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Investigation of a Treatment Approach for Reactive Attachment Disorder

by

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ABSTRACT

This study is an evaluative case study case study of a treatment program for children diagnosed with Reactive Attachment Disorder (RAD). Four children and their caregivers were included in the study. The objective of the study was to investigate issues related to the child in RAD treatment, and describe the caregivers' role in the treatment of their child. The treatment consisted of 12 weekly sessions which included a children's play therapy group, a caregiver support and educational group, and a caregiver and child interaction segment. Three of the children appeared to respond positively to the treatment group, and their caregivers also identified changes in their approach to parenting and ability to cope. The fourth child dropped out of the group, and the issues that may have affected his participation and progress are described in detail. The children's involvement in the group was discussed from the perspective of their context, or starting point for treatment, their pattern of social interaction at home and school, and their response to the treatment program. The investigation of the caregiver's role in the treatment included a discussion of the caregiver's expectations for treatment, opinions regarding the group format, and challenges in parenting their child. The findings are discussed with respect to the implications for children diagnosed with RAD, caregivers, social workers and social services, and clinicians and agencies providing RAD treatment.

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My deepest gratitude is extended to the caregivers and children who participated in this study. These families were traveling a long and difficult road together, and I appreciate their openness in sharing their journey with me.

It is said that it takes a village to raise a child, and it took the combined efforts of my own personal village to complete this dissertation. To my parents, Peter and Sherie, thank you for your boundless optimism and belief in my ability to finish this degree. To my mother-in-law and father-in-law, Gaetane and Jerry, and my sister Kimberley, thank you for providing me with the time to write and revise this document. To my husband, Bryan, thank you for your unwavering understanding and encouragement. Finally, to my own little ones, Nicolas, Jenna, and Aren, who each arrived during the course of this degree, thank you for your patience for “mama’s ‘puta time”.

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Chapter 1

OVERVIEW AND OBJECTIVES OF THE STUDY

Introduction

In the United States each year, statistics indicate that there are 800,000 children with severe attachment disorder coming to the attention of child welfare (Cicchetti, 2007; Levy & Orlano, 1998). These children are at risk for low self-esteem, inability to handle stress, lack of self-control, inability to form sustaining relationships, oppositional behaviors toward authority figures, aggression and violence, and inability to empathize. Attachment problems have been related to the development of Conduct Disorder in adolescence, and Anti-Social Personality Disorder and substance abuse in adulthood (Holland, Moretti, Verlaan, & Peterson, 1993). Literature indicates that teenage boys who have experienced attachment difficulties are three times more likely to commit violent crimes (Levy et al., 1998). Of serious concern is that due to the very nature of this disorder, children with attachment disturbance tend to perpetuate the problem in their own children.

However, there is evidence that patterns of attachment can change, and can be influenced by factors such as changes in family stresses and living situation, changes in the quality of parental care, and changes in secondary attachment relationships (Thompson, 2000). According to Thompson (2000) the combination of developmental history and current circumstances is what determines the attachment style demonstrated at the present time. The belief in the potential for change, however difficult, is essential when approaching the treatment of attachment disorder. This study has been designed to make a contribution toward the development of a treatment for Reactive Attachment Disorder. The treatment examined in this study included psychoeducation and support for foster caregivers, group play therapy for the children, and caregiver-child dyadic work.

Purpose of Research

This project is an Evaluative Case study of a model for treatment of children diagnosed with Reactive Attachment Disorder (RAD) living in foster care. The group was designed for children in a secure foster care placement. Therefore, a primary goal of the group was to create stability for the child diagnosed with RAD by developing the basic elements of attachment between the child and their foster parent. Treatment included a play therapy group for children, a psycho educational and support component for their caregivers, and an intensive caregiver-child interaction segment. The children's play therapy group provided children with opportunities to interact with peers through non-directive and directive play experiences, in addition to addressing individual issues in a safe and supportive environment.

The objective of the caregivers' group was to educate the group about attachment disturbances and support the foster parents in connecting to and caring for their children. The objective of the caregiver-child interaction segment was to foster the child's relationship with the caregiver through attachment based play activities including touch, eye contact, and positive affect.

Objectives of Study

The objective of this study is two-fold: to investigate the children's responses to the treatment within the context of the RAD disorder, and to describe the caregivers' parenting concerns and role in the treatment of their child. This information will be presented in the form of an Evaluative Case Study consisting of two parts.

The first part will include a discussion of issues related to the child participating in the RAD treatment. The focus will be on the child's response to treatment given their personal context, or starting point, when entering the program. A discussion of the child's relationship history, co-morbid psychological and medical conditions, and ability to interact with others in different settings will be included. The second part of the Evaluative Case Study will be concerned with the caregiver's role in treatment and their issues with parenting a child with RAD.

Significance of the Study

This study has particular relevance to foster parents, clinicians, and researchers committed to working with children with Reactive Attachment Disorder (RAD). The importance of attachment for optimal child development, and belief in the potential for foster families to promote positive attachment behaviors in children with RAD are principles in which this study is grounded. The significance and rationale for the study is discussed below.

Attachment is a critical process in human development, contributing to the likelihood of survival in infancy, and optimizing adaptive functioning and positive development across the lifespan (Cicchetti, Cummings, Greenberg, & Marvin, 1990). Attachment results from consistent, responsive care giving that includes activities that are vital to brain development (Randolph & Myeroff, 1999). In the presence of inconsistent, neglectful, or abusive parenting, there is an increased possibility that an attachment problem may develop. Reactive Attachment Disorder is a condition defined by a marked disturbance in social relatedness demonstrated before age five, associated with grossly pathological care (DSM-IV-TR; APA, 2000). The inference when applying this diagnosis is that the presence of pathological care such as neglect or abuse has disrupted the child's ability to develop appropriate attachment behavior.

Given the features of this diagnosis, it is reasonable to expect that it may be seen more often in foster or adoptive family situations, where a child has experienced mistreatment prior to removal from their biological parents (Juffer, Hoksbergen, Riksen-Walveren & Kohnstamm, 1997). According to Ocasio and Knight (2003), increasing numbers of children are entering the foster care system. This increase has been attributed to a number of factors, most notably the increase in the number of babies born to mothers who are habitual drug users (U.S. Department of Health and Human Services, 2001). Maternal drug use, psychopathology, poverty, and domestic violence have all been identified as factors which increase the risk that a child will be placed in foster care, and interestingly, are also common to children who are diagnosed with RAD. On average, children who are placed in foster care prior to their first birthday spend upwards of two and a half years in care, and may go through several placements in that time (U.S. Department of Health and Human Services, 2001).

Vulnerable and maltreated children are placed in foster care on the assumption that it will provide a protective and safe environment. Wilson (2001) highlights the unique position of foster care either to propagate negative attachment cycles through multiple placements, or to mediate and promote positive attachment patterns with caring foster parents. Few empirical studies have been conducted on approaches to treating attachment disorder, particularly the role that foster parents may have in the success of therapeutic attempts (Hanson & Spratt, 2000; Zeanah & Boris, 2000; Zeanah, Mammen, and Lieberman, 1993).

The existing research on treatment of RAD reflects growing trends toward novel approaches for the treatment of attachment problems. Hanson and Spratt (2000) highlight the potential harm of approaches such as holding therapy or "rage reduction" techniques particularly when applied to already traumatized children, and suggest that therapy for attachment disorders be based on established techniques used to treat other disorders. Zeanah, Mammen, and Lieberman (1993) state that treatment for RAD is most effective when it is intensive and long term, and providing the child with a stable foster home placement is the first step in treating attachment problems.

The above concerns were considered in developing the three-pronged treatment approach in this study. First, the treatment was developed for children in long term foster care, with the belief that a safe, stable environment and a committed caregiver are key elements in the remediation of behaviors associated with RAD. To support and maintain the home placement, the treatment included an intensive segment for the child's caregiver, and the foster parent's attendance and participation was considered as important as the child's participation.

The second part of the treatment was the children's portion of the group. It was developed based on accepted techniques for the treatment of children's psychiatric disorders (e.g. play therapy, cognitive-behavioral techniques) applied in a new format. Although play therapy is commonly used to treat some forms of children's mental illness, this group was unique in providing a non-directive play therapy component to children with severe pathology in a group setting. The group format, including non-directive play therapy coupled with directed activities, was chosen to give the child an opportunity to address individual issues through play, as well as improve the child's ability to function with peers.

The third component of the treatment was the caregiver-child interaction segment. This portion of the group was specifically designed to develop attachment between the caregiver and the child. Activities were chosen to promote eye contact, appropriate and safe touch, and one-on-one interaction.

Overall, the treatment approach presented in this study includes commonly used therapeutic techniques (e.g. play therapy, parent education and support), yet includes components to address the unique needs of children who have been diagnosed with RAD and their caregivers. This study will add to the relatively sparse literature on treatment of RAD by exploring a unique approach to treatment of RAD, investigating the children's response to treatment, and describing the foster parent's role in treatment. This project has clinical utility as it provides a greater understanding of the unique challenges faced by foster parents dealing with RAD on a daily basis and the resources and supports that are beneficial to them, as well as detailing the successes and challenges demonstrated by the children participating in the treatment.

Theoretical Framework

Due to the exploratory nature of this study, a qualitative orientation and an Evaluative Case Study methodology was chosen as the most effective method of studying this treatment program. The data were presented as a Case Study of the treatment program to allow for deeper exploration and description of the participants' backgrounds, the children's diagnostic and behavioral presentation, and to accurately reflect the context in which treatment was attempted. To examine the children's response to treatment, and investigate and describe issues of relevance to the participating caregivers, interviews, observations, and information from other instruments were used. The researcher allowed the caregivers to guide the direction and process of relating events, incidents, and perceptions during individual interviews and a focus group. Standardized measures of the children's behavior, clinical evaluation from the group therapists, and other supporting documentation provided information on the children's progress and participation in the group.

Participation in the research study was voluntary, and did not affect a family's access to the treatment group. Five families initially agreed to participate in the research study, and four completed the research protocol. A large amount of data was generated from these four families, and a rich description of their participation in the group was made possible using a case study approach.

Definition of Terms

Several significant and central concepts are used throughout this document and require definition as follows:

Attachment: Bowlby (1969) defined attachment as the "lasting psychological connectedness between human beings". A more detailed definition of attachment developed by Ainsworth is described in Cassidy (1999):

> First, an [attachment] bond is persistent, not transitory. Second, an [attachment] bond involves a specific person, a figure who is not interchangeable with anyone else. Third, the relationship is emotionally significant. Fourth, the individual wishes to maintain proximity to or contact with the person. Fifth, the individual feels distress at involuntary separation from the person. [Sixth], the individual seeks security and comfort in the relationship with the person (p. 12).

Attachment Theory: Bowlby's (1969) ethological-evolutionary theory of attachment proposes that attachment is one of the most vital building blocks for normal human development. Besides providing necessary safety and protection for the young, it is through attachment that a child learns basic trust, and regulation of impulses and emotions. The development of a sense of competence, empathy, and resilience results from secure attachment and forms the base for balance between autonomy and dependence (Levy & Orlano, 1998).

Attachment influences the child's physical, cognitive, and psychological development. If the attachment process is disrupted, the secure base necessary for future development is lacking and there is potential for severe interpersonal, emotional, and cognitive deficits (Association for Treatment and Training in the Attachment of Children (ATTACH), 2000).

Classification of Attachment Style: The above definition and theory of attachment were the basis for the development of a classification system for children's level of attachment to their primary caregiver. Ainsworth, Blehar, Waters, and Wall (1978) developed a laboratory paradigm called "the Strange Situation" to identify the attachment styles of one year old infants. The classification system developed by Ainsworth et al. was based on the types of behavior exhibited by infants towards their mothers when reunited with after a brief separation. The infants' behavior toward their mothers after being left alone in a strange environment (the laboratory play room) was considered to be reflective of the infants' view of their relationship. Securely attached infants were easily soothed after their mothers returned, and resumed exploration of the play room. Secure infants have experienced consistent care from their mothers. Consequently, they will signal their needs to caregivers, and have an expectation of response. Ainsworth et al.'s second category, "avoidant" infants, appear to ignore their mothers at reunion. Caregivers of avoidant infants have been shown to be rejecting or non-responsive to the infants' signalling behavior. Therefore, avoidant infants deactivate attachment needs and exert defensive independence. The third category Ainsworth et al. called "ambivalent". Infants in this category will both cling to and push away their mothers at reunion. Caregivers of ambivalently attached infants have been shown to be inconsistent when responding to their baby. For example, the caregiver may pick up the infant when they are content, but not respond when the child is signalling for comfort.

Later studies have modified and further developed Ainsworth et al.'s classification of attachment styles (Cassidy & Shaver, 1999; Delaney, 1998; Meisels & Shonkoff, 1990; Steinhauer, 1998). A fourth category of attachment style, called the disorganized or disoriented pattern has been added to Ainsworth's three identified patterns of secure, ambivalent/anxious, and avoidant/non-attached. Children who demonstrate a disorganized pattern of attachment display odd, erratic behavior at reunion with their caregiver following separation. Lyons-Ruth & Jacobvitz (1999) describe examples of such behavior: "[the child may] appear apprehensive, cry and fall huddled to the floor… [or] display conflicting behavioral movements, such as turning in circles while simultaneously approaching their parents" (p. 520). This pattern is usually seen in children in response to frightening or unpredictable behavior from their caregiver (Lyons-Ruth & Jacobvitz, 1999).

Ainsworth (1979) determined that approximately two-thirds of the children in her studies demonstrated secure attachment styles. Ainsworth's categorization of attachment styles is a theory of normal childhood development. It has been widely applied to examine the nature of childhood and adult intimate relationships and personality development, but was not developed to describe a clinical population. It is important to note that even when a child is classified as insecure in their attachment relationships, most do not develop a psychiatric disorder (Greenberg, Cicchetti, & Cummings, 1990).

Although children with a clinically defined attachment disorder such as RAD would likely demonstrate an insecure or disorganized pattern of attachment, not all children with insecure attachments have RAD. A specific etiology and set of diagnostic criteria accompany a diagnosis of Reactive Attachment Disorder.

Reactive Attachment Disorder: The fourth edition text revision of the Diagnostic and Statistical Manual of Mental Disorders defines Reactive Attachment Disorder (RAD) as the presence of "markedly disturbed and developmentally inappropriate social relatedness in most contexts" present before age 5 (DSM-IV-TR; APA, 2000). Two clinical presentations of RAD are described in the diagnostic criteria. The Inhibited Type is characterized by "excessively inhibited, hypervigilant" responses, which may involve a pattern of "approach and avoidance" with caregivers or "frozen watchfulness". The Disinhibited Type is characterized by "diffuse attachments and indiscriminate sociability" with no demonstration of "selective attachment" to a caregiver. A child given the diagnosis of the Disinhibited Type may show "excessive familiarity with strangers or lack of selectivity in choice of attachment figures". To give the RAD diagnosis, there must be evidence that pathogenic care in the form of severe neglect, abuse, or other maltreatment is responsible for the deficits in social relatedness observed in a child. Underlying these diagnostic criteria is the assumption that specific deficits in care giving create insecure patterns of attachment which interfere with the development of relationships (Bradford & Lyddon, 1994). This distinguishes the diagnosis of RAD from the more general category of "attachment disorders", which do not specify a history of pathological care.

Organization of the Thesis

The thesis is organized into six chapters. The first two chapters introduce the project and review the topic according to the related literature. The third chapter discusses the research design and the research methodology for the study. Chapter four presents the issues related to the children who participated in the RAD treatment, and chapter five covers the issues related to their caregivers. The sixth chapter provides a summary of the Case Study and an analysis of this treatment approach, implications for treatment of Reactive Attachment Disorder, and concludes with suggestions for further research.

Identification of Participants

To preserve and protect the identity of the participants in this project, all names have been changed. Only information necessary to describe the participants' background and experience as they relate to the objectives of this study was included.

Chapter 2

REVIEW OF RELATED LITERATURE

Introduction

This study examines a treatment developed for children diagnosed with RAD and their foster parents. The existing literature on the treatment of RAD highlights the lack of consensus in how to accurately assess and effectively treat this disorder. To contribute to the literature on treatment, this study was designed to explore the response of the children and foster caregivers to a group play therapy treatment paradigm. The treatment incorporated techniques designed to promote attachment between the child and their caregiver, and tenets of attachment theory formed the underlying philosophy of the treatment group. Given that this treatment was specifically developed for children diagnosed with RAD, the following review will begin with a detailed description of this disorder and the controversy surrounding the application of this diagnosis. Research on the importance of caregiver stability and support and approaches to the treatment of RAD will be presented. This will be followed by a discussion of the general principles of attachment theory underlying the treatment paradigm in this study.

Reactive Attachment Disorder

Disorders of attachment were formally recognized only 20 years ago in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Zeanah et al., 1993). The fourth edition text revision of the Diagnostic and Statistical Manual of

Mental Disorders includes Reactive Attachment Disorder (RAD) as a diagnosis for infants and children (DSM-IV-TR; APA, 2000). Diagnostic criteria for RAD state that "markedly disturbed and developmentally inappropriate social relatedness in most contexts" must be present beginning before age 5 (DSM-IV-TR; APA, 2000). Two clinical presentations of RAD are described in the diagnostic criteria. The Inhibited Type is characterized by "excessively inhibited, hypervigilant" responses, which may involve a pattern of "approach and avoidance" with caregivers or "frozen watchfulness". The Disinhibited Type is characterized by "diffuse attachments and indiscriminate sociability" with no demonstration of "selective attachment" to a caregiver. A child given the diagnosis of the Disinhibited Type may show "excessive familiarity with strangers or lack of selectivity in choice of attachment figures".

To give the RAD diagnosis, there must be evidence that pathogenic care in the form of severe neglect, abuse, or other maltreatment is responsible for the deficits in social relatedness observed in a child. Underlying these diagnostic criteria is the assumption that specific deficits in care giving create insecure patterns of attachment which interfere with the development of relationships (Bradford & Lyddon, 1994). This premise is supported by studies which have found that abused children seek closeness from their mothers in ineffective ways (Ainsworth, Blehar, & Wall, 1978). In prescribing a specific etiology for RAD, this diagnosis is unique in the DSM-IV-TR.

Behaviors associated with Reactive Attachment Disorder can be behavioral, cognitive, affective, social, physical, and moral (Levy & Orlano, 1998). Delaney (1998) described behaviors often displayed by children who have experienced disturbances in attachment. These may include: sadism and violence to animals or other people, disordered eating, superficial or feigned emotions, kleptomania and compulsive lying, sexual obsession and compulsion, passive-aggressive methods of relating, and an absence of appropriate emotional response (e.g. empathy, guilt, remorse).

In addition to the behaviors described above, children with attachment problems may often demonstrate unusual patterns of language development, motor delays, failure to acquire age-appropriate self-care skills, poor attention and concentration, emotional lability, aggressiveness, impulsive and oppositional behavior (Richters & Volkmar, 1994; Zeanah, Smyke, and Dumitrescu, 2002). Any or all of the above behaviors may be seen in a child with RAD, making it difficult to accurately identify whether a true disturbance in social relatedness is present and distinguish RAD from other behavioral disorders.

Issues surrounding the Diagnosis of RAD

There is no standardized or comprehensive system for assessing RAD, and diagnosis can be difficult given the broad array of symptoms that a child may display (Sheperis, Doggett, Hoda, Blanchard, Renfro-Michel, Holdiness, & Schlagheck, 2003; Zeanah, Scheeringa, Boris, Heller, & Smyke, 2004). The presence of RAD may be overlooked due to the salience of conduct issues, or a child's symptoms may closely resemble the outward presentation of another disorder. For example, Mukaddes, Bilge, Alyanak, and Kora (2000) investigated the diagnosis of 15 children presenting with impaired social skills, speech and language delays, and repetitive, stereotypical behaviors.

The children were originally diagnosed with Pervasive Developmental Disorder (PDD), an organic syndrome. However, upon closer investigation of their family histories and secondary symptoms, the children did not meet the criteria for PDD. Mukaddes et al. (2000) suggested that a defining feature of RAD that should be used to differentiate this disorder from others with similar symptoms is a history of pathological care and maltreatment. The authors also note that those children with RAD responded positively to treatment interventions, whereas children who were accurately diagnosed with PDD did not make gains in treatment.

Differentiating RAD from Conduct Disorder, Oppositional Defiant Disorder, ADHD, Anxiety, and other mental health disorders can be difficult, particularly as the child grows older and the attachment history may not be as accessible to a clinician. Byrne (2003) highlighted the problems inherent with applying the diagnosis of RAD to a teenager with many symptoms and long term involvement with Children's Services. Other issues surrounding diagnosis relate to the definition of RAD itself. Zeanah et al. (2004) examined clinician's ability to reliably discriminate between the two presentations of RAD, characterized respectively by inhibited or "frozen" behavior, or indiscriminate sociability. The authors found that clinicians reliably identified children with attachment disturbances, however, the two types of RAD were not mutually exclusive and the same child could demonstrate behaviors from both RAD sub-types.

This result has led some researchers to propose that continuous scales for measuring attachment more accurately reflect the range of presentation than traditional categorical diagnoses that classify attachment (Stafford, Zeanah, Scheeringa, 2003; Zeanah et al, 2004). Debate remains regarding the most accurate method to assess and diagnose RAD. Sheperis et al. (2003) suggested that an assessment that includes "a battery of semi-structured interviews, global assessment scales, attachment-specific scales and behavioral observation" will provide the most comprehensive look at a child who may be affected by RAD (p. 291). Although there is some confusion in the literature around methods of diagnosis and assessment, it is widely agreed that obtaining a detailed history and examining multiple sources of information increases the accuracy of the RAD diagnosis.

Given the broad spectrum of problems associated with RAD, Richters and Volkmar (1993) proposed that RAD may actually be a syndrome of maltreatment rather than a specific disorder of attachment. Zeanah et al. (1993) suggested a more specific set of criteria for attachment disorder in which evidence of "profound disturbance in the child's use of a caregiver as a source of safety and security" is present. The child-caregiver relationship would be assessed based on the presence or absence of comfort seeking, exploratory behavior by the child, and affectionate responses and cooperativeness between caregiver and child. The central role of the caregiver-child relationship is emphasized throughout the literature on attachment, and the disturbance of same is the hallmark of RAD. Many children with attachment disturbances have experienced trauma and abuse, but not all children who have experienced trauma develop RAD.

Individual variations in the experience of stressful events are developed through the caregiver relationship (Cole, Michel, & O'Donnell, 1994; Sroufe, 1995). There is evidence that children with a history of attachment issues and poor early relationships have a lessened ability to cope with subsequent stressors. An example of the different impact of trauma on two people with differing attachment histories is described by Mishne (2001). She presents two case examples of teenage girls who have experienced trauma. One experienced trauma against a background of chaotic family interactions and a history of secrets and betrayal within the family. The second case is of a girl who experienced horrific trauma but had a history of dependable and responsive care from her parents. The long term adjustment of the first child was considerably more affected than the second, who had the benefit of solid family support. Mishne states that these cases demonstrate the "power of a loving original home and its opposite, the power of negative, assaultive parenting in [the mediation of] traumatic events in the life of a child" (p. 78).

Trauma, or the experience of a traumatic event, is an integral contributing factor in the development of an attachment disturbance. It is possible to experience trauma without a disturbance in attachment, but it is not possible to have an attachment disturbance without an experience of trauma. The term "trauma" in this case is used loosely to encompass everything from psychological trauma such as neglect or abandonment, to direct physical trauma such as physical or sexual abuse. Whether the presence of trauma leads to attachment problem will be determined by the nature of the trauma itself and the surrounding circumstances. Overall, different responses to extreme stress are related to the nature and duration of the trauma, as well as the personal and developmental history of the child. Relational trauma in early life, such as abuse or neglect by a parent, appears to cause the most severe behavioral and psychological effects. It is this type of traumatic experience that results in the development of RAD symptoms.

Sheperis, Renfro-Michel, and Doggett (2003) caution practitioners who are applying the diagnosis of RAD, as the wide spectrum of associated behaviors can often resemble other disorders. Differential diagnosis is crucial so that a child receives the treatment appropriate for his or her needs and the underlying causes of behavioral concerns are not overlooked (Sheperis et al., 2003). Careful assessment of the social, cognitive, and physical health of a child is essential to determine if RAD is the correct diagnosis for a particular child. Children diagnosed with RAD often present with multiple mental health and medical concerns. The presence and nature of such co-morbid conditions will affect the child's presenting behavior, their requirements for treatment, and their response to intervention. For children with RAD, the most commonly occurring co-morbid mental health diagnoses include Post-traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD). Neurological or medical conditions such as Alcohol Related Spectrum Disorder or Fetal Alcohol Syndrome (FAS) are also present or suspected in many cases.

Prognosis for Children with RAD

Treatment of children who are diagnosed with Reactive Attachment Disorder is often difficult and usually long term (Steinhauer, 1983; Zeanah et al. 1993; Zeanah & Boris, 2000). This is because the effects of RAD are pervasive, as children diagnosed with RAD typically demonstrate maladaptive functioning in many areas of development. Basic physical functions such as eating and sleeping are often affected and establishing basic routines for activities of daily living such as bathing and dressing can be difficult. Higher level processes are also impacted, and a child's emotional responses, attention and focus, speech and language development, and social skills can all be affected by RAD. RAD has such widespread effects on a child's functioning as attachment and a person's ability to emotionally relate to others is formed in early childhood and has direct physical, biological correlates in both brain structure and function. The following review of the biological basis of attachment is important in understanding the nature of RAD, and the prognosis for treatment.

Biological Basis of Attachment

The most significant brain development in a person's life occurs in the first three years after birth (Levy & Orlano, 1998; Schore, 2001). It is within this accelerated growth period that 90% of neural connections are made in the brain. Potential for cell development is determined by biology, but actual growth of connections is strongly influenced by the environment (Schore, 2001; Steinhauer, 1998). Glaser (2000) discussed the concept of "ontogenesis". This is the development of the self through self-regulation. Applying this concept, development is seen as more than the interaction of between nature and nurture, as ontogenesis allows for the modification of the process by the contribution of the individual child. Sufficient levels of constructive stimulation and regulated interpersonal experience with caregivers in this period is crucial for optimal brain development.

The regulation of affect is a central organizing principle of human development (Schore, 2001). The right brain is centrally involved in processing social-emotional information, facilitating attachment functions, and regulating bodily and affective states. It is also important in the control of vital functions supporting survival and allowing the person to cope with stress. The maturation of right brain regulatory capacities is experience dependent, and "is embedded in the attachment relationship between an infant and their primary caregiver" (Schore, 2001, p. 11). Infants are born immature in both brain structure and function, and it is through interaction with their caregiver that they are able to regulate emotions and other capacities.

Schore (2001) describes the interaction between the physical and psychological aspects of child development in the "Transactional Model". In this model, development and brain organization are a transaction between genetic potential and environmental influence. As Stoff and Cairns (1996) stated, it is necessary to go beyond the accepted notion that biological variables influence behavior and the environment, to recognize that behavioral and environmental variables impact on biology. Emotion depends on the communication between the autonomic nervous system and the brain, as well as the central nervous system limbic circuits. The limbic system is involved in stress functions, and components of this system are responsible for appraising the salience of a stressor and then initiating and organizing a psycho-biological response (Schore, 1996; Schore, 2001).

Individual differences in peripheral and central nervous system (CNS) balance emerge early in development, and are reflected in affective and cognitive domains. The lower subcortical sympathetic and parasympathetic components of the autonomic nervous system (ANS) as well as the higher cortical-limbic components of the CNS are organizing in the pre and post natal period, and their maturation is experience dependent (Schore, 1996). The early post-natal period is a critical period of limbic-autonomic circuit development, during which time experience or environmental events shape ongoing synapse formation. This organization is seen particularly in the early forming right brain which forms deep connections between the limbic system (hypothalamus, amygdale, cingulated cortex, and the orbitofrontal cortex) and the ANS. Cortical paralimbic networks are formed through ontogenic plasticity; that is through a natural selection of those connections that match data in the environment. Adverse experiences with caregivers very early in life have longstanding and complex effects on a range of neurochemicals relevant to emotional regulation. Overall, severely compromised attachment histories are associated with brain organization that is inefficient in regulating affective states and stress. This results in changes to the brain structure, such as the neural synaptic connections in the limbic system, and brain function, such as the over or under production of some chemicals.

Different areas of the brain mature at different rates, and rapid growth and differentiation in neural connections occur during critical periods. During a critical period, a certain part of the brain is particularly sensitive to stimulation. Steinhauer (1998) states that the critical period for attachment stretches from birth to age 18 months, and the critical period for self-regulation of emotions ends at the age of 24 months. This means that patterns of attachment and self-regulation are largely determined during the first two years. Secure attachment develops when the primary caregiver consistently meets the infant's emotional needs through touch, eye contact, and smiles, and also meets the infant's physical needs for food and safety. According to Hanson and Spratt (2000), at age three a child who has developed secure attachment to their caregiver will have the ability to use their knowledge of that caregiver to plan and direct their own behavior. For example, the child is able to engage in planning to maintain proximity to the caregiver, and manage separation. Mary Salter Ainsworth's (1978, 1979) seminal studies of attachment in children found that two thirds of children from middle class homes display secure patterns of attachment.

Exposure to negative care giving during the period for attachment can disrupt the attachment process and impair emotional and psychological development. Severe cognitive, emotional, and interpersonal deficits can become evident in children who are born healthy but experience neglect or other disruption in early infancy (Ainsworth, 1978; Ainsworth, 1989; Bowlby, 1979; Delaney, 1998; Wilson, 2001). Factors which impair the attachment process may include the following (ATTACH, 2000; Steinhauer, 1998):

Sudden or traumatic separation from the primary caretaker, frequent moves and/or placements in foster care, physical, emotional, or sexual abuse of the child, neglect of physical or emotional needs, inconsistent or inadequate care, a neurological problem in the child which interferes with perception or ability to receive nurturing (e.g. babies exposed to crack cocaine in-utero), and chronic depression or mental illness in the caretaker which renders them unable to consistently care for their child.

Hanson and Spratt (2000) suggest that traumatic responses and disruption in attachment influence the pruning of specific neurological pathways, particularly those that regulate affect and emotion. Schore's (2001) examination of the role of brain structures in attachment supports the link between emotional regulation and early caregiver-child relationships. He states that "severely compromised attachment histories are associated with brain organizations that are inefficient in regulating affective states and coping with stress" (p. 16). Early relational trauma is described as affecting the developing attachment system, which in turn inhibits cortical development in the right brain which is largely responsible for the experience and processing of emotions. In particular, the development of the limbic system and associated pathways, along with the production of certain neurochemicals involved with affective states, are inhibited. This then impairs the ability to regulate emotion, and respond in a flexible and adaptive way to change and stress (Schore, 2001). Such putative changes to the structure of the brain are confirmed in studies of children with a history of abuse and neglect. Dozier, Albus, Fisher, & Sepulveda (2002) reported that foster children show "atypical" levels of cortisol across the day, as compared to an average child who displays a consistent pattern of cortisol production. Abnormalities in the brain structure and function of such children have also been found in studies using functional magnetic resonance imaging, ECG, and autopsy (Teicher, Anderson, Polcari, Anderson, and Navalta, 2002).

Biological factors may also increase the likelihood that a child will react in a pathological manner to maltreatment. Genetic predisposition, temperament, and prenatal exposure to toxins or trauma, may mediate a child's vulnerability to early deprivation (Berger, 2003). The presence of Fetal Alcohol Spectrum Disorder, a genetic syndrome, or maternal malnutrition may exacerbate the effects of neglect or abuse on a child.

The duration of deprivation has also been linked to the severity of later attachment disorder behaviors (O'Connor & Rutter, 2000). Studies of orphans in Romania have found that children adopted before they are six months of age are less likely to demonstrate behavior and social patterns associated with attachment disorders. Those children adopted at older ages show significantly more behavioral problems and delays in social, emotional, and cognitive functioning (O'Connor & Rutter, 2000; Smyke, Dumitrescu, & Zeanah, 2002). The quality of care received by a child living in an institution is also related to subsequent development of attachment problems (Smyke, Dumitrescu, & Zeanah, 2002). Smyke et al. (2002) found that children assigned to an institutional unit with a consistent and limited number of caregivers, showed less behavioral disturbance and more selective bonding with a particular caregiver. This supports the assertion that it is the quality of the caregiver relationship available to a child and not just institutionalization or neglect that contributes to a child's later behavior.

The development of attachment can be influenced by many factors, but reaction to disruption in the attachment process usually follows a predictable course. Delaney (1998) calls this the "Protest-Despair-Detachment Cycle". In the first stage, the child protests the disruption by crying, showing distress, searching for, and pursuing the caregiver. The second stage, despair, is when the child becomes depressed, withdraws, and shows disinterest in play or exploration. The final stage of detachment is characterized by lack of interaction with or avoidance of the primary caretaker. This process is central to the development of the long-term problems associated with Reactive Attachment Disorder because after the critical period for attachment is over, patterns of relating to caregivers can be difficult to change.

Change Factors for Children with RAD

Given that attachment difficulties tend to be enduring, it is not surprising that treatment appears to be most successful when it is intensive and long term. There is no "quick-fix" for children diagnosed with RAD, so what can caregivers and therapists expect for a child presenting with symptoms of RAD?

The long term picture for children diagnosed with RAD appears to be largely dependent on the supports and interventions provided for them in childhood. Ocasio and Knight (2003) stated that "children lacking secure attachments with caregivers commonly grow up to be parents who are incapable of establishing this crucial foundation [trust] with their own children" (p. 6). However, the authors suggest that if a child is exposed to an environment where there is a consistent response to their needs, the child can be "conditioned to use human relationships for security and comfort" (Ocasio & Knight, 2003, p. 6). Further to this, Earnest (2002) suggested that there is a link between mental health treatment completed in early childhood and long-term improvements in functioning for children with mental health disorders.

There is a great deal of literature on developmental outcomes for abused children, and given that children diagnosed with RAD form a subset of the larger population of abused children, that research may also shed light on the prognosis for children with RAD. The relationship between childhood experience of abuse and neglect and the development of antisocial behavior appears to be mediated by support in childhood. A review of the factors related to childhood experience of abuse and neglect and subsequent development of criminal behavior in adulthood found that a minority of abused children grow up to commit criminal acts resulting in incarceration (Palermo, 2004). Palermo (2004) presents several possible explanations for the differences in outcome for children who have experienced similar levels of childhood trauma. Length and duration of maltreatment has been related to outcome, with chronic maltreatment over a long period of time predicting poorer development. The presence of positive role models in the home, school and community was identified as contributing to the resiliency of those adults not involved with the justice system.

Findings in the research on RAD differ in terms of the treatment models presented and the therapeutic approaches used, but a common theme in research on RAD and the resiliency of maltreated children in general, is the emphasis placed on the child developing positive secondary relationships. The presence of a steady, positive relationship with an adult appears to create a "window of opportunity" for the child and may be the key component of a successful intervention.

The Role of the Caregiver in the Treatment of RAD

The literature on attachment disorder suggests that therapy can only be attempted after the child's environment has been stabilized (Hanson & Spratt, 2000; O'Connor & Rutter, 2000; Steinhauer, 1998; Zeanah et al. 1993; Zeanah & Boris, 2000). Research has demonstrated that insecure attachment can be positively influenced by the presence of a reliable, stable, secondary caregiver (Zeanah & Boris, 2000). Caregiver involvement in treatment has been reliably shown to be related to treatment outcome (Hanson & Spratt, 2000). Reich, Bickman, and Heflinger (2004) also highlight the importance of caregiver involvement in children's mental health treatment. Caregiver participation in all stages of the treatment process has been recognized by many researchers as contributing to the success of mental health intervention with children (Heflinger & Bickman, 1996). For children in foster or adoptive families, caregiver support and active involvement in treatment appears to be even more critical in stabilizing the child and creating opportunities for positive development (Wilson, 2001; Zeanah, Mammen, &Lieberman, 1993). Given this, it is important to understand some of the issues that affect caregivers' participation in treatment programs for their children.

A variety of characteristics have been related to the effective participation of caregivers in mental health treatment. Reich et al. (2004) described the concept of self-efficacy, or "one's belief in his or her ability to produce desired results" as a key influence on caregivers' successful participation in treatment programs (p. 99). Attitudes toward parenting and personal ability, knowledge and skills in parenting, and financial and emotional resources have all been related to parenting self-efficacy (Bandura, 1997; Reich et al., 2004; Swick & Broadway, 1997). Another important variable identified as contributing to caregivers' feelings of self-efficacy is the nature of their relationship with the mental health professional treating their child. Reich et al. (2004) stated that "the more caregivers perceive their relationship with their child's provider to be collaborative, the more efficacious they feel in that treatment" (p. 105). In other words, when caregivers feel that they have a collaborative relationship with their child's therapist, they are likely to be more positively inclined toward participating in the treatment.

The issue of creating a collaborative and inclusive relationship between caregivers and mental health professionals has been identified as important in other research. Fine and Gardner (1994) discussed caregivers' perceptions that mental health professionals hold them responsible for their children's behavior problems, and do not provide adequate understanding or support for caregivers parenting challenging children. Reich et al. (2004) stated that this may decrease caregivers' confidence and willingness to participate in their child's treatment.

In addition to caregivers' perceived lack of support from mental health professionals, research has been identified that lack of understanding and support in the workplace and from schools affects the ability of caregivers to parent children with behavioral and emotional disorders. To combat this problem, Rosenzweig, Brennan, and Ogilvie (2002) found that caregivers of children with emotional or behavioral disorders often made changes in their employment and childcare arrangements to accommodate the needs of their child. For example, the caregivers who participated in Rosenweig et al's (2002) study chose to take less demanding jobs with fewer hours, and they avoided daycare or after school child care arrangements, opting to have their children cared for by relatives or an in-home babysitter or nanny.

Other factors that may impact a foster parent's ability to provide quality care for a displaced child include foster parent level of education, financial resources, level of stress, social support and specific training (US Department of Health and Human Services, 2001). Full-disclosure by Children's Services staff regarding a child's history and current behavioral and emotional needs before placement occurs was also emphasized as critical to the creation of a positive caregiver-child relationship (Ocasio & Knight, 2003). Open communication and a coordinated and collaborative approach between Children's Services, medical professionals, foster parents, and where appropriate, biological parents, has been suggested as the way to best support a child in care. Norman (1985) stated that it is "the job of the foster-care agencies to help build and support strong relationships among the foster parents, the natural parents, and the children" (p. 11). This is particularly important when a child has been diagnosed with RAD, as forming positive, new relationships and developing trust is the cornerstone of most interventions for this disorder.

Given that many children with attachment problems have been placed in foster care, attention needs to be directed to the experience of children in the foster care system (Wilson, 2001). Due to the often extreme nature of their conduct problems, these children are prone to experience “foster care drift” (Steinhauer, 1983). Berger (2003) stated that a child’s behavior will deteriorate with each change in family placement. This deterioration in behavior is a reaction to the detachment of relationships from the previous foster family. Each detachment is experienced as a trauma, and each trauma is expressed behaviorally in the next relationship (Berger, 2003). This of course, will increase the likelihood of failure of a new placement, and a negative cycle results. Multiple placements, often in short spans of time, worsen the child’s attachment problems.

In order to maintain a foster placement long enough to begin to address the child’s attachment disorder, the foster parent must be informed about the phases they will experience with their attachment disordered foster child (Delaney, 1998). The initial “honeymoon” phase usually surprises foster parents as the child appears to magically fit into the foster family. The normal period of adjustment seen in children without attachment problems when they enter a new home is absent. As the child becomes comfortable in the new foster family, they begin to re-enact past experiences with caregivers. The child seems to be able to identify precisely what they need to do to elicit mistreatment, abusive feelings and rejection from others. Delaney (1998) suggests that the negative working model held by children with attachment problems leads them to expect mistreatment, and then to create that mistreatment in a safe environment in an effort to take control of what happens to them.

This period has also been called the "unfreezing" phase as the child is wary of revealing too much of their inner experiences until their defenses have begun to "melt". This stage signals the beginning of fledgling attachment to the new foster parents. Unfortunately, this is also the stage at which the foster parents are most likely to decide that they cannot handle the behaviors displayed by the child, and return the child to the system for a different placement. Ideally, a therapeutic foster or group home with the potential for long term involvement with the child is the best placement option (Steinhauer, 1983, 1998).

Treatment of RAD

Although there has been a great deal of research on attachment processes and the identification of attachment problems, few empirical studies have been conducted on approaches to treating attachment disorder (Hanson & Spratt, 2000; Sheperis et al., 2003; Zeanah & Boris, 2000). Traditional psychosocial treatment for behavioral symptoms may be effective; however, development of selective attachment does not necessarily follow.

Attachment Based-Therapies

According to the Association for Treatment and Training in the Attachment of Children (2000), traditional parenting and therapy is often ineffective "since both rely on the child's ability to form relationships". Therapy and parenting that involve the elements of basic attachment have been found to be most helpful in treating Reactive Attachment

Disorder. For example, therapy that encourages the development of eye contact, touch, and safety with the primary caregiver has had beneficial effects on children's behavior and social interactions (ATTACH, 2000). Randolph and Myeroff (1999) state that therapy that involves the following components has shown increased parental satisfaction, a decrease in anxiety, and a decrease in aggression and delinquent behaviors: (1) caregiver training and support, (2) cognitive restructuring of the child, (3) psychodrama with the child, (4) helping the child find ways to give voice and support to the severely wounded "inner child", and (5) nurturing and re-parenting activities involving the child-care giver dyad.

Dozier (2003) supports a nurturing foster placement coupled with therapy that presents a "gentle challenge" to the child's resistance to forming a close bond. She states that attachment disordered children who enter foster care typically push their new foster parents away, and the foster parent usually responds in a complementary fashion, allowing themselves to be pushed away. The first step to changing this pattern is to assist caregivers to provide nurturing care even when it appears that it is not wanted by the child. In this way, foster parents are encouraged to continue to make nurturing and caring overtures to the child and gently challenge the child's behavioral signals.

Similarly, Hanson and Spratt (2000) described five key components for a treatment program for RAD: (1) identify attachment disordered children at an early age (2) provide a nurturing and secure environment, (3) improve the caregiver's parenting skills, (4) promote the child's interaction with their family, (5) maintain the child in the least restrictive level of care. This research supported Dozier's view that therapy should be undertaken in a natural setting rather than outside the child's normal life.

Support for the application of attachment based therapies has also come from the treatment of other psychiatric disorders. For example, Moretti, Holland, and Peterson (1994) described a residential treatment program based on elements of attachment for adolescents with Conduct Disorder. Conduct Disorder symptoms were significantly reduced at a six-month follow-up to treatment. To be effective in addressing behavior problems, Moretti et al. (1994) emphasize the importance of conducting attachment based therapy in an environment that allows for adequate intensity and length of treatment. Although their study focussed on Conduct Disorder, similar conditions for success in treating RAD with attachment based therapy would likely apply.

Multi-modal Treatments

Given the wide-range of behavioral and emotional issues that children with RAD typically present, treatment approaches that have a broad focus or incorporate several different therapeutic techniques may be expected to have greater success. In support of this idea, Howe and Fearnley (2003) suggested that children diagnosed with RAD do not respond well to brief, cognitive-behavioral methods. These authors are the founders of an attachment treatment center which offers day treatment and residential programs to address the issues associated with RAD. Children attending their program have extreme behavioral difficulties and receive an average of 18 to 24 months of a multi-modal treatment that includes individual play therapy, Eye Movement Desensitization and

Reprogramming therapy (EMDR), cognitive-behavior therapy, and relaxation techniques. Cognitive restructuring and the development of a close therapeutic relationship are also important aspects of the program. The authors state that therapy must be close, nurturing and intrusive to overcome the child's resistance to intimate relationships. All the children in this program were in foster care, and therapy is aimed at creating a strong bond between the child and their surrogate caregiver.

Zeanah (2000) also identified the stabilization of the child-caregiver relationship as a vital component of any intervention for RAD. Zeanah reported on a lengthy, multimodal, individualized intervention program for children with RAD. The program included foster-parent counselling, parent-child psychotherapy, and other interventions to promote permanency and a secure base for the children. The overall risk reduction for the children was reported to be between 55 and 73 percent. A variety of therapeutic techniques were used and drew from different theoretical orientations (e.g. psychotherapeutic techniques, behavioral cognitive approaches, relationship-based interventions etc.).

The need for individualized treatment that utilizes multiple therapies was highlighted by Sheperis, Renfro-Michel, and Doggett (2003) in their case study of a child's placement in therapeutic foster care. Sheperis et al. (2003) suggested that the child's own abilities should determine the approach taken in therapy. For example, with a highly verbal child, cognitive re-structuring may be appropriate. The authors stated that the clear development of a treatment plan, measurable goals, support and training for the foster parents, multi-disciplinary treatment and consistent therapeutic relationships are essential to success (Sheperis et al., 2003). In their view, the overall goal in treating a child with RAD is not to "cure" them, but to stabilize their behavior and primary relationships.

Caregiver Psycho-education

The inclusion of caregiver education and support is also an important part of nearly all the interventions discussed above, recognizing the key role that caregivers play in treatment of RAD. Mukaddes, Kaynak, Kinali, Besicki, and Issever (2004) studied the effectiveness of a standardized psycho-educational treatment program for parents of children with RAD. Their progress was compared to children diagnosed with Autism who participated in the same intervention. The treatment focussed on parent education, teaching parents dyadic play activities to do in the home, as well as allowing for parent support and individual sessions with the child. Social and language training was provided for the children, and parents were taught skills to deal with behavior problems and increase their child's self-care skills. Children with RAD and those with Autism all showed significant improvement as measured by the Ankara Developmental Screening Scale (ADSI). However, the children diagnosed with RAD demonstrated significantly greater improvement in language development skills, social development, and self-care skills.

Non-traditional Therapies

Non-traditional therapeutic methods have also been used to treat RAD (James, 1994; O'Connor & Zeanah, 2003; Taylor, 2002). Taylor (2002) suggested that traditional psychotherapies are ineffective in treating RAD as they presume individual characteristics that RAD children do not have. This author described a case study of the use of a non-traditional therapy, Eye-movement Desensitization and Re-programming (EMDR), to treat an eight year old child with RAD. Qualitative reports of the child's progress indicated that her attitude and behavior steadily improved in the year following the EMDR treatment. EMDR has been used to treat other conditions, most commonly symptoms of Post-traumatic stress disorder, and other programs have incorporated this approach as part of a larger intervention for RAD (Howe & Fearnley, 2003).

However, not all non-traditional treatment approaches have been accepted by the academic community. One method that has caused considerable debate and controversy among clinicians and researchers is holding therapy. This restraint-based approach has made news headlines in recent years and the use of this technique resulted in the deaths of several children in North America (Boris, 2003). James (1994) stated that there is no empirical support for this controversial technique, and the use of this method can in itself be "traumatizing and damaging to an already vulnerable child" (p. 94). The majority of researchers appear to share this view of holding therapy, and a recent special issue of the journal 'Attachment and Human Development' included several articles discussing the questionable merit and potential harmful effects of this therapy. Even though there is little support for this method, and many researchers have taken strong stands against its use, this approach is still in demand by caregivers (Boris, 2003). O'Connor and Zeanah (2003) stated that caregivers appear to be attracted to such extreme interventions because they are not well served by the “mainstream” mental health system. For caregivers who have been struggling with their children’s severe, multiple issues, an intervention that promises dramatic results is difficult to pass over, even if it has potentially damaging consequences (O’Connor & Zeanah, 2003). The systematic investigation and promotion of treatment approaches for RAD that are grounded in theory and best practice is the best way to ensure that caregivers have safe and effective treatment options for their children.

Play Therapy

A common treatment approach employed with children diagnosed with a psychiatric disorder is Play Therapy. As children of this age group have language skills that are still developing, play is the preferred medium for expression (Landreth, 1993). Research supports the idea that play behavior is a child’s way of communicating thoughts and feelings in a concrete manner (Kot, Landreth, & Giordano, 1998). The information communicated through a child’s play can provide valuable information to clinicians about the child’s experiences. For example, the play of maladjusted children has been shown to be different from same-age peers with no history of disturbance. Lous, de Wit, de Bruyn, Rikson-Walraven, and Rost (2000) found that sadness and anxiety hindered the capacity for complex play in children. Further, the play behavior of depressed children has been found to be qualitatively different from that of non-depressed children (Lous et al., 2000).

Most important for the present study, is the distinct play patterns of children who have experienced trauma and disrupted attachment. Gil (1991) suggests that children reenact traumatic events through play. Traumatized children may show patterns of aggression and hyper-vigilance in play themes, and their play may become repetitive (Frick-Helms, 1997). Children who have experienced trauma may also appear "stuck" in an earlier developmental stage of play. For example, a school age child may be drawn to play activities usually enjoyed by younger children.

The literature on play therapy has provided evidence for the use of this form of treatment for various childhood psychiatric disorders (Phillips & Landreth, 1998). Nondirective play therapy has been shown to be effective in increasing self-efficacy, self-control, and social skills (Fall, Balvanz, Johnson, & Nelson, 1999; Johnson, McLeod, & Fall, 1997; Landreth, Homeyer, Glover, & Sweeney, 1996). In addition, play therapy has been found to decrease autistic features, aggressive behaviors, and the effects of trauma (Gil, 1991; Kot, Landreth, Giordano, 1998; Mittledorf, Hendricks, & Landreth, 2001).

Summary of Treatment Literature

With respect to treatment of RAD, the literature supports an individualized approach to treatment of children diagnosed with RAD. The diverse needs of children and families presenting with RAD require multi-modal, multi-disciplinary interventions that provide a holistic approach to the child (Zeanah & Boris, 2000). While Earnest (2003) calls for client driven approaches to treatment, Southam-Gerow (2004) points out the limitations of treatments that are developed based solely on client "symptom patterns" (p. 186). He calls for the consideration of many variables when constructing a treatment program, including "nonsymptom" client variables, and clinician and agency variables. According to Southam-Gerow, the development of mental health treatment has "tended to emphasize techniques and outcome rather than relationships and process" (p. 188). This distinction is particularly important when designing a program for children with RAD. Children with RAD tend to present with multiple medical and mental health problems, and treatment may take place in a mental health agency, a hospital, or a school environment. In addition, characteristics of the child's home life and the financial resources of the family may vary greatly. Given these factors, it is important to consider the specific needs of the children who will be participating in a program, in conjunction with the agency's resources and expertise to provide treatment.

Overall, to treat children with RAD, researchers have suggested that it is necessary to work from a strength-based approach rooted firmly in the belief that children can achieve a level of positive functioning in spite of severe maltreatment (Masten & Powell, 2003). An essential step in treating children with RAD is comprehensive assessment. An assessment should use multiple sources of information and a detailed history in order to document children's level of functioning and provide a context for their treatment. Following thorough assessment and an accurate diagnosis, the research on treatment reviewed above revealed four features identified as critical for effective treatment for RAD. First, the importance of creating and maintaining a long-term, stable foster home placement appears to be of greatest importance when attempting treatment with children with RAD. Next, a comprehensive multi-modal treatment approach including features of relationship, attachment, and other therapies appears to be best suited to treating the complex presentations seen in RAD. Third, the education and support of the foster caregiver appears to play a key part in the success of an intervention for RAD. Last, treatment that is long-term and intense has been described as most effective in the literature.

These key features were given primary consideration when creating the treatment approach used in the present study. Only children in a long-term foster placement were accepted into the treatment. Multi-modal techniques were used throughout the treatment. For example, the children were involved in a play therapy group which included psychodynamic components and directed activities. Each child had behavioral goals identified by the caregiver, and cognitive-behavioral methods were taught to the caregivers to help the children achieve their goals. Caregiver education and support also played an important role in the current study, and foster parents were asked to participate in a parent-group and carry out attachment-based activities each day in their own home. Finally, recognizing the importance of long-term treatment and follow-up for children with RAD and their caregivers, the group in the present study was originally planned to include a five month intensive treatment phase with follow-up at six, nine, and twelve month intervals. Unfortunately, due to resource limitations, the group was not carried out this way, and was reduced to a more short-term intervention of 12 weeks. It was hoped that the promotion of the caregivers' work with the child in their home environment would increase the carry-over of skills learned in the group, and off-set the shorter duration of the group. A more detailed description of the treatment protocol appears in the Methods chapter.

Research Questions

Based on the review of the literature as presented above, research questions were generated to form the framework for an Evaluative Case Study of the RAD treatment group. The case study consists of two parts; the first section is concerned with the issues related to the child in treatment, and the second part examines issues of relevance to the caregiver. Questions related to the child participating in the RAD treatment focused on the challenges that exist in treating children with this diagnosis. As discussed in the literature, the severity of the child's disorder and their level of functioning when entering treatment may influence their response to the treatment. Therefore information describing the children's co-morbid psychological and medical conditions, history of trauma, and current ability to relate to other people is included to provide a context for the children's therapeutic journey and response to treatment. The second part of the Evaluative Case Study will be concerned with the caregiver's role in treatment and their issues with parenting children with RAD. The following questions guided this research:

Issues Related to the Child in RAD Treatment

1. What was the child's context for treatment?
    a. What was the child's relationship history?
    b. What were the main presenting problems for each child?
    c. What underlying medical concerns and co-morbid psychological conditions contributed to the child's presenting problems?
2. What were the primary issues identified for the child with social interaction at:
    a. Home?

    b. School?

3. What was the child's response to the treatment intervention?
    a. What type of play behavior did the child demonstrate in the group and in the individual play sessions?
    b. What was the child's response to participation in the group?

The Caregiver's Role in Treatment

1. What were the caregiver's expectations of the treatment? Were those expectations fulfilled?
2. What did the caregivers like about the treatment and what things would they change about the program?
3. What did the caregiver identify as their greatest challenges in parenting a child diagnosed with RAD? How did the group allow the caregiver to address those challenges?

Chapter Summary

The recognition and acceptance of the importance of attachment in child development is an essential step to providing adequate and focussed treatment for children with attachment disorders. Often in the past, clinicians have attempted to treat the behavioral symptoms of attachment disorder, neglecting the attachment problem itself (Moretti, Holland, & Peterson, 1994). With increased awareness of the symptoms and behavior associated with attachment problems, earlier and more accurate assessment and diagnosis may be possible. In turn, treatment can be offered to children with RAD at an earlier stage before conduct problems become the focus of treatment.

As part of a multi-modal treatment program for RAD, play therapy could be valuable as a means of expression for children who have experienced trauma, and as a therapeutic tool for decreasing problem behaviors. In addition, cognitive behavioral interventions that target symptoms stemming from the experiences of abuse (e.g. fear and anxiety) may also be effective in treating children with attachment disorder. Treatment is generally more effective in developing attachment behaviors in younger children. Of greatest importance, the inclusion of a supportive caregiver and a stable home environment is instrumental to the success of a treatment program aimed at developing attachment (Hanson & Spratt, 2000). Given the review of the literature in this area, the research questions for this study were developed to investigate the challenges identified in treating children with RAD, and the role of their caregivers in the treatment process.

Chapter 3

METHODS

Overview

This study examines a treatment group for children diagnosed with RAD, and support for their caregivers. The children's responses to treatment and the parenting concerns of the caregivers and their role in treatment are investigated using an Evaluative Case Study approach.

Evaluative Case Study Approach

An Evaluative Case Study approach was chosen as the method for this study. The treatment group is a discrete entity that forms the bounds of the case study. The overall objective is to develop a better understanding of the dynamics of the treatment program. This approach is appropriate when an examination of a program is conducted but there are no "reasonable indicators of programmatic success which can be formulated in terms of behavioral objectives or individual differences" (Kenny & Grotleueschen, 1980). An Evaluative Case Study derives data from verbal responses to questions, observations of the phenomena under study, and extant documents. The qualitative design of the evaluative case study allows for the inclusion and examination of data without concern for the limitations of statistical relevance (Merriam, 2001).

The method used in this study was chosen in recognition that the nature of the disorder to be investigated, RAD, is such that children usually present with multiple psychiatric, behavioral, and family concerns. Therefore, the children's response to treatment will be strongly influenced by their developmental histories and the severity of their current difficulties. Yin (1994) stated that the case study approach is particularly suited to situations where the variables of a phenomenon are impossible to separate from the context. The case study as an "interpretation in context" provides a holistic explanation and description of a "real-life" phenomenon (Cronbach, 1975). The wide range of symptoms associated with RAD are inherently tied to the context and larger life experiences of the child. Given this, in order to document the affect of the RAD treatment on children and caregivers with diverse experience and backgrounds, the most appropriate methodology is the case study. Only an evaluative case study will allow for the inclusion of specific data unique to each child and caregiver, and provide sufficient information to describe the contextual factors that influenced each family's experience in the treatment group.

Data Extraction and Presentation

The research questions outlined in chapter two form the framework for this Case Study. Information gathered was reviewed and sorted based on its relevance to answering each question. Overall themes including the child's starting point for treatment or context for treatment, child's response to treatment, and caregiver concerns emerged, and more detailed information was mined from these larger categories to answer specific research questions.

Aspects of Rigor

Aspects of rigor for Evaluative Case Study research concern trustworthiness. Guba and Lincoln (1981) identified four aspects of trustworthiness; credibility, transferability, dependability, and confirmability. The researcher addressed each of these aspects as outlined below.

Credibility

Credibility is also described as the internal validity of a case study and deals with how well the study's findings match reality. In this study, the researcher had the sole responsibility for collecting and analyzing the data. Triangulation was used to ensure credibility, that is multiple sources of data from interviews, observations, and documents were cross-checked and compared to verify the credibility of findings. Member checks were also conducted at various points, with information from caregiver interviews confirmed or re-addressed in later meetings, and information from therapists and other informants checked on an on-going basis. In addition, the researcher shared aspects of the inquiry with her supervisor and other colleagues in order to clarify and justify findings.

The researcher in this study identified a bias toward wanting the treatment intervention to make a difference for participant families, and a worldview based on the belief in the ability of families and children to change and overcome difficult life circumstances. The researcher recognized this bias toward positive interpretation of results, and took particular care to present as detailed and comprehensive a picture as possible of each participating family in order to address this bias.

Transferability

Guba and Lincoln (1981) suggested that the idea of generalizability should be replaced by the idea of transferability. Generalizability implies that the data are context free, whereas transferability is meant to imply context (p. 118-119). This study has limited generalizability. It is limited to a particular context, which will be described in terms of a particular subject matter in a particular treatment environment. However, the researcher has endeavored to provide sufficient descriptive data so that readers can compare or relate this study to similar subject matter and environments. This aspect was checked by seeking the opinions of a research colleague unfamiliar with the topic. Both the topic and its description were reported to be readable, its content understood, and the findings consistent with other areas of human endeavor.

Dependability

Guba and Lincoln (1985) suggested that instead of consistency or reliability, the concept of dependability should be used for Case Study methods. Dey (1993) stated that "if we cannot expect others to replicate our account, we must be able to explain the way we arrived at our results" (p. 95). This is done by creating an audit trail such that independent judges are able to follow the trail of the researcher and determine whether the findings make sense and are consistent with the data collected. The dependability of the researcher's interpretation involved the verification of collected information by one or more of the key participants.

Confirmability

The burden of proof in a case study is shifted from the investigator to the information itself. This requires that the researcher "reports his data in such a way that it can be confirmed from other sources if necessary" (Guba & Lincoln, 1981, p. 126). The descriptions in this research are based on the direct quotations or paraphrasing of respondents' comments, and supported by documentation and observation where possible. The report of the data may be confirmed by reviewing audiotapes, videotapes, and other documents used in record information.

Participants in the Treatment Group

The participants were caregivers and children with the primary diagnosis of Reactive Attachment Disorder (RAD) who were between 5 and 10 years of age, and were patients at Child and Adolescent Services Association (CASA) at the time the group took place. Children were referred to CASA for treatment by a mental health professional, teacher, physician, or family member. All the children described in this study had been assessed by a psychiatrist and mental health therapist and received a diagnosis of RAD. Secondary diagnoses included Post-traumatic Stress Disorder, ADHD, ODD, Anxiety Disorder, Conduct Disorder, Specific Language Disability, and Speech and Language Disorder.

The children were living in a stable, safe, foster care placement, with a committed foster parent who was willing to attend the concurrent caregiver's group. Children were accepted into the group on the condition that a therapist or psychiatrist at CASA or in the community had agreed to assume responsibility for the child's treatment following their involvement with the group. Due to the intensity of this group treatment, while in this program children were not involved in concurrent treatment, other than psychiatric consultation and medication reviews, where necessary. Therapists referring a child to the group were aware of this requirement.

Seven children were accepted into the group, and four children and their caregivers agreed to participate in this study. The children's length of time in foster care varied, as did their number of placements since entering care. Please see Table One below for a description of the children who participated in the treatment study.

Table 1. Descriptive Information

	Jane	Charlie	Rachel	Jason
Age (years)	5	6	6	8
Gender	Female	Male	Female	Male
Ancestry	Native	Caucasian	Metis	Native
Grade	Kindergarten	Kindergarten	Grade One	Grade Three
Guardian(s)	Foster Parents	Foster Parents	Adoptive Parents	Paternal Grandmother
Children's Services Status	Permanent Guardianship Order	Permanent Guardianship Order	Adopted	Private Guardianship
Time in Placement	2 years	9 months	4 years	3.5 years
Placements	1	7	3	1
DSM-IV Axis I Diagnoses	RAD* PTSD** ADHD*** ARSD *****	RAD PTSD ADHD Dysthymia	RAD PTSD ADHD ARSD*****	RAD PTSD ADHD Dysthymia ODD****

* Reactive Attachment Disorder
** Post-traumatic Stress Disorder
*** Attention-Deficit Hyperactivity Disorder
**** Oppositional Defiant Disorder
***** Alcohol Related Spectrum Disorder

Treatment Intervention

The treatment consisted of three components.

1. <u>Caregivers group:</u> The objective of the caregivers' group was to educate the caregivers regarding attachment disturbances, help them process the emotions and experiences associated with parenting their children, help them learn how to connect with their child, and to help caregivers identify and set appropriate limits for their child's behavior.
2. <u>Children's Group:</u> The second component of the treatment was a group play therapy experience for the children to work through their past experiences in a nurturing, safe environment. The children had opportunities for interaction with peers through group activities in addition to addressing individual past experiences. This component included both non-directive and directive play activities. The children's play therapy room was set up in centers to help the children work through their specific concerns. The centers included: an art center, a domestic nurturing center, communication and language center, water and sand center, building center, gross motor center, comfort center, and dress-up center. Each session included time for the child to have individual non-directed play, a group activity led by the therapist (e.g. drama exercise or craft), and a closure exercise (e.g. circle-time song or rhyme).

3. Caregiver-Child Interaction: The third component was guided care giver-child interaction in which play activities were focused on fostering nurturing touch, eye contact, smiles and positive affect, and need fulfillment within the relationship between each child and his/her caregiver (Levy and Orlano, 1998). Activities utilized a "play kit" which included items of the child's choosing in addition to items recommended by the therapists. For example, the child could choose a favorite storybook or CD of songs to include in the kit. Therapist recommended items included face paints, hand lotion, drawing materials, and a family of dolls. The caregiver-child dyad was expected to engage in at least one 15 minute play session once per day during the course of the group. Other homework was assigned to address the specific needs of the child as the group progressed.

The treatment program ran once a week for 12 consecutive weeks. The children's play therapy group and the parent group ran concurrently and both were one hour in duration. Following the separate groups, the children and parents came together for the caregiver-child interaction segment, for a half hour. Caregivers and children were required to commit to attend all twelve sessions to get maximum benefit from the program. Of the four families who completed the research study, three families attended all twelve sessions, and one family completed nine of twelve sessions.

Two therapists guided the care givers group and one therapist observed the caregiver-child interaction segment behind a one-way mirror. The group leaders were experienced mental health therapists trained as psychologists, social workers, or psychiatric nurses.

Each parent-child dyad attended a one and one half hour orientation session prior to the first group session. During the orientation, the group procedures, philosophy, and expectations for participation were discussed with the parents. The children received an orientation to the play room, and had the opportunity to meet the therapists involved with the children's group.

Sources of Information for the Case Study

Data for the case study were collected from three sources – interviews, observations, and documents. For each caregiver-child dyad participating in the group, information was gathered regarding the child's general background, biological family history, school history, and major behavioral concerns. The therapists involved with the group and the child's social worker (where appropriate), in addition to the child and their caregiver were surveyed, interviewed, and/or observed. The following methods were used to gather information (See Table 2 for summary).

1. Caregiver Interviews. The child's caregiver was interviewed prior to beginning the group, and again at the completion of the group. The questions in the interview were open-ended and designed to stimulate free discussion with the caregiver. The interview was loosely divided into two parts. The first part consisted of questions about the child. The caregiver was asked to outline the main difficulties the child was experiencing in the home, at school, and in the community. The caregiver was also asked more specific questions about the child's ability to control their own behavior and express their needs in a developmentally, and socially appropriate manner. For example, the caregiver was

asked how the child expresses their anger/frustration. Questions were also asked about the child's interaction with the caregiver. For example, caregivers were asked if their child seeks comfort from them when upset.

The second part of the interview included questions about the caregiver's own thoughts and feelings toward their child and the treatment group. The caregiver was asked what their expectations of the group were, and what they hoped would happen with their child as a result of attending the group. The caregivers were asked about the kinds of support they had to help them parent their child, and how they felt about their child. Most importantly, the caregiver was asked about the place of the child in the caregiver's family, relationships with other family members, whether the child would be able to remain with the family and the caregiver's hopes for the child's future. A complete outline of the interview format appears in Appendix B.

All interviews were audio taped and transcripts were made of each session. The participants were asked to verify the information provided in the interview sessions following the completion of the study.

2. Focus Groups. At the completion of the group, a focus group with the parents and the child's case worker/social worker was held. The purpose of this group discussion was to gather information relative to the social workers' perception of the child's progress over the course of the group, and to receive feedback on the group process from the caregivers. Information from the caregivers regarding their opinion regarding the progress of their

child, the status of the child's home placement, and the coordination of follow-up services were gathered from this discussion. The focus group was led by the CASA Research Associate, and was approximately 90 minutes in length.

3. Children's Play Therapy Instrument (CPTI) (Kernberg, Chazen, & Normandin, 1998). The CPTI is a comprehensive qualitative measurement tool that assesses the duration of play behavior and the quality of play in children. It requires the examiner to visually record the play sessions and later observe and rate them on a variety of subscales. The instrument consists of three levels: Segmentation of the child's activity, dimensional analysis of the play activity, and pattern of child activity over time. Within the level of play activity analysis, there are three parameters on which the child's play behavior is measured. These are the descriptive, structural, and adaptive parameters. These factors are further divided into subscales that measure the specific components of the child's play activity. The instrument's levels, parameters, and subscales can be used in combination, or exist independently of each other. Its sensitivity to treatment effects has been described in two case studies (Chazen, 2000; Chazen & Wolf, in press). Initial reliability studies conducted by the CPTI authors (Kernberg et al., 1998) showed that each of the levels, as well as the subscales, had good to excellent interrater reliability. Specifically, the kappa coefficient for the segmentation level among three raters was 0.72. For the dimensional analysis level, each of the three raters' performances was compared to the standard established by the creator of the instrument. Mean intraclass correlation coefficients for the seven subscales that make up the three parameters were for Rater A, 0.81 (range 0.61

– 0.94); Rater B, 0.84 (range 0.69 – 0.92); and Rater C, 0.84 (range 0.72 – 0.96). The CPTI is a non-standardized instrument and has been obtained from its authors.

Before and after the group, each child in the research study participated in an individual 30 minute play session with a CASA Psychologist trained in Play Therapy. The author of this study is trained in the application of this instrument, and was the primary rater of the videotaped play sessions. Assistance and reliability rating checks were provided by a research assistant who had also received training in the application of this instrument. Inter-rater reliability for this study was calculated based on these scoring sessions, and the degree of agreement between raters was 0.82.

4. Supporting Documents. Homework record sheets and goal charts were used to help caregivers' track their children's behavior over the course of the group. In addition, the progress of the child and caregiver in the group was recorded in note form by the therapists after each group session. The child's family, school, and medical history was available from the child's CASA file and was reviewed to provide the context for each child's response to treatment.

Standardized Instruments

A number of standardized assessment instruments were included in the study to provide a snapshot of aspects of the children's behavior before and after their participation in the group. This information was originally intended for use in a larger quantitative study. Descriptions of the instruments used and the results obtained are presented below to describe the presenting behaviors of the children before and after participation in the group. Results of these instruments are consistent with the qualitative information presented in Chapters 4 and 5 of this document.

1. Behavior Assessment System for Children (BASC). The children's behavior was measured by the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992). The BASC for ages 6-11 is comprised of items that measure competencies and behavioral/emotional problems of children and adolescents. Normalized T scores are provided for externalizing (e.g. acting out behaviors) and for internalizing (e.g. depressive symptoms) problems. In addition, a total T score is provided as a general indicator of the severity of problem behavior. Scores 65 or above are indicative of problematic behavior; scores 70 or higher are considered to be within the clinical range of problem behavior. The caregiver completed the parent version of this test during the orientation to the group (pre-group assessment), and during the 12th group session (post-group assessment).

Prior to the children's participation in the group, all four caregivers rated their child as demonstrating clinically significant levels of Externalizing Behavior, Internalizing Behavior, and overall severity of Behavior. Scores in this range suggest that children are presenting with multiple behavioral problems of high intensity and frequency that likely warrant formal treatment and intervention. After participation in the group, ratings of three of the children's behavior had improved. However, even though the scores for three children moved in the direction of more healthy behaviors, their overall scores still remained within the Clinically Significant or At-Risk ranges. This indicates the continued presence of significant and severe behavioral problems. The fourth child did not demonstrate any improvement on this scale.

2. Porter Parental Acceptance Scale (Porter, Unpublished). The Porter Parental Acceptance Scale assesses parents' acceptance of their child. Two scales are included in this measure. The first scale assesses the parent's degree of affection for their child in ten different situations. The second scale gives 30 different parent-child situations, each having five different possible parent responses to that situation. Parents are asked to choose the response that most closely matches how they think they would respond in that situation. Higher scores indicate greater parental acceptance of the child. The caregivers' ratings of their level of acceptance of their child pre- and post- group fell within the average range for each caregiver-child pair. This indicates that no difficulties with parental acceptance were reported prior to or following participation in the group.

3. The Parent Report of Post-traumatic Symptoms (PROPS; Greenwald & Rubin, 1999). The PROPS questionnaire consists of a list of 30 problem behaviors that represent an element of post-traumatic reaction. This measure was developed from two other scales, the Children's Impact of Traumatic Events Scale (CITES; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991) and the Child Behavior Checklist (Achenbach, 1991). These scales were modified and updated to reflect current DSM-IV categories for post-traumatic stress, and the PROPS was created. The thirty items currently included in the PROPS are answered by parents on a scale from 0 to 2, and higher scores indicate the presence of a

greater level of post-traumatic stress symptoms. The children were all rated as demonstrating high levels of symptoms related to post-traumatic stress prior to the group. The post-group assessment of this construct was completed for three of the children, with two demonstrating some lessening of demonstrated symptoms, while the other child's symptoms were rated at the same high level as before the group began.

Table 2. Sources of Information

Concept monitored	Method of Inquiry	Respondent	Assessment
Care giver's perception of their child's progress	Interview	Care giver	pre and post
Care giver-child attachment relationship	Clinical Interview Observation of dyad during parent-child portion of group	Care giver Therapist observation	pre and post each session
Care giver's Acceptance of their Child	Porter Parental Acceptance Scale	Care giver	pre and post
Level of Post-traumatic Stress Symptoms	Parent Report of Post-traumatic Symptoms (PROPS)	Care giver	pre and post
Child's behavior	Behavior Assessment System for Children (BASC) Weekly Rating of Child and Parent Behaviors	Care giver and teacher Caregiver	pre and post each session
Child's Play Behavior	Children's Play Therapy Instrument (CPTI) Summary play therapy report	Videotape of play session coded by researcher Therapist	pre and post post
Caregiver's experience of the group process	Focus Group		post

Selection of Research Participants

Participation in the study was voluntary, and a family could participate in the treatment program without participating in the research study. During the family's orientation to the treatment, the caregivers were approached to participate in the research study. An explanation of the purpose of the study and the instruments to be used were given to each caregiver. If consent to participate in the study was received from the parent, an appointment for each dyad was arranged to conduct the pre-group interview with the caregiver, and the pre-group videotaped play session for the child.

Seven children and their care givers committed to attending the RAD group and began the treatment. Of these, only five families initially agreed to participate in the research study. Four of the families who agreed to participate in the study completed the group; however, one family withdrew from the research study due to time constraints. The fifth family withdrew from the group following the ninth session, but still agreed to remain in the research study. Information from four families is presented here including three families who completed the group and one that withdrew.

Ethical Considerations

Ethical approval has been obtained for this study from the Department of Education Ethics Committee and the host agency's ethical review process conducted by the Health Research Ethics Board of the University of Alberta. The responsible authorities were fully informed regarding the progress of this study, and permission to participate in the research study was obtained from each family and social worker (where appropriate). All potential participants were invited to take part on a voluntary basis and were informed that they have the right to withdraw from the study at any time. Refusal to participate in the research did not in any way affect the child and caregiver's participation in the treatment program. Confidentiality and anonymity were assured.

Delimitations

This study is bounded by its major questions and central theme, a particular time in the evolution of the program, the research methodology, and the context. The major questions concern the experiences of children and caregivers who participated in a treatment protocol for RAD. The collection of data occurred during 2002, and the descriptions and discussion in this study pertain to participants in the treatment group during that year. Data from interviews, observations, and other extant documentation collected from the group members provide the basis for discussion in this study. Because this study is delimited by its case study methodology and context, generalizations can be made from this study only to the extent that other children and caregivers may have had similar experiences.

Limitations

This study is limited by using participants as the major source of the data, and by having the researcher as the primary interviewer, collector, and analyzer of the data.

The credibility of this study depends to a large extent on the truthfulness of participants, their ability to remember and describe their experiences accurately, their willingness to be interviewed, and their willingness to divulge particular information. Because the researcher was the sole interviewer, the research is limited by her ability to set and sustain an appropriate climate for the interviews, to set participants at ease, to ask appropriate initial probing questions, and to understand a participant's meaning. Given that the interpretation of the data was done primarily by the researcher, there will need to be an awareness of any unconscious bias that may be present.

This study is also limited by the design of the treatment program. The structure of the program, decisions regarding the selection of participants, and the implementation of the treatment were at the discretion of the host agency. The researcher was limited to studying the treatment program as it existed at that time.

Assumptions

Several assumptions were made in this study. The major assumptions concern the significance of the study, the collection of information, and the suitability of the research method. It is assumed that a study of children and caregivers' experiences in a treatment protocol for RAD will contribute to the continued development of this particular treatment program. Also, it is assumed that this study may also have implications for the implementation of other treatment programs.

It was assumed that all pertinent information was made available to the researcher, and that adequate data were collected to describe the experiences of the children and caregivers who participated in the treatment. It was also assumed that the host agency of the program and the therapists who delivered the treatment were supportive of this research.

Chapter 4

RESULTS: ISSUES RELATED TO THE CHILD IN RAD TREATMENT

This chapter includes a discussion of issues related to children participating in the RAD treatment. The focus is on the children's response to treatment viewed within the context of the challenges that exist in treating children with RAD. Some of the challenges that are discussed include the children's starting point or personal contexts for treatment, and the children's issues with social interaction. The children's response to treatment is discussed in terms of their functioning in the group and at home, their demonstration of attachment related behaviors, and their play behavior. Information and data for this section is presented in terms of the research questions identified in chapter two of this document.

Theme One: The Child's Context for Treatment

1. What was the child's relationship history?

This question will be explored from the perspective of three issues identified in the literature related to the child's relationship history: a) number of foster care placements, b) contact with biological parents, and c) history of trauma and abuse experienced by the child. Each of these factors appears to impact a child's ability to benefit from treatment, as described below.

Foster Care Placements

The treatment described in this study was chiefly focused on developing the children's relationship with, and attachment to, their foster caregiver. A primary issue identified in the literature with treating children with RAD is related to "foster care drift" or multiple placements once the child has entered the care of Children's Services (Steinhauer, 1983). The general consensus in the literature is that the more placements a child has had, the more difficult it may be for the child to form a secure attachment to their current caregiver (Berger, 2003; Delaney, 1998). Fortunately, two of the children who participated in this group had only one placement following their removal from their biological families. One of the children, Rachel, had three placements before coming to her current family, and the last child, Charlie, had seven placements. Charlie's history illustrates the additional challenges in attempting to forge an attachment relationship when a child has had multiple placements beginning at a very early age.

For Charlie, reports in his clinical file indicated that he was first removed from the care of his biological mother, Ms. McIntosh, when he was four months old. This apprehension occurred following an admission to hospital for treatment of pneumonia. Since his first removal from his mother's care, Charlie had been back and forth between foster care and his mother. At the time of the group Charlie was six years old and living in his seventh foster placement, a home he shared with his younger sister Susan. Charlie's two older brothers were also in foster placements with two other families. Interestingly, Charlie's CASA file indicated that his maternal grandmother and his biological mother were raised by foster families themselves, making Charlie and his siblings the third generation of this family to be taken into the care of Children's Services.

Charlie's foster mother, Mrs. Galli, described a number of behavioral concerns that appeared to be related to his history of multiple placements. Mrs. Galli stated that Charlie "monitors my every move" and frequently becomes very "anxious and hypervigilant". Mrs. Galli stated that "just putting my shoes on at the door can cause a meltdown for him". According to Mrs. Galli, Charlie was extremely upset by small changes in routine, and responded to even brief separations from his foster parents with "days of clinginess and crying spells". During these episodes, Charlie would make statements such as "no one would miss me if I were gone". Charlie's psychiatric evaluation described him as "rejection sensitive" and indicated that this is an obstacle to Charlie forming new attachments.

Charlie's extreme emotional responses to separation appeared to be related to his history of multiple broken placements and constantly changing caregivers. This was vital to consider when attempting treatment with Charlie and encouraging him to form an attachment relationship with his new foster mother. For him, treatment had to begin with addressing Charlie's very real fear of losing his foster mother. Treatment of other behavioral and emotional issues could not occur until he felt secure in his foster home.

Contact with Biological Parents

Again, the majority of research on interventions for RAD has identified the stabilization of children's placements as critical to support genuine change. Many programs do not treat children who are living with biological family members due to the increased complexity of treating children while they remain in the environment where they presumably experienced trauma. To be included in this study, children had to be living in a stable long-term foster placement. However, even though the children in this study had been removed from the daily care of their biological parents, Jane, Charlie and Jason still had regular visitation with their biological mothers when the group began. Only Rachel had been permanently removed from the care of her parents by Children's Services before the start of the group. For Jane, Charlie and Jason, regular visits with their biological mothers were reported to be extremely disruptive to their progress at home and in the group, as described below.

Jane: At the time of the RAD group, Jane still had bi-monthly visits with her biological mother, and a petition was before the courts to terminate her mother's visitation rights. According to Jane's foster mother, Mrs. Moore, Jane's problems with sleeping and eating were exacerbated following visits with her mother. Mrs. Moore reported that the frequency and intensity of Jane's nightmares increased in the days following a visit with her biological mother. Jane also wet the bed in the two to three days following each visit. Medication was prescribed to help Jane sleep, but even with medication Mrs. Moore reported that Jane still experienced frequent nightmares and was waking up at least once per night.

With respect to Jane's food hoarding behavior, Mrs. Moore stated that Jane would no longer horde food when she was in the foster family's home, but when on visits with her biological mother, Jane would horde junk food and eat to the point of vomiting. Mrs.

Moore stated that she began sending Jane with healthy food when she visited her mother in an attempt to prevent her from becoming ill.

During the time that Jane attended the RAD group, her visits with her biological mother were stopped. Subsequently, Mrs. Moore reported that she noticed an "enormous improvement in Jane's behavior and attitude" and Jane appeared able to maintain progress made during the group rather than "taking one step forward and three back".

Charlie: Like Jane, Charlie's behavior became more extreme and erratic in the days immediately following a visit with his biological mother and a petition was put before the courts to remove her parental rights, and terminate visitation. Mrs. Galli, Charlie's foster mother, stated that although she and her husband had intended from the start to adopt Charlie and his sister, Charlie had "seemed scared" to discuss the possibility of adoption. According to Mrs. Galli, Charlie had stated that "they [Mr. and Mrs. Galli] would change their minds". This changed following the termination of visitation with his biological mother, and Charlie began to talk to Mrs. Galli about the adoption process. Mrs. Galli also reported that Charlie seemed better able to "concentrate on the group" when he was no longer "worrying about me leaving him".

Jason: At the end of the group, Jason was the only child who still had regular contact with his biological mother, and the long term custody arrangements for him had not been finalized. This introduced an additional element of uncertainty in Jason's life that was not present for the other three children at the time of the group. Reports of Jason's early childhood history describe an unsettled family life, with frequent moves and changing caregivers. Jason and his three older brothers all had different fathers, and Jason's biological parents had separated after a brief time together. During his early life, Jason had lived for stretches of time with his biological mother, his father, his paternal aunt, and a family friend. Throughout this time, Jason had regularly spent weekends with his paternal grandmother, Mrs. Landry, and this became a permanent arrangement when Jason was five years old. At the time of the group, Jason had been living with Mrs. Landry for three and a half years. Although Mrs. Landry had guardianship of Jason, issues over custody of Jason were still present. Jason's mother, Ms. Green, had retained custody of her three older boys, and wanted Jason to live with her and Jason's brothers. Jason's father, Mr. Landry, supported Ms. Green's claim, and a rift had occurred between him and his own mother, Mrs. Landry. When Jason entered the RAD group, he had visits with each of his parents once per month, and a custody hearing was pending.

Mrs. Landry expressed the desire to keep Jason "for the long term" and raise him "as my own". However, she also stated that she is "getting older" and she was not sure if she had the energy to fight both her own son and Jason's mother for custody. Therefore, Mrs. Landry stated that she was "ambivalent" and hoped that mediation or the courts would help decide the matter. Mr. Landry had apparently expressed a great deal of anger toward his mother for restricting his access to Jason, and Mrs. Landry reported that he had withdrawn all financial support of Jason until he has "free visitation". Mrs. Landry stated that she continually invited her son to visit with Jason at her house, but he apparently refused to do so. Jason was also to have court ordered visits with his mother, who Mrs. Landry described as “unreliable” and often missed her visitation times.

Jason’s behavior reflected a great deal of anxiety and anger as a result of the discord amongst his family. Mrs. Landry stated that Jason’s behavior was worse following visits with his mother and father, and he was very difficult to manage for several days after visits both at home and at school. During one of these episodes following a visit to his mother, Jason became out of control at school and hit his teacher. Jason had also attacked his grandmother following a visit to his mother and in one instance, stabbed her in the hand with a fork. According to his psychiatrist’s report, Jason had stated that “my mom tells me to do bad things”. However, when confronted about this statement, Jason said that “it is a secret” and he would not elaborate on his comment. Jason had also expressed the desire to run away from home, but had denied any suicidal ideation or intent at that time.

Jason’s case highlighted some of the difficulties in attempting treatment in such an arrangement. The frequent disruptions in Jason’s life and the ongoing stress resulting from his sporadic contact with his biological parents appeared to impact his ability to benefit from the RAD program. The more immediate affects of the family’s custody battle on Jason became the focus for intervention, rather than any deeper, underlying motivations for his behavior. The family relationships also appeared to absorb much of Jason’s grandmother’s energy, and she did not seem fully engaged or committed to the treatment program. This in turn affected her ability to carry out the "homework" exercises that formed a central part of the RAD treatment, and to attend all the group sessions. In contrast, the other three children described in the case studies were in secure placements with committed foster parents. For the most part, these families consistently worked with their children at home and attended all the group sessions. Consequently, Jane, Charlie, and Rachel appeared to benefit more from the treatment than Jason.

Without exception, the literature on treating children with RAD emphasizes the importance of a stable foster care placement. However, the effect of ongoing contact with biological family members after placement in a foster home is an issue not often addressed in the literature on treating RAD. As seen in this study, continued involvement with biological relatives can be a major source of disruption to the child, challenging the stability provided by the foster home. This type of regular contact with biological family members appeared to limit the children's ability to benefit from treatment. This may be important to bear in mind when considering a child for inclusion in treatment.

History of Abuse and Trauma

Research has suggested that the severity, duration, and age of onset of abuse and neglect contribute to children's current level of functioning and in turn, may influence their response to treatment. The four children included in the study had experienced both physical and/or sexual abuse from an early age, in addition to various forms of neglect while living with their biological parents. Information gathered for each child is presented below.

Rachel: Reports of Rachel's early childhood history describe an extremely chaotic family life. Overall, Rachel's foster mother, Mrs. Hurley, described Rachel's early home life as characterized by parental drug use and a drug lifestyle. Both Rachel's biological parents apparently abused drugs and alcohol, and it was suspected that her parents may be affected by Fetal Alcohol Syndrome themselves. Rachel's biological father had a history of fire setting, and had been in and out of jail for arson and drug related charges. At four months of age, Rachel and her twin brother Nathan, were kidnapped by a neighbor who apparently believed them to be her children fathered by the rock star Jimi Hendrix. The children were eventually found and returned to their parents, but little is known about their experiences during that time. According to Children's Services reports, when Rachel and her twin brother Nathan were removed from their biological parents at 15 months of age, they were severely malnourished, and were treated at the hospital emergency room for cigarette burns on their backs and feet. In addition to neglect and physical abuse, it was strongly suspected that Rachel was sexually abused while in the care of her biological parents.

Jane: When Jane was removed from the care of her biological mother at the age of three, she was severely malnourished. According to Children's Services reports, Jane's biological mother suffered from Major Depressive Disorder and Alcoholism, and allegedly left Jane alone with her siblings during frequent drinking episodes. In addition to neglect, at the time Jane joined the RAD group, her biological father was under investigation for sexually abusing Jane and her younger sister. He was denied access to the children. Allegedly, Jane's older brother, who was seven years old, may also have been involved as a participant in the abuse. This brother lived in the same foster home as Jane, and Mrs. Moore stated that she had found him initiating sexual contact with Jane. No other information regarding Jane's early life was available.

Charlie: Records note that Charlie and his three siblings were removed to the care of Children's Services due to his mother's neglect. Apparently Charlie and his siblings were often left alone in their home, were not fed on a regular basis, and were living in an unhygienic environment (dog feces was found throughout the home).

Since his first removal from his mother's care at four months of age, Charlie had been back and forth between foster care and his mother. It was not clear if Charlie and his siblings were physically abused while in the care of his biological mother, but Charlie had recently begun to talk about several incidents that may have been perpetrated by his stepfather during this time. These included being hit, locked in a closet, and having his head banged against a wall.

Jason: Jason's early life was characterized by frequent moves and changing caregivers. Jason's biological mother periodically drank when he was very young, and it was during those times that he was left with other caregivers, including his father, grandmother, and family friends. Jason's mother apparently had many different relationships with men, and Jason also lived for periods of time with these boyfriends. While in the care of his biological father, Jason was sexually abused by his stepbrother.

Each of the children in this study had a history of significant abuse, trauma and neglect beginning at birth and lasting until their removal from the care of their biological relatives. In light of the literature on this topic, these children would be considered difficult candidates for treatment. This is particularly important to note when embarking on therapy, as expectations for change in a short-term treatment program should be kept realistic.

2. What were the main presenting problems for each child?

While the specific behavioral concerns of each child described in this chapter varied, there were many similarities in the issues reported by their caregivers. Temper tantrums, disturbances in sleep, including nightmares and bedwetting, gorging and hoarding of food, anxiety, depression, and inappropriate behavior toward other children were behavioral concerns identified in all of the children. These issues are described in more detail for each child below.

Charlie: Charlie's foster mother, Mrs. Galli reported that Charlie experienced apparent dissociative episodes where he either becomes panicked or "dreamily fuzzy", and "we lose him for some time". Following these episodes, Charlie would often talk about incidents which apparently occurred with his stepfather. Mrs. Galli stated that these episodes had occurred with greater frequency over the past several weeks, and he had disclosed several more instances of abuse.

In addition, Mrs. Galli described a number of other concerns with Charlie's behavior. She stated that he often appeared very anxious and sad. He had been diagnosed with Dysthymia, and in keeping with this disorder, his moods appeared to be cyclic, with several good days followed by one or two days where he was very anxious and withdrawn. Crying spells, clinginess, and disorganized behavior were characteristic of Charlie's "down days". Mrs. Galli reported that these dysphoric episodes seemed to be triggered by changes in routine or being away from his foster parents, and had resulted in attempts to run away from home.

Mrs. Galli stated that Charlie's expressions of emotion in situations of conflict did not seem genuine. For example, he would say that he was angry, but his tone of voice and facial expression did not match this emotion. Mrs. Galli described Charlie as a "pleaser" who would pretend to be happy or sad because he thought that he should. He appeared to "live in the moment", was very impulsive, and did not seem to learn from the consequences of his behavior.

Other behaviors of note included lying, deceitful behavior related to hoarding of food, and problems with sleeping. Mrs. Galli reported that Charlie would sneak large quantities of food out of the kitchen and hide it under his bed. Then Mrs. Galli stated that Charlie would gorge himself on enormous amounts of food, eating and eating until he was sick. According to Mrs. Galli, Charlie's preference was to eat junk food such as Pepsi and chips, but he would also eat frozen foods straight out of the freezer, and any other type of food that was available. Mr. and Mrs. Galli closely supervised Charlie at mealtimes, and his gorging behavior appeared to be improving. With respect to bedtime and sleeping routines, Mrs. Galli reported that Charlie was very restless at night. She stated that Charlie would go to bed without a fight, but that he would often wake up screaming due to frequent nightmares about dogs. This appeared to reflect his acute fear of these animals.

Rachel: Mrs. Hurley reported that when the children first came to her home, Rachel's behavior was extreme and unusual. Rachel was completely non-verbal, and would "hide out" with junk food gorging herself until she was sick. Rachel also regularly engaged in "head banging", banging her head on the floor and walls up to 160 times per episode. These episodes would occur when Rachel did not get her way, or when she was going to bed. Mrs. Hurley thought that the head banging at bedtime appeared to be a self-soothing behavior, and Rachel would curl into a ball in the bed and rock herself back and forth. Rachel was unable to sleep more than three hours per night, and even those hours were fitful and restless as she was "in constant motion" in the bed. Rachel experienced "constant nightmares" and would wake up "screaming and thrashing" in the bed. Mrs. Hurley stated that the only time Rachel was able to sleep soundly was when she slept with Mrs. Hurley in her bed. At those times, Mr. Hurley would go and sleep in another room.

It appeared that Rachel would also have flashbacks or dissociative episodes, as she would "completely zone out" and then "come back" a few minutes later. Rachel was examined by a doctor and received an EEG to determine if the "zoning out" was a symptom of epilepsy, however, all of Rachel's test results were normal. Mrs. Hurley also described that at five years of age, Rachel began seeing "a man in her window" and she would panic and scream for her mother. Mrs. Hurley stated that this went on for approximately four weeks.

At the time Rachel entered the group, Mrs. Hurley reported that Rachel still needed supervision "24-7" and she described Rachel as "very sneaky" in getting away and doing things "if your eyes are not glued on her". For example, Rachel had lit several fires in the family home using matches she found in a closet, and after her parents removed all the matches and lighters from their home, Rachel lit candles using the embers from the living room fireplace. Since that time, Mrs. Hurley stated that the fireplace is no longer in use.

Other disturbing episodes have occurred around animals and small children. Mrs. Hurley reported that Rachel did not seem to recognize when a baby or animal is in distress and would not correctly identify emotions in others. For example, Rachel did not realize that a neighborhood dog was threatening her, even though the dog was growling, barking, and baring its teeth. In addition, Mrs. Hurley described several incidents of aggression and violence from Rachel toward younger children, and in one case, Rachel choked a child who wanted to stop playing a game that Rachel was enjoying (giving each other piggy backs). Mrs. Hurley also stated that on the Hurley's acreage, Rachel used to wander out into the middle of a group of cattle with no regard for her own safety, and had torn down a greenhouse on the property and killed a baby goat. Mrs. Hurley stated that Rachel showed no empathy or remorse for killing the goat, and Rachel did not appear to understand what she had done wrong. After this incident, Mr. and Mrs. Hurley found new homes for their cattle and house pets, and Mrs. Hurley resigned from her job to spend more time with Rachel and her brother.

Overall, Mrs. Hurley stated that she believed Rachel was a danger to herself and others. Mrs. Hurley stated that "something is always happening with her", and as one anxiety or behavior disappeared, another emerged to replace it. For example, Mrs. Hurley reported that Rachel's head-banging behavior had declined, but Rachel had recently begun to bite her fingers and toes until they bled. Rachel continued to pose a threat to animals, and just prior to attending the group she had attacked a kitten. Mrs. Hurley stated that Rachel often talked about "blood and gore and hurting animals". Rachel was also presenting with severe symptoms of Attention Deficit Disorder, with high levels of hyperactivity, distractibility, and impulsivity. In addition, Rachel's anxiety and poor sleep patterns were a continuing concern. Mrs. Hurley stated that she cannot take her eyes off Rachel and she had put an alarm on her bedroom door so that Rachel would not get out at night and “take off”.

Jane: Mrs. Moore reported that Jane had problems with patterns of sleeping and eating. Jane’s appetite for food was described by as insatiable, and that she was “a gorger” who would eat anything and everything and was always hungry. Mrs. Moore reported that Jane used food as a comfort measure, and usually ate when she was upset.

Jane had apparently suffered nightmares and flashbacks concerning the sexual abuse she had allegedly suffered, and Mrs. Moore described apparent dissociative episodes where Jane “phases out, and we lose her for a few minutes”. Mrs. Moore stated that following the dissociative episodes, Jane wanted to talk about her “bad memories of daddy”. After an episode, Jane also demonstrated a marked loss of spontaneous activity, as Mrs. Moore reported that when Jane was put in a certain position or place she would “just sit there”. The nightmares were apparently occurring nearly every night, and the dissociative episodes occurred approximately once a week.

Jason: Jason’s grandmother, Mrs. Landry, reported that he was very emotional and would apparently enter into acute depressive episodes characterized by crying, temper tantrums, “smashing things”, and “screaming bathroom talk”. Jason had also been physically and verbally aggressive to adults and other children, and episodes of sexual acting out had occurred at school. Jason had been sexually abused by his ten-year-old stepbrother while visiting his father, and had expressed fear of his stepbrother following this incident.

According to Mrs. Landry, he had refused to invite this child to his birthday party, as "no one would be around to protect him". Jason had apparently experienced flashbacks to the abusive episode, but Mrs. Landry reported that he would not discuss or talk about the experience. Jason experienced nightmares, and Mrs. Landry described him as a "poor sleeper". Overall, Mrs. Landry stated that Jason "has to be watched at all times" and she was worried about his development.

The behavioral issues described for the children in this study are consistent with the diagnosis of RAD as discussed in the literature. The breadth and severity of the children's presenting problems again marks them as a high-risk group for treatment. Given this, a realistic expectation for short-term treatment might be that improvement is seen in one or two behavioral areas.

3. What underlying medical concerns and co-morbid psychological conditions contributed to the children's presenting problems?

In addition to behavioral and emotional difficulties related to their early childhood experiences, it was suspected that Jane, Rachel, and Jason may also have underlying neurological problems related to prenatal exposure to alcohol and/or drugs.

Symptoms of Post-traumatic stress were identified in all the children, as were the symptoms of ADHD, particularly impulsive, distractible, and inattentive behavior. All of the children had delays in speech and language development, and school achievement and adjustment were ongoing issues. Difficulty coping with change and managing stress were also issues reported for all four children.

Rachel: Medically, Rachel had a history of ear, nose and throat infections, and had tubes placed in her ears following multiple ear infections. At times, Rachel would have trouble hearing due to the severity of the ear infections. According to Mrs. Hurley, Rachel also had a "tremendous" reaction to sugar, and developed yeast infections following the consumption of sugary foods. Rachel also had a very difficult time with toilet training, and Mrs. Hurley stated that Rachel did not regularly use the toilet until she was nearly five years old. Mrs. Hurley reported that there were still occasions when Rachel would "mess in her pants", and had trouble with bowel movements.

According to social services reports, Rachel's biological mother, Ms. Rowan, was addicted to drugs and alcohol, and Rachel's four older siblings had been diagnosed with alcohol and narcotic related birth defects. Ms. Rowan denied the use of cocaine during her pregnancy with Rachel and her twin Nathan, but it was reported that alcohol and marijuana were used on a regular basis. Given this, it was suspected that Rachel also had alcohol related birth defects or Fetal Alcohol Spectrum Disorder.

Jason: For Jason, prenatal exposure to alcohol and drugs was also suspected, although it had never been confirmed. Mrs. Landry stated that Jason was a poor sleeper, who was restless and woke often through the night, and she stated that he had episodes of bedwetting at least twice per month. It was unclear if these problems with sleeping were due to nightmares or a side effect of the medication Jason was taking for his Attention Deficit Disorder symptoms. Jason was described by his grandmother as “restless, fidgety, inattentive, easily bored, hyperactive, and distractible” even while on medication, and he has experienced great difficulty in school as a result. Language delays and the possibility of a Learning Disability were under investigation at the time of the group.

Jane: Similar to Rachel and Jason, it was suspected that Jane’s biological mother drank alcohol heavily during her pregnancy with Jane. However, no other information regarding prenatal or birth history were available. With respect to developmental milestones, Jane appeared to have been severely delayed in some areas. According to Jane’s foster mother, Mrs. Moore, when Jane arrived in her care at three and a half years of age, she was non-verbal and still in diapers. Mrs. Moore stated that before Jane developed meaningful language, she would chant and rock back and forth in a ritualistic manner. This behavior would intensify when Mrs. Moore attempted to interact with Jane. Mrs. Moore reported that within two weeks of entering her care, she had toilet trained Jane and begun to address her language deficits. Jane was enrolled in a Head Start program and received speech and language therapy. After several courses of speech therapy, Jane’s language skills were considered within the average range for her age, and Jane was able to attend a regular kindergarten program with the support of a teaching assistant.

Other physical issues described by Mrs. Moore included a high sensitivity to smells, where Jane would become physically ill when exposed to certain smells on clothes and people. Jane had also reported that "her brain hurt" and according to Mrs. Moore, this appeared to refer to headaches that Jane experienced after eating certain foods. While in the care of her biological mother, Jane apparently suffered from poor muscle tone (as a result of malnutrition), frequent ear infections, and pneumonia. However, none of these conditions had been an issue since coming to live with Mrs. Moore.

Charlie: Unlike Rachel, Jane, and Jason, Charlie was not thought to suffer from pre-natal alcohol or drug exposure. However, it was suspected that Charlie's biological mother, Ms. McIntosh, may have suffered from Munchausen's Disorder. Munchausen's was suspected due to Ms. McIntosh's frequent visits to doctors of all varieties, and her seeming precipitation of medical events in order to receive medical care. It was suspected that she also exaggerated and possibly produced medical issues in her children as well. Instances of such behavior were documented in Charlie's psychiatric file.

Charlie also presented with a variety of real physical and medical issues. Charlie was described by Mrs. Galli as highly distractible and restless. He was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and had difficulty with attention and focus in school as well as in the home. Charlie's three siblings had also been diagnosed with ADHD. According to Charlie's psychiatric evaluation, he received a brief trial of medication for this disorder, but while living in a previous foster placement, he was taken off his medication due to the previous foster parent's opposition to medicating children.

Charlie's school records showed that this was his second year in kindergarten, and he had speech and language delays. Charlie received speech therapy in his first year of kindergarten, and according to Mrs. Galli his language was now comparable to other children his age. According to Charlie's CASA file, vision problems were identified while he was living in a previous foster home, however, after breaking his glasses, they were never replaced. Mrs. Galli reported that she was not initially aware of Charlie's poor eyesight, and when he first came to her home, he would touch everything and bring objects right up to his face. To begin with this was seen as a behavior problem, but after Mrs. Galli discovered that Charlie could only see things at close range, he was given glasses and he no longer "touches things". Charlie's fine motor skills were also an area of concern when he first came to Mrs. Galli's home, as he was unable to hold a pencil properly or use scissors in classroom activities. However, Mrs. Galli stated that Charlie was now able to build Lego models and construct racetracks when playing at home, so she felt that his fine motor skills were adequate at this stage.

All four children presented with multiple medical problems, co-morbid psychological disorders, and developmental delays. Therefore, it would appear that medical treatment and appropriate strategies to address the children's co-morbid conditions would need to be in place for the RAD treatment to be optimally effective.

Given this, an effective treatment for RAD may include help or support for caregivers in coordinating their children's multiple treatment requirements. This is consistent with the literature that suggests that coordination of treatment and collaboration among professionals treating a child with RAD is important for a positive outcome. In this study, a psychiatrist involved with the treatment provided the children's psychiatric medication, and co-morbid psychological conditions were also addressed through therapy at the same agency. However, the treatment team did not directly address developmental and academic delays and very little liaison was initiated with the children's schools.

Theme Two: Social Interaction

1. What were the primary issues identified for the child with social interaction at home?

Separation anxiety, emotional extremes, and poor personal boundaries were reported for all the children in their relationships with their foster caregivers. Each child's issues are described in detail below.

Rachel: Mrs. Hurley stated that Rachel demonstrated high levels of anxiety in her interactions with family members. According to Mrs. Hurley, Rachel had panic attacks if approached by her adoptive father, Mr. Hurley, when she was changing her clothes or taking a bath. Rachel would also respond by freezing to the spot if her adoptive father entered her bedroom or sat on her bed. Mrs. Hurley stated that her husband was very careful around Rachel, and Mrs. Hurley handled all her personal needs. It also appeared that severe separation anxiety was evident in Rachel's behavior. When Mrs. Hurley would leave Rachel even for a short time, Rachel would stand frozen at the window until her adoptive mother returned. Another major concern prior to beginning the group was Rachel's poor boundaries with others. Mrs. Hurley reported that Rachel would jump into the laps of strangers and cuddle up with them, and "would go off with anyone".

Jane: Jane was described by Mrs. Moore as very moody and clingy, and she would frequently cry and whine to get Mrs. Moore's attention. Mrs. Moore reported that Jane seemed to need a lot of preparation if she was to be separated from her foster mother, or else she would "cling like a leech" and refuse to go. She also stated that Jane appeared to have had more difficulty than her brothers and sisters adjusting to the foster placement, and she apparently became very jealous of her siblings receiving affection from Mrs. Moore. Mrs. Moore stated that Jane hugged and kissed her constantly and "pushes in" when she hugs one of the other children.

According to Mrs. Moore, Jane would do anything for attention including interrupting or acting out inappropriately. Incidents of sexual acting out are documented in Jane's CASA file. These incidents included instances where Jane grabbed the breasts of her therapist and her foster mother, groped her brother and sister's genitals, and jumped into a stranger's lap. Such sexual acting out appeared to be related to Jane's disclosure of her experience of sexual abuse. Mrs. Moore also reported that Jane had indiscriminate boundaries with strangers and would walk up and hug people she did not know.

Jane's previous experiences with men had seemingly affected her ability to interact with her foster father. Mrs. Moore reported that after two years with their family, Jane had only recently started to speak to Mr. Moore, and had just one outing alone with Mr. Moore.

Another issue of concern was Jane's preoccupation with her appearance. Although Jane's biological parents were both of native descent, Jane had blonde hair and blue eyes. According to Jane's file, this combination was highly prized by Jane's mother, and she had been told from a young age that she was very beautiful and special because of her appearance. Apparently, Jane was favored over her siblings, who had dark eyes and hair. According to Mrs. Moore, Jane had carried the expectation of preferential treatment into the foster home, and often "struts around" saying "aren't I the most beautiful thing, look at me, look at my blue eyes, look at my blonde hair". This had caused some conflict between Jane and her siblings.

Charlie: Like Jane and Rachel, Charlie demonstrated high levels of anxiety in his interactions with his foster parents. Charlie was described as hypervigilant and constantly monitoring his parents every move. Separation from Mr. and Mrs. Galli caused days of emotional upset for Charlie. In spite of this, Mrs. Galli described Charlie as a very affectionate child, often seeking comfort from her. Unfortunately, according to Mrs.

Galli, Charlie was indiscriminate with expressions of affection, and he would hug strangers, jump in their laps, and go off with people he didn't know. With Mrs. Galli, Charlie was argumentative and defiant, challenging the house rules and the limits set on his behavior. Mrs. Galli had employed time outs, removal of privileges, and mutual problem solving to address these problems. However, she reported that such consequences were not effective.

According to Mrs. Galli, Charlie was very possessive of Mr. Galli and would work very hard to please him. Mrs. Galli described Charlie's desire to be with Mr. Galli as a "blessing and a curse" as it was a motivator for good behavior in Charlie, but also a source of jealousy when Mr. Galli spent time with Charlie's sister.

Jason: According to his grandmother, Jason moved from one behavioral extreme to another, displaying clinginess and fear of separation in some instances, and in others, displaying hostility and aggression and actively pushing his grandmother away. Jason's boundaries with other children were also a problem, particularly relating to sexual acting out.

The children's specific problems with social interaction at home are typical of children with RAD described in the literature. The patterns of interaction described above are the hallmark of the RAD presentation demonstrating both severely inhibited and indiscriminate social relatedness, "frozen watchfulness", excessive vigilance in close relationships, and inappropriate or non-existent personal boundaries. Of interest, is the presence of dissociative episodes in three of the children. This is a particularly significant response to psychological trauma, and is an important consideration for treatment (Macfie, Cicchetti, & Toth, 2001).

2. What were the primary issues identified for the child with social interaction at school?

Similar to the social interaction problems reported in the home environment, poor boundaries with other children and adults were reported for each of the children in the school environment. High levels of aggression toward other children were reported for three of the children, and all the children reportedly displayed other unusual behavior in the classroom. All the caregivers described their children's behavior at school as a major concern. Details for each child are presented below.

Charlie: Mrs. Galli reported that Charlie had inappropriate boundaries with children at school. Mrs. Galli stated that although Charlie loved animals and babies, he often tried to parent other children. This type of "parenting" behavior had caused problems in Charlie's interaction with peers as he became very bossy with them and only wanted to play if he could be in charge. However, Mrs. Galli reported that she had not observed any outbursts or temper tantrums with Charlie, in fact, when confronted by other children, she reported that Charlie "folds in on himself" and would allow them to take things from him.

Jane: At school, Jane had demonstrated inappropriate behavior with children and adults. Mrs. Moore described Jane's behavior around other children as immature, and stated that Jane "regresses" when she is with younger children, acting "babyish", copying their actions and annoying them. Mrs. Moore stated that Jane could be destructive and unpredictable, and could become very nasty, hitting and shoving other children. According to Mrs. Moore, Jane required one-on-one adult supervision to monitor her behavior.

Rachel: In the school environment, Mrs. Hurley reported that Rachel was close to being expelled from school, and was only allowed to attend until 11:30 in the morning. Rachel participated in the "REACH" program in kindergarten, and her teachers had recommended holding her back from grade one. However, Mrs. Hurley stated that they were not able to do that, and so far grade one had been "a terrible year". Mrs. Hurley described that Rachel had developed some "inappropriate friendships" at school, and had displayed some bizarre behavior in the classroom, such as howling like a wolf. Mrs. Hurley stated that Rachel was "getting craftier" at school and was learning to "outwit the system", and regularly escaped from her classroom to wander the halls. Rachel had received a psychoeducational assessment, and although her overall cognitive functioning was low, Mrs. Hurley reported that Rachel's scores "were not low enough to have an aide". Mrs. Hurley stated that Rachel did work well with one-on-one assistance, but with no special education funding, Rachel was part of the regular grade one class. According to Mrs. Hurley, Rachel's school placement "wasn't working for anyone", and Rachel was in danger of permanent expulsion from her school.

Jason: Mrs. Landry stated that one of the biggest problems she was facing with Jason was his progress at school. She reported that Jason had problems at school from kindergarten, and had been placed in a "Positive Developmental Classroom" for grade one. Although it was a small class, this apparently did not help as Jason did not receive enough one-on-one assistance. In grade two, Mrs. Landry reported that Jason had a full-time aide and he "really connected with her" and made some "decent progress". However, since Jason had entered grade three, Mrs. Landry stated that he had "gone down hill fast" as he was in a behavior classroom with "15 other kids just like him". Mrs. Landry stated that Jason did not cope well with change, and he required a great deal of preparation and warning before changes occurred. According to Mrs. Landry, the frequent and sometimes sudden changes that occur in the school environment "set Jason off" and his behavior at school was erratic and difficult to manage. In addition to his behavioral issues, Mrs. Landry reported that Jason had a language delay and had a "very hard time expressing himself". Given this, Jason was often very quiet and Mrs. Landry stated that it was difficult to tell "what is going on with him" or predict what his next move might be. Jason had been physically and verbally aggressive to adults and other children, and episodes of sexual acting out had occurred at school. According to Mrs. Landry, Jason had attempted to touch other children's genitals and put his penis in another child's face.

The discussion of the children's difficulties with social interaction at school raises one of the difficulties of treating RAD. The treatment approach discussed in this study, as well as many described in the literature, takes place in a clinic with the child's caregiver in attendance. Direct intervention in the school setting is rarely attempted even though children spend a large part of their day at school and demonstrate significant problems in that setting. Therefore, it becomes the caregivers' responsibility to transfer some of their learning from the treatment program to the professionals involved with their child's schooling. As discussed in more detail in chapter five, this can be very difficult for the caregiver, and the child's problems at school may be left largely unaddressed.

Theme Three: Response to Treatment

1. What type of play behavior did the child demonstrate?

Individual Play Sessions

The children's play behavior was directly observed and rated using the Children's Play Therapy Instrument (CPTI). This instrument allowed the researcher to describe and categorize the children's play behavior. There are two sections in this instrument. The first section is a qualitative description of the play segment chosen for analysis. The second section is an analysis of the specific play behaviors observed, including the structural, functional and developmental features of the play.

As noted in the literature, children communicate through play, and depression, anxiety, trauma and disrupted attachment can all change the quality of a child's play behavior (Kot et al, 1998). Of particular relevance to this study is the finding that children who have experienced trauma may demonstrate repetitive or immature types of play. If the children had benefited from the treatment intervention, it was hypothesized that their play may be qualitatively different at the end of the study. For example, the themes and developmental features of the play may reflect positive growth, as measured by the CPTI. The changes that were observed in the children's play from the initial play session before the group to the post-group play session are reported below.

Jane: Jane's presentation in the post-group session appeared very different from the pre-group play session. Throughout the post-group session Jane was animated and expressed a range of emotions including enjoyment, aggression, and humor. This was in direct contrast to the marked lack of emotion and absence of interest Jane displayed in the pre-group session. Jane did not develop any play activity during the pre-group session, engaging in repetitive and sensory based actions. During the post-group session, Jane initiated and engaged in cooperative role-play with the therapist, actively directing the play activity. Jane's use of language was also markedly different in the play sessions before and after the group. In the pre-group session, Jane remained silent, issuing just one statement to the therapist. In contrast, Jane talked continually throughout the post-group session, laughing and chatting to the therapist about the toys in the room and verbalizing during play activities. Overall, Jane's play behavior in the post-group session indicated a greater level of emotional integration and expression. She expressed intense emotions through play, and demonstrated the ability to move from play to ordinary conversation without carrying over any negative affect. In addition, the play behaviors observed in the post-group session were more age appropriate than those observed in the pre-group session. Jane's involvement in a cooperative role-play activity in the post-group session indicated an appropriate level of cognitive development, and a level of social ability that would be expected for her age.

Charlie: The changes in Charlie's play behavior from the pre to the post-group session were subtle, and may reflect more of an internal change in orientation rather than overt changes. The play in both sessions was at the expected developmental level, and Charlie demonstrated age appropriate language and social skills. Charlie also demonstrated positive, flexible affect, and interacted with the therapist in a consistent, appropriate manner in both sessions. The differences between Charlie's pre and post-group play sessions emerge when the play themes are examined more closely.

The play themes that emerged from the pre to the post group play session suggest a shift in motivation for Charlie's activities. The pre-session revolved around creating a good home with everything in its place, food to eat, and parents to look after the children. In the pre-session, Charlie used figures to portray the action and described the play from an outside point of view. In contrast, in the post-group session, Charlie himself assumed the role of "fix-it-guy" and actively investigated the workings of the walkie-talkie and repairing the dollhouse. The activities in the post-session demonstrated a shift from gender neutral play to activities that were more masculine in nature, and may reflect the growing relationship Charlie was forming with his foster father. In the post-group session, Charlie also demonstrated the ability to clearly and directly refuse an offer of help from the therapist. Given Charlie's history of compliance and "pleaser" behavior, the ability to politely decline an adult's suggestion indicates progress in relating to authority figures.

Rachel: Rachel's play in both sessions was imaginative and revealed a well-developed ability to portray the actions and emotions of several different characters. Rachel's play was at the expected developmental level, and contrary to reports of her usually hyperactive and distractible behavior, she displayed a high level of focus and attention throughout both sessions. Rachel was able to set up and develop themes through play in both sessions, and displayed appropriate interest in the both the therapist and the play room.

The changes in Rachel's play behavior from the pre to the post group were reflected in the themes of her play activity. In the first session, separation of the animals and their potential abandonment by the family dominated the play segment. The animals were transported back and forth, and discussion between the father and the female figure centred on whether the animals could be happy in this household. In contrast, in the post-group session Rachel portrayed a happy family unit taking their baby for a walk, with the parents both expressing concern for the baby's welfare and responding to the baby's needs. Her play within the rest of the play session also focussed on care giving and nurturing babies. Given Mrs. Hurley's statements regarding Rachel's apparent inability to recognize and respond to distress in people and animals, it is important to note that in her play Rachel portrayed appropriate responses to the crying baby. In both sessions, Rachel's play centred on themes related to parenting and the stability of home life. However, in the pre-group session Rachel presented an unsettled picture of a family with an ambivalent father figure, whereas in the post-group session, Rachel presented a positive nurturing picture of a stable family unit.

Jason: As Jason did not participate in a post-group play session, only information gathered from the pre-session is presented below. Although this does not allow for an assessment of change, the following description does provide insight into Jason's functioning and level of play behavior.

Jason's overall affective tone during the play session was one of obvious pleasure in the play activity, and he displayed a broad spectrum of affect through his play activity and his conversation. Jason presented as emotionally intense, and he switched from a high level of aggression in his play with the action figures, to a high level of enthusiasm in his conversation with the therapist. Jason transitioned rather abruptly between affective states, moving rapidly back and forth from his aggressive play with the action figures to talking with the therapist.

Jason demonstrated realistic use of his play objects (the action figures) and displayed the beginning stage of role-play by animating the action figure 'The Rock'. He engaged in verbal elaboration of his play through discussion of the World Wrestling Federation (WWF), and used the action figures to demonstrate the situations he described in conversation. Jason, the therapist, and the action figures all maintained stable role representations, and no transformation in roles was observed. The play activity was integrated and demonstrated Jason's obvious interest in aggressive, contact-based activities. Jason's focus on "killing" all the action figures using his favourite figure demonstrated a high level of violence and aggression in his play. However, Jason's discussion of "real life" action versus the "fake" action involved with the WWF, demonstrated an understanding of the differences between fights staged for entertainment and real sporting events, such as the Canadian Football League (CFL).

Overall, Jason's play appeared to be somewhat immature for his age, and the chosen activity was predominantly masculine. He engaged in realistic play, and generally used play objects in the way they were designed. Jason's verbal skills were age-appropriate, and he talked almost constantly throughout the session. Jason's affective tone was highly aggressive when playing with the action figures. However, this seemed to accurately reflect the nature of the WWF and the action figures themselves (i.e. figures equipped with miniature weapons, big muscles, and aggressive appearances). Jason demonstrated an obvious enthusiasm for his play activity and he seemed to enjoy sharing his knowledge of the WWF and the CFL with the therapist.

The three children who completed both the pre and post group play sessions demonstrated shifts in their play behavior toward more integrated, developmentally appropriate play. The themes in their post-group play generally reflected less anxiety than those in the pre-group sessions. This is consistent with their caregivers' reports of improvements in other areas of their functioning at home. Jason demonstrated a high level of aggression in his pre-group play session, but it is not possible to assess whether the treatment affected his play as he did not participate in a post-group session.

Play Behavior and Behavior in the Group

The information below is drawn from the group therapists' written and verbal reports of the children's presentation during the group play therapy sessions. These sessions included both directed and non-directive play activities.

Jane: The Children's Group therapist reported that Jane demonstrated good progress in the group. Themes of safety, secrecy, good versus evil, nurturing, and hope were displayed in her unstructured play activities. According to Jane's therapist, Jane appeared less anxious and more willing to address past trauma after her participation in the group. This became apparent as Jane initiated conversations with her foster mother and with the therapist about things that had happened when she was living with her biological mother. The therapist noted that toward the end of the group, Jane appeared most animated and relaxed during one-on-one play time with her foster mother. This appeared to support the idea that there was movement toward attachment between Jane and her foster mother. Recommendations for further treatment suggested that Jane and her foster mother would benefit from continued relational therapy, and one-on-one time with her foster mother.

Charlie: The Children's Group therapist reported that Charlie's overall affective presentation in the group progressed from anxious to defiant to sadness. The therapist stated that over the course of the group, Charlie appeared to be beginning to explore his past traumas, and to process his sadness. His foster mother was described by the therapist as warm and nurturing toward Charlie and the therapist also stated that Mrs. Galli responded to Charlie's verbal and nonverbal cues immediately and appropriately. In the group play environment, the therapist reported that Charlie initially sought out adult interaction and discouraged contact with peers. His play themes in the first four sessions centred on hiding and withholding food, disasters, and children locked in closets. During the fifth and sixth sessions, the therapist reported that Charlie appeared to reach some resolution through his play. He crafted a smiling clay face stating that "the face is smiling because there is enough food". Objects were hidden in play rather than people, and the therapist reported that Charlie demonstrated more assertive behavior and some parallel play with other children in the group. The therapist reported that themes in Charlie's sand tray play progressed from chaotic movement to a central home theme with a mom as a safety figure. Recommendations to support Charlie's progress included the continuation of one-on-one time with Mrs. Galli, the maintenance of a stable, safe home environment where Charlie can express his feelings and talk about past experiences, and play therapy within an attachment framework with Mrs. Galli actively involved.

Rachel: The therapist who worked with Rachel in the group reported that she and her foster mother made slow, but consistent progress over the course of the group. The therapist stated that Rachel participated in group activities, but initially needed a lot of support to organize her behavior and relate appropriately to the other children in the group. According to the therapist, Rachel preferred to play solitary games independent of the other children, and had to be carefully supervised when engaged in cooperative play. Rachel appeared to respond to the one-on-one parent-child work both during the group and at home, and the therapist reported that Rachel appeared to enjoy her foster mother's attention. Recurrent and predominant themes that emerged in Rachel's play during the group included danger versus safety, nurturing, and characters representing mothers and babies. The therapist's report noted that Rachel's play included more human characters toward the end of the group, and her play appeared more integrated and purposeful by the conclusion of the group. Recommendations for further treatment were made, with Rachel to continue seeing a play therapist for individual and parent-child work, and regular consultation with a psychiatrist to monitor her medication needs. One-on-one play sessions at home with Rachel and her foster mother were also recommended as Rachel appeared to respond positively to this and seek out time alone with her foster mother.

Jason: The therapist who worked with Jason in the group reported that he had many "ups and downs" over the course of the group. Jason and his grandmother attended eight of the twelve group sessions, and dropped out of the group at week nine. The therapist stated that Jason and his grandmother participated in group activities, but they had not seemed to "fully embrace the group process or philosophy". Some gains were made, and the therapist reported that Jason's ability to interact appropriately with the other children in the group had improved, and he made more eye contact with his grandmother during the caregiver-child activities. Jason's play often included themes of fighting, dominance, and destruction, and these themes did not evolve significantly over the course of the group. The therapist endorsed Jason's referral to a children's day treatment program stating that Jason and his family would benefit from the comprehensive program including intensive family therapy and schooling.

All of the children demonstrated some progress in their play over the course of the program. Jane, Charlie, and Rachel, in particular, appeared to benefit from the opportunity to process their experiences through play, and responded well to the one-on-one play times with their caregivers. Jason appeared to change the least in his style and type of play, and this appears to be related in part to his grandmother's ambivalence toward treatment and eventual withdrawal from the program.

2. What was the child's overall response to the treatment intervention?

Prior to the group, each child described in this study demonstrated some unusual patterns of relating to their caregivers. Jane, Charlie, Rachel, and Jason displayed extremes of behavior, moving between indiscriminate affection and inappropriate social contact, to severely inhibited behavior characterized by lack of eye contact and "frozen" stillness. Following the group sessions, Jane, Charlie, and Rachel's caregivers reported a reduction in the anxiety displayed by these three children, and this appeared to lessen the frequency of anxious behavior, including episodes of hypervigilance and frozen watchfulness. Boundaries with adults and other children continued to be a problem for Rachel, although Jane and Charlie's caregivers reported some improvement for them. Jane and Charlie's caregivers also reported that they were more affectionate and used more eye contact following participation in the group, and Jason was observed by his therapist to use more eye contact in the group. Although Rachel's caregiver did not report a great deal of improvement for her in developing personal boundaries, she did report that Rachel enjoyed their one-on-one play time and actively sought out her foster mother to spend time together. After the group, Rachel also began to hug her caregiver and asked for good night kisses before going to bed.

Following participation in the group, the children had made varying degrees of progress. Over the time that the group was conducted, Jason's difficulties at school escalated to a point where he was unable to remain in his community school, and he entered a day treatment program. Addressing the more pressing school issues took precedence over the RAD intervention, and Jason and his grandmother withdrew from the program after session nine. In spite of their withdrawal from the group, Jason's grandmother did report that Jason had made some positive changes, and he was calmer and more manageable at home. It is important to note that the ongoing family unrest between Jason's grandmother and his parents appeared to affect their ability to fully engage in the treatment process.

In contrast, Jane, Charlie, Rachel and their respective caregivers appeared to commit to the group, and each of these children demonstrated some positive changes in their behavior. The caregivers of these children all reported an increase in their child's expression of genuine emotion following participation in the group. Each of the children was rated as displaying less anxiety and mood disturbances (as measured by the BASC Internalizing scale), with Jane and Rachel moving into the average range for these behaviors.

With respect to Charlie's progress, his foster mother Mrs. Galli reported that since participation in the group Charlie has been expressing a greater range of genuine emotions, and his "incessant chatter" has become more meaningful. For Charlie, ratings of his ability to cope with stress and manage change were significantly improved after his participation in the group, and he was having less frequent dissociative episodes.

According to Mrs. Galli, Charlie appeared much more comfortable with the family, and this led him to express himself more often. For example, Mrs. Galli stated that Charlie could now admit when something was wrong, and express happy and sad feelings. This had led in some cases to an increase in fights and defiance. Mrs. Galli stated that Charlie used to be "disconnected" and "overly compliant" and now that he seemed to feel safe with Mr. and Mrs. Galli, he appeared to feel secure enough to show his anger. Charlie was also talking more about his adoption, and seemed to be more comfortable with this subject.

Charlie's relationship with his sister had also changed, according to Mrs. Galli. When Charlie and Susan first came to Mrs. Galli's home, she stated that they were very protective of each other and "stuck close together". Now Mrs. Galli described their relationship as that of "normal siblings". Mrs. Galli also stated that Charlie seemed closer to his foster father, although any kind of rough-housing upset Charlie very quickly. Mrs. Galli reported that overall, Charlie appeared happier and less anxious since the group, and he seemed to have more self-esteem. Charlie's foster mother reported that he "is more like a regular 6 year old and does not seem as afraid of us [his parents]". Charlie was also responding well to a new medication for treatment of his ADHD symptoms, and Mrs. Galli stated that this had a positive effect on Charlie's interaction with all family members.

In the school environment, Mrs. Galli reported that she still had many concerns about Charlie's progress. Charlie was entering grade one following two years in kindergarten, and Mrs. Galli stated that she would like some liaison between the school and Charlie's therapists and doctors. She stated that more information and education for teachers around the issues faced by children like Charlie would help them create realistic expectations for him. Mrs. Galli also stated that she felt Charlie was now being singled out and given consequences for "normal kid misbehavior" and she hoped that his grade one teacher might be more supportive of his needs. Mrs. Galli stated that Charlie will face many challenges in school given his attention, learning, and behavior problems, and they would likely become more of an issue as Charlie progressed through the grades.

Jane's foster mother reported that she was generally more compliant following their time in the group, with Jane listening better and following her family's rules. Jane now appeared to understand the consequences that Mrs. Moore assigned for misbehavior, and would pick up her toys and keep her room clean. Jane was also demonstrating more appropriate emotional responses, and talked more when things bothered her, as opposed to acting out and crying. With her siblings, there had been a reduction in the number of instances of sexualized behavior, and Jane was generally less violent toward her sisters. According to Mrs. Moore, Jane still had a love-hate relationship with her older brother and issues remained around his possible participation in the abuse that Jane experienced.

Jane was also able to make and keep a friend during her time in the group, and her foster mother reported that Jane had less instances of inappropriate or "nasty" behavior toward other children. Ratings of Jane's Post-traumatic symptoms decreased significantly after the group, and her foster mother reported that her nightmares and unusual eating habits improved. In addition, Jane showed a marked difference in her play behavior from the beginning of the group to the end.

Important to note is that during the time that Jane attended the group, her visits with her biological mother were stopped. Subsequently, Mrs. Moore noticed an enormous improvement in Jane's behavior and attitude. Given this, Mrs. Moore could not say how much the group had contributed to Jane's improvement and how much was due to the removal of the disruptive effect of visits with Jane's biological mother. However, Mrs. Moore did state that she felt Jane had responded well to the activities included in the group and that she had appeared to enjoy spending one-on-one time with Mrs. Moore. Overall, Mrs. Moore reported that following the group, Jane was doing very well at home and at school.

For Rachel, her progress toward the behavioral goals identified by her foster mother was sporadic. Her foster mother reported that overall, Rachel appeared more relaxed and less anxious, and instances of extreme behavior, such as head banging, were less frequent. Rachel was reportedly expressing more genuine emotion following participation in the group, and demonstrated more spontaneous activity.

When examining Rachel's play behavior, her play in the post-group session reflected a preoccupation with more nurturing and family centered themes than in the pre-group play session. In addition, Rachel was now using play and acting to express herself. According to Mrs. Hurley, Rachel put on plays and acted out situations with Mrs. Hurley providing the dialogue. Mrs. Hurley stated that this was something Rachel had learned in the group, and both she and Rachel really enjoyed playing together in this way.

Mrs. Hurley stated that the best thing about the program was the parent-child one-on-one time during the group sessions, and the encouragement to spend daily one-on-one time with Rachel at home. Mrs. Hurley reported that Rachel responded extremely well during these parent-child play times, and Rachel treated it as a very special activity.

Mrs. Hurley described the group as a positive experience; however, she stated that there had been "no monumental changes" in Rachel's behavior. At the end of the group Rachel still presented with numerous behavioral problems. Rachel's symptoms of Post-traumatic stress remained at a high level, and she still required constant supervision of her activities to ensure her own and other children's safety. Rachel's foster mother reported that Rachel continued to have serious problems in school, and she was at risk for expulsion at the end of the group. Mrs. Hurley described that Rachel still needed "100 percent supervision", although some of Rachel's "problem behaviors" were less severe and occurring less often.

Chapter Summary

In this chapter, an examination of the issues related to the children involved with the treatment for RAD was organized into three main themes. The first was the child's context for treatment. The child's relationship history, main presenting problems, and their co-morbid medical and psychological conditions formed the backdrop for their treatment, and in some instances, affected their ability to fully engage in the treatment program. The second theme concerned the children's difficulties with social interactions at home and school. The third theme described the children's response to the treatment, particularly as reflected in their play behavior throughout the group and in the individual play sessions.

Overall, each of the children in the group made improvements in some areas of behavior. Many behavioral concerns remained. However, given the severity of the children's presenting concerns, their caregivers expressed satisfaction with the progress their children had made during the group. One caregiver expressed some disappointment that her child was still not a normally adjusted child although, intellectually, she understood that this was not likely to happen over a short time. Another caregiver indicated that she had come to the group with few expectations and thus regarded even small improvements as a big change. A theme that emerged for all the caregivers was the concern for their children at school, and transferring the gains the child had made in the home environment to the school environment.

Chapter 5

RESULTS: THE CAREGIVER'S ROLE IN TREATMENT

This chapter includes a discussion of issues related to the caregiver's role in the RAD treatment. The caregiver's role will be discussed in terms of their expectations of the group, their likes and dislikes about the group format, and their challenges in parenting a RAD child. Information and data for this section will be presented in terms of the research questions identified in chapter two of this document.

Theme One: Expectations of Treatment

1. What were the caregiver's expectations of the treatment? Were those expectations fulfilled?

Overall, by attending the group the caregivers expected to see improvements in their children's behavior and ability to interact with others, and develop closer relationships with their children. They also expected to receive emotional support from the group therapists and other parents. The caregivers presented similar concerns regarding parenting prior to the group. Each caregiver had reported a need for strategies and skills to cope with the often extreme and unusual behavior displayed by their child.

After participating in the group, the four caregivers reported that they had learned new ways to manage their child, and most importantly, they all reported that they had a better understanding of underlying reasons for their child's difficult behavior. This increase in knowledge had led some of the caregivers to adjust their expectations and change the way they interacted with their child. For example, one parent reported that she was more patient and focused her attention on promoting positive behavior instead of emphasizing her child's misbehavior. Those caregivers who applied their knowledge of RAD reported that their child had responded to the change in their parenting, and the child's behavior had also changed and improved. Each caregiver's specific expectations are described below.

Jane: Before the group began, Jane's foster mother Mrs. Moore was asked to describe her expectations of the RAD Group. Mrs. Moore stated that she would like to develop a more natural mother-daughter relationship with Jane. In addition, Mrs. Moore hoped for a reduction in Jane's anxiety and neediness, and the development of greater trust. Mrs. Moore also wanted to access support for herself. She felt that she had no energy left, and when Jane was at school she felt great relief and stated "I can breathe". Mrs. Moore also stated that she would like more information about Jane's presenting problems, and the opportunity to interact with other parents of children like Jane.

After the group concluded, Mrs. Moore reported that she received a lot of information from the RAD group, and that many of the issues she has had with Jane now make more sense. For example, Mrs. Moore stated that she has a much greater understanding that Jane's emotions are rooted in past experiences. She now realizes that Jane's behavior is not deliberate, and she will give Jane more leeway when interpreting the motives for her behavior. Mrs. Moore stated that she works with Jane better now, as she is more patient and able to separate her own reactions from the situations that arise with Jane. In addition, Mrs. Moore reported that she is more proactive and acts to intervene in situations before Jane gets upset. As a result, Jane is more able to listen and process what is said to her, and her behavior has improved. Jane now appears to understand the consequences assigned for misbehavior, and is following house rules, such as picking up her toys and keeping her room clean.

With respect to the format of the group itself, Mrs. Moore was generally satisfied with the service that she and Jane received. She did offer some suggestions to improve the group, particularly the inclusion of more time for interaction between the parents so they could provide support for each other. She reported that specific components of the group, such as the daily "homework" of a fifteen-minute one-on-one play time, did not work in her family situation. She chose to modify this component by spending the day with Jane once a week.

With regard to future treatment, Mrs. Moore stated that Jane has attended therapy every week for two years, and that it was "time for a rest". Jane was to remain under the care of a psychiatrist to monitor the medication she receives for sleep disturbances, and would return to therapy if she is unable to maintain her current level of functioning.

Charlie: Mrs. Galli stated that through participation in the RAD group she wanted to receive resources to build her parenting skills. She also stated that she would like support for herself in coping with the "crazy behavior" that Charlie often displays. She talked about the potential she saw in Charlie, and that she had great hope for his future. She described her concern for his development, and would like to see him grow into a contented and well-balanced child. Specific goals for Charlie in the RAD group included an increase in the amount of eye contact and emotion he displayed when interacting with family and other children, and greater compliance with house rules.

Following the group, Mrs. Galli reported that the support she received from the RAD group team was “awesome”. In particular, she stated that the group helped “normalize” the experiences she has had with Charlie, and reduce her feelings of frustration and isolation. She “got lots of ideas” on parenting from other parents in the group, and she received a lot of positive feedback around the issues she brought forward. She increased her knowledge about Reactive Attachment Disorder, and learned a number of effective strategies to use with Charlie. Since attending the group, Mrs. Galli had tried to “release” more control to the children by involving them more in rule making. In addition, she had a better understanding of what was motivating Charlie’s behavior, and she had tried to focus more energy on positive reinforcement for good behavior than consequences for negative behavior.

Mrs. Galli offered some feedback on the structure of the RAD group itself. She suggested that it would be helpful to spend a longer amount of time in each session for parent-to-parent support and discussion, because this type of support was very useful. She would also like to be given the contact information for other parents (who were willing) who had been through similar experiences. Mrs. Galli found that the homework kit used in the group was not useful for Charlie. Therefore, both of them made up their own activities to do during their 15 minute per day play session. Since more physical activities worked best with Charlie, they often went rollerblading or bike riding instead.

In general, Mrs. Galli reported that her experience in the RAD group was very positive and she felt that the support she and Charlie had received "cemented" them as a family. She stated that the support she received validated what she was seeing in Charlie, and made her feel "less crazy". Mrs. Galli also felt that she had been given some useful tools to do something about her relationship with Charlie. Mrs. Galli stated that Charlie was coming up to his one year anniversary living with her family, and she had lots of hopes for him in the future. Immediate goals for Charlie included encouraging him to develop more leadership skills and make good choices for behavior (not follow the crowd). Mrs. Galli and Charlie were planning to take a break from therapy for the summer, and re-assess his needs for support in the fall.

Rachel: Rachel's foster mother, Mrs. Hurley, stated that she and her family were "under a lot of stress", and she needed support and respite. Mrs. Hurley stated that she needed assistance in managing Rachel's behavior, and she hoped that the group would provide her with some "fresh ideas". Reductions in defiant and aggressive behavior were identified as the key behavioral goals for Rachel in the group. Mrs. Hurley's own goals included creating a more peaceful and organized atmosphere in the family home, and working with Rachel's behavior to get her to a point where she did not need "arms-length" supervision.

Following the group, Mrs. Hurley stated that Rachel's progress peaked approximately three-quarters of the way through the group treatment. The information she received in the parent portion of the group helped her understand why Rachel behaves the way she does, and Mrs. Hurley had adjusted her expectations of Rachel. By changing her expectations, she was less frustrated with Rachel's behavior, and Rachel appeared less anxious at home. Mrs. Hurley described the group as a positive experience; however, she stated that there had been "no monumental changes" in Rachel's behavior.

Mrs. Hurley stated that the group "started something", but she would like the sessions to continue over a longer period of time. She expressed the need for continued emotional support and encouragement to "keep going" in parenting Rachel. She learned a lot from the group and she felt that she was now "heading in the right direction". However, given her starting point with Rachel, Mrs. Hurley stated that at the end of the program she would have liked "to be given permission not to be the great success story". Mrs. Hurley stated that she intended to keep working with Rachel's therapists and psychiatrist to find the right combination of medication and therapy to support Rachel's progress. Mrs. Hurley also talked about the importance of working with Rachel's schoolteachers to receive the accommodations that Rachel would need to participate in the classroom.

Jason: Through participation in the RAD group Mrs. Landry stated that she would like to see Jason begin to function better at home and at school. She also stated that she would like to develop more trust in Jason and feel confident that he would behave in an appropriate manner. For example, she would like to be comfortable allowing him to play with other children. Mrs. Landry also expressed a desire to learn better ways to deal with Jason's behavior and anxiety.

Following the group, Mrs. Landry reported that it had been difficult to "really focus" on the group given the continued stress of the on-going custody dispute over Jason and her own personal conflict with her son, Jason's father. Jason's behavior was still being negatively affected following visits with his mother or father, and Mrs. Landry stated that after visits Jason was tired and unmanageable. She stated that she thought there was no structure at his parent's homes, and she had to work twice as hard when Jason returned just to get him to the point he had been at prior to the visit. In spite of this situation, Mrs. Landry had learned some "better ways to deal with Jason" and she had consistently used the play kit with Jason at home. Mrs. Landry stated that the individual play times she had with Jason "made a difference" to his behavior, and he appeared calmer and easier to talk to at home. She reported that school issues continued to be the "biggest problem" for Jason, and she felt that he was not in the right school placement.

Given this, Mrs. Landry had accepted a referral for Jason to enter the CASA children's day treatment program to address his problems with school as well as his emotional and behavioral difficulties. Mrs. Landry described this program as a "one-stop shop" and she stated that she hoped it addressed Jason's problems in a more holistic way.

Theme Two: Suggested Changes to Treatment

2. What did the caregivers like about the treatment and what things would they change about the program?

The following information was gathered through a focus group held with the caregivers after the group had concluded. Caregivers began their discussion of their experience in the RAD group with some specific comments related to the activities and materials used in the program. Some caregivers stated that more explanation of the therapeutic activities, such as sand tray work, would have been helpful. Greater direction and information from the therapists would have helped them understand the purpose of certain activities and clarify the role of the caregiver.

Particular concern was expressed by the caregivers about the toy box kit that was suggested for use in their one-on-one daily play sessions with their child. The cost of the kit ($30) was thought to be quite high. Also, the use of the kit did not take the whole family situation into account. For example, one caregiver reported that her child's sibling felt left out because the child attending the RAD group would tease her siblings by "making a point of drawing attention to the kit and then not letting siblings play with it" (i.e. the kit became a "weapon"). Other caregivers reported that their children simply were not very interested in the activities in the kit because the contents were too “baby like”.

A more general concern with the activities required of the participants, was the level of stress that caregivers were feeling. All the caregivers reported a great deal of stress just doing the activities of daily living with a RAD child in their family. The additional activities prescribed by the program were difficult to implement because they “had used most of their energy just to get through the day”, and there “wasn’t much left over”. One caregiver stated that she had other demands on her time, particularly the need to spend some one-on-one time with her husband. Some suggested that a self-care “parent kit” was needed, and it was really hard to write in a journal (a homework exercise) at the end of a difficult day. A high level of frustration was expressed by the caregivers as they did not feel that the seriousness of their difficulties in following through with suggested activities, and their difficulties in day-to-day coping, were appreciated. One caregiver stated that there was too much pressure from the group therapist to do activities exactly as suggested (i.e. one-on-one time), and if her child did not improve, then the caregiver felt that she had failed.

The caregivers involved in this study all clearly stated that they needed a lot of support in caring for their child. All strongly expressed the need to give and receive support from each other; however, the emphasis in this group was on the children, not the parents. One caregiver stated that she did not have adequate opportunity to interact with other parents during this group. Another caregiver who had attended a different group treatment program noted that there was time for interaction with other parents in the other group, but that the RAD group was quite different in this respect, with less opportunity for interaction. This caregiver stated that although they had been in the group together for 12 weeks, at the end of the group, the parents still did not know each other.

A final concern related to the differences between foster and adoptive family arrangements. One caregiver pointed out that foster parents have to maintain "a good rating" with Children's Services to continue to be a foster parent, and therefore they are especially sensitive to anything that might upset their relationship with their social worker. Adoptive parents or biological relatives do not have the same relationship to Children's Services. This was apparently the reason why some of the foster parents were reluctant to implement some of the therapists' suggested activities for homework. For example, as part of an exercise to allow the child to experience "safe" touching, caregivers were encouraged to rub lotion on their child's hands. Some of the foster-parents were uncomfortable with using lotion in caregiver-child activities, because of concerns about being reported to Children's Services for inappropriate touching.

Theme Three: Caregiver Challenges

3. What did the caregiver identify as their greatest challenges in parenting a child diagnosed with RAD? How did the group allow the caregiver to address those challenges?

The challenges in parenting a child with RAD that were described by the caregivers could be grouped into two general areas; personal challenges and difficulties coordinating treatment services. Below is a discussion of these two areas.

Personal Challenges

All the caregivers described a need for support and validation of their own experiences in caring for a challenging child. Each caregiver in this study described numerous sacrifices and accommodations they had made personally, professionally, and as a family to meet the needs of their child. Each parent had gone to great lengths to create a home life conducive to the positive development of their child. For example, Rachel's mother had quit her job, given away all her pets and farm animals, and moved from an acreage into the city to provide a safer environment for Rachel.

Each of the caregivers reported the stress and day to day logistics of caring for a RAD child had impacted their personal relationships within and outside the family. Inside the family unit, marital relationships appeared to suffer the most from the demands of parenting a RAD child, and all the caregivers reported difficulty "finding the time and energy" to nurture their relationship with their partner.

In addition, given that the children described in this study had experienced sexual abuse, in many ways the foster fathers' had particularly limited their involvement with the child. Although this practice demonstrated sensitivity to the child's past trauma and resultant wariness of men, it also resulted in the isolation of the foster dad from the mother and children. In one case, the foster father was literally restricted to two rooms in his own home.

Outside the family unit, friendships and participation in community activities had also been limited in the families in this study. Caregivers reported that they were either too busy or worn out from caring for their child to visit friends, or because they felt uncomfortable taking a behaviorally unpredictable child to public events.

In general, the caregivers reported that they had been well-supported by the therapists and the other parents in the group throughout the treatment process. One caregiver had noted that it was particularly helpful to receive the therapists' validation to the parents in the group and to others (the child's school and their social worker) about the seriousness of their child's disability. Assistance in educating a new social worker about the behavior associated with RAD was also appreciated by one caregiver. At the end of the group, the caregivers' parenting concerns centered on maintaining gains that the child had made, and structuring the long-term support of the child so that they could continue their progress.

Coordination of Treatment Services

A concern common to each of the caregivers in the four case studies was related to the ongoing coordination of services for their child and the long-term plan for their child following participation in the RAD group. Given the breadth and variety of each child's presenting problems, many different professionals were involved in their care. Each caregiver identified difficulties coordinating the teachers, social workers, therapists and doctors involved with their child in order to provide an integrated and consistent approach to their child's care. Caregivers reported that different and often contradictory advice was given to them by professionals, and it was confusing to know what would be the best options to try with their particular child.

In particular, the school personnel's apparent lack of knowledge and awareness of RAD and its associated behaviors was identified by all the caregivers as particularly detrimental to the children's progress. Significant problems at school were present for each of the four children profiled in this study, and academic and behavioral issues at school were becoming increasingly evident as the children progressed through each grade level. The caregivers expressed a need for teacher education around RAD, and a greater understanding of the severity of their children's disorder and its impact on learning. In particular, caregivers indicated a desire to work cooperatively with teachers so that behavioral goals established in the home environment could also be part of the child's school program. Increased opportunities to communicate directly with teachers about their child's needs and incidents at home that might impact their child's day at school were also desired by the caregivers.

Continuity and a consistent approach from social workers was also identified as a need for caregivers, as supports for their child could change dramatically depending on the social worker assigned to their child. It was reported that turnover with social workers was high, and each time a family received a new case manager, the caregivers stated that they had to educate the new social worker and explain their child's needs all over again. This situation created anxiety for the foster parents, as some reported negative experiences dealing with Children's Services and having to repeatedly "break in" new workers.

Support from physicians was also identified as important for the integrated treatment of the children in this study. Medication can address some of the physical and neurological underpinnings of the behaviors of a child diagnosed with RAD, and all the caregivers acknowledged the importance of having a family doctor or psychiatrist who knew their child and could monitor their child's medication needs.

With respect to plans for follow-up care for the children, at the time of the focus group, the caregivers expressed that they "didn't know what to do" with their child after the RAD group ended. Three of the four caregivers expressed the desire for the RAD group to continue for more sessions, and all of the caregivers wanted information on resources and supports they could access following the completion of the group. The group therapists held individual sessions with each caregiver to discuss their child's needs for additional therapy; however, the caregivers reported concerns about the availability of treatment. One caregiver expressed the fear that her child would lose the gains she had made during the group if they could not continue with treatment. Issues around Children's Services funding for ongoing treatment were brought up by another caregiver, and anxiety about limited resources and therapeutic options for children with severe needs was expressed by all the caregivers. Resources for parenting and the continued need for personal support in parenting a child diagnosed with RAD were also identified as concerns after the group had finished. Overall, post-group treatment planning was clearly identified as an important part of the group process.

Chapter Summary

In this chapter the caregiver's role in their foster child's treatment for RAD was investigated. The caregivers reported that through participation in the RAD group they expected to learn parenting skills to manage their child's difficult behavior, and receive emotional support from the group therapist and other parents attending treatment. The caregivers also expected that their child's specific behavioral concerns would be addressed and improved through treatment. The caregivers reported that through participation in the group, their knowledge of RAD increased. This in turn, changed the way they interacted with their children, and the child's behavior subsequently improved. With respect to receiving emotional support through attending the group, the caregivers reported that they would like more time to give and receive support during the treatment program.

The caregivers' great need for emotional support was discussed and identified by all the caregivers as an area that the RAD treatment program could be improved. Suggestions included more group time for support activities and additional group sessions over a longer period to facilitate parent contact and support. Other suggestions for changes to the group format centered on the assigned homework activities, particularly the one-on-one daily play time for caregivers and their child. Parents felt the activities in the play kit recommended by the treatment program were not ideal for their individual child, and some caregivers chose other activities to use when spending time with their child.

Challenges identified by the caregivers in parenting their child included coping with their child's unusual and extreme behaviors, nurturing and maintaining their own personal relationships, and difficulty coordinating and working with the many professionals involved with their child's care.

Chapter 6

DISCUSSION OF THE TREATMENT APPROACH FOR RAD

A summary of this study is followed by a discussion of the study's findings, the limitations of the treatment and the study, and suggestions for future research.

Summary of the Evaluative Case Study

This study included four children diagnosed with RAD who had participated in a treatment group with their caregivers. The objectives of the study were to describe the children's response to the treatment, and the role of the caregiver in the child's treatment.

Issues related to the child in RAD Treatment were investigated. The child's context for treatment was explored from the perspective of the child's relationship history, the child's main presenting problems, and any underlying medical concerns and co-morbid psychological conditions. Given that this treatment was designed specifically to treat RAD, it is important to note that the behavioral presentation of the children in this study was consistent with the description of RAD that appears in the literature.

All of the children demonstrated behaviors that are hallmarks of the RAD diagnosis. For example, the children displayed problems with personal boundaries and indiscriminate sociability with adults. They also demonstrated "frozen watchfulness" in anxiety producing situations, and experienced dissociative episodes related to past trauma. Other behaviors commonly associated with the RAD diagnosis were demonstrated by the children including gorging and hoarding food, ritualistic and self-stimulating behavior such as rocking, chanting and head-banging, depression and anxiety, and inappropriate behavior with other children. All four children had experienced significant trauma and abuse, and had histories of disrupted and neglectful relationships with their biological parents.

Given the breadth and severity of the children's presenting problems, coupled with their histories of long-term abuse and neglect, the children in this study could be considered difficult candidates for therapy. The development of reasonable goals for treatment is important for children with RAD, as their treatment needs are likely long-term and comprehensive. It is necessary to clarify for participants the limits of treatment and what can be realistically expected from a short-term treatment program. For example, given the children's background, improvement in one or two areas may be considered a success.

Within the child's context or starting point for treatment, the child's response to the treatment intervention in this study was discussed. The child's play behavior in the group and in the individual play sessions formed part of this discussion. Three of the children demonstrated shifts in play behavior toward more age-appropriate activities and their play reflected more positive themes. One child did not complete an individual play session following the group, and demonstrated very little evolution in play activity over the course of the group. However, even the child that did not demonstrate improvements in play did make progress. All four caregivers noted improvements in their relationship with their children, their children's behavior, and their children's ability to interact with family members.

The caregiver's role in treatment was also examined. Their expectations of the group included learning new parenting strategies to address their child's behavior problems, improvement in their child's behavior, and support for their own emotional needs in parenting a child with RAD. Caregivers reported that they had learned more about RAD, and had applied their knowledge to their interactions with their child. The children had responded positively to their caregivers new parenting techniques and their behavior had subsequently improved.

Although the caregivers gave positive reviews of the RAD treatment overall, they all indicated that they would have liked greater opportunity to interact with other parents, and give and receive a greater level of emotional support. Caregivers described numerous challenges that they faced in parenting their child with RAD, in particular their ability to cope with their child's severe and unusual behaviors and the impact this had on their personal relationships. Difficulty coordinating the professionals involved in their child's treatment was also identified as a challenge for these caregivers.

Discussion of the Treatment Approach

The following discussion is related to the literature presented in Chapter 2, and will examine four main points that emerged from the investigation of this treatment approach for RAD: (a) stabilization of the child, (b) support for caregiver's participation, (c) social worker involvement with RAD treatment, and (d) agency variables in providing RAD treatment. The discussion will conclude with an examination of the limitations of this study and the treatment approach itself.

Stabilization of the Child in RAD Treatment

The model of intervention presented in this study included an emphasis on the stability of the child's placement and the primary role of the caregiver in creating an opportunity for the child to develop a safe attachment relationship. The quality of that relationship, and the stamina and capacity of the caregiver to remain committed to the child when faced with severe emotional and behavioral issues, did appear to affect the child's progress in the group. However, when assessing the stability of a child's home life it does not appear to be enough to simply consider their foster placement. As seen in this study, the children's contact with their biological family members also appeared to have a strong affect on the stability of their environment and consequently, their ability to benefit from the treatment. For example, in Jason's case, apparent ambivalence and fatigue on the part of his grandmother due to ongoing conflict with other biological relatives seemed to contribute to that family's withdrawal from the group. In Rachel's case, permanent termination of visitation with her biological parents' and extraordinary commitment and effort by her foster mother appeared to stabilize Rachel and reduce the frequency of some severe and disturbing behaviors.

Rachel's case and the others presented in this study highlighted an important consideration for children with RAD. Stabilization both within the foster placement and in terms of contact with biological family would seem to be optimal to give a child with RAD the best chance to develop positive functioning. Although the children's contact with their biological relatives is not generally a factor that can be directly influenced through treatment, it is an important issue that should be considered when engaging in treatment with children in this situation. The literature on stabilization of the child with RAD in foster care rarely discusses this issue, and the focus for stabilizing the child is the development of the relationship with the foster caregiver. This is still an essential component of a RAD treatment program, and was recognized in the design of the treatment in this study.

The treatment described in this study included a number of strategies designed to support and facilitate the development of a strong bond between the child and caregiver. The strengthening of the caregiver-child attachment relationship was thought to be critical not only for the child's behavioral and emotional well-being, but to help maintain the stability of the child's placement. One-on-one activities, education of the caregiver about RAD to increase their level of understanding of their child, and a focus on nurturing, flexible and responsive parenting techniques rather than a proscriptive approach supported the development of a positive relationship between child and caregiver in this treatment. Each caregiver that participated in the treatment reported positive changes in their ability to relate and respond to their child's needs. This in turn appeared to decrease the frequency and intensity of the child's negative behavior. These changes would likely contribute to the continuing stability of the child's placement with the caregiver, and increase the likelihood of further positive progress.

Support for Caregiver's Participating in RAD Treatment

Overall, research has shown that it is not only desirable but critical for caregivers to participate in the mental health treatment of their children. To accomplish this goal, the literature in this area suggests that it is important for mental health professionals to develop collaborative relationships with caregivers that convey the message that caregivers' participation is valued and critical to their child's progress. This study confirms that view as all four caregivers described a need for greater support and understanding from the social workers, teachers, and other professionals involved with their child. Some had reported feeling blamed for their child's problems, and indicated that there appeared to be a lack of knowledge about their child's disorder even among mental health professionals. It was reported that the magnitude of the task each caregiver had taken on when agreeing to parent their RAD child was not recognized or appreciated by those involved with their child's case.

The treatment described in this study included a caregiver education and support component. Feedback from the caregivers who participated indicated that their knowledge of RAD increased, and they learned some useful skills for managing their child's behavior. However, the caregivers indicated that their need for emotional support and connection with other caregivers of RAD children was not met, and they desired greater opportunities to interact with the other caregivers. In addition, caregivers expressed frustration when dealing with multiple therapists, physicians, and social workers, and articulated a need for a simpler, less confusing intake process and treatment plan.

To address the above issues, the difficult and unique emotional challenges present in parenting an adoptive or foster child with RAD should be acknowledged and reflected in the design of intervention programs. Ensuring that professionals involved with a RAD child have a good understanding of their diagnosis and prognosis for treatment may help avoid situations where the foster parent is blamed for the child's on-going difficulties. The inclusion of caregiver support or caregiver therapy in a treatment program designed for children diagnosed with RAD is desirable to maintain caregivers' wellbeing and ensure that they have the emotional resources to meet the needs of their child. Assistance in finding appropriate respite care or substitute caregivers would also enable caregivers to spend time with their partners and other family members and friends. It is apparent that parenting a child with RAD is an ongoing challenge, requiring long term emotional, mental, and physical commitment. Caregivers are in need of a commensurate level of support and understanding, and to be effective, treatment programs must address that need.

Social Worker Involvement with RAD Treatment

Given that children participating in RAD treatment are usually in foster care placements, the involvement of their Children's Services social worker in the treatment plan appears to be vital. In the present study, feedback from the children's caregivers highlighted some issues related to their interaction with the Social Workers managing their child's case, and the Children's Services agency. In general, the children had involvement with several different Children's Services Social Workers and Case Managers, and turnover in these positions appeared to be high. The caregivers indicated that this was a particular problem for them, as knowledge of this disorder appeared to vary greatly among Children's Services staff. Caregivers stated that each time their child was assigned a new Social Worker they needed to educate the worker about RAD, as well as orient them to their child's specific needs. One caregiver stated that each time there was a change in her child's Social Worker any plans for support or intervention were put on hold. This was usually done because new social workers did not understand why so many resources and supports were in place for this child until they were able to familiarize themselves with RAD and the high needs that accompany this diagnosis.

The treatment presented in this study included opportunities for the child's social worker to attend parent meetings, and be an active part of the intake and discharge planning sessions. In this way, treatment group therapists were able to communicate directly with Children's Services staff, and discussions about the child's needs and progress in treatment were facilitated. Two of the children described in this study experienced a change in social worker during the time of the group, and inclusion of the new case worker in meetings whenever possible appeared to help orient the new worker to the child's specific needs for treatment and support. Even so, difficulties with transition planning were identified by caregivers as resource limitations appeared to influence decisions made by the children's social workers regarding continued therapy and follow-up care after the RAD group.

Given that the treatment program described in this study was provided by a funded mental health agency, it would be difficult to address the issue of social worker turnover directly. However, the social worker represents an important piece of a coordinated treatment program as they are uniquely placed to support the caregiver-child relationship, and to facilitate access to treatment for the child and respite and support for the caregiver. Therefore, involvement of the social worker in therapeutic programs may provide additional avenues for communication between professionals and caregivers, and address some of the problems associated with changes in case workers.

Agency Variables in Providing RAD Treatment

In the present study, a treatment model was developed based on literature for best practice in children's mental health treatment, and incorporated a relationship and strength-based approach to developing specific attachment behavior. The therapists' in the program were highly trained and experienced in working with children with mental health issues. Based on feedback from the caregivers who participated in the group, greater flexibility within the program for the therapists to respond to, and accommodate, individual needs was desired. Unfortunately, variables related to agency resources and staffing limited the amount of time available to address each family's needs individually.

Given that mental health treatments are often limited by the resources available at the host agency, creative and flexible approaches to supporting children with RAD must be employed. The nature of the disorder presents long term and challenging issues for treatment and the unique symptoms that children demonstrate indicate a need for individual intervention. However, in the current study the group component appeared to offer both the caregivers and the children an opportunity to normalize their experiences, receive social support, and interact socially. The children in particular appeared to benefit from the group environment, as they had a forum to practice their social skills and express emotion in a safe place. Overall, the model in the current study appeared to contain successful elements such as the caregiver-child interaction component and the children's play therapy activities. However, the treatment may have been enriched by additional resources to address individual child and caregiver concerns, or offer additional sessions to provide more emotional support to caregivers.

Limitations of the Treatment Approach for RAD

The treatment described in this study had a number of limitations including the length of the treatment, the type of homework exercises required of participants, and the lack of liaison with the children's schools. These limitations are discussed further below.

Length of Treatment

The literature suggests that long-term treatment and support is the most effective intervention for children with RAD. However, like the present study, very few research projects have employed a longitudinal design. The original proposal for this treatment recognized the need for long-term intervention and follow-up for children with RAD, and proposed a program of 20 group sessions with regularly scheduled follow-up sessions at three, six, and 12 months post-group. However, agency resources and other workload demands for the group therapists shaped the length and pace of the group and only 12 weekly sessions were held. The effects of a long-term treatment program, or at the very least, follow-up with families over an extended period, would help determine the effects of treatment over time and the optimal length of treatment for children with RAD.

Homework Exercises

The caregivers all noted that the homework exercises required of them, such as using the homework play kit for 15 minutes per day, were not suitable. Issues included the cost of the homework play kit, the developmental level of the activities, and the time required to perform the activities. However, the caregivers did report that the children had a very positive response to spending one-on-one time with them. The caregivers had chosen not to follow the prescribed homework, but had instead substituted more individualized and age-appropriate activities suitable for each child. Some caregivers also chose to spend a full day each week with their child, rather than performing daily 15-minute play sessions. This feedback would be important to incorporate into future treatment programs, as although the homework requirement was the most disliked component of the group, the time spent with the children at home appeared to have a powerful impact on their progress in the treatment.

Liaison with Schools

The management of a child with RAD in a classroom environment usually presents a number of challenges. As described in this study, children diagnosed with RAD display behavioral problems, but may also have delays in speech and language, problems with fine and gross motor functioning, and deficits in attention and the ability to focus. These issues present serious obstacles to the child's ability to learn and develop academic skills. In addition, the deficits in social relatedness that are present in the child's family relationships, are carried into the school environment and can affect how the child interacts with the teacher and other children.

Issues at school were identified as one of the foremost concerns for each of the caregivers in this study. All the caregivers expressed a high level of anxiety around their child's lack of academic progress, and they were frustrated with dealing with their children's schools. The caregivers reported that their children's teachers appeared to know very little about RAD, and attempts to share information with teachers or administrators had not always been welcomed. This is consistent with descriptions of caregivers' dealings with schools in the literature (Rosenweig, Brennan, & Ogilvie, 2002).

Geddes (2005) recommended that developing teachers' understanding of the behaviors that are associated with attachment disturbances may improve their ability to respond to such children in the classroom. One caregiver reported that proactive strategies and school-wide awareness of her child's needs had greatly improved her child's behavior at school. Similarly, developing teachers' and administrators' understanding and knowledge of RAD would likely be helpful to support children with this diagnosis in the school system. Proactive intervention and school-wide awareness of a child's needs, in addition to specific behavior management plans, and ideally, small group environments appear to allow children with RAD the best opportunity to participate in school activities.

Suggestions for Further Research

The following suggestions for further research emerged from the issues and information provided by this case study.

Caregiver Stress

Caregivers in this study reported that coping with the extreme behavioral and emotional needs of their children created a great deal of personal and family stress. The ability of the caregiver to remain physically and emotionally healthy while under such stress appears to be essential to maintaining a stable foster placement. Investigating the type, intensity, and frequency of support or respite that may reduce this stress would be useful in designing future interventions.

Collaboration and Organizational Cooperation

It became obvious during this study that organizations and agencies providing services to a child must be prepared to work together and collaborate to best serve the child. This did not always happen, and it was not clear what factors prevented the therapists, doctors, and other professionals involved with a child from communicating with each other. The ways in which service delivery models, treatment philosophies of different disciplines, and limits on time and financial resources affect the ability of professionals to provide integrated, collaborative treatment would be pertinent to consider in future research on treatment in a real-world setting.

Theoretical Basis of the Diagnosis

Issues surrounding the accurate diagnosis of RAD suggest the importance of further research on the theoretical basis of the diagnosis. The relationship between the theoretical construct of attachment, attachment styles, and the clinical application of the diagnosis of RAD has yet to be defined. Refinements of the specific diagnostic criteria of RAD could be driven by such theoretical work. Alternatively, continued research on the accuracy of the RAD diagnosis in applied clinical settings could inform theory on attachment based disorders.

Development of a RAD Assessment Tool or Battery

There are numerous tools and checklists used to evaluate attachment behaviors (Sheperis et al., 2003). However, the complex presentation that accompanies RAD is not easily captured by such checklists. Sheperis, et al. (2003) suggested that a comprehensive battery should be developed to aid in the assessment and diagnosis of RAD. Research to develop and refine an assessment tool or comprehensive diagnostic battery for RAD would contribute to the consistent application of the diagnosis.

Treatment of RAD children in a Biological Family Environment

The majority of the treatment programs for RAD that are described in the literature examine intervention for children who have been removed from their biological families. By definition, children diagnosed with RAD have suffered abuse or neglect perpetrated by their caregivers. Therefore, many children receive intervention in a foster home. In the present study, children diagnosed with RAD who were living with their biological parents were excluded from participating in the treatment group. This was done to avoid the difficult family dynamics and potential harm to the child that might occur during treatment while still living with their biological parents. However, there are children diagnosed with RAD who are in a position to receive treatment while still living with their biological family. The type of treatment and the characteristics of a family that may be conducive to an intervention for children in biological family situations warrants investigation.

Examination of the Effects of RAD on Children's Academic Development

For the children in the present study, there were high levels of concern regarding their progress at school. The relationship between RAD and a child's academic development appears to be a largely neglected area for research. Given the high levels of behavioral problems that accompany a diagnosis of RAD, specific issues with learning can be overlooked. Do the academic problems often seen in children with RAD develop as a secondary issue resulting from the negative behaviors they display, or are issues with learning an independent symptom that is directly associated with RAD? Answers to these questions may inform the teaching and learning strategies employed for children with RAD.

Concluding Remarks

Providing an effective intervention for children diagnosed with RAD requires a commitment from the caregivers, social workers and social services, therapists and mental health agencies, schools and teachers, and most importantly, the children themselves. Based on the participants' experiences in this study and reports in the literature, an effective intervention is one that promotes collaboration and communication among professionals and therapists, is supportive and validating for the caregiver, and is focused on the development of relationship stability and physical security for the child. In this study, it became clear that the professionals working with the children- the social workers, therapists, and other professionals- may have underestimated the breadth and severity of the children's problems. Establishing a realistic vision for the child's progress in treatment was attempted through caregiver education and communication among therapists, physicians, and social workers. With greater understanding of the issues that children diagnosed with RAD may present, a coordinated and effective individualized treatment plan is possible.

Given that RAD may affect many domains of functioning, including the physical, emotional, medical, academic, and social abilities of the child, caregivers assume a Herculean task when they commit to parenting a child with RAD. The literature and the experiences of the families in this study indicate that the success or failure of RAD treatment may lie in the commitment and abilities of the caregiver. Therefore, a vital component of a RAD treatment program is support for the caregivers. Maintaining the caregivers' stamina and commitment, and developing their skills in managing the difficult behaviors that are associated with RAD are possibly the most important goals of an intervention for RAD.

Overall, an approach grounded in the belief that children have the potential to develop positively in the face of significant trauma appears to be an important value for those working with children with RAD. The information collected in this study suggested that the children involved were able to make behavioral gains through participation in the treatment program, and the caregivers described positive changes in their relationships with their children. Several issues emerged that appeared to be important for caregivers in carrying out their role in the treatment process, most particularly, increased levels of individual support in caring for their children. As this study attempted only to describe children and caregivers' involvement in a RAD treatment program, there is much that is incomplete and much that needs further research. Continued studies of treatment options for children with RAD will increase the knowledge and ability of mental health professionals to meet their significant needs, and those of their families.

REFERENCES

Achenbach, T. M. (1991). Manual for the Child Behavior Checklist/ 4-18 and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry.

Ainsworth, M. D. S. (1979). Infant-mother attachment. American Psychologist, 34(10), 932 - 937.

Ainsworth, M. D. S. (1989). Attachments beyond infancy. American Psychologist, 44, 709 - 716.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A study of the strange situation. Hillsdale, NJ: Lawrence Erlbaum.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th Ed, text revision). Washington, DC: American Psychiatric Association.

Association for Treatment and Training in the Attachment of Children (ATTACH). (2000). What is Attachment? (Available from ATTACH, P. O. Box 665, Annandale. VA, 22003).

Bandura, A. (1997). Self-efficacy: The exercise of control.

Berger, S. P. (2003). International adoption: A four-year-old child with unusual behaviors adopted at six months of age. Journal of Developmental and Behavioral Pediatrics, 24(1), 63 – 69.

Boris, N. W. (2003). Attachment, aggression and holding: A cautionary tale.

Attachment & Human Development, 5(3), 245-247.

Bowlby, J. (1969). Attachment and loss: Volume 1, attachment. New York: Basic Books.

Bowlby, J. (1979). The making and breaking of affectional bonds. London: Tavistock Publications.

Bradford, E. & Lyddon, W. J. (1994). Assessing adolescent and adult attachment. Journal of Counselling and Development, 73, 215 - 219.

Byrne, J. (2003). Referral biases and diagnostic dilemmas. Attachment and Human Development, 5, 249 -253.

Cassidy, J. (1999). The nature of the child's ties. In J. Cassidy & P. R. Shaver (Eds.). Handbook of attachment: Theory, research, and clinical applications. New York: The Guilford Press.

Cassidy, J., & Shaver, P. R. (1999). Handbook of attachment: Theory, research, and clinical applications. New York: The Guilford Press.

Chazen, S. E. (2000). Using the Children's Play Therapy Instrument (CPTI) to measure the development of play in simultaneous treatment: A case study. Infant Mental Health Journal, 21(3), 211 – 221.

Chazen, S. E., & Wolf, J. (in press). Using the Children's Play Therapy Instrument to measure change in psychotherapy: The conflicted player. Journal of Infant and Child &

Adolescent Psychotherapy.

Cicchetti, D. (2007). Intervention and policy implications of research on neurobiological functioning in maltreated children. In L. J. Aber, S. J. Bishop-Josef, S. M. Jones, K. T. McLearn, & D. A. Phillips, (Eds). Child development and social policy: Knowledge for action. (p. 167-184). Washington, DC, US: American Psychological Association.

Cicchetti, D., Cummings, E. M., Greenberg, M. T., & Marvin, R. S. (1990). An organizational perspective on attachment beyond infancy: Implications for theory, measurement, and research. In M. T. Greenberg, M., D. Cicchetti, & E. M. Cummings (Eds). Attachment in the preschool years: Theory, research, and intervention. (p. 3-49). Chicago, IL, US: University of Chicago Press.

Cole, P. M., Michel, M. K., & O'Donnell Teti, L. (1994). The development of emotion regulation and dysregulation: A clinical perspective. Monographs of the Society for Research in Child Development, 59, 73 – 100.

Cronbach, L. J. (1975). Five decades of public controversy over mental testing. American Psychologist, 30(1), 1-14.

Delaney, R. J. (1998). Fostering changes: Treating attachment-disordered foster children (2nd Ed.). Oklahoma City, OK: Wood 'N' Barnes Publishing.

Dey, E. L., & Astin, A. W. (1993). Statistical alternatives for studying college student retention: A comparative analysis of logit, probit, and linear regression. Research in Higher Education, 34(5), 569-81.

Dozier, M. (2003). Attachment-based treatment for vulnerable children. Attachment & Human Development, 5(3), 253-257.

Dozier, M., Albus, K., Fisher, P. A., & Sepulveda, S. (2002). Interventions for foster parents: Implications for developmental theory. Development and Psychopathology, 14(4), 843-860.

Fall, M., Balvanz, J., Johnson, L., & Nelson, L. (1999). A play therapy intervention and its relationship to self-efficacy and learning behaviors. Professional School Counseling, 2(3), 194 – 204.

Earnest, L. L. (2002). Long-term outcomes of early childhood mental health services. Dissertation Abstracts International: Section B: The Sciences and Engineering, 63(6-B, 3005.

Fine, M., & Gardner, A. (1994). Collaboration consultation with families with special needs: Why bother? Journal of Educational and Psychological Consultation, 5, 283 – 308.

Frick-Helms, S. B. (1997). "Boys cry better than girls": Play therapy behaviors of children residing in a shelter for battered women. International Journal of Play Therapy, 6(1), 73 – 91.

Geddes, H. (2005). Attachment and Learning. Part II: The Learning Profile of the Avoidant and Disorganized Attachment Patterns. Thousand Oaks, CA: Sage Publications.

Gil, E. (1991). The healing power of play. New York: Guilford Press.

Glaser, D. (2000). Child abuse and neglect and the brain--A review. Journal of Child Psychology and Psychiatry, 41(1) Jan 2000, 97-116.

Greenberg, M. T. [Ed], Cicchetti, D. [Ed], & Cummings, E. M. (1990). Attachment in the preschool years: Theory, research, and intervention. The John D. and Catherine T. MacArthur Foundation series on mental health and development. Chicago, IL, US: University of Chicago Press.

Greenwald, R., & Rubin, A. (1999). Brief assessment of children's post-traumatic symptoms: Development and preliminary validation of parent and child scales. Research on Social Work Practice, 9, 61 – 75.

Guba, E. G., & Lincoln, Y.S. (1981). Effective evaluation: Improving the results through responsive and naturalistic approaches. San Francisco, CA: Jossey Bass.

Guba, E. G., & Lincoln, Y.S. (1985). Naturalistic Inquiry. Beverly Hills, CA: Sage Publications.

Hanson, R. F., & Spratt, E. G. (2000). Reactive attachment disorder: What we know about the disorder and implications for treatment. Child Maltreatment, 5(2), 137 – 145.

Heflinger, C. A., & Bickman, L. (1996). Family empowerment: A conceptual model for promoting parent-professional partnership. In C. A. Heflinger, & C. T. Nixon (Eds). Families and the mental health system for children and adolescents: Policy, services, and research. (p. 96-116). Thousand Oaks, CA, US: Sage Publications, Inc.

Holland, R., Moretti, M. M., Verlaan, V., & Peterson, S. (1993). Attachment and conduct disorder: The response program. Canadian Journal of Psychiatry, 38, 420- 431.

Howe, D., & Fearnley, S. (2003). Disorders of Attachment in Adopted and Fostered Children: Recognition and Treatment. Clinical Child Psychology and Psychiatry, 8(3), 369-387.

James, B. (1994). Handbook for treatment of attachment trauma problems in children. New York: Lexington Books.

Johnson, L., McLeod, E. H., & Fall, M. (1997). Play therapy with labelled children in the schools. Professional School Counseling, 1(1), 31 – 34.

Juffer, F., Hoksbergen, R. A. C., Riksen-Walraven, J. M., & Kohnstamm, G. A. (1997). Early intervention in adoptive families: Supporting maternal sensitive responsiveness, infant-mother attachment, and infant competence. Journal of Child Psychology and Psychiatry, 38(8), 1039-1050.

Kernberg, P. F., Chazen, S. E., & Normandin, L. (1998). The Children's Play Therapy Instrument (CPTI): Description, development, and reliability studies. Journal of Psychotherapy Practice and Research, 7(3), 196 - 207.

Kot, S., Landreth, G. L., & Giordano, M. (1998). Intensive child-centered play therapy with child witnesses of domestic violence. International Journal of Play Therapy, 7(2), 17 – 36.

Landreth, G. L. (1993). Child-centered play therapy. Elementary School Guidance &

Counseling, 28, 17 – 29.

Landreth, G. L., Homeyer, L. E., Glover, G., & Sweeney, D. S. (1996). Play therapy interventions with children's problems. Northvale, NJ: Jason Aronson, Inc.

Levy, T. M., & Orlano, M. (1998). Attachment, trauma, and healing. Washington, DC: CWLA Press.

Lous, A. M., de Wit, C. A. M., de Bruyn, E. E. J., Riksen-Walraven, J. M., & Rost, H. (2000). Depression and play in early childhood: Play behavior of depressed and nondepresed 3- to 6-year olds in various play situations. Journal of Emotional & Behavioral Disorders, 8(4), 249 – 260.

Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.). Handbook of attachment: Theory, research, and clinical applications. New York: The Guilford Press.

Macfie, J., Cicchetti, D., & Toth, S. L. (2001). The development of dissociation in maltreated preschool-aged children. Development and Psychopathology, 13(2), 233-254.

Masten, A.S., & Powell, J. L. (2003). A resilience framework for research, policy, and practice. In S. S. Luthar (Ed). Resilience and vulnerability: Adaptation in the context of childhood adversities. (p. 1-25). New York, NY, US: Cambridge University Press.

Meisels, S. J., & Shonkoff, J. P. (Eds.). (1990). Handbook of early childhood intervention. New York: Cambridge University Press.

Merriam, S. B. (2001). Qualitative research and case study applications in education. San Francisco, CA: Jossey-Bass.

Mishne, J. M. (2001). Psychological trauma in adolescence: Familial disillusionment and loss of personal identity. The American Journal of Psychoanalysis, 61(1), 63 – 83.

Mittledorf, W., Hendricks, S., & Landreth, G. L. (2001). Play therapy with autistic children. In G.L. Landreth (Ed.), Innovations in Play Therapy. Philadelphia: Brunner-Routledge.

Moretti, M. M., Holland, R., Peterson, S. (1994). Long term outcome of an attachment-bases program for conduct disorder. Canadian Journal of Psychiatry, 39, 360-369.

Mukaddes, N. M., Bilge, S., Alyanak, B., & Kora, M. E. (2000). Clinical characteristics and treatment responses in cases diagnosed as reactive attachment disorder. Child Psychiatry & Human Development, 30(4), 273-287.

Mukaddes, N. M., Kaynak, F. N., Kinali, G., Besikci, H., & Issever, H. (2004). Psychoeducational treatment of children with autism and reactive attachment disorder. Autism, 8(1), 101-109.

Norman, A. (1985). Keeping families together: The case for family preservation. New York: Edna MacConnell Clark Foundation.

Ocasio, J., & Knight, J. (2003). Rediscovery of trust: Erikson, Kaplan, and the myth of foster care. Opinion Papers, AN: ED475662.

O'Connor, T. G., & Rutter, M. (2000). Attachment disorder behavior following early severe deprivation: Extension and longitudinal follow-up. Journal of the American Academy of child and adolescent psychiatry, 39(6), 703 – 712.

O'Connor, T. G., & Zeanah, C. H. (2003). Current perspectives on attachment disorders: Rejoinder and synthesis. Attachment & Human Development, 5(3), 321-326.

O'Connor, T. G., & Zeanah, C. H. (2003). Introduction to the special issue: Current perspectives on assessment and treatment of attachment disorders. Attachment & Human Development, 5(3), 221-222.

O'Connor, Thomas G., & Zeanah, Charles H. (2003). Attachment disorders: Assessment strategies and treatment approaches. Attachment & Human Development, 5(3), 223-244.

Palermo, George B [Ed]. (2004). Adult antisocial behavior following childhood abuse: A new protective factor? International Journal of Offender Therapy and Comparative Criminology, 48(6), 635-637.

Phillips, R. D., & Landreth, G. L. (1998). Play therapists on play therapy: II. Clinical issues in play therapy. International Journal of Play Therapy, 7(1), 1-24.

Porter, B. (Unpublished). Porter Parental Acceptance Scale. Permission to use received from Dr. Blaine Porter, Brigham Young University.

Randolph, L. & Myeroff (1999). Does Attachment Therapy Work? Results of

Two Preliminary Studies. http://www.attachmentcenter.org/ranmyer.html

Reich, S., Bickman, L., & Heflinger, C. A. (2004). Covariates of Self-Efficacy: Caregiver Characteristics Related to Mental Health Services Self-Efficacy. Journal of Emotional and Behavioral Disorders, 12(2), 99-108.

Reynolds, C. R. & Kamphaus, R. W. (1992). Behavior Assessment System for Children (BASC). Circle Pines, MN:AGS Publishing.

Richters, M. M., Volkmar, F. R. (1994). Reactive attachment disorder of infancy or early childhood. Journal of American Academy of Child and Adolescent Psychiatry, 33(3), 328 - 332.

Rosenzweig, J. M., Brennan, E. M., & Ogilvie, A. M. (2002). Work-family fit: Voices of parents of children with emotional and behavioral disorders. Social Work, 47(4), 415-424.

Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal, 22(1-2), 7 – 66.

Schore, Allan N. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. Development and Psychopathology, 8(1), 59-87.

Sheperis, C. J., Doggett, A. R., Hoda, N. E., Blanchard, T., Renfro-Michel, E. L, Holdiness, S. H., & Schlagheck, R. (2003). The Development of an Assessment Protocol for Reactive Attachment Disorder. Journal of Mental Health Counseling, 25(4), 291-310.

Sheperis, C. J., Renfro-Michel, E. L., & Doggett, R. A. (2003). In-home treatment of reactive attachment disorder in a therapeutic foster care system: A case example. Journal of Mental Health Counseling, 25(1), 76 – 88.

Smyke, A. T., Dumitrescu, A., & Zeanah, C. H. (2002). Attachment disturbances in young children 1: The continuum of caretaking casualty. Child and Adolescent Psychiatry, 41(8), 972 – 982.

Southam-Gerow, M. A. (2004). Some Reasons that Mental Health Treatments Are Not Technologies: Toward Treatment Development and Adaptation Outside Labs. Clinical Psychology: Science and Practice, 11(2), 186-189.

Sroufe, A. L. (1995). Emotional development: The organization of emotional life in the early years. Cambridge: Cambridge University Press.

Stafford, B., Zeanah, C. H., & Scheeringa, M. (2003). Exploring psychopathology in early childhood: PTSD and attachment disorders in DC: 0-3 and DSM-IV. Infant Mental Health Journal, 24(4), 398-409.

Steinhauer, P. D. (1983). The management of children admitted to child welfare services in Ontario: A review and discussion of current problems and practices. Canadian Journal of Psychiatry, 29, 473 - 483.

Steinhauer, P. D. (1998, November). The recognition and management of attachment disorders. Presentation at Child and Adolescent Services Association, Edmonton, AB.

Stoff, D. M (Ed), & Cairns, R. B. (Ed). (1996). Aggression and violence: Genetic, neurobiological, and biosocial perspectives. Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

Swick, K. J., & Broadway, F. (1997). Parental efficacy and successful parent involvement. Journal of Instructional Psychology, 24(1), 69-75.

Taylor, R. J. (2002). Family unification with reactive attachment disorder children: A brief treatment. Contemporary Family Therapy, 24(3), 475 – 481.

Teicher, M. H., Anderson, S. L., Polcari, A. Anderson, C. M., & Navalta, C. P. (2002). Developmental Neurobiology of childhood stress and trauma. Psychiatric Clinics of North America, 25, 397 – 426.

Thompson, R. A. (2000). The legacy of early attachments. Child Development, 71(1), 145 – 152.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2001). Child Maltreatment 1999. Washington: U.S. Government Printing Office.

Wilson, S. L. (2001). Attachment disorders: Review and current status. Journal of Psychology, 135(1), 37 - 52.

Wolfe, V. V., Gentile, C., Michienzi, T., Sas, L., & Wolfe, D. A. (1991). The children's impact of traumatic events scale: A measure of post-sexual abuse PTSD symptoms. Behavioral Assessment, 13, 359-383.

Yin, R. K. (1994). Discovering the future of the case study method in evaluation research. Evaluation Practice, 15(3), 283-90.

Zeanah, C. H. (2000). Disturbances of attachment in young children adopted from institutions. Journal of Developmental & Behavioral Pediatrics, 21(3), 230-236.

Zeanah, C. H., Jr., & Boris, N. W. (2000). Disturbances and disorders of attachment in early childhood. In C. H. Zeanah Jr. (Ed.), Handbook of Infant Mental Health (2^{nd} Ed.). New York: The Guilford Press.

Zeanah, C. H., Jr., Mammen, O. K., & Lieberman, A. F. (1993). Disorders of attachment. In C.H. Zeanah, Jr. (Ed.), Handbook of infant mental health. (pp. 332 - 360). New York: The Guilford Press.

Zeanah, C. H., Jr., Scheeringa, M., Boris, N., Heller, S. S., & Smyke, A. (2004). Reactive attachment disorder in maltreated toddlers. Child Abuse & Neglect, 28(8), 877 – 888.

Zeanah, C. H., Smyke, A. T., & Dumitrescu, A. (2002). Attachment disturbances in young children 2: Indiscriminate behavior and institutional care. Child and Adolescent Psychiatry, 41(8), 983 – 989.

Appendix A: Caregiver Interview Questions

The pre- and post- treatment interviews were loosely shaped by the questions below, allowing the interviewer to follow the caregiver's lead and shifting the focus according to the concerns raised by the caregiver. The post-treatment interview included additional focus on changes in the child's behavior at home and at school, changes in parenting, and any changes noted in social interaction with the caregiver, family members, and other children.

Demographic and historical information was also confirmed at the time of the pre-group interview.

Topic: Child's Needs

1. What are the main difficulties that your child is experiencing at this time:
    a. At home
    b. At school
    c. In the community

2. Regarding your child's control of their own behavior:
    a. Is your child able to verbalize his/her needs?
    b. Is your child able to set physical/emotional boundaries for himself
    c. How does your child express anger and frustration?
    d. How frequently does your child get angry or frustrated?
    e. How intense are the expressions of anger?
    f. What makes your child angry (precursors/events etc.)?

3. Interaction with caregiver:
    a. When does your child seek comfort from you (ie. Goes to you when upset)?
    b. Is your child able to make/maintain eye contact with you?
    c. In what situations are you able to calm your child when they become upset?

Topic: Caregiver Needs

1. Expectations of the Group
    a. What do you hope will happen with you and your child as a result of attending the RAD Group?
    b. What kind of content would you like to see covered in the group?
    c. Do you feel you understand your child's diagnosis and treatment plan?

2. Caregiver Support
    a. What kinds of support do you have for parenting your child?

   - b. At this time, do you have adequate support to parent your child?

3. Feelings for the child
   - a. Describe how you feel about your child.
   - b. How do you feel when you are away from your child?

4. Place of the child in the family
   - a. What length of time do you feel your child will be living with your family?
   - b. How do the other members of your family feel about your child?
   - c. What hopes do you have for your child's future?

Appendix B: Caregiver and Social Worker Letters of Informed Consent

Developmental Play Therapy Group for Children with Attachment Disorder (RAD Group)

Caregiver Information Letter

Title of Project: Developmental Play Therapy Group for Children with Attachment Disorder

Principal Investigators:

Petrina Hough	Educational Psychology, University of Alberta and Child and Adolescent Services Association	415-9659

Co-Investigators:

Dr. Liana Urichuk	Child and Adolescent Services Association	430-2667

The Reactive Attachment Disorder (RAD) group is a unique group that is offered at Child and Adolescent Services Association (CASA) in Edmonton. The goal of the RAD group is to promote a positive attachment between child and caregiver. This study is looking at experiences of caregivers and children who join the RAD group. The study will look at the benefits of different types of therapy offered in the group. The results may help us to offer better treatments for children and their families in the future. The results from this study will also be used as part of a graduate student dissertation for the Department of Educational Psychology at the University of Alberta.

The RAD group has three parts. These include: 1) a caregiver group part; 2) a children group part; and 3) a caregiver-child interaction part. The goal of the caregiver group is to teach caregivers about RAD. The caregivers may also talk about things their child has done or about their own feelings. The goal of the children's group is to let the children work through emotionally damaging experiences during safe play sessions. The child may play at several stations in the play therapy room, including:

1. An art centre.
2. A domestic nurturing centre.
3. A communication and language centre.
4. A water and sand centre.
5. A building centre.
6. A gross motor control centre.
7. A comfort centre.
8. A dress-up centre.

The goal of the caregiver-child interaction part is to use play activities to help the child and caregiver build a positive relationship. The focus will be on developing appropriate touch, eye contact, smile and positive mood, and on fulfilling needs. Homework assignments will be assigned so participants can practice during the week.

We are looking for children to participate in the RAD group who:

1. Have been diagnosed with RAD.
2. Are between 5 and 8 years old.
3. Are clients at CASA.
4. Are in stable and safe foster care homes.
5. Have a caregiver who will go to the caregiver group.

If you and your child choose to participate in the RAD group, you will go to regularly scheduled groups for 12 weeks. These groups will be 90 minutes long every week. You will also attend a 90-minute orientation before the first group session. During this orientation, you will be asked to answer some surveys. The surveys will ask about your child and about your feelings. The surveys will take about 60 minutes to answer. You will be asked to repeat these same surveys at the last RAD group. You will also be asked to answer a short list of questions after every visit. The questions will ask you about your child's behaviors and attitude. The questions will take about 5 minutes to answer.

Your child will be asked to come to one session before the RAD group starts and one session after the group ends. During these extra sessions, we will videotape your child while they are playing. This will help us to measure changes that may have occurred in your child. An appointment will be made for these extra sessions. These sessions will take about 30 minutes.

Many types of therapy could help people feel better. The therapy you and your child get might make you feel better. However, you should be aware that there is a risk that by coming to this group, your child may begin to acknowledge past experiences and relationships, and will need to deal with the emotions associated with traumatic events in the past. This process is important, but may be accompanied by a temporary regression in behaviour, temper tantrums, or other expressions of emotion that may be difficult for you to cope with. In order to help decrease the risks, trained therapists will lead the groups and will provide support to the participants whenever it is needed. However, there may still be risks in this study that are hard to guess.

Your participation in the study is voluntary. You always have the right to refuse to participate in the study. You can also withdraw from the study at any time. If you choose not to participate in the study, your child will still receive therapy. The answers you give in the surveys will be kept strictly confidential. You will not be identified in any way. But, if there are questions in any of the forms we give you that you do not wish to answer, then you do not have to answer them.

Only members of the research team will see the information you give in the surveys. Your answers and your child's videotapes will be kept in a secure area for at least five years after they are completed. After that time, they will be destroyed.

Thank you for your participation.

If you have any questions, comments or concerns about this study, please call:

Ms. Petrina Hough
Clinical Intern, CASA
780-415-9659

Developmental Play Therapy Group for Children with Attachment Disorder (RAD Group)
Caregiver Consent Agreement

Title of Project: Developmental Play Therapy Group for Children with Attachment Disorder

Principal Investigators:		
Petrina Hough	Educational Psychology, University of Alberta and Child and Adolescent Services Association	415-9659
Co-Investigators:		
Dr. Liana Urichuk	Child and Adolescent Services Association	430-2667

Do you understand that you have been asked to be in a research study?	Yes	No
Have you received and read a copy of the attached information sheet?	Yes	No
Do you understand the benefits and risks involved if you take part in this research study?	Yes	No
Have you had a chance to ask questions and talk about this study?	Yes	No
Do you understand that do not have to participate in this study? You may withdraw from the study at any time. You do not have to give a reason and it will not affect your treatment.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will see your records?	Yes	No

This study was explained to me by: ______________________________

I agree to take part in this study, together with my child __________________________.
Child's Name

______________________________ ______________________ ___________
Signature of Research Participant   Printed Name   Date

______________________________ ______________________ ___________
Signature of Witness   Printed Name   Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

______________________________ ______________________ ___________
Signature of Investigator or Designee   Printed Name   Date

Developmental Play Therapy Group for Children with Attachment Disorder (RAD Group)

Legal Guardian Information Letter

Title of Project: Developmental Play Therapy Group for Children with Attachment Disorder

Principal Investigators:		
Petrina Hough	Educational Psychology, University of Alberta and Child and Adolescent Services Association	415-9659
Co-Investigators:		
Dr. Liana Urichuk	Child and Adolescent Services Association	430-2667

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The RAD group has three parts. These include: 1) a caregiver group part; 2) a children group part; and 3) a caregiver-child interaction part. The goal of the caregiver group is to teach caregivers about RAD. The caregivers may also talk about things their child has done or about their own feelings. The goal of the children's group is to let the children work through emotionally damaging experiences during safe play sessions. The child may play at several stations in the play therapy room, including:

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7. A comfort centre.
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The goal of the caregiver-child interaction part is to use play activities to help the child and caregiver build a positive relationship. The focus will be on developing appropriate touch, eye contact, smile and positive mood, and on fulfilling needs. Homework assignments will be assigned so participants can practice during the week.

We are looking for children to participate in the RAD group who:

1. Have been diagnosed with RAD.
2. Are between 5 and 8 years old.
3. Are clients at CASA.
4. Are in stable and safe foster care homes.
5. Have a caregiver who will go to the caregiver group.

If you agree to allow the child under your care to participate in the RAD group, the child and caregiver will go to regularly scheduled groups for 12 weeks. These groups will be 90 minutes long every week. You will also attend a 90-minute orientation before the first group session. During this orientation, the caregiver will be asked to answer some surveys. The surveys will ask about the child and about the caregivers feelings. The surveys will take about 60 minutes to answer. The caregiver will be asked to repeat these same surveys at the last RAD group. The caregivers will also be asked to answer a short list of questions after every visit. The questions will ask about the child's behaviors and attitude. The questions will take about 5 minutes to answer. During the orientation session, you and the caregiver will also have the opportunity to observe the children while they are in the play therapy room.

The child and caregiver will be asked to come to one session before the RAD group starts and one session after the group ends. During these extra sessions, we will videotape the child while they are playing. This will help us to measure changes that may have occurred in the child. An appointment will be made for these extra sessions. These sessions will take about 30 minutes.

Many types of therapy could help people feel better. The therapy the caregiver and child get might make them feel better. However, you should be aware that there is a risk that by coming to this group, the child may begin to acknowledge past experiences and relationships, and will need to deal with the emotions associated with traumatic events in the past. This process is important, but may be accompanied by a temporary regression in behaviour, temper tantrums, or other expressions of emotion that may be difficult for the caregiver to cope with. In order to help decrease the risks, trained therapists will lead the groups and will provide support to the participants whenever it is needed. However, there may still be risks in this study that are hard to guess.

Participation in the study is voluntary. The caregiver and child always have the right to refuse to participate in the study. They can also withdraw from the study at any time. If they choose not to participate in the study, the caregiver and child will still receive therapy. The answers the caregivers give in the surveys will be kept strictly confidential. The caregiver and child will not be identified in any way. But, if there are questions in any of the forms we give that the caregiver does not wish to answer, then they do not have to answer them.

Only members of the research team will see the information given in the surveys. The answers and the child's videotapes will be kept in a secure area for at least five years after they are completed. After that time, they will be destroyed.

Thank you for your participation.

If you have any questions, comments or concerns about this study, please call:

Ms. Petrina Hough
Clinical Intern, CASA
780-415-9659

Developmental Play Therapy Group for Children with Attachment Disorder (RAD Group)
Legal GuardianConsent Agreement

Title of Project: Developmental Play Therapy Group for Children with Attachment Disorder

Principal Investigators:

Petrina Hough	Educational Psychology, University of Alberta and Child and Adolescent Services Association	415-9659

Co-Investigators:

Dr. Liana Urichuk	Child and Adolescent Services Association	430-2667

Do you understand that the child under your care has been asked to be in a research study?	Yes	No
Have you received and read a copy of the attached information sheet?	Yes	No
Do you understand the benefits and risks involved if the child participates in this research study?	Yes	No
Have you had a chance to ask questions and talk about this study?	Yes	No
Do you understand that the child does not have to participate in this study? You may withdraw the child from the study at any time. You do not have to give a reason and it will not affect the child's treatment.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will see the child's records?	Yes	No

This study was explained to me by: ______________________

I agree that ______________________ may take part in this study.
Child's Name

Signature of Legal Guardian	Printed Name	Date
Signature of Witness	Printed Name	Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees that the child may participate.

Signature of Investigator or Designee	Printed Name	Date

Appendix C: Study Instruments

PROPS

Mark how well each item describes your child *in the past week.* Circle the 0 if the item is *not true* or *rarely true* of the child. Circle the 1 if the item is *somewhat* or *sometimes true* of the child. Circle the 2 if the item is *very true* or *often true* of the child. Don't skip any, even if you're not sure.

0 = None
1 = Some
2 = Lots

1. Difficulty concentrating	0	1	2
2. Mood swings	0	1	2
3. Thinks of bad memories	0	1	2
4. Spaces out	0	1	2
5. Feels too guilty	0	1	2
6. Anxious	0	1	2
7. Irrational fears	0	1	2
8. Repeats the same game or activity	0	1	2
9. Clings to adults	0	1	2
10. Avoids former interests	0	1	2
11. Fights	0	1	2
12. Bossy with peers	0	1	2
13. Sad or depressed	0	1	2
14. Hyper-alert	0	1	2
15. Feels picked on	0	1	2
16. Gets in trouble	0	1	2
17. Worries	0	1	2
18. Fearful	0	1	2
19. Withdrawn	0	1	2
20. Nervous	0	1	2
21. Startles easily	0	1	2
22. Irritable	0	1	2
23. Quick temper	0	1	2
24. Argues	0	1	2
25. Secretive	0	1	2
26. Doesn't care anymore	0	1	2
27. Difficulty sleeping	0	1	2
28. Nightmares or bad dreams	0	1	2
29. Stomachaches	0	1	2
30. Headaches	0	1	2

PORTER PARENTAL ACCEPTANCE SCALE

We are trying to learn more about parent-child relationships. Please assist us by filing out this questionnaire as frankly and as carefully as possible. Your answers will be absolutely confidential. You have been asked to focus on only one child during this training...please think only of that child as you answer these questions. Please answer all questions. If you cannot give an exact answer, answer the best you can.

INFORMATION ABOUT YOUR CHILD

Many parents say that their feelings of affection toward or for their child varies with the child's behaviour and with circumstances. Please read each item carefully and place a check in the column which most nearly describes the degree of feeling of affection which you have for your child in that situation.

	Degree of Feeling of Affection				
Check One Column For Each Item Below	**Much more than usual.**	**A little more than usual.**	**The same.**	**A little less than usual.**	**Much less than usual.**
1. When my child is obedient.					
2. When my child is with me.					
3. When my child misbehaves in front of special guests.					
4. When my child expresses unsolicited affection. "You're the nicest mommy/daddy in the whole world."					
5. When my child is away from me.					
6. When my child shows off in public.					
7. When my child behaves according to my highest expectations.					
8. When my child expresses angry and hateful things to me.					
9. When my child does things I have hoped my child would not do.					
10. When we are doing things together.					

(Unpublished: Permission to use received from Dr. Blaine Porter, Brigham Young University).

Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action.

Read each statement carefully and then place a circle around the number in front of the one response which most nearly describes the feeling you usually have or the course of action you most generally take when your child says or does these things.

It is possible that you may find a few statements which describe a type of behaviour which you have not yet experienced with your child. In such cases, mark the response which most nearly describes how you think you would feel or what you think you would do.

Be sure that you answer every statement and mark only one response for each statement.

****

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet. it:
    1. Makes me feel annoyed.
    2. Makes me want to know more about what excites my child.
    3. Makes me feel like punishing my child.
    4. Makes me feel that I will be glad when my child is past this stage.
    5. Makes me feel like telling my child to stop.

12. When my child misbehaves while others in the group he/she is with are behaving well, I:
    1. See to it that my child behaves as the others.
    2. Tell my child it is important to behave well when he/she is in a group.
    3. Let my child alone if he/she isn't disturbing the others too much.
    4. Ask my child to tell me what he/she would like to do.
    5. Help my child find some activity that he/she can enjoy and at the same time not disturb the group.

13. When my child is unable to do something which I think is important for him/her, it:
    1. Makes me want to help my child find success in the things he/she can do.
    2. Makes me feel disappointed in my child.
    3. Makes me wish my child could do it.
    4. Makes me realize that my child can't do everything.
    5. Makes me want to know more about the things my child can do.

14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, it:
    1. Makes me realize that my child is growing up.
    2. Pleases me to see my child's interests widening to other people.
    3. Makes me feel resentful.
    4. Makes me feel that my child doesn't appreciate what I have done for him/her.
    5. Makes me wish my child liked me more.

15. When my child is faced with two or more choices and has to choose only one, I:

    1. Tell my child which choice to make and why.
    2. Think it through with my child.
    3. Point out the advantages and disadvantages of each, but let my child decide for him/herself.
    4. Tell my child that I am sure he/she can make a wise choice and help my child foresee the consequences.
    5. Make the decision for my child.

16. When my child makes decisions without consulting me, I:

    1. Punish my child for not consulting me.
    2. Encourage my child to make his/her own decisions if my child can foresee the consequences.
    3. Allow my child to make many of his/her own decisions.
    4. Suggest that we talk it over before my child make his/her decision.
    5. Tell my child he/she must consult me first before making a decision.

17. When my child kicks, hits, or knocks his/her things about, it:

    1. Makes me feel like telling my child to stop.
    2. Makes me feel like punishing my child.
    3. Pleases me that my child feels free to express him/herself.
    4. Makes me feel that I will be glad when he/she is past this stage.
    5. Makes me feel annoyed.

18. When my child is not interested in some of the usual activities of his/her age group, it:

    1. Makes me realize that each child is different.
    2. Makes me wish my child were interested in the same activities.
    3. Makes me feel disappointed in my child.
    4. Makes me want to help my child find ways to make the most of his/her interests.
    5. Makes me want to know more about the activities in which my child is interested.

19. When my child acts silly and giggly, I:

    1. Tell my child I know how he/she feels.
    2. Pay no attention to my child.
    3. Tell my child he/she shouldn't act that way.
    4. Make my child quit.
    5. Tell my child it is all right to feel that way, but help him/her find other ways of expressing him/herself.

20. When my child prefers to do things with his/her friends rather than with his/her family, I:

    1. Encourage my child to do things with his/her friends.
    2. Accept this as part of growing up.
    3. Plan special activities so that my child will want to be with the family.
    4. Try to minimize my child's associations with his/her friends.
    5. Make my child stay with the family.

21. When my child disagrees with me about something which I think is important, it:

    1. Makes me feel like punishing my child.
    2. Pleases me that my child feels free to express him/herself.
    3. Makes me feel like persuading my child that I am right.
    4. Makes me realize my child has ideas of his/her own.
    5. Makes me feel annoyed.

22. When my child misbehaves while others in the group my child is with are behaving well, it:

    1. Makes me realize that my child does not always behave as others in his/her group.
    2. Makes me feel embarrassed.
    3. Makes me want to help my child find the best ways to express his/her feelings.
    4. Makes me wish my child would behave like the others.
    5. Makes me want to know more about my child's feelings.

23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:

    1. Give my child something quiet to do.
    2. Tell my child that I wish he/she would stop.
    3. Make my child be quiet.
    4. Let my child tell me about what excites him/her.
    5. Send my child somewhere else.

24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:

    1. Try to minimize my child's association with that person.
    2. Let my child have such associations when I think he/she is ready for them.
    3. Do some special things for my child to remind him/her of how nice I am.
    4. Point out the weaknesses and faults of that other person.
    5. Encourage my child to create and maintain such associations.

25. When my child says angry and hateful things about me to my face, it:

    1. Makes me feel annoyed.
    2. Makes me feel that I will be glad when my child is past this stage.
    3. Pleases me that my child feels free to express him/herself.
    4. Makes me feel like punishing my child.
    5. Makes me feel like telling my child not to talk that way to me.

26. When my child shows a deep in interest in something I don't think is important, it:

    1. Makes me realize my child has interests of his/her own.
    2. Makes me want to help my child find ways to make the most of this interest.
    3. Makes me feel disappointed in my child.
    4. Makes me want to know more about my child's interests.
    5. Makes me wish my child were more interested in the things I think are important for him/her.

27. When my child is unable to do some things as well as others in his/her group, I:

    1. Tell my child he/she must try to do as well as the others.
    2. Encourage my child to keep trying.
    3. Tell my child that no one can do everything well.
    4. Call my child's attention to the things he/she does well.
    5. Help my child make the most of the activities which he/she can do.

28. When my child wants to do something which I am sure will lead to disappointment for him/her, I:

    1. Occasionally let my child carry such an activity to its conclusion.
    2. Don't let my child do it.
    3. Advise my child not to do it.
    4. Help my child with it in order to ease the disappointment.
    5. Point out what is likely to happen.

29. When my child acts silly and giggly, it:

    1. Makes me feel that I will be glad when my child is past this stage.
    2. Pleases me that my child feels free to express him/herself.
    3. Makes me feel like punishing my child.
    4. Makes me feel like telling my child to stop.
    5. Makes me feel annoyed.

30. When my child is faced with two or more choices and has to choose only one, it:

    1. Makes me feel that I should tell my child which choice to make and why.
    2. Makes me feel that I should point out the advantages and disadvantages.
    3. Makes me hope that I have prepared my child to choose wisely.
    4. Makes me want to encourage my child to make his/her own choice.
    5. Makes me want to make the decision for my child.

31. When my child is unable to do something which I think is important for my child, I:

    1. Tell my child he/she must do better.
    2. Help my child make the most of the things which he/she can do.
    3. Ask my child to tell me more about the things which he/she can do.
    4. Tell my child that no one can do everything.
    5. Encourage my child to keep trying.

32. When my child disagrees with me about something which I think is important, I:

    1. Tell my child he/she shouldn't disagree with me.
    2. Make my child quit.
    3. Listen to my child's side of the problem and change my mind if I am wrong.
    4. Tell my child maybe we can do it his/her way another time.
    5. Explain that I am doing what is best for him/her.

33. When my child is unable to do some things as well as others in his/her group, it:

    1. Makes me realize that my child can't be best in everything.
    2. Makes me wish my child could do well.
    3. Makes me feel embarrassed.
    4. Makes me want to help my child find success in the things he/she can do.
    5. Makes me want to know more about the things my child can do well.

34. When my child makes decisions without consulting me, it:

    1. Makes me hope that I have prepared my child adequately to make his/her decisions.
    2. Makes me wish my child would consult with me.
    3. Makes me feel disturbed.
    4. Makes me want to restrict my child's freedom.
    5. Pleases me to see that as my child grows he/she needs me less.

35. When my child says angry and hateful things about me to my face, I:

    1. Tell my child it is alright to feel that way, but help my child find other ways to express him/herself.
    2. Tell my child I know how he/she feels.
    3. Pay no attention to my child.
    4. Tell my child he/she shouldn't say such things to me.
    5. Make my child quit.

36. When my child kicks, hits, and knocks things about, I:

    1. Make my child quit.
    2. Tell my child it's alright to feel that way, but help my child find other ways of expressing him/herself.
    3. Tell my child he/she shouldn't do such things.
    4. Tell my child I know how he/she feels.
    5. Pay no attention to my child.

37. When my child prefers to do things with friends rather than with his/her family, it:

    1. Makes me wish my child would spend more time with us.
    2. Makes me feel resentful.
    3. Pleases me to see my child's interests widening to other people.
    4. Makes me feel my child doesn't appreciate us.
    5. Makes me realize that my child is growing up.

38. When my child wants to do something which I am sure will lead to disappointment for him/her, it:

    1. Makes me hope that I have prepared my child to meet disappointment.
    2. Makes me wish my child didn't have to meet unpleasant experiences.
    3. Makes me want to keep my child from doing it.
    4. Makes me realize that occasionally such experiences will be good for my child.
    5. Makes me want to postpone these experiences.

39. When my child is not interested in some of the usual activities of his/her age group, I:
    1. Try to help my child realize that it is important to be interested in the same things as others in his/her group.
    2. Call my child's attention to the activities in which he/she is interested.
    3. Tell my child it is alright if he/she isn't interested in the same things.
    4. See to it that my child does the same things as others in his/her group.
    5. Help my child find ways of making the most of his/her interests.

40. When my child shows a deep interest in something I don't think is important, I:
    1. Let my child go ahead with his/her interest.
    2. Ask my child to tell me more about this interest.
    3. Help my child find ways to make the most of this interest.
    4. Do everything I can to discourage my child's interest in it.
    5. Try to interest my child in more worthwhile things.

THANK YOU VERY MUCH FOR YOUR COOPERATION

/slk
porter.sca

Patient Name ______________________
File Number______________________

Parent-Child Dyadic Interaction Worksheet
Reactive Attachment Disorder Group

Eye Contact (Over a 2 minute period)

Fleeting vs. Sustained

Touch/Body Contact

Accept vs. Reject touch

Fleeting vs. Sustained

Close vs. Parallel

Comfort Level

Position of mom and child

Verbal Interaction

One-sided vs. Reciprocal

Working Cooperatively

Aggressive vs. Passive

Additional Comments

Midpoint Interview Questions

1. Solicit reactions to the group

    What has been your experience in the group so far?

2. What have you learned from the group?

3. How have you changed in your parenting since participation in the group?

    Relating to your child?
    Control of your child?
    View of the child's intentions?

4. How has your child changed?

    Positive changes?
    Decrease in problem behaviours?

5. How has your child changed in relating to you?

6. How has your child changed in relating to other members of your family (siblings, spouse)?

7. How has your child changed at school and with peers?

8. What content would you like to see covered for the rest of the group?

9. Suggestions for improvement/modification of group.