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The impact of attachment disorder on the family and child

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University of Northern Iowa

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THE IMPACT OF ATTACHMENT DISORDER ON THE FAMILY AND CHILD

An Abstract of a Thesis
Submitted
In Partial Fulfillment
Of the Requirements for the Degree
Education Specialist

Stephanie DuRocher
University of Northern Iowa
July 2011
ABSTRACT

John Bowlby’s attachment theory suggests that based on their needs for protection, comfort and nurturance, infants form attachments with their primary caregivers. The initial relationships a person has with others will serve as a blueprint for all future relationships. This connection has a significant influence on every area of a person’s life, including cognition, physical and emotional health, future relationships, education and development of values. When an infant’s needs are met with inconsistency, abuse or maltreatment, the influence on a child’s life and those caring for the child is widespread. This study sought to explore the impact caring for a child with attachment disorder has on a family as well as the supports needed for foster and/or adoptive families dealing with attachment disorders to be successful and to determine the areas of need regarding a child’s education. Results indicate that caring for a child with attachment difficulties has a negative impact on the family, including other children in the home, as well as the overall family environment, such as routines. However, the parents surveyed remain positive towards their children with attachment difficulties and committed to helping them. The study also reflects that schools are not fully prepared for the challenges a child with attachment difficulties can present.
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A Thesis
Submitted
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Stephanie DuRocher
University of Northern Iowa
July 2011
This Study by: Stephanie M. DuRocher

Entitled: The Impact of Attachment Disorder on the Family and Child

Has been approved as meeting the thesis requirement for the

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>LIST OF TABLES</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>v</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>vi</td>
</tr>
<tr>
<td>CHAPTER 1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER 2. LITERATURE REVIEW</td>
<td>4</td>
</tr>
<tr>
<td>CHAPTER 3. METHODS</td>
<td>29</td>
</tr>
<tr>
<td>CHAPTER 4. RESULTS</td>
<td>34</td>
</tr>
<tr>
<td>CHAPTER 5. DISCUSSION</td>
<td>48</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>60</td>
</tr>
<tr>
<td>APPENDIX: SURVEY FORMAT</td>
<td>64</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>6</td>
<td>41</td>
</tr>
<tr>
<td>7</td>
<td>47</td>
</tr>
</tbody>
</table>

1. Domains of functioning hypothesized to be associated with attachment security.
2. Comorbidity frequency counts.
3. Prescription medications reported by parents that children diagnosed with RAD are currently taking.
5. Means, Standard Deviations, and Frequencies of items regarding respondents' attitude towards a child with attachment difficulties.
7. Means, Standard Deviations, and Frequencies of school preparedness for a child with attachment difficulties.
### LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Cycle of Need</td>
<td>6</td>
</tr>
<tr>
<td>2 Broken Cycle of Attachment</td>
<td>11</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

Attachment theory suggests that based on their need for protection, comfort and nurturance, infants form attachments with their primary caregivers. This connection has a significant influence on every area of a person’s life, including cognition, physical and emotional health, future relationships, education and values. When an infant’s needs are met with inconsistency, abuse or maltreatment, the influence on a child’s life and those caring for the child is widespread. Often times, an impaired attachment leaves children unable to trust that adults will meet their needs.

There are variations of attachment disorder found in the research. For the purpose of this study, the term attachment disorder will be used as a description of the circumstances that occur when healthy development of an attachment has been impaired or interrupted affecting the child’s behavior in a negative way unless referring specifically to the official DSM-IV diagnosis and then the term Reactive Attachment Disorder or RAD will be utilized.

For their caregivers, children with attachment issues can pose unique challenges in their daily functioning because of their behaviors and socio-emotional needs. Few studies have examined the influence that raising a child with an attachment disorder can have on the family and even less have focused on the influence on siblings in that family. Children in foster care and those available for adoption are at greater risk to develop attachment issues. Reber (1996) reports that “52% of adoptable children have attachment disorder symptoms” (p. 85). Zeanah et al. (2004) report that 38-40% of maltreated
toddlers in foster care showed a prevalence of RAD based on their study. Due to these numbers, foster and adoptive families have an increased chance of parenting and providing care for children with attachment disorders.

Another area that lacks information is the impact of an attachment disorder on a child’s education. Schools are often unprepared and unaware of how to handle the challenges associated with students with attachment difficulties. Neither special education nor general education programs seem to offer the right supports for a child with attachment disorder (Parker & Forrest, 1993). Providing professional development to those working in the education system about successful methods of helping children with attachment disorder could improve the educational experiences of children diagnosed with this disorder.

This study sought to explore the impact caring for a child with an attachment disorder has on a family as well as the supports needed for families to be successful when dealing with attachment disorders and determine the services offered to support the child’s education. Chapter 2 will look at the current literature regarding the development of a healthy attachment as well as the different types of attachment that can be observed. It will also consider the current parameters of attachment disorder and/or Reactive Attachment Disorder and the signs and symptoms associated with such as well as current therapy or treatment approaches. Finally, the impact of attachment disorder on the family and the child’s education is examined. Chapter 3 will describe the survey research that sought to answer the questions: (1) What is the impact on the family of caring for a child with attachment issues? More specifically, what behavioral challenges do the
families face? (2) What impact does raising a child with attachment difficulties have on the parent directly, such as the parent's job and perceived parenting ability?

Additionally, what supports are needed for the parents to help the children be successful?

(3) How prepared are schools to handle children with attachment difficulties? Chapter 4 will outline the results while Chapter 5 will discuss the implications of the results, limitations of the study, and future research needed.
CHAPTER 2
LITERATURE REVIEW

John Bowlby has spent the last several decades studying attachment and its influence on human development. He developed what is known as attachment theory (Bowlby, 1973). Attachment theory suggests that based on an infant’s need for protection, comfort and nurturance, infants form attachments with their primary caregivers. The initial relationships a person has with others will serve as a blueprint for all future relationships. This connection has a significant influence on every area of a person’s life, including cognition, physical and emotional health, future relationships, education and values. When an infant’s needs are met with inconsistency, abuse or maltreatment, the influence on a child’s life and those caring for the child is widespread. Often times, an impaired attachment leaves children unable to trust that adults will meet their needs. For their caregivers, children with attachment issues can pose unique challenges in their daily functioning because of their behaviors and socio-emotional needs. Schools are often unprepared and unaware of how to handle these challenges as well. The current study seeks to understand the prevalence of attachment issues in the child welfare system, explore the supports needed for families dealing with attachment disorders to be successful and determine the services offered to support the child’s education.

Healthy Development of Attachment

To understand attachment disorders, it is imperative first to have a solid understanding of attachment and its development. Attachment, in the context of
attachment theory, is defined as a connection that is meaningful and lasts over time and space, formed between a child and his or her caregiver during the first few years of life (Levy & Orlans, 1998). More specifically, Prior and Glaser (2006) define attachment as "a tie based on the need for safety, security and protection" (p. 15). Levy and Orlans (1998) describe the attachment process as "not something that parents do to their children; rather, it is something that children and parents create together, in an ongoing, reciprocal relationship" (p. 1).

Attachment begins at birth through the caregiver’s appropriate responses to an infant’s cycle of need. When an infant has a need, he or she engages in an attachment behavior (e.g. crying, looking or whining) to express that need (e.g. hunger, diaper change, comfort). The caregiver’s response to that need should produce a sense of relaxation for the child. When completed appropriately, this cycle builds trust and attachment between a child and caregiver. Through these experiences, the infant learns that he or she can depend on the caregiver to meet needs of comfort, support, nurturance and protection, especially in times of stress. Attachment behavior can be seen from an infant towards several established adults, but typically, it occurs earlier, more strongly and more consistently towards the mother (Bowlby, 1982). Figure 1 illustrates the cycle of need and what children can gain from the interaction.
Figure 1—Cycle of Need. The infant has a need and expresses that need (i.e. crying). The need is met in a timely, consistent and appropriate manner which sends the message to the child that he or she is worthy. The infant feels relief and gratification which leads to the development of skills such as cause and effect, trusting others and emotional reciprocity. (Best, 2008. Received at the Iowa Foster and Adoptive Parents Association Conference.)

When the attachment process occurs as it should, a secure attachment is formed which provides safety and protection for children, a secure-base from which they can grow. Levy and Orlans (1998) describe seven functions that a secure attachment provides for children: a model of trust and a representation of what a good relationship should look like; the ability to discover his or her environment with a secure base, the comfort of knowing someone is there if you need them; the ability to manage impulses and emotions through self-regulation; establishes the groundwork to build a sense of competency and self-worth; a development of values and ethics; produce a foundational
belief system about how the world works, how adults respond and assess one’s self within that system; and impart in a child the ingenuity and capability to defend against stress and trauma. These early experiences with the primary caregiver have a significant influence on future attachment styles. The primary caregiver is assumed to serve as the archetype for future relationships.

**Attachment Classifications**

As attachment develops, an infant will begin to explore his or her surroundings. In a healthy relationship, the infant will use his or her caregiver, typically the mother, as a safe base from which to explore. Ainsworth and Bell (1970) describe the unique balance of attachment and exploration:

> at first infant and mother are in almost continuous close contact, soon they are in collusion to make more elastic the bonds that unite them. The infant ventures forth to investigate his environment and to play with other infants, and gradually spends more and more time “off” his mother. His expeditions take him further and further away from her, and she becomes increasingly permissive and retrieves him less promptly and less frequently. Alarm or threat of separation, however, quickly bring mother and infant together again. (p. 51 – 52)

Ainsworth and her colleagues were among the first researchers to provide applied evidence for the attachment theory described above through utilizing what is now known as the “strange situation” procedure. The strange situation procedure has become a key component in the research of assessment for attachment styles. The purpose of the strange situation was to “create mild but increasing stress on the attachment relationship, in order to observe the infant’s attachment strategies and the degree of security of attachment” (Davies, 2004, p. 11).
Infants near the age of 12 months old and their mothers were used for the strange situation. The infant was introduced to eight varying situations beginning with the least stress provoking and gradually increasing. None of the situations was thought to be any different from what may occur in the typical life of a child. For example, the mother and child would come to a room with toys that was unfamiliar to the infant. They would sit and play for a little while together and then a stranger would enter the room and visit with the mother. In another situation, the mother would leave the child while the stranger was still present. In yet another situation, the mother would leave the room and a stranger would enter the room while the mother was gone. In each episode, the infant’s reaction to the situation was observed as well as the baby’s reaction upon the mother’s return to the room if she had left.

Based upon their observations, Ainsworth, Blehar, Water, and Wall, as cited by Main and Solomon (1990) classified types of attachment into three categories. The first type of attachment classification is secure. In a secure attachment relationship during the strange situation, the baby used his or her mother as a secure base for exploration and sought contact with her after being separated. The second type of attachment relationship identified is the anxious-ambivalent (or resistant) type. In this relationship, the baby was incapable of using his mother as a secure base during exploration and upon her return following separation the baby appeared angry and pushed the mother away. The third type of attachment classification is anxious-avoidant. These babies failed to use their mother as a secure base and following a period of separation avoided the mother upon her return or approached her indirectly. Main and Solomon (1990) later identified a fourth
category of attachment type, disorganized-disoriented, in which the baby showed no predictable or effective pattern of attaining attachment behaviors when stressed. The four types of attachment should not be seen as indicators of attachment disorder but as risk and protective factors (Zeanah & Smyke, 2008). The actual determinants of the effects of those factors are unclear.

**Internal Working Model**

While developing attachment to a primary caregiver, Bowlby theorizes that children develop an internal working model (IWM) from the attachment relationship. Prior and Glaser (2006) define internal working models as "predictions which the child develops about him or herself, others, and the response of significant others to his or her attachment needs” (p. 21). Children use these models to negotiate future relationships and predict how others will respond to them and additionally inform children of their own sense of worth (Kennedy & Kennedy, 2004). Whether the internal working model of a child is positive or negative, it has an influence on how the child interacts with others and on what he or she believes about them. Children, for example, who have experienced trauma and maltreatment, have a negative internal working model of the world, adults, relationships and themselves due to the early experiences in which their needs were not met (Becker-Weidman, 2006). These children then come to believe that all adults will respond negatively to them and that they cannot depend on adults to meet their needs. They may doubt that they deserve anything to the contrary.

A number of longitudinal studies indicate the importance of attachment on the future development of a child. As Davies (2004) points out, the amount of evidence
provided in these empirical studies makes it “clear that quality of attachment is a fundamental mediator of development” (p. 22). Just how broad of an influence attachment can have remains unclear. There are a number of theories. Prior and Glaser (2006) summarize research by Belsky and Cassidy and Thompson in Table 1 below. It continues to be unclear whether attachment directly influences each of these areas or if it is a more indirect influence on the child’s functioning.

\[ Table 1 \]

**Domains of functioning hypothesized to be associated with attachment security**

<table>
<thead>
<tr>
<th>Narrow view</th>
<th>Broad view</th>
<th>Very broad view</th>
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</thead>
<tbody>
<tr>
<td>Trust, confidence and harmony in relationship with parent and significant others</td>
<td>The above plus:</td>
<td>The above plus:</td>
</tr>
<tr>
<td>Emotion regulation</td>
<td>Sociability with unfamiliar adults and peers</td>
<td>Language and cognitive competence</td>
</tr>
<tr>
<td>Self-reliance (versus dependency), ego-resilience, personal efficacy</td>
<td>Understanding of and orientations towards others</td>
<td>Play competence, exploratory skill</td>
</tr>
<tr>
<td>Relational intimacy</td>
<td></td>
<td>Communication style</td>
</tr>
<tr>
<td>Interpersonal (social) competence</td>
<td></td>
<td>Other outcomes influenced by self-confidence and ego functioning</td>
</tr>
<tr>
<td>Relationship-based developmental disorders</td>
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</table>


**Disorders of Attachment**

When adults fail to meet the needs of children with predictability and consistency, the normal development of a secure attachment is interrupted. The infant is unable to feel the relief and gratification of having his or her needs satisfied, which leads to the development of coping skills and the inability to trust others to meet those needs. After
experiencing this disrupted cycle of need over and over again, the child begins to feel that they are not worthy of having their needs met, sadness, confusion and anger ensue.

Figure 2 illustrates this cycle. Children who have been maltreated, through physical or psychological neglect, physical abuse, or sexual abuse demonstrate trauma-attachment problems (Becker-Weidman, 2006).

Figure 2—Broken cycle of Attachment. The infant has a need and expresses that need. The infant, because of previous inconsistency is terrified that the need is not going to be met and feels deep sadness and alone-ness. This sends the message of unworthiness to the child. Rather than relief, the child feels pseudo relief and engages in self-soothing skills. This inconsistency leaves the child with poor cause and effect and the child learns that he or she must meet their own needs. (Best, 2008. Received at the Iowa Foster and Adoptive Parents Association Conference.)
One possible outcome of maltreatment at a young age could be Reactive Attachment Disorder (RAD). While it has been nearly twenty years since the diagnosis of RAD was first introduced, much is still unknown regarding RAD. In the Attachment Task Force Report from Chaffin et al., (2006) they note that “Reactive Attachment Disorder is one of the least researched and most poorly understood disorders in the DSM” (p. 80). It can be difficult to diagnose because there is no uniformly identified tool for assessing it and usually co-exists with other disorders (Chaffin, et al. 2006; Hanson & Spratt, 2000).

The 2000 American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (4th ed. Text rev.)* (DSM-IV-TR) diagnostic criteria for reactive attachment disorder of infancy or early childhood is as follows: a “markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care” (p. 127). According to the DSM-IV-TR, there are two possible classifications of RAD, a) the inhibited type, which is identified when “the child persistently fails to initiate and to respond to most social interactions in a developmentally appropriate way” (p. 127); or b) the disinhibited type, in which “the child exhibits indiscriminate sociability or a lack of selectivity in the choice of attachment figures” (p. 128). Additionally, the child must have been subjected to gross pathological care, as illustrated by one of three additional criterion, “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 (e.g., frequent changes in foster care)” (p.128).

The DSM-IV criteria have been scrutinized on many different levels. First, because it looks at the behavior of the child in relation to other people, the above diagnostic criterion concentrates on the child’s social behavior as opposed to the primary attachment relationships (Hanson & Spratt, 2000; Richters & Volkmar, 1994; Zeanah, 1996). Secondly, the fact that pathogenic care is included in the diagnosis leaves out some children such as those who have an unhealthy relationship with their caregiver and it makes assumptions about people who suffer through pathogenic care (Hanson & Spratt, 2000; Richters & Volkmar, 1994; Zeanah, 1996). Some researchers agree that pathogenic care at an early age can interrupt a child’s attachment process and possibly cause an attachment disorder; however, abuse alone does not cause an attachment disorder. Researchers also argue that the requirement of pathogenic care in the criteria for diagnosis may be difficult to document in some situations (Richters & Volkmar, 1994; Zeanah, Mammen, & Lieberman, 1993). Boris, Zeanah, Larrieu, Scheeringa, and Heller, 1998 documented case studies in which pathogenic care was not necessary to determine that the children were diagnosed with RAD. Zeanah (1996) poses that the DSM-IV-TR criteria for Reactive Attachment Disorder is “more maltreatment syndromes rather than attachment disorders” (p. 46). He goes on to acknowledge that “maltreatment is probably one important contributor to some types of attachment disorders, [but] it is neither necessary nor sufficient to make the diagnosis” (p.46).
Infants form different types of attachment with different caregivers and can have multiple attachments at one time. Just because an infant possesses a disturbed attachment with one caregiver does not mean that the infant will have a disturbed attachment with every caregiver. Using this and other findings from developmental research along with clinical observations, Zeanah, Boris, and Lieberman (2000) proposed a set of alternative criteria that involved three broad types of attachment disorders. The first is Disorders of Nonattachment, which is similar to the current DSM-IV-TR criteria for Reactive Attachment Disorder, but this classification does not require the presence of documented pathogenic care. It continues to pose two types of behavior in children with no preferred attachment figures comparable to the inhibited and disinhibited types of RAD. The second proposed category is called Secure Base Distortions. The second is Secure Base Distortions, in which the child has a seriously unhealthy relationship with a preferred attachment figure. Within this second proposed category, there are four different subtypes, all relationship specific. The third broad category proposed is Disrupted Attachment Disorder that is diagnosed when the child experiences the sudden loss of an attachment relationship for example through death or through being placed in foster care.

The categories proposed by Zeanah, et al. (2000) are not yet considered official diagnostic criteria. RAD continues to be the only officially recognized diagnosis for disturbances in attachment. However, during the formation of the proposed criteria, Boris, et al. (1998) compared the reliability between the DSM-IV criteria with the developing proposed categories through a retrospective case review. The reliability of the alternative criteria was acceptable; however, the reliability of the DSM-IV criteria
was only marginal. It would seem that the proposed categories encompass and explain greater depth in relationship that the influence a disturbed attachment can have on a child’s life. Further research regarding diagnostic criteria is needed in order to develop the best way to identify attachment disorders.

**Signs or Symptoms of Attachment Disorder**

As identified earlier, having an insecure attachment does not mean that the child has an attachment disorder. One of the difficulties in assessing a child for disorders of attachment is determining when the signs or symptoms are more than just risk factors. The signs of an attachment disorder can be difficult to identify because similar characteristics occur in many other diagnoses. Attachment theorists propose that the defining feature of attachment disorder is that there is a significant disturbance in a child’s ability to use his or her primary caregiver as a source of comfort, safety and security (Zeanah, et al., 1993). Zeanah, et al. (1993) identified the following signs of attachment disorder in young children that include: lack of sincere and affectionate connections with others; indiscriminate affection with adults who are not familiar to the child; inability to seek comfort from an attachment figure when ill, scared or injured; comfort seeking behaviors done in such a way that is unusual or in a hesitant manner; extreme dependence; when help is needed, the child does not turn to the attachment figure for support; failure to act in accordance with caregiver requests; excessively insistent; when in unfamiliar surroundings, child does not utilize the caregiver as a source of security or information; exploration limited by reluctance to leave caregiver; excessively dominant and interfering of the behaviors of those around the child in an
attempt to control the situation; failure to engage the caregiver after being separated; and disregard, steer clear of, show anger towards or show no affection to the caregiver after being separated. From the above list, a person can start to understand why the diagnosis of attachment disorder becomes difficult, as many of the behaviors are contradictory. Each child is affected by attachment disorder in such unique ways and shows similar behaviors to many other disorders that it is very difficult to determine.

**Behavioral and Personality Characteristics Associated with Attachment Disorder**

One of the greatest challenges in taking care of children diagnosed with attachment disorder is the struggle to deal with the behaviors presented. When compared to children without Reactive Attachment Disorder, children with Reactive Attachment Disorder display significantly more inappropriate behaviors, are less empathic, and possess more challenging behaviors (Hall & Geher, 2003). Hall and Geher also found that children diagnosed with RAD appeared to be consciously aware of their behaviors, whether appropriate or inappropriate, and possessed the ability to self-monitor their behaviors to appear more socially acceptable which could result in misdiagnosis and misinterpretation of the behaviors.

There are innumerous lists of behaviors that children with RAD may present, but it is important to note that not every child will exhibit all of the same behaviors and characteristics; each child (case) is unique. There is also considerable disagreement among practitioners as to what the true behavioral characteristics are that pertain to attachment disorders. One of the behaviors commonly found in children with the disinhibited type of RAD is their affection towards strangers and when distressed, they
look to random people for comfort as opposed to those with whom they have a close relationship (Parker & Forrest, 1993; O'Connor, Bredenkamp, Rutter, & Team, 1999). Some researchers identify behaviors of children with RAD to include the destruction of property, cruelty to others and/or pets, lack of ability to give and receive affection, hoarding or gorging of food, lack of eye contact with others, stealing and lying (Hall & Geher, 2003; Parker & Forrest, 1993).

Interventions for Attachment Disorder

Given that there is controversy concerning the diagnosis of an attachment disorder, it is not too surprising to discover discord when it comes to the appropriate therapy approach, which may yield the most success for the child and family. One of the questions posed concerning evaluation of successful interventions is whether or not it is more important to focus therapy on the attachment relationship or if you focus treatment on specific behaviors that the child is exhibiting (Cornell & Hamrin, 2008; Hall & Geher, 2003).

Some components of helping children with attachment problems are a treatment that emphasizes providing a consistent environment, teaching relationship skills, and behavioral interventions for the child, as well as retaining sensitivity towards the child (Haugaard & Hazan, 2004). As summarized by O'Connor and Zeanah (2003), the focus of attachment-based interventions should be “to facilitate the parent’s capacity to act as a secure base for the child and, in turn, to increase the child’s willingness to use the parent as a secure base” (p. 234). Prior and Glaser (2006) write that several studies have shown the efficacy of interventions which focus on the caregiver-child interaction, in particular focusing on caregiver sensitivity and
therefore behavior towards the child, in improving the security of attachment of young children to their caregivers. This has included both preventive work with high-risk groups and a reactive therapeutic response to dyads where significant difficulties have already emerged. (p. 250)

One such therapy is Dyadic Developmental Psychotherapy, which attempts to reverse the child’s negative internal working model the child has developed by modeling a healthy attachment cycle, helping the child learn to regulate their emotions surrounding the trauma they experienced, and assisting the caregiver at developing an understanding of why the child responds or acts the way they do (Becker-Weidman, 2006). Becker-Weidman studied 64 children and compared treatment outcomes to children receiving Dyadic Developmental Psychotherapy (n=34) and those not receiving such a therapy (n=30). A statistically significant reduction in behaviors and other symptoms of attachment disorder was found in the group receiving Dyadic Developmental Psychotherapy.

A second form of treatment that has been studied is a three-month psychoeducational treatment for parents of children diagnosed with RAD (Mukaddes, Kaynak, Besikci, & Issever, 2004). Mukaddes et al. focused the intervention on dealing with behavior problems, increasing positive parent-child interactions, and educating parents about their child’s diagnosis. Their study consisted of 11 children diagnosed with RAD and 10 children diagnosed with autism. They also found significant improvement in the children with RAD in comparison to children with autism with regards to behaviors, motor skills, cognitive development, social interaction and self-care abilities. However, this study did not measure any type of attachment relationship so it is unclear how the treatment affected those symptoms.
As mentioned above, the question of whether to focus on specific behaviors or the actual attachment relationship has been raised. One treatment model in particular, focuses on the social and cognitive problems causing the behaviors, which teach parents to deal more effectively with the behaviors, and thus allowing more positive attachment behavior to occur (O'Conner & Zeanah, 2003). One of the more well-known controversial treatments is holding therapy or rage reduction, attachment, coercive therapy (Hanson & Spratt, 2000). The theory behind these controversial attachment therapies is that young children who experience maltreatment, loss, separations and other childhood stressors become very angry, leaving them unable to attach or be genuinely affectionate with others (Chaffin et al., 2006; Reber 1996). The therapists from this viewpoint believe that the rage must be released in order to allow normal functioning and this may be done through physical holding or other aggressive means. This type of therapy has been taken to the extremes by some therapist and according to O'Conner and Zeanah (2003) six children have died associated with one form or another of holding therapy.

As with all theories, there is a continuum of applications associated with each. Attachment therapy is one that has variations in its application. As described above, there are professionals who believe holding therapy is a matter of rage reduction, aggression, and perhaps that need to experience rebirthing. Holding therapists should not be lumped together with attachment therapists as many researchers do. There are attachment therapists that have a different definition of holding therapy that involves the child lying across the lap of a parent and another parent or therapist, cradled by the parent
with legs resting on the other (Wimmer, Vonk, & Reeves, 2010). In a recent study, Wimmer et al. interviewed adoptive mothers who had participated in attachment therapy and found it to be emotionally painful yet always encouraging. The mothers expressed that the attachment therapists seemed truly to understand what they were going through, emotionally and behaviorally and they were able to offer new ideas with how to approach the next situation. The attachment therapy protocol that these mothers participated in also involved psychoeducational training about their child’s diagnosis as well as narrative therapy, all comparable to Becker-Weidman’s (2006) Dyadic Developmental Psychotherapy. The same mothers viewed attachment therapy as a key factor in their ability to maintain the child as a part of their family. Another notable characteristic to therapeutic success is the level of commitment to the child expressed by the mothers (Wimmer et al., 2010).

Parental commitment is a consistent attribution for success also found in a study by Drisko and Zilberstein (2008) who surveyed parents of children diagnosed with Reactive Attachment Disorder. This commitment was expressed as not just the commitment towards raising the child, but also the amount of time it takes to supervise the child. Another characteristic is the parents’ ability to identify and enjoy the small steps that occurred towards success and change within the child. Drisko and Zilberstein also found that the psychoeducational training to increase parents’ awareness and sensitivity of their child’s issues, mentioned previously, is another attribution for success. Parents also attributed the support of therapists as key in the ability to persevere, describing them as “attuned helpers” (p.483).
Impact of Attachment Disorder on the Family

There is limited information about the type of impact raising a child with an attachment disorder has on the family. Children with attachment problems tend to ignore internal and external signs that may prompt children with healthy attachment problems to give and/or receive love (Bowlby, 1988). This can pose many challenges when trying to enjoy this child as a part of the family. Parents are likely to feel ineffective and discouraged in trying to care for a child with RAD (O'Connor & Zeanah, 2003). This feeling of ineffectiveness and failure also lends to the need for therapy and assistance with processing the experience of parenting and understanding the child’s thought process behind the behaviors. Children with RAD spend years building barriers around themselves to block out closeness they may feel with parents (Coleman, 2003) because they have never understood what the relationship of a parent and child should feel like and much time parenting a child with RAD can be spent trying to overcome those barriers.

Parents of children with RAD are not the only members of a family to be influenced by RAD. Due to the amount of time a parent may have to spend dealing with behaviors of the child with RAD, siblings or other children in the home may often feel neglected. Siblings can often be called upon to take more responsibility and suffer from anxiety or depression as they experience the ups and downs with their family (Coleman, 2003).

Children in foster care and those available for adoption are at greater risk to develop attachment issues. Reber (1996) reports that “52% of adoptable children have
attachment disorder symptoms" (p. 85). Zeanah, et al. (2004) report that 38-40% of 94 maltreated toddlers in foster care in their study showed a prevalence of RAD. Due to these numbers, foster and adoptive families have an increased chance of parenting and providing care for children with attachment disorders. Younes and Harp (2007) separately interviewed ten foster parents and their biological children to explore the influence of foster care on biological children and their families. The study provides unique insight into what happens inside a foster home.

Parents reported observing their children becoming 'more inquisitive,' 'more outgoing,' 'more caring,' 'more loving,' 'more willing to help these kids,' 'more responsible,' and setting a 'good example' for foster children. However, eight of the ten foster parents interviewed observed their children also becoming 'more quiet,' 'withdrawn,' 'angry,' 'jealous,' 'quick-tempered' or 'more stubborn' (p. 31).

One of the disadvantages described by parents was the limited amount of time that providing foster care left for their relationship with their biological children. This issue was described by every parent and child interviewed. “Many [parents] admitted not really knowing the long-term influence on their children but hoped their children would utilize their experience with fostering to become better people” (Younes & Harp, p.36).

Rosenzweig, Brennan, and Ogilvie (2002) completed a qualitative study conducted with parents of children with emotional or behavioral disorders including Reactive Attachment Disorder that revealed the supports and changes that occurred in a family’s life in order to provide the best care for the child with the diagnosis. With regards to the influence on the parents' work, four main themes transpired which included modification of work responsibilities, essential flexibility at work, the consequence on daily work execution, and the use of coworkers as a foundation of
encouragement. Providing care for the children while the parents were at work was also a challenge such as before and after school. Many reported the inability to find quality childcare providers that could provide the type of care needed for children with emotional disorders. A need for respite and temporary care such as during school holidays was also reported as a factor. Parents also conveyed the influence of having a child in the education system had on their work because of having to miss work frequently for numerous meetings and the need to help the school learn how to handle their child’s needs.

Support groups, respite and weekly in-home supportive services are possible supports in order to decrease the likelihood of adoption disruption (Hughes, 1999; O’Connor & Zeanah, 2003). In a study of 249 adoptive families of children considered to have special needs, counseling services and in-home supports that included respite, daycare and babysitting services were considered to be the unmet needs of these families (Reilly & Platz, 2004). Drisko and Zilberstein (2008) interviewed parents of children diagnosed with Reactive Attachment Disorder and the parents noted the importance of support whether from family members and friends or professionals such as social workers and therapists.

Attachment Disorder in the Schools

Children who have encountered disruptions in attachment through maltreatment or frequent caregiver changes are apt to have serious emotional and behavioral problems across an array of settings, which for school-age children includes the school environment (Schwartz & Davis, 2006). In addition to behavioral challenges, cognitive
and academic struggles can also be an area of need for children diagnosed with RAD (Floyd, Hester, Griffin, Golden, & Canter, 2008). Teachers and other school personnel are often left with more questions than answers in regards to how to best deal with the behaviors presented by students with Reactive Attachment Disorder. There is limited information regarding the best way to support and assist children with attachment disorders in the school.

From the child’s perspective, the school setting presents the child with unique challenges. Children with RAD are concerned with internal issues of safety, security, and trust due to their history of maltreatment. This constant worry about their survival leaves them helpless to succeed in the learning environment. Their internal working model, through which they base all interactions, is based on their earlier experiences of mistrust and inconsistency. In school, success is often obtained through working with others, but children with RAD struggle with the social aspect (Schwartz & Davis, 2006).

One factor considered when determining whether a child is ready for school and then considered to help a student be successful throughout their educational career is the ability to self-regulate feelings and cope with stress. A secure attachment allows the child to learn the skills necessary for self-regulation and the ability to cope with stress. Because these are not skills that students with attachment disorders are typically able to demonstrate successfully, school interventions need to focus on helping students with attachment disorder regulate their feelings and actions (Floyd, et al., 2008; Schwartz & Davis, 2006).
In 2003, the President’s New Freedom Commission on Mental Health noted the important role that schools can play in the support of children:

schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children. (p. 58)

While this is true, school personnel typically already have a lot of extra commitments to worry about and have limited resources to do more. Teachers, school counselors, school psychologists and other educational staff can be part of a team that looks to serve a student with attachment disorder in the best way possible. These school employees have the advantage of being able to observe the student and their behaviors in one of the child’s natural settings, which could provide invaluable information for parents and other mental health professionals that may be involved (Davis, Kruczek, & McIntosh, 2006). Teachers and school mental health professionals are also able to develop and directly implement interventions within the school setting.

Included in the qualitative study conducted by Rosenzweig, et al. (2002) was the issue of education for children with serious emotional disorders and several concerns arose. From the parents’ perspective, there was a lack of knowledge within the school regarding the children’s specific disorder and parents did not feel that the school system could handle the needs of their children. Parents felt that they spent a lot of time at school trying to explain how best to handle their child or defending and arguing with the school about their child’s specific needs.
As previously identified, there are four different classifications of attachment styles. In her book, *Attachment in the Classroom*, Heather Geddes offers her thoughts regarding the implications these varying styles have on students’ learning (Geddes, 2006). A student with an insecure avoidant attachment will appear to approach the classroom as if he or she does not care whether they are there or not. The student will be mindful of how physically close the teacher is and will deny the fact that he or she may need assistance from the teacher. Students with an avoidant attachment style will want to complete assigned tasks without help from the teacher. They are likely to achieve less than what they are capable of doing and possess limited use of creativity and language.

Geddes (2006) describes students who possess an insecure resistant/ambivalent attachment style as viewing the classroom with elevated levels of anxiety and hesitation. They will consistently engage in teacher-seeking behaviors because they have a need to depend on the teacher for learning, however, when frustrated, these students will also show opposition towards the teacher. Students with a resistant/ambivalent attachment will have difficulties attempting the task without the attention of the teacher and likely will not attempt the task without assistance. These students are also likely to be underachieving, however, will probably possess a well-developed grasp of language and probably struggle with numeracy (Geddes, 2006).

Those students with an insecure disorganized/disorientated attachment style will hold an intense level of anxiety towards school and the classroom, which may be conveyed through controlling and unstoppable behavior (Geddes 2006). They will find it difficult to trust the teacher, but may accept the authority of the principal. Because the
teacher is perceived to know more than the student does, this type of attachment style gets in the way of the students allowing themselves to be taught for fear of not having all the answers. The same goes when completing assignments. The fear of incompetence controls much of their actions and they may put up a front of already knowing everything. Students with a disorganized/disorientated attachment style are likely to be underachieving and possibly also at a very juvenile juncture in their learning. They may seem unable to create original ideas and struggle with abstract concepts (Geddes 2006).

Description of Present Study

The development of a healthy attachment is important for the development of a healthy child. Attachment can affect every aspect of a child's life including cognition, physical and emotional health, future relationships, education and values. An insecure attachment leaves children unable to trust that adults will meet their needs. When this occurs over and over again, the child begins to expect that the rest of the world will respond to them in the same way. An important question to consider is when an insecure attachment moves from being a risk factor to a disorder. Much discussion surrounds the definition of an attachment disorder. Very few empirical studies are available to test the validity of the criteria used for diagnosis. Alternative criteria that cover a more broad scope have also been proposed.

Surprisingly little is known about the impact raising a child with an attachment disorder has on a family, especially any siblings in the home. Information regarding the educational experiences of a child with an attachment disorder is also lacking. This study seeks to explore the supports needed for families dealing with attachment disorders to be
successful and to determine the services offered to support the child’s education. This research seeks to answer the following questions: (1) What is the impact on the family of caring for a child with attachment issues? More specifically, what behavioral challenges do the families face? (2) What impact does raising a child with attachment difficulties have on the parent directly, such as the parent’s job and perceived parenting ability? Additionally, what supports are needed for the parents to help the children be successful? (3) How prepared are schools to handle children with attachment difficulties?
CHAPTER 3

METHODS

To gain a better understanding of the impact attachment disorder has on a family and the supports necessary for a family with a child who has attachment disorder, as well as the impact attachment disorder has on a child’s education, a survey was administered to foster and adoptive families throughout Iowa. The on-line survey asked parents to identify specific behaviors they have encountered and the different types of services and supports they have received or that they perceive would help them. It also asked the parents about their experiences with raising a child with attachment disorder and the impact children with attachment issues have had on their family as a whole.

Procedures

After receiving approval from the university’s Institutional Review Board, the principal investigator submitted a recruitment article to a state foster and adoptive parent association monthly electronic newsletter. The recruitment article included a link to the online survey. When the respondents went to this link, a letter informing the invited participants of their rights preceded the survey. Invited participants were informed of the nature of the study, the fact that participation was voluntary, and that anonymity was assured to the degree permitted by the technology used as no guarantees can be made regarding the interception of data sent electronically. They were told that they could stop participating in this research at any time and if they chose to stop or decided that they did not want to participate at all, there would be no negative consequences for them.
Participants were not asked to provide identifying information anywhere in their responses.

Participants were also recruited from Iowa-based therapists who work with parents of children with attachment difficulties. These therapists were provided with hard copies of the recruitment article and asked to share them with parents. The therapists only provided the parents with copies of the article; they were not involved further with recruitment.

**Instrument**

The on-line survey was developed by the principal investigator based upon the three research questions and the research literature. The three research questions were broken apart in to subcategories to elicit information regarding each question. Five questions gathered demographic data on the respondents. Nineteen questions gathered demographic data for each child. The next three sections addressed the three research questions and asked specifically for respondents to answer if they have cared for a child with attachment difficulties. Within the first section regarding family impact, there were 12 Likert-scale questions. The second section of the survey was in regards to the school experiences the families have had and there were 12 questions. The final section was looking to answer the question regarding parenting impact and the day-to-day balance of work and home life such as childcare and services or supports sought. This final section contained 14 questions. The survey was informally piloted amongst a select group of foster/adoptive parents as well as colleagues and family therapists to determine readability and ease of answering. A copy of the survey is provided in the Appendix.
Participants

Thirty-nine parents returned surveys. Of those 39 surveys, 31 met criteria as having children diagnosed with Reactive Attachment Disorder or as reporting children diagnosed with attachment difficulties by professionals working with them. Of those 31 participants, 30 were mothers and one was a father. Twenty-one respondents reported a two-parent household while the remaining 10 reported a single parent household. The average number of children in each household was 2.94 children 20 years old and younger.

In all, 96 children were reported on by parents. Forty-five children, 15 males and 30 females, within the 31 homes met the criteria as having Reactive Attachment Disorder or being diagnosed by a professional as having attachment difficulties. The range in ages of the children was from 4-years-old to 20-years-old and the average age of the children was 10.56 years old. Thirty-seven of the children were adopted children, 7 were still in the foster care system, and 1 was considered pre-adoptive at the time the survey was completed. The average age of the children upon entering the parents’ home was 4.5 years old.

Of the 45 children diagnosed with either Reactive Attachment Disorder or identified by a professional as having attachment difficulties, 38 of them had comorbid diagnoses. Among those children with two or more diagnoses, the most common diagnoses in addition to RAD or attachment difficulties were Attention Deficit Hyperactivity Disorder \((n = 24)\) and Oppositional Defiant Disorder \((n = 23)\). For more details regarding comorbidity diagnoses, see Table 2.
Table 2

*Comorbidity frequency counts*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>N</th>
<th>Diagnosis</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Hyperactivity Disorder</td>
<td>24</td>
<td>Bipolar</td>
<td>2</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>23</td>
<td>Pervasive Developmental Disorder</td>
<td>2</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>9</td>
<td>Drug Exposure</td>
<td>1</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>13</td>
<td>Non-Verbal Learning Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>6</td>
<td>Borderline Personality Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
<td>Tourettes Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Participants could report more than one additional diagnosis.

Twenty-seven of the 45 children were taking prescription medication for emotional or behavioral issues (see Table 3). While the most commonly prescribed medication was Risperdal (n=11), the children participating in this study were prescribed over two dozen different medications.
Table 3

*Prescription medications reported by parents that children diagnosed with RAD are currently taking*

<table>
<thead>
<tr>
<th>Medication</th>
<th>N</th>
<th>Medication</th>
<th>N</th>
<th>Medication</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperdal</td>
<td>11</td>
<td>Trazadone</td>
<td>2</td>
<td>Paxil</td>
<td>1</td>
</tr>
<tr>
<td>Concerta</td>
<td>5</td>
<td>Straterra</td>
<td>2</td>
<td>Namenda</td>
<td>1</td>
</tr>
<tr>
<td>Ritalin</td>
<td>4</td>
<td>Metadate</td>
<td>2</td>
<td>Methaphendalate</td>
<td>1</td>
</tr>
<tr>
<td>Guafacine</td>
<td>4</td>
<td>Fluoxetine</td>
<td>2</td>
<td>Lamictal</td>
<td>1</td>
</tr>
<tr>
<td>Adderall</td>
<td>4</td>
<td>Clonidine</td>
<td>2</td>
<td>Effexor</td>
<td>1</td>
</tr>
<tr>
<td>Zoloft</td>
<td>3</td>
<td>Abilify</td>
<td>2</td>
<td>Depakote</td>
<td>1</td>
</tr>
<tr>
<td>Lexapro</td>
<td>3</td>
<td>Triliptol</td>
<td>1</td>
<td>Citalopram</td>
<td>1</td>
</tr>
<tr>
<td>Focalin</td>
<td>3</td>
<td>Remeron</td>
<td>1</td>
<td>Buspar</td>
<td>1</td>
</tr>
<tr>
<td>Vyvanse</td>
<td>2</td>
<td>Prozac</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Participants could list more than one medication for each child.
For their caregivers, children with attachment issues can pose unique challenges in their daily functioning because of their behavioral and socio-emotional needs. There is discourse in research regarding what behaviors displayed by children could be attributed to attachment issues. Few studies have examined the impact that raising a child with an attachment disorder can have on the family and even fewer have focused on the influence on siblings in that family. Another area that lacks information is the influence of an attachment disorder on a child's education. Schools are often unprepared and unaware of how to handle the associated challenges as well. This study sought to explore the following questions: (1) What is the impact on the family of caring for a child with attachment issues? More specifically, what behavioral challenges do the families face? (2) What impact does raising a child with attachment difficulties have on the parent directly, such as the parent's job and perceived parenting ability? Additionally, what supports are needed for the parents to help the children be successful? (3) How prepared are schools to handle children with attachment difficulties?

The Impact on the Family

The first research question this study sought to answer was investigating the impact raising a child with attachment difficulties had on the family as a whole. This included the parent relationship with the child, relationships amongst others in the house, siblings in the home, and the overall family environment such as vacations and schedules. One factor that can influence the impact is the behaviors the child is displaying, so this
question also looked at what behaviors parents of children with attachment difficulties had observed in their children as well as the attitude parents had towards the child.

**Overall Family Environment**

On the section of the survey that explored how caring for a child with attachment difficulties impacted family relationships, siblings and family routines, respondents were asked 12 questions related to various aspects of family life. They responded using a 5-point scale: 1 = *Changed for much better*; 2 = *Changed for better*; 3 = *No relevant change*; 4 = *Changed for worse*; and 5 = *Changed for much worse*. On average, the respondents thought that the behavior of other children in the home had become more challenging since caring for a child with attachment difficulties ($M = 3.67, SD = .87$) with 42% reporting that the behavior of other children in the home had changed for the worse. Additionally, 74% of the parents said that other children in the home also would say that things in the home have changed for the worse ($M = 4.04, SD = .64$). The respondent’s relationship between his or her mother improved ($M = 2.81, SD = .93$) as did the respondent’s relationship between his or her father ($M = 2.95, SD = .6$). When asked to report on how family routines have changed, 63% of the parents reported that routines had changed for worse and 17% reported family routines having changed for much worse ($M = 3.87, SD = .82$). See Table 4 for a summary of items on the impact on a family of raising a child with attachment disorder.
### Table 4

*Means, Standard Deviations, and Frequencies of items regarding overall family impact*

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in behavior of other children in home</td>
<td>3.67</td>
<td>.87</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 8% 3 - 33% 4 - 42% 5 - 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other children's perception of change</td>
<td>4.04</td>
<td>.64</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 4% 3 - 4% 4 - 74% 5 - 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in relationship with other children</td>
<td>3.48</td>
<td>.79</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 13% 3 - 30% 4 - 52% 5 - 4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in spouse's relationship with other children</td>
<td>3.55</td>
<td>.89</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 15% 3 - 25% 4 - 50% 5 - 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship among children changed</td>
<td>3.43</td>
<td>.79</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 13% 3 - 35% 4 - 48% 5 - 43%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in relationship with spouse</td>
<td>3.38</td>
<td>.97</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 24% 3 - 24% 4 - 43% 5 - 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in relationship with own mother</td>
<td>2.8</td>
<td>.92</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>1 -10% 2 - 19% 3 - 57% 4 - 10% 5 - 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in relationship with own father</td>
<td>2.95</td>
<td>.6</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 20% 3 - 65% 4 - 15% 5 - 0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in relationship with closest friend</td>
<td>3.07</td>
<td>.7</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>1 - 3% 2 - 10% 3 - 62% 4 - 24% 5 - 0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in family routines</td>
<td>3.87</td>
<td>.82</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 10% 3 - 10% 4 - 63% 5 - 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in holidays/special events</td>
<td>3.7</td>
<td>.84</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 7% 3 - 33% 4 - 43% 5 - 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in vacations</td>
<td>3.8</td>
<td>.89</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>1 - 0% 2 - 10% 3 - 20% 4 - 50% 5 - 20%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. 1 = Changed for much better; 5 = Changed for much worse*

### Attitude Towards Child and Circumstances

To determine the attitude or perception the respondents had towards the child they were reporting about, the respondents were asked 4 questions related to how they felt
about the child and what they enjoyed about the child. They rated their answers on a 5-point scale (1 = Always; 2 = Usually; 3 = Sometimes; 4 = Rarely; and 5 = Never). Table 5 reports the means, standard deviations, and frequencies of each item. When asked if the parent enjoyed spending time with the child, 44% reported they enjoyed spending time with the child sometimes with an average response of 2.67 (SD = .85). The parent was asked if the child brought happiness to their home and the average response was 2.91 (SD = .87) again with 44% of the respondents reporting sometimes. Forty-three percent of the respondents reported that they were usually happy that the child was in their home and the average response was 2.39 (SD = .92). Parents were also asked to describe some things they enjoyed about the child. Some of the themes that emerged included the following: smart, willingness to help, fun to be around when making the right choices, creative, and when sincere is able to show compassion or caring towards others.

When asked to rate how their feelings towards the child with attachment difficulties has changed since the child moved in (1 = Changed for much better; 2 = Changed for better; 3 = No relevant change; 4 = Changed for worse; 5 = Changed for much worse), 35% of the respondents reported feelings changing for the worse with a reported a mean of 3.1 (SD = 1.29). Through their experience, 45% of the respondents reported that their attitude towards foster parenting, in general, had changed for the worse; 39% expressed the same change in attitude towards adoption.
Table 5

Means, Standard Deviations, and Frequencies of items regarding respondents' attitude towards a child with attachment difficulties

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoy spending time with this child.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2.67</td>
<td>.85</td>
<td>45</td>
</tr>
<tr>
<td>2</td>
<td>1 - 9%</td>
<td>2 - 31%</td>
<td>3 - 44%</td>
</tr>
<tr>
<td>This child brings happiness to our home.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.91</td>
<td>.87</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>1 - 4%</td>
<td>2 - 27%</td>
<td>3 - 44%</td>
<td>4 - 22%</td>
</tr>
<tr>
<td>I am happy that this child is in our home.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.39</td>
<td>.92</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>1 - 16%</td>
<td>2 - 43%</td>
<td>3 - 27%</td>
<td>4 - 14%</td>
</tr>
<tr>
<td>How have feelings towards child changed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>1.29</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>1 - 10%</td>
<td>2 - 31%</td>
<td>3 - 10%</td>
<td>4 - 35%</td>
</tr>
<tr>
<td>How have feelings changed towards fostering?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.62</td>
<td>.98</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>1 - 0%</td>
<td>2 - 14%</td>
<td>3 - 28%</td>
<td>4 - 45%</td>
</tr>
<tr>
<td>How have feelings changed towards adoption?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.36</td>
<td>.87</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>1 - 0%</td>
<td>2 - 18%</td>
<td>3 - 36%</td>
<td>4 - 39%</td>
</tr>
</tbody>
</table>

Note. Items with a ^ indicate the scale used is 1 = Always; 5 = Never. Items with an * indicate the scale used is 1 = Changed for much better; 5 = Changed for much worse.

Behavioral Challenges Impacting the Family

As reported in the literature review, there is considerable disagreement about which behaviors are directly associated with Reactive Attachment Disorder. Utilizing previous research and including behaviors found throughout all sides of the disagreement, a list of behaviors was created and respondents were asked to indicate which behaviors on the list they had observed in their child. Of the 96 children that were reported on by parents, two groups were used for comparison of the behaviors reported.

The first group was comprised of the children who were reported as diagnosed for having Reactive Attachment Disorder or had been diagnosed by a professional as having
attachment difficulties ($N = 45$). In this group, there were 15 males and 30 females. The average age was 10.56 years old and the range in age of the children was from 4-years-old to 20-years-old. Thirty-seven of the children were adopted children, seven were still in the foster care system, and one was considered pre-adoptive at the time the survey was completed. The average age of the children upon entering the parents' home was 4.5 years old. Of the 45 children diagnosed with either Reactive Attachment Disorder or identified by a professional as having attachment difficulties, 38 of them had comorbid diagnoses. Among those children with two or more diagnoses, the most common diagnoses in addition to RAD or attachment difficulties were Attention Deficit Hyperactivity Disorder ($n = 24$) and Oppositional Defiant Disorder ($n = 23$).

The second group of children was comprised of the children who did not meet criteria for having attachment difficulties and were not diagnosed with Reactive Attachment Disorder ($N = 47$). In this group there were 23 males and 24 females. The average age was 9.37 years old and the range in age of the children was from a few months old to 20-years-old. Thirty-nine of the children were adopted children, seven were still in the foster care system, and one was considered pre-adoptive at the time the survey was completed. The average age of the children upon entering the parents' home was 3.38 years old. Of the 47 children in this comparison group, 24 of them had mental health diagnoses and 16 of those had more than one diagnosis. The most common diagnoses were Attention Deficit Hyperactivity Disorder ($n = 18$) and Anxiety Disorder ($n = 8$).
Behaviors that the participants reported having dealt with in their child with attachment difficulties are outlined in Table 6. The most frequent responses of the group with attachment difficulties included oppositional, argumentative, and defiant behaviors (n=38) as well as lying (n=36), and manipulative or controlling behavior (n=36) on the part of the child. The most frequent responses of the group without attachment difficulties included oppositional, argumentative, and defiant behaviors (n=17) as well as lying (n=17), and poor impulse control (n=17) on the part of the child.
### Table 6

**Behaviors Displayed by Children**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>With Attachment Difficulties</th>
<th>Without Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oppositional, argumentative, defiant</td>
<td>38 (84%)</td>
<td>17 (37%)</td>
</tr>
<tr>
<td>Lies</td>
<td>36 (80%)</td>
<td>17 (37%)</td>
</tr>
<tr>
<td>Manipulative or controlling</td>
<td>36 (80%)</td>
<td>13 (28%)</td>
</tr>
<tr>
<td>Frequent or intense angry outbursts</td>
<td>34 (76%)</td>
<td>12 (26%)</td>
</tr>
<tr>
<td>Poor peer relationships</td>
<td>33 (73%)</td>
<td>15 (33%)</td>
</tr>
<tr>
<td>Poor impulse control</td>
<td>33 (73%)</td>
<td>17 (37%)</td>
</tr>
<tr>
<td>Indifferent to cause and effect</td>
<td>30 (67%)</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>Does not care about making good choices</td>
<td>29 (64%)</td>
<td>6 (13%)</td>
</tr>
<tr>
<td>Asks persistent nonsense questions or chatters incessantly</td>
<td>29 (64%)</td>
<td>12 (26%)</td>
</tr>
<tr>
<td>Superficially engaging and charming</td>
<td>28 (62%)</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>Fear of abandonment</td>
<td>28 (62%)</td>
<td>12 (26%)</td>
</tr>
<tr>
<td>Anxious in new situations</td>
<td>27 (60%)</td>
<td>13 (28%)</td>
</tr>
<tr>
<td>Inappropriately demanding or clingy</td>
<td>25 (56%)</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>Difficulty making eye contact</td>
<td>24 (53%)</td>
<td>9 (20%)</td>
</tr>
<tr>
<td>Destructive of self, others, or property</td>
<td>23 (51%)</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>23 (51%)</td>
<td>9 (20%)</td>
</tr>
<tr>
<td>Has developmental delays</td>
<td>22 (49%)</td>
<td>12 (26%)</td>
</tr>
<tr>
<td>Indiscriminately affectionate with strangers</td>
<td>21 (47%)</td>
<td>9 (20%)</td>
</tr>
<tr>
<td>Steals</td>
<td>19 (42%)</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>Not cuddly w/ parents or only when child initiates affection</td>
<td>19 (42%)</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>Cruel to siblings</td>
<td>18 (40%)</td>
<td>8 (17%)</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one behavior for each child. This list is not inclusive of all behaviors that respondents could choose from. It is a representation of those chosen greater than 40%.*
Parenting Impact

The second research question sought to determine the impact caring for a child with attachment difficulties had on the parent directly. It examined the effects on parents’ career and the choices they had to make regarding work in order to support their child as well as their own perceptions of their parenting ability. It also sought to find out what supports families needed or were accessing to help them as they parented a child with attachment difficulties.

Balancing Work and Home

This section of the survey asked how parenting a child with attachment difficulties impacted the day-to-day activities of parenting such as balancing work and home. The average number of hours per week a parent took off from work in order to meet the needs of a child with attachment difficulties was 8.46 hours (SD = 5.48). Reported time off work ranged from zero hours to 16 or more hours. Those missing between zero and five hours of work were 10 parents; between six and ten hours of work missed were nine parents; and those missing eleven or more hours of work were five parents. On average, parents found their employers to be somewhat supportive (M = 2.33, SD = .58), based on a 3-point scale (1 = not at all supportive; 2 = somewhat supportive; and 3 = very supportive). In response to an open-ended question, one parent reported accessing the Family Medical Leave Act.

The survey asked respondents to rate how difficult it was for them to find childcare while they were at work on a 5-point scale (1 = very difficult; 2 = somewhat difficult; 3 = difficult; 4 = easy; 5 = Very easy). When asked how difficult it was to find
childcare for children with attachment difficulties while they are at work, 52% reported that it was very difficult while 30% indicated that it was somewhat difficult ($M = 1.74, SD = .96$).

Additionally, there are occasions when parents spend time away from their children for activities such as going out with friends or to non-work related appointments. Using the same 5-point scale, the survey asked respondents to rate how easy it was to find someone outside of the home to care for a child on such occasions. Similarly to the previous question, 54% of the respondents reported that it was very difficult to find additional childcare from someone outside the home to care for the child in order for them to spend time away from the child ($M = 1.82, SD = 1.09$).

Perceived Parenting Ability

Next, the survey asked parents to rate how prepared they were to handle the behaviors they had encountered as well as how they thought their parenting ability was at the time of the survey. When asked how prepared the respondent felt to handle the behaviors of a child with attachment difficulties (1 = Not at all prepared; 2 = A little prepared; 3 = Adequately prepared; 4 = Very prepared), 60% of the parents felt they were a little prepared ($M = 2.1, SD = .84$). Respondents were also asked to rate their perceptions of their own parenting ability as well as their perception of their spouse’s parenting ability since caring for a child with attachment difficulties (1 = Changed for much better; 2 = Changed for better; 3 = No relevant change; 4 = Changed for worse; and 5 = Changed for much worse). The respondents described, on average, no relative change in their perception of their own parenting abilities ($M = 3.41, SD = 1.11$), or their
spouse’s parenting ability ($M = 3.38, SD = 1.16$) with 44% of the respondents reporting that they felt their own parenting ability had changed for the worse and 33% of the respondents with a spouse or partner thought their spouse’s parenting ability had changed for the worse. On the contrary, 24% of respondents felt their own parenting abilities had improved, while 33% of those with a partner or spouse that their spouse’s parenting ability had changed for the better.

**Services and Supports Utilized by Family**

Part of the survey focused on the services families have accessed to help support them as they parent a child with attachment difficulties. The first question asked them to rate how easy it was to find those services from $1 = Very easy; 2 = easy; 3 = somewhat easy; to 4 = Not at all easy$. Those that have sought help in dealing with their child’s attachment difficulties found it somewhat easy to find services ($M = 3.48, SD = .69$) with 59% reporting that it was not at all easy to find those services. The survey also asked respondents to rate how helpful the services were from $1 = Very helpful; 2 = helpful; 3 = no difference; to 4 = Not at all helpful$. Sixty-six percent of those receiving services found them to be helpful ($M = 2.1, SD = .67$).

The next question on the survey asked respondents to rate how convenient (i.e. location, scheduling) the services were based on a 4-point scale ($1 = Very convenient to 4 = Not at all convenient$). For those respondents who had sought help in dealing with their child’s attachment difficulties, on average, they rated the services as only a little convenient while 30% of the respondent reported the services as not at all convenient ($M = 2.47, SD = .67$). Twenty-four respondents reported that the most helpful service was
therapy. Six respondents found in-home services to be helpful while only four noted Early Access or the Area Educational Associations to be helpful. Twelve parents noted that utilizing respite was most helpful.

When in need of support, 17 respondents turn to a friend, 19 turn to the support of a relative, 4 seek out their social worker, and 14 turn to their therapist. Other supports named as an open-ended question were the remedial care specialist and support worker, books and resources, adult children, other adoptive parents, including support groups, and their faith.

**Educational Impact and Preparedness**

The final question looked at the impact attachment difficulties may have on a child’s education and how prepared the schools were to handle the associated challenges. Twenty-five (56%) of the children with attachment difficulties attended public school at the time of the study. Seven (16%) were in private school. Six (13%) were in preschool. Three (1%) children had already graduated from high school. Four (9%) children were home-schooled. Twelve (27%) of the children were currently identified for special education services. Of the students eligible for special education services either currently or in the past, nine were identified as having academic issues and five had behavioral concerns. When asked what type of problems their child with attachment difficulties has dealt with at school, 20 indicated academic issues, 19 indicated motivational issues, 20 indicated discipline issues, and 25 indicated social issues.

Respondents were then asked to describe the relationship between them and their child’s school regarding their child’s needs on the following 5-point scale: They rated
their answers on the following 5-point scale: 1 = No problems; 2 = Minor occasional problems; 3 = Minor ongoing problems; 4 = Major occasional problems; and 5 = Major ongoing problems. On average, respondents reported that their relationship could be described as minor occasional problems ($M = 2.4, SD = 1.08$) with 36% reporting minor ongoing problems.

Table 7 describes questions regarding how prepared the school was to care for the student with attachment difficulties. Respondents were asked to rate various school personnel on a 4-point scale regarding how prepared the staff was to provide instruction or support to their child with attachment difficulties (1 = Not at all prepared; 2 = a little prepared; 3 = adequately prepared; 4 = Very prepared). The table below describes those results. Twenty-nine (93%) of the participants answered the question about who the most prepared staff member was. Thirty-four percent (n=10) parents indicated that the most prepared staff was the general education teacher. Eight parents entered an "other" choice, which indicated answers of no one being prepared or knowledgeable, the school secretary, preschool teacher, AEA liaison, and an associate.
Table 7

Means, Standard Deviations, and Frequencies of school preparedness for a child with attachment difficulties

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>General education teacher</td>
<td>1.72</td>
<td>.89</td>
<td>25</td>
</tr>
<tr>
<td>1 - 48%</td>
<td>2 - 40%</td>
<td>3 - 4%</td>
<td>4 - 8%</td>
</tr>
<tr>
<td>Special education teacher</td>
<td>2.13</td>
<td>.92</td>
<td>15</td>
</tr>
<tr>
<td>1 - 27%</td>
<td>2 - 40%</td>
<td>3 - 27%</td>
<td>4 - 7%</td>
</tr>
<tr>
<td>School counselor</td>
<td>1.67</td>
<td>.91</td>
<td>18</td>
</tr>
<tr>
<td>1 - 56%</td>
<td>2 - 28%</td>
<td>3 - 11%</td>
<td>4 - 6%</td>
</tr>
<tr>
<td>School psychologist</td>
<td>2.3</td>
<td>1.49</td>
<td>10</td>
</tr>
<tr>
<td>1 - 50%</td>
<td>2 - 10%</td>
<td>3 - 0%</td>
<td>4 - 40%</td>
</tr>
<tr>
<td>School social worker</td>
<td>1.5</td>
<td>.55</td>
<td>6</td>
</tr>
<tr>
<td>1 - 50%</td>
<td>2 - 50%</td>
<td>3 - 0%</td>
<td>4 - 0%</td>
</tr>
<tr>
<td>School nurse</td>
<td>1.6</td>
<td>.83</td>
<td>15</td>
</tr>
<tr>
<td>1 - 53%</td>
<td>2 - 40%</td>
<td>3 - 0%</td>
<td>4 - 7%</td>
</tr>
<tr>
<td>School administration</td>
<td>1.86</td>
<td>.89</td>
<td>22</td>
</tr>
<tr>
<td>1 - 41%</td>
<td>2 - 36%</td>
<td>3 - 18%</td>
<td>4 - 5%</td>
</tr>
<tr>
<td>Overall preparedness</td>
<td>1.88</td>
<td>.77</td>
<td>26</td>
</tr>
<tr>
<td>1 - 31%</td>
<td>2 - 54%</td>
<td>3 - 12%</td>
<td>4 - 4%</td>
</tr>
</tbody>
</table>

Note. 1 = Not at all prepared; 4 = Very prepared.
CHAPTER 5
DISCUSSION

Attachment theory suggests that based on an infant’s need for protection, comfort and nurturance, infants form attachments with their primary caregivers. This connection has a significant influence on every area of a person’s life, including cognition, physical and emotional health, future relationships, education and values. When an infant’s needs are met with inconsistency, abuse or maltreatment, the influence on a child’s life and those caring for the child is widespread. Often times, an impaired attachment leaves children unable to trust that adults will meet their needs. Children in foster care and those available for adoption are at greater risk to develop attachment issues. Therefore, foster and adoptive families have an increased chance of parenting and providing care for children with attachment disorders.

This study sought to explore the impact caring for a child with an attachment disorder has on the family as well as the supports needed for families to be successful when dealing with attachment disorders and determine the services offered to support the child’s education through the following questions: (1) What is the impact on the family of caring for a child with attachment issues? More specifically, what behavioral challenges do the families face? (2) What impact does raising a child with attachment difficulties have on the parent directly, such as the parent’s job and perceived parenting ability? Additionally, what supports are needed for the parents to help the children be successful? (3) How prepared are schools to handle children with attachment difficulties?
Impact on the Family

The results of this study indicate that caring for a child with attachment difficulties is indeed a challenging position to undertake and has the potential to influence every aspect of family life. Forty-one percent of the respondents reported that the behaviors of other children in the home became increasingly challenging. Seventy-four percent of the respondents believed that if their children were asked how things had changed in the home since caring for a child with attachment difficulties, that the other children would say things had changed for the worse. Relationships between parents and other children and relationships between spouses also changed. Other areas of family impacted included family routines, in which 63% of the respondents said that family routines had changed for the worse.

The decision to foster and/or adopt children in need of a home is a major life decision and it should not be entered in to lightly. Too many times, families have not prepared themselves for the broad impact that raising someone else’s child can have on their family. Emphasis needs to be placed on these possible changes when parents/families go through pre-service training and a home study prior to fostering or adopting a child. Families willing to bring a child in need into their home are often altruistic in nature and have a goal simply to help the child. Careful thought needs to be put in to the possible costs of helping the child and how to prepare for the potential negative impact; including advocacy for the child and family as well as utilizing the supports in place, especially when there are other children in the home.
Attitude Towards Child and Circumstances

Despite the challenges and changes that occur when caring for a child with attachment difficulties, the respondents in this study were still able to find positive attributes about their child. When asked if they enjoy spending time with the child, 41% reported that they usually do. Similar results occurred when asked if the child brings joy to the home. Overall, 43% of the respondents reported they were usually happy that the child was in their home. When asked about how their feelings had changed towards the child with attachment difficulties, 31% indicated their feelings had changed for better, while 35% indicated their feelings had changed for the worse. Throughout the literature review, characteristics of parents found to influence success within the child included commitment to the child and an awareness and understanding of the child's difficulties. The respondents were able to see the positive of the child involved and were usually able to enjoy their company.

Behavioral Challenges Impacting the Family

Interesting results came from the subcategory of looking at the behavioral challenges impacting the family. Both groups were similar in descriptive statistics. Yet the frequency of reported behaviors is greater when the child meets the criteria for attachment difficulties. Eighty-four percent of the respondents of children with attachment difficulties reported dealing with oppositional behavior while only 37% of the respondents of children without attachment difficulties reported oppositional behavior. Similar discrepancy exists when looking at the behavior of lying; 80% of respondents
caring for children with attachment difficulties reported lying, while 37% of respondents of children without attachment difficulties reported lying.

One of the greatest disagreements among the various views of attachment disorder is what attachment looks like within the child, what types of behavior the child displays. While it is understandable that behaviors associated with attachment disorder should relate directly to an attachment relationship, in more than one study, additional behaviors are being reported consistently by the parents. These observations and reports need to be taken into account from the people who spend the most time with the child who has attachment difficulties. One argument is that many of the behaviors listed are related to comorbid diagnoses and should be treated as each diagnosis separately. However, if multiple sources are beginning to verify the consistency found in behaviors displayed, then perhaps that is not the right argument to make.

The children in this study shared a common thread of having experienced the foster care system or having been adopted so they had experienced the loss of the primary attachment figure at varying ages. Many of them had experienced maltreatment or neglect or some type of care that resulted in the biological parent being unable to take care of the child. If attachment disorder is a disorder in the primary attachment figure and it renders their internal working model of future relationships tainted, the behaviors that are being observed could be a result of this working model and the new relationships. This information could give credence to the alternative criteria proposed by Zeanah, et al., 2003, which encompasses various subcategories of attachment disorder including the loss of the primary attachment figure.
An alternative explanation could be that the histories of the children involved and the behaviors observed by parents is actually a result of what impact maltreatment and neglect can have on a child’s functioning. Rather than purely attachment disorder, the behaviors and experiences that the child has because of the trauma and inconsistent upbringing could indicate a different diagnosis that encompasses all the behaviors. Instead of multiple diagnoses for each child, perhaps one diagnosis encompasses all of the others.

Regardless of the diagnosis, dealing with the multitude of behaviors identified in this study presents a very challenging task for even the most skilled parent. Parenting a child with special needs such as ADHD alone can be trying from day to day. The preparation and training of parents caring for children with attachment difficulties again becomes key as well as the support that should continue long after initial placement.

Parenting Impact

The second research question sought to determine the impact caring for a child with attachment difficulties had on the parent directly. It examined how much time parents have to take off from work in order to support the child. It also asked the respondents what they thought about their own parenting ability now that they have been parenting a child with attachment difficulties. This part of the survey sought to find out what supports families need or are accessing to help them.

Balancing Work and Home

Being a working parent brings challenges as you try to balance work responsibilities with parenting responsibilities. Having a child with special needs and
requirements such as therapy increases that challenge. For parents of children with attachment difficulties in this survey, the average number of hours per week that the parent was missing from work was 8.46 hours. Another important aspect of being a working parent is finding childcare for your child. When working, it is essential that a parent have trusted and reliable childcare, someone able to handle a child’s challenging behavior. In this survey, the respondents reported finding it very difficult to find childcare for their child with attachment difficulties. In fact, when asked how difficult it was to find childcare for children with attachment difficulties while they are at work, 52% reported that it was very difficult while 30% indicated that it was somewhat difficult. Similar findings were reported regarding finding childcare to spend leisure time away from the child.

Having the comfort of knowing a child is being cared for appropriately is a necessity for positive work production as a parent. As reported in this study, working parents of children with attachment difficulties are struggling with finding that needed service. Added to that stress are the needed hours off from work responsibilities for therapy, psychiatry, and school appointments. These issues can impact not only work performance, but also the ability of the parent to provide the necessary care to their children consistently. For this reason, some countries consider foster/adoption parenting to be a job and foster/adoptive parents are paid well enough to allow for direct care and more attention to be able to be focused on the job of parenting.
Perceived Parenting Ability

From the literature review, one of the effects experienced by parents raising a child with attachment difficulties is that the parent may start to feel ineffective at their attempts to care and nurture their child. Plus, as mentioned, the types of behaviors being reported that parents are dealing with involves a lot of knowledge and skills to handle them. When asked how prepared the respondent felt to handle the behaviors of a child with attachment difficulties, 60% of the parents felt they were a little prepared.

Respondents were also asked to rate their perceptions of their own parenting ability as well as their perception of their spouse’s parenting ability since caring for a child with attachment difficulties. Forty-four percent of the respondents reported that they felt their own parenting ability had changed for the worse and 33% of the respondents with a spouse or partner thought their spouse’s parenting ability had changed for the worse. On the contrary, 24% of respondents felt their own parenting abilities had improved, while 33% of those with a partner or spouse felt that their spouse’s parenting ability had changed for the better.

Parenting a child with attachment difficulties can be a demanding and perhaps isolating position. When the child you are trying to love and care for acts one way in your home and a completely different way in public, it can be difficult to feel like a successful, proud parent. The demands of the behavioral challenges can wear on the person primarily responsible for care. With 60% of parents reporting that they felt only a little prepared to take on this challenge, additional support seems to be a necessity.
Services and Supports Utilized by Family

An important factor related to the success of families linked to the literature review is the support received by families and 66% of the respondents in our study found the services they were utilizing to be helpful. However, in this study, the ease of accessing those supports is an issue that families face. For those respondents who had sought help in dealing with their child’s attachment difficulties, on average, they rated the services as only a little convenient (i.e., scheduling, location) while 30% of the respondent reported the services as not at all convenient.

Finding a trusted service provider, such as a therapist or a family services worker, can be a daunting task. Depending on where you live, it can also be an expensive task. Many rural areas find themselves at a disadvantage with a lack of service providers who have the background in attachment disorder to provide treatment for the family. It may be greater than 30 miles to the nearest provider. Families finding that support, however, could be a key in helping to restore the home environment. When looking at respondents who indicated that the household changed for the worse and that other children in the home were impacted as well, support plays an important factor.

Educational Impact and Preparedness

There is limited research on the impact that attachment disorders can have on a child’s educational experience. About half of the children in this survey were reported as having academic, social, motivational, or discipline problems or a combination of multiple factors. On average, the respondents described their relationship with the school as having “minor occasional problems”. Just over a quarter of the students with
attachment difficulties were receiving special education services. Many of the answers given in response to open-ended questions regarding school preparedness were expressions of frustration regarding the lack of awareness the school had regarding their children’s needs. Overall, 54% of the respondents estimated that their school was only a little prepared for the needs of their child with attachment difficulties. According to those responding, the school psychologist received the highest average rating, followed by the special education teacher, who were both considered “a little prepared.”

A limitation on this section of the survey was that not all respondents interacted with special education teachers or special education support staff, like school psychologists so the N varied frequently. However, with that being said, no one school professional was identified as being the primary resource for the family. The schools are understandably overwhelmed with the requirements that the government places on the system, but the schools are also a place where families and students can be better and more appropriately supported.

The number of students with attachment difficulties not eligible for special education was surprising. Perhaps because of the frequent moves children in foster care often experience, special education disabilities are not easily identifiable. Perhaps the school environment offers enough structure and freedom from having to focus on the attachment relationship that students are able to concentrate their efforts on academic work. More information is needed regarding the best way to support students and families.
Implications for School Psychologists

One of the important ideas to take away from this study is the importance of an ecological evaluation, an evaluation that includes every aspect of a student’s life. For example, frequently, when school psychologists see a student demonstrate off-task behavior, it is assumed to be associated with ADHD. When a parent is complaining about behavioral issues at home and the school is not seeing the same behaviors, the tendency is to think the parents are making a big deal out of nothing. Sometimes when a student is observed to act inappropriate towards another student, the assumption is that it is related to the home environment.

However, a child with attachment difficulties, changes the family environment. A child with attachment disorder is able to be superficially charming and engaging and that will typically occur in the presence of other people, but that is not the true picture of how they treat their family at home. For children without an attachment figure from which they gain trust and security and nurturance, a child may be seeking out that need in other areas of their life. When a child constantly wants hugs from every adult walking down the hallway of a school, we have a duty to help that child learn boundaries and safety rules as well as support the family as they try to rebuild the attachment.

Limitations

One limitation of this study is that the sample size of this study was small which does not allow for generalization. Yet, the study also used targeted recruitment of foster/adoptive families who were providing care for children with attachment difficulties. If the proportion remains the same on a larger scale and 74% of this sample
size is reporting that other children in the home would say things have changed for the worse since caring for a child with attachment difficulties, a larger sample with 74% reporting the same feelings is not something that should be taken lightly. Another limitation is that all of the responses were based on parent perceptions. There could be bias in parents’ responses dependent on their experience at the time they completed the survey.

**Future Research**

Future research needs to focus on the behavioral challenges parents of children with attachment disorders are reporting. If more studies are validating that parents of children diagnosed with Reactive Attachment Disorder or attachment difficulties under alternative criteria are consistently dealing with the multitude of behaviors found in this study, more needs to be done to prepare and support the families taking on this responsibility. In addition to preparation and support of the families, the diagnosis of Reactive Attachment Disorder needs further examined. Is what we are seeing in the children who lose their primary attachment figure purely attachment difficulties or is there more that we should be looking at overall? More studies also need to be completed in the area of the treatment for attachment difficulties. Recent studies are showing promise of treatment protocols that are indicating success, hope, and change for families.

**Conclusion**

Those who have lost their primary attachment figure through foster care have a significant challenge to overcome because they have been removed from all that they know of love, trust, and nurturance and thrust in to a new family, just waiting to show
how much they care. The child is then expected to overcome whatever maltreatment and abuse he/she may have suffered and ignore their internal working model of the world around them and replace it with something foreign to them. This process leaves some children resistant to throwing out their old way of thinking. They are unable to gauge whether or not this new way of doing things is going to be better than where they were before. Through this internal struggle, lacking the words to express what they are feeling, children externalize their behaviors perhaps in an effort to test this new love or perhaps as a defense mechanism of not wanting to forget the past.

For their caregivers, children with attachment issues can pose unique challenges in their daily functioning because of their behaviors and socio-emotional needs. This study provides a glimpse into the impact that raising a child with an attachment disorder can have on a family, including siblings in that family. The impact of this struggle is felt by all in the home as seen in this study. Other children in the home begin to act out more. The relationships amongst family members begin to change and the overall family environment is modified to make accommodations for the child’s needs. More needs to be done to help families prepare and deal with the multitude of challenges they will face. These families have shown their commitment to care for the child with attachment difficulties through all of the highs and lows. By learning more about the impact these families undergo, we can better support them as they continue to help a child rebuild what should be rightfully every child’s gift at birth...a secure attachment.
 REFERENCES


APPENDIX

SURVEY FORMAT
Dear Parent:

My name is Stephanie DuRocher and I am a School Psychology graduate student at the University of Northern Iowa. I would like to invite you to participate in a research project that seeks to gain a better understanding of how parenting a child with attachment difficulties impacts the family.

Research has shown that children involved with the child welfare system are at-risk for attachment issues. For this reason, foster and/or adoptive parents across Iowa are being invited to participate in an on-line survey. (If you do not have access to the Internet, please contact me at the information listed below and I will be happy to mail you a paper-copy of the survey.) It will take approximately 20 minutes of your time. Your responses, together with others, will be combined and used for statistical summaries only. Your confidentiality will be maintained to the degree permitted by the technology used, but no guarantees can be made regarding the interception of data sent electronically. The summarized findings with no identifying information may be published in an academic journal, presented at a scholarly conference, or used in future studies.

Your participation in this study is voluntary. You are free to withdraw from participation at any time or choose not to participate at all, and by doing so, you will not be penalized or lose benefits to which you are otherwise entitled. It is possible that you may feel uncomfortable answering questions on the survey, however, this discomfort is expected to be minimal, and you are free not to answer a question. Potentially, this study may assist current and future professionals and parents understand better attachment, which may in turn provide better support and outcomes throughout a child’s life.

If you have any questions about the survey, please contact me at (319) 273-3353 or by e-mail at duroches@uni.edu. If I am not available when you call, please leave a message and I will call back. You can also contact the office of the IRB Administrator, University of Northern Iowa, at 319-273-6148 for answers to questions about rights of research participants and the participant review process. By completing the survey below, you are indicating that you are fully aware of the nature and extent of your participation in this project as stated above and the possible risks arising from it. By completing the survey
you are agreeing to participate in the research and acknowledge that you are 18 years of age or older. Please print a copy of this form for your records or future reference.

Thank you for your help. I appreciate your cooperation.

Sincerely,
Stephanie DuRocher
School Psychology Graduate Student
How Parenting a Child with Attachment Difficulties Impacts the Family

For the following questions, please indicate which answers are most appropriate for your household:

Person completing this survey:
Mother/Step-Mother/Foster Mother
Father/Step-Father/Foster Father
Relative
Other:

Do you consider yourself to be a primary caretaker? Yes No

Definition of a primary caretaker—a person over the age of 18 who has or has had significant responsibility for the daily care and rearing of a child.

How many parents reside in the home?
1-parent household
2-parent household

Father/Step-Father/Foster Father works outside the home Yes No (Part-time/Full-time)
Mother/Step-Mother/Foster Mother works outside the home Yes No (Part-time/Full-time)

How many children, 18 years and under, are currently living in the home? ________

(Please fill out next section for each child in the home, beginning with the oldest.)

Age: ________
Sex: ________
Relationship to you: biological child adopted child foster child other

If the child is in foster care or is adopted, at what age did they enter your home? ________

If the child is in foster care or is adopted, how long did they spend in foster care or how long did they spend until the adoption finalization occurred? ________

Has a medical professional diagnosed your child with any of the following: (mark all that apply) ADHD, ODD, Anxiety, PTSD, RAD, other (acronyms spelled out for clarification)

Has this child been identified by a licensed medical professional or licensed psychologist as having attachment issues? Yes or No

Has this child been identified by anyone else as having attachment disorder or attachment issues? Yes or No

If yes, by whom? (List options)

Is this child currently taking any prescription medication for emotional or behavioral issues? (Mark no or yes. If yes, please list.)
Please indicate with an X if you observe the following behaviors in your child:

- superficially engaging and charming
- difficulty making eye contact
- poor peer relations
- Asks persistent nonsense questions or chatters incessantly
- Manipulative or controlling
- Indiscriminately affectionate with strangers
- Not cuddly with parents or only when child initiates affection
- inappropriately demanding or clingy
- Destructive to self, others, things
- Cruel to animals
- Cruel to siblings
- Steals
- Lies
- Poor impulse control
- Hoards or gorges on food
- pre-occupied with fire, blood or gore
- has developmental delays
- indifferent to cause and effect
- Does not care about making good choices
- Fear of Abandonment
- oppositional, argumentative, defiant
- frequent or intense angry outbursts
- Other: Please describe behavior.

1. Type of education child is currently receiving: (circle)

<table>
<thead>
<tr>
<th>Preschool</th>
<th>Private</th>
<th>Public</th>
<th>Home school</th>
<th>Other:</th>
</tr>
</thead>
</table>

2. Does your child receive special education services? (circle) Yes  No

3. If yes, is your child identified for special education services because of academic difficulties? (circle) Yes  No

4. If yes, is your child identified for special education services because of behavioral or emotional difficulties? (circle) Yes  No

5. If your child is receiving special education services, please describe those services.

6. I enjoy spending time with this child.

   Always  Usually  Sometimes  Rarely  Never

7. This child brings happiness to our home.

   Always  Usually  Sometimes  Rarely  Never

8. I am happy that this child is in our home.

   Always  Usually  Sometimes  Rarely  Never

9. Please describe some things that you enjoy about this child.
Now I am going to ask you questions about how things have changed or not changed since parenting a child with attachment difficulties. Please remember that this information will be kept confidential.

**HOME RELATIONSHIPS**

1) **How do you think caring for a child with attachment difficulties has changed the behavior of other children in your home?**
   - ___ Not applicable—No other children at home
   - Changed for much better
   - Changed for better
   - No relevant change
   - Changed for worse
   - Changed for much worse

2) **What do you think the other children in the home would say about how things at home changed since caring for a child with attachment difficulties?**
   - ___ N/A—No other children at home
   - Changed for much better
   - Changed for better
   - No relevant change
   - Changed for worse
   - Changed for much worse

3) **How do you think the relationship between you and the other children in the home has changed since caring for a child with attachment difficulties?**
   - ___ N/A—No other children at home
   - Changed for much better
   - Changed for better
   - No relevant change
   - Changed for worse
   - Changed for much worse

4) **How do you think the relationship between your partner/spouse and the other children in your home has changed since caring for a child with attachment difficulties?**
   - ___ N/A—No other children at home
   - Changed for much better
   - Changed for better
   - No relevant change
   - Changed for worse
   - Changed for much worse

5) **From your perspective, how has the relationship among the children in the home changed since caring for a child with attachment difficulties?**
   - ___ N/A—No other children at home
   - Changed for much better
   - Changed for better
   - No relevant change
   - Changed for worse
   - Changed for much worse

6) **From your perspective, how has the relationship between you and your spouse/partner changed since caring for a child with attachment difficulties?**
   - ___ N/A—No spouse or partner
   - Changed for much better
   - Changed for better
   - No relevant change
   - Changed for worse
   - Changed for much worse

7) **How has the relationship between you and your own mother changed since caring for a child with attachment difficulties?**
   - Check here: if mother deceased
   - or if your contact has been limited since before the child moved to your home
   - Changed for much better
   - Changed for better
   - No relevant change
   - Changed for worse
   - Changed for much worse

8) **How has the relationship between you and your own father changed since caring for a child with attachment difficulties?**
   - Check here: if father is deceased
   - or if your contact has been limited since before the child moved to your home
Changed for much better  Changed for better  No relevant change  Changed for worse  Changed for much worse

9) **How has the relationship between you and your closest friend** changed since caring for a child with attachment difficulties?

Changed for much better  Changed for better  No relevant change  Changed for worse  Changed for much worse

AND

Talk/Spend more positive time together  Talk/Spend same amount of positive time together  
Talk/Spend less positive time together  Talk/Spend much less positive time together

10) **How have family routines changed since caring for a child with attachment difficulties?**

Changed for much better  Changed for better  No relevant change  Changed for worse  Changed for much worse

11) **How have holidays changed since caring for a child with attachment difficulties?**

More relatives agree to come over  Same relatives agree to come over  Fewer relatives agree to come over

More friends agree to come over  Same friends agree to come over  Fewer friends agree to come over

12) **How have vacations changed since caring for a child with attachment difficulties?**

Don't take vacations now  Take fewer vacations  Don't take child with on vacations  No change

**SCHOOL ISSUES**

Now I am going to ask you some questions about your experience with the school system as a parent who has a child with attachment difficulties.

1) **What types of problems, if any, has your child(ren) with attachment difficulties experienced at school?** (Circle all that apply)

Academic skills  Motivation  Discipline  Social  Other: ___  No significant problems experienced

2) **How would you describe the relationship between you and your child's school regarding your child's needs?**

Major ongoing problems  Major occasional problems  Minor ongoing problems  Minor occasional problems  No problems

3) **How prepared do you feel your child's current general education teacher was to provide instruction to your child with attachment difficulties?**

Not at all prepared  A little prepared  Adequately prepared  Very prepared  Not applicable

4) **How prepared do you feel your child's current special education teacher was to provide instruction to your child with attachment difficulties?**

Not at all prepared  A little prepared  Adequately Prepared  Very prepared  Not applicable

5) **How prepared do you feel your child's current school psychologist teacher was to provide support for your child with attachment difficulties?**
6) How prepared do you feel your child’s current school counselor was to provide support for your child with attachment difficulties?

7) How prepared do you feel your child’s current school social worker was to provide support for your child with attachment difficulties?

8) How prepared do you feel your child’s current school nurse was to provide support for your child with attachment difficulties?

9) How prepared do you feel your child’s current principal/school administrator was to provide support for your child with attachment difficulties?

10) Who in the school was best able to support your child with attachment difficulties? (circle one)

   Regular education teacher  Special education teacher  Social worker  Counselor  School principal

   School psychologist  Nurse  other: _______________

11) Overall, how prepared do you feel your child’s current school was to provide support for your child with attachment difficulties?

PARENTING ISSUES

Now I am going to ask you some questions about your experience and feelings towards a child with attachment difficulties.

1) How prepared do you feel you were to handle the behaviors of a child with attachment difficulties?

   Very Prepared  Prepared  Adequately Prepared  A little prepared  Not at all prepared

2) How has caring for a child with attachment difficulties changed your perception/feelings about your own parenting ability?

   Changed for much better  Changed for better  No relevant change  Changed for worse  Changed for much worse

3) How has caring for a child with attachment difficulties changed your perception/feelings about your spouse’s/partner’s parenting ability?  Not applicable. No spouse/partner.

   Changed for much better  Changed for better  No relevant change  Changed for worse  Changed for much worse
4) If you have sought help in dealing with your child’s attachment difficulties, how easy was it to find those services?

<table>
<thead>
<tr>
<th>Very easy</th>
<th>Easy</th>
<th>Somewhat Easy</th>
<th>Not at all easy</th>
<th>Have not sought help</th>
</tr>
</thead>
</table>

5) If you have sought help in dealing with your child’s attachment difficulties, how helpful were those services?

<table>
<thead>
<tr>
<th>Very helpful</th>
<th>Helpful</th>
<th>No difference</th>
<th>Not at all helpful</th>
<th>Have not sought help</th>
</tr>
</thead>
</table>

6) If you have sought help in dealing with your child’s attachment difficulties, how convenient (i.e. location, scheduling) were those services?

<table>
<thead>
<tr>
<th>Very Convenient</th>
<th>A Little Convenient</th>
<th>No difference</th>
<th>Not at all convenient</th>
<th>Have not sought help</th>
</tr>
</thead>
</table>

7) What types of services have been most helpful?

<table>
<thead>
<tr>
<th>AEA</th>
<th>Early Access</th>
<th>Therapy</th>
<th>In-home services</th>
<th>Respite</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Have not sought help</td>
</tr>
</tbody>
</table>

8) How have your feelings towards the child with attachment difficulties changed since initial placement?

<table>
<thead>
<tr>
<th>Changed for much better</th>
<th>Changed for better</th>
<th>No relevant change</th>
<th>Changed for worse</th>
<th>Changed for much worse</th>
</tr>
</thead>
</table>

9) How has this experience changed your perception/feelings towards fostering?  

<table>
<thead>
<tr>
<th>N/A</th>
</tr>
</thead>
</table>

10) How has this experience changed your perception/feelings towards adoption?  

<table>
<thead>
<tr>
<th>N/A</th>
</tr>
</thead>
</table>

11) On average, if working, how many hours per month do you take off from work in order to meet the needs of the child with attachment difficulties?  

Fill in the blank

12) How supportive have employers been with your choice to provide foster care and/or adoption? Choose all that apply.

<table>
<thead>
<tr>
<th>Not at all supportive</th>
<th>Somewhat supportive</th>
<th>Very supportive</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

13) As a parent of a child with attachment difficulties, how difficult is it to find childcare while you are at work?

<table>
<thead>
<tr>
<th>Very difficult</th>
<th>Somewhat difficult</th>
<th>Difficult</th>
<th>Easy</th>
<th>Very easy</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

14) As a parent of a child with attachment difficulties, how easy is it to find someone outside the home in order for you to spend time away from the child?

<table>
<thead>
<tr>
<th>Very difficult</th>
<th>Somewhat difficult</th>
<th>Difficult</th>
<th>Easy</th>
<th>Very easy</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

15) Who do you turn to when you need support?

<table>
<thead>
<tr>
<th>Friend</th>
<th>Relative</th>
<th>Social Worker</th>
<th>Therapist</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
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