

**CHILDREN DIAGNOSED WITH ATTACHMENT DISORDER:
A QUALITATIVE STUDY OF THE PARENTAL EXPERIENCE**

By

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(ABSTRACT)

Parents of children who have been diagnosed with Reactive Attachment Disorder (RAD) often face a challenging dilemma. They are faced with parenting children who often respond from an orientation of feeling unloved and mistrustful of their caregivers. The purpose of this study was to develop a detailed description of the story of four such parents. A multi-case qualitative design and constructivist and coping theoretical frameworks guided the investigation. The constant comparative method of analysis was used to develop three core categories that described the subtitles of parent's experiences. Parent's quotes were used to further embellish the findings.

The findings include parent's experiences in recognizing RAD behavior, their response to this behavior, and advice and recommendations they would share with others dealing with this diagnosis. Parents described their child's behavior, resources and methods they used to cope, and had both encouraging and critical reflections of their experiences.

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CHAPTER I

INTRODUCTION

Statement of the Problem

Being the parent of a child diagnosed with attachment disorder can be extremely stressful (Pickle, 1994). These children do not learn to trust, and can be oppositional, angry, and often dangerous to themselves and others. They are unable to give and receive affection in a healthy way. They lack cause and effect thinking and frequently do not develop a conscience (Delaney, 1991). Their sense of survival is linked to being in control of their environment. As a result, they do not allow themselves to be parented. They frequently pit one parent against the other and paradoxically, they are prone to appear charming and well behaved when out in public. Consequently, parents are often left feeling isolated, misunderstood, blamed and confused (Pickle, 1994). Having other children whose behavior falls more within normal parameters makes the experience all the more bewildering.

Therapists, too, can experience great difficulty and challenge when treating a child diagnosed with attachment disorder. In severe cases, children with deeply ingrained negative expectations may not respond to conventional mental health approaches such as non-directive play therapy, insight-oriented psychotherapy and standard family therapy (Delaney, 1991). Somewhat unorthodox approaches may be called for. Additional, specific training is usually necessary.

To date, the vast majority of research on attachment disorder has been sensorimotor in nature and focused on diagnostic/assessment measures (Cicchetti, Cummings, Greenberg & Marvin, 1990). Research has also been restricted to individual and dyadic levels (Marvin and Stewart, 1990). There has been essentially no research on attachment that reflects a family perspective or that emphasizes the attitudes, feelings and ideas of family members (Cicchetti, Cummings, Greenberg & Marvin, 1990).

The purpose of this study was to describe in detail the experience of parents who have children diagnosed with attachment disorder. By compiling a detailed collection of parents' perceptions and experiences, this study attempted to raise awareness of the distinctive and challenging aspects of this disorder, and at the same time hopefully

decrease the isolation experienced by these parents. Inasmuch as the child seen in therapy is quite different from the child the parent lives with (Pickle, 1993), this study also attempted to provide therapists with a window into the chaotic family life experienced as a result of this disorder. The objective of this research was to listen to parents and acknowledge their expertise as they described and made sense of their experiences and added to the growing body of knowledge on the subject of attachment disorder. The constructivist and family stress/coping theoretical frameworks guided this qualitative study.

My personal bias as a researcher has been a factor in this study. My initial interest in this study was based on my experience as a foster parent of a RAD child. She arrived in my home with a diagnosis of attachment disorder, but I had no idea what that actually referred to. Over the next year and a half, I became familiar with attachment disorder and was instrumental in having my local community services board invite a RAD therapist to come and hold workshops for personnel to inform them about the diagnosis and treatment of RAD. As it turned out, one of the participants of this study initially learned about RAD from a CSB therapist who attended these workshops. So, although I had a particular experience with a RAD child, I attempted to approach this study from a “not knowing” point of reference. Selecting the qualitative research model as well as a narrative interview approach were both intentional attempts to eliminate any preconceived bias towards the data. However, my experiences undoubtedly colored the tenor of my questioning, regardless of how unbiased I tried to make it. Although I continually reminded myself not to “fish” for any desired responses (in fact, not to have any desired responses), it would be reasonable to suspect that I was not one hundred percent successful. Also, because of my experiences, I probably paid more attention to responses that struck emotional chords in me, than I did to responses that were outside my circle of experience.

Significance of the Study

Normal development of human beings occurs within a social context, which for a newborn is usually the mother-child relationship (Welch, 1988). Optimal development appears to be enhanced when there is a secure attachment in that context. Broadly speaking, attachment may be defined as a lasting psychological connectedness between human beings (Delaney, 1991). In the psychological study of children, more specifically, attachment refers to the emotional bond which grows between the child and caregiver and vice versa. Attachment is a vital process in human development, not only because it enhances the likelihood of survival during infancy, but also because it optimizes adaptive personality development across the life span (Cicchetti, Cummings, Greenberg & Marvin, 1990).

The attachment process begins at birth and is therefore occurring at the same time as increases in brain functioning and neurological development, especially in the first one to two years of life (Randolph, 1995). Under optimum conditions, an infant's environment includes activities (parental response, sensory stimulation) which are critically beneficial to brain development. When there are lapses, deficits or inconsistencies regarding these activities, there exists an increased possibility that an attachment problem may develop. In the absence of favorable stimulation, significant areas of the brain fail to develop adequate skills for taking in, processing and comprehending information and planning some appropriate response to it. This failure to develop along a healthy path may result in childhood behavior which appears strange, out of place or inappropriate.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994), the essential feature of Reactive Attachment Disorder (RAD) is markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care. The pathological care may take the form of persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection; persistent disregard of the child's basic physical needs; or repeated changes of primary caregiver that prevent formation of stable attachments.

Given these developmental features, one might expect to find RAD in adoptive families, especially in situations of inadequate care of a child prior to adoption (Juffer, Hoksbergen, Riksen-Walraven & Kohnstamm, 1997) and in foster care situations. Hospitalization or serious illness of either the caregiver or the child, or the occurrence of a death could also be a contributing factor to the development of RAD (Welch, 1988). A lack of time and attention (Kirkland, 1994), or in other words unresponsive parenting, by itself or in combination with any of the above may play a part in the development of

attachment problems (Delaney & Kunstal, 1993; Delaney, 1991; Welch, 1988). In situations where infants or toddlers are placed in day care, not only is the separation from parents a potential risk factor, but the feelings of stress and anxiety experienced by the parents as a result of leaving a child in someone else's care may also diminish the attachment process (McMahon, 1994).

The explosion of research on attachment theory in the last decade (Mickelson, Kristin, Kessle, & Shaver, 1997) has roots in the earlier (1940's-1950's) work of John Bowlby (Bretherton, 1992) and subsequently in his joint work with Mary Ainsworth (Ainsworth & Bowlby, 1991). Bowlby was interested in the link between maternal loss or deprivation and later personality development (Bretherton, 1992), and he studied the psychopathogenic effects of the lack of maternal care on children from many different countries (Lebovici, 1989). Ainsworth was attracted to security theory and conducted the first empirical study of infant-mother attachment patterns (Bretherton, 1992).

More recently, others have reiterated the importance of the infant's experience in the first years of life to the development of healthy attachment (Schneider, 1991). An appropriate, timely and sensitive response to an infant's needs are of great significance (Vereijken, Riksen-Walraven & Kondo-Ikemura, 1997; Meins, 1997; Teti & Teti, 1996; Isabella, 1993). Separations from the primary care giver have been shown to have lasting effects on attachment (Frankel, 1994; Hinde, 1991). Chronic stressors may interfere with the attachment process (Shaw & Vondra, 1993) by altering the neuro-development of the brain (Schore, 1997; Perry, Pollard, Blakely, Baker & Vigilante, 1995).

Another body of research demonstrates a developmental relationship between attachment disorder and other problem behaviors (Goldberg, 1997; Waters, Posada, Crowell & Keng-ling, 1993; Allen, Aber & Leadbeater, 1990). Attachment disorders have been shown to have explanatory power in the development of depression (Dadds & Barrett, 1996; Hortacsu, Cesur & Oral, 1993) and agoraphobia (Shear, 1996; de-Ruiter & Van-Ijzendoorn, 1992; Sable, 1991). A combination of disordered attachment issues

are central to the development of multiple personality disorder (Barach, 1991) and borderline personality disorder (Fonagy, Target, Steele, Steele, Leigh, Levinson & Kennedy, 1997). Other research points to the relevance of attachment disorder to the development of various addictions (Cook, 1991) and eating disorders (Chassler, 1997; Mallinckrodt, McCreary, & Robertson, 1995).

Still other research has focused on the link between patterns of disordered attachment in children and the attachment patterns of their parents. Bretherton, Ridgeway & Cassidy (1990) quote Bowlby:

“Because in all these respects children tend unwittingly to identify with parents and therefore to adopt, when they become parents, the same patterns of behaviour towards children that they themselves have experienced during their own childhood, patterns of interaction are transmitted, more or less faithfully, from one generation to another. Thus the inheritance of mental health and of mental ill through the medium of family microculture is certainly no less important, and may well be far more important, than is their inheritance through the medium of genes.” (p. 278)

Because attachment between a parent and child is an on-going process and not a single event, it may be very difficult for parents to pin-point how and when a problem may be developing or why a problem exists. Generally speaking, attachment problems come to light when parents begin noticing a pattern of behavior which seemingly defies rational explanation and does not get resolved by using generally accepted parenting techniques.

Welch (1988) acknowledges that all children reject their parents or respond negatively some of the time. Parents of children with attachment disorder often experience constant rejection, consistently negative responses or no response at all. Parents often feel hurt, confused and even guilty. Furthermore, they may feel isolated or in fact isolate themselves as they observe in bewilderment the comparative success of other parents they know.

Although much research has been done detailing the development of attachment disorders, how attachment disorder relates to other disorders, and how attachment orientation affects subsequent stages of a persons life, to date the researcher has not found any published studies detailing the experience of parents who are coping with attachment disorder in their children. Several authors have documented the process of diagnosing presenting problems (Holmes, 1996; Delaney & Kunstal, 1993; Delaney, 1991; Welch, 1988) as disorders of attachment, but little detail is given of the parental experience, how parents have coped and what resources they have accessed.

Authors Marvin and Stewart (1990) quote noted family therapist Salvador Minuchin as stating that of all current research in developmental psychology, the area of

attachment behavior is most logically viewed from a family perspective. Cicchetti, Cummings, Greenberg & Marvin (1990) explain the need to expand research on attachment relationships to include the attitudes, feelings, ideas, goals and plans of parents. Amy Grier (1999), a therapist with Adoption/Attachment Partners, P.C. in Annandale, Virginia, enthusiastically supports research which would detail the experiences of parents of children with attachment disorder. She concurs that these parents often feel very isolated. Learning how parents make sense of their experiences and what resources have been helpful in coping with the impact of attachment disorder in their home would be useful information for other families and therapists.

This research project filled the gap in the research by taking a detailed look at the experiences of parents as they dealt with attachment disorder on a day-to-day basis. This study provided greater understanding of the unique challenges faced by parents who are raising a child diagnosed with reactive attachment disorder. The study looked at what resources the parents have accessed to help them cope with the stresses encountered in their families. The study attempted to show what has been helpful to these parents.

This study may help other parents to better cope with attachment disorder behavior in their own families. The research results may also help to lessen the isolation of parents who may be wondering if their experience is unique as well as if they are doing something wrong.

This study has implications for clinical practice. It will raise the awareness of therapists who may have had little exposure to attachment disorders. Parent's descriptions of what was helpful and what was not may result in therapists utilizing resource referrals, seeking further training or changing therapeutic techniques in order to enhance their helpfulness.

Theoretical Framework

In this study, a constructivist theoretical framework was used to guide the study of parents' experiences with their children diagnosed with attachment disorder. Constructivist theory attends to the process of how people make sense and give meaning to the experiences in their lives (White, 1995). Gergen (1985) adds that constructivism is principally concerned with the processes by which people come to describe, explain, or otherwise account for the world in which they live.

Anderson and Goolishian (1988) state that a problem exists only when there is communicative action (complaint or concern) between people. A problem exists if it is described and understood by those involved. To put it another way, how we talk about a problem can sometimes be the problem. Sprenkle and Piercy (1992) describe how families can become saturated by a problem as a result of how they talk about it, the length of time it has been a focus, and the extent to which positive aspects of the family become blocked out as a result. Berg and de Shazer (1993) believe that how we talk about something, and indeed what we talk about, makes a difference. How we talk influences how we perceive. Attachment disorder is characterized by behaviors which are long-term and pervasive in nature. Parents of children with attachment disorder had a considerably problematic story to share.

A constructivist framework in qualitative research neither searches for truth nor holds the researcher up as a source of truth (Hoffman, 1993). Rather it sets the stage for a collaborative discourse with study participants. Hoffman further states that a constructivist focus is non-judgmental and non-control oriented, but indeed employed on a lateral rather than hierarchical plane. The researcher's role is to create an atmosphere which invites exploration and free reflection, not a molded answer to a question.

Constructivist theory has informed the study by challenging the notion that there can ever be a totally objective observer of an event. Anderson and Goolishian (1988) describe the fluid and evolving nature of meaning and the many factors which influence the meaning we apply to an experience. In the case of attachment disorder, which can present in a wide spectrum of nuance and severity, the researcher is mandated to respect the story related by parents and be mindful of the unique nature of how behaviors may be experienced. The researcher allowed the parents to play a major part in guiding and ordering the direction and process of relating events, incidents and perceptions.

Hoffman (1993) asserts that constructivist theory focuses on many views rather than just one. Too often that ‘just one’ would be those views of the researcher or therapist. The researcher or therapist must realize that their experience of the world does not in itself dictate the terms by which the world is understood (Gergen, 1985). The pitfalls of relying exclusively on one’s own views in research or therapy are summarized by von Glasersfeld (1987) :

Copernicus...successfully abolished the egocentric notion that the little planet on which we live must be the center of the universe. We know that it was a difficult step to take and that resistance against it lasted longer than a century. It seems that now there is yet another, even more difficult step in that direction we shall have to make, namely, to give *up the notion that the representations we construct from our experience should in any sense reflect a world as it might be without us.* (p.143)

Families generally are only concerned with those things that do not appear to be working for them. This is based on their own view of family functionality. If the researcher is focusing questions based on his own view or experience, the result will be a diminished picture of the parental experience. A constructivist approach allowed for parental narratives in context which might have been lost by the researcher weighed down by etiological imperatives or prior experience.

In summary, a constructivist theoretical framework was the guiding influence on the focus of the proposed study. The researcher attempted to recapture the experiences of parents by posing questions which allowed them to share their narrative in a relatively unstructured manner. The researcher regarded the participants as experts on relating the perceptions of their lives. An atmosphere of openness, willingness to listen, and to hear was maintained. It appears that this process provided for the sharing of a detailed and descriptive narrative of the experiences the parents had encountered with their children diagnosed with attachment disorder.

A second theoretical perspective that guided the study, and which dovetails nicely with the constructivist framework, is family stress and coping theory, an interactive variation on earlier stress and coping theoretical frameworks (McCubbin & McCubbin, 1989). Stress theory is described by Hill (1965) as a linear model with four components, ABC-X. These components are (A) the stressor or stressor event, (B) the individual’s or family’s coping resources, (C) the perception or meaning placed on the stressor and (X) the extent or severity of the resulting crisis (Burr, 1990; Walker, 1985). Since originally applied to families by Hill (1965), this model has significantly added to the understanding

of family processes.

Changes in the ABC-X model have addressed original shortcomings and increased its usefulness. Evolutionary refinements have shifted the understanding of stress and coping from a consideration of discrete events to viewing stress over time as an interactive process between stressors and responses to them (Cotton, 1990). The Double ABC-X Model (Patterson & Garwick, 1994) expands each component of the model to better reflect a longitudinal view.

Recent developments in stress and coping theory toward an expanded view of family stressors, and its current emphasis on how families construct meaning, support the focus of the proposed study in several ways. These approaches take a non-pathologizing view of families and focus on their ability to access resources and the resultant affect on their particular situation (McCubbin & McCubbin, 1989). In terms of research issues for the proposed study, family stress and coping theory invites consideration of the coping resources used by families throughout their experience with a child diagnosed with attachment disorder. It also guides exploration of what meanings parents affix to their experiences in terms of their unique circumstances, their family identity, and their world view. This framework also lends clinical applicability to the study. Therapists are one resource from whom families tend to seek help. Having a detailed look at the coping experience of families dealing with attachment disorder will inform clinical work with families who are searching for stress relief.

Research Topics

Based on these theoretical perspectives, the following research issues guided the inquiry into the experiences of parents of children diagnosed with attachment disorder.

2. How do parents view their experience with a child diagnosed with attachment disorder? Have their thoughts and perceptions changed over time? What is their outlook for the short term and long term?

2. Do parents recognize behaviors, dispositions or personality characteristics that are specific to, or unique in, their child diagnosed with attachment disorder? If so, what are they?

2. What resources had the family identified that had been or could be helpful to them in their experiences with attachment disorder.

4. What would parents recommend to other families coping with similar experiences?

CHAPTER II

LITERATURE REVIEW

Introduction

This study examines the stories told by parents who had a child diagnosed with Reactive Attachment Disorder (RAD). Recently, there has been an interest in the effect of children's experiences in early life on the development of their personalities and relationships with others. Traditionally, research has focused on sensory-motor development and early attachments in infants as a result of early life experience. This literature review examines the relevant research on attachment theory and the origins and development of RAD. The absence of a body of research on parent's experiences with children diagnosed with RAD points to the need for this study. The following review lays the groundwork for understanding various aspects of the research in this study.

Attachment Theory

Just as the absence of contact and sensory input has a stressful, and therefore negative impact on attachment, so too does the presence of abusive or traumatic situations (Randolph, 1995). Infant sized bodies subjected to huge amounts of stress hormones and endorphins may actually come to expect that high levels of these chemicals represent normality. Thus, the stage is set for feeling abnormal or out of place in the absence of highly stimulating or even dangerous and/or painful situations.

At about age two, the brain undergoes a significant change in the way memory is processed and stored (Randolph, 1995). Remembering events that took place prior to age two is very difficult. Accessing beliefs associated with those events is therefore extremely difficult as well. A child may therefore be responding in any given situation based on deeply implanted beliefs or convictions even in the absence of any contemporary evidence for the need to do so.

Bowlby contributed the concept of balance (rather than conflict) between attachment and exploration. Neither extreme attachment nor excessive detachment is deemed to be healthy, but a balance on the continuum appears to allow for healthy adjustment. Both Excessive clinginess and excessive aloofness would fall outside the bounds of normal healthy development. Another Bowlby concept, that of the internal working model (i.e. representations used to organize both experience and an individual's response to that experience (Crittenden, 1992) was studied in 146 maltreated children and

39 adequately reared children. Based on interviews with the mothers and video tapes of the children at play, successful coping strategies of the children appeared to be a function of the degree of abuse/neglect or lack thereof. Bowlby viewed the parent as a psychological secure base (Bretherton, 1997), and therefore instrumental in the healthy development of attachment behaviors including the ability to relate well with people outside the nuclear family.

Attachment theory is not without its detractors and controversy (Hazen and Shaver, 1994; Field, 1996). Michael Lewis (1994) asserts that a theory relying on only a single attachment to our mothers is insufficient to explain our needs and relationships. Simon Wilkinson (1994) emphasizes the need to step away from phase-based models of development such as attachment theory. The exclusivity of the mother-child bond is questioned by Steven Frankel (1994) who cites research that indicates that children are capable of forming multiple bonds, while retaining the central importance of the mother-child relationship. He further states, however, that most researchers remain convinced that chronic disruptions to the core connection may result in a variety of disturbances, some of which might not become manifest until later in life.

An observational research study in the Netherlands (Juffer and Rosenboom, 1997) of 80 mothers and their infants, who were adopted from several different countries, concluded that 74% of the attachment relationships between mother and infant were secure. Indeed, Robert Emde M.D. (Greenberg, Cicchetti & Cummings, 1990) explains that even when classified as insecure in their attachment relationships, most infants will not develop a psychiatric disorder. He cites the need for more study regarding the impact individual personality and internalization plays in the onset of infant/child psychopathologies.

While some are hesitant to fully embrace attachment theory as a useable model for diagnosis, treatment and research, others are not. Virginia Colin (1996) states that attachment theory is widely regarded as one of the most viable theories of personality development and intimate relationships ever proposed. Ainsworth (1992) adds that attachment theory has had greater impact on American psychology than any theory of personality development since Freud's. Much of the current focus on adult attachment is an extension of Bowlby's work on attachments in children (Weiss, 1994). Attachment theory is a valid framework for a comprehensive theory of close relationships (Hazen & Shaver, 1994).

Attachment theory research indicates that infants are pre-designed from birth to relate to others, and that their relationships are of preeminent importance in shaping their psychic development (Schneider, 1991). Infants' proximity, safety and security needs and caregiver's responses to them activate an attachment system (Silverman, 1991).

These organized patterns of interaction between infants and significant figures become structuralized. A short-term separation between mother/caregiver and infant can produce long-term effects (Hinde, 1991). These effects depend on a large number of factors, but could include the development of despair and lack of trust in close relationships, and the need to control relationships in order to avoid disappointment or rejection. Balanced research needs to focus on individual, relationship and family differences regarding attachment, including environmental and biological factors.

Schore (1997) has proposed a model of developmental attachment dynamics which addresses the roles of biomines and brain mitochondria as they relate to state regulation. He describes the energy-dependent imprinting of synaptic connectivity and neural circuitry in the infant brain. Developmental models of resistance and vulnerability to mental disorders emphasize experience-dependent maturation of the brain system which regulates psychobiological states. This system generates stress-regulating coping strategies. Early forming microstructural alterations and energetic limitations of this regulatory system are suggested to be associated with a predisposition to psychiatric disorders. Perry (1995) specifically details the altering developmental course of chronic trauma to the infantile brain, resulting in a predisposition to pathologically abnormal response to ordinary stimulus.

Shaw (1993) examined the relationship between significant familial stressors and attachment security among 12-month-old infants in a sample of 100 parent-infant dyads. Cumulative family adversity was found to differentiate secure from insecure infants among families with 3 or 4 stressors present, suggesting a threshold for successful attachment.

A parent's style of caregiving is related to their attachment orientation which in turn is mirrored in their children (George & Solomon, 1996; Cohn, Cowan, Cowan & Pearson). Secure parental attachment is associated with more cooperative, prosocial child behavior in the context of the parent-child relationship and with others (Bretherton, Golby & Cho, 1997). Self concept and achievement can also be predicted based on parental attachment and support (Cutrona, Cole, Colangelo & Assouline, 1994). A study of 160 undergraduates measured family conflict and achievement orientation, and college entrance exam scores and GPA's. Support from parents, but not from friends or romantic partners significantly predicted GPAs. Conversely, research by Moncher (1996) and Alexander (1992) indicates that neglectful parental attachment orientation can be a risk factor for the onset of a negative self concept.

The intergenerational influence on attachment is described by George and Solomon (1996). Historically, the field of child development has not been interested in trying to describe or understand parents as developing adults. However, their past

experience, family and cultural contexts, and their interaction with their child, all work together to influence the quality of the parent-child relationship. Interviews with 32 mothers of 6-year-olds revealed a significant correspondence between maternal internal working models of care giving and their children's attachment classification. In an observational study of 27 two-parent families and their preschool-aged children, an insecure working model of attachment was a risk factor for less competent parenting (Cohn, Cowan, Cowan & Pearson, 1992). The risk was further pronounced when both parents exhibited insecure working models of attachment, that is, they displayed less warmth and closeness to their child, and provided less structure and personal involvement with their child when given the opportunity to interact. As defined by the study, children were reciprocally less warm and less structurally interactive with insecure parents than were children of secure parents. Teti and Teti (1996) suggest that another critical factor in shaping parent/child attachment is infant temperament, which influences the "goodness of fit" between parent and infant. Parents' propensity to feel close to their infant is an important factor in determining their ability to interact sensitively with their child, and thus influencing the attachment relationship (Meins, 1997). Children in the same family may develop wide variances in degree of attachment as a result of sibling competition for parental investment and discriminative parental solicitude (Lalumiere, Quinsey & Craig, 1996). In other words, as parents relate differently to each child, possibly because of changes in parenting styles caused by new learning of by different events in the family over the years, a parent may encounter varying relationships and experiences with parenting their various aged children. Sibling competition for parental investment may also result in differing behavioral outcomes on the part of the child.

Other disorders with links or similarities to reactive attachment disorder (RAD) include autism and non-organic-failure-to-thrive (NOFTT) (Greco & Routh, 1997). Several symptoms of autism overlap with RAD (Rooney & Byrne, 1997). These would include impairment in social interaction, absence of separation anxiety, and poor attachment formation with others. Some of the more intense therapy treatment for RAD was adapted from treatment for autism, presenting the possibility for looking at autism as an extreme degree of RAD (Welch).

NOFTT also shares over-lapping symptoms with RAD (Powell and Bettes, 1992). Krystal (1997) cites failure-to-thrive as occurring resultant to infantile trauma followed by an absence of empathetic parenting. Hagekull, Bohlin and Rydell (1997) report on a longitudinal study of 115 participants using a model for development of NOFTT. Feeding problems were predicted by interactions between infant temperament and manageability and maternal sensitivity. Infants were reported to have more problems if their mothers were less sensitive to their signals. Call (1984) states that RAD is described and found almost universally in NOFTT. He believes a diagnosis of RAD is preferable because of the preventive and interventive action to which it leads. It can help educate parents as to the meaning of signals of distress displayed by their infant child and

help them to achieve a greater sensitivity in responding appropriately to these signals.

A laboratory-based observation called the Strange Situation was developed by Ainsworth and others to delineate categories of attachment (Main and Solomon, 1990; Main, 1996). Observation of infant response to two brief separations from, and reunions with, the parent is used to classify between four overall patterns of behavioral organization (Main and Solomon). These categories are defined by Delaney(1991) as follows:

Type A) insecure-avoidant: infants casually avoid and nonchalantly ignore the caretaker after being reunited; ironically may show little distress during the separation period; might be seen as relatively detached.

Type B) secure: shows clear signs of missing caretaker; then, upon reunion seeks and finds closeness and, as a result seems to be secure enough to eventually resume play or exploration. One could say this child shows protest but does not despair or detach.

Type C) insecure-ambivalent: markedly distressed during separation and upon reunion are inconsolable, obsessed with the caretaker; vacillate between need for closeness with and anger at the caretaker. Not seen as detached, but rather as highly protesting.

Type D) disorganized-disoriented: confusing, contradictory behavior, conflicted drives (one to approach and the other to flee the caretaker). May show burst of angry behavior followed by sudden “freezing” or “dazed behavior”. After being reunited might sit on caretaker’s lap but with eyes averted, or might allow to be held but with limbs stiff. Show an unusual form of detachment.

Identified classification types of attachment in infants have been found to be predictive of child narratives (Main, 1996). For example, in a study by Lyons, Easterbrooks, and Cibelli (1997) avoidant attachment was found to be associated with internalizing problems (which could present itself in depression, despair, over/under eating, poor self-concept, etc), while disorganized attachment was found to constitute an early step toward externalizing problem behavior (which could present itself in acts of violence, substance abuse, stealing, sexually acting out, lying, etc.).

A poor history of attachment appears to negatively influence people beyond childhood as well (Levitt, Silver and Franco,1996). Insecure attachment has been shown

to affect adolescent mental development (Goldberg, 1991), and in general to exert a pervasive influence on relationships (Strahan, 1991). A study of 193 couples measuring their attachment construct, showed a significant difference between insecure and secure patterns of attachment relative to family functioning. The conclusion was that a person's attachment style exerts a pervasive influence on his or her relationships with others. Simpson, Rholes and Phillips (1996) studied the influence of ambivalent attachment on adult relationships and found it to be predictive of conflict during distressing events.

Several studies have linked violence to insecure patterns of attachment. The less secure a person feels in a relationship, the greater the likelihood for issues of trust and self concept to arise. In interviews with 91 men, attachment related factors were found to predict male violence toward female intimates (Kesner, Julian and McHenry, 1997). Roberts and Noller (1998) suggest that couple violence can be explained by dysfunctional communication patterns linked to insecure attachment. Conversely, secure attachment may facilitate the development of mental capacities that both inhibit the individual's potential to commit acts of aggression and reduce the motivation for criminal behavior (Fonagy, Target, Steele, Steele, and Osofsky, 1997).

Adoption

Foster care placement and adoption are two situations where RAD should be considered as a possible diagnosis when severe problems exist (Juffer, Hoksbergen, Riksen-Walraven & Kohnstamm, 1997). Although foster care placement can reduce the risk of child maltreatment, it can also interfere with healthy emotional development by disrupting caregiver relationships (Troutman, Ryan, & Cardi, 2000). Children can be affected when they are taken from any caregiver, birth family or foster family.

Adopted children appear to have an increased risk for serious disturbances of attachment (Zeanah, 2000). They have often gone through changes in caregiver at critical times relative to the formation of a secure attachment orientation. When they are looking for a discriminant attachment figure from whom to venture out to unfamiliar adults, they often do not have that secure base established. The length and severity of early deprivation appears to add to the increased risk (O'Conner & Rutter, 2000). In a study from the United Kingdom, 165 children adopted from Romania, were compared with 52 children adopted within the U.K. There was a close association between length of deprivation and severity of attachment disorder. Although the majority of adopted children do not demonstrate severe problem behavior, many continue to exhibit indiscriminate sociability long after they become attached to their adoptive parents.

Institutionalized children appear to have a dramatically increased risk for social

and behavioral abnormalities (Zeanah, 2000). They sometimes develop an attachment orientation marked by indiscriminate or diffuse attachments, wherein they may seek comfort, support and nurturance in a peculiar manner with unfamiliar adults. Adoptive parents sense this orientation as very superficial. Many children are being adopted out of institutions in Eastern Europe and Russia. The quality of care is often appalling in these institutions. Mental and physical development is often severely delayed in these children. Although adoption does appear to have an ameliorative effect, it remains unclear whether many children recover largely or completely from severe, early deprivation.

Early-placed adoptees seem to experience fewer problems than children placed at a later age (O'Conner & Rutter, 2000) and the post-adoptive caregiving environment appears to be an important factor influencing successful improvement in behavior and socialization (Zeanah, 2000). Parents who are considering adoption should be made aware of the potential behavioral, emotional, and social problems their child may have (Fisher, Thompson, Ferrari, Savoie, & Lukie, 2001). Parents who were initially asked if they had any concerns about adopting a child mentioned the potential for health problems in 94% of the cases. Only 18% mentioned a concern over behavioral problems. And yet the potential for behavioral problems is relatively high, long lasting and far reaching.

Therapy for RAD

RAD children seek to adapt to their developmental environment in ways that are protective (Crittenden, 1995). They become very self reliant to the point of not allowing anyone to do anything for them. They can be very distrustful of apparent authority figures because they have been so disappointed in the past. Their level of love and attachment can be very superficial as a self-protective measure. This adaptation can be dysfunctional for some children when they move to other environments (Perry, 1995). In these situations, successful therapy can be challenging because these children are operating in the only way they know how to survive (Cline, 2001). Many of the competencies required for productive therapy are not in their range of experience (Mallinckrodt, 2000). RAD children are frequently unable to identify feelings or identify what is behind those feelings. Traditional therapeutic methods requiring a trusting therapist-client relationship often fail with RAD children (Cline, 2001). Additionally, traditional parental interventions often do not successfully engage RAD children (Hughes, 1997).

Rochelle Hanson and Eve Spratt (2000) note that in recent years there has been an increase in the number of children diagnosed with RAD. They voice concern over what they see as the emergence of 'novel' treatments lacking a sound theoretical or empirical basis that may also be potentially traumatizing and dangerous to a child.

Conversely, Jeremy Holmes (1994) argues that attachment theory offers a useful theoretical framework for psychodynamic counseling. He further asserts that attachment theory is not a new school of psychotherapy, but addresses principles that underlie all effective therapies. Lyddon (1995) echoes the potential of attachment theory as a meta-perspective for counseling psychology. He applauds its capacity to bring biological, psychological, and social dimensions of experience to bear on the understanding of the developmental dynamics of self-change and self-stability over the life span.

Treatment for RAD, such as holding therapy, is confrontive and intrusive (Cline, 1992; Hoyle, 1995). Intensive therapy consisting of cognitive restructuring, psychodramatic reenactment, inner child metaphor, and therapeutic holding has been applied in attempts to decrease problem behaviors in RAD children (Myeroff, Mertlich & Gross, 1999).

The following description of therapeutic holding is provided to the public by Adoption/Attachment Partners, P.C. of Annandale, Virginia.

Although attachment—the innate need to connect to another human being—is a natural process usually begun at birth, not every child has the opportunity to develop healthy, loving, trusting relationships with the adults in his/her world. Because of this, attachment therapy is a form of therapy that allows a client to establish trusting relationships with others which include honest, full expressions of the client’s anger, sadness, fear and grief as well as love, affection and joy.

One of the interventions used to promote the development of a nurturing and healthy attachment is called “therapeutic holding.” This approach includes holding the client in a completely safe position that restricts the client’s ability to move and makes the client dependent upon others to be in control of the present moment. By having to relinquish control, the client often experiences intense fear and/or panic. As terrifying as this can be, it also reassures the client that there is an emotionally and physically safe way to express all thoughts and feelings, and a way to understand the futility of power struggles with others. For children and adolescents, it especially helps them to release the burden of trying to totally manage their own lives and creates a desire to accept parents as nurturing caregivers and respected authority figures.

While being held, the client is encouraged to fully experience and verbalize the feelings that arise. The client may experience intense rage

or fear at losing control, have long buried past events, thoughts or feelings emerge, or be confronted by others with some of the client's problematic behaviors. The expression of these feelings can be an extremely noisy, aggressive physical and verbally escalated battle in an attempt to gain back control and stop the process. As these feelings are contained and the client is kept safe by the therapist and others in the room, the client moves into experiencing the peace, relief and joy that comes with fully trusting another person in a completely vulnerable, honest and intimate way. Instead of fighting with others to keep them at a distance, or running away and avoiding the conflicts, the client is offered a third alternative of attaching and bonding so that continued nurturance and growth can take place.

Therapeutic holding can benefit children who have undergone traumatic experiences that make trusting others seem risky. Severe abuse and/or of neglect; placement in multiple foster homes; early months or years in orphanages or similar institutions; illness or death of a parent; extended hospital stays of invasive medical treatments; discovering being adopted; all these can lead a child to be psychologically and emotionally distant, extremely unmanageable, desperate for control, sometimes dangerous and highly resistant to attaching to appropriate caregivers. Therapeutic holding is also an avenue for the child's perceptions and distorted thoughts to be challenged so that the parent's advice and guidance will be accepted.

Therapeutic holding can also benefit adults as well. Adults who have had non-nurturing childhoods can suffer from attachment difficulties that create intimacy problems in adult relationships. Even those who have not experienced trauma or problematic relationships, can use therapeutic holding to increase honest communication and enhance intimacy. Therapeutic holding can be used with clients of any age, with individuals of couples, and as adjunct therapy to other work.

Fowler (1998) stresses the need for choosing an appropriate therapist to work with families. In the case of RAD therapy, intense initial sessions of up to three hours per day for two or three weeks with a highly trained therapist are followed by several months of treatment by trained therapeutic parents (Fairfax County Department of Family Services, 1996; Hage, 1995). The therapeutic parenting takes place in a structured family environment. A proactive approach focuses on avoiding problems and encouraging positive behavior. Contracting with the child also plays an important role. Reactive discipline relies on consequencing in order to have children experience real world consequences for their behavior.

From an attachment perspective, a fundamental aim of family therapy is to create a secure base in therapy sessions (Byng-Hall, 1990). This serves as a model to the family of how they can collectively provide a secure base for one another. The family can use this secure base to explore new solutions to family problems both during and after therapy (Byng-Hall, 1995). Attachment focused therapy can provide a new model of what close relationships can be like (Sable, 1997). The therapist may act as an attachment figure, providing new perspectives on therapeutic work, particularly with boundary issues (Farber, Lippert, and Nevas, 1995).

Attachment organization can affect the relationship between client and therapist (Pearce and Pezzot-Pearce, 1994; Robbins, 1995). By altering their interpersonal stance relative to the attachment style of the client, therapists may enhance the outcome of treatment (Dolan, Arnkoff, and Glass, 1993), as well as improve their client's perception of the therapeutic alliance. This would be similar to adapting your speech to match that of the client as far as speed and word usage are concerned, or becoming enmeshed in a system in order to work within it. Adopting an attachment style similar to the client can be a way to join with that client and create a feeling of allied connectedness.

Early attachments have a continuing influence on later relationships (Feeney and Raphael, 1992). Feeney and Raphael suggest that future research directed toward adult relationships and sexuality would be useful. Goldberg (1993), too, sees attachment as an enduring rather than short-term phenomenon. She suggests that future research focus on ontogenetic development and intergenerational transmission of attachment. Solomon and George (1996) recommend further research on understanding parents as developing adults and how this influences the parent-child relationship. Ryle (1995) does not believe sufficient attention has been given to children's organization of meaning in the early interaction with caretakers. Stevenson (1990) would advocate for more research on the dimensions of family functioning that are relevant to the development of secure attachments and how such dimensions may change with age and stage in the family life cycle. Lyons-Ruth (1998) states that attachment research would be greatly enhanced by continuing to draw hypotheses and directions of inquiry from psychoanalytic clinical observations.

Summary

Attachment theory provides the basis for understanding the diagnosis of Reactive Attachment Disorder. Consistent and adequate care in the early developmental stages of infants and toddlers appears to be a significant indicator of mental wellness and healthy social interaction throughout the life span. Deprivation, trauma, abuse, and neglect in these early developmental stages have the potential for creating long lasting impediments to healthy adjustment.

Parents of RAD children are subject to feelings of frustration, isolation, and depression. Difficulties in correct diagnosis and effective treatment can result in years of unsatisfying family experiences and relationships. Adoptive parents are often ill informed and unprepared for the emotional and behavioral problems of their adopted child. Effective therapy for RAD is intensive and long-term and often takes a physical, financial and emotional toll on parents and other family members.

This study provides narratives on the impact early insecure attachment formations have on family relationships.

CHAPTER III

Methods

Design of the Study

A qualitative design was employed to build a rich, detailed and comprehensive description of the experiences of parents of children diagnosed with attachment disorder. A qualitative design was chosen because it focuses on participants' beliefs about their experiences (Strauss, 1987). A qualitative design aided in the attempt to understand how participants make meaning of their experiences. This design is highly compatible with the constructivist theoretical framework that guided this study.

A qualitative research design was appropriate for this research project for several reasons. This design lends itself to the discovery of events beyond the stricture of statistical relevance and allows for the distinctively individualistic descriptions of parental experience (Moon, Dillon, & Sprenkle, 1990). Innately focused on the participants, this design attempts to understand how they make sense of their interactions and necessitates a collaborative stance between researcher and participant (Heppner, Kivlighan, & Wampold, 1992). This manner of research facilitates an empathic, unstructured and hopefully unbiased entrance into the participant's framework of reference.

The qualitative interview holds the potential for a stream of thoughts, observations, opinions and recollections that may provide introductions for further inquiry (Yin, 1989). Given the strong researcher presence in the descriptive questioning of the qualitative interview, the likelihood of entering private spheres of family experience is to be expected (Daly, 1992). The researcher did bear in mind that participants in qualitative research may seek and/or experience therapeutic benefits during the study, even though the purpose of conducting research had been clearly stated as that of gathering information.

To date, research appears to be lacking with regard to documenting intimate experiences of parents with children diagnosed with attachment disorder. The

researcher's intent was to bring together from patterns of data a body of information characterized by stories, language, similarities and differences which will be helpful to other families and therapists.

In summary, the qualitative design and constructivist approach appear to lend themselves well to the purpose of this investigative study. The goodness of fit between the body of information sought by the researcher and the best way to gather it was a key factor in choosing a qualitative design for this study.

Description of Participants and Selection Process

As the researcher, my goal was to interview four sets of parents, each of which having at least one child who had been diagnosed with reactive attachment disorder (RAD). To be eligible, the child needed to be between the ages of 5 and 15. Priority was given to locating two-parent households in order to obtain the perspective of both mother and father. One-parent households were not ruled out since their inclusion would enhance the usefulness of the research results.

I made an attempt to recruit participants from several sources. I contacted three therapists who had expressed an interest in the study and had offered to refer potential participants. I also contacted other therapists known personally by me. One particular therapist expressed a great deal of interest in the study and provided a list of six potential participants. Of these six, two indicated that this was not a good time for them to participate. The remaining four were informed of the study and scheduled for a first interview.

The children diagnosed with RAD ranged in age from 7 to 14. There were two males and two females. Of the four children, one was biological, one was adopted, one was a nephew, and one was a foster placement. All of the children had been diagnosed with RAD within the past three years.

Three of the families in the study reported incomes in the \$40,000 to \$80,000 annual range, while one family reported an income over \$80,000. All of the males were employed, two of the females provided day care services, one female was self-employed and a part-time student, and one female was a homemaker. One parent was remarried and the rest were in first marriages. Two sets of parents had high school educations and the other two sets had one bachelors, two masters, and one Ph.D. among them.

Procedures

Interviews in qualitative research are based upon interest, curiosity and previous knowledge surrounding a particular phenomenon (Daly, 1992). A qualitative approach to the study allowed me to focus on the topic of inquiry while retaining a desirable degree of flexibility and adaptability. The following paragraphs contain a description of procedures followed in the study.

As stated earlier, participants were recruited from a therapists involved in the treatment of RAD and the support of parents of RAD children. Once the scope of the study had been explained, the therapist was asked to sign the therapist informed consent (Appendix A) describing the study's basic purpose and design, confidentiality, and their right to discontinue the referral of participants to the study at any time.

The participating therapist was asked to review her client population for families who met the study criteria. After contacting potential participants, the therapist suggested to those who showed an interest in participating that they speak with me concerning the study. Interested candidates for participation were then contacted by phone. I began to establish rapport as further information was given regarding the purpose of the study, procedures of research and time commitment involved. Candidates were encouraged to ask questions and address concerns. I emphasized the voluntary nature of participation including the freedom to selectively respond to questions or to electively withdraw from the study. Those candidates who chose to participate were scheduled for an initial interview at a mutually acceptable time and setting.

Each participating family was interviewed twice. The initial interview was face to face. Only one of these initial interviews was with both parents together. In the other three cases, one parent was out of town, one was ill, and one was at work. At the onset of the first interview, each parent was asked to read and sign an informed consent (Appendix B) outlining the study's basic purpose, design, extent and limits of confidentiality, and their right to withdraw from the study at any time. The duration of the first interview was approximately two hours.

As the first interview began, I focused on building rapport with the participants and attempted to instill the idea of a collaborative partnership (Marshall & Rossman, 1989). During this process, a brief set of demographic information was collected (Appendix C). The balance of the interview utilized a semi-structured design facilitated by an initial set of pre-determined questions (Appendix D). Using these open-ended questions, I set the stage for a free flowing dialogue. My plan was, in fact, to defer to the participants as the authoritative source of information pertaining to their unique

experience.

One of my goals was to test the accuracy of my understanding of the participant's perceptions (Yin, 1989). To that end, following transcription and preliminary analysis of data from the first interview, I shared a summary of the initial transcripts with the participants by mail. I then followed up with a second interview lasting approximately 30 minutes in order to confirm the accuracy of initial findings. Three of these second interviews were by telephone and one was in person. Having had an opportunity to reflect on their experience, the participants were also invited to share further thoughts or chronicle additional events if desired.

In addition to audio recording all interviews, I kept a written and taped record of my own notes, memos and perceptions (Strauss & Corbin, 1990). These aided in tracing reaction to the content and process of interviews. Additionally, these records enriched other analysis as the constant comparison method of analysis was employed in the development of data categories (Glasser & Strauss, 1967).

During interviews with each participant, I was mindful of the possibility that parents may have been experiencing difficulty talking about the focus of inquiry. I asked the participants to let me know if they would like to suspend the interview process. Also, if desired by the participants, I was prepared to offer a referral to appropriate therapeutic relief.

All information obtained from this study is confidential. Pseudonyms were assigned to each participant prior to transcribing the audiotapes. Demographics and other identifying information were kept in a separate file from research data. Audio recordings and transcripts were identified by pseudonym only. Access to raw data was restricted to me, my advisor, and two transcribers. The transcribers were required to sign a statement (Appendix E) pledging confidentiality and to withdraw from further involvement had it been discovered that he or she knew the participant. The tapes were destroyed upon completion of the data analysis.

Measures

The principal mode of data collection in this study was a semi-structured, in-depth interview (see Appendix D). The interview questions and subjects of interest that guided the inquiry were culled during the process of studying the literature on attachment disorder and the challenges faced by parents with a child diagnosed with RAD. As mentioned in the introduction to this study, the research is also filtered through the

experience that I had as a foster parent to a RAD child. While trying to remain objective, I nonetheless was influenced by my particular experience, formulating questions and emphasizing data based on my personal bias to the subject of the research. Heeding a constructivist theoretical perspective, this research was intended to elude a sweeping and intense narrative of the parental experience with RAD. Questioning of participants was open-ended and both verbal and non-verbal responses served as a basis for further inquiry. I was mindful of the need to remain flexible during the interview process to allow for the development of a unique discussion and chronicle of experience.

Data Analysis and Interpretation

The main body of data for this study was compiled from transcripts of the audio recorded interviews with study participants. Designed for use in studies with multiple sources of data, the constant comparative method of data analysis was appropriate to this research (Snyder, 1992). As the interviews were transcribed, I provided copies to my advisor, who began the process of open coding using NUD*IST (1999) software. Meeting together, I began open coding also, and we yielded 20-25 categories of data from the transcribed content of the interviews. Every recorded incident was compared to earlier data, uncovering similarities and differences while developing appropriate codes. This process facilitated the formation of general categories of interest (Strauss, 1987). Attention was given to the diversity of data within categories due to unique individual parental experiences. As themes, events and incidents were compared, categories of a higher level of detail emerged and lower level codes were expanded or changed due to a broader conceptual perspective (Strauss & Corbin, 1990). . I observed that the categories were supported and enlightened by one another. We eventually arrived at the core and sub-categories illustrated in Table I that appeared to provide for a systematic and organized way of analyzing and reporting the findings of this study

Audio recordings and a written journal of notes consisting of impressions, recollections and theoretical notations were employed as data was compiled and coded (Strauss & Corbin, 1990). Reviewing these memos was helpful to me while a summary and description of compiled data was written. The report of findings also relied heavily on these recordings and notes.

An intimate and detailed account of parents' experience with children diagnosed with attachment disorder comprises the final report. Illustrative field note quotations were integrated with the body of data, augmenting the narration resulting from this study. Participants' experiences were further enlightened by a review of relevant literature in the final report (Strauss & Corbin, 1990).

CHAPTER IV

RESULTS

The Story

The story revolves around the lives of parents whose mettle was forged through their experiences raising a child diagnosed with Reactive Attachment Disorder (RAD). These parents attempted to find their way through the maze of strange behaviors of their child. At the same time they had to grapple with the comments and reactions of neighbors, friends, family and even therapists and other “professionals” whose limited understanding of the situation often elicited negative feedback, suspicions and accusations regarding their parenting. Their stories were both similar and diverse, and characterized by sharing events which described the various behaviors attributed to attachment disorder and the unique aspects of each family as they coped with children presenting often bizarre and out of control behavior. Most of these parents have endured a long journey of trying to understand what it was that was “not working” in their attempts to parent their child. They were filled at various times with guilt, worry, despair and perturbation over their seeming inability to enjoy a “normal” parent/child relationship.

Participating in this research gave these parents the opportunity to share the multiple facets of their experience. The emotional impact of their experience has been profound. Also notable were the various resources that have been to degrees helpful or not helpful in coping with events and situations that to the “outsider” may appear to be nightmarish. As the researcher, I attempted to provide an open and free atmosphere for these parents to tell their stories in whatever way they saw fit. My hope was that they felt comfortable in sharing intimate and guarded information. Indeed, all of the participants appeared eager to share their experiences with the hope that they might help someone else wondering and struggling for answers. I thank them for their generosity and I hope they feel justly portrayed here.

Core Categories

Three core categories emerged from the data, which in combination provide the conceptual framework for the description of parents’ experiences with their child diagnosed with Reactive Attachment Disorder. The three core categories are

Recognizing RAD Behavior, Responding to RAD Behavior, and Advice and Recommendations (see Table 1).

Recognizing RAD Behavior

The category of Recognizing RAD Behavior is defined as the details shared by parents of the various behaviors and characteristics of their child relative to attachment disorder. These details vary by family and may be conceptualized on a continuum from relatively ordinary (defiant attitude toward rules, difficulty making friends) to highly problematic and bizarre (constantly stealing from parents, smearing or hiding bodily waste throughout the house). This category also encompasses neurophysical characteristics such as developmental delays, learning disabilities and physical impairments. The two themes that appear to constitute Recognizing RAD Behavior are **onset of RAD behavior** and **RAD related behavior and characteristics**.

Onset of RAD Behavior

The category **onset of RAD behavior** refers to parents' recollections of their earliest or initial observations of behavior in their child that appeared out of the ordinary or coherently unexplainable. For some of the families these observations consisted of noticing deviations in normal age-appropriate development or socialization, while in other families RAD behavior emerged following a post-adoption or post-foster care placement 'honeymoon' period. In each case this was the beginning of a long journey of discovery both of their child and of themselves as parents.

RAD Related Behavior and Characteristics

The category of **RAD related behavior and characteristics** documents parents' narrative of the many difficult and challenging attributes of their child. These include not only their child's **actions**, but also their various **moods** (depressive, maniacal) and **dispositions** (fear of abandonment, lack of trust). **Developmental delays or impairments** were also noted with regard to their contribution to overall parenting difficulties and the extent to which they may have contributed to RAD behavior.

Responding to RAD Behavior

Explaining RAD Behavior

The category of **explaining RAD behavior** is defined as those responses from parents, which were attempts to answer the ‘why’ of their child’s behavior, to pinpoint its developmental cause or beginning. Some parents spoke about neglect and the resultant self-protective, survival behavior. This included fear of relinquishing control to their parents, lack of trust and inability to develop close loving relationships.

Reacting to RAD Behavior

The category of **reacting to RAD behavior** is defined as responses that described the range of feelings and emotions experienced by participants’ as a result of their child’s behavior. Responses included depression, anger, guilt, horror, frustration, embarrassment, isolation and bewilderment.

Coping with RAD Behavior

Each of the participants had various approaches to **coping with RAD behavior**. The focus of this research as it pertains to coping was to highlight the various aspects of those approaches. Some parents relied more on family, while others accessed more community resources. Although there were a number of resources common to all parents, each one was utilized to varying degrees and with individual approaches.

Marital Team

The **marital team** is defined as the degree of teamwork, support, and sharing of strategies between the spouses. There was a wide range among participants in how useful the marital team was in terms of coping, alleviating stress, and providing relief.

Self-Adaptive Parenting Strategies

Self-adaptive parenting strategies are disciplinary strategies parents used with the intent of successfully coping with negative attachment behavior. In some instances, parents dealt with recurring behavior and changed their response so as to place consequences on their child, rather than saddle themselves with it.

Rethinking of Parental Expectations

As a result of their experiences with reactive attachment disorder, some of the parents chose to rethink their parental expectations. They began to see their roles as parents in a different light as well as to see that they could not employ their usual and customary parenting techniques with their child and still hope to get satisfactory results. For some parents this was a major shift with profound consequences.

Accessing Resources

Some of the participants reported accessing a variety of resources to greater or lesser degrees. Other participants seemed to make limited use of resources or, perhaps, had limited knowledge of possible resources. Resources included **extended family, financial help, spirituality, respite care/relief, medications, church, community services, foundations, school committees, therapists, psychologists, psychiatrists, doctors, school counselors, teachers, and others.**

Advice and Recommendations

In each case, with varying emphasis on a range of topics, parents were very willing to share **advice and recommendations** gleaned from thoughtful reflections on their experiences. These comments were directed at **other parents** in similar situations as well as **professionals** who might be asked for help with these children.

Summary

Using these core categories as topic guides, and relying on the constructivist and coping theoretical frameworks, the following stories reflect the findings of this study.

Joan Powell

Joan was operating a daycare business out of her home so we arranged to meet around mid-day in between the comings and goings of children. Her husband, Tim, was out of town. They were in the middle of plans to move out of state and Tim was already working at the new location.

The Powell's have five children. Amanda, the eldest, is a recent college graduate; Tim Jr. is a high school sophomore; John is thirteen; David is twelve; and Terry is eleven. The three youngest are the biological children of Joan's sister, Janet, who was adopted by Joan's parents. Janet was not successful in caring for her children and they were removed from her because of neglect. The three children have been with the Powell family about seven years. The middle of the three, David, is the child diagnosed with reactive attachment disorder, a diagnosis that was made only in the last several months.

When I first spoke with Joan on the phone, I recognized her address and as I drove to her house realized I was quite familiar with the neighborhood. It is a nice middle class suburban development with a large population of younger families with children.

Joan greeted me at the door and directed me to the kitchen table where I began to set up my interviewing materials and equipment. I sensed that Joan was slightly tentative in her approach to the interview, so we spent some time chatting prior to starting the tape recorder. She had another woman managing the daycare with her, so we were able to proceed with relatively few interruptions. As the interview progressed, it became apparent that talking about David was very emotional for Joan. She shared with me that one of the looming decisions for her was whether or not to take David with them when they move. Joan's eyes were moist for most of the duration of the interview and at one point she was very close to tears.

This was my first of four interviews and upon leaving the interview I had very mixed feelings. On one hand I felt exhilarated by the process of gathering such a wealth of information, while conversely I also had an empty feeling as I contemplated Joan's ordeal and her own struggle in deciding what she would do when the family moved. I felt like a 'pathology chaser' in the research field, akin to an 'ambulance chaser' in the legal profession.

I was not able to conduct a second interview with Joan prior to her family's move to Florida. I have since learned that David continues to live with the Powell's and he is continuing therapy in their new location.

Findings

Joan reflected that her original motivation for taking her sisters three children was to help her sister get back on her feet. Now, seven years later, she explained that her own family is suffering, she feels awful, horrible, and her marriage is under tremendous stress. She felt guilty when she expressed that she would not take on this responsibility if she had it to do over again.

Joan's account places the **onset of RAD behavior** in the middle of David's childhood after the initial 'honeymoon' period of their relationship was over. He was already five years old when Joan became his primary caretaker. Although he is her nephew, it is not clear whether she was aware of his challenges prior to his living with her.

When David was around age five, in conjunction with being removed from his mother's care, he had an in-home psychiatric evaluation performed by the department of health. Joan was informed by the administrator, that he had never seen a child score as high in the 'delinquency' category. She couldn't even imagine what questions they would pose to a five year old to make such a determination. One question addressed reasons you might turn off your bedroom light. In her own mind, Joan thought appropriate responses might include that it was daytime or because you were leaving the room. David said he would turn his bedroom lights off so that no one could see what he was doing. When asked what he might like to be when he grew up, David responded with "a policeman". When asked why, he responded, "because, they get to shoot people". Joan was quite troubled to hear this type of response from a child David's age.

Having the experience of observing David over the last seven years, Joan was able to provide me with an account of his **RAD related behavior and characteristics**.

Joan describes David as a child who is always in the middle of other people's business. His **actions** often instigate trouble and he runs his mouth like a 'faucet'. Joan worries that as he gets older he will 'mouth off' to the wrong person and start getting in fights. As of now he has not been physically violent. However, Joan notes that he is very athletic and coordinated and has a fearless **disposition**, not being afraid of anyone or anything.

Because of his apparent lack of control in saying whatever comes to mind, Joan sees the possibility of big problems in the not too distant future.

After going through that bit of dialogue, Joan added that not everything about David is negative. She noted that he is not violent and that his behavior is less severe than some RAD children.

...(he's) never threatening to do bodily harm to anybody, so I guess we should be thankful, like with the children, he's loving and the little kids love to be with him because he's nice to them and he plays with them, so I see really good things...

Joan's next comment in the interview centered around the bad choices David makes in his life. One of these bad choices is to steal things. He steals at home, he steals at school, and he steals around their neighborhood. Joan has experienced incalculable hours of agony over this problem. At home, David steals cash from Joan and Tim. He will go into their bedroom, empty the dresser drawers onto their bed, and sift through the contents. Sometimes he will steal or break items he comes across.

David shoplifts from a convenience store in their neighborhood. He'll come home with things and say that he found them on the pavement behind the store. It's always brand new things still in the wrapper. Sometimes he'll come home with hats or balls or other toys and say that so-and-so down the street gave it to him. Later Joan will learn that so-and-so is missing whatever the item is and David will have to return it.

Connected with the stealing is lying. David will never admit to having stolen something. Even when he is caught in the act, he will say that he was just picking it up, it fell on the floor, or it rolled into his book bag. Once David was being questioned by the police for slashing bicycle tires down the street (he also commits acts of vandalism) and got them so confused by his 'story' that they didn't know what to believe.

According to Joan, David has no respect for his or other people's property.

He tears up everything, like I said. Of course his hockey stick he got. He broke it the first day. He took it outside and just beat it on the concrete until it cracked. And of course he took his dad's \$200 tennis racket and beat it on the sidewalk

until he cracked the frame. I asked him why and he said because he felt like it. He just wanted to do it he shows no remorse for anything he has ever done.

Joan describes how David has taken many of her things, sometimes precious heirlooms, and broken them. He seems to have no regard for feelings that may have been hurt. Joan sees David as “not feeling guilty over what he’s done. What he does is perfectly acceptable to him”. This is highly distressful to Joan. She says all the other kids will feel sorry for hurting someone and apologize. David appears to have no conscience about such things.

During a recent Christmas holiday, David was told that he would not be receiving any presents, in accordance with the consequence of his stealing and destroying things around the house. Rather than be distraught, he announced that he would be handing out presents to everyone else instead. This he proceeded to do without any apparent remorse over the situation, effectively rejecting the discipline and once again controlling his environment.

According to Joan, David displays **developmental delay** in his emotional reactions when he does have them. A recent example was when he set his soda can on the kitchen counter as he passed by. When he returned some one had moved the soda and he couldn’t find it. He began wailing and lamenting the loss of his soda and fiercely asking how anyone could have done such a thing. Joan said, “Okay, I know you’re crying, but how do you feel inside? Are you sad?” David just walked off without answering. Then Joan turned and asked him how he thinks the rest of the family feels when he destroys or takes their things. He answered that he no longer cared about the soda and asked if he could go to a friends’ house.

In a similar incident, David took money to school and was flashing it around. Joan had told the teacher that David was not allowed to bring money to school because of past problems and that she should confiscate it. When the teacher did so, David began crying until the class was upset and feeling sorry for him. He never mentioned the incident to Joan. She found out about it several days later.

The concept of reactive attachment disorder had been introduced to the Powell’s only in the last several months. Therefore, Joan’s **explanation of RAD behavior** was relatively limited. She was, however, beginning to conceptualize various aspects of what she has observed.

In the Powell's case, their **reaction to RAD behavior** has been severe. As stated earlier, Joan had a difficult time through our entire interview. One of her comments illustrated the degree of emotion elicited by David's behavior.

I get very upset. I used to do a lot of yelling. And I guess I just sit back, you know I would go upstairs and I would tell my husband, you know numerous times, I said you hear of these people who, who know they got in trouble because they beat their child or they smacked him or something, and I said, you know what, he almost pushes you to that point. I have to go to my room and shut the door.

Joan further explained that the challenges with David are nearly constant; everyday seems to bring fighting, bickering, arguing, and crying. She described the situation as being extremely frustrating since nothing seems to have an affect on David. Joan said, "A lot of these children just feed off of getting you upset." This remark concurs with Delanay's (1993) statement that children diagnosed with reactive attachment disorder appear to thrive on chaos. Joan quoted recent comments she made to David:

What am I getting out of this? You know you're living here and you're getting to do everything you wanna do and you're lovin' life, but my life is really horrible. I'm in tears, you know, you're nasty and rude to me, you're disrespectful, you steal my stuff. What am I getting out of this? This isn't enjoyable for me this is awful.

A further example of Joan's **reaction to RAD behavior** is her constant worry about people calling to complain about David. He's stolen something; he's called their kids names; he's been disruptive at school. It's difficult for Joan not to take these things personally. She tries not to, but she sees the **actions** of her children as a reflection on her parenting. Although people have told her that it's not her fault, that your kids make their own choices, Joan mused, "You teach them right and wrong, and what makes one not follow that?"

In the back of her mind, Joan wondered what she would do if David really hurt someone badly. She thinks about the things she hears about in the news, shootings, bombings and the like. She wonders if she is doing everything she could be doing to prevent such things from happening.

In public, David is perfectly behaved, but at home he is manipulative and scheming. Joan said, “I am shocked by things David says, I am being treated like crap”. Joan said she still is often in tears when she talks about these struggles. She finds herself putting up with things that she told her mom she would never put up with, and yet her mom criticizes her for not being “nice”.

Joan’s use of the **marital team** has been a helpful approach in **coping with RAD behavior**. She and Tim act as sounding boards to one another and have implemented a form of “tag team” that enables each to experience some degree of **relief** from the stressful parenting situations brought about by David’s behavior.

When discussing **coping with RAD behavior** and **accessing resources**, Joan gave credit to Jim, the **therapist** who first informed her about attachment disorder, as the source of some of the recent improvements in coping with David’s behavior.

Prior to therapy with Jim, much of David’s therapy was individual, and according to Joan, David seemed to manipulate therapy to be pretty much what he wanted it to be. Joan said she and Tim did not feel a part of what was going on. David played games and told stories and didn’t have to address his behavior. Jim has included Joan and Tim in therapy and spent time educating them about the details of attachment disorder. David has had to own up to some of his behavior, and the therapeutic interventions introduced by Jim have been helpful.

Joan has not felt confident about her **self-adaptive parenting strategies**. Referring to disciplinary strategies, Joan said, “you don’t really know about these things, and you’ve never really heard about (them)”. She marveled at the various strategies Jim had introduced, saying that they sounded very simple, but that she would never have thought of them on her own. For example, if David decides not to wash his clothes, then he gets to wear dirty clothes. If he doesn’t do his homework, he misses out on his favorite food for dinner and gets to eat oatmeal. These strategies have really made a difference in helping David make better decisions. As he is faced more and more with the consequences of his choices. Joan says, “I think that’s helped us a lot”. Joan said that she has also been encouraged by her ability to talk with other people in David’s life and ask that they also hold him accountable for his choices and actions.

Teachers at David’s school have been helpful according to Joan. They have been her eyes and ears away from home. When she has requested their help in extending her home rules to the school environment, they have been supportive and effective. As noted earlier, Joan’s mother has been critical of her in the past regarding her parenting of

David. Therefore, **extended family** has not been a particularly useful **resource** to this point.

Toward the end of the interview, I asked Joan if she had any **advice or recommendations** that she would like to share with **other parents** or **professionals** dealing with reactive attachment disorder. To **other parents**, Joan said, “You tend to feel at fault when your child is behaving in terrible ways, but let the diagnosis help you to feel that you have not done something bad.” Regarding **professionals**, Joan said that she hopes more therapists will become familiar with RAD, so that they can diagnose and treat it.

Throughout all of our counseling (professionals) have all acknowledged a problem, but never really helped, kind of just left us saying, yes, he has these problems, yes, this is the problem he's done stealing and lying and all of this, but never really helped us to really understand what was causing it this year we started this counseling and got the diagnosis it's helped a lot with us being involved and knowing, but not knowing all these years I feel bad because I think he could have gotten the help sooner.

Cam and Elaine Curtis

Cam and Elaine are well educated, both holding masters degrees. Cam has an MBA and is an administrator at a nearby university. Elaine's degree is in human resource development. She has not worked outside the home in many years because of her time involvement with their son, Greg. The Curtis's educational background seemed to be an asset in helping them understand the reactive attachment disorder diagnosis. Although they both spoke emotionally of the affects of RAD, they were also able to calmly share their experiences and were eager to provide information that they hoped would help other parents.

The Curtis home is in a residential development that borders on country living. They are on the very outer edge of suburbia, and yet still have the benefits of an established community. We met for the interview on a sunny but quiet Saturday morning. They both had been hoping that their kids would stay asleep until we were finished, knowing that if the kids were awake, they would be very curious about what we were talking about. Besides Greg, 14, the other boys are William, 16, and Steven, 10. Greg was awake and did make attempts to get involved with the interview. Cam and Elaine were very understanding and also very firm in keeping him occupied elsewhere in the house. At one point Steven also ventured into the room. He had a marvelous Mohawk haircut. After saying his hellos, he also exited to other activities.

I was a bit distracted during the interview by Elaine's constant movement around the kitchen. She only took brief moments to sit and talk. I did, however, appreciate the chocolate chip muffins she shared with me. She related how cooking has been a very therapeutic activity for her.

That is one thing that had gotten me through the years, my husband realizes that at midnight it was not unusual for me to get up and bake, but that was my therapy, right? It wasn't so much, you know, eating, although we enjoy doing that, but there was something about actually putting certain ingredients together in a combination and then coming out with a product, which was something I was not able to seemingly do with my children, so it was very therapeutic.

This statement relates to the fact that Greg is their biological child and, therefore, Elaine said it was pretty tough thinking that she may have done something along the way that contributed to Greg's problems.

Findings

The Curtis' oldest son provided some challenging behaviors to deal with, so when Greg came along Cam attributed some of their difficulties with him as just being related to the added challenge of having two kids to deal with. Since Greg is a biological child, I asked Cam and Elaine to reflect on when they first noticed that something was different about Greg. According to Cam, the **onset of RAD behavior** began at a young age.

As a young child, he was always quite defiant. He was the one who when you went out on a family outing would always sit down on the sidewalk when you were walking with him and choose not to go. And so as time went on, we saw that defiance continuing and accelerating, I guess to the point where we noticed more things were upsetting him, he wasn't comfortable with himself.

Elaine added that he exhibited a number of behaviors that were problematic,

“...lying, cheating, being cruel to animals, not respecting authority, if I had the list here in front of me I could go on and on.” Cam added that Greg had problems with stealing for example. “He would go in somewhere and he would see something he would like and when it got in his pocket it was his. He would then lie about where he got it. He would lie about other things, too.”

So, although Cam and Elaine were aware of Greg's problems at an early age, it has not kept them from recognizing the positive **moods** and **dispositions** they have observed in him. Cam said that Greg is the kind of kid who likes to help people. He likes to be a mentor to younger kids. Gail added that “he's always been very sensitive. He likes sports, but he's more the artsy kind, he likes pretty things, he's always been attracted to beauty.” She said he loves flowers and loves planting. Cam added, “I think when he works hard physically, when he's on a project, he's not thinking. He doesn't have to be thinking about anything else and he feels this mental health satisfaction that he gets in very few places.”

In the interview, I asked Cam and Elaine to relate what they saw as **RAD related behavior and characteristics**. They were able to provide a number of examples. According to Elaine, Greg has had a terrible time ending relationships. Departures are stressful for him. One of the worst experiences was at age seven when his grandmother died. Elaine said there was much more acting out after that and much more depression. Related to the depression were other challenges that Cam related, including Greg's

allergic reaction to antidepressants. Prior to discovering this allergy, Greg experienced a number of bouts of psychosis that Cam believes were medically induced. Greg has also gone through periods of paranoia. **Developmental delays** in speech and academic skills have also been a real problem for Greg.

Elaine related that when Greg was younger, he would take out frustrations on animals. For example, if a dog was around, he would antagonize it. He would not go to the extent of killing, but he would torture animals. This was especially true if he was upset. Elaine said she is relieved that he seems to have outgrown this type of behavior.

In general, Greg was often out of control. Elaine related her basic impression.

There was a lot of throwing, wailing, you know, just pitching, launching things, attacking, charging so at his worst he was seeing things, hearing things, he was a danger to have in the house, he was threatening to kill people, he was threatening to hurt people, he was extremely defiantthat was another thing actually that made it seem very much like attachment disorder, that the brunt and the heat of his anger was at me, and he truly, truly wanted to kill me. I mean he tried...he was...God, he would just attack me in the house like physicallyI would not put it past him if he had woken up in the night and in some sort of way tried to hurt meit was his rage, his real hard core brutal rage was directed at me. You know at seven Greg was threatening to stab me. He's not good at not blaming Mom. His anger and his real violence and aggressiveness, although directed at everyone, was really funneled and focused directly at me, he wanted to hurt me badly, he wanted to kill me.....

As the interviewer, I was amazed to hear such details. I was further amazed that these parents were still able to spend so much effort on a child who had obviously caused such turmoil. In sharing their **response to RAD behavior**, Cam and Elaine provided details on how they have been able to get through these challenging experiences.

Cam began sharing his **explanation of RAD behavior** by stating that Greg “does not fit the typical attachment disorder description. He is not adopted, he has never been abused, he's never been abandoned. Most people who are looking for attachment disorder are looking for a background of abuse or adoption”. Cam believes that as an infant and a toddler Greg did not neurologically perceive the world the way most people do. Elaine added that for some reason he did not seem to feel the love and bonding that his brothers did or that a ‘normal’ child would. She believes that Greg did not sense that he was being cared for and therefore did not respond in a reciprocal manner. Both Cam

and Elaine see Greg's behavior as a way to protect himself from loss and as an effort to control his environment to his advantage.

Cam and Elaine's **reaction to RAD behavior** is exemplified in Elaine's statement about the period of time when they were thinking of a residential placement for Greg. "I was at the end of the rope, I did not want to give him up, but I had to protect myself and my other kids." They both felt that they could no longer safely keep Greg at home. "We were terrified at night, I was afraid that he'd come in and try to, you know, hurt me in the night."

As it turned out at that time, they simply could not afford residential treatment. Greg had been hospitalized a number of times already and they had not yet learned of sources of financial assistance. Elaine had not been working outside the home because she was spending so much time dealing with Greg and doctors and therapists. She was quite frustrated.

It was very emotionally stressful, and of course I didn't understand why, here I am, the one that's giving him all the love and care, but he was very, very...at some deep level, I had not saved him, I was not saving him, I was supposed to be helping him out of this. There are just so many stacks against you, you wonder about most people being able to survive this. You know, talk about people working. How can people work. How can two parents work and deal with a child like this. And how many parents, how many families can afford to not have both people work, at least in some capacity. It was completely emotionally and physically draining, and then you're constantly in a position, you are constantly in this subservient position of looking for help, you know, and the thought always is, you know, what have you done wrong.

As the interview progressed, I could see that Cam and Elaine treated each other with deep love and respect. They had been through a lot together and it was obvious that they had used the **marital team** to their advantage. A number of times they finished each other's sentences or both responded in tandem with the same word or phrase. Elaine shared that she thinks they have an unusually strong marriage. "If you don't have a strong marriage, if it's only a normal marriage, forget it, it won't work".

In our second interview, which we conducted by phone, I learned that Greg had been hospitalized several times in the months since we first met. His bouts with psychosis were no longer restricted to onset by allergic reaction to medication. It now apparently was a near constant state for him. Cam and Elaine were seriously considering

institutionalization. The **rethinking of parental expectations** was influenced by the worsening of Greg's symptoms. Prior to this, Cam and Elaine were sure that they would be able to handle whatever might come up.

Throughout this entire experience with Greg, **accessing resources** has been very important to the Curtis family. One of the first resources they mentioned was FAPT. That stands for Family Assistance Planning Team. FAPT is a community based organization that can provide financial assistance to families that are unable to meet the medical expenses associated with caring for a family member. This proved to be a great **financial** resource. But it didn't come without challenges. In Elaine's words, "FAPT...talk about a humiliating, intimidating situation that was for me. We went into FAPT and they were like, what do you want? And I was like, I don't know. But I don't want to lose my natural born child." Elaine says most people don't even know that FAPT exists, and that there are other sources of financial help as well. Cam's parents also provided **financial** assistance at a time when they simply didn't have the money to pay for therapy and day hospitalization.

Extended family was a huge resource according to Elaine. Cam's parents were very emotionally supportive. And even though their extended family is not local, Cam and Elaine received a lot of support from them.

Towards the end of the interview, Elaine had to leave. Cam and I remained for a while and I asked him if there were any other resources that had not been mentioned to that point. He thought for a moment and then presented some very intimate comments.

One of the things that we haven't really talked about is dealing with a spiritual level. The fact that I know that there is a stronger power behind me. I don't see myself as being an overly religious person, but I am a very actively religious person. And I feel that the support not just from the other Christians in my church, but just the support that I feel from God to continue moving forward and to raise these children, in particularly this child. I know that it is my job to do that. And it is a job that was given to me, and that I need to continue with and work with, and that I can't give up in knowing that. That's a lot of support. I mean there is a feeling that everything is going to be all right in the end, and I can work through this. So I guess we talk about the physical support. The support that you get from the county and that you get from a good counselor, a good holding therapist, and the financial support and all of that. There is also the

spiritual support that just keeps you moving. Just keeps you going. And that is important and I wouldn't suggest to someone who was going through this situation, if they didn't have a church home, that they might want to consider it. Cause that's to be able to want just for the people support that that would be, that that could be very helpful, but also for the spiritual support. Which is what it is all about. So I would encourage people to at least look at that avenue. That can be hard because a lot of people don't want to look at that avenue. And don't feel they have it in them. Doesn't mean they can't get it. So I guess that's an area of support that is important. It's interesting, in this support group that I am a member of, a tremendous number of strong Christian families are a part of that support group and bring it into the support group and they talk about the relationship with God. And dealing with all of this, and the support that they've felt. So I think that is an important aspect. That they look for some spiritual guidance as well as the physical.

When it came to citing **professional resources**, Cam and Elaine had quite a bit to say. Elaine said, "We've had, probably twelve different pretty certain diagnoses on that child. RAD matched so much. Everything else that they'd give us with a list of twelve symptoms, you know he'd have six. You know with attachment disorder he had (Cam and Elaine in unison) eleven out of twelve".

And you know it was the first thing that really truly sounded like him. Everything else you know they didn't call him back, you know they wouldn't let you call somebody bi-polar if they were under twelve, you know I mean we were told he was schizophrenic. We were told he had organic brain syndrome. We were told he had chronic depression. We

were told he had attention deficit hyperactivity disorder, you know the list goes on and on. We were told he had many, many, many things and sure he probably has components of all of them but I think so do most of them (RAD kids). You can pretty much find in there whatever you want. The one I like is organic brain syndrome. That we paid a company \$500, over 3 hours of consulting to find out and get a very sympathetic look and "I wish you a lot of luck." You know it burned me. You know that blows my mind when I think about it. Now I mean these were all in attempt to get a diagnosis. But nobody could diagnose it. So whether the diagnosis was correct, you know, how do you treat it if you don't know what it is?

Cam said that they were literally kicked out of sessions with **therapists** numerous times because Greg was out of control and they couldn't evaluate him. They did have one bit of luck from a psychologist.

I don't know that he was the greatest of psychologists in the world, I don't...he was a nice guy, struck me like somebody who had also come from a troubled background and was trying to do some help and whatever else the man did or didn't do, he told us about reactive attachment disorder, and about Erin and Carol (RAD therapists), and if it hadn't been for him, I shudder to think..

With Erin and Carol they had quite a different experience. They felt very supported. Elaine said, "They told us what great parents we were. I mean we just wanted to cry. After all these years of people just beating on you." Cam said that these **therapists** acted as if they really cared about making Greg's life right. After 13 or so months, he felt that they came out with a very different child. Elaine also added her thoughts.

And I mean you've got to understand that as I said the first day was probably seven hours and we met everyday for probably a week and for multiple, multiple hours and you're talking two parents and two therapists. And then you go to the following week when you probably met three or four times for many, many hours. And then you go to the following week where you know, I think probably then we went back down to three times a week, then two times a week and after a while you know it was one therapist, two times a week. So you are talking hundred upon hundreds of hours of therapy. How many families are going to give both parents up? How many families can afford physically and emotionally and time wise with other children to have both parents available for that kind of thing. So I mean that's why I'm saying I haven't written a book (researcher's note: she says she wouldn't know how to individualize the experience). What do you say to these people, you know?

After all the experiences they have had, Cam and Elaine thought of many things they would like to share with **other parents** who find themselves in a similar situation. They know that people think "how did you let your child get so out of control?" and that a 'bad' child reflects negatively on parents in our society. Cam and Elaine said that they felt like bad parents for many years.

My husband and I both have masters degrees, we have good educations,

we both come from good families, and then we have this kid who goes through ADHD and all the trials of medication, a separate self-contained learning environment...then we get this other kid who's got RAD and at that point we're feeling very defeated, as it turns out our third one ends up in the gifted and talented program. But we weren't able to put that in perspective for a long time.

Cam recommends that anyone with a RAD child should seriously consider taking advantage of a support group. He said he found one on the internet and wound up meeting a number of members of the group for picnics and other supportive gatherings.

I think support groups are really important. There are people like me who will only do it on the internet. Or they will sit in a room on a Tuesday night and drink coffee. You know there are other people out there. Whether you give a knowing wave and a smile or you sit down and actually have a conversation with them. The fact that you know that there are other people in the same situation.... It can be real helpful. And they really do support the idea of support groups. I think that that's important. And it's worked in so many different ways. I mean when you take a look at alcoholics anonymous, you don't take a look at the differences. You know the fact is when you get together with other people with the same problems, you don't feel so isolated, like nobody understands what it is like to have this problem. To find somebody who does and you can make the connection. You can share ideas. You can talk about anything with these people. Because they know a little bit about what your life is like.

Something else Cam felt very strongly about was not isolating yourself.

Don't isolate yourself. You've got to open the doors. You've got to step outside, to bring the kid out in public. You don't notice these things until you've been through them. But so many times now I've been in the 7-11 and I've seen the RAD kid sitting on the floor. And you know and as painful as that is for that mother or father, or brother who is standing there totally humiliated by the whole thing. They are out there. They are out in the world. And you've got to do that. And that person could be on their way to just the greatest holding therapy that there is. Or could be on their way to church, whatever. They are going to get the power to continue through another day. But you've got to push yourself outside. The

temptation is to not let anybody in our house. You can't have parties. You can't have dinner guests. You can't bring in a student to do research. You can't do anything because we've got this monster living with us. And you've got to avoid that. You've got to think smart. Three years ago, if you wanted to come and talk to us we would have said no. You know. We'll meet you somewhere where we can talk with you, maybe. If we can find some place to hold him down for a while. You just can't lock yourself in and say I've got this bad child. And I've got to just keep him here. Cause he's not going to get better within the four walls of your house.

Both Cam and Elaine had **recommendations for professionals**. Elaine said that the big joke between Cam and her was that every counselor they went to, in addition to everything else, would say, "Can we give you a piece of advice?" Elaine wryly commented, "Please don't say this." She also said that it was very frustrating when doctors or therapists would tell them that they needed to get a break. They would say, "Where there's a will, there's a way." Well, Elaine asserted that they already knew they needed a break, and "let me tell you, there ain't no way, there was just nobody to watch our children". Elaine said that just being supportive is one of the best things a therapist can do.

Just to be supportive in that way. And to have them tell us, I mean these were people that sat there and told us what great parents we were. I mean we just wanted to cry. After all these years of people just beating on you.

Cam talked about the controversy over some attachment therapy treatments. He urged therapists to be open to things that work, to learn about them.

.... Holding therapy being as controversial as it is, I mean if somebody had told me ten years ago that, well if a kid needs help you've gotta hold him down and do this stuff, it's like...no way...you know, that's not the way you do therapy. But when you get to the end of your rope, you'll find lots of different things, and you've got to think outside the box.

Diane Bowes

Diane told me that from an early age she knew that taking care of children would be a big part of her life. Children seemed to always gravitate towards her. She was often at the library reading children's books. After graduating from high school, Diane began working as a teacher's aide. That led to jobs working with mentally, emotionally and physically challenged children. In the early 1980's she started a day care business. That lasted a few years until her first child was born. Since then she's been caring for children in her home and taking in foster children as well.

When I asked Diane if her husband, Harrison, would be available for the interview, she explained that he worked long hours and didn't have a lot of involvement with the foster children and we should proceed without him. Diane's children are Michael, age 14, and Melanie, age 7. She also currently has three foster children. They are Susan, five months, Ricky, 5 years old, and Heather, who is 7. Heather is the child diagnosed with RAD and had been living with Diane for two years.

Heather was five years old when she came to live with Diane. The original plan for Diane was to only take infants and toddlers up to four years of age. Diane's own daughter was five at the time and she thought maybe it would work out. She hoped that perhaps the two of them would be good for each other and be playmates.

Diane is an example of a great foster parent. She really advocates for the kids she cares for. Heather is a prime example. She related to me the many experiences with teachers and committees at school where she tried to educate them on what she saw in Heather's behavior that they were apparently missing. She also met with Heather's grandmother and tried to help her prepare for the possible plan of caring for Heather. That plan never materialized. At the time of the second interview, Diane informed me that Heather was now living in a group home. I could tell that Diane had mixed emotions about this. She truly felt that it was in Heather's best interest because of the severe behavior problems she posed. Based on our interview, it sounded as though Diane made this decision as a last resort.

Findings

Attachment disorder was unknown to Diane when Heather arrived. So, although she didn't have a name for it at the time, for Diane, the **onset of RAD behavior** came almost immediately. From the beginning, Diane noticed something 'different' in Heather.

You know you could kind of feel the current. She was a cute little girl, though. She had a lot of problems. She kind of watched me, you know. She'd color and watch me she'd tried to be this nice little girl, but all the while you could see that there was a current just watching her. And then she would start doing just little things, saying things, and I would say you know you shouldn't do this. You know that's not right. She'd say 'okay mommy'. Cause she came in the first day calling me Mommy, you know right off the bat. That was a little.... Too soon. You know.... Most kids kind of wait before they jump in with that. She came in with that and I was Mom.

With regard to **RAD related behavior and characteristics**, Gail related a significant problem that I will describe initially. Heather had a severe form of encopresis. She made a habit of smearing her stool throughout the house.

She would smear poop all over my bathroom. All over my rugs. My toilet seat covers, curtains, shower curtain. There is poop in the hanging basket, on the wall. And then there was a little valance over the top of the shower curtain. She pulled that down and there was poop smeared all over that. On the back of the toilet and everything. It went all over the floor. There was poop on the towels, on the little vanity, all over the toilet. She would put it up under the rug. And even up in my daughter's room. In the tracks of the closet. She put poop in it. You know where you have the sliding doors.

With that behavior as a backdrop, Diane shared other characteristics about Heather. She liked arts and crafts. She played games nicely with other kids. Reading stories and watching videos were favorites for Heather. Short family trips, picnics, and the zoo were also activities that she enjoyed. There were days, according to Diane, that Heather was just “this nice little girl, a nice kid”.

Then there were the days that Heather seemed to sabotage any good that had built up. Diane saw a lot of her behavior as a power struggle. She was also very obstinate and stubborn according to Diane. Heather would move real slow, and she'd try to make other people late. She would act as if she didn't know how to accomplish a particular task. Diane said that when she first arrived she would put her clothes on backwards or inside out and put her shoes on the wrong foot.

Eating was also a problem.

At school. She would always throw her food away and come home and tell me she ate it. She wasn't eating her lunch. And then the teacher would say she's hungry all day long. At home. But if she didn't get the special treat, because she was having a bad day, she would make herself throw her food up. She would just gag it up. She would put so much in her mouth it would make her gag it up. There was a time when she would sit and take forever to eat her food. We would be there at the table two or three hours. She wouldn't eat. She used to sit at the table and eat with us until she would be very disruptive. She would eat with her mouth open and let the food fall out. You know, and be really obnoxious.

Diane stated that there were **developmental delays or impairments** as well. Heather appeared to have some sort of dyslexia. "She would write from right to left and from bottom to top. Even when she was copying from a blackboard, letters were missing, things were backwards. She also appeared to have a very short attention span."

Diane said she has had the opportunity to be in Heather's mother's home and talk with her and Heather's grandmother. She had also met one of Heather's previous foster mothers. Based on these experiences, Diane has put together an **explanation of RAD behavior** as it pertains to Heather. Diane told me that she sees Heather's mother as having some sort of attachment disorder herself. "The mother apparently didn't get what she needed. Now she is doing the same thing. The little one who is home.... is starting these things like Heather."

Diane also related some of the stories of neglect she heard about.

There wasn't much hugging or nurturing. Not enough holding or saying I love you. Things like that were not there. I guess having to do a lot of things for yourself. I'm sure there was food. One of them would cook and give it to them. Then there were times when nobody did anything. The neighbors were the ones who said they saw them eating out of the trash can and on the ground. So I don't think there was a lot of mothering or teaching or nurturing. She didn't get that. And Heather wants to be the baby. She is constantly trying to be the baby.

“So I think we came to the conclusion that she got stuck somewhere in that mode. She doesn’t know how to come out of it. She doesn’t act like a seven year old,” said Diane.

According to Diane, Heather has pushed her away emotionally. She sees this as intentional on Heather’s part so that Diane can’t love her and can’t help her. She said that she thinks Heather would rather be angry and feed on her anger because that’s what she’s used to.

*They want love, but they are afraid to let you love them.
They know that they are going to have to leave. Or maybe they
feel that if they love you what’s going to happen if they let their
guard down.*

Diane started relating her **reaction to RAD behavior** by saying that Heather was really beginning to take a toll on her. “It was hard and I was frustrated. You know it was like I was bending over backwards to make this child happy. I was doing everything possible to help her to adjust...”. She added that in the beginning she would holler a lot because she was so angry.

Once, when Diane was speaking with a social worker’s supervisor, she was told, “I hear the anger and frustration in your voice. I’m going to get you help.” At that point Diane said she was thinking, “The heck with that. I can’t do any more!”

Because Heather was able to get teachers and counselors at school to feel sorry for her, Diane said that she would get calls from them telling her that she was not a good foster mother. They told her she was unfair. “So I looked like the bad guy, but Heather was in there playing the role. She was manipulating and controlling them. Diane would go to meetings at school and said “I’m begging, begging” them to work with me. She said that she felt very isolated at these times.

Although Diane said that her husband did not take an overly active role with Heather, she did say that the **marital team** was an important factor in coping. She said that her husband was emotionally supportive of what she was doing and that the two of them were able to work together at not allowing themselves to become triangulated by Heather’s behavior.

Heather lived with Diane for about two years before Diane learned about attachment disorder. In the mean time, Diane came up with her own **self-adaptive**

parenting strategies. When Heather first began smearing her stool around the house, Diane would take toys away. She soon progressed to bringing out a bucket and disinfectant. Whenever Heather made a mess, she was required to clean it all up on her own. This didn't cause the behavior to stop, but it took a lot of work and worry off of Diane. She dumped the consequences onto Heather instead of herself.

Diane said that she learned a lot by trial and error. She came up with various rewards and punishments and would use them until they were no longer effective and then move on to something new. She relied heavily on the concept of earning rewards.

Despite her efforts, Diane came to the point of **rethinking of parental expectations** on two occasions. The first time, she was all ready to return Heather to the foster care agency, because the severe behavior was not changing. She relented when foster care told her that they wanted her help in transitioning Heather back to her birth mother. That plan was not successful, and so Diane again was at the point of realizing that her best efforts were not succeeding. This was when she began advocating for a group home setting for Heather.

When it came to **accessing resources**, Diane's **spiritual** base was very important and helpful. She stated that she is a minister and a Sunday school teacher. Her husband is a church deacon. I asked Diane if her faith helps her cope and influences the way she thinks about caring for children.

Yes, yes. Because without the Lord, some days I don't think I would make it. And I do pray throughout the day for more strength and patience. Cause I mean I'm human and I'm in the flesh. I'm not perfect and I do need that. Sometimes I'll give my mom a call and we'll have a prayer. Because my family has a lot of gatherings together. They also pray for Heather. Yes, because this gives me the strength. This gives me strength everyday to deal with this situation. Because when you look at the word and you talk about the spiritual Christian virtues. About love, patience, long suffering, goodness and kindness. This is a part, even with our own children. Not with just foster children. But with her so much more. Each day you're dealing with one of those fruits. What day is it going to be today. You have to love. You have to do that. Even though you might not like what they're doing. You can't say, I'm not going to love you or I'm not going to like you anymore.

Diane has dealt a lot with **teachers, school counselors, and school committees.** This was usually very challenging because none of them could see Heather's behavior at home. She had to do a lot of pleading and advocating for services on Heather's behalf. Diane asserted that this was one of the most frustrating experiences for her.

There were several experiences with **therapists.** Diane was able to quickly determine which ones understood Heather's problems and which ones were fooled by her. When Diane finally located **therapists** who were familiar with attachment disorder, she recalls, "It was so nice to hear somebody say you are doing something right. I could finally talk to somebody who does understand".

There are a number of things that Diane would say by way of **advice and recommendations** to **other parents.**

....it's not easy. It's just not. You know we have to have patience. We have to be tough and strong. And not crumble. These kids can push you over the edge. And they can make you lose control. And that's what they want you to do. And it is frustrating.... You know, I can understand your frustration. With all the problems we're going through. We're not told that these kids.... have any issues. They just kind of tell you what they (foster parent agencies) know.

Diane stated that although it can be extremely frustrating to care for these children, there are also times when it can be very rewarding.

Because there are days Heather will let go. And she will let you come in. Really care about her. And she's just totally this other little person. When she is like that. I mean you can actually see the change in her. There might be a few times when we might say Heather come on, don't do that let's get back on the ball. But then her whole persona changes. You can see that there is a little girl in there. There is not a little animal that's mean and cruel. That has to tear up everything. But there is a nice little girl in there. Who is crying for love. So you really do have to overlook and try to reach in there. And it is not easy every day to do that.

Diane's advice to **professionals** is aimed at teachers, since she had many challenging times with them.

....get educated.... Then having these children come into the school system, you need to know something. And I think they need to have some teachers trained in these areas. With special children like this. Because you can't just mainstream them in the classroom. They can be disruptive. They can manipulate and control. You need to work with the parent. Not make the parent feel like because we are foster parents, taking care of these kids, that we are the bad guys. These children know how to manipulate and control. They've been doing it. So they know the routine. They know how to reel you in.

Diane said that if you think something is going on in the foster home, call and find out. Take the time, don't just assume that what you see with the child at school is the whole story.

Gail Faulkner

Arranging a meeting with Gail proved to be challenging because she was in the middle of working on her masters thesis in theological studies. This is a second master's degree for her in addition to a Ph.D. Her background includes extensive knowledge in the field of linguistics, which was helpful in relating her story. It was also helpful to her when she first adopted her daughter, Christine. Gail was quickly able to recognize some of the developmental delays that would present challenges.

Christine was adopted as a toddler from Central America. Gail provided a detailed and engaging account of the entire adoption process. This allowed me to see the articulate and accomplished side of Gail as a person. She encountered some harrowing experiences going to Central America, and she has triumphed over numerous challenges involving Christine.

Gail's husband, Henry, has been very involved with Christine and with therapy. He unfortunately had the flu when I visited them and only made one brief appearance to see what was going on. He works for the government and is active as a leader in youth organizations and youth sports.

Gail and Henry have one biological son, Robert, who is married and expecting his first child. Gail related that Christine was very excited about being an aunt, saying that she will be a very 'cool' one.

An overriding challenge for the Faulkner's has been dealing with depression. Gail said that she and Henry and Christine have each been depressed over significant periods of time in the last several years. At the second interview, Gail indicated that the challenge of dealing with depression was still a big factor in their lives.

Findings

For Gail, the **onset of RAD behavior** began even before they left Central America for the return trip to the United States. Gail responded quickly when I asked her when she first noticed troubling behavior.

Our trip back. It was hard for me. She was frightened any time I left her, which was really horrible. I mean I couldn't get up and go to the bathroom on the same floor without her screaming. After a while it loses it's appeal.

When they got home, Gail noticed another unusual behavior of Christine's, that caused her concern. The following quote illustrates not only Gail's understandable excitability as a parent, but also her ability to find humor in the bizarre.

We'd have to keep her from picking up food in the gutter and eating it. I mean that freaked me out. I was not an ideal mother. I just screamed. NO, NO, NO, NO, Never. It doesn't taste better with mud on it. Or whatever is in the gutter.

Based on Gail's comments, Christine was definitely a child who came with a lot of challenges for a parent to deal with. Chief among **RAD related behavior and characteristics** was anger. Gail stated that most of this anger was focused on her.

And she would take it all out on me. So that's the part that's like living with a domestic terrorist. You're taking her in the car and you never know when she might start screaming when you are in traffic. Occasionally she would throw things at the back of my head when I was driving. She'd take off her shoes and throw them at me. It's not like it happened all of the time. But a shred of that was always there.

Christine was also frequently controlling and manipulating according to Gail. Those were her two main skills. They kept the relationship from being easy going in Gail's view.

.....she always had to be hyper vigilant to keep me under control. Which meant I couldn't go to the bathroom unattended. Or go get my husband. Or other things. It wasn't a trusting relationship with me. She felt she had to control it. And at the same time she had such anger

There were also a number of **developmental delays or impairments** that contributed to difficulties. One of these was language. Because of her linguistic background, Gail estimated Christine's Spanish to be at the 18 to 22 month level, even though she was 3 years and 3 months old. Christine did not have the linguistic capacity to talk about her experiences and feelings.

Another problem was Christine's developmental eye disorder. This was a problem when she started school. Gail recalled when Christine really started needing to see the blackboard in the third grade, that she began falling behind and really acting up. She has other developmental disabilities, probably caused by the developmental eye disorder, by the delay in language development, and the stage-two malnutrition that she suffered as a child. Gail explained that Christine has had a lot of difficulty in math because of her vision problems. She missed learning the fundamentals and had recently flunked a half semester of math. This put Christine back into depression, something she has been struggling with periodically.

Other school problems aside, Gail said that Christine usually "charms the socks off her teachers. She has a sterling perception. She can figure out what they want and give it to them." But Gail added that the strain of doing this would show up at home.

That's why it would be so hard. Her behavior would be typical, but her.... Temper tantrums would have kind of a wild energetic edge That I could feel. And every once in a while (she) would explode and just go and pop.

Gail has made an effort to help Christine compensate for some of her challenges. At an early age, she started Christine in martial arts. That helped improve her coordination and confidence. Gail said she has also encouraged Christine to develop her talents, and she has become very good at drawing and very good with animals. Gail proudly related that horseback riding is one of Christine's favorite pastimes.

"I don't know if she ever had the opportunity for a positive attachment during her first three years." Gail began her **explanation of RAD behavior** by sharing what information she has been able to put together regarding Christine's first years of life. Some of what she knows came from the nuns at the orphanage. They told her that Christine was terribly neglected and usually had very little to eat.

Gail had been assuming that the woman who brought Christine to the orphanage was her mother, but Christine told Gail that she witnessed her mother being shot to death.

According to Gail, Christine fantasizes her birth mother to be "a perfect saint". Meanwhile, Gail gets blamed by Christine for anything that goes wrong. Gail stated that this is her understanding about attachment disorder; that the adopted mother is "always at fault", while the birth mother is "absolved" of any wrongdoing.

Gail explains Christine's manipulating and controlling behaviors as survival skills. In the orphanage, she was the "favorite" of the head nun. She had an "uncanny" ability to 'read' adults.

That's how she survived. So the problem came when she assumed that her relationship with me was one that she had to control and manipulate. Because controlling and manipulating powerful adults was how she survived... and she knew I was a safe person to act out on. No matter what would happen, it would be my fault. So I was the person that she took her anger out on. She usually did it when she was alone with me. I don't think my husband saw more than ten percent of it. Believe me.

Referring back to Christine's language development, Gail said that if a child is adopted after about ten months old, that it's better to wait until roughly thirty months. At this age they generally have enough language to be able to verbalize what they are experiencing. Gail expected that at 3 years, 3 months, Christine would be fine. However, because of her language delays, she was not able to talk about what had happened to her and Gail said she thinks this was a contributor to Christine's continued trauma as a child.

"It was very frightening... Extremely isolating.... we were most under stress." These are some of the phrases uttered by Gail to describe the **reaction to RAD behavior**, which she and her husband experienced. Christine could change her demeanor so quickly, that Gail would often appear hysterical or over reactive in the eyes of other professionals. Gail asserts that Christine was able to "con" many therapists into thinking that the problem was all Gail's fault. Gail stated that as a result of suspicions regarding her parenting, and the emptiness she felt because of Christine's emotional distance, her mental health deteriorated.

I went into a depression. I had never been depressed before. You know I've had a colorful life. So it's not like I hadn't had a reason to get depressed. But the depression came when she pulled away from me. She would pick those little places for the fight where I was tired or hungry. But she pulled away from me.... And I was trying to help her. And I just felt hopeless.

One of the most helpful and successful approaches to **coping with RAD behavior**

for Gail has been the **marital team**. Gail emphasized that “our strength as a couple has always been our ability to work as a team”. Many times Henry has gone in and dealt with therapists or teachers when Gail had run out of patience with the way they were dealing with Christine. One of their worst experiences was when a therapist directed them to split up their team effort and have Gail deal with Christine alone. Gail said this resulted in all of them going into depression.

Early in their relationship, Gail said she observed that Christine often felt insecure and frightened, especially at night. Gail implemented one of many **self-adaptive parenting strategies** by sleeping in the same room with her. Then Gail moved out and the dog moved in. When the dog died, they got an alarm system, in part to give Christine that extra measure of security.

Also, shortly after Christine arrived, Gail said she started getting videos for her. She got “The Land Before Time” in Spanish. It portrays a dinosaur whose mother dies. Gail said that Christine would curl up on a chair and watch it over and over. They also got “American Tale” in Spanish, and later, Bambi.

Again the mother gets shot. That’s real life for her. That’s not fantasy. So that’s a lot of the way we did therapy. I would cuddle her. And give her bottled juice and things like that. Give her bottles.

Although Gail initially felt prepared and capable to parent Christine, she did arrive at a point where there was a **rethinking of parental expectations**. After many challenging experiences and therapies that didn’t seem to be helping, Gail shared that she started to waiver.

My health was starting to deteriorate. She was getting bigger and stronger than me. I just felt that soon we’d have violence breaking out in the house. And I said to (the therapist), if Christine’s health depends on me than we have to find another alternative because I can’t live like this. We have to look to foster care or something else. If it all depends on the mother, I can’t be that mother. We have to find another mother.

Fortunately, it never came to the point of having to find another mother. Gail continued **accessing resources** and experienced a degree of improvement. Gail spoke highly of the help she received from a homeopathic practitioner. Christine has taken certain homeopathic **medications** targeted to a particular symptom. Gail said she

preferred this route over more “generic, shotgun affect” drugs like Ritalin, Dexedrine, or Paxil.

Included in those resources that Gail said she accessed are a **therapist** through her **church** counseling service, a family **doctor** who referred them to a helpful **psychiatrist**, a very helpful **school counselor** who let Gail contact her at home whenever she felt the need, and an ethnic/cultural **foundation** that has been very helpful to Christine in addressing ethnic issues.

Gail explained that she has spent a tremendous amount of time with various **teachers** and **school committees**. She has had mixed support from **teachers**, some have been helpful, while others have been resistant to making allowances for Christine’s challenges. Accessing special services through **school committees** has often been frustrating according to Gail. She has spent a lot of time advocating for her daughter, sometimes to no avail.

Another resource that stands out in Gail’s mind is the help from **therapists** who were familiar with reactive attachment disorder. They provided tremendous support and engaged in therapeutic work that was different from what Gail had previously experienced. Gail and Henry were given much more active roles in therapy. Holding therapy was implemented as an alternative treatment for re-establishing secure attachments.

Gail had several pieces of **advice and recommendations** for **other parents**. She advises working with therapists who are well versed in RAD theory and treatment. She also recommends working with therapists who are not afraid to admit it when they have been fooled by a RAD child. She would look for a therapist with a “destination philosophy”, that is, one who believes in therapeutic recovery. Stay away from therapists who have a “journey philosophy”, who never expect to reach a final state of being well. Lastly, Gail would support parents in realizing “that you usually know your own situation better than anyone else”.

To **professionals**, Gail said the most important thing they can do is to listen and believe parents, and not judge them on how a RAD child appears to them in their office. Next, she urged professionals to use the strengths found in the family, such as the marital team. Getting educated in RAD theory and treatment would also be high on her list of recommendations.

Table 1

Core Categories

Recognition of RAD Behavior

Onset of RAD behavior

RAD related behavior and characteristics

Actions, moods, dispositions

Developmental delays or impairments

Response to RAD Behavior

Explanation of RAD Behavior

Reaction to RAD Behavior

Coping with RAD Behavior

Marital Team

Self-Adaptive Parenting Strategies

Rethinking of Parental Expectations

Accessing Resources

Extended Family

Financial

Spiritual

Respite Care/Relief

Medications

Organizations

Church

School Committees

Community Services

Foundations

Professionals

Therapists

Psychologists

Psychiatrists

Doctors

School Counselors

Teachers

Others

Advice and Recommendations

Other Parents

Professionals

CHAPTER V

DISCUSSION

The purpose of this study was to examine the experience parents had with a child diagnosed with Reactive Attachment Disorder (RAD). I accomplished this by conducting in-depth field interviews with five parents in four households, and conducting follow-up interviews by phone or in person. In each case, parents were generous with their time and willing to freely reveal intimate and detailed accounts of their experiences. Both a constructivist and a coping theoretical framework guided my investigation. As I began to analyze the results of my fieldwork, several categories and themes surfaced. Constant comparative qualitative analysis resulted in the formation of common core categories that became the basis for describing the experiences of the participating parents. Numerous verbatim quotes were used to convey the emotion and thoughts of parents exactly as presented in the interview.

This chapter begins with a summary of findings and references to supporting literature. This is followed by a discussion about the limitations of the study, and sections on the implications for clinical practice and future research. The concluding section contains brief personal reflections regarding my experience of the process of compiling this research.

Summary of the Findings

The parents in this study were asked to share their personal experience with RAD. Interviews were conducted in a semi-structured format using broad-based questions that allowed for a free range of response. My investigation was intended to produce a general narrative of experiences rather than specific details about therapy or individuals with whom parents interacted. This narrative was intended to help fill the gap in research reflecting a family perspective on RAD (Cicchetti, Cummings, Greenberg & Marvin, 1990). The general focus of this summary is on the response to RAD that parents shared, including coping strategies and use of available resources, and on the thoughts that they would like to share with others based on what they have been through.

Consistently, parents shared the range of emotions they had experienced as a result of having a RAD child in their family and home. The stories of frustration, anger, stress, depression and isolation had strikingly familiar sounds across the cases studied. These parental responses are quite typical according to Delaney and Kunstal (1993) in

cases where children see their parents as “unresponsive, unreliable, and dangerous” and act accordingly.

Further, the ‘not knowing’ aspect of why their child was responding in this manner, left parents feeling helpless and hopeless, feelings that are not uncommon for parents of RAD children (Pickle, 1994). The self-protecting, mistrustful, and unloving behavior of their child caused feelings of rejection and failure in parents. It was extremely hard not to take these behaviors personally or to rule out intentional malice towards them from their child. Again, this is a common parental response to RAD behavior (Welch, 1988).

Having the diagnosis of Reactive Attachment Disorder appeared to help most parents make sense of their child’s behavior. In looking at the stories through a constructivist lens, I realize that parents were relating their perception of reality as they had construed it. I can not comprehend what it must have been like for them prior to having a diagnosis for their child that made sense. Because in each case parents related what a relief it was to finally have a name for what was happening. In some cases, having a diagnosis that seemed to fit provided partial closure to some of their pain. It also appeared to provide some hope.

Parents used many of the same words and phrases as they talked about their child’s behavior and about their experience in general. Some of the terms I heard often were ‘manipulation, control, nurture, neglect, chaos, can’t love, doesn’t trust, make you pay’. Many of these terms are commonly used in attachment literature (Welch, 1988; Delaney, 1991; Randolph, 1995; Pickle, 1995). I had the feeling that learning about RAD had given parents a new vocabulary with which to express things that previously they had no words for. It appeared to be empowering.

Another source of satisfaction for parents was when they successfully implemented parenting skills specifically designed to deal with RAD behavior. Whether they had come up with the idea on their own, or a therapist or counselor had given them the idea, did not seem to matter. They knew they had parenting skills that worked with their other children. So when a strategy geared to RAD behavior worked, parents’ confidence was boosted and chaos in the home lessened.

A number of different resources were accessed by parents to help them cope with RAD behavior and related concerns. Not all parents used the same resources or particular resources to the same degree. There appeared to be some relationship between educational level and the ability to ‘ferret out’ resources, especially those involving community based services.

Parents unanimously named their spouse as a source of emotional support, feedback, and as a 'reality check' person. Even if one parent was more involved in the day-to-day interaction with the child, the spouse provided affirmative support and the opportunity to 'blow off some steam'. A great deal of stress was also placed on marital relationships, but the parents in this study all professed a high level of commitment to maintaining a successful marriage.

Reliance on a spiritual base for comfort, or for help in coming to terms with their situation, was acknowledged by four of the five parents in the study. As a researcher, I was keenly interested in the place religion or spirituality played in helping parents cope with RAD. However, I didn't want to lead my questioning by asking about specific resources. If spirituality had not been mentioned yet, I asked parents if there were any other resources they used that they hadn't mentioned yet. Invariably, they would hesitate briefly and then share with me at length about spiritual resources.

Throughout the interviews, parents were amazingly open to sharing their stories. They seemed to be even more eager to share things they had discovered or learned that they thought might be helpful to someone else. They knew the pain and trials they had been through, and were happy to share anything that might alleviate that for someone else.

When parents talked about their experiences with therapy the responses were mixed. Somewhat unique to RAD children is the phenomenon that these kids often prefer a pseudo-attachment to neighbors, school personnel, therapists, caseworkers, or strangers to a genuine attachment to their parents (Delaney, 1991). Coupling a deceitful relationship with the therapist to reports that RAD children often engage in lying, it is understandable that parents reported that therapy was seldom helpful to them. Instead, therapy often turned out to be more of a 'vacation' for their child according to parent's recollections. Parents were quick to add that most therapists they dealt with were sincere and well intentioned. It was just that RAD presented particular challenges that were out of the sphere of most models of treatment. Most traditional therapy relies on a relationship of mutual trust, respect, reciprocity, and emotional honesty between therapist and client (Cline, 1998). RAD children are unable to meet these requirements.

According to the parents, the breakthrough in their experience with therapy was when they connected with someone specifically trained in attachment theory, RAD diagnosis, and treatment. Intensive therapy consisting of cognitive restructuring, psychodramatic reenactment, inner child metaphor, and therapeutic holding has been shown to decrease problem behaviors in RAD children (Myeroff, Mertlich & Gross, 1999). The etiology of RAD made sense to parents and seemed to explain their experience. When so many parents tell you that they finally felt valued and affirmed as a parent, you begin to

think that there must be something to the training of these therapists and the treatment they provided.

Over the course of my contact with the participants in this study (first and second interviews were between 10 months and one year apart), I was disheartened to observe that the life-experience for these parents did not appear to improve over time. In each case, the diagnosis of RAD came when the child was at or near the age of adolescence. According to the literature, the success of work with RAD children is limited when begun at this later age (Randolph, 1995). In fact, for the second interview, each of the parents seemed to have less available time to meet, and sounded as if they may have been functioning on a lower level of energy than when we first met. This perception weighed heavily on me as I compiled these results.

Limitations of the Study

Before stating the clinical implications and the possibilities for future research, there are limitations to this study to be considered. The participants for the study were not selected purposefully, but rather by arbitrary convenience. The therapist who agreed to supply the names of potential participants, consulted with colleagues and put together a list of clients whom they thought would volunteer for the experience of sharing their stories. I am not aware of any other qualifying criteria, but fortunately I ended up with a group of participants who provided useful information as well as representative examples of RAD etiology. The participants were not a diverse group in terms of socio-economics and life styles, although they did vary in degree of educational background.

The small sample of four families does not allow for generalizing reported findings in the traditional sense. A larger sampling would have provided more in-depth saturation of the subject. The findings do appear to provide a legitimate link to theory and a stepping-stone to future research. However, this study only begins to paint the picture of the experiences encountered by parents of RAD children.

According to Coffey & Atkinson (1996), “establishing the trustworthiness of the insights generated through exploratory research is the job of those who are consumers of the research, not the job of social science researchers” (p. 163). The usefulness of this research will be up to those who read it and will be considered through their personal interpretation of the findings.

And finally, my personal bias as a researcher must be taken into consideration. My initial interest in this study was based on my experience as a foster parent of a RAD child. I attempted to approach each participant from a “not knowing” point of reference. Selecting the qualitative research model as well as a narrative interview approach were both intentional attempts to eliminate any preconceived bias towards the data. Although I continually reminded myself not to “fish” for any desired responses (in fact, not to have any desired responses), it would be reasonable to suspect that I was not one hundred percent successful.

Implications for Clinical Practice

The implications of this research for working with parents of RAD children in clinical practice include considerations sought by most consumers of mental health services. As with any client, the feeling that you are being heard and understood is often the first hurdle to clear enroute to a therapist-client relationship that produces a fertile environment for success. Often, parents feel blamed for the behaviors of their children. This may foster a reluctance to seek further help or create an adversarial relationship in the therapeutic setting between the parent and the therapist (Robbins, 1995).

Are therapists generally prepared for the challenge of identifying the neurologically based behavior of RAD children? A recent study pointing out the symptomatic similarities between RAD and PDD (pervasive development disorder), found good response to treatment for RAD in children previously diagnosed with PDD (Mukaddes, Bilge, Alyanak & Kora, 2000). As some participants stated, many therapists were ‘fooled’ by their child’s ‘clinic’ behavior, and the only therapists who were helpful were the ones that could admit that they had been ‘fooled’.

Clearly, the parents of RAD children are asking for therapists with a broad range of knowledge regarding childhood disorders. The difference between a correct diagnosis and an incorrect or absent diagnosis was definitely an added frustration and stress to parents. A therapist’s ability to acknowledge ‘mistakes’ is more likely to build a bond of trust in the therapeutic relationship than one who needs to be ‘right’. Every therapist may not have the opportunity or interest in gaining an expertise in treating RAD kids. But just the ability to recognize RAD behavior and know where to refer were remembered by some parents and mentioned as being very helpful.

One of the biggest challenges for a therapist is to truly get a sense of what goes on with a client outside of the clinical setting. RAD children can be obsessed with the idea of self-preservation to the point of amazing deception. Parents can become frustrated and distraught to the point of appearing pathological and suspected of being the cause of the

presenting problem. This research holds the possibility of expanding the worldview of those in the therapeutic community who read it.

Implications for Future Research

A number of topics for future research surfaced as a result of this study. The vast majority of RAD research to date has focused on sensory-motor development during infancy (Greenburg, Cicchetti & Cummings, 1990). This study opens the door for a directional shift in research into the attitudes, feelings and ideas of families dealing with RAD.

Although this particular project spanned nearly a one year time period, it was not intended to be a longitudinal study. A long-term look at the course of RAD and the effect of therapy over an extended period of time would be illuminating. Tied to that would be a study of the course RAD takes as a child grows older and what parents and therapists should be aware of. In addition, a study of children diagnosed at an earlier age would be informative. The literature speaks of the increased odds of successful treatment when RAD is diagnosed early (Delaney, 1991).

Some of the treatment alternatives for RAD are proactive and intrusive (Cline, 1992; Hage, 1995). A level of controversy surrounds some these methods of treatment. The viability of these and other alternatives deserve further study.

Many of the comments by participants in this study were critical of their experience with some therapists. Research from the therapist's point of view could provide insight into the challenges encountered in treating the RAD population. A look at the nature of attachment in the therapist-client relationship would also be enriching (Byng-Hall, 1995; Dolan, Arnkoff & Glass, 1993; Mallinckrodt, 2000).

Further studies of the effect that dealing with RAD children has on the marriage and also on other siblings could further diminish the isolation and helplessness some parents spoke of. A look at the attachment style of parents and how that impacts treatment (Main, 1996; Goldberg, 1991) and the quality of relationships in the family are some other topics which surfaced from the literature and the interviews.

Some final topics for future research are the faith and spiritual base of the participants. Spirituality is often ignored or downplayed in therapy (Frame, 2000). For some in this study, faith and prayer were spiritual tools used on a daily basis to lessen stress and to invoke the aid of a higher power in coping with RAD behavior. For others,

their faith served as a framework for how to look at life, and how the challenges of RAD fit into their world view of how they should think concerning their role as parents. Although this study contained a small sample of families, their concept of “faith” fell along an interesting continuum.

Personal Reflections

The process of accomplishing this project was at times highly emotional, at others tedious and arduous, but always extremely interesting. I underestimated the feelings I would experience as a result of the intimate collaboration I felt with the tellers of this story. The participants have occupied my thoughts for such a long time that I find it difficult to see an end come to wondering how their lives are progressing.

At this point, attachment theory permeates so many of my thoughts regarding human development, human response and my own personal relationships. I feel very fortunate to have ‘stumbled’ upon a body of thought that is not only mentally captivating, but one that I believe will forever color the lens through which I look at life.

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Appendix A

Participating Therapist's Informed Consent

Title of the Study:

Children Diagnosed with Attachment Disorder: A Qualitative Study of the Parental Experience

Investigator:

This study is being conducted by Robin P. Shepley, candidate for master's degree in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. His faculty advisor is Dr. Karen Rosen. Robin can be reached at 703-713-1444.

2. Study Purpose

The purpose of this study is to examine the experience of parents who are raising a child diagnosed with attachment disorder. The study will focus on the parents' perceptions of what their experience has been, how they have responded and what impact it has had on them. Further focus will be placed on learning what resources have been used by parents to help them cope with any stresses related to having a child diagnosed with attachment disorder in their home. The focus will not be on specific experiences in therapy nor on evaluating your performance as their therapist.

2. Procedures

Participation in this study will consist of reviewing your client population and then selecting and contacting families who meet the study's criteria to request that they speak with me concerning the project. For those families willing to be contacted, I will provide you with an information packet which includes a letter introducing the study, release form allowing me to speak with the family, and a self-addressed stamped mail-back envelope.

I will not be asking you to share information about the details of therapy. My intention is to solicit information regarding the participants' experiences with their child diagnosed with attachment disorder as well as to learn of the scope of coping resources which may have been accessed.

2. Risks

For participating therapists, the risks are minimal. Some of your clients may offer evaluations of your work. The study, however, will focus on the client's general experiences and will not be used in any way to evaluate the participating therapists.

2. Benefits of the Project

Your participation in this project will provide the researcher with families to interview who have experienced raising a child with attachment disorder. Upon request I will provide all participating therapists with a summary of the findings upon completion of the project. Therapists who have participated in similar qualitative research projects have found that this type of research experience provides valuable insight which may benefit their work with other clients in the future.

2. Scope of Anonymity and Confidentiality

The information you provide for this study will be treated in a completely confidential manner. Any identifying material regarding your clients will be disguised or eliminated. Only the researcher and his advisor will have access to the audiotapes of participating client's interviews and other raw data. Any oral or written presentation associated with this study will not include participant's real names. At the time of completion, all raw data pertaining to this study will be destroyed. Specific information received from your clients will not be made available to you at any time during or after the study.

2. Compensation

Upon completion of this project, participating therapists will be provided with summaries of the study's findings upon request. The final report in its entirety will also be on file at the Virginia Tech Graduate Center in Falls Church, Virginia.

2. Freedom To Withdraw

If at any time you change your mind about participating in the study, you are encouraged to withdraw your consent and to cancel your participation.

2. Approval of Research

As required, this study has received approval as a project involving human subjects by the Institutional Review Board of Virginia Polytechnic Institute and State University and by the Department of Human Resources.

2. Participant's Responsibilities

I voluntarily agree to participate in this study. I understand that my responsibility lies in providing the researcher with potential family participants.

2. Participant's Permission

I have read and understand the informed consent and conditions of this project. I have had all of my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project. I agree to abide by the guidelines of this project. I realize I have the right to withdraw at any time.

Participant's Signature

Date

Should I have any questions about this research I will contact:

Robin P. Shepley

Karen Rosen

Jerry Cline

Researcher

Faculty Advisor

College IRB Representative

703-713-1444

703-538-8461

703-538-8492

Appendix B

Participation Informed Consent

Title of the Study:

Children Diagnosed with Attachment Disorder: A Qualitative Study of the Parental Experience

Investigator:

This study is being conducted by Robin P. Shepley, candidate for master's degree in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. His advisor is Dr. Karen Rosen. Robin can be reached at 703-713-1444.

2. Study Purpose

The purpose of this study is to examine the experience of parents who are raising a child diagnosed with attachment disorder. The study will focus on the parents' perceptions of what their experience has been, how they have responded and what impact it has had on them. Further focus will be placed on learning what resources have been identified by parents which could help them cope with any stresses related to having a child diagnosed with attachment disorder in their home. We are seeking five families to participate in this study.

2. Procedures

Your participation in this study will consist of two interviews. The first will be conducted in person lasting approximately one and a half hours. You will be asked to share your experiences and perceptions regarding your child diagnosed with attachment disorder. This interview will be audiotape and transcribed for analysis. Following the transcription, a summary of the findings will be sent to you and a second interview will be scheduled in order to obtain your response to the summary. This interview will also be in person and last approximately thirty minutes.

2. Risks

Potentially, uncomfortable issues, experiences or memories may arise during these interviews. You will not be asked to participate in discussions which may cause discomfort. If at any time during this process you choose to withdraw, you need only inform the researcher.

2. Benefits of the Project

Your participation in this project will provide the researcher and professionals who work with attachment disorder the opportunity to learn how parents perceive the range of experience with a diagnosed child. Additionally, we will learn what resources may be of help to families similar to yours. Upon request, the researcher will provide participating families with a summary of study findings at the completion of the project.

2. Scope of Anonymity and Confidentiality

The information you provide for this study will be treated in a completely confidential manner. The researcher has the responsibility, however, to report any information regarding potential danger to participants or anyone else, or suspicions of child abuse. Your name will be removed from the Parent Questionnaire and be replaced with pseudonyms for use during analysis and in the final written report. Any identifying material will be disguised or eliminated. Only the researcher and his advisor will have access to the audiotapes of the interviews and other raw data. Any oral or written presentation associated with this study will not include your real name. At the time of completion, all raw data pertaining to this study will be destroyed. Should a research assistant transcribe your audiotape, he or she will be required to sign a statement pledging confidentiality and to withdraw from further involvement should it be discovered that he or she knows you. In addition, you will have an opportunity to review a draft for accuracy and anonymity.

2. Compensation

Other than sincere appreciation, no guarantee of benefits is being made to encourage you to participate in this study.

2. Freedom To Withdraw

If at any time you change your mind about participating in the study, you are encouraged to withdraw your consent and to cancel your participation.

2. Approval of Research

As required, this study has received approval as a project involving human subjects by the Institutional Review Board of Virginia Polytechnic Institute and State University and by the Department of Human Resources.

2. Participant's Responsibilities

I voluntarily agree to participate in this study. I understand that it is my responsibility to call and reschedule an interview if I need to have it postponed.

2. Participant's Permission

I have read and understand the informed consent and conditions of this project. I hereby acknowledge the above and give my voluntary consent for participation in this project. I agree to the use of an audio tape recorder to record my interviews. I realize I have the right to withdraw at any time.

Participant's Signature

Date

Participant's Signature

Date

Should I have any questions about this research I will contact:

Robin P. Shepley

Karen Rosen

Jerry Cline

Researcher

Faculty Advisor

College IRB Representative

703-713-1444

703-538-8461

703-538-8492

Appendix C

Family Information Form

Name _____

Name _____

Address _____

Phone Number _____

Children _____ age _____

Education _____ (female)

_____ (male)

Employer/position _____ (female)

_____ (male)

Gross annual family income:

____ under \$20,000

____ \$20,000-40,000

____ \$40,000-60,000

____ \$60,000-80,000

____ Over \$80,000

Appendix D

Guiding Interview Questions

These interview questions will serve as a guide during the actual interviews.

First Interview

2. I am interested in getting to know your child through your eyes. Please tell me about her/his likes and dislikes, accomplishments and frustrations, memorable events, etc...
2. I am interested in knowing about your experiences raising your child. What can you tell me?
2. When was your child first diagnosed with attachment disorder? At what age? What events or conditions preceded the diagnosis?
2. How much did you initially know about attachment disorder? Did you have any particular expectations as to what your experience would be?
2. Are there any significant factors that have contributed to your experience thus far?
2. Tell me about your biggest joys and biggest challenges specific to attachment disorder.
2. Do you think you have a good understanding of attachment disorder? If so, how has this been helpful/not helpful? Would knowing more be helpful/not helpful? In what way?

2. What has been helpful to you in dealing with attachment disorder? How did you find out about it or access it? What else do you think would be helpful?
 2. What, if anything, would have been more helpful had you known about it earlier?
 2. Is there anything that you have learned or accessed that has diminished your parenting experience?
11. In terms of other parents with children diagnosed with attachment disorder, what do you think are the most important things for them to consider and to know about.

Second Interview

First I will share a summary of the first interview and invite thoughts and impressions about my own interpretations as well as any thoughts the parents would like to share.

2. What else have you thought of since our first interview that you would like to share?
2. What else is there that you think is important that we haven't talked about?

Appendix E

Research Assistant's Confidentiality Statement

Title of the Study: Children Diagnosed with Attachment Disorder:

A Qualitative Study of the Parental Experience

Primary Researcher: Robin P. Shepley

Confidentiality Pledge: I understand that the information being collected in this study is sensitive, personal and is strictly confidential. I hereby pledge that I will keep all such information confidential. I also pledge to withdraw immediately from further involvement with a particular interview if I discover that the participant whose interview I am transcribing is an acquaintance of mine, or known by me in any way.

Signature

Date

VITA

Robin Paul Shepley

Robin graduated from Virginia Polytechnic and State University in 2001 with a Master of Science degree in Marriage and Family Therapy. He graduated in 1980 from Brigham Young University with a Bachelor of Science degree in Family Financial and Estate Planning. He became a Certified Financial Planner in 1982 and obtained his Real Estate license in 1985. Since 1986, he has been a painting contractor and faux finish technician. During this time he has also been a foster parent, facilitator for Parents Anonymous, Juvenile Detention Center staffer, teacher of parenting classes, in-home therapist for Head Start, youth group leader for his church and a student.

Robin is the parent of two sons and three step-sons.