MALTREATMENT AND ATTACHMENT DISORDER

“A nine-month-old girl becomes very excited about a toy and reaches for it. As she grabs for it, she lets out an exuberant “aaah” and looks at her mother. Her mother looks back, scrunches up her shoulders, and performs a terrific shimmy with her upper body, like a go-go dancer. The shimmy lasts only about as long as her daughter’s ‘aaah’ but is equally excited, joyful and intense” (Stern, 1985, p. 140 cited in Hughes, 1997).

This example of affective attunement is but one of thousands of interactions between parent and child in the first two years of life. The interactions may last only seconds, but they are the building blocks for attachment between caretakers and child.

Attachment can be defined as one type of “lasting psychological connectedness between human beings” (Bowlby, 1969, p. 194). It is one of the most important building blocks for human development. Attachment begins in utero and continues to develop after birth. The “mother/infant bond” is considered crucial for the survival and development of the infant. Specific interactions thought necessary in the development of the caregiver-child bond include eye contact, skin-to-skin contact, rocking, the provision of food, and communication such as vocalization (Reber, 1996). Attachment is not static. Attachments undergo transformations and reintegration as the child progresses in development (Pearce & Pezzot-Pearce, 1994).

There are many controversies in attachment research. The universality of attachment is debated. Some researchers maintain that attachment patterns transcend cultures (Sagi, 1990). Other researchers note that attachment research has been fraught with assumptions and values of Western civilization and maintain that attachment patterns and their meanings are not universal (Solomon & George, 1999; Takahashi, 1990). Some researchers believe that attachment patterns are learned. Others see attachment behaviors as primarily influenced by inborn traits.

Problems in Evaluating Research

Developmental psychologists who are doing research on attachment refer to “disordered” attachments. Clinical psychologists, medical doctors and social workers treat children who have severe relationship problems that are sometimes termed “disrupted” attachments or “attachment disorders”. There appears to be little collaboration between these two groups. It is unclear as to whether the “disorganized attachments” being delineated by development psychologists are the same group of children being treated by clinicians or how much overlap there is between them.

Furthermore, the official diagnostic system, DSM-IV (Diagnostic Statistical Manual, IV, 1994) defines “Reactive Attachment Disorder” extremely narrowly. Clinicians writing about “attachment disorder” do not appear to be limiting themselves to writing about children who meet DSM-IV diagnostic criteria.

Most research on attachment has centered upon attachment relationships between mothers and infants (Greenberg, Cicchetti & Cummings, 1990). Some studies have examined attachment between infants and fathers. While fathers are attachment figures for their infants, paternal sensitivity, if measured in the same manner as maternal sensitivity, predicts attachment patterns only weakly or not at all (Grossman, Grossman & Zimmermann, 1999). Measures of reciprocity during play and a father’s sensitive support of their child’s explorations have emerged as the strongest predictors ofsecure infants, suggesting that fathers promote security in different ways than mothers do. Still, questions remain about measuring attachment for infant-father relationships as well as for relationships with other caregivers (Solomon & George, 1999).

Finally, over the last decade, research has accelerated and expanded from examining infant-mother dyads to considering attachments throughout the life span. While there is some consensus about measuring attachment in infants, there is less agreement about measuring attachment in preschool or older children. There are several competing systems and conceptualizations for measuring attachment in preschool and older children (Solomon & George, 1999).

Diagnosis of Attachment Disorder

Reactive Attachment Disorder refers to a fundamental disturbance in the parent-child attachment relationship. Children with this disorder show disturbance in social relatedness not only with their primary caretaker but across individuals and contexts. It is thought that disturbances in the early relationship between parent and child set conditions for social dysfunction within Continued on page 2
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the child. The behavioral constellation persists over time.

Disrupted attachment can result from grossly negligent or pathological care of infants and young children. Certain situations such as prolonged hospitalization of the child, extreme poverty, parental depression or substance abuse, marital discord, or parental inexperience can heighten the likelihood of pathological care. Reactive Attachment Disorder may also be associated with developmental delays, with unrecognized feeding disorders, Pica or Ruminative Disorder. Laboratory findings consistent with malnutrition may be present.

A DSM-IV diagnosis of Reactive Attachment Disorder requires that pathogenic care be in the child's history and the assumption is that inadequate care is a causative factor in the disorder.

Pathogenic care is further defined as: 1) persistent disregard for the child's emotional needs for comfort, stimulation, and affection; 2) persistent disregard for the child's physical needs; and 3) repeated changes of primary caregivers. These traits of pathogenic care are elements of emotional and physical neglect, and are frequently present in families where children are physically abused.

However, it should be noted that grossly pathological care does not always result in attachment disorder. Some children form stable attachments and positive social relationships even though they have experienced serious and protracted maltreatment. Other maltreated children show negative effects on attachment and socialization that fall short of a diagnosis of Reactive Attachment Disorder.

The DSM-IV diagnosis requires that Reactive Attachment Disorder occurs in the first several years of life and must begin before age 5. For other criteria, see block "What is 'Attachment Disorder'?"

The clinical literature reveals an array of diagnostic labels which have been applied to children who have experienced pathological care and maltreatment. Some labels emphasize major signs and symptoms such as nonorganic failure to thrive, psychosocial dwarfism and anallactic depression. Others have emphasized the major environmental circumstances of the infant or child such as hospitalism or maternal deprivation. The label Reactive Attachment Disorder attempts to capture both the context of the disorder ("reactive" in response to caregiving) and the sequela of the insufficient caregiving (problems in the child's social relatedness) (Richers & Volkmar, 1996).

It is interesting to notice that the criteria for Reactive Attachment Disorder do not directly address attachment as defined by developmental psychologists. For instance, the diagnosis does not require an assessment of the child-caregiver relationship in terms of variables shown by researchers to be important such as comfort-seeking, exploratory behaviors, secure-base behavior, or responsiveness (Richers & Volkmar, 1996). Diagnostic criteria focus on the child's socially aberrant behaviors in general, rather than on attachment behaviors per se (Zeanah, 1996). Furthermore, the criteria used by clinicians and "attachment treatment centers" to identify "attachment problems" or "attachment disorders" are often broader than the DSM-IV criteria and are applied to older children.

Differential Diagnosis

Children with other diagnosed conditions may have some symptoms similar to children with Reactive Attachment Disorder. Therefore, it is important for clinicians to distinguish between social relatedness problems due to other causes and those which are Reactive Attachment Disorder. Some ways to distinguish between conditions are discussed below.

Some infants and young children with Severe Mental Retardation may exhibit symptoms of Reactive Attachment Disorder (although it is more common with Mental Retardation that appropriate attachments to caregivers develop consistent with the child's general developmental level). Reactive Attachment Disorder should only be diagnosed in children with Mental Retardation if it is clear that attachment problems are not a function of the retardation (DSM-IV, 1994).

Reactive Attachment Disorder should also be differentiated from Autistic Disorder and other Pervasive Developmental Disorders (PDD). With PDD, selective attachments either fail to develop or are highly deviant but these problems occur in the context of a reasonably supportive psychosocial environment. With Autistic Disorder or PDD there is often a qualitative impairment in communication and restricted, repetitive and stereotyped patterns of behavior. Also, deficits are thought to be neurobiological in nature, resulting in a lack of capacity for normal social development (Richers & Volkmar, 1996). If the criteria for PDD are met, Reactive Attachment Disorder should not be diagnosed (DSM-IV, 1994).

Further, the Disinhibited subtype of Reactive Attachment Disorder needs to be distinguished from the impulsive or hyperactive behaviors seen in Attention-Deficit/Hyperactivity Disorder. A factor distinguishing the two conditions is that the child with Reactive Attachment Disorder (Disinhibited type) shows indiscriminate friendliness after a very brief acquaintance (DSM-IV, 1994).

To what extent can attachment disorder be distinguished from other behavioral problems? This question was examined by O'Connor, Bredenkamp, Rutter & English and Romanian Adoptees (ERA) Study Team (1999). They compared 111 children who experienced institutional deprivation and were later adopted to 52 adopted children not exposed to early deprivation. They found support for a distinction between attachment disorders and other forms of behavioral problems. The only marked overlap was with inattention/hyperactivity.

Diagnostic Controversies

There is dissatisfaction with the DSM-IV criteria for Reactive Attachment Disorder. The World Health Organization also has a classification for attachment disorder in their system, The International Classification of Diseases (ICD-10). Researchers note that there are no published studies concerning the validity of either system's diagnosis of Reactive Attachment Disorder (Zeanah, 1996). Both diagnostic systems share agreement about the major features of the disorder. Some feel that both diagnostic systems more properly define "maltreatment disorders" than "attachment disorders" (Zeanah, 1996).

There are several alternative conceptualizations to disordered attachment in addition to the two official nosologies. These alternatives were created from clinical observation and incorporate the major findings of developmental attachment research. They are broader in focus, emphasize the child-caretaker attachment, and are not limited to maltreated children. The alternative systems recognize that children can have differing attachments to different adults and do not require that the child's relationships be disordered in all contexts.

Obviously, much work remains to be done concerning diagnostic issues. This article will attempt to discuss both the literature about developmental attachment, the research on Reactive Attachment Disorder, and research on children being treated for "attachment problems" or "attachment disorder" that does not meet DSM-IV criteria.

Theoretical Underpinnings

Interest in attachment dates to the work of John Bowlby. Bowlby, a British psychiatrist, believed that the infant-mother relationship was central to healthy psychological and social development. He believed that infants are predisposed to form attachments to caregivers and that infants have a repertoire of attachment behaviors (such as crying, smiling, grasping) that facilitate bonding. Attachment, according to Bowlby, serves a biological function by keeping the
infant close to the caregiver, thus protecting the infant from harm and also by stimulating nurturing caregiving behaviors from adults. In studying antisocial children, Bowlby found early separations from caretakers to be common. Bowlby believed that these children developed behavioral problems and criminal inclinations as a result of early emotional deprivation.

Other early researchers such as Loretta Bender and David Levy studied similar children who had numerous out-of-home placements. These children were delayed in speech and social behavior; indiscriminately affectionate, abusive towards peers, clingy with adults, had attentional problems and frequent temper tantrums. Harry Bakwin studied babies in institutions who failed to thrive. These babies improved when they were placed in nurturing homes. Harold Skeels demonstrated that deprived, institutionalized children with language and cognitive deficits improved an average of 30 IQ points within 18 months when cared for by affectionate caregivers. Rene Spitz studied children left in hospitals and institutions. These children became apathetic and depressed but recovered if returned to their parents within three months.

Mary Ainsworth (1979) developed these early findings by describing the developmental phases of attachment. The baby is at first indiscriminating and responds to anyone. Soon, however, a baby shows differential responsiveness, preferring his or her primary caregiver. The infant begins to show separation anxiety, crying when the mother leaves and crying when she is near. Active initiation is seen where the infant protests when separated from the mother, actively pursues her, and greets her upon return. Between 6 and 8 months, the infant will show stranger anxiety and be uncomfortable or wary with strangers.

Ainsworth developed a research procedure, the Strange Situation, to study attachment behaviors. In this structured laboratory situation, an infant and caretaker are involved in two brief separations and reunions. The infant is rated on behaviors in the caretaker’s presence, behaviors when separated from the caretaker, reunion behaviors and behavior after the reunion.

Ainsworth and developmental psychologists who added to her research began to delineate attachment patterns. They believed that parenting styles affected the development of attachment. According to the work of Ainsworth and her followers, attachment patterns can be divided into those which are “ordered” and those which are “disordered”. Ordered attachments can be further subdivided into three categories: secure, avoidant and ambivalent. These are described below:

**Ordered Attachments**

**Secure Attachment:** These babies have mothers who are affectionate, feed them on demand, and respond quickly when the baby cries. Securely attached babies readily separate to explore toys and actively seek their parent when distressed. They show signs of missing the attachment figure when he or she leaves the room. On reunion, these infants actively seek contact, are easily comforted and quickly return to play. They show an obvious preference for their parent over a stranger. Secure infants appear to strike a balance between attachment behaviors and exploratory behaviors.

As the child develops into the preschool years, parents of securely attached children use discipline sensitively and effectively. When the children are older, they can talk about feelings and offer ideas for coping with stress. Securely attached children have relationships with their parents that are relaxed, friendly, warm and natural, but not clingy. Secure attachment in infancy predicts greater competence with peers, resiliency, resourcefulness, empathy and popularity among preschoolers (Sroufe, 1988, cited in Alexander, 1992).

**Insecure-Avoidant Attachment** (sometimes called “Anxious-Avoidant Attachment”): Mothers of avoidant babies are rejecting, interfering, or neglectful. The babies readily separate from their mothers to explore the playroom and show little affective sharing with them. Rather, the babies focus on toys or the environment and seem disinterested in their mothers at the very time when their attachment needs are activated. It is hypothesized that the infants show indifference to disguise their hurt and anger. Upon reunion they either mngle proximity-seeking and avoidant behaviors or ignore the mother altogether (Ainsworth, 1979). When distressed, avoidantly attached children are distant from their parents and reject them, avoiding intimacy and connection. “The child seems to say, ‘who needs you - I can do it on my own’” (Karen, 1990, p.211). They may have an “I don’t care” attitude.

Avoidant children may seek attachments with teachers or other role models, and, if lucky, will find a special person who can provide an alternative model of relatedness. However, the youngster may have trouble finding such an alternative attachment. The strategies he or she has adopted tend to alienate the child from people who might help. The behaviors of these children range from antisocial and aggressive to clinging and from “puffed up to deflated”. They try the patience of adults and peers alike. The reactions reconfirm the child’s distorted view of the world (“people will never love me”).

**Insecure-Ambivalent Attachment** (sometimes called “Anxious-Resistant Attachment” or “Insecure-Resistant Attachment”): Mothers of these babies are inconsistent and unpredictable. The babies have difficulty separating in order to explore and are wary of novel situations and people. These infants are preoccupied with the whereabouts of their attachment figures. They are extremely distressed by separation. They are clingy but are also difficult to sooth on reunion and they resist their mother’s comfort. They may mix contact seeking with resistance such as hitting, kicking or squirming, and continuing to cry and fuss or they may be passive. When older they respond with anger mixed with seeking closeness and appear to be “overdependent” on their mothers. Children in the ambivalent category have relationships with their parents characterized by a mixture of closeness and hostility and often the relationship appears contrived. “The ambivalent child is desperately trying to influence his mother. He is hooked by the fact that she does indeed come through on occasion - if the pleads and makes a big enough fuss” (Karen, 1990, p.211).

Infants with ordered attachments (whether secure, avoidant or ambivalent) are considered to be within normal limits and the behavior patterns are not extreme. Also they have developed coherent strategies for dealing with stress such as being separated and then reunited with a caretaker.

According to Robert Marvin, Ph.D., co-director of the Mary D. Ainsworth Child-Parent Attachment Clinic, infants with se-

**WHAT IS “ATTACHMENT DISORDER”?**

“Attachment Disorder” refers to the diagnosis 313.89 “Reactive Attachment Disorder of Infancy or Early Childhood”. The essential feature of this disorder is markedly disturbed and developmentally inappropriate social relatedness. The disorder must onset prior to age five and is associated with grossly pathological care (Criterion A).

There are two subtypes: Inhibited and Disinhibited. The Inhibited subtype shows disturbance in social relatedness because of a persistent failure to initiate or respond to most social interactions in a developmentally appropriate way. The Disinhibited subtype shows disturbance in social relatedness due to indiscriminative sociability or a lack of selectivity in the choice of attachment figures.

Criterion B is to “rule out” Mental Retardation or Pervasive Development Disorders.

Criterion C is pathogenic care as shown by any of the following: 1) persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection; 2) persistent disregard of the child’s basic physical needs; 3) repeated changes of the primary caregiver that prevent formation of stable attachments.

Criterion D states that there is a presumption that the deficient care in Criterion C is responsible for the disturbed behavior in criterion A. Thus, the behavioral disturbance occurs after the lack of care.

Excerpted from the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, 1994)
anxious behaviors and may fit diagnostic criteria for Attention Deficit Disorder or Separation Anxiety Disorder. Disorganized children are punitive or caregiving towards their parents. Either way, the child’s stance is to control or dominate the parent (Main & Cassidy, 1988).

Findings About Attachments Patterns

Researchers have followed children throughout their development. Those children with secure attachments between 12 to 18 months fare better on many measures. They make more and better friends, show greater self-esteem, are more competent problem-solvers, receive more positive feedback from others, are more resilient and have greater independence than other children. In addition, children with secure attachments are more cooperative, more flexible, less aggressive, less avoidant, are more enthusiastic, more persistent, more self-directed and explore longer. They are better able than infants with other attachment patterns to elicit and accept their mother’s help. They have higher scores on developmental tasks and on language development. When older, they are more sympathetic to distress of peers, more assertive about what they want and are more likely to be leaders. Children with secure attachment are unlikely to be either victims or exploiters if placed in pairs.

Attachment patterns also affect how others relate to children. Teachers tend to treat securely attached children in matter-of-fact, age appropriate ways. In contrast, teachers excuse and infantilize the clingier ambivalent children and tend to be controlling and angry with avoidant ones (Karen, 1990). Most research about attachment has investigated infant or preschool children. In the last decade, attachment in other developmental periods is being investigated. Attachment is now being seen as a life-span task. Children, as they grow, continually renegotiate the balance between being independent and being connected to others. Most developmentalists no longer expect children to necessarily be permanently scarred by negative early experiences or permanently inoculated from later insults by early positive experience. Thus, early experience is not necessarily more consequential than later experiences (Cicchetti, Cummings, Greenberg & Marvin, 1990).

Cicchetti et al. discuss some of the circumstances which may cause a securely attached infant or child to become insecure. These include trauma, birth of a new sibling, a divorce, or a loss of an attachment figure. It is less clear how infants and children with insecure attachments can improve and develop secure attachments. One intervention for early attachment problems developed in Toronto, Canada is described in the video “When the Bough Breaks” (see review, this issue).

Models of Causation

Attachment theorists view maltreatment as an expression of underlying dysfunction in the parent-child-environment system rather than due only to stress or aberrant parent characteristics (Schmidt & Eldridge, 1986). This conceptualization fits well with Belsky’s ecological theory of child maltreatment which was discussed in depth in VCPN, volume 46. Belsky’s integrative theory discusses causation of child maltreatment as due to a combination of factors in society, the community, the extended family, the caregiver, and the immediate parent-child interactions.

Some researchers have noted cross-generational effects. For example, a parent’s failure to resolve mourning of the loss of an attachment figure through death can be associated with disorganized attachment patterns with her own children. Further, if the parent’s loss was in early childhood, the negative effects are heightened (Ainsworth & Eichberg, 1991; Main & Hesse, 1990). The key is unresolved mourning, Ainsworth and Eichberg note that most parents with early losses had infants with secure attachment.

Both parent and baby make contributions to the attachment process. The infant’s responsiveness, learning and growth reinforces the parent’s continued nurturance. The infant has much more at stake, however, than the parent. If the attachment process fares poorly, the entire course of the baby’s development will be affected (Schmidt & Eldridge, 1986).

Many factors can influence the attachment process. Disruptions can occur due to organic deficiencies in the child, difficult child temperament and separation from the parent due to prematurity. Parents may respond poorly if the child is a disappointment, such as being a different sex than was hoped for.

In most cases, parents deal with disappointments and problems and make adjustments. Adequate parents recognize the infant’s needs for physical care and protection, for nurturance, for love, for the opportunity to relate to others, for exercise of physical and mental functions and for help in organizing and mastering experiences. The adequate parent meets these needs and facilitates growth. The attachment that promotes the child’s growth is accomplished.

A Reactive Attachment Disorder develops when adaptation can not be achieved. In Reactive Attachment Disorder, the parent brings psychological interference to parenting that adversely affect the baby’s developmental progress and emotional well-being. In a Reactive Attachment Disorder, the parent is unable to perform adequately and can not act in accordance with the needs of the child (Schmidt & Eldridge, 1986).

It is important to note that there are challenges to attachment theory. Jerome Kagan, a Harvard psychologist, has been a vocal critic (See Karen, 1994 for a discussion). Also
cross-cultural research disputes the notion that attachment is similar in all cultures or family constellations (Rothbaum et al., 2000). Especially in situations where clinicians are evaluating competency to parent, care should be taken in utilizing assessments of attachment.

The Relationship Between Maltreatment and Attachment

According to DSM-IV criteria, pathogenic parental care or deprivation is a required cause for diagnosing Reactive Attachment Disorder. The relationship between the duration of the deprivation and the likelihood of attachment disorders behaves has been found to be relatively linear (O'Connor, Bredenkamp & Rutter, and English & Romanian Adoptees (ERA) Study Team, 1999). That is, the longer and more severe the pathogenic care, the greater the likelihood of attachment problems. The critical factor appears to be a lack of a consistent and responsive caregiver (or small number of caregivers). The opportunity to form selective attachments is a key factor in avoiding attachment disorder.

There is research to support the idea that maltreatment is related to attachment problems. Early studies by Spitz (1950) and Harlow (1961) (cited in Hanson & Spratt, 2000) demonstrated a relationship between profound social deprivation and later pathology. Later studies on attachment found that the vast majority of maltreated children had formed insecure attachments with their caregivers (Egeland & Sroufe, 1981). Ortman (1979) found evidence of marked inhibition and wariness in attachment behaviors among abused children. There was a lack of separation anxiety for the abused group. A later study by Carlson et al. (1989) found that maltreated infants were much more likely than demographically matched comparison infants to be rated as insecurely attached and were particularly likely to demonstrate disorganized attachment. Carlson et al.’s findings are similar to findings by Ainsworth (1990). She found that maltreated children were difficult or compliant in interactions with their mothers, avoidant under stress, and aggressive with siblings. In comparison, adequately-reared children were cooperative with both their mothers and their siblings and were secure under stress.

In an earlier study, Crittenden (1981) was able to identify patterns of maternal behavior that distinguished among abusing, neglecting and adequate mothers of infants aged one to 19 months. Abusing mothers showed insensitive interference with goal-directed behaviors of the infants. They also displayed conflicting emotional signals that involved covert hostility. Neglecting parents lacked interaction, were physically distant from their infants, had an absence of affective expression, had long pauses between verbal initiations and lacked eye contact. Adequate mothers were contingent in responsiveness to their infants, were affectionate, showed enjoyment of their infants and adapted to the infant’s goals.

These findings have been validated by Lyons-Ruth, Connell, Zoll and Stahl (1987) who found that maltreating mothers could be discriminated by uninformed coders (“blind” coders) from normal-treating mothers based on observations of everyday interactions with their infants at home. Maltreating mothers were more likely to demonstrate hostility towards their infants in subtle ways and to interfere with their infants’ goals and activities. Maternal behaviors related to maltreatment were also related to the infant’s security of attachment. Consistent with prior reports, maternal hostility was related to the infant’s avoidance of the mother after a brief separation and lack of maternal communication was related to infant resistance or mixed avoidance and resistance. Moreover, studies of offspring of parents with major depressive disorder have shown that maternal unpredictability is strongly associated with disorganized attachments (Cummings & Cicchetti, 1990).

A study by Egeland and Sroufe (1981) followed a sample of 267 impoverished mothers. At 12 months for those mothers providing excellent care, a majority had secure attachment (75 percent) with their babies whereas for mothers who had abused or neglected their babies only 38 percent had secure attachments. By 18 months the excellent care mothers had 76 percent of babies with secure attachment. The maltreating mothers (some of whom had received intervention) still had a lower percentage of babies with secure attachment (56 percent).

The development of the Adult Attachment Interview (AAI) gave researchers a method to categorize parents according to the patterns of attachment experienced as children. The method has been shown to have “remarkable reliability and discriminate validity” (van IJzendoorn, 1995, p. 388).

Participants are classified as autonomous or secure when their presentation and responses are clear, relevant and reasonably succinct. Both individuals with supportive childhood experiences as well as those with difficult backgrounds can be classified as autonomous if they are coherent in discussing and evaluating experiences (whether positive or negative). Participants are classified as dismissing when they describe parents in highly positive terms that are unsupported or that are contradicted later in the interview. Dismissing participants often insist that they are unable to remember childhood attachment experiences and may minimize their attention to attachment-related experiences. Participants are classified as preoccupied when they show a confused, angry, or passive preoccupation with attachment figures. Both dismissing and preoccupied participants are considered to be insecure. Finally, participants may be classified as unresolved/disorganized with respect to potentially traumatic experiences involving loss or abuse. Participants classified as unresolved/disorganized are always given one of the other three categories as underlying primary classifications.

It has been found that parental representations of past and present attachment experiences relate to the degree of sensitivity and responsiveness with which parents react to infant attachment signals (van IJzendoorn, 1995). Responsiveness to infants, in turn, is linked to attachment patterns. Autonomous parents tend to perceive their infant’s attachment signals accurately, are appropriately responsive, and are likely to have infants who are securely attached. Dismissing parents, in contrast, tend to reject their child’s bids for attachment because the expression of such behaviors serve as a stimulus for unward attachment-related memories. Their children are likely to be insecure/avoidant in attachment. Preoccupied parents, on the other hand, may still be focused primarily on their own attachment experiences and are therefore unable to attend to their child’s attachment signals in a predictable manner. At times they ignore the infant and at other times overcompensate by excessive responses. Their children are likely to be insecure/resistant in attachment. Finally, parents who are unresolved with respect to traumatic experiences may at times exhibit frightened/frightening behavior. When the parents, rather than the environment, are a source.
of alarm, infants cannot develop a coherent attachment strategy and become disorganized (van IJzendoorn, 1995).

It should be noted that insecure adult attachment (dismissing, preoccupied or unresolved) is neither a necessary nor a sufficient condition for attachment dysfunction of the infant or child. Beyond an agreement about the role of caretaker deprivation, very little is known about the epidemiology of Reactive Attachment Disorder. There is not agreement about the biological, psychological and family factors that may contribute to the disorder. Further, there are no epidemiological studies that examine the prevalence, incidence or natural course of the disorder (Hanson & Spratt, 2000).

Not all children who experience deprivation in caretaking develop Reactive Attachment Disorder. Rather, some children manage to tolerate pathogenic caregiving without showing symptoms of Reactive Attachment Disorder. Likewise, some children diagnosed with Reactive Attachment Disorder do not have the required history of pathogenic care (O’Connor et al., 1999).

Assessment Issues

In recent years, Reactive Attachment disorder has been used as a diagnosis for a myriad of problem behaviors and interactions that extend beyond the DSM-IV criteria (Hanson & Spratt, 2000). A concern is the possibility that children, particularly those who have been maltreated, are being over-diagnosed as having Reactive Attachment Disorder based on broad and nonspecific symptoms lists (Hanson & Spratt, 2000).

The lack of diagnostic integrity also makes it difficult to examine research about Reactive Attachment Disorder or to determine the effectiveness of treatments for the disorder.

For example, diagnostic criteria used by some treatment programs contain behaviors not included in DSM-IV diagnostic criteria (see, for example, Pickle, 1994). Behaviors supposedly indicative of Reactive Attachment Disorder include cruelty to animals, preoccupation with fire, blood, and gore, poor peer relationships, compulsive lying, lack of a conscience, chronic stealing, fighting for control, gorging food, and refusal to make eye contact. These symptoms are not part of the DSM-IV diagnosis of Reactive Attachment Disorder but can be found in disorders such as Conduct Disorder and other behavioral problems that do not necessarily involve disruptions in attachment (Hanson & Spratt, 2000).

There is no standardized or even widely accepted assessment protocol used to validate a diagnosis of Reactive Attachment Disorder (Hanson & Spratt, 2000). Further, the diagnosis is based mainly on clinical observation and information provided by caregivers.

The classic tool developmental psychologists use for assessing infant/caretaker attachment is the “Strange Situation”, a research protocol developed by Mary Ainsworth. In this procedure, caretaker and child play together, the caretaker leaves the room for a short time period, then returns. The separation and reunion is repeated. The quality of the relationship and the actions and reactions of both parties are recorded and assessed, then categorized into one of the attachment patterns described earlier (secure, avoidant, ambivalent or disorganized). For a complete description of the laboratory procedure and assessment, see Main and Solomon, 1990.

While the “Strange Situation” procedure can yield information that is helpful to clinicians in structuring treatment interventions, the procedure is not designed to assist in diagnosing Reactive Attachment Disorder, the way it is currently defined by DSM-IV. The DSM-IV criteria do not emphasize the child’s bond to the caretaker, but rather the social relatedness of the child in all contexts. As mentioned before, there are also several tools and checklists assembled by practicing clinicians for diagnosing Reactive Attachment Disorder. These contain symptoms/items not currently included in DSM-IV, and thus, are not designed to identify children meeting DSM-IV criteria.

For an accurate diagnosis using DSM IV criteria, four areas should be assessed (Reber, 1996).

1. History – Was there a significant trauma to the child in-utero or during the early years? Was there separation(s) from caregivers? Did the child experience significant neglect and/or maltreatment?
2. Social relations – What are child’s interactions with others?
3. Presenting behaviors – What symptoms and problems is the child experiencing?
4. Family functioning – What level of functioning has the family of origin shown?

One needs also to assess the areas of strength and weakness in the child’s current family, if different from the family of origin.

Another assessment protocol for Reactive Attachment Disorder (Anders, 1989) recommends three areas of assessment: (1) the current state of the relationship and its history; (2) each party as an individual including the caregiver’s past history of significant relationships; and (3) the family’s socioeconomic status, current stressors and social supports. The focus of this assessment is not the infant as an individual but the dyad of infant and caregiver.

Anders suggests examining patterns of regulation (designated as appropriate, over-regulation, underregulation, inappropriate regulation, unregulated regulation or chaotic regulation). The range, modulation and attenuation of the relationship is rated. At first these patterns are imposed by the adults. As the infant matures, both parts of the dyad are active in perpetrating patterns.

To assess the caretaker’s past relationships, Anders suggests using the Adult Attachment Interview developed by Mary Main and her colleagues. To assess the parent’s specific relationship to each child, Anders suggests a semi-structured interview developed by Charles Zeanah and colleagues.

In assessing each individual in the dyad (infant/child and caregiver), Anders suggests noting some specific problems which can interfere with attachment. These include postpartum depression (for more information see VCPN, volume 59), serious mental illness, (see VCPN, volume 56), and substance abuse (see VCPN, volume 53). Illness, handicaps and unique temperaments in the infant/child need to be assessed as well (for more information, see VCPN, volume 59). Anders notes that distorted interactions that result from individual parent pathology or disabling conditions of the infant can be long-lasting or recurrent and, thus, affect the relationship over time.

Finally, Anders evaluates the family’s stresses and supports. These are assessed not only in the context of the family but also in the larger context of society and culture. Does the relationship fit with or is it in conflict with cultural values? How is the parent’s sense of competency and fulfillment impacted by society and cultural milieu?

Assessment and diagnosis is of limited use if it merely results in a label. Rather, classification is useful to identify key symptoms and challenges as well as delineate strengths, coping capacities, and abilities.

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SPOTLIGHT ON CHARLOTTESVILLE

The Mary D. Ainsworth Child-Parent Attachment Clinic

It is fitting that the students of Mary Ainsworth, having devoted their careers to the study of attachment, have expanded to service provision to assist families with attachment problems. For the last 3 years, the clinic has been offering a wide range of services, including evaluation, consultation, and intervention.

The clinic is jointly managed by Bob Marvin, Ph.D. and Bill Whalan, PsyD. Dr. Marvin worked at the Kluge Center for 20 years, acquiring an excellent background in serving children with a wide variety of medical conditions as well as psychiatric difficulties. Dr. Whalan is a veteran of the Kluge Center as well, having worked there 8 years.

Dr. Marvin describes the evolution from research to service, “I was one of Mary Ainsworth’s first students,” explains Dr. Marvin, “and have been involved in attachment research since the 1960’s. Starting in 1985, I began to apply the research data to clinical practice, performing assessments of attachment patterns in families with maltreatment towards children. About five years ago, I formed the Attachment Clinic in order to devote myself full-time to work with attachment.”

The Clinic is for families experiencing divorce, for families with disputed custody and visitation, for families where there is risk of maltreatment or a fostered case of maltreatment, for children in foster care and for adopted children.

Dr. Marvin offers some examples of the clinic’s service. “When a child first enters foster care, we can do an evaluation with the child and the biological parents in order to assist in developing intervention goals that address relationship and attachment problems”, says Dr. Marvin. He notes that sometimes a parent can meet concrete goals such as obtaining employment, establishing better housing, and attending parenting classes. However, their relationship with the child may still be dysfunctional. Without specific goals targeting the relationship problems, it sometimes happens that the parent has satisfied the limited service contract and the judge returns the child to the home. “An attachment assessment at the time of entry into foster care can serve as a baseline. Then, a reassessment can determine progress prior to a child going home, notes Dr. Marvin.

The assessments at the Clinic are extremely thorough. They are a blend of traditional clinical procedures, plus an extensive evaluation of the parent-child interactions in many contexts such as discipline, teaching, playing and listening. The attachment-caregiving relationship between parent and child is assessed also, using extended play observations as well as a form of the “Strange Situation” appropriate to the child’s age (see main article for a description of the “Strange Situation”).

Another area where the clinic can help is with prospective adoptive parents. “We are able to help parents considering adoption learn to better read their child’s cues and, thus, facilitate the bonding process,” notes Dr. Marvin.

The Clinic is also called upon to assist adoptive families where the adoption is in danger of disrupting. “Typically the child has been in the family 4 to 5 years,” explains Dr. Marvin, “and is either 8 or 10 years old, or else is entering teenage years. We often find a situation where parent and child are mismatched rather than the threatened disruption being due to failings on the part of the adoptive parent”.

There are many other situations involving attachment problems, according to Dr. Marvin. For example, a mom may be killed in a car accident and her spouse is having difficulty raising the children alone. It may be that the parent has suffered a loss and this has reawakened attachment issues from the parent’s past. These issues begin to interfere with daily parenting in the present. Also, the clinic provides assessments of divorcing parents to assist courts in deciding custody and visitation for children.

Children adopted from Eastern Europe are referred to the Clinic. Dr. Marvin is part of the European and British team that is evaluating Eastern European children adopted by British families.

As part of the clinical assessment, the Clinic offers consultation to therapists who are working with the children. Thus, families not in the immediate area can have their therapist benefit from Clinic expertise.

The clinics offer interventions for those with attachment problems. Dr. Marvin is excited about using the videotaped assessment to assist with intervention. “Viewing the videotapes is such a powerful tool!” exclaims Dr. Marvin. He continues, “We start by viewing positives, what went right in the interaction. Then we begin to educate the parent about where their response is not matching the child’s needs. We help them improve their skills at ‘reading’ their child and becoming more sophisticated in understanding their child’s motivations and behaviors.” Dr. Marvin discussed the process of learning. “There is a point where you can see an internal shift in the parent’s thinking. The parent then begins to act in a more sensitive and more adaptive way.”

The clinic’s services are not, for the most part, covered by Medicaid or most insurance companies. People pay out-of-pocket or communities authorize payment through FAPT (Family Assessment and Planning Teams) or through adoptions services funding.

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Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families, By Terry M. Levy and Michael Orlans, 1998, 328 pages, $34.95

Available from: CWLA c/o PMDS 9050 Junction Drive, P.O. Box 2019, Annapolis Junction, MD 20701-2019, (800) 407-5273, FAX: (302) 206-3766, e-mail: cwla@pmds.com web site: http://www.cwla.org

This source book explains attachment theory and disrupted attachment. The authors hope to increase understanding of attachment, offer answers to common questions, and strive to provide a framework for assessment and treatment of attachment problems. Separate chapters address assessment, treatment and parenting issues. This source book is written clearly and is comprehensive. It is enhanced by Appendices which offer references, sample treatment plans, comparison of symptom presentations between ADHD, Bipolar, and RAD, case examples, and other treatment/assessment resources.
DOMESTIC VIOLENCE

Stahly, 1993). Legally a husband could use physical force at his discretion. There are many documented cases where women and children were beaten, severely injured and killed. Over the years, laws were passed which gave women more rights and responsibilities. Still, the attitude that a man had proprietary rights persisted for many years.

This attitude influenced divorce and custody arenas as well. Historically, the law and tradition of custody has been one of paternal right. Upon divorce, custody of the children was awarded to the husband. Evidence of beatings of women or children had no place in the courts. Domestic violence was considered a private family matter. It was not until the nineteenth century that child abuse was addressed in the courts (Liss & Stahly, 1993).

In the twentieth century the “tender years” doctrine evolved. This doctrine suggests that all things being equal (religion, sexual orientation, psychological distance) custody should be awarded to mothers during the child’s early development years. In 1981, the supreme court of Alabama struck down the presumption of the “tender years doctrine” based on the failure to provide equal rights to fathers (Institute for Advanced Legal Studies, 1990; Lemon, 1999; Liss & Stahly, 1993).

Recent years have seen a focus on “joint custody”. In this model, parents share custody responsibilities. The model is designed to afford access to the children for both parents. Therefore, “the best interests of the child” emerges as the primary consideration when deciding issues of custody or visitation. This standard suggests that the court determine which custody/visitation arrangement will provide for the health, safety and general well-being of the child (Lemon, 1999, Liss & Stahly, 1993). Joint custody is presumed to fit that model.

While in the past domestic violence would have been considered irrelevant to child custody decisions, the 1980’s saw a change. The presence of domestic violence became one consideration in custody decisions, along with the relationship of each parent to each child, the parent’s parenting abilities, mental health, moral fitness and financial stability and whether the current custody arrangements were working well for the child(ren). Courts differed on the relative importance of domestic violence within those many factors. However, by 1997, 44 states and Washington DC had statutes requiring courts to consider domestic violence in all custody cases (Lemon, 1999).

Custody

With control being a primary dynamic in domestic violence cases, separation by the victim may lead to the batterer attempting to continue his control through the abuse of the legal system. One of the more powerful methods of maintaining control is to engage a woman in a lengthy and costly custody battle (Twining, 1996). Abusers may seek custody of children as a way to punish their partner, re-establish control and demonstrate that the partner is a less valued and less important person in the children’s lives (Jaffe & Gefner, 1998).

Women leaving marriages fraught with violence are at a serious disadvantage when entering the legal arena. Traumatized by the dynamics of abuse, finally denying a husband who has dominated her for years, afraid of losing her children, she enters the “foreign and impersonal world of court-houses people with fast-moving lawyers, judges, uniformed marshals, and court personnel, all speaking a specialized language ‘outsiders’ do not always understand. More than most people outside the legal system, battered women just breaking free of the social isolation of violent marriages are even more handicapped in their attempts to deal with it and to get it to work for themselves” (Pagelow, 1991, p.8).

Often, the motive to leave is based on the effects the domestic violence is having on the children. The effects may be emotional damage or the violence may include physical abuse of the children. Regardless, escaping the relationship while maintaining custody of the children is paramount. Thus, involvement in the court battle is essential to the end.

Unfortunately, intimidation may make it difficult, if not impossible, for a battered woman to assert her desire for sole custody. Threats by the batterer may lead her to compromise her best interest and the best interests of her children in a effort to decrease their physical and psychological danger (Liss & Stahly, 1993).

If a woman does assert a desire for sole custody on grounds of domestic violence, three possibilities exist:

a. She may fail to meet the burden of proof and must allow frequent and continuing contact between the children and her spouse (“friendly parent” provision of shared responsibility).

b. She prevails. The court limits contact between parents and fashion a means for protecting children from

Historical Overview

As far back as the Roman Empire, the legal system considered wives and children to be the husband’s property (Institute for Advanced Legal Studies, 1991; Liss &
AND CUSTODY ISSUES

further exposure to abuse.

c. Shared parental responsibility (joint custody) is ordered. This presumes that parents will communicate and share in decision-making regarding their children (White, 1994).

Joint custody, a focus in recent years, requires that parents share custodial responsibilities upon dissolution of the marriage. When the arrangement works well, it allows the advantages to the child of access and continued involvement with both parents who work together in the child's best interest. Joint custody, however, is inappropriate in cases of domestic violence (Keenan, 1985; Liss & Stahl, 1993; Pagelow, 1991; White, 1994). When there is a history of one parent exerting control and domination during the time the family was intact, it is unlikely those dynamics will change upon divorce.

Unfortunately, many battered women are placed in a situation where they are advised to promote a positive relationship with their abusive spouses who may be a danger to themselves and their children. If they do not comply, they may be regarded as "unfriendly" or "unfit" and even lose custody to the abusive father (Jaffe & Geffner, 1998).

What often is unrecognized by some courts and mental health professionals is that violence does not necessarily end with separation. Separation can evoke an escalation of violence and greater danger for the safety of mothers and children.

Studies indicate the children exposed to domestic violence do not fare well in cases of joint custody. In fact, these children appear more emotionally troubled and behaviorally disturbed when compared to children witnesses of domestic violence who live with other custody arrangements. Children in situations of joint custody often appear depressed, withdrawn and uncommunicative. Children appear to fare better when sole custody is awarded to the mother even if there is little or no parental contact from the violent parent (Liss & Stahl, 1993; National Center on Women and Family Law, 1987; Pagelow, 1991; Tinning, 1996; White, 1994).

Findings such as these led to reconsideration of the impact of domestic violence and the role it should play in contested custody cases. In 1994, the National Council of Juvenile and Family Court Judges adopted a Model Code which states, in part:

"In every proceeding where there is at issue a dispute as to the custody of a child, a determination by the court that domestic or family violence has occurred raises a rebuttable presumption that it is detrimental to the child and not in the best interest of the child to be placed in sole custody, joint legal custody, or joint physical custody with the perpetrator of family violence" (Model Code, p. 401).

Stahl (1999) reports that, at the time his book was published, 13 states had adopted a "rebutable presumption that a parent who has been found to have committed an act of domestic violence should not have either sole or joint custody, unless the court finds that it is still in the child's best interest" (p.26). While the intent is to protect children, Stahl suggests that placing the weight of a custody decision on a single issue is of concern. He prefers California's law which stipulates that in a contested custody case where domestic violence is an issue, the judge states for the record that he/she has addressed the issue. If the judge grants sole or joint custody to a parent who has been violent, the reasons for such an order must also be stated. Stahl believes that this allows a judge to have necessary leeway.

Because domestic violence has subtleties that are difficult for legal personnel to understand, custody evaluations are often ordered to assist in providing information for a decision. Stahl (1999) reports about a study which suggests that evaluators have not kept current with the trends related to domestic violence and custody decisions. It revealed that many of the evaluators, domestic violence was the second least likely reason for not giving a parent custody. California has responded by requiring custody evaluators to receive training in domestic violence issues in order to be appointed by the court. "The purpose for the law and the training is to inform evaluators about the dynamics of domestic violence, the effects of domestic violence on children, the California laws on domestic violence, and treatment resources for families" (p.26).

It is imperative that lethality screening be conducted in cases of disrupted custody when domestic violence is part of the history. Separation, filing for divorce and deciding custody are potentially dangerous times for many battered women.

Training may be needed as there is a strong tendency to believe that women exaggerate claims of violence in order to manipulate court decisions. Also, some judges consider estrangement from the father more traumatic than witnessing abuse (Jaffe & Geffner, 1998).

Model programs for courts and legal personnel have been developed by the American Bar Association Committee on Children and the Law.

Visitation

A related issue is that of visitation. The risk of violence directed toward both the child and the battered parent is frequently greater after separation than before. Violence is threatened or enacted for many reasons: an attempt to regain control; retaliation for the separation and legal protection; or an attempt to reclaim the family or coerce reconciliation. In addition, parental abduction is another strategy the perpetrator can use to punish the battered spouse for separation and legal interventions (Olvera, 1993; Sheeran & Hampton, 1999).

Hostility around visitation leads to significant distress for children. According to Liss and Stahl (1993) several coping strategies may emerge. The first regards a young child's natural need to place blame in a dispute. In this situation, and with the batterer's encouragement, children blame their mother for the separation. Because of her tendency toward submission, she may be viewed as less influential and powerful. Children may regard her as ineffectual in spite of her attempts to protect them. The children, especially sons, may identify with the powerful and aggressive father.

A second strategy is one in which the child are aligned with the mother against the violent father. They may regard visitation with fear and as a time when they are without protection. If the father uses visitation to continue to abuse the mother, the children may feel responsible for the continuing abuse. At the same time, the children may desire a relationship with the father. The child, then, is placed in a bind.

Parental abduction is also an associated problem. According to White (1994) half of all parent abductions occur during court ordered visitation, and many of these are fathers who abduct their children in order to hurt the mother.

Supervised visitation is an option that offers safety to children. When there is danger to children in the form of violence, severe emotional abuse or threat of abduction, supervised visitation can be utilized. Either a parent who is out of control or a child who is fearful of visits can signal a need for supervision (Stahl, 1999).

Supervised visitation is generally seen as a short-term situation to be used until an identified problem can be corrected. Therapy aimed at normalizing the relationship and helping the parent regain control should accompany the use of supervised visits (Stahl, 1999).

Although friends and relatives may be the only available options as supervisors, these individuals may feel under considerable pressure to accommodate the violent parent and can be lax in supervision. A professional supervisor has many advantages, however, the cost may be prohibitive (Stahl, 1999).

Role of Mediation

It is common for custody and visitation cases without agreements to be referred by the courts for mediation. "Court-ordered mediation for custody disputes began in California in 1981, and has gained in popularity because it gives parents an opportunity to negotiate their differences with the Continued on page 10
Spotlight on Chesterfield County

On July 1, 2001, all Virginia courts will be required to order divorcing parents to attend a seminar about the effects of divorce on children. What will the 12th District Juvenile and Domestic Relations (JDR) Court do? The answer: they have been doing for the last six years.

The Honorable Jerry Hendrick, Jr. began as judge for the 12th District Juvenile and Domestic Relations Court in 1989. In 1993, he received a letter from Pat Cullen, Manager of Prevention Services for Chesterfield County Community Services Board. Ms. Cullen was interested in offering workshops for divorcing parents in order to facilitate children's adjustment to divorce. In January 1994, Judge Hendrick and the other judges of the 12th District JDR Court began to require the program for all divorcing couples. "The benefits have been considerable," stated Judge Hendrick in a seminar at the Power of Prevention Conference in Richmond in May 2001. "I have received uniformly positive feedback from the participants, I am seeing a decline in disputed custody cases, and the disputes that are in court are more focused." explained Judge Hendrick.

The workshop, "Living Apart, Parenting Together" consists of two seminars of two hours each. Seminars are held both in the evenings and during the day. Each parent pays a $30 fee (although up to a $50 fee can be charged under the new legislation). Parents do not need to attend together. "The seminars are informational, not skill-building," explained Cullen. "We always have a uniformed police officer present for safety reasons. There are generally 50 to 60 persons attending."

The first seminar covers a number of topics: children's emotional reactions to divorce, how conflict impacts children, handling new relationships, time-frames for children's adjustment. The second session considers talking to children about divorce, establishing co-parenting, developmental stages of children, how the age/stage of the child influences perceptions, and helping children adjust to parental divorce.

There is also a more extensive, 8-session skill-building class available. Judge Hendrick chooses couples he feels can benefit and orders them to attend "The Business of Co-parenting" class. Parents must attend together. The cost is $65 per parent and the class is limited to 12 sets of parents. The goal of the co-parenting class is getting parents to cooperate for the benefit of their children. Although no followup has been done, both Judge Hendrick and Ms. Cullen believe that the class has been effective. The program will soon be evaluated by the University of Virginia Psychology Department.

For more information about Chesterfield County's approach, contact The Honorable Jerry Hendrick, P.O. Box 520, Chesterfield, VA 23832, E-mail: jhendrick@court.state.va.us or Patricia Cullen, M.S.N., Prevention Services Manager, County of Chesterfield Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 92, Chesterfield, VA 23832, (804) 748-7204, voice mail (804) 769-7229, e-mail: Culenp@co.chesterfield.va.us


Available from: Division of Legislative Automated Systems, P.O. Box 654, Richmond, VA 23218 (804) 786-6894, FAX: (804) 786-1896, Web site: http://leg1.state.va.us

The 1999 Session of the General Assembly of Virginia directed the Supreme Court of Virginia to conduct a study relating to child custody determinations. This study was preparatory to consideration of legislation or guidelines for a presumption of joint physical custody when a marriage or other relationship is at issue.

The study addressed the following questions: 1) How are judges rendering decisions in disputed child custody cases? 2) What factors are given the greatest priority? 3) Do in-court and process variables such as effectiveness and demeanor of counsel, experts and litigants shape judges' decisions? and 4) Does parents' gender influence the judges' decisions?

The findings of the study, along with a summary of psychological literature on the issue of child custody, is presented.

Domestic Violence and Custody Issues continued from page 9

help of a trained neutral third party and avoid the adversarial system of the courtroom" (Olvera, 1993, p.11). In some states, mediation is mandatory except in cases of child abuse. Courts use mediation to divert cases from their busy dockets. In this case, the potential emotional costs to battered women and their children are not taken into account.

Most states, however, include provisions for cases involving domestic violence. In these cases, to assure that the exception for mediation is appropriately available to victims of domestic violence, a screening for violence has been instituted. However, these screening systems appear to be weak or inadequate (Olvera, 1993).

Lemon (1999) provides information about a recent study of 200 court-based mediation programs. It was found that while domestic violence was a factor in 50 to 80 percent of the divorce cases nationwide, only about 5 percent of divorce cases are excluded from mediation due to domestic violence. Thirty percent of the mediation centers surveyed across the country said that their staff received no training on domestic violence issues. In Virginia, however, all mediators are required to take an 8-hour course in domestic violence screening.

Problems for Child Protective Services

Reports indicate that there is a strong correlation between spouse abuse and child abuse (National Center on Women and Family Law, 1987). Edelson (1998) reports that a majority of studies that have identified an overlap report that both forms of abuse occur in 30 percent to 60 percent of the cases. He also reports that studies from Britain, Oregon and Massachusetts revealed large numbers of families in which child fatalities have occurred were also known to have histories of abuse by male partners toward the children's mothers.

Davidson (1995) notes four law-related topics connecting spouse abuse and child abuse:

1) Women battered by their male partners frequently report that their partners have committed child physical and/or sexual abuse within their homes.
2) Battered women are unable or unwilling to protect their children.
3) Some women who are victims of violence are also the perpetrators of violence against their children.
4) Allowing children to witness repeated adult domestic violence, even in the absence of violence directed towards the child, may be considered as psychological or emotional child abuse/neglect.

Intervention in these situations by child protective services (CPS) varies from state to state.
Edelson (1998) notes that interviews with child protective workers revealed a recognition that current practices tend to be those that increase pressure on battered mothers to think about what is “failure to protect”, charging them with child endangerment. The male partner, then, becomes invisible and the burden is placed on battered mothers. There is also a recognition that involvement of child protective services does not always enhance safety for children and mothers. Therefore, Edelson makes three recommendations.

1) Establishing national efforts to revise management information systems in child welfare and the courts so that abusive mates can be more easily identified and tracked;

2) Collaboration between CPS, the courts and domestic violence agencies to aggressively intervene;

3) New strategies to assist battered mothers in child protection caseloads to achieve safety for themselves and their children.

Recommendations

Ultimately, the issue of child custody must have the well-being of children as its primary concern. There are several actions suggested in the literature to assure that the best interests of the child are the focus. These are:

1) Education for judges and other court personnel about domestic violence, its effects on children and legislative changes that impact court decision-making;

2) Providing funding, training, and technical assistance so that child protective services, law enforcement and prosecutors can address the needs for children and their parents;

3) Encouraging visitation arrangements at safe, accessible and public places, such as a supervised visitation center. Child contact should be facilitated while minimizing concern for abusive behavior or parental abduction;

4) Making court-ordered treatment for the perpetrators, victims and children available, as well as evaluation by trained clinicians. Communities are encouraged to develop strategies for coordinating services in a manner that addresses safety;

5) Providing children with a guardian ad litem. This is a court-designated representative who is charged with advocating for the child and for his or her best interests throughout court custody considerations and proceedings;

6) Judges should consider the option for in-chamber interviews with the children. This affords children an opportunity to express an opinion removed from the intimidating atmosphere of the courtroom;

7) Mediation should be used only when certain conditions are met. These conditions include: a) the provision of mediation in a specialized manner which protects the safety of the victim; b) mediators who are certified and trained in domestic and family violence issues; c) effective screening protocols which include an opportunity for each parent to discuss concerns about safety or intimidation without the other parent present; d) screening questions specific to prior abuse, decision-making procedures, conflict resolution practices and concerns about safety; e) options which allow parents to avoid face-to-face contact; and f) the option of having a support person and/or legal counsel to assist (Besseneyey, 1989; Cahn, 1991; Critt & Coker, 1988; Davidson, 1995; Lemon, 1999; Newark & Harrell, 1994; Stahl, 1999; Straus, 1995; Tortorella, 1996; Voris, 1991).

Coordinated Court Responses

Cases involving domestic violence can appear simultaneously in multiple branches of the judicial system. Courts in several states are experimenting with having one unified court that hears all of the legal issues of the individual family. Hawaii already uses this approach. In its Honolulu court, one judge hears all of the family’s criminal, family law and juvenile court matters. California and New Hampshire have similar programs (Lemon, 1999). This approach is controversial. Proponents argue that this system delivers coordinated responses. Opponents, on the other hand, are concerned that criminal matters will not be taken as seriously and that there could be a violation of a defendant’s right to due process.

The Dade County, Florida, juvenile court has implemented a program which addresses domestic violence issues in the context of juvenile dependency issues. It includes assessment of domestic violence with children involved in dependency cases, treatment protocols for mothers and children, support for mothers during the CPS investigation process, and the use of battered women’s advocates. The advocates assist women in obtaining restraining orders, developing safety plans, and finding housing. The program includes domestic violence training for CPS workers. The program is voluntary, and about 15 percent of families have refused the service. “As of October, 1998 some 100 dependent children, ages 6 to 17, had been evaluated for exposure to domestic violence, and all but three reported that the level of violence was serious” (Lemon, 1999, p.75).

Summary

Communities with coordinated services and trained professionals are in the best position to address critical and complicated custody issues in cases involving domestic violence. Domestic violence signals a need for assessment of safety for children and assessment concerning the impact of violence on the children. Courts and judicial staff are beginning to meet this challenge through innovative approaches.

References Available Upon Request

Special Issues in Visitation Disputes
With The Presence of Domestic Violence

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Adapted from Jaffe & Geffner (1996/97)
In 1994, the Virginia General Assembly established the Virginia Commission on Family Violence Prevention as an office under the Office of the Executive Secretary of the Supreme Court of Virginia. As a legislative commission, staff must submit a yearly report to the General Assembly on their activities and recommendations. Each year, if a commission is to continue, the General Assembly must vote to do so through a resolution stating which subject areas are to be studied during that particular year. The Virginia Commission on Family Violence Prevention was continued through 1999 with its final report to be submitted during the 2000 session of the General Assembly.

The Commission had several subcommittees. The Legislative/Judicial Subcommittee began its work in 1996, examining the impact of family violence on children. It recommended that the Virginia Department of Social Services incorporate questions related to family violence in the assessment tool for screening and referral for the Child Protective Services Multiple Response pilots. It also recommended doing training for child protective service workers and domestic violence service providers. Both of these recommendations were implemented by the Virginia Department of Social Services.

The Commission developed a task force to review how family violence impacts custody and visitation decisions. "Currently a statute in the Virginia Code states that family violence shall be considered when making custody and visitation decisions. However, the statute is not specific about the extent to which courts should investigate family violence and include information about it in their decisions. The Commission is interested in the extent to which and the manner in which courts throughout the Commonwealth are taking family violence into consideration when deciding on custody and visitation issues" (Preliminary Findings: The Impact of Family Violence on Custody and Visitation Issues, 1997, p.1).

As a result of this interest, a three-part investigation was undertaken. It included research, data collection, and analysis in three parts: 1) a judicial survey of Juvenile and Domestic Relations (JDR) court judges in Virginia; 2) a systematic review of 50 to 100 custody and visitation cases at each of six representative courts throughout the Commonwealth; and 3) site visits and in-depth interviews with key court personnel at each of these six courts.

The survey was administered at the August, 1997, Annual District Court Judges Conference in Virginia Beach. The objective was to obtain judges' perceptions of the process by which family violence informa-

While the Task Group studied options for recommendations to the legislature, they concluded that, due to time and resource constraints, necessary information was lacking. The consensus was to recommend additional study.

**Custody Evaluations**—Among people performing home studies and custody evaluations, there is a broad range of education, experience, and knowledge. In addition, the information in these evaluation reports varies widely. There is no common format for custody reports. While training is available for those offering custody investigations, it is not mandatory.

The Task Group recommended that the Office of the Executive Secretary of the Supreme Court of Virginia develop and distribute to Circuit and Juvenile and Domestic Relations Courts in Virginia suggested formats for custody reports that would include: 1) relevant issues and areas to be covered by a report; 2) information that should be included in the final report; and 3) preferred qualifications of evaluators.

**Screening Tools**—The Task Group considered it crucial that judges have information about the presence of family violence when making custody decisions. Members considered the use of a screening tool used by the clerk's office or intake workers in the Court Service Unit. They also considered barriers to full implementation of this type of screening. As a result the following recommendations were made:

The Office of the Executive Secretary of the Supreme Court of Virginia should:

- continue to explore methods to ensure that information on the presence of family violence is before the court in custody and visitation matters.
- collaborate with the Virginia Department of Social Services and the Virginia Department of Juvenile Justice to review and revise the custody investigation forms to include questions on family violence and the nine factors (VA Code 20-124.3) the court is to consider when making custody decisions.

**Current Status**

The current status is that the Virginia Commission on Family Violence has become a subcommittee of the State Crime Commission.

More information about the work of Virginia's Commission is available from: Cynthia Lowery, General Assembly Building, Virginia State Crime Commission, 910 Capitol Street, Suite 915, Richmond, VA 23219, (804) 225-4534, E-mail: clowery@leg.state.va.us
Attachment Disorder are very limited. Studies located were retrospective, had small samples and did not include experimental controls. A variety of treatments, some conventional and others controversial, are being offered to children appropriately diagnosed with Reactive Attachment Disorder as well as to children labeled as having “attachment problems” which don’t fit DSM-IV criteria. What is lacking are scientific studies of treatment effectiveness.

Also lacking is comprehensive conceptualization of how developmental attachment theory applies to clinical intervention. The systematic application of attachment theory to clinical issues is still in a rudimentary stage of development (Liebermen & Zeana, 1999). A particular concern is the “emergence of novel treatments that lack a sound theoretical basis or empirical support, and may potentially be traumatizing and dangerous to the child” (Hanson & Spratt, 2000, p. 137).

Intrusive therapies such as “holding” therapy (sometimes called “rage reduction”) are especially controversial. The child can be subjected to prolonged restraint and noxious stimulation (such as yelling, tickling or poking). Such procedures “are theorized to release the rage and teach the child that adults can and will control him” (Hanson & Spratt, 2000, p. 142). The child may resist by screaming, fighting or crying, but eventually capitulates. While some anecdotal statements from parents are positive, there is no empirical evidence to support an assertion that this type of therapy is more effective or even as effective as conventional alternatives (Hanson & Spratt, 2000).

The recent conviction of reckless child abuse in the case of two Colorado “therapists” (neither was licensed) using “rebirth therapy” is illustrative. A ten-year-old child wrapped in a flannel sheet to simulate a wound, died in April, 2000 after four adults pushed against her with pillows. This case prompted the Colorado legislature to enact “Candace’s Law” which prohibits the use of “rebirth” techniques.

Children diagnosed with Reactive Attachment Disorder can show aggressive, defiant and disruptive behaviors that tend to provoke a punitive response in adults (such as deliberately provoking pain, fear, emotional outbursts or withdrawal in the child). “Stress-producing interventions, even when well-intentioned and carefully thought-out, reinforce and perpetuate the aggressive and victimizing relationship patterns that have shaped children with disorders of attachment” (Lieberman & Zeana, 1999, p. 572). Rather than using emotional pressure or encouraging anger, Lieberman & Zeana advocate that the therapist be a secure base for exploration of feelings and maintain a working relationship characterized by reciprocity, emotional contingency, and mutual trust.

The use of therapeutic touch in a non-coercive manner for the treatment of Reactive Attachment Disorder is advocated by some therapists. (For a discussion, see Levy & Orleans, 1998). “My sense is that there is a strong belief in the part of many therapists that touch is a part of the remediation process. I regard touch as a critical and necessary part of treatment for attachment disorders,” states Jonathan Barlow, LCSW, therapist at Adoption/Attachment Partners, PC, in Annandale, VA. However, to date, no empirical data is available to support the idea that touch is a helpful or necessary part of therapeutic intervention.

One research study was located which examined the effectiveness of an intensive treatment for aggressive children ages four to fourteen who were being adopted (Myeroff, Mertlich & Gross, 1999). Criteria for inclusion in the study was “evidence of destructive behaviors and difficulty attaching to their parents” (p. 305). The intensive, two-week, 30-hour intervention consisted of therapy using “four basic techniques which include cognitive restructuring, psycho-drama re-enactment, inner child metaphor, and therapeutic holding” (p. 307). Subjects were 23 children divided between a treatment group (12 children) and a control group (11 children).

Results showed a significant decrease in delinquent and aggressive behaviors for the treatment group at six weeks after therapy. The control group showed no change. Only scores on two scales of Achenbach’s Child Behavior checklist (aggression and group disinhibition) were reported. The results of the other scales measuring anxiety, somatic complaints, depression, attention problems, and social problems were not discussed. No specific diagnostic information was included.

If a conventional therapy approach is utilized, the clinician first performs a thorough assessment of the child, the child’s family and the child’s environment. The child’s safety is the primary concern. After stabilizing any immediate crisis, the practitioner seeks to establish trust and ensure that the child is in a nurturing and secure environment.

The treatment centers interviewed for this article are primarily serving adopted children. For example, Terry Levy, Ph.D. of the Evergreen Psychotherapy Center in Colorado said that 95 percent of families coming to his clinic have adopted the child with Reactive Attachment Disorder. Parents who adopt children with histories of severe maltreatment and attachment disorder are...
often unprepared to deal with the extent and chronicity of the child’s problems as well as the impact the child will have on the family system. By the time families reach a treatment provider, the parents are often angry, demoralized and are experiencing “burn-out” (emotional exhaustion) (Levy & Orlans, 2000).

Children with Reactive Attachment Disorder compulsively re-enact negative patterns of relating. They engage in provocative and destructive behaviors that invite rejection, abuse and emotional distance. Parents feel rejected, unappreciated and inadequate as their usual methods of child rearing are ineffective with this child. Parents can respond by being punitive and rejecting, by becoming depressed and withdrawn, or by failing to set appropriate rules, limits, and boundaries.

Children with Reactive Attachment Disorder may maintain an excessive control orientation towards parents and others. They act as though their very survival depends upon coercion and manipulation. Chronic power struggles ensue. Children with Reactive Attachment Disorder may form coalitions with one parent against the other. By being charming and cooperative with one parent and oppositional with the other, the child may trigger marital conflict. In a similar fashion, the child may engage teachers, extended kin or mental health professionals and cause conflict between helping systems or between helpers and the family (Levy & Orlans, 2000).

Sibling conflicts are intensified by the addition of a child with Reactive Attachment Disorder. The adoptive child with attachment problems can be jealous and resentful of siblings and act in an abusive, manipulative and rejecting fashion towards them. Siblings can then feel traumatized, and may develop hypervigilance, sleep disorders, psychosomatic problems and other difficulties. Older siblings may simply avoid being home. Feelings of guilt and shame are common for siblings because they want to love and support the new sibling but are angry and mistrustful. Family life becomes restrictive (Levy & Orlans, 2000).

Establishing trust can be difficult, as the child expects the world to be dangerous and abusive. The child and therapist should reach agreement about how therapy sessions will be conducted. The child needs to know who he/she is receiving the therapy (Pearce & Pezzoti-Pearce, 1994).

In order to counteract the lack of consistency and reliability in the child’s earlier life, therapy sessions should be regular and consistent. After a sense of safety and predictability is established, the child can use the therapist as a “secure base”.

Children with attachment problems have not had their basic needs met. They may engage in regressive behaviors, such as demanding to be bottle-fed or rocked. The child may demand to be the center of attention at all times. The child then becomes angry upon realizing that a parent or therapist can’t or won’t satisfy these massive dependency needs. The child interprets the refusal to meet his or her demands as additional proof that people are untrustworthy and that he/she is unlovable. The rage and anger, originally developed towards the undependable attachment figure, is now projected onto the parent or therapist.

Anger and rage can have other sources as well. The child may be modeling aggressive and coercive interactions. The child may be actively hostile (hitting, kicking, verbal assaults) or may adopt a posture of stubborn noncompliance, refusing to talk, play or follow directions.

Due to inconsistent care, the child engages in a constant struggle with the parent for control. Contention and disagreement characterize the child’s relationships and are part of therapy as well. Rather than rejecting the child, the therapist has the opportunity to relate to the child in ways that are different. For example, the therapist can place appropriate limits while acknowledging and empathizing with the child’s anger at being limited. The child will benefit from learning that, even if people are angry and annoyed, rejection and abuse will not occur. This response can be contrasted to earlier experiences and lead to discussion about what factors might have caused the abuse (Pearce & Pezzot-Pearce, 1994). Allowing the child choices and control is important. The therapist can gradually assume a more active role as the child is able to tolerate this involvement.

There is support for cognitive behavioral interventions that target symptoms resulting from the abuse experience (for example, fear, anxiety, and post-traumatic stress). Although such interventions have not been proven to be effective for attachment problems, they have been shown to be effective for other abuse-related problems. Furthermore, the approach is based upon accepted theory and is not associated with adverse effects (Hanson & Spratt, 2000).

Some therapists recommend “revisiting” prior significant attachment and trauma experiences (Levy & Orlans, 1998). This is done to identify the emotional, cognitive, social and physical sequelae. The therapist seeks to learn the child’s personal meaning of the events, to help the child learn the facts about the past, to acknowledge the child’s feelings about earlier relationships, to grieve prior losses, and to help the child with coping skills.

The child then learns new ways of relating and challenges the negative model of relationships. This requires much repetition and rehearsal. Developing new communication skills, self-control, and new ways of coping is an ongoing process.

Accepting a child with attachment problems requires parents and families with exceptional skill and motivation. Thus, a child’s caretakers must be actively involved and treatment must focus on the family, since all family members are affected (Hughes, 1997; Levy & Orlans, 2000; Richters & Volkmar, 1996). Parents and siblings may have unrealistic expectations about change. Change is generally an ongoing process and not short-term. While adoptive parents are not to blame for the child’s difficulties, they must be able to examine and modify any personal or family difficulties that may be contributing to the problems (Levy & Orlans, 2000).

Parents must create a framework of love, sensitivity, empathy, caring, security and nurturance for the child. Thus, parents are active partners in the therapeutic process. Parents need to provide consequences rather than punishment, to provide clear structure and to provide participation and a place for the child in the family structure. Creative parenting and a sense of humor are helpful.

Offering hope is important, although expectations must be realistic. Hope is crucial in breaking the cycle of negativity and pessimism. Secure attachment is learned. While it is best to learn this from birth to three, it can be learned later in life. The stages of attachment are similar. In the first stage, the caregiver gratifies the child’s needs in a sensitive, appropriate and consistent manner. This results in a reduction in anxiety for the child allowing feelings of security, safety and trust. In the second stage, the parents initiate positive interactions and the child learns to respond favorably to feelings and messages. Finally, “claiming” helps the child feel a part of the family and fosters a sense of belonging (physical closeness, traditions, and inclusion in family events are examples of “claiming” behaviors). A balance of structure and nurturance is essential. A “united front” on the part of the parents and the treatment team is necessary.

The clinician should educate the caretakers about the child’s special needs and help the parents acquire and practice

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needed skills. Suggestions for intervention are to change the parent’s and the child’s internal working models of relationships (George, 1996). The goal is to assist parent and child in learning reciprocal adaption that can lead to secure attachment. Teaching the parent to relate to the child can be a focus for therapy. Rather than the therapist relating to the child, the parent is taught how to notice and respond to the child. (For an example, see video review, “When the Bough Breaks”, this issue).

What might be “good-enough parenting” for many children is often insufficient for the poorly attached child. Parents of these children will need much understanding and support. Many months of living in a safe and nurturing home will be needed before the child will begin to make the profound changes necessary to facilitate attachment (Hughes, 1997).

A therapeutic home must offer empathy, sharing, security, love, and fun while eliminating tension, rage, isolation, and fear.

When the Bough Breaks: Identifying Behavioral Problems Early, 1997, Canadian Broadcasting Corporation, 90 minutes, Cost: $195

Available from; Filmmakers Library, 124 East 40th Street, New York, NY 10016 (212) 808-4980

This film crew followed three mothers and their problem children aged ten months to three years. All were middle class, low risk for maltreatment and intact families. The film traces the families through three months of therapy at the C.M. Shanks Treatment Centre in Toronto. The assessment and treatment process clearly demonstrate the importance of attachment and an intervention that holds promise of positively changing relationship problems.

Maintaining a positive atmosphere in the face of the child’s oppositional, destructive behaviors is difficult. However, the child will need attunement and empathy in order to begin to attach.

The attachment-disordered child may also have psychological problems and symptoms that do not relate to the insecure attachment. Interventions focused on these problems could include those with research support such as cognitive behavioral interventions that target symptoms arising from the maltreatment such as fear, anxiety, and post-traumatic stress.

All interventions do not have to be targeted towards the family. Sroufe, in particular, believes that teachers can be alternate attachment figures (cited in Karen, 1994). Key interventions are examples of how teachers were trained to bypass the resistance of insecure and avoidant children. These children were able to stop being behavior problems and formed strong attachments with their teacher.

Therapy, if successful, will be long term, rather than a brief intervention. It can be difficult to terminate therapy, as termination can reactivate feelings of dependency. The child might assume the therapist no longer cares. Having experienced painful losses in the past, the child may lack skills for termination of relationships. Thus, termination should be gradual.

Therapists should be mindful that therapy is only one component of intervention. While important and significant, psychotherapy is not sufficient to ameliorate the extreme difficulties that can result from maltreatment. Abused children require multiple positive experiences in many contexts to begin to change the negative internal working models.

Early Detection

Because symptoms of Reactive Attachment Disorder resemble other clinical problems and because attachment problems, once established, are difficult to treat, effective intervention is greatly enhanced by early intervention (Reber, 1996). Hospitals, clinics and obstetricians can be alert to parents who may be high-risk for poor attachment. These parents can be referred to early intervention and support programs (see VCPN, volumes 1, 21, 30 and 52). Pediatricians can also be alert to the possibility of attachment problems. Parents with repeated visits and complaints may be at risk. Parents of children who are colicky or who fail to develop consistent patterns of eating and sleep may be at increased risk. It is possible to discern high-risk families through the use of screening tools such as the Parenting Stress Index (Abdin, 1983). Such measures identify parents who are feeling overwhelmed or who are emotionally distant from their infants.

Poor nutrition, short stature and cold extremities can alert a primary care physician to consider the possibility of attachment problems. Inadequate nutrition can accompany maternal rejection. One child can be literally starving while the family as a whole has enough to eat. Growth impairment can occur even if body weight is normal, thus, measuring height is an important detection tool. (McCarthy, 1974).

Prevention

As early as the 1970’s, there were reports that differences in birthing practices could affect bonding and ongoing child care. For example, an NIH study (reported in Hersh & Levin, 1978) of infants born to disadvantaged families found that “rooming in” positively influenced bonding and child care. Infants who were “roomed in” were held more, cried less and were more alert than those kept in the hospital nursery. When tested several months later, they showed better health and closer ties to their mothers than the control infants. Findings such as these sparked widespread changes in services and procedures in hospital birthing units.

There is some evidence that observations of parental sensitivity towards an infant are most reliable in the earliest years, when the patterns of interaction are being established. Observations once patterns are set are less revealing, as behaviors are under control of expectations learned in earlier years (Isabella, 1993). Thus, identification of attachment problems and changes to the developing patterns may best be undertaken in the first year of life.

One effort to prevent attachment problems has been piloted by Egeland and Erickson (1993). Guided by attachment theory, they developed a preventive intervention program for high-risk mothers and their infants. A major goal of the STEEP Program (Steps Toward Effective Enjoyable Parenting) is to improve interactions and the relationship between mother and infant.

In prior work with high-risk mothers, Egeland and Erickson found many who had experienced abuse as children were improperly nurtured as children. These women expected to be rejected, unloved or abandoned. A major goal of STEEP is to help these mothers integrate the emotions and memories of negative childhood experiences and develop more positive models of themselves and others.

A variety of educational, therapeutic, and support services are provided to participants in the STEEP Program. Mothers are recruited during pregnancy. Both group and individual treatment is part of the program. Mothers are videotaped with their infants and then the tape is reviewed with a therapist to enhance the mother’s understanding of the infant’s cues.

The intervention had a positive impact on several variables associated with good parent-infant relationships. Compared to the control group, the treatment group had a better understanding of infants and exhibited a better relationship with infants. Treatment group mothers had lower depression and anxiety scores compared to controls; also, they were more competent in managing daily living. The treatment group had higher scores on the HOME, an instrument measuring how stimulating and organized the home environment is. However, control mothers scored better on the attachment measure (the Strange Situation Test) than did those in the treatment group.

Groups high-risk for maltreatment, longitudinal studies by Egeland and colleagues also attempted to identify which factors distinguished between those who maltreated and those who did not. The primary distinguishing factor between adequate caregivers and those who maltreated was the nature of the early parent-infant relationship. Conversely, when tested at 18 months, a significantly higher proportion of maltreated infants displayed insecure attachments compared to the control group. The earlier the maltreatment occurred, the greater the likelihood of an insecure attachment (as reported in Continued on page 16
Maltreatment and Attachment Disorder continued from page 15

Schmidt & Eldridge, 1986).

vanJzendooorn, Juffer and Duyvesteyn (1995) reviewed 16 studies (including the STEEP program) and performed a quantitative meta-analysis of 12 studies involving 869 mother-infant dyads. Interventions were quite divergent and varied from providing soft baby carriers (in order to enhance the physical contact between parent and infant) to psychotherapy (in which the mother discussed “ghosts” of her past) to the provision of social support.

The researchers concluded that the interventions were effective in enhancing maternal sensitivity to infant attachment cues. The interventions were not as successful in enhancing the quality of the infant-mother attachment relationship. Short-term interventions with a clear focus appear to be more effective than long-term broadband interventions. Finally, improvements in maternal sensitivity and infant attachment security did not necessarily result in a change in the mother’s intergenerational attachment orientation.

Another prevention strategy is to facilitate attachment in adoptions. Children who have experienced maltreatment and problematic attachment in their family of origin are especially high-risk for disrupted adoptions. Adoptive families who receive ongoing support and intervention specific to attachment issues appear more likely to manage stress effectively.

Levy & Orlans (1998) have suggested a number of ways to increase the probability of successful adoptions:
- Place early;
- Minimize moves;
- Begin permanency planning when the child enters the welfare system;
- Offer pre-placement services;
- Attempt to match temperament between child and family;
- Do full disclosure of the child’s history;
- Make a realistic appraisal of risks;
- Post-placement services;
- Offer ongoing assistance.

Summary

Maltreatment can cause or accompany moderate to severe problems in caregiver-infant attachment. Attachment patterns established in infancy can have profound effect upon the child’s development and later adult adjustment.

Developmental psychologists have delineated attachment patterns and are studying the significance of these. Clinical treatment providers are identifying and treating children who appear to have relationship problems (sometimes labeling these as “attachment disorders”). Although the terminology is the same, the developmental psychologists and the clinical treatment providers do not seem to be using the same definitions and measurements for “attachment disorders” or “disordered attachment.” To complicate matters further, the official diagnostic system (DSM-IV) severely limits who can be properly diagnosed with “Reactive Attachment Disorder.”

There is much agreement about how to prevent attachment problems and facilitate healthy development. However, once a child has acquired a disordered attachment, there is little agreement about how to effectively intervene to change the maladaptive patterns. Research is needed to clarify diagnostic questions. Research is also needed to determine the course of the disorder and to learn what interventions are most effective.

References Available Upon Request

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