, selected subscales of the Personality Inventory for Children (PIC), subscales of the Child Behavior Checklist (CBCL), and the common concerns subscales of the Millon Adolescent Personality Inventory (MAPI). The PIC subscales that were significantly correlated with the RADQ were Delinquency (DLQ $p < .001$) and Hyperactivity (HPR $p < .05$). The high correlation with the DLQ subscale and lack of correlation with the depression (DEP), Withdrawal (WDL) Psychosis (PSY) and Social Skills (SSK) subscales indicated that the RADQ measures behaviors that are commonly considered to indicate delinquent behavior, which would be expected from a test that measures oppositional /defiant and conduct disordered behaviors.

RADQ scores were correlated with CBCL scores of the 35 AD subjects from the Attachment Center at Evergreen. Significant correlations from the RADQ were found with the CBCL subscales Delinquent Behavior (DLQ) and Aggressive Behavior (AGG) (Randolph, 2000). The RADQ was examined in relation to the Common Concerns Scales of the Millon Adolescent Personality Inventory (MAPI), and only Scale B (Personal Esteem) was significantly correlated with the RADQ. The two MAPI scales that might have been expected to reach significance with the RADQ (Impulse Control and Societal Compliance) did not. However, as the MAPI can only be used with an age range between 13 and 16, the comparison between the RADQ and MAPI only used 34 AD subjects and therefore did not have sufficient data for an accurate correlation.

Personality Inventory for Children, Second Edition (PIC-2)

The other instrument that was used in this study was the Personality Inventory for Children, Second Edition (PIC-2) (Lachar & Graber, 2001). The PIC-2 was chosen so there would be an alternative measure of behavior problems of participants in the study. It was designed to evaluate the emotional, behavioral, cognitive, and interpersonal adjustment of children and teens through age 19. The PIC-2 provides extensive and clinically relevant personality descriptions of the child, as well as family characteristics. It is a parent report checklist of true/false items that has a standard form (275 items) and a behavioral summary form (96 items).

This study used the standard form of true/false items because it gives a comprehensive picture of various behavior problems and of some of the symptoms related to Attachment Disorder, such as hyperactivity, and impulsivity, delinquency, oppositionality, and conduct problems. In addition to examining PIC-2 scales in correlation to elevations on the RADQ, the PIC-2 was chosen because of its Validity Scales. The Validity scales were used to assess for the presence of possible overestimation or underestimation of the problems of the child. Below are the PIC-2 scales and subscales:

Response Validity

- Inconsistency
- Dissimulation (“Fake Bad”)
- Defensiveness

Cognitive Impairment (COG)

- Inadequate Abilities

- Poor Achievement
- Developmental Delay

Impulsivity/Distractibility (ADH)

- Disruptive Behavior
- Rash Fearlessness

Delinquency (DLQ)

- Antisocial Behavior
- Dyscontrol
- Noncompliance

Family Dysfunction (FAM)

- Conflict Among Members
- Parent Maladjustment

Reality Distortion (RLT)

- Developmental Deviation
- Hallucinations and Delusions

Somatic Concerns (SOM)

- Psychosomatic Preoccupation
- Muscular Tension and Anxiety

Psychological Discomfort (DIS)

- Fear and Worry
- Depression
- Sleep Disturbance/Preoccupation with Death

Social Withdrawal (WDL)

- Social Introversion
- Isolation

Social Skills Deficits (SSK)

- Limited Peer Status
- Conflict With Peers

Reliability and validity of the PIC-2. The PIC-2 was standardized on ratings from 2306 parents of boys and girls in kindergarten through 12th grade. Protocols were collected from 23 urban, rural and suburban schools in 12 states. Participants' parents represented all social and economic levels and major ethnic groups. In addition, data was collected from a sample of 1551 parents whose children had been referred for educational or clinical intervention (Lacher & Graber, 2001). The PIC-2 is an extension of the Personality Inventory for Children (PIC), an instrument that was first used in 1958 and has been widely applied since. The test validation process for the PIC-2 has as its basis a substantial body of validation evidence already available from the original version, the PIC. Several hundred research reports demonstrate the effectiveness of the PIC and the Personality Inventory for Children, Revised (PIC-R) in a variety of applications (Lachar & Graber, 2001; Kelly, 1988; Kelly, & Van Vactor, 1991; Clark, Kehle, & Bullock, 1988; Clark, Kehle, Bullock, & Jenson, 1987; Kline, Lachar, & Gdowski, 1987; 1992; DeKrey & Ehly, 1981; DeKrey & Ehly, 1985; Goh, Cody, & Dollinger, 1984; Clark, 1982).

The PIC-2 content revisions began with changes to test statements and were reduced from the original 600 –item PIC instrument to its present Standard Form of 275 items. Double negative responses were deleted, and a more even-handed reference to

both parents was introduced rather than the original implied presumption of only mothers as reporters. Item clarity was improved, and a fourth area was introduced to address areas of recent interest in clinical evaluation, such as eating disorders and substance abuse. A 178-item clinician symptom checklist was completed for 888 children in the referred sample. Ultimately, 110 of these ratings items were placed into six factor-derived dimensions of psychopathology. The relationship between these groupings of items and the PIC-2 ranges from coefficients of .30 to .75 for the 275 item Standard Form adjustment scales and subscales. Subscales are combined into the main scales.

Procedure

Part one: Completion of Testing Instruments and Demographic Data

The first part of the study consisted of the administration and scoring of the demographic sheets and the two assessment instruments in order to answer research questions one through six. The clinicians who had agreed to provide participants for the study met with the researcher. They were told that the purpose of the investigation was to examine the psychological functioning and behavior of children who came in for treatment. Neither clinicians nor caregivers were alerted to the study's purpose of examining the attachment relationship so as not to compromise the results of the study. The RADQ form itself does not use the word "attachment" in either its title or within the body of the test. The researcher told the clinicians that the results of the PIC-2 and RADQ for each individual client would be explained to them and the caregivers who had completed the packets. This psychological testing could then help clinicians with the specific treatment needs of their clients.

Clinicians were given packets containing the two assessment instruments as well as demographic sheets and consent forms. The researcher then instructed clinicians on how to insure that the caregivers fill out the RADQ and PIC-2 accurately. Clinicians or the primary investigator obtained a signed consent for participation from the caregivers, completed the demographic sheet during the instruction period, and then gave the two test instruments to the caregivers to fill out.

Caregivers who were most familiar with their child's behaviors (usually the maternal parent) were the ones who were asked to complete the instruments. Most of them were able to complete both the RADQ and the PIC-2 in the lobby while their children were in individual sessions with their therapists. Approximately 20 caregivers were unable to complete the instruments in one session but completed them on their return visit to the Central Office. The clinician attached the demographic sheet and consent form pertaining to the child to the two testing instruments. These four items were then returned to the researcher in person or by interoffice mail. The researcher subsequently scored all test instruments and informed the clinicians of the results pertaining to each individual client.

Ten PIC-2 response sheets were removed from the study because the caregiver inadvertently skipped over items or failed to complete the testing. Four participants' response sheets were reviewed in depth due to elevations on one of the PIC-2 Validity scales called *Dissimulation*, or the "fake bad" scale. However, collateral information was obtained through hospital discharge summaries, psychiatric evaluations, and discussion with the child's service coordinator and the parents' therapists (if applicable). In each of the four tests in question, this information insured that the caregivers were not

exaggerating the child's symptoms, and thus these response sheets were determined to be valid measures of the children's behaviors and personality traits.

Research question 1. The first research question for this study was: What percent of child clients seen in the Central Office of this Community Mental Health Agency actually received a DSM-IV diagnosis of Reactive Attachment Disorder? In order to answer this question, the Central Office administration staff generated a report on all clients brought for services to that office in the year 2002. This report contained information obtained at the initial intake sessions and if available, the annual chart reviews, and contained the name and diagnosis of each child, as well as the child's assigned clinician. A one-sample test of a proportion used the information from this report to answer research question one.

Research questions 2 and 3. Results of the Randolph Attachment Disorder Questionnaire (RADQ) were used to answer research questions 2 and 3: Research question 2 asked: What percent of CMHA child clients met the criteria for attachment problems as measured by the Randolph Attachment Disorder Questionnaire (RADQ)? Research question 3 asked: What percent of CMHA child clients met the criteria for Attachment Disorder as measured by the RADQ? The researcher calculated the RADQ scores on all participants in the study and then performed several one-sample tests of a proportion to answer each of these questions.

Research questions 4 and 5. Information from the demographic data sheet and the RADQ was used to answer research questions 4 and 5. Research question 4 asked: What was the relationship between RADQ scores and the number of caregivers? Research question 5 asked: What was the relationship between clients' scores on the RADQ and

the client's current living arrangement? A Pearson correlation was calculated between RADQ scores and the number of caregivers, and an analysis of variance was used to compute the relationship between RADQ scores and current living arrangement.

Research question 6. Research question 6 asked: What was the relationship between RADQ scores and scale scores of the Personality Inventory for Children – Second Edition (PIC-2)? The researcher put all scores of the PIC-2 test response sheets and the RADQ results into a database. Pearson correlations were then calculated between RADQ scores and scales of the PIC-2. A factor analysis was also performed to examine factor loadings for the RADQ and PIC-2 scale scores.

Part Two: Interviews of Clinicians

Part two of the research study involved interviewing CMHA clinicians about attachment issues. There are several rationales for the interview portion of this study. One reason is that interviewing provides a versatile approach to exploring social issues in depth and also can help explain quantitative information. Interviewing the actual professionals who see troubled children and who provide the diagnoses that guides treatment gives the reader a greater understanding of the world in which CMHA clinicians must do their work. It also allows these clinicians to have the opportunity to describe what they think is occurring on this issue and make recommendations of their own about the needs of their clients regarding attachment problems.

Interviews were conducted after all testing was done and demographic sheets were collected so that clinicians who chose to be interviewed were not alerted to the purpose of the study beforehand. All clinicians from the Central Office, East office, and Acute Services of the CMHA were invited to participate in individual discussions with

the researcher. Seven clinicians from the Central Office, two clinicians from the East office and two clinicians from Acute Services agreed to be interviewed. Each interview was a semi-structured format that lasted between twenty and forty-five minutes, depending upon the responses of the clinician, and all interviews were audiotaped and transcribed. After the interviews, clinicians completed a researcher-developed scale (Appendix B) of 26 symptoms or criteria that may alert them to the possibility of attachment-disordered behaviors in their clients.

All of the interviewees were master level clinicians or above and came from five graduate program specialties: Counseling Psychology, Clinical Psychology, Social Work, Art Therapy, and Marriage and Family Therapy. Interviewees ranged in experience from less than one year to thirteen years of clinical experience. Overall, these clinicians provided assessment, diagnosing, and treatment through a variety of formats for emotional and behavioral disorders of children and adolescents. All of the clinicians worked in multi-disciplinary settings and received clinical supervision. They also collaborated extensively with other community agencies for the best treatment of their clients.

Research question 7. Interview questions of the CMHA clinicians came from five primary areas of interest: the Reactive Attachment Disorder diagnosis, Attachment Disorder and the difference between the two, etiology of attachment problems, training and education about attachment, and treatment of attachment-disordered children. The questions attempted to differentiate whether clinicians based their diagnostic decision on information contained in the DSM-IV criteria for RAD or on information about known behavioral problems associated with attachment-disordered children (such as hoarding

food or cruelty to animals), or whether they made their diagnostic decisions for other reasons. The following were the five questions asked in the interviews:

7a. What do you know about the etiology of attachment issues?

7b. What do you know about the diagnosis of Reactive Attachment Disorder (RAD)?

7c. Where did you learn about these issues?

7d. What do you know about Attachment Disorder (AD) and the difference between AD and RAD?

7e. What treatment would you provide for clients with attachment problems?

After the interview process, clinicians were asked to complete a 26-item Likert-type scale (Appendix B) with response choices of *Never*, *Sometimes*, *Often*, *Very Often*, and *Always*. This researcher-developed scale was based on the behavioral symptoms from the RADQ and the Attachment Disorder Symptom Checklist (see page 47 for the complete ADSC checklist). Two additional items were added by the researcher (*death of a parent* and *previous diagnosis of RAD*). Interviewees were asked to mark those items with the frequency with which that particular item made them think of attachment problems in their clients, or when they were considering a diagnosis of RAD. Ten of the eleven clinicians completed the scale. One clinician was unable to complete the scale due to time constraints.

Interview analysis. A descriptive and pragmatic approach (Miles & Huberman, 1994) to this analysis was followed in order to most efficiently answer the questions posed by this study. In some instances the interview data revealed additional findings that were not in direct response to the research questions, but added valuable information about recognition and treatment of Attachment Disorder. These findings are included in

the final report as well. The general procedures were to describe patterns or regularities in the data set (Bryam & Burgess, 1994; Miles & Huberman, 1994), but the researcher also looked for specific “telling” examples that illustrate what clinicians know or do not know.

To begin, the researcher reviewed her research question concerning this analysis: What do clinicians know about attachment issues? She read all transcripts, making notations in the margins of the transcripts about her hunches about what is being communicated by the clinicians. Then, using key words or phrases found in the original transcripts, the researcher made a list of the *content* of the interviews (Miles & Huberman, 1994). After multiple readings of the interviews, marginal notes, and a list of key words that represent the content, the researcher created a set of codes that potentially answered the research question of this data set. These codes are defined below.

The researcher coded the interviews by assigning each response to a question with a color code that represents the content in that response. As the coding continued the researcher refined her analysis (i.e., adding additional color codes). After coding and re-coding was completed, the researcher trained a fellow researcher in how she had interpreted the content of the interviews using her set of codes. The second researcher then coded a portion of the interviews. When needed, the two researchers negotiated their different views and codes were redefined. Finally, the researchers looked across the interviews for patterns, paying special attention to what both experienced and new clinicians knew, and how they learned their information. This data was then linked to the quantitative findings as one explanation for some of the results of the study.

Reciprocity and Ethical Considerations

The researcher paid careful attention to securing the anonymity of the participants (both clients and clinicians) and all data were held confidential. The researcher met individually with each of the participating clinicians and discussed the results of their clients' RADQ and PIC-2 test scores. Elevations on any of the scales were discussed with the clinician so that he or she would have more knowledge about their clients and consequently clarify effective treatment goals for them. The parents of the clients were also given the results of the testing, either by the researcher herself or by the child's clinician. Further, when the researcher recognized what she believed to be the likelihood of an attachment problem based on the scores obtained, she respectfully informed the clinicians so that the child could get appropriate treatment.

CHAPTER IV

PRESENTATION OF FINDINGS

Introduction

The purpose of this study was to address the question of whether children who are brought for treatment at community mental health agencies (CMHA) may have unrecognized attachment difficulties as the root of their behavior problems. A particular dilemma is that CMHAs generally require clinicians to give their clients a diagnosis on the initial intake session, yet the DSM-IV criterion for Reactive Attachment Disorder does not address the severe behaviors that generally bring the attachment-disordered child into treatment. Since these behaviors fit several different disorders, there is considerable diagnostic confusion, leading clinicians to choose diagnoses that may not address the underlying etiology of the disturbed behaviors (i.e., an insecure attachment to the caregiver). Therefore, early recognition that some behavior problems may stem from attachment issues is critical.

The process of addressing this issue began with a thorough review of the literature. This review covered the severe behaviors associated with Attachment Disorder, as well as reviewed observational techniques (Strange Situation protocols) to assess the early parent-child relationship. However, few practical instruments were

found that assess the attachment-disordered behaviors of older children. Perhaps because of this dearth of assessment instruments, the frequency of this disorder appears to be unknown. Nevertheless, one available instrument, the Randolph Attachment Disorder Questionnaire, was used in this study to screen for the assessment and frequency of attachment problems and Attachment Disorder, as conceptualized by Randolph (2000). The Personality Inventory for Children, Second Edition was used as a measure of behavior problems of the children to confirm the additional disorder needed for Randolph's concept of AD. It was also included because of its validity scales.

Descriptive Statistics

Participants in this study were 100 caregivers of child clients in one office site of a community mental health agency. This agency is located in an urban county in the central part of the United States. Caregivers included birth parents (N = 13), birth mothers (N = 50), birth fathers (N = 6), relatives (N = 22), foster parents (N = 3), and adoptive parents (N = 6). Over 30% of the study's participants had been in treatment for less than a month; however, the average number of months in treatment for all study participants was 16 months. Other statistics from the study can be seen in Table 1.

Table 1

Descriptive Statistics of Study Participants

	Minimum	Maximum	Mean	
Age	5	17	9.39	
	Male	Female		
Gender	53%	47%		
	Caucasian	African American	Bi-racial/Other	
Ethnicity	78	16	6	
	Yes	No	Unknown	Total
Behavior Problems				
Prior to Age 5	59%	34%	7%	100%

Research Question 1: What Percent of CMHA Clients Received a Diagnosis of Reactive Attachment Disorder?

In order to answer this question, on August 8, 2002, the Central Office administration staff generated a report on all 662 clients who had received services through the Central office of this CMHA. A total of 271 clients came from the Behavioral Health team. Clinicians on this team provide individual, family and group

therapy for behavior problems related to neglect, unsubstantiated cases of abuse, and problems due to changes in life circumstances.

The Transitions team had 125 clients receiving services at the time of the study. This treatment team provides a comprehensive array of mental health services for victims and perpetrators of spouse abuse, sexual abuse, and familial child abuse. Finally, 266 clients were being seen by the Family Connections team that provides a wide range of outpatient mental health services for children and adolescents with severe emotional disabilities (SED). Table 2 gives a list of the diagnoses that were given to these clients at the beginning of data collection for this study, regardless of their time in treatment.

Table 2

Percent of Primary Diagnoses of Child Clients in the Central Office of the Community Mental Health Agency

Diagnoses	Percent of total
Disruptive Behavior Disorders	44
Depressive Disorders	12
Anxiety Disorders	8
Adjustment Disorders	34
Other Disorders (Developmental and Psychotic Disorders)	0.90
Reactive Attachment Disorder	0.90

The proportion of CMHA child clients diagnosed with Reactive Attachment Disorder was $6/662 = .00906$. Because of the lack of epidemiological studies on the frequency of this disorder, the author's research hypothesis was that the proportion would be less than five percent. A one sample test of a proportion resulted in $z = -11.17$, $p < .05$, indicating support for the hypothesis that the proportion was less than five percent. A 95% confidence interval for the proportion was calculated and ranged from .00184 to .01627. Thus, one can be 95% confident that the percentage of clients diagnosed with RAD is between .18% and 1.6%.

As a comparison to the diagnostic results of the study sample, Table 3 illustrates the diagnoses given on approximately 30,000 children from the evaluation of the Comprehensive Community Mental Health Services for Children and Their Families program (1999). No one in that study had been listed as receiving a diagnosis of Reactive Attachment Disorder. The authors of this evaluation program did not delineate how the diagnoses were obtained. Therefore, it is not clear if RAD was not a choice in the list of diagnoses, or if in fact no child in the program evaluation had been given a diagnosis of Reactive Attachment Disorder.

Table 3

Percent of Diagnoses of 30,000 Child Clients of the Comprehensive Community Mental Health Services for Children and Their Families Program Evaluation (1999)

Diagnoses	Percent of Total
Disruptive behavior disorders (ADHD, ODD, CD)	43
Depressive disorders	27
Anxiety disorders	8
Adjustment disorders	6
Other disorders:	8
(Substance abuse, eating disorders, somatic, speech problems, enuresis, poor self-concept, phobia, and psychosis)	

Note. Reactive Attachment Disorder was not listed as a diagnosis in this program evaluation.

Research Question 2: What Percent of CMHA Clients Scored with Attachment Problems as Measured by the RADQ?

The proportion of CMHA child clients who scored between 50 - 64, thus indicating the likelihood of having attachment problems as measured by the RADQ was $18/100 = .18$ (18%). Based on the literature review that showed similar percentages of

foster and adopted children who show the presence of behavior problems, the author's research hypothesis was that the proportion would be less than 30%. A one sample test of a proportion resulted in $z = 3.125$, $p < .30$, indicating support for the hypothesis that the proportion was less than thirty percent. A 95% confidence interval for the proportion was calculated and ranged from .1047 to .2552. Thus, one can be 95% confident that the percentage of clients who are likely to have attachment problems is between 10% and 25%.

Research Question 3: What Percent of CMHA Clients Scored with Attachment Disorder as Measured by the RADQ?

The proportion of CMHA child clients who scored 65 and above on the RADQ, indicating the likelihood of Attachment Disorder, was $23/100 = .23$ (23%). The researcher's hypothesis was that the proportion would be less than two percent, per the CMHA study that showed no occurrence of RAD (Annual Report to Congress, 1999). A one-sample test of a proportion resulted in $z = 4.99$, $p > .02$, indicating the null hypothesis was retained. Thus, the research hypothesis was not supported.

Research Question 4: What Was the Relationship Between RADQ Scores and the Number of Caregivers?

An explanation of "caregiver" is necessary for the reader to understand what participants were asked regarding the number of caregivers that their child had. Birth parents who had been living together in the same home since the child was born were coded as one caregiver; birth parents who lived apart, requiring the child to spend time in two homes with two separate parents (and possibly stepfamilies), were coded as two

caregivers. If the child had not spent any significant time with the noncustodial parent, only one caregiver was coded. Children who had lived with a grandparent for part of their lives prior to moving to a separate home with a birth parent were coded with at least two caregivers, with the grandparent being coded as a separate caregiver. Foster and adoptive parents were coded as separate caregivers as well. In this study, the number of caregivers ranged from 1 to 8.

A Pearson correlation was calculated between RADQ scores and the number of caregivers ($r = .352$). As the number of caregivers increased, RADQ scores increased, indicating that a positive, significant relationship at the .01 level was found between RADQ scores and the number of caregivers with whom the child had lived.

Research question 5: What Was the Relationship Between RADQ Scores and the Client's Current Living Arrangement?

Caregivers were asked to choose their child's current living arrangement out of seven choices (both birth parents, birth mother, birth father, relative, foster family, adoptive family, or residential/hospital setting). The final number in each of the categories was quite uneven and too small for analyses in some cases. Therefore, the researcher chose to combine living arrangements into two groups, birth parents (birth mother, birth father, both birth parents) ($N = 69$) and all other caregivers (relative, foster family, adoptive family, or residential/hospital setting), a variable called non-birth parents ($N = 31$). For the comparison of RADQ scores of children with their birth parents versus children in other living arrangements (non-birth parents), a one-way analysis of variance (ANOVA) was performed. There was no statistically significant

difference in the means, $F(1, 98) = .032, p = .86$. The RADQ scores of birth parents ($M = 44.96$) and non birth parents ($M = 44.13$) were similar.

Research question 6: What Was the Relationship Between RADQ Scores and PIC-2 Scale Scores?

Pearson correlations were calculated between RADQ scores and scales of the Personality Inventory for Children, Second Edition (PIC-2). Results are shown in Table 4. As can be seen in the table, significant correlations were found between the RADQ scores and Cognitive Impairment (COG), Impulsivity/Distractibility (ADH), Delinquency (DLQ), Reality Distortion (RLT), Psychological Discomfort (DIS), and Social Skills Deficits (SSK). The two strongest relationships were between RADQ and ADH ($r = .745$) and between RADQ and DLQ ($r = .814$). No relationship was found between RADQ scores and the PIC-2 scales of Family Dysfunction (FAM), Somatic Concerns (SOM) and Social Withdrawal (WDL).

Table 4

Pearson Correlations between RADQ scores and PIC-2 Scale Scores

PIC-2 Scale Score	r
COG	.446**
ADH	.745**
DLQ	.814**
FAM	.138
RLT	.606**
SOM	-.007
DIS	.335**
WDL	.006
SSK	.404**

$p < .01$ ** Correlation is significant at the .01 level (2 tailed)

Factor analysis of research question 6. To further address the relationship between RADQ Scores and PIC-2 scale scores, a factor analysis was performed using the RADQ scores and the PIC-2 scores as variables. Table 5 shows a summary of the factor analysis. Principal component analysis was performed, followed by a varimax rotation of components with an eigenvalue exceeding 1.00. The latter components were interpreted as factors.

The Kaiser-Meyer-Olkin measure of sampling adequacy was .79. This exceeds the minimum value of .60 that is used to indicate whether data can be factor analyzed (Stevens, 2002). Thus the data were appropriate for the analysis performed. Two factors were extracted and these accounted for 61% of the variance in the 10 variables that were analyzed.

As can be seen in Table 5, the first factor (externalizing behaviors) had the highest loadings on the variables Attachment Problems (RADQ), Cognitive Impairment (COG), Inattention and Impulsivity (ADH), Delinquency (DLQ), and Reality Distortion (RLT). The second factor (internalizing behaviors) had the highest loadings on Somatic Concerns (SOM), Psychological Discomfort (DIS), Withdrawal (WDL), and Social Skills Deficits (SSK).

Table 5

Factor Loadings and Communalities Estimates for Varimax Rotated Solution of RADQ and PIC-2 Variables

Variable	Factors		Communality
	1	2	
RADQ	.89	.06	.80
COG	.62	.29	.47
ADH	.90	.00	.82
DLQ	.90	.04	.81
FAM	.14	.29	.11
RLT	.69	.48	.71
SOM	-.09	.66	.44
DIS	.40	.66	.59
WDL	-.10	.86	.75
SSK	.39	.66	.58

Summary of Quantitative Results

In review, the proportion of 662 CMHA child clients who had been diagnosed with Reactive Attachment Disorder was less than one percent. The actual proportion of CMHA child clients who scored between 50 – 64 on the Randolph Attachment Disorder Questionnaire, thus indicating the likelihood of having attachment problems was 18%.

The proportion of CMHA child clients who scored with Attachment Disorder as measured by the RADQ was 23%, for a total of 41% of study participants showing the presence of attachment problems ranging in severity. There was no significant difference in the means on the RADQ between participants living with their birth parents and those living with non-birth parents. However, a positive, significant relationship was found between RADQ scores and the number of caregivers with whom the child had lived, indicating the greater the number of caregivers, the greater the likelihood of attachment problems and Attachment Disorder.

Significant correlations were found between the RADQ scores and scale scores on the Personality Inventory for Children, Second Edition (PIC-2). The two strongest relationships were found between RADQ scores and scores on the PIC-2 scales of Delinquency and Impulsivity/Distractibility. Significant correlations were also found between RADQ scores and these PIC-2 scales: Cognitive Impairment, Reality Distortion, Psychological Discomfort, and Social Skills Deficits. No relationship was found between RADQ scores and the PIC-2 scale scores of Family Dysfunction, Somatic Concerns, and Social Withdrawal. Results of the factor analysis on the two testing instruments showed that the first factor of primarily externalizing behaviors had the highest loadings on the variables Attachment Problems (RADQ), Cognitive Impairment, Impulsivity/Distractibility, Delinquency, and Reality Distortion. The second factor (internalizing behaviors) had the highest loadings on Somatic Concerns, Psychological Discomfort, Withdrawal, and Social Skills Deficits.

Research Question 7: What Do CMHA Clinicians Know About Attachment Disorder?

All clinicians from the Central office, East office, and Acute Services of the CMHA were invited to participate in individual discussions with the researcher. Seven clinicians from the Central office, two clinicians from the East office, and two clinicians from Acute Services agreed to be interviewed. All interviewees were master level clinicians or above and had between thirteen years to less than one year of experience working as therapists. These CMHA clinicians came from five different specialties of graduate programs: Clinical Psychology (N=2), Counseling Psychology (N = 4), Art Therapy (N=1), Social Work (N =3), and Marriage and Family Therapy (N=1). Interview questions of the CMHA clinicians came from five primary areas of interest:

7a. What do you know about the etiology of attachment issues? The individual interviews began with each therapist elaborating on their understanding of attachment and the knowledge they had about the development of attachment problems. Despite some gaps in information and training on the subject of Attachment Disorder, each person thoughtfully considered what it was they knew and believed about this topic. All of the interviewees recognized that the attachment relationship began in infancy or early childhood and involved the relationship with the primary caregiver. According to several of the clinicians, when the attachment became problematic, it was considered to be “a deeper problem” than normal relationship concerns surrounding transitional life issues, and involved a fundamental dilemma. Several clinicians discussed their insight that neglect or sexual and physical abuse could be possible causal factors.

Despite a general understanding of the attachment relationship, some misperceptions were apparent about the etiology of this disorder. Although clinicians

understood that attachment problems likely stemmed from a problem in the primary relationship, few discussed specifically what it was about that relationship or the caregiver's behavior that was unhealthy and led to the development of the child's attachment problems. For instance, one clinician speculated that attachment problems began because of a parenting style; parents simply did not pay enough attention to their children. Another interviewee thought attachment problems developed because parents believed that they would spoil their children if they held them too much, or picked them up when they were crying. A relatively new clinician believed that Reactive Attachment Disorder was something that a child "had as a baby," which then went away after he or she reached elementary age. Finally, one person pointed out that it was excessive use of television that contributed to the development of an Attachment Disorder. However, she did not clarify whether it was the violence on TV or the absence of interaction with the caregiver while the child was watching TV that had the negative impact.

7b. What do you know about the diagnosis of Reactive Attachment Disorder (RAD)? Most of the clinicians were familiar with the DSM-IV criteria for Reactive Attachment Disorder. The most fundamental perception of the RAD diagnosis was that it was associated with Criterion A2, indiscriminant sociability and poor boundaries. Clinicians described these children as "kids who will give you a hug and talk to you like they've known you forever, and divulge their most intimate details." As one therapist put it, "whenever a kid instantly makes me their best friend, I always think of RAD and do a rule out." Clinicians discussed seeing clients who displayed attachment behaviors to strangers they knew less than a day or even an hour, and stated that they saw more of these unhealthy attachments from their adolescent clients. Not many clinicians had

observed clients with Criterion A1, excessive inhibition or hypervigilance, though one described it this way: “They do not like to be genuinely touched or hugged, and they won’t show emotion with other people.” Finally, several interviewees associated Reactive Attachment Disorder with multiple placements and children in foster care. However, no one mentioned adopted children as being at greater risk for attachment problems.

Most of the interviewees were knowledgeable about the criteria for a diagnosis of Reactive Attachment Disorder, although one clinician who had recently finished graduate school expressed surprise that it was an actual diagnosis in the DSM-IV. Only two of the more experienced clinicians had ever given a diagnosis of Reactive Attachment Disorder, and very few interviewees even mentioned ruling it out. A reason given by one of the clinicians was that relationship issues seemed secondary to the mood or behavior problems that brought their clients to treatment. Instead, they gave diagnoses such as Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Disruptive Disorder, Intermittent Explosive Disorder, Generalized Anxiety Disorder, or Oppositional Defiant Disorder. Yet in the interviews, clinicians described attachment-disordered behaviors in clients for which they had given these other diagnoses. If a client had experienced an early trauma with a caregiver, mentioned one interviewee, she might give a diagnosis of Post Traumatic Stress Disorder, with an additional code of neglect or abuse on Axis I.

“Our supervisors prefer that you just note ‘attachment problems,’” stated one clinician. She was unsure why this was so, but reported that many of her coworkers were very uncomfortable giving this diagnosis. “Maybe because we have to go with what the doctors say, and doctors don’t give this diagnosis. It’s not medically-based, and there’s

not a pill for it.” Another therapist felt that a RAD diagnosis was demeaning and would not assign this to anyone. Nor would she give a Conduct Disorder diagnosis because they were both “too serious.” Clients who had had these diagnoses were considered incorrigible in a sense, and were very difficult to treat, in her estimation. Therefore, by assigning a diagnosis of Reactive Attachment Disorder or Conduct Disorder implied the client had an extremely difficult and perhaps untreatable diagnosis.

7c. What do you know about Attachment Disorder (AD) and the difference between AD and Reactive Attachment Disorder? Only two of the clinicians were conscious of the fact that Attachment Disorder was considered a separate syndrome from RAD by specialists in the field. However, when questioned about behaviors they thought were attachment-related, many were correctly able to identify some of the symptoms associated with an attachment-disordered child. One of the clinicians speculated that pathological lying, stealing, hoarding food, and doing dangerous things could be part of an attachment problem, because as she pointed out, these symptoms did not appear to belong to other diagnoses. Another mentioned intentional encopresis, manipulative, passive-aggressive actions, and self-injury as possible symptoms. Other symptoms that were identified as possible indicators for attachment problems were serious noncompliance and violent behavior.

There were some mistaken beliefs and general confusion between AD symptoms and symptoms of other disorders. For instance, several clinicians thought that being whiny and anxious in general was a definite sign of an attachment problem. One therapist also felt that regression in social skills was a result of a problem in the attachment relationship. They appeared “almost autistic,” she reported, saying such

children would pick on other students, and then fail to understand why those peers would get upset with them. Descriptions of hyperactivity and inattention were cited as symptoms, as well as “irrational emotionality,” as one therapist put it. No one mentioned that a lack of remorse, fire setting, or cruelty to animals or people might be possible symptoms of an Attachment Disorder.

7d. Where did you learn about attachment issues? The interviewees represented five different graduate training specialties: Counseling Psychology, Clinical Psychology, Social Work, Art Therapy, and Marriage and Family Therapy. All of the clinicians felt that the diagnosis of Reactive Attachment Disorder was troublesome, and many felt ill prepared to recognize or treat this disorder. The foremost reason, according to the interviewees, was due to the lack of education about this and other areas of child psychopathology in their graduate programs. None of the clinicians had learned about attachment theory in their coursework, and no one identified attachment theory as their orientation.

The diagnostic focus of their programs seemed to be adult psychopathology and diagnoses such as Major Depression, Anxiety Disorders, Schizophrenia, Psychotic Disorders, and “whatever the professor was interested in.” There was a general consensus that classes on theories, techniques and the Diagnostic Statistical Manual only lightly covered children’s issues, even well known childhood problems such as Attention Deficit Hyperactivity Disorder. In fact, according to one interviewee, her Social Work program did not offer clinical courses at the time she was enrolled. However, it was in this same program that one of her professors showed a film about a child with Attachment Disorder, “otherwise I wouldn’t have had a clue.”

Clinicians who had taken a child psychology class as an elective learned about attachment theory, although by their report, it wasn't usually discussed for more than part of one class period. One of the interviewees reported that a therapy technique class for children was offered in her program but only sporadically, so she was unable to fit it in her schedule before she graduated. Generally, therapists agreed that they hadn't had much exposure through their programs in terms of recognizing problems in the attachment relationship or behaviors related to Attachment Disorder, and most of them were either unaware of or confused by the variety and magnitude of the behavioral symptoms of attachment-disordered children.

Despite staffing every new case, some of the therapists couldn't think of a single coworker who had ever given a diagnosis of RAD, and most had never had a client who came to them from another therapist with that diagnosis. One of the clinicians stated that because her field experience had been with adolescents in a residential setting, she was unfamiliar with Reactive Attachment Disorder. She believed that it only pertained to younger children, and therefore did not consider it a factor in any of her older child clients. However, another therapist reported that it wasn't until she worked in a residential treatment setting for teenagers that she became familiar with this diagnosis, as some of the treatment center's staff recognized that some of the residents there had attachment problems. One interviewee reported that she learned about attachment issues because of her work with foster care children.

A member of the Transitions team stated that because "most folks come here for sexual abuse and trauma issues, we probably don't see as much of it [RAD] as the other teams." Conversely, another Transitions therapist believed that the Transitions team

clinicians were *more likely* to see attachment problems in their clients because they were the team that accepted referrals for physical and sexual abuse, a risk factor for the disorder. However, she herself had never given this diagnosis to a client. Many clinicians pointed out that it was only after they had worked with children for a long period of time that they had heard of this disorder, although even then it was not a focus of diagnosis or treatment.

7e. What treatment would you provide for clients with attachment problems?

Very few therapists felt prepared to treat a child with Attachment Disorder. “If I had a case I knew for sure was RAD, I’d be pretty concerned about my own abilities,” stated one clinician. Some mentioned that they would provide individual, family and group therapy for a child with attachment problems, essentially the same treatment they provide for children with other disorders. One therapist stated that a technique that she would use would be to show a video on attachment disorder to her clients with this diagnosis, so they would not “feel so alone.” Although several clinicians felt some confidence in their abilities to treat a child with attachment problems, most of them stated they would further their knowledge by reading books, exploring available training, or seeking supervision from someone knowledgeable in the field.

The strongest reaction most clinicians had concerning treatment for attachment-disordered children was the perception that therapy for children with AD was completely different from the clinical work they were providing for other troubled children. They were quite intimidated, so much so that they avoided the diagnosis altogether. “I’m not going to look at it [RAD] because I really don’t know what to do. When I do see stuff I know what to do, like behavior or mood problems, I focus on that. RAD is one of those

diagnoses that don't tend to be in my frame of vision.”

After the interview process, clinicians were asked to complete a 26-item Likert-type scale (Appendix B) with response choices of *Never*, *Sometimes*, *Often*, *Very Often*, and *Always*. This researcher-developed scale was based on some of the behavioral symptoms from the RADQ and items from the Attachment Disorder Symptom Checklist. Two items were added by the researcher (*death of a parent* and *previous diagnosis of RAD*). Interviewees were asked to mark those items with the frequency with which that particular item made them think of attachment problems in their clients, or when they were considering a diagnosis of RAD.

The symptoms listed below were *Never* or *Sometimes* recognized by clinicians as associated with attachment problems/RAD diagnosis:

- a. Death of a parent
- b. Defiant and oppositional behavior
- c. Stealing
- d. Persistent nonsense questions / incessant chatter
- e. Lying
- f. Aggressive towards self, self injury
- g. Aggression towards others
- h. Cruelty to animals
- i. Encopresis, enuresis
- j. Impulsivity
- k. Destroys property
- l. Preoccupied with fire and gore

- m. Sleep problems
- n. Learning problems in school
- o. Difficulty paying attention

Only two symptoms were chosen by the clinicians as *Very Often* or *Always* in association with RAD: *indiscriminate friendliness with strangers*, and *a previous diagnosis of RAD*. It seems that these were the primary “red flags” for clinicians when considering attachment problems. However, as stated earlier, only two clinicians reported that they had ever given a diagnosis of RAD or worked with a child who had come to them with a diagnosis of RAD. In examining the individual responses of the interviewees on this scale, it appeared that clinicians who had more years of experience or who had had a client with a diagnosis of RAD were more likely to recognized symptoms related to Attachment Disorder.

CHAPTER V

SUMMARY, EXPLANATIONS, AND RECOMMENDATIONS

Summary of the Study

This study addressed a problem with several components: the identification of clients in a community mental health agency who may have attachment problems or Attachment Disorder, and then measuring the frequency with which this particular disorder occurs. The specific CMHA that provided the participants for this study is located in an urban area in the central part of the United States. This agency has over 1300 employees and offers a wide variety of services such as outpatient treatment, crisis intervention, drug and alcohol services, and residential living facilities. The Central Office of this CMHA typically sees hundreds of child and adult clients each year, and was the site of this study.

Three instruments were used to answer the quantitative research questions: a demographic sheet developed by the researcher, the Randolph Attachment Disorder Questionnaire (RADQ) (Randolph, 2000), and the Personality Inventory for Children-Second Edition (PIC-2) (Lachar & Gruber 2001). The qualitative research question, addressing the knowledge and experience of CMHA clinicians regarding this diagnosis and disorder, was carried out through interviews of eleven CMHA clinicians. The

interviews were conducted after all testing was completed so that clinicians who volunteered for the interviews/discussions were not alerted to the purpose of the study beforehand. The eleven clinicians ranged in experience from one year to thirteen years of clinical work and represented five types of specializations in the mental health field: Counseling Psychology, Clinical Psychology, Social Work, Art Therapy, and Marriage and Family Therapy.

Results of the quantitative part of the study revealed several things. In August 2002, less than one percent of all 662 of the child clients of the CMHA had received a diagnosis of Reactive Attachment Disorder. However, testing results from the 100 study participants during the same time period showed that 18% of CMHA child clients received scores on the Randolph Attachment Disorder Questionnaire indicating the presence of attachment problems, and an additional 23% of CMHA child clients in the study received RADQ scores indicating the likelihood of having Attachment Disorder. Results also showed that there was no significant difference in RADQ scores between participants living with their birth parents and those who were living with relatives or in other living situations. However, an increase in the number of caregivers a child had lived with did significantly impact the development of this disorder.

Significant correlations were found between the RADQ scores and over half of the scale scores on the Personality Inventory for Children, Second Edition (PIC-2). The two strongest relationships were found between RADQ scores and the PIC-2 scale scores of Delinquency and Impulsivity/Distractibility. Significant correlations were also found between RADQ scores and the PIC-2 scales of Cognitive Impairment, Reality Distortion, Psychological Discomfort, and Social Skills Deficits. No relationship was found between

RADQ scores and the PIC-2 scale scores of Family Dysfunction, Somatic Concerns, and Social Withdrawal. Results of the factor analysis of these two testing instruments showed that the first factor (Externalizing Behaviors) had the highest loadings on the variables of Attachment Problems (RADQ), Cognitive Impairment, Impulsivity/Distractibility, Delinquency, and Reality Distortion. The second factor (Internalizing Behaviors) had the highest loadings on Somatic Concerns, Psychological Discomfort, Withdrawal, and Social Skills Deficits.

Explanations and Implications

When children experience serious disruptions in the attachment relationship with their primary caregivers, they may change in ways that have lasting consequences for themselves, their caregivers, and their community. It has been several decades since researchers began to report longitudinal relations between insecure attachment organizations in early childhood, and angry, noncompliant, and remorseless behaviors in older children (Ainsworth et al., 1978; Arend & Sroufe, 1978; Egeland & Sroufe, 1981; Erikson et al., 1985; Fagot & Kavanagh, 1990; Lynam, 1996; Matas et al., 1978).

This relation between attachment disruptions and severely disturbed behaviors has been found to be particularly true for children in living situations with multiple risk factors. In particular, a review of the literature shows that children are at an increased risk of developing attachment problems if they live in severely abusive or violent homes. Caregivers who are teenagers, single parents, who have mental illnesses, substance abuse problems or psychopathy have also been found to contribute to the increase in attachment disturbances seen in their children (Bates et al., 1991; Belsky et al., 1996; Fagot & Kavanagh, 1990; Goldberg et al., 1986; Hay et al., 1992; Lyons-Ruth et al., 1991; Lyons-

Ruth, et al., 1994; Lyons-Ruth, 1996; Main & Hesse, 1990; Rutter, 1979; Sroufe, 1983; van IJzendoorn et al., 1992; Zahn-Waxler et al., 1990).

The identification of attachment problems through the use of the DSM-IV is a troublesome issue for clinicians in community mental health agencies. The only available diagnosis that addresses an attachment relationship is Reactive Attachment Disorder. This disorder simply addresses the problem of social relatedness, a criterion that is difficult for parents to recognize and clinicians to assess in therapeutic sessions. Additionally, for many CMHAs, if abuse and/or neglect have not been substantiated by child protective services or within a court system, the RAD diagnosis cannot be given. Consequently, the inclusion of pathogenic care as a criterion for RAD may actually inhibit clinicians from assigning this diagnosis to their clients, rather than lead to overdiagnosing, a concern that had been expressed by Hanson and Spratt (2000).

Clinicians also tend to choose less restrictive diagnoses for their child clients, such as adjustment disorders, especially if it is the child's first time in treatment at that agency. Some CMHA clinicians also have a perception that the RAD diagnosis is a demeaning label and therefore will not use it. Another difficulty for clinicians is that the severely disturbed behaviors associated with Attachment Disorder fit other disorders as well. Symptoms of Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD), and Conduct Disorder (CD) have been associated with histories of abuse/neglect, adoption, and multiple foster homes prior to adoption, as well as with insecure attachments (Alston, 2000; Barkley, 1990; Simmel et al., 2001). Despite this association, none of these diagnoses address the possibility that the underlying etiology of the disturbed behaviors

may be a problem with the attachment relationship. Since it is the diagnosis that guides treatment, this issue raises serious concern.

Frequency of the Reactive Attachment Disorder Diagnosis

The Diagnostic and Statistical Manual-IV (APA, DSM-IV, 1994) noted in 1994 that epidemiological data on Reactive Attachment Disorder was limited, but that RAD appeared to be very uncommon. The DSM authors' meaning of the term "uncommon" is not clear and could have several different connotations. The question in this case is whether attachment problems or attachment disorders rarely occur, or whether RAD is a diagnosis that is infrequently assigned to clients. This study points out that less than one percent of CMHA clients had received a primary diagnosis of Reactive Attachment Disorder, yet 23% showed behaviors at a severity level indicative of Attachment Disorder. In addition, CMHA clinicians reported in the interviews that they rarely assigned this diagnosis due to the complexity involved in recognizing the RAD criteria. There was also a lack of awareness that the severe behaviors seen with other disorders have been associated with Attachment Disorder.

Frequency of Attachment Problems and Attachment Disorder

CMHAs are not alone in facing this difficulty, as neither the National Institute of Mental Health listed RAD as a diagnosis (NIMH, 2002), nor did the Comprehensive Community Mental Health Services Program Evaluation list RAD in the report's diagnoses (Annual Report to Congress, 1999). An important fact must be considered concerning the families and children in this CMHA Program Evaluation. Data was collected on over 40,000 children receiving services from CMHAs across the country.

Seventy nine percent of these families reported the presence of one or more risk factors such as physical abuse, sexual abuse, family violence, drug/alcohol abuse, or a family history of mental illness (Annual Report to Congress, 1999). All of these risk factors have been highly correlated with attachment problems. This presumes then, that a certain percentage of the children who had received services at the CMHAs in this program evaluation may have had the presence of undetected attachment problems or Attachment Disorder, despite the fact that none of them had received a diagnosis of RAD.

Readers may ask why this seems to be such a significant problem. A strong concern is that community mental health agencies may be the first mental health resource to come in contact with a child with an undetected attachment problem, particularly those children who live in high risk settings. CMHAs often are the agencies that treat the families with the highest number of risk factors, making it more likely that they might see children with this disorder. If children do not get better with their first round of treatment at a CMHA, they often are brought back with worsening behavior over time, creating a revolving door effect. Therefore, the need for identifying the presence of these problems at the first treatment level is essential, both for providing the best possible treatment for these children and their families, and for the good of the community at large.

Despite the results that indicated that less than one percent of CMHA clients received a diagnosis of RAD, the actual presence of attachment problems and Attachment Disorder as measured by the RADQ appeared to be far more prevalent, with almost 41% of study participants falling in these two categories. As a note of caution, the RADQ was used as primarily as a screener for Attachment Disorder and not as a diagnostic certainty. However, findings from this study are similar to the attachment studies in the meta-

analysis by van IJzendoorn (1995) that showed 55% of individuals in the general population had secure attachments, and 45% showed some kind of insecure attachment (avoidant, ambivalent, disorganized). The outcome of this present study and the van IJzendoorn meta analysis supports the idea that perhaps attachment problems may be present in CMHA clients but simply difficult to distinguish.

Number of Caregivers and Attachment Problems

Numerous researchers have reported that multiple caregivers increase the risk of attachment problems (Barber et al., 2001; Bowlby, 1988; Brown & Epps, 1966; Craft et al., 1964; Earle & Earle, 1961; Fanshel & Shin, 1978; Greer, 1964; Hughes, 1997; Naess, 1962). This study appeared to confirm that as well. A positive, significant relationship was found between the number of caregivers and attachment scores. As the number of caregivers increased, RADQ scores increased also, indicating an increase in attachment-related behavior problems.

Current Living Arrangement and Attachment Problems

One focus of this study was to call attention to neglect as a risk factor for Attachment Disorder, particularly a form of neglect that Bowlby calls “pathogenic parenting,” when the caregiver cannot or does not respond to the needs of the child. This form of neglect may be difficult to recognize or substantiate, and as a result, attachment issues may be overlooked in children still living with their biological parents (Bowlby, 1979; Fahlberg, 1991). Numerous studies have documented the relationship between neglect and insecure attachments (Belsky et al., 1984; Grossman et al., 1985; Lyons-Ruth et al., 1987; Main et al., 1979; Matas et al., 1978; Rutter, 1997). Therefore, removal from

the birth home is often an indicator that behavior problems may be related to an attachment problem. However, as discussed earlier, there was no difference in mean RADQ scores from those children living with birth parents and those children who were in a living arrangement with other caregivers such as relatives, foster families or adoptive families.

During the interviews of the CMHA clinicians, an interesting point was made. When asked directly if any of their current clients might have attachment problems, the clinicians only identified clients who were no longer living with their birth parents. None of the clinicians had considered that the behavior problems of children who were still living at home might have been due to a disturbance in the attachment relationship. However, in view of the fact that pathogenic parenting is difficult to identify and document, and birth parents may not admit to or even recognize such dynamics themselves, it was not surprising that clinicians missed some of the attachment problems in this population. The implication that some of the children who were showing the presence of an attachment disorder were living with a birth parent implies that all children must be assessed for attachment disturbances, not just those who have been removed from their birth home.

Correlation of the RADQ and the Personality Inventory for Children – Second Edition

This study found significant correlations between scores on the Randolph Attachment Disorder Questionnaire and more than half of the scales on the Personality Inventory for Children, Second Edition (PIC-2). The highest correlation was between RADQ scores and the PIC-2 scale of Delinquency. Children with high Delinquency scores are described as demonstrating poor judgment and irresponsible, selfish behavior.

They lie, steal, and threaten to run away from home, get in trouble with the police, and damage the property of others. High scorers on the Delinquency scale are often irritable, defiant, and tend to blame others for their own problems. Both parents and teachers report that these children are disobedient, disruptive, argumentative, and complain frequently. Many of them underachieve in school, are often truant, and get in frequent fights with other students. Of particular concern is their assaultive and violent behavior.

This PIC-2 scale description of delinquency is similar to McKelvey (1995) and Randolph's (2000) conceptualization of the delinquency associated with attachment-disordered children. According to McKelvey and Randolph, attachment-disordered children steal and engage in "crazy lying." They are described as manipulative, controlling, and exhibiting behaviors that reflect serious power struggles. Attachment-disordered children have been found to be extremely defiant and oppositional, with demanding and intrusive social styles. Parents report that attachment-disordered children destroy the property of others and are aggressive, either overtly through acts of physical violence, or in passive-aggressive ways (McKelvey, 1995; Randolph, 2000). Both groups of parents describe their children as manipulative, uncooperative, and seeking excessive attention. These children are difficult to manage because they are prone to testing limits, and caregivers' disciplinary efforts are often ineffective. A primary consideration that brings these children into treatment is the caregivers' search for effective methods of discipline.

The PIC-2 scale of Impulsivity/Distractibility was also highly correlated with RADQ scores, indicating children with attachment problems may also be very impulsive, distractible, and disruptive. Children with high scores on the Impulsivity/Distractibility

scale are described as acting without *thinking*, forgetting their responsibilities, and never finishing what they start. In addition to these behaviors, similar traits that are seen in attachment-disordered children are intrusiveness, limited tolerance for frustration, and an inability to learn from previous mistakes.

The PIC-2 scale of Reality Distortion, a scale that reflects a deficiency in adaptive skills, was also highly correlated with attachment (RADQ) scores. Children with high Reality Distortion scores are described as different, often confused, and sometimes difficult to understand. Two other PIC-2 scales measuring deficiencies in adaptive functioning that were highly correlated with the RADQ were Cognitive Impairment and Social Skills Deficits. Similar symptomology related to attachment problems as conceptualized by Randolph and researchers at Evergreen (ACE) are no impulse control, learning lags, lack of cause and effect thinking, abnormal eating habits, poor peer relationships, persistent nonsense questions and incessant chatter, and abnormal speech patterns (Randolph, 2000, p. 4). Psychological Discomfort was also significantly related to RADQ scores, indicating children with attachment problems show the presence of anxiety, moodiness, and depression.

Despite the primarily externalizing behaviors in attachment-disordered children (behaviors that would normally cause difficulties for their families) no relationship was found between RADQ scores and the PIC-2 scale of Family Dysfunction. The Family Dysfunction scale is made up of two subscales, Conflict Among Members and Parent Maladjustment. The Conflict Among Members subscale has been associated with clinicians' reports of conflict between parents and the need to rule out emotional abuse for some of these children. The Parent Maladjustment subscale has been associated with

poor relations between the parents leading to separation and divorce. It also reflects problematic parent adjustment such as alcohol or drug abuse, illegal behaviors or other complaints and symptoms of sufficient magnitude to require treatment. In some cases, caregivers may have been reluctant to acknowledge such problems within their own families and therefore these PIC-2 scores were not elevated enough to be significant.

Since attachment-disordered children appear to engage in primarily externalizing behaviors, it was not surprising that the PIC-2 scale of Social Withdrawal, reflecting more internalizing behaviors, was not correlated. The Somatic Concerns scale describes children who respond to stress with health complaints and reports of excessive sleeping and chronic listlessness and also was also not significantly correlated with RADQ scores.

Synopsis of Clinician Interviews

Diagnosing childhood disorders is rarely an easy task. Symptoms such as aggression, inattention, fears, or shyness are normal in young children and may occur sporadically throughout childhood. Recognizing a given symptom and determining whether it is occurring at an unexpected point in development, occurring more frequently, or lasting longer than normal takes education, training, and practice. In this study, CMHA clinicians were asked to discuss the etiology of attachment problems, to discuss the symptoms and criteria for both Reactive Attachment Disorder and Attachment Disorder, and then talk about the treatment they would provide for an attachment-disordered child. Most of the CMHA clinicians had a great deal of difficulty with this diagnosis for several reasons.

Symptoms that have been related to Attachment Disorder such as aggression, hoarding food, cruelty to animals, intentional encopresis, and preoccupation with fire and

gore were not recognized as such by the CMHA clinicians. Most clinicians were also unaware that behaviors of other diagnoses such as Conduct Disorder or Oppositional Defiant Disorder have also been found to be related to attachment problems. The majority of clinicians carefully weighed only two criteria when considering a diagnosis of RAD, indiscriminate friendliness, and a previous diagnosis of RAD. However, the more experienced clinicians did consider a RAD diagnosis for a client based on the symptomatology of Attachment Disorder, despite the fact that these symptoms are not currently a part of the criteria for RAD. Nevertheless, few therapists had ever assigned a diagnosis of RAD or treated a child who had been given this diagnosis from a previous therapist.

In general, CMHA clinicians were uncomfortable with this diagnosis. Some felt it was a demeaning label, while others stated that relationship issues were secondary to the mood or behavior problems that brought them to treatment. Many clinicians admitted they would not know what to do if they had had a client with this kind of problem. In a few cases, the perception of the need for specialized treatment appeared to have prevented a few of them from even examining for the presence of this disorder, thus making it quite difficult to treat what was not even acknowledged as a problem.

This lack of recognition in identifying Attachment Disorder may have been due in part to their graduate training. No specifically designated child tracks were available in any of the five graduate programs, though courses on children were offered and most of the clinicians reported taking some of them. There was a general consensus among the clinicians that their graduate schools did not prepare them for diagnosing and treating attachment problems. However, one reason for this may be that graduate programs teach

from the Diagnostic and Statistical Manual. Although the manifestation of a particular disorder can vary, students are taught to follow as closely as possible the guidelines and criteria when assigning a diagnosis, down to counting the required number of symptoms needed to assign a particular diagnosis. Therefore, if the criteria for a disorder are unclear or difficult to assess, it is understandable if graduate schools are not able to prepare their students to recognize and treat that disorder. It becomes even more complicated when a particular diagnosis such as Attachment Disorder is recognized in the field but is not yet in the current DSM.

Study Limitations

Several limitations of this study may restrict interpretation of the results, and generalizing beyond this study must be done with some caution. First, the sample size was relatively small (100), given that Community Mental Health Agencies in urban cities such as this one typically treat thousands of children a year. Another consideration about this study concerns the way the attachment relationship (and consequent behaviors) was measured, in this case, with the Randolph Attachment Disorder Questionnaire. The RADQ is an instrument that does not require observers to evaluate the relationship between parent and child in stressful situations and then measure consequent attachment behaviors (a Strange Situation paradigm). Rather, it asks the parent/caregiver to report on behaviors that have been most associated with attachment-disordered children. Parent-report forms may not objectively measure the attachment relationship since they rely on the caregivers' memories and observations.

Another limitation of the RADQ is that item 30, the last question of the RADQ, is really a two-part question. The first part asks the caregiver to report on the presence of

abuse or neglect, while the second part of this same item asks whether the child had experienced several changes in his/her primary caregiver. Consequently, it was unclear what parents or caregivers were responding to when they answered item 30. Randolph cautions that the RADQ must not be used as the sole basis for a diagnosis of AD. Although this research study also used the PIC-2 as a measure of related behavior problems, these findings should be considered preliminary.

Recommendations

Recommendations for Future Research

One recommendation for future research is for authors of the Diagnostic and Statistical Manual to focus on further delineation of symptom and problems stemming from the attachment relationship, and thus develop clearer guidelines in the diagnosis of Reactive Attachment Disorder. Another research recommendation concerns assessing attachment styles and consequent behavior problems. The Randolph Attachment Disorder Questionnaire is an instrument that caregivers find quite simple to use, and clinicians or researchers will find relatively easy to score. However, it has been largely untried in the assessment of attachment problems in children who are brought for therapy in community mental health agencies. A need exists for further research with this instrument in outpatient settings to determine if it is a valid instrument for this purpose. Clinicians are on the safest ethical and practice grounds when using the RADQ in the manner for which it was designed, as an initial assessment screener for the presence of Attachment Disorder.

Researchers might be advised to assess the presence of attachment problems in CMHA clients by using additional measures of attachment for older children. For

example, internal representational models of relationships are believed to develop from actual experiences that a child has had. Therefore, tapping into these internal working models by using picture response procedures, doll play, or other representational measures may give a more accurate assessment of a child's attachment organization and would further validate a parent report form such as the RADQ.

Another suggestion for research is to add an instrument that measures the caregivers' attachment organization such as the *Adult Attachment Interview (AAI)* (George et al., 1996). Studies have repeatedly shown adult attachment styles influences parenting, and thereby influence attachment security in the child. A measurement of the caregiver's attachment organization is likely to be very valuable in assessing attachment issues. In summary, use of several attachment instruments may yield a more clear-cut appraisal of an attachment problem.

Policy Recommendations

Community mental health agencies. In the CMHA program evaluation referred to earlier, there was a significant increase from 1994 to 1997 in the number of children who were brought for treatment at CMHAs. Most of the children were diagnosed with disruptive behavior disorders, and many of them had a secondary diagnosis of Conduct Disorder (Annual Report to Congress, 1999). These results, as well as the outcome of this study, appear to indicate that there is an increase in children with overwhelming problems who arrive at the doorstep of community mental health agencies. As a consequence, there is an urgent need for CMHAs to assess for the presence of attachment problems at the entry level of treatment before the child has been through an array of

services and ends up, often as a last resort, in a psychiatric hospital or residential treatment facility.

Clinicians often develop “red flags” or signs that certain behaviors or traits exhibited by their clients may indicate a particular disorder. Often they will then assess for the presence of other symptoms in order to rule out that particular disorder. Given the complex array of behaviors leading to the diagnostic dilemma of RAD, several other factors might be purported to be “red flags” for attachment problems.

- Consistently poor relationships in different contexts,
- High number of caregivers (attachment disruptions),
- Confusing diagnostic history or multiple diagnoses,
- Cycling through treatment,
- Resistance to standard treatment that has been shown to be effective for the client’s diagnosis.

Anderson (1990) and Cline (1990) state that traditional child therapies are usually not effective with attachment-disordered children, and many of these children have had years of therapy with little or no change in how they approach relationships. Attachment therapy is generally offered outside of community mental health settings, as this kind of specialized treatment appears to require considerable training and supervision. There are no standardized methods of treatment for this particular disorder, and some of the techniques that have been associated with attachment therapy are controversial, effectively discouraging many therapists from attempting to identify and treat this problem. Attachment Disorder is treatable however, and the sooner it is identified, the easier it may be to absolve.

Graduate programs. One recommendation concerns graduate programs in the mental health field. Graduate schools in psychology and social work should be encouraged to specifically address theories on child development, childhood disorders, and in particular the recognition and treatment of attachment problems. The National Institute of Mental Health might also be encouraged to fund projects addressing this diagnostic problem, including demonstration projects that support tailoring intervention for Attachment Disorder for use by CMHA clinicians. A final recommendation is for mental health professionals to be given the time and resources by their employers for specialized training in the recognition and treatment of attachment disorders.

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APPENDIX A

Demographic Sheet

Therapist _____ Discipline (i.e., social work) _____

Office Site: _____

Client Name _____

Client Age _____ Gender: M F Ethnicity _____

CURRENT DIAGNOSIS

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Were behavior problems present before age five? YES NO UNKNOWN

Previous Treatment YES NO UNKNOWN

Has treatment been provided:

CONTINUOUSLY INTERMITTENTLY UNKNOWN

Number of months in treatment _____

Current living arrangement:

- | | |
|------------------------------------|----------------------------------|
| 1) Living with birth parents | 5) Living with foster family |
| 2) Living primarily with birth mom | 6) Living with adoptive family |
| 3) Living primarily with birth dad | 7) Living in a residential group |
| 4) Living with relatives | home/psychiatric hospitalization |

Age of first out of home placement (if any) _____

Number of different caregivers with whom client has lived _____

(Comments)

Please return this form with the consent form and attached testing sheets to:

Paula Morgan, Central Office

APPENDIX B

Clinician Questionnaire

Therapist _____ Years of Experience _____

How often do you use the following symptoms/problems in choosing a diagnosis of Reactive Attachment Disorder?

- | | | | | | |
|---|-------|-----------|-------|------------|--------|
| 1. Client had a previous diagnosis of RAD | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 2. Inhibited in social interactions, hypervigilant, frozen watchfulness | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 3. Child resists comforting | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 4. Indiscriminately friendly with relative strangers | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 5. Neglect | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 6. Self-sexualized behavior (excessive masturbation) | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 7. Death of parent | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 8. Defiant and oppositional | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 9. Stealing | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 10. Lying | NEVER | SOMETIMES | OFTEN | VERY OFTEN | ALWAYS |
| 11. Hoarding food, gorging | | | | | |

	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
12. Aggression towards self, self-injury	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
13. Aggression towards others	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
14. Lack of empathy	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
15. Cruelty to animals	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
16. Encopresis/enuresis	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
17. Impulsivity	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
18. Destroys property	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
19. Preoccupied with fire and gore	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
20. Insincere, phony	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
21. Manipulative, controlling	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
22. Demanding and intrusive social styles	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
23. Persistent nonsense questions/ incessant chatter	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
24. Sleep problems (nightmares, sleepwalking)	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
25. Learning problems in school	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS
26. Difficulty paying attention	NEVER	SOMETIMES	OFTEN	VERY OFTEN	ALWAYS

Seven Counties Services, Inc.

For appointments

call 589-1100
or 1-800-264-8799
TDD-589-4259
or 1-877-589-4259

Behavioral Health

- 4400 Breckenridge Ln.
Suite 215
Louisville KY 40218-4082
502-495-7805
FAX 502-495-7814
- 1512 Crums Ln., 4th Floor
Louisville KY 40216-3861
502-589-8920
FAX 502-447-1967
- 2225 West Broadway
Louisville KY 40211-1087
502-589-8910
FAX 502-772-2084
- School-Based Services
3717 Taylorsville Rd.
Suite 223
Louisville KY 40220-1366
502-454-6343
FAX 502-459-9209
- Geriatrics/Landmarks
929 South 3rd St.
Louisville KY 40203-2215
502-585-2008 or
502-562-5694
FAX 502-589-8741


TO: Ron Van Treuren, Ph.D.,
SCS Research Committee

FROM: Christina Coates
Division Director, South
1512 Crums Lane 4th floor
Louisville, KY 40216

DATE: March 18, 2002

I grant permission for Paula Schuh, under the direction of Elizabeth Jackson, Ph.D. and the University of Louisville, Counseling Psychology Department, to conduct a study on the psychological functioning of child clients using the Personality Inventory for Children, Second Edition, and the RADQ at the SCS South office.

Sincerely,


Christina Coates,
Division Director, South

*Providing behavioral health,
chemical dependency, and
developmental disabilities
planning and services for Bullitt,
Henry, Jefferson, Oldham, Shelby,
Spencer and Trimble counties.*

CURRICULUM VITAE

NAME: Paula S. Morgan

ADDRESS: Educational and Counseling Psychology
University of Louisville
Louisville, KY 40202

DOB: Ft. Thomas, Kentucky - November 18, 1958

EDUCATION & TRAINING:

B.S., Social Work
Eastern Kentucky University
1982

M.Ed., Counseling Psychology
University of Maryland, Asian Division
1992

Ph.D., Counseling Psychology
Educational and Counseling Psychology
University of Louisville
2004