4-30-1999

Preadolescents with Attachment Disorders: An Explanatory Study in a Residential Treatment Center

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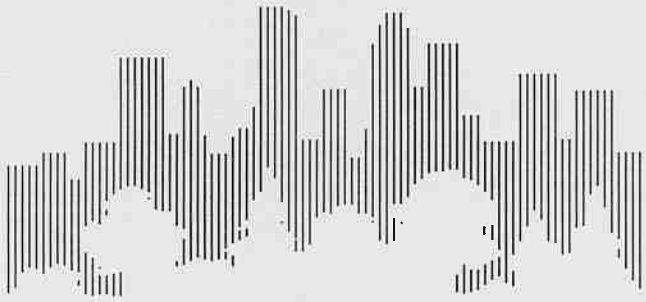

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MASTERS IN SOCIAL WORK THESIS

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Preadolescents with Attachment Disorders: An Explanatory Study in a Residential Treatment Center

1999

PREADOLESCENTS WITH ATTACHMENT DISORDERS:

AN EXPLORATORY STUDY IN A RESIDENTIAL TREATMENT CENTER

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Submitted in partial fulfillment of
the requirement for the degree of
Master of Social Work

AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

1999

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

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Date of Oral Presentation: April 30, 1999

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ABSTRACT

PREADOLESCENTS WITH ATTACHMENT DISORDERS:

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APRIL 30, 1999

An increasing number of children are failing to develop secure attachments to caregivers. Many are involved with the child welfare system and display an overwhelming number of problems--emotional, cognitive, developmental, physical, moral, behavioral, and social. This exploratory study using qualitative and quantitative methods addresses how one residential treatment center has worked with this population. Case records, selected through a purposive sampling, of 14 discharged preadolescents and information from key informants support findings of this research. Themes discovered assist this treatment center, and possibly others, in understanding the relationship between the behavioral and therapeutic needs of these children and the practice interventions for those children discharged from this unit to a similar residential facility or more restricted environment.

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Chapter 1

Introduction

There is an increasing number of children failing to develop secure attachments to caregivers. Many are involved with the child welfare system and display an overwhelming number of problems--emotional, cognitive, developmental, physical, moral, behavioral, and social. They remain at risk to further perpetuate this pattern with others as they enter various stages in life. Research has shown that up to 80 percent of high-risk families create disorganized/disoriented patterns of attachment in children (Levy et al., 1998). These children come from families where the following may exist: poverty, substance abuse, abuse and neglect, domestic violence, history of maltreatment in parents' childhood, depression, and other psychological disorders in parents. There is also another group of children coming into care who have been adopted from other countries. Understanding this population of children with attachment issues is important not only for their health, but for the health of society.

This study is exploratory in nature to become familiar with how one residential treatment center has worked with children, ages 8 to 12, diagnosed with Reactive Attachment Disorder and Attachment Disorder. Children with these issues are increasing in number and being able to intervene with them proactively and successfully is vital for their development. Reaching them before they continue being placed in other out-of-home settings provides stability rather than lending to a need to address even more separation and loss in these children's lives. This study explores what is working well and how to better serve the needs of children with attachment issues. This is especially important for

those in the social work profession who seek to address how systems can better address these needs to improve the well-being of children and families.

Exploration is used in this study to gain insight into the following research questions: 1) For children with an Attachment Disorder who have been discharged from this unit, which diagnostic challenges were most resistant to change, and 2) What are the needs of children with an Attachment Disorder in relation to their progress in an urban residential treatment center?

Summary

Exploring the residential care placements of these children diagnosed with Reactive Attachment Disorder and Attachment Disorder has involved information which has been incorporated into the following chapters. Chapter 2 includes a literature review involving various resources and a theoretical framework. Chapter 3 explains the research methodology used in this study. Chapter 4 discusses the findings of this study. The final chapter, 5, includes a discussion of limitations and implications of this study along with a conclusion.

Chapter 2

A Literature Review

Introduction

Attachments are the foundation of healthy physical, psychological, and cognitive development. Infants who are not physically cared for, stimulated, and connected to a primary caretaker may not survive (Bayless, 1990; Field, 1996; Steinhauer, 1983; Wright, 1997). The attachments a person forms during their first three years of life effects much of how they form relationships in later years. Examining attachment in relation to physical, psychological, and cognitive development is important not only for understanding individuals, but also for understanding its impact on society. This literature review explores attachment on several levels. It begins with a conceptual framework and theoretical basis to lead the reader into more specific information gained through various sources. These areas include protective factors for children, effects of attachment on children, youth at risk for attachment disorders, and case management for youth who enter care outside of home with attachment disorders.

Conceptual Framework

Attachment has been defined as the psychological connection between people that permits them to have significance to each other (Bayless, 1990; Nachmias, Gunnar, Mangelsdorf, Parritz, & Buss, 1996). It has further been defined as an "affectional bond between two individuals that endures through space and time and serves to join them emotionally" (Bayless, 1990, p. 3). Although the terms bonding and attachment have been used interchangeably, recently people have tried to separate the two, using bonding to

define the unique tie between child and biological parent, primarily mothers, that occurs as a result of the shared physical experience during pregnancy and birth (Bayless, 1990).

Attachment is a learned behavior that begins shortly after birth and continues naturally during the first three years of life. A newborn infant cries out in pain, hunger, or discomfort and a mother or father arrives to gratify the need. They touch, hold, feed, and make eye contact according to the child's needs. This pattern repeats itself numerous times each day, eventually helping the infant develop a core of trust so that the world is perceived as a safe and loving place (Keogh, 1993). Many experts believe that during this time a pattern of interaction is established regarding how the child learns and responds to attachment situations (Bayless, 1990). Once this core of trust is established, the child can look beyond mother and father for other social attachments that are also rewarding. After the age of three, further learning will take place; however, it will build on the foundation developed previously--a base which will strongly shape the individual's future responses (Bayless, 1990). Learning to form attachments after this age may be more challenging but is not impossible to learn in later ages of life.

Healthy attachments are the means by which relationships and affectual ties develop and are maintained. The ability to attach is a fundamental part of our humanness. Attachments help people know they are valued (Bayless, 1990). This connection fosters trust to develop which permits children to experience future relationships, to take risks and to learn from mistakes as well as successes. Bayless (1990) further adds that numerous studies have shown that even when a child receives substantial physical care, if there is no attachment to a primary caretaker, the child will most likely incur delays in physical and psychological development.

Factors disrupting the natural process of trust building between a parent and child include child abuse and neglect, teen pregnancy, and unprepared parenthood, illness of parent or child, low-quality child care, and mistreatment due to war or extreme poverty. Generally, the younger the child when the break in this process occurs, the more harsh the consequences (Keogh, 1993). The development of both adaptive and maladaptive anxiety is a central construct within attachment theory. Once infants become attached to the caregiver (during the second half-year of life), there is a period in which they are made anxious by brief separations. This response is adaptive and serves the purpose of protecting the infant by prompting proximity within the caregiver and reducing the likelihood of harm (Bowlby, 1969). Another distressing separation for a child is with his/her peers. Separation stress has been displayed when children as young as 15 months are separated (Field, 1996).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994) of the American Psychiatric Association lists one diagnosis for those with an attachment disorder. This is entitled Reactive Attachment Disorder of Infancy or Early Childhood. The essential feature of this diagnosis is, "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age five years and is associated with grossly pathological care" (p.116). The cause of this disorder varies depending on individual duration of associated psychosocial deprivation, and the nature of intervention. Those labeled with Reactive Attachment Disorder often have at least one other area of diagnosis as a concern area such as an anxiety disorder, oppositional defiance, conduct disorder, and learning disorders. Considerable improvement may occur if a child is provided an appropriately supportive environment.

Attachment Theory

Research into this question has been stimulated by attachment theory which was first defined by John Bowlby in 1960. He described the behaviors of infants and young children who were in residential nurseries and hospital wards and therefore separated from their mothers. The children who had experienced a secure relationship with their mothers showed a predictable behavior sequence during the separations. Bowlby described three stages of mourning by which children react to separation from parental figures. The first, protest, was described as lasting as long as the child retains hope of reunion with the lost mother (loved one or ones). Next, despair was described as having lost hope of the mother's returning where the child accepts care from others but is not yet ready to accept full reattachment to parent substitutes. Lastly, detachment is the stage where children showed more interest in their surroundings (Bowlby, 1969; Field, 1996; Steinhauer, 1983). Bowlby stated that unless detachment occurs, the child will not be free to form the new attachments needed to support ongoing development. Many researchers stress the crucial importance of the substitute caregiver or other significant adults in actively assisting completion of the work of mourning as a prerequisite for reattachment (Steinhauer, 1983).

Mary Salter Ainsworth (1978) and her colleagues also had an impact on attachment theory as she developed the Strange Situation, an instrument to assess quality of attachment. The final assessment is a classification of each infant-mother relationship into one of three categories--A (avoidant), B (secure), and C (resistant). Infants with mothers who responded consistently to their needs had secure relationships (B classification). Infants whose mothers frequently rejected them when the infant sought

contact later tended to avoid their caregiver on reunion after a brief separation (A classification). Infants who had experienced inconsistent or intrusive care giving showed angry, resistant, and ambivalent behavior upon reunion when assessed later (C classification). This instrument has been deemed appropriate for infants between 12 and 18 months of age (DeWolff & Van Ijzendoorn, 1997; Field, 1996; Greenberg, 1997; Kroonenberg, Basford, & Van Dam, 1995; Nachmias, et al., 1996; Speltz, DeKlyess, Greenberg, & Dryden, 1995).

Field (1996) and Greenberg (1997) discuss the contribution made by Bowlby and Ainsworth to the development of attachment theory and its limitations. In this model, attachment is based on behaviors that occur during momentary separations (stressful situations) rather than during non-stressful situations (Greenberg, 1997). In a circular process, attachment has been defined on the basis of those behaviors directed to the persons referred to as the attachment figure during an impending separation and following reunion (Field, 1996; Kroonenberg et al., 1995). The list of attachment behaviors is limited to those that occur with the primary attachment figure, typically the mother. However, other attachments are not necessarily characterized by those same behaviors (Field, 1996; Wright, 1997). The behavior list also only includes overt behaviors (Field, 1996). Finally, in models and data presented by Bowlby and Ainsworth, the mother is viewed as the primary attachment figure (Field, 1996; Van Ijzendoorn & DeWolff, 1997).

Application of Theory

Clinicians and educators grounded in developmental psychology describe Ainsworth's types of attachments in relation of the development of children. Secure attachments with a primary caregiver are critical for children to learn self-control. This

relates to a child's ability to regulate emotions, impulses, and responses to external stress. Children with anxious attachments are generally passive and are more inclined to have internalizing problems such as self-abuse, depression, and/or suicidal thoughts. Finally, those children with avoidant and adult-wary attachments are likely to develop a hostile approach to life. They are commonly described as self-centered and antisocial and many become involved in criminal activity (Tully et al., 1998).

Bowlby (1973) contends that rejection probably produces the most violent, angry, and dysfunctional responses of all, particularly when children are subject to repeated threats of being sent away. This is particularly troubling as threats of exclusion or expulsion are common methods of behavior-control in placements for troubled youth. By the time a preadolescent is placed in a residential treatment center they have often endured multiple out-of-home placements and have thus become even more mistrustful. This is compounded to even a greater degree for those children diagnosed with attachment disorders. They often lose hope that anyone will care for them without wanting to get rid of them at some point especially if the child exhibits aggressive or destructive behaviors on a repeated basis.

Diagnostic categories developed by the American Psychiatric Association (DSM-IV, 1994) can only be helpful if the strengths, capacity for coping, and desire for growth and development of children are not ignored. The classifications can be useful in identifying symptoms, challenges, and abilities necessary for planning and implementing effective interventions. A child with a particular diagnosis can behave differently depending on the level of emotional support, cognitive stimulation, form of structure and discipline, and sense of well-being or stress (Levy et al., 1998). Focusing on these

strengths on diagnosed conditions can provide hope and growth with children who are often seen as being challenging to reach.

Protective Factors

As individual children develop, their vulnerability to separation experiences varies. Their reaction to these separations may be influenced by what researchers call "protective factors." These include: the age of the child, previous mother-child relationship, temperament of the child, previous separation experiences, duration of the separation, effects of strange environment, and nature of child's situation subsequent to separation (Steinhauer, 1983). Several studies have examined these factors closely.

As a child is in utero, there are factors which can hamper the attachment process. During an embryo's development, the following areas have been shown to have an effect: young maternal age, maternal drug/alcohol use, and premature birth (Harting, 1994; Malind, 1994). Each of these areas puts stress on a child's earliest development. It is this stress which may then lead to the attachment process being strained. Addressing these issues proactively can lead to some protection for healthy attachments to develop.

A child's biological make-up and adaptation to life events can be enhanced through various protective factors. This can then lead to increased health in the area of attachment issues. Research done in this area has shown that the qualities that define individual resilience have been demonstrated in children from different socioeconomic stratas, different ethnic groups, and different cultural contexts. This was shown in research by Werner (1989) among the multiracial children of Kauai, Hawaii as well as among black children on the US mainland, and Caucasian children in the US and in Europe. In her research, Werner found three main areas to be protective factors for high-risk children as

related to resiliency. The first area includes dispositional attributes of children such as activity level and sociability, having at least average intelligence, competence in communication skills (language and reading), and having an internal locus of control. One specific dispositional quality many researchers have studied is temperament. They have found this to effect attachment during significant separations for children (Harting, 1994; Malind, 1994). The second area relates to affectional ties within a child's family that provide emotional support during stress, whether from a parent or sibling. The final area includes external support systems whether in school, at work, or church, that reward a child's competencies and determination while also providing a belief system by which to live. The results of Werner's research show that these three factors may have a more generalized effect on adaptation in childhood and adolescence than do specific risk factors or stressful events such as poverty, perinatal stress, parental alcoholism or psychopathology, and teenage pregnancy.

The protective factor of affectional ties has been studied in depth in relation to attachment. Three studies examined here found a significant relationship between parental sensitivity and attachment of children. DeWolff et al. (1997) found maternal sensitivity, defined as the ability to respond appropriately and promptly to the signals of the infant, indeed appears to be an important condition for the development of attachment security. This cannot be considered to be the exclusive and most important factor in this regard. Other factors were found to include mutuality, synchrony, stimulation, positive attitude, and emotional support. Another study by Van Ijzendoorn et al. (1997) found that fathers do shape their infant's attachment, but to a lesser extent than mothers. These authors believe that fathers may compensate for their relative lack of influence through indirect

channels, that is by way of their impact on mothers' attachment and sensitivity. To generalize this finding, that fathers shape infants' attachments to a lesser extent than mothers, can be misleading due to the complex interplay of influences on parental sensitivity. Temperament is another factor involved in the attachment process. Nachmias et al. (1996) found attachment security moderated the effect of inhibited temperament on the activity of the HPA system (system in human body which secretes cortisol from the cortises of the adrenal glands). Their data also suggests processes whereby maternal behavior in insecure attachment relationships may be stimulating increased levels of cortisol. In addressing the coping model used in this study, linkages between inhibition and elevations in cortisol should be modified by children's coping resources. These resources include the behavior of the caregiver and the child.

On the other hand, Kroonenberg et al. (1995) replicated Ainsworth's Strange Situation instrument as they used clustering procedures. The three-way data that was clustered includes infants, variables, and episodes. From results of a discriminate analysis, one single dimension appeared to underlie the clustering--the extent to which infant primarily seek proximity and contact with the mother or primarily stay at a distance from her. This points toward different styles of behavior of the infants, largely independent of their attachment classification which include A (avoidant), B (secure), and C (resistant).

As a whole therefore, three studies found a significant relationship between parental sensitivity and attachment. Analysis of these studies leads to acknowledging the complex interplay of influences on parental sensitivity for both mothers and fathers. DeWolff et al. (1997) began to address a few other variables of sensitivity. The interplay of parents as a couple was not addressed in any of the studies. One study which used the

instrument originated to test maternal sensitivity found other explanations for the attachment between infants and parents (Kroonenberg et al., 1995).

Much research in the area of attachment includes father-child attachment with mother-child paradigms. To move beyond this focus, two authors address the need to look at family systems models for understanding the development of secure and insecure attachment of children (Cowan, 1997; Steinhauer, 1983). They looked at other studies to make conclusions. Studies of both clinical and nonclinical samples outside the attachment paradigm have shown that 1) qualities of the mother-child and father-child relationships combine to predict children's outcomes and 2) quality of the marital relationship has both indirect and direct impact on children's development. Other studies show that previous separation experiences, duration of separation, nature of child's situation subsequent to separation, abuse and neglect, and day care being used too much and too soon affects children's and adolescents' adaptation (Harting, 1994; Malind, 1994). Steinhauer (1983) adds that children from warring families that consistently failed to meet their needs did better if placed in a secure, consistent, nurturing environment than if left in the inadequate parental home. One must also beware of "wars" within system which can include battles over policy implementation, issues between systems needing to work together, and intervention strategies with children.

Effects of Attachment

Resiliency factors for children are important for understanding the effects that the attachment process has in their lives. A child who has healthy attachments with at least one person can more easily attach to other people. This promotes increased self-worth and self-esteem. They also respond more positively as they interact with others. Bayless

(1990) describes healthy attachment for a grade-school-aged child to include the following indicators in the child's life: is inquisitive about the world and explores the environment age appropriately, behaves in a way that demonstrates that he/she likes himself/herself, performs academically according to ability, shows accomplishments with pride, shares and plays with others, tests limits age appropriately, tries new tasks, reacts realistically to making a mistake, is able to identify personal strengths, expresses emotions age appropriately, demonstrates a range of emotions, exhibits confidence in abilities and doesn't frequently express lack of confidence, does not exhibit overly dependent behavior, reacts positively to parents being in close physical proximity, feels comfortable speaking to adults, smiles easily, moves in an open and relaxed way, has positive peer and sibling interactions, appears comfortable with own sexual identification, and initiates positive interactions with adults. Parents of these children demonstrate an interest in the child's accomplishments, show interest in the child's school performance, initiate affectionate overtures, accept expressions of child's negative overtures, support the child in developing positive peer relationships, effectively work out problems between siblings, use disciplinary measures appropriate to the child's age and development, give the child age-appropriate responsibilities, state positively the child being like other family members, support the child in activities to develop independence, initiate positive activities with the child, and can identify and speak positively about the child's strengths and needs. Much research has examined specific effects of poor attachments both physically and psychologically.

Physical Effects

Three studies examined here found three physical effects of poor attachments. These are described as racing heartbeat, suppressed immune systems, and stressed hormone levels. These have been found to occur in humans and monkeys alike. It is this hyperactive stress-response system that wreaks havoc on a person's body when an attachment is not made to a primary caregiver (Field, 1996; Steinhauer, 1983; Wright, 1997).

Psychological Effects

Trust. How a child moves about his/her world relates strongly to trust. The experience of a child having their trust violated by an adult who is supposed to be their caretaker has taught them that their survival does not depend on trusting any adult. This is especially true for one who is seeking their trust. If a child such as this is placed in an environment where he/she is safe, the child will actually feel in danger. Severely unattached children determine they can only rely on themselves. They do not put themselves into positions to be vulnerable because their experience is that they cannot afford to do that. They become controlling of their environment and in relationships (Keogh, 1993).

Moral Development. Moral reasoning involves making moral judgments in situations of moral conflict. Kohlberg (1984) describes six stages of development of moral reasoning. The stages imply distinct or qualitatively different modes of thinking. Each stage presupposes the understanding gained at previous stages. As a result, each stage provides a more adequate way of making and justifying moral judgments and represents a higher level of moral reasoning. The stages are supposed to form an invariant

sequence in individual development, but people can and do differ in rate and eventual level of moral reasoning.

Autonomous attachment may be at the core of mature moral reasoning. This research question was examined by Van Ijzendoorn and Zwart-Woudstra (1995). They hypothesized that parents with securely attached children would be better able to stimulate their children's moral development than would parents with insecurely attached children. Findings show that moral type B reasoning (where ethical ideals are expressed) was more prevalent in respondents with an autonomous attachment representation. This means that only individuals with a strong personal identity and balanced perspective on their personal attachment history may have the ability to internalize the ideas of mature morality and to act accordingly. If they fail to live up to the ethical ideals, their self-definition may be at stake. These conclusions are further reinforced by those who have examined conscience formation of varying degrees in adults. Keogh (1993) studied how childhood bonding shapes morality. He developed six categories to address different degrees of bonding and the types of people who would fit into these characteristics. Those defined as "extremely bonded and attached" include saints and humanitarians. Those considered at the other end of the spectrum are defined as "extremely unbonded and unattached." They include serial killers and sadists.

Further psychological effects of attachment disorder included a lack of ability to give and receive affection; phoniness, manipulativeness, and superficial charm; "crazy" lying; cruelty to children or animals; self-destructive/risk-taking behaviors; stealing, hoarding, gorging, and other eating disorders; speech pathology; lack of long-term friends; abnormalities in eye contact; learning disorders; preoccupation with blood, fire, and gore;

parents seem unreasonably angry; lack of ability to generalize; lack of ability to predict; severe impairment in cause and effect thinking; weak impulse controls; persistent nonsense questions and chatter; and inappropriately demanding and clingy behavior (Harting, 1994; Keogh, 1993).

Anxiety Disorders.

The DSM-IV (1994) of the American Psychiatric Association describes the essential feature of a generalized anxiety disorder as, "excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least six months, about a number of events or activities" (p. 432). Along with this anxiety and worry, a child must exhibit at least one of the following additional symptoms--restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep. Two other types of anxiety disorders are described in the DSM-IV, anxiety disorder due to a general medical condition and substance induced anxiety disorder.

Studies have analyzed the relationship between attachment and anxiety disorders. Warren et al. (1997) found that anxious/resistant attachment continued to significantly predict child/adolescent anxiety disorders even when entered last, after maternal anxiety and temperament, in multiple regression analysis. The attachment relationship appears to play an important role in the development of anxiety disorders. They found genetic and temperamental factors to have some influence but not as significant. Central within attachment theory, which Bowlby developed, is the construct of both adaptive and mal adaptive anxiety. In attachment theory, it is noted that the strength in attachment between a child and a primary caregiver may increase his/her ability to learn and to cope with stress

(Bayless, 1990; Greenberg, 1997; Steinhauer, 1983; Warren, Huston, Egeland, & Sroufe, 1997; Wright, 1997).

Oppositional Defiant Disorder.

The DSM-IV (1994) describes the essential feature of oppositional defiant disorder as, "a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least six months and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry or resentful, or being spiteful or vindictive" (p. 91). To qualify for this diagnosis, the behaviors must occur more frequently than what is typically seen in individuals of comparable age and developmental level and must lead to significant impairment is social, academic, or occupational functioning.

Other studies have analyzed the relationship between attachment and oppositional defiant disorder. Speltz et al. (1995) found ratings of attachment quality are vital to the assessment of early disruptive behavior, and that measurement of discrete behaviors in a clinical setting is also dependent on ratings of attachment quality. Among the significant relationships found, child security was inversely correlated with maternal critical comments and child deviant behavior separation distress also correlated positively with maternal critical comments . Their hypothesis that attachment measures would offer better concurrent discrimination of clinic-referred and control group children than would micro behavioral variables was supported when these measures were compared with

behaviors found in previous social learning research to distinguish between disruptive and well-functioning children (parental directiveness and criticism, and child deviance and compliance). Clinic status was defined as preschool boys with and without oppositional defiant disorder. Attachment security provided the single best indicator of clinic status. Other authors discuss several coping strategies of children in Bowlby's stages of mourning (Bayless, 1990; Field, 1996; Speltz, 1995). These strategies include persistent, diffuse rage, chronic depression, asocial and antisocial behavior, low self-concept chronic dependency, and permanent detachment.

Youth at Risk

Much of the current literature regarding youth deemed as being "difficult" is negative, pessimistic, and occasionally even cynical. Negative labels assigned to a child's behavior easily generalize to the child as a person. A concept becoming more widely known is "youth at risk." This is a broad term and avoids blaming the child. It points attention toward environmental hazards which also need to be addressed. Ecological hazards in the lives of youth at risk include destructive relationships, climates of futility, learned irresponsibility, and a loss of purpose. One must be clear about the nature of this alienation and its locus in the life space of these children (Brendtro et al., 1990). Some of these youth at risk have attachment disorders which make the process of connecting with others that much more difficult.

Magrid and McKelvey (1987) estimate as much as 15% of the population in the United States--some 13 million people--may be effected with some degree of attachment disorder (Keogh, 1993). Others say the scope of the problem is more difficult to define. For years, many of these children have been misdiagnosed. There are also several factors

leading to the development of attachment disorders which makes gathering statistics on this information challenging. One population at high risk in this area includes adopted children who have experienced multiple placements before settling into one home. Joe Kroll, Executive Director for the North American Council on Adopted Children, says 30,000 children currently are available for adoption in the United States (Keogh, 1993). There has also been an increase in international adoptions in the US. Many children have been adopted from Eastern Europe, mainly Romania, and the former Soviet Union since 1989, when Communism ceased in those regions. Many of these children were raised in orphanages where they experienced much deprivation. Currently there are researchers studying this population as many adoptive parents are bringing these children into out-of-home placements due to challenging behaviors related to attachment concerns (Talbot, 1998). In general, there are more older, hard to place behaviorally and emotionally disturbed children coming into care. The percentage of children transferred from protective services (supervised care in their own homes) to in-care services (i.e. placements) has steadily increased (Steinhauer, 1983). Due to this, there has been a definite shift in foster care services becoming more specialized and residential treatment centers also noticing the changes in meeting the needs of youth at risk.

Therapeutic Interventions

For a clinician, intervention with an attachment disordered child may be conceived as an attempt to shift the balance for the child from vulnerability to resilience, either by decreasing exposure to stressful health risks or life events or by increasing the number of protective factors available. Thorough assessment by a professional knowledgeable about attachment disorders, but also well grounded in neurologic function, family and individual

therapy, grief and loss issues, and psychodynamics is necessary for an accurate diagnosis. And an accurate diagnosis is essential for an effective treatment (Malind, 1994).

Holding or Rage Reduction Therapy

There remains a great deal of debate among clinicians regarding holding or rage reduction therapy. This therapy has been used in varying forms across the US based on a model for working with autistic children that was developed in the 1960s by analyst Robert Zaslow. Foster Cline, after working with Zaslow, applied the holding technique to unattached children in the early 1970s. This technique aims to help the unattached child relinquish the control that he/she has come to depend on for survival. By letting go, the child gains a first experience of connection with someone outside of himself/herself. Many feel this therapy is too provocative and perhaps damaging to children (Keogh, 1993). All attempts to locate information on the success of this technique with children have shown nothing. In trying to reach Foster Cline's Treatment Center in Evergreen, Colorado, there was no information found relating to outcomes of their therapy.

Combination of Care

Many sources point to the following interventions as being important in combination based upon a child's needs. These include medication, possibly for those with brain dysfunctions, addressing learning problems, dealing with unresolved grief/loss issues, addressing depression and drug usage, reparenting techniques, family-centered approaches, behavior management, cognitive restructuring, music therapy, art therapy and recreation therapy (Malind, 1994; Small, Kennedy & Bender, 1991). One other important intervention includes considering the "tribe" rather than only the nuclear family to ensure cultural survival. Clinicians can help build and encourage social supports including

schools, religion, business, and social systems. This can only enhance children's self-esteem which is vital for the socialization of at risk youth (Brendtro, Brokenleg, & Van Bockern, 1990).

Gaps

In reviewing the presenting literature, there exists some gaps which can be noted for further study. Areas included are looking at cultures where multiple caregivers are involved in the attachment process, studying attachment in more natural environments as compared to lab settings used in replication of the strange situation, further examining the role of fathers as they bond with their children, studying the impact of family systems further as related to attachment, the impact of religion in relation to attachment, the impact of spirituality in relation to attachment, further examination into diagnostic issues with children labeled with Reactive Attachment Disorder or Attachment Disorder, and examining the impact of various treatment interventions with children identified as being attachment disordered. Finally, attachment is increasingly being considered a life span phenomenon. A future model would provide for multiple attachments to various people at different stages of life.

This research study explores two of these gaps; diagnostic issues with children labeled with Reactive Attachment Disorder or Attachment Disorder and the impact of various treatment interventions for children with these diagnoses. Research into children at risk of maintaining characteristics of these disorders will be examined here through case studies of children who have been discharged from a residential treatment center. Multiple diagnosis of both boys and girls in the age range of 8 to 12 will be addressed along with

examining factors of differing types of treatment success leading to discharge to other care. At the core of this study is attachment theory.

Summary

To gain a deeper understanding of the importance of attachment in children, one must begin with an understanding of attachment theory. Since attachments are the foundation for healthy physical, psychological, and cognitive development, past research contributions and areas of further study can be appreciated. Previous research and literature examined here has discussed protective factors for children, effects of attachment with children, youth at risk for attachment disorders, and case management for youth who enter care outside of home with attachment disorders. This leads to the purpose of this research study, to further examine these areas as related to children with attachment disorders who have experienced residential care. In the next chapter, methodology of this study will be discussed to explain various details of the research.

Chapter 3

Research Methodology

Research Design

This study involves qualitative and quantitative research methods. It is exploratory in nature to become familiar with how a residential treatment center in Minnesota has worked with children, ages 8 to 12, diagnosed with Reactive Attachment Disorder and Attachment Disorder.

This design is used to gain a greater depth of meaning while exploring research questions. Generalizing the results to a larger population is difficult due to a small sample size. To explore what is working well and how to better serve the needs of these children, this design lends depth of meaning to research results.

Major Research Questions

Exploration is used in this study to gain insight into the following research questions:

1. For children with an Attachment Disorder who have been discharged from this unit, which diagnostic challenges were most resistant to change? Diagnostic challenges refer to the psychiatric diagnosis assigned to a child which include specific behaviors and emotional qualities as noted in the DSM-IV (1994).

2. What are the needs of children with an Attachment Disorder in relation to their progress in an urban residential treatment center?

Important Concepts

One concept important to define relates to the diagnosis of Reactive Attachment Disorder and Attachment Disorder. The Diagnostic and Statistical Manual of Mental

Disorders (DSM-IV, 1994) of the American Psychiatric Association lists one category for those with attachment issues. This is entitled Reactive Attachment Disorder of Infancy or Early Childhood. The essential feature of this diagnosis is, "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age five years and is associated with grossly pathological care" (p. 116). For those children who do not react to their environment and relationships as extremely as this diagnosis suggests yet display symptoms due to attachment issues, the diagnosis may include a notation of Attachment Disorder rather than Reactive Attachment Disorder.

In regards to children's success in this treatment unit, three different definitions are used. "Graduation" from treatment refers to the child's completion of treatment goals and discharge to a less restricted environment. "Progress" in treatment refers to the child showing some progress in treatment goals and discharge to a less restricted environment. Finally, "lack of progress" in treatment refers to the child showing little to no progress in treatment goals and discharge to a similar residential facility or more restricted environment. For a child to be discharged to a locked facility, which is a not a hospital setting, a waiver must be obtained through the Department of Human Services.

Units of Analysis

The units of analysis in this study are the case records of preadolescent girls and boys, ages 8 to 12, diagnosed with Reactive Attachment Disorder or Attachment Disorder. Each child has been discharged from the same unit in a residential treatment center in Minnesota.

Characteristics of Study Population

The population in this treatment unit of the residential treatment center consists of children ages 8 to 12 who are emotionally disturbed. The children have a variety of diagnoses such as Depression, ADHD, ADD, Post Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Oppositional Defiant Disorder, Conduct Disorder, learning disorders, and/or Attachment Disorder. It is a coed unit with varying numbers of girls and boys at any given time due to different lengths of stay. Capacity is 12 children, and most often this is the number in residence. Each child came to this treatment facility from one of various counties in Minnesota.

Sampling

The setting for this study is in an open (as opposed to locked/secure) residential treatment center for youth, ages 8 to 17, in Minnesota. To begin sampling, key informants were accessed to aid in selection of case records through a purposive sampling consisting of typical case sampling. The key informants include the therapist and unit supervisor who worked with each of these children, a consulting psychiatrist who worked with some of the children identified in this study, two social workers from a social service agency who worked with several of these children, and the clinical supervisor of the treatment center.

Data sources included in this study involve case records of the last fourteen (of fifteen) children diagnosed with Reactive Attachment Disorder and Attachment Disorder who have been discharged from the unit. These case records consist of psychiatric consultations, diagnostic testing results, staffings (Treatment Planning Staffing, Placement Review Staffings, and Discharge Staffing), Individual Education Plans (IEPs), Medical and Nursing Summaries, Clinical Support Summaries, Incident Reports, Behavior Consequence Checklists, referral information, Initial Admission Assessments, Physical

Intervention Forms, Time-Out Room Forms, Quiet Room Forms, and Treatment Objectives.

Data Collection Instruments

Key informants were accessed to seek their understanding of the sample population, knowledge and experience, and thoughts and feelings of working with these children in this unit and within this residential treatment center. Their understandings enhance the use of case records for looking at the previously mentioned research questions.

Case records are the other sources for data collection in this study. To begin the informed consent process, the unit's therapist sent an information letter (Appendix B) to possible participants, parents or guardians on behalf of the researcher. Those who wished to seek more information or be involved in the study then returned the enclosed post card (Appendix C) directly to the researcher. The researcher made a return telephone call to answer their questions and concerns while clarifying informed consent. Finally, a formal consent letter (Appendix D) was mailed to these possible participants in a self-addressed, stamped envelope. Data collection then began with the aid of a Case Review Guide (Appendix E).

Measurement Issues

Levels of measurement in this study include nominal and ratio. Nominal and discrete measures consist of gender, ethnicity, religion, and diagnosis. Gender relates to being male or female. Ethnicity relates to the agency's identified categories of Caucasian (C), Hispanic (H), African American (AA), Native American (NA), and Asian (A). For children with more than one ethnic background, all are listed (such as C/AA). Religion is

noted with those who describe an affiliation. Diagnosis relates to the various diagnostic categories as identified in the DSM-IV. Interval and continuous measures consist of age of the children and lengths of stay while residing in this unit of the residential treatment center.

Systematic error takes place due to issues relating to bias. This affects validity of the research. The researcher and key informants have all worked with the children in the sample population and work within the system being examined. Observations made by informants and writers of documents also include subjective and some objective assessments. While protecting anonymity and confidentiality, an outsider to the agency was obtained for a subjective opinion regarding the interpretations made by the researcher to benefit accuracy and improve validity.

Random error does not exist regarding this study population in so far that consistent patterns of effects do exist. The random error that is apparent as a whole is the use of diagnostic categories which relies on some subjective assessment by a practitioner (three psychiatrists were involved with these children). The case records also changed form to further include or exclude what was previously recorded. The Case Review Guide was developed with the assistance of two key informants to increase reliability due to the change in records, and to increase the likelihood that information would be accurately represented.

Data Analysis

The first step in analyzing this data consisted of case analysis. Raw data was assembled and reviewed regarding information sought to answer research questions. A

case record was then constructed by organizing the data into a comprehensive primary resource package. Finally, a case study narrative was written to represent each case.

A content analysis then took place to look for patterns, themes, and categories coming from the data. This took place from having coded units of data such as gender, age, ethnicity, lengths of stay in the unit, diagnosis labels, factors leading to diagnosis, resiliency factors, and type of treatment success and discharge. The Clinical Supervisor, Agency Director, and thesis advisor read the final research results to seek their input into the interpretations that were made from the data that was collected and analyzed.

The majority of data was qualitative due to its content and/or the format of records changing throughout the years. In this latter instance consistent quantitative values do not exist. A Pearson correlation was determined for two sets of variables which did meet this qualification.

Procedures for Protection for Human Subjects

Voluntary participation occurred first by seeking the Clinical Supervisor and Agency Director's approval for conducting this research. Each case deemed a typical case of this study by key informants was not examined unless approval was given by the child's parent, parents, or legal guardian. The unit therapist was the initial contact to invite possible participants into the study.

Confidentiality was addressed in various ways, all of which reflect agency policies. With the unit therapist being the initial contact, information about children and families remained unknown to the researcher until possible participants sought more information. All case records remained in the agency and were locked in a file cabinet when not being accessed by this researcher. Records were viewed in a private room with only the

researcher observing them. All information from case records and key informants will remain confidential and anonymous and not be discussed outside the research setting regarding identifying factors of these children and their families. Case Review Guides will be destroyed on August 1, 2000.

Harm was reduced by using case records for information rather than interviewing children and their families. The researcher informed parents and guardians of precautions in place to protect them: voluntary participation and confidentiality; and anonymity.

Anonymity was provided by coding information and not using any names in data collection, analysis, or research results. All identifying information from these cases have been concealed as specific identifiers of the agency have been also. Approval was gained by the IRB (Institutional Review Board) at Augsburg College to reassure that this study will protect children and families in this study. The IRB number for this study is 99-01-2.

Summary

This exploratory study involving qualitative research has been explained with details of the research design and procedures for protecting individuals involved in the study. In the next chapter, findings of the inductive analysis will be discussed in reference to the research questions addressed.

Chapter 4

Findings

Overview

The sample involved in this research study consists of the last 14, out of 15, children diagnosed with an attachment disorder who have been discharged from a specific unit in an urban residential treatment center in Minnesota. At their time of admission, and throughout their stay, their ages ranged from 8 to 12 years old. Twelve children were solely Caucasian, one was Caucasian/Cuban, and one was Caucasion/Russian. Table 1 displays demographics of this sample, including gender, caregiver status, length of stay in the unit, and discharge classification.

Table 1

Demographic (n=14)

Demographic Category	N	%
Gender:		
Female	9	64
Male	5	36
	14	100
Caregiver Status:		
With birth family	0	0
With foster care	4	29
With adoptive family	7	50
None outside of unit	3	21
	14	100
Length of Stay:		
0-6 mo.	0	0
6 mo. - 1 yr.	5	36
1 yr. - 1 yr. 6 mo.	3	21
1 yr. 6 mo. - 2 yr.	1	7
2 yr. - 2 yr. 6 mo.	4	29
2 yr. 6 mo. - 3 yr.	1	7
	14	100
Discharge Classification:		
"Graduation"	5	36
"Progress"	6	43
"Lack of Progress"	3	21
	14	100

Note: Average length of stay is one year four months.

In determining children's success in this treatment unit, two variables were deciding factors--progress on treatment goals and the location to which they were discharged. All children in this unit worked on treatment goals during their entire stay based upon their personal needs (emotional, behavioral, physical, spiritual) and in relation to their psychiatric diagnosis as determined by a consulting psychiatrist. Their progress on treatment goals was evaluated quarterly based upon Goal Attainment Scales which were developed at their time of admission to the unit. These scales outlined five specific steps for a child to progress on each treatment goal. The location to which children were discharged included less restrictive settings (as compared to placement in a residential treatment facility) such as foster homes and adoptive homes, similar residential treatment settings, or more restrictive settings such as hospitalization. Hospitalization was used for emergency emotional and/or behavioral concerns. An alternative plan included a brief stay in a secure (locked) residential treatment center until another placement could be determined. In this latter case, permission needed to be obtained from the Minnesota Department of Human Services due to their licensing regulations through which this treatment center is governed.

Discharge classifications in this study were made based upon these two variables related to success--progress on treatment goals and the location to which children were discharged. The greatest degree of success, "Graduation", refers to a child's completion of treatment goals and a discharge to a less restricted environment. "Progress" refers to a child showing some progress (but not completion) on treatment goals and a discharge to a less restricted environment. Finally, "Lack of Progress" refers to a child showing little to

no progress on treatment goals and a discharge to a similar residential treatment center or more restricted environment.

This residential treatment center serves youth ages 8 to 17 and is governed by Rule 5 licensing regulations as described by the Department of Human Resources. There are seven separate units on the campus, one of which is an assessment unit, and one other a secure (locked) unit. Six of these units serve youth ages 12 to 18. The other unit, the same one involved in this study, serves youth ages 8 to 12. Most units have capacity for 12 youth. These residents remain in this 24 hour facility with an average length of stay of one year. All youth come from one of the counties in Minnesota and are generally placed upon the request of a county social worker. All youth suffer various degrees of emotional disturbance and come from backgrounds containing experiences such as abuse, mental illness, chemical abuse, communication and/or learning disorders, family issues, grief/loss issues, illegal activities, and various behavioral concerns. They arrive in this treatment center after being unable to succeed in a less restricted environment such as their birth family, foster family, therapeutic foster care, adoptive family, or group home. All youth then leave this treatment center with varying degrees of progress on their treatment goals. Youth in this study are discharged from the unit when the youth, family members, unit's team of workers and the county social worker agree that the individual is ready to be maintained in a less restricted environment, or when they need an alternative plan to a similar residential treatment center or an emergency placement in a more restrictive environment. The hope is to place youth in less restricted settings such as with their birth family, foster care, group home, or an adoptive family.

Research Question 1

For children with an Attachment Disorder who have been discharged from this unit, which diagnostic challenges were most resistant to change? Diagnostic challenges refer to the psychiatric diagnosis assigned to a child which include specific behaviors and emotional qualities as noted in the DSM-IV (1994). Each child was assessed by a consulting psychiatrist to determine which diagnosis areas needed to be addressed. All children had an Attachment Disorder diagnosis along with various other diagnoses. A treatment plan was then developed to address areas needing attention for growth to occur. Upon growth in these areas, the hope was that children could then be maintained in less restrictive settings.

In reviewing these case records, it became evident that themes existed regarding the diagnostic challenges which were the most challenging for children. The more growth that occurred in these challenging areas, the more likely a child was to be discharged with a more successful discharge classification, "graduation" or "progress". These theme areas involved the following: intrapsychic characteristics (moral reasoning and conscience development), behavioral characteristics (managing feelings/coping and controlling behaviors), and an ability of a child to form connections with significant people in his/her life (birth family, new family, siblings, and during the treatment process).

Intrapsychic Characteristics

Moral reasoning and conscience development - Characteristics within an individual's mind and soul which relate to attachment include moral reasoning and conscience development. This involves making moral judgments for oneself during times of moral conflict. The three children discharged from this unit with "lack of progress" displayed significant delays in this area. "He demonstrates a total lack of respect and

understanding for the feelings of others," and "has a tendency to be very narcissistic and self-centered in meeting his own needs at the expense of others" (001). The "hurtfulness he may demonstrate toward others is very intentional and appears to gain some enjoyment out of watching others suffer with the results of his inappropriate or unhealthy behavior" (001). The psychiatrist involved in the majority of these cases noted that "in more ambiguous situations where rules have not been specified, they fail to generalize the basic rule of empathic respect for others and then one is surprised that they have transgressed in a way they did not seem capable of." All three children with this least successful classification, "lack of progress," maintained delayed conscience development throughout their stay.

For the eleven children who "graduated" or had "progress" during their treatment stay, each displayed growth in moral reasoning and conscience development. All grew to some extent in their ability to accept responsibility for their actions and how they affected others. For these children, the harm they inflicted upon themselves and/or others was greatly reduced as their time progressed in this unit. Significant incidents of children were recorded throughout their stay and included behaviors such as self-harm, physical aggression, sexual acting-out, property destruction, stealing, running away, and physical interventions. When children acted-out in such ways that they would not stop harming themselves or others, adults needed to physically intervene to "hold" them according to nonviolent crisis intervention techniques in which they were trained. Monthly reports were written to describe each child's progress on their treatment goals. The eleven children who "graduated" or had "progress" during their treatment stay, rarely resorted back to such harmful behaviors during times of stress and moral conflict. Though the

report forms used changed over time (so numbers of incidents could not be recorded for all cases), the narrative descriptions included references of progress in this area. "She has increased her ability to show care for others on a daily basis" (012), and "displays signs of remorse when hurting others' feelings" (012). He "has continued to decrease the number of physical interventions needed to maintain his behaviors and most often makes decisions now to deal with stress without affecting others negatively" (006). Being able to reduce harm toward others played a role in these 11 of 14 children being discharged from the unit to less restricted environments.

Behavioral Characteristics

Managing feelings/coping - All children in this study worked on treatment objectives related to managing their feelings/coping. All three discharged with "lack of progress" failed to find healthy avenues to do this on a daily basis. One child worked "diligently at avoiding any discussions related to his relationship with his parents or his sister" (004). Another child had "unresolved feelings related both to birth family and a failed effort to form some degree of attachment with another family" (009). It was also evident in daily interactions that these children needed much adult intervening to help them manage their feelings. This was noted in all three cases through monthly reports. Each had a treatment goal related to managing feelings and none progressed beyond the second, of five, steps in their Goal Attainment Scale.

For the eleven children who "graduated" or had "progress" during their treatment stay, each displayed growth in managing feelings/coping. All were seen as being resilient in this area as observed in daily interactions. This resiliency could be seen as the "ability to bounce back from difficulties and disappointments and maintain healthy emotional

perspective in daily living situations" (008). Though some displayed "little affect" during discussions around vulnerable topics, such as abuse, all were able to speak about what they experienced and were open to learning about and trying new ways to deal with such feelings. Being resilient in managing feelings also relates to temperament of a child. One description of such temperament was being "fun loving and nearly always having a positive attitude" (012). Communication development also increased for all of these children, many of whom were assessed as having communication delays (as compared to other children their own age) or disorders at their time of admission to the unit. All children discharged with "progress" or "graduation" were able to communicate their feelings and needs on a consistent basis without harming themselves or others as noted in their discharge reports on Goal Attainment Scale progress.

Controlling Behaviors - Children with attachment issues generally do not put themselves into positions to be vulnerable because their experience is that they could not afford to do so. Thus, they become controlling of their environment and in relationships. At their time of admission, all fourteen children in this study were observed as significantly more controlling than children who develop with secure attachments to significant caregivers. All three children discharged with "lack of progress" were unable to lessen this control consistently where they could allow others to care for them without trying to control their environment and relationships with harm and emotional detachment from vulnerable feelings and situations. He "remains disengaged in conversation and often tries to control the person with whom he is interacting" (004). She "speaks of sensitive topics about her life factually rather than allowing herself to become connected to her emotions about these issues" (009). Finally, she "consistently tries to control both peers and adults

during daily interactions" (009). To control their environment in this treatment center, all three children discharged with "lack of progress" continued to do this through significant incidents of harm as was previously noted in their monthly reports in Goal Attainment Scale progress.

Diagnostic areas - Categories of psychiatric diagnosis related to children exhibiting controlling behaviors were found to play a role in determining success during and after their treatment stay. For these children diagnosed with an attachment disorder, the 9 of 14 with an accompanying diagnosis of ODD (Oppositional Defiant Disorder), or Conduct Disorder had the most difficulty with success in treatment. Table 2 displays this in relation to the three types of discharge types.

Table 2

Accompanying Diagnosis Related to Controlling Behaviors (n = 9)

Type	Number of Cases
ODD	
"Lack of Progress"	2
"Progress"	3
"Graduation"	2
Conduct Disorder	
"Lack of Progress	0
"Progress"	1
"Graduation"	1

Note: Of these 9 children, 8 continued with out-of-home placements at some point after their discharge.

Two of the three children discharged with a "lack of progress" had one of these accompanying diagnoses (ODD or Conduct Disorder). The other child had Reactive Attachment Disorder as a primary diagnosis. Four of the five children who were discharged as having "progress" had an accompanying diagnosis of ODD. Of these four, after discharge, one went home briefly and then went to a treatment center for sexual offenders. Another was involved in numerous out-of-home placements and then died years later in her last residential treatment placement while in a physical intervention, her heart failed. The third child remains, to this day, at the foster home to which she was discharged. She was discharged one year ago. The fourth child had an accompanying diagnosis of Conduct Disorder. After his discharge from the unit, he ended up in numerous out-of-home placements and eventually had his adopted status terminated. Three of the six children with a "graduation" from this unit had an accompanying diagnosis of ODD or Conduct Disorder. All of them had out-of-home placements after discharge from the unit. Thus, for all children in this study who had an accompanying diagnosis of ODD or Conduct Disorder (9 out of 14), eight had further out-of-home placements after their discharge. They were, however, most resistant to change in areas related to controlling behaviors as noted in these diagnosis categories.

Physical and/or sexual aggression - Children with attachment issues who do not trust their environment and/or themselves may avoid dealing with their emotions and instead act-out their feelings through physical and/or sexual aggression. Four of the children in this study never required a physical intervention by an adult due to physical or sexual aggression. All of them were discharged with "progress" or "graduation." Of the 10 others, 7 significantly reduced their number of physical interventions by adults to the

point where they no longer needed such intervening. They were discharged to less restricted environments with success of a "graduation" or "progress." Then as previously mentioned, the final three children, discharged with a "lack of progress," continued to consistently assault towards others physically and/or sexually to the point that they also needed consistent physical interventions by adults.

These behaviors also affected school success. All eleven children discharged with "progress" or "graduation" made considerable academic and behavioral growth in a public school setting (contained EBD classroom and/or mainstream classroom). For those discharged with "lack of progress", only one made considerable academic and behavioral progress. She was able to not aggress physically or sexually at school and never needed a behavior intervention plan at school. This, however, was not the case for her in the unit.

Risky behaviors - All three children discharged with a "lack of progress" continued to put themselves and/or others at risk prior to their discharge. This was a deciding factor in their needing to be discharged to a similar setting or a more restrictive one. The majority of these risky behaviors involved body fluids on a consistent basis. One child urinated on people's property. He also put himself at risk walking on the roof of the treatment center and sitting on a suspended ledge outside his bedroom window. Another defecated in inappropriate areas of the unit, urinated on herself and others (during physical interventions), and often strategically placed her own blood in areas where others needed to touch (door knobs, light switches). The third child profusely blew nasal secretions onto adults during physical interventions. Finally, all three children used profuse spitting towards others while aggressing. These risky behaviors did not subside for any

considerable length of time and were especially heightened at the time of their discharges. They also did not display remorse for these incidents.

Ability to Connect with Significant Others

Birth parents - The final theme in this study relating to children's success in the unit involved their ability to connect with significant others, including caregivers and family members. None of the children in this study were involved with their birth parents at their time of discharge, with only three having some contact with their birth parents at the beginning of their treatment stay. Only 3 of 14 children experienced a formal good-bye with their birth parents. Two of these children were siblings. As a part of this process, their mom wrote them a letter she read aloud to them and then gave them each a copy. She went on to write, "to give up my rights...does not mean that I don't care/want you both very much or that I don't care/want you both very much." "I will always be your mom and you will always be my kids in my heart." "I know I've hurt you very much...I am very sorry" (003 and 004). Only one other child in this study experienced a formal good-bye with a biological family member and this was through a videotaped message from her mom. Four other children experienced a good-bye from a biological parent through their mom or dad's death. The seven other children in this study, never had any type of final good-bye with either biological parent. Parents, relatives, and/or siblings were sought for visits and invited to staffings and a Family Day at the treatment center.

New family - As previously mentioned, all three children discharged with "lack of progress" were not involved with a family (foster, respite, adoptive, or biological) at their time of discharge. In fact, they each had remained uninvolved this way during their entire treatment stay and/or for several months prior to their discharge. The eleven other

children involved in this study were discharged to foster care or an adoptive home. These families also played an active part with their children in this unit prior to discharge. They attended family therapy sessions with their children and maintained contact with their children through telephone conversations, letters, and visits home.

Siblings - Connections with siblings were also noted in the case records. Two sets of children in this study were brother and sister (biological siblings) and resided in the unit at the same time. Two other children had a biological sibling in the same unit--one, at the same time as her stay, and the other, prior to his stay, so he had some connection to the unit before his own stay. Of the two sets of siblings who resided in this unit at the same time, each had a sibling who was discharged with a "lack of progress". These two children were younger brothers to their older sisters in the unit and had no connection to a family outside of the unit at their time of discharge. Their sisters had been involved with foster families for a large part of their treatment stay to which they were discharged. The attachments each of these children had with their sibling was underdeveloped. "Interactions with his sister have been noticeably absent of emotional qualities of support and interest" (001). "Both have maintained a degree of separation from each other that is rather uncommon for siblings" (004).

Treatment process - Throughout their stay in this treatment center, many references were made regarding the ability of these children to attach with significant caregivers along with their reactions to what they perceived as interactions of rejection. One child was noted as being "very sensitive to themes of rejection and abandonment. When she is experiencing these feelings or situations, she has a tendency to mask her anxiety in immature or distancing behaviors" (007). At the beginning of her stay in this

unit, she "often tested limits especially when in new situations to check how adults would care for her. She would also often initiate rejection by adults in daily interactions rather than being on the receiving end of abandonment possibilities" (007). These qualities were common for each child in this study when he/she first came to this unit. The psychiatrist involved with the majority of these children added, "sometimes these children actually work out better in group homes where there is no expectation for bonding--a bonding that, of course, will never happen to the same extent that it happens to an infant or young child" (011). He also states that the "internal world" of children with attachment disorders "organizes relationships into two categories: 'I like you and I want to be with you', or 'I hate you and I don't want to have anything to do with you and I think you hate me and don't want to have anything to do with me either'" (011). These children respond to "a very objective non emotional form of parenting with little openness to debating or being drawn into emotional reactions to their behaviors" (011).

Diagnostic challenges most resistant to change for these children with attachment disorders included intrapsychic characteristics, behavioral characteristics, and an ability to form connections with significant people in their lives. The more growth, which occurred in these areas, the more likely these children were to be discharged from this residential treatment center with successful progress to a less restricted environment. This leads to an examination of these children's' needs as they live in residential care.

Research Question 2

What are the needs of children with an Attachment Disorder in relation to their progress in an urban residential treatment center? The needs which this unit aimed to meet for all children included safety, security, consistency, and respect for individuals.

These needs were addressed through various parts of their program such as rules, treatment goals, supportive caregiving, nonviolent crisis interventions, and upholding the mission statement and code of ethics of the treatment center--to mention just a few areas. The needs of children with an Attachment Disorder included these areas plus those related specifically to their psychiatric diagnosis categories. There were three themes related to a child "graduating" or showing "progress" in this residential treatment center. They included: 1) Connecting children to a family outside of the unit to which they could be discharged, 2) Encouraging children to become connected to their emotions in order to deal with them in healthy ways, and 3) Case management.

Connecting with a Family

Being able to connect a child to a family outside of this treatment center was important in this study. The 11 of 14 children who "graduated" or showed "progress" had this connection. The other three children were described by the therapist as appearing to have a "lost sense of hope" and being "difficult to place in other less restricted care due to their needs and the process of the county". This process related to the county social worker involved with each child following their guidelines to first try reuniting children with their birth families. Then if this did not work, parental rights were terminated. Only then could other care be pursued such as foster care, adoptive care, or group homes. For two of the three children with "lack of progress", this process took a greater length of time as they needed to go through the entire process. Both children were in this unit for periods of time lasting two years and two years five months respectively. The third child was in the unit only six months. His mother had just died and he was awaiting foster care. Their lost sense of hope may have related to their feelings of grief and loss regarding their

birth parents and the "prospect of other people caring for them long-term" (009). Even though the other eleven children also had to connect with parents and/or families to which they were not born, they all seemed to have some hope that their new families would accept them as they were.

Coping with Emotions

All fourteen children in this study had treatment goals involving learning how to identify and express feelings/emotions. These goals involved strategies to use to cope with these emotions in healthy ways without trying to harm themselves and/or others. When children struggled in dealing with their feelings healthily, adults first tried verbal strategies to de-escalate them in hopes of proactively deterring them from harming themselves or others. If a child did not respond to this support and moved on to harm themselves or others, adults in the unit would intervene physically with a nonviolent crisis intervention. This was one type of a last resort intervention. Two other possibilities, which were out of the norm for interventions used in this unit, included a time-out placement and Quiet Room placement. Outside of this unit, but in the treatment center, existed a time-out area. This was an area where a child could be away from the unit to de-escalate with one adult supervising. An adult used this when the child could not be maintained in the unit or when a child had a treatment plan which deemed physical interventions unsuccessful. In the same area where a child would have a time-out placement, were two Quiet Rooms. These were locked rooms where a child would de-escalate as supervised by an adult. In each of these last resort interventions, adults tried to de-escalate the child and reintegrate them into the routine of the unit as soon as possible.

The 3, of 14, children discharged with a "lack of progress" continued to need physical interventions and then proceeded to consistently have numerous time-out and Quiet Room placements. Table 3 shows significant correlation's between discharge types and these last resort interventions.

Table 3

Correlation Between Discharge Type and Last Resort Interventions (n = 14)

Discharge Type	Physical Interventions	Time-Outs	Quiet Room
Pearson Correlation	.687	.804	.804
P-Value	.007	.001	.001

Note: All correlation's have a p-value less than .01 showing a significant relationship between discharge types ("lack of progress", "progress", and "graduation") and last resort interventions (physical interventions, time-outs, and Quiet Room use).

With a two-tailed Pearson Correlation test, all relationships display a significant correlation with all p-values being less than .01. Children continuing to need last resort interventions on a consistent basis were all discharged with "lack of progress."

Therapeutic Interventions

Therapeutic interventions were used with all children in this study based upon individual needs. A combination of the following was included in each child's treatment plan--psychiatric consultations, medication, treatment objectives, spiritual/religious services, ELP (Experiential Learning Program) involving recreational therapy, play therapy, group therapy in the unit, group therapy with other children in the treatment center, one-to-one counseling, clinical services in the larger community, recreational involvement in the larger community, and individually designed therapeutic treatment plans occurring for a limited yet intense few days to support children in looking at their stages of development as related to their experiences. To support these interventions, the unit had a program based in consistency with rules, limits, treatment expectations, and nurturance. Families, when available, were also an important part of this therapeutic process.

Conclusion

Two research questions were examined in relation to this study's findings. Both relate to the needs of children diagnosed with an attachment disorder. The majority of children in this study succeeded in this unit to be discharged to less restrictive setting. Of those who did not (discharged to similar or more restrictive setting) and those who succeeded in the unit but continued to have out-of-home placements after their discharge, several areas of diagnostic qualities were noted as important for their success in remaining

in a least restrictive environment and be able to attach to significant others. These areas included the following: intrapsychic characteristics (moral reasoning and conscience development), behavioral characteristics (managing feelings/coping and controlling behaviors), and an ability of a child to form connections with significant people in his/her life. During their stay in this unit, it was important for people to meet the following needs: connecting children to a family outside of the unit to which they could be discharged, encouraging children to become connected to their emotions in order to deal with them in healthier ways, and therapeutic interventions tailored to children's specific needs. After care programming was crucial and developed with collaborative efforts between the unit therapist and county agency. Addressing these needs of children with Attachment Disorders is important not only for their own growth and their family's, but also for society, as they become more fully integrated.

Strengths and Limitations of Study

One strength of this study includes limiting harm to the units of analysis while providing a sample which most accurately represents those needing to be studied to address the research questions. Reviewing case records is the most harmless way to obtain this data while also providing comprehensive information. Prior to these fourteen children residing in this residential treatment center, the American Psychiatric Association did not have a diagnosis to address Attachment Disorders. For this reason, this sample is the largest that could be obtained to accurately discuss this population.

Another strength relates to the understanding which may be gained to benefit the experience that is provided in this unit for future children with an Attachment Disorder. This understanding is reached through an examination of various records, showing various

interactions of these children with others, and information from key informants. There are many variables needing examination to provide beneficial information for improving services. This study provides a comprehensive approach.

Limitations exist in the bias of the researcher (having worked with these children in the study), writers of the various records, and key informants. With the written records accuracy can be a question. With key informants, they may respond by trying to please the agency as they will be aware that agency administrators will examine the finalized research. Bias is difficult to eliminate in research. The bias described here needs to also be qualified with the willingness that exists for those involved in the agency to look at this issue and the professional expertise of those involved.

Implications for Practice and Policy

The most direct implication of this research is for services provided in this unit for children diagnosed with Reactive Attachment Disorder and Attachment Disorder. Children with these issues are increasing in number and being able to intervene with them proactively and successfully is vital for their development. Reaching them before they continue being placed in other out-of-home settings provides stability rather than lending to a need to address even more separation and loss in these children's lives.

Throughout the process of placing children in out-of-home settings, systems involved must address the importance of family ties and permanency. Nothing can replace the attachments a child can develop with immediate and extended family members. Family ties need to be enhanced to resolve damage that has occurred and to empower change to strengthen families. It is also vital for systems involved to develop permanency plans

which keep the number of out-of-home placements for a child to a minimum while encouraging lengths of stay which are only as long as necessary.

An important part of encouraging success for children once they move from an out-of-home setting to a less restrictive setting is after care. Strengthening the family by providing a well-constructed and clear after care plan can only enhance possibilities for success. Such programming may involve professionals and systems from a variety of disciplines. It is vital for these people involved to unite in a plan with the family to work together in providing a foundation of community support.

Those involved in policy making must also look at how to proactively meet the needs of children and families to prevent damage from occurring. Currently, many are concerned about youth who have committed senseless acts of violence which have affected many individuals, families, and communities. Much has been done to stress the importance in the development of children. To look then at this concern, policies must be developed and maintained to encourage such development of children and families. This can only lead to a healthier and stronger society.

Chapter 5

Discussion

This qualitative study sought to explore the needs and challenges of children diagnosed with an attachment disorder who resided in an urban residential treatment center. At the basis of this study, which began with sampling, exists the topic of diagnosis. Though the DSM-IV (1994) contains diagnostic categories, there still remains a subjective assessment by practitioners in assigning the label of attachment disorder to a child. This may be due to insurance reimbursement issues, relying on accompanying diagnosis categories which may more specifically describe a child's extreme behavior, not wanting to label a child with Attachment Disorder or Reactive Attachment Disorder due to many others negative connotations which exist, the practitioners' experience with diagnosis, and biases in how to diagnosis individuals. The description of attachment disorders as noted in the DSM-IV is somewhat vague and may need further study to examine its effectiveness.

The thoroughness with which Bayless (1990) describes grade-school-aged children with healthy attachments is alarming when looking at the children involved in this study. In comparison, the children in this study had numerous needs related to developing emotionally, physically, morally, behaviorally and socially. They also had years of family issues (including abuse) and out-of-home placements to add to their development. As was stated in the literature reviewed, rejection probably produces the most violent, angry, and dysfunctional responses of all particularly when children are subjected to repeated threats of being sent away (Bowlby, 1973). Such is the case with children in this study and especially true for those discharged with the least amount of success. These children

continued to exhibit aggressive, destructive behaviors on a repeated basis. Perhaps their continued lack of conscience development, self-esteem, and trust in themselves and others contributed to their resistance to change especially when a lack of a connection to a family existed.

These "youth at risk" (Brendro et al, 1990) by the ages of 8 to 12 had already experienced a decreased number of protective factors in comparison to other children their same age. Addressing ecological hazards in the lives of these children is important in developing a more holistic approach to better understand them. It also is important in recognizing the responsibility all people in society have for supporting children with attachment issues. There are people in prisons known to have a lack of conscience and positive connections to others in society. Perhaps meeting their needs more proactively when they were children could have led to less acting-out and a higher degree of conscience development for these individuals. Youth at risk are often considered quite challenging for caregivers in regards to responding positively in relationships. As these challenges are noted and then supported for growth, it is vital that people do not lose sight of the strengths of these children. Not only did they all endure great challenges, but they also have skills, talents, and unique personal qualities that can contribute to society when supported.

There were two findings in this study which were surprising. One involves the significant lack of birth family involvement. As these children try to develop their identities, many have questions which may never be able to be answered. Their foundation for understanding who they are may only come from how they perceive their experiences as they do not have birth family members available to reflect back to them who they are in

their eyes. These children then need to take their questioning identities into new families which are often already defined regarding roles and identities. It is particularly difficult for these children when new parents (generally foster parents and adoptive parents) have expectations for bonding/attaching with these children that are unrealistic for these children's abilities. This can be difficult to address when these parents' hearts are often in the right place for wanting to connect with these children. It just needs to be done with some emotional detachment and focus on meeting specific needs as addressed in this study's findings. Though they may not be involved with their birth families, these children are able to develop with supportive new families who accept them as they are and encourage their growth.

Another finding that was surprising related to the clear distinction of children with "lack of progress" resorting to behaviors beyond physical and sexual aggression, to risky behaviors of secreting various bodily fluids when acting-out. And they did this on a consistent basis throughout their stays. Perhaps they resorted to these behaviors which are often viewed as repulsive to try distancing themselves even further from others than they were able to do with aggressive and sexual behaviors. It was not surprising that the aggressive and sexual aggression were contributing factors when these children continued to exhibit these behaviors and not respond to treatment interventions. The use of bodily fluids then not only compounded to this problem, but also put other children and adults at risk for various health concerns.

A finding that was not surprising, and yet still alarming, was the lack of information about birth fathers. For many, they were too young to remember their fathers when their fathers left their lives. The literature points to a need in addressing the

importance of fathers in relation to attachment of children. In a society where a father's role in caring for his children has been viewed as secondary to that of a mother's role, children have often missed out on the many benefits of fatherhood. In looking at the attachment of children, it is vital to address both motherhood and fatherhood. Public policies could also be developed to further enhance and support families.

Findings of this study relate directly to this treatment unit and others being able to meet the needs of children with attachment issues. In this unit, it was evident that there were needs significantly related to success of a child including intrapsychic characteristics, behavioral characteristics, and an ability to form connections with significant people in a child's life. As caregivers support children in meeting these needs, it is also helpful to look at the process counties go through to connect these children with a long-term family placement. As children wait for this process to run its course, they may experience numerous out-of-home placements as the children in this study had. Often these numerous out-of-home placements are due to neglect by the system which is not always a good parent nor substitute for family. Further studies may benefit children by looking at this process in best meeting the needs of children. It could also benefit other children, ages 8 to 12, to look at possibilities available when these children continue to need last resort interventions which involve locked placements (e.g. Quiet Room placements) without responding to behavioral and/or therapeutic interventions.

Summary

As shown in this research, children can make significant changes to enhance their lives, even when their lives from the start included factors which challenged their ability to form attachments to significant caregivers and family members. Shifting the balance for

the child from vulnerability to resilience, either by decreasing exposure to stressful health risks or life events or by increasing the number of protective factors available appears to be the key. Empowering a child to use such a key to open a door to opportunities and growth, as they have significant others to support them, can enhance their lives and the lives of others whom they touch both directly and indirectly.

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APPENDICES

APPENDIX A

MEMO

January 21, 1999

TO: Ms. Teresina Schellinger

FROM: Dr. Lucie Ferrell, IRB Chair

RE: Your IRB Application

Thank you for responding to the issues raised by the Institutional Review Board review of your proposal, "Preadolescents with Attachment Disorders: An Exploratory Study in a Residential Treatment Center." I am writing to inform you that your application is approved, IRB# 99-01-2. Please use this number on all official correspondence relative to your study.

LF:lmn

c: Laura Boisen

APPENDIX B

Preadolescents with Attachment Disorders:
An Exploratory Study in a Residential Treatment Center

Information Form

Dear _____,

I am contacting you on behalf of Teresina (Tere) Schellinger, a student at Augsburg College and an employee at the St. Cloud Children's Home. She is pursuing her Master's thesis which involves a research study of children with Attachment issues who have been discharged from Cottage 6. I thought of _____, the child in your care, and wanted to invite you to participate in this study.

The purpose of this study is to explore different questions related to children with attachment issues who also resided in Cottage 6. Through an examination of case records, insight will hopefully be gained to improve services in Cottage 6 and/or to discover what needs can be addressed to benefit these children more.

If you agree to be in this study, we are asking for your consent to review your child's case record. Collecting this data will begin in January, 1999 and end by March 31, 1999.

In collecting the data all identifiers from the records will be concealed. The only people who will have access to the data collected will be the clinical supervisor, agency director, and Tere. The data will be kept in a locked file cabinet as will the case records, when not being examined.

There will not be a direct benefit to participation. The indirect benefits may be a contribution to knowledge of these children and possible ways to better serve their needs.

The records of this study will be kept confidential. The results of this research will be shared with the agency without identifying any children or families. If publication would occur, it could only be done with approval by the Board of Directors at Catholic Charities. Research records will remain in a locked file cabinet with only Tere having access. Raw data will be destroyed on August 1, 2000.

Your decision whether or not to participate will not affect your current or future relations with Augsburg College or the St. Cloud Children's Home. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

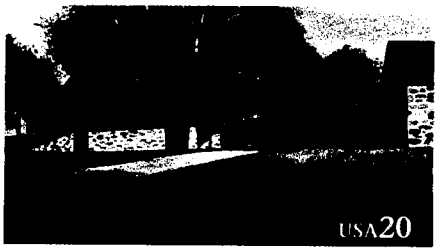
The researcher conducting this study is Teresina (Tere) Schellinger. If you would like to participate in this study, you can fill out the self-addressed, stamped postcard and mail it back to Tere. She will then call you to answer any questions or concerns you may have.

I thank you for your consideration of this study and wish you and your family much health and happiness.

Sincerely,

Robert S. Hanks, MA
Cottage Six Therapist

APPENDIX C



Teresina Schellinger
St. Cloud Children's Home
1726 7th Ave. South
St. Cloud, MN 56301

Yes, I would be interested in speaking more with you about this letter.

Name: _____

Phone: _____

Address: _____

_____

The best times to reach me include: _____

_____

APPENDIX D

Preadolescents with Attachment Disorders:
An Exploratory Study in a Residential Treatment Center

Consent Form

Dear _____,

You are invited to be in a research study of children with Attachment issues who have been discharged from Cottage 6 at the St. Cloud Children's Home. You were selected as a possible participant because the child in your care fits this category as stated by the Cottage Therapist in Cottage 6. We ask that you read this form and ask any questions you may have before agreeing to be in this study.

This study is being conducted by me as part of my master's thesis at Augsburg College.

The purpose of this study is to explore different questions related to children with attachment issues who also resided in Cottage 6. Through an examination of case records, insight will hopefully be gained to improve services in Cottage 6 and/or to discover what needs can be addressed to benefit these children more.

If you agree to be in this study, we are asking for your consent to review your child's case record. Collecting this data will begin in January, 1999 and end by March 31, 1999.

In collecting the data all identifiers from the records will be concealed. The only people who will have access to the data collected will be the clinical supervisor, agency director and myself. The data will be kept in a locked file cabinet as will the case records, when not being examined.

There will not be a direct benefit to participation. The indirect benefits may be a contribution to knowledge of these children and possible ways to better serve their needs.

The records of this study will be kept confidential. The results of this research will be shared with the agency without identifying any children or families. If publication would occur, it could only be done with approval by the Board of Directors at Catholic Charities. Research records will remain in a locked file cabinet with only myself having access. Raw data will be destroyed on August 1, 2000.

Your decision whether or not to participate will not affect your current or future relations with Augsburg College or the St. Cloud Children's Home. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

The researcher conducting this study is Teresina J. Schellinger. You may ask any questions you have now. If you have questions later, you may contact me at the St. Cloud Children's Home at (320) 251-8948 (Cottage 6). You may also contact my thesis advisor, Laura Boisen, at Augsburg College at (612) 330-1439.

You will be given a copy of the form to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____ Date: _____

Signature of parent or guardian: _____ Date: _____

Signature for oral consent of a minor: _____ Date: _____

Signature of investigator: _____ Date: _____

APPENDIX E

Case Review Guide

Case # _____

Date of Case Review _____

Time began _____ Time ended _____

REFERRAL INFORMATION

Demographics:

Gender: Male _____ Female _____

Age _____

Ethnicity: Caucasian (C) _____

Hispanic (H) _____

African American (AA) _____

Native American (NA) _____

Asian (A) _____

Other _____

Religion: Catholic _____

Lutheran _____

Protestant _____

Baptist _____

Nonaffiliated _____

Other _____

Case # _____

Genogram (Birth Family, Foster Family, Adoptive Family):

Case #_____

REFERRAL INFORMATION

Resiliency Factors:

Perinatal Health:

Maternal Age _____

Maternal drug/alcohol use _____

Premature birth _____

Other _____

Family Environment:

Arguments _____

Abandonment _____

Physical violence _____

Sexual abuse _____

Verbal abuse _____

Neglect _____

Parental Substance Abuse _____

Psychological disturbance _____

Other _____

Parental Status:

Educational level _____

Psychological health _____

Other _____

Family Resources & Support:

Food _____

Shelter _____

Clothing _____

Recreational _____

Spiritual _____

Religious ____

Other _____

Case #_____

REFERRAL INFORMATION

Protective Factors:

Places of residence:

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

Other _____

Environmental:

Current family ties _____

Current community ties _____

Parents set rules _____

Parents show respect for individuality _____

Stable family environment ____

DIAGNOSTIC TESTING

IQ _____

Depression Inventory _____

Caps & Connors _____

Language: Verbal _____

Written _____

Learning Disorder: Negative _____

Positive _____

Other _____

Case #_____

INITIAL ADMISSION ASSESSMENT

Places of Residence:

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

With _____ from _____ to _____

Other _____

Psychiatric Diagnosis:

Reactive Attachment _____

Attachment _____

Anxiety _____

Oppositional Defiance _____

Conduct Disorder _____

Post Traumatic Stress _____

ADD _____

ADHD _____

Learning Disorder

Other _____

Case # _____

STAFFINGS

Length of Stay in Unit _____

Individual Protective Factors:

Communication skills _____

Cognitive skills _____

Alertness _____

Curiosity _____

Enthusiasm _____

Goal setting _____

High self-esteem _____

Internal locus of control _____

Temperament _____

Case #_____

STAFFINGS

Family Changes:

Connection with New Family _____

Divorce _____

Marriage _____

Death _____

Physical health _____

Psychological health _____

Other _____

Home Visits:

Birth Parent(s) _____

Foster Family _____

Adoptive Family _____

Other _____

Goals in Treatment:

#1 _____

#2 _____

#3 _____

#4 _____

Other _____

Goal Progress at Each Staffing:

#1 _____

#2 _____

#3 _____

#4 _____

Other _____

Case #_____

STAFFINGS

Therapeutic Groups Attended:

- Children of Color _____
- Children Are People _____
- Sexual Issues _____
- Sexual Survivors _____
- Adoption _____
- Ouch _____
- Growth Education _____
- Rainbow _____
- Grief and Loss _____
- Other _____

Clinical Support:

ELP:

- Rock Climbing _____
- Music Videos _____
- Arts and Crafts _____
- Skateboarding _____
- Cross Country Skiing _____
- Horse Riding _____
- Recreational Games _____
- Other _____

Case # _____

Religious Education:

One to One Counseling _____

Special Friends _____

Holiday Rituals at SCCH _____

Winnie the Pooh _____

Youth Group _____

Worship Service _____

Outside Church _____

Mentor Volunteer _____

Other _____

Other Clinical Support: _____

Case #_____

STAFFINGS

Nursing Summaries:

Perinatal Health issues _____

Height change _____

Weight change _____

Growth Concerns _____

Medications _____

Medical Treatments _____

Enuresis _____

Encopresis _____

Sleep Disturbance _____

Other _____

Community Activities:

Extracurricular _____

Athletic _____

Swimming Lessons _____

Day Camp _____

Church _____

Cultural Activities _____

Volunteer Work _____

Mentor _____

Other _____

Behavioral Treatment Plan Interventions:

Number _____ Duration _____

Discharge Type:

"Graduation" _____

"Progress" _____

"Lack of Progress" _____

Case # _____

PSYCHIATRIC CONSULTATIONS

Behaviors Observed:

Unreasonably angry (out of context)_____

Abnormal eye contact _____

Lack of conscience development _____

Controlling _____

Anxiousness _____

Superficial charm _____

Preoccupation with blood, fire, or gore ____

Severe impairment in cause & effect thinking _____

Lack of ability to generalize _____

Lack of ability to predict _____

Weak impulse controls _____

Persistent nonsense questions or chatter _____

Other _____

INDIVIDUAL EDUCATION PLANS (IEP)

School Status:

EBD Classroom _____

Mainstream _____

Day Treatment _____

Other _____

Behavioral Intervention Plans:

Number_____ Duration _____

Physical Interventions:

Number _____

Strengths _____

Challenges _____

Case #_____

INCIDENT REPORTS

Abuse Reporting:

- Emotional _____
- Verbal _____
- Neglect _____
- Physical _____
- Sexual _____
- Other _____

Family Communication:

- With Child _____
- With Staff Member _____
- Other _____

Behavioral Incident:

- Stealing _____
- Property Destruction _____
- Self-Harm _____
- Verbal Aggression _____
- Physical Aggression _____
- Sexual Boundaries _____
- Sexual Acting-Out _____
- Other _____

Other Incident _____

PHYSICAL INTERVENTION FORMS

Number _____

Case # _____

BEHAVIORAL CONSEQUENCE CHECKLISTS

Stealing _____

Property Destruction _____

Self-Harm _____

Verbal Aggression:

- Toward Peer _____
- Toward Adult _____
- Other _____

Physical Aggression:

- Toward Peer _____
- Toward Adult _____
- Other _____

Sexual Boundaries _____

Sexual Acting-Out _____

Running Away _____

Physical Intervention _____

Other _____

Case # _____

TREATMENT OBJECTIVES

Adult Relationships _____

Peer Relationships _____

Hygiene _____

Self-Esteem _____

Family Relationships _____

Moral Development _____

Anger Management _____

Coping _____

Feelings _____

Other _____