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Disorganized Attachment and Trauma in Children

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University & University of St. Thomas
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In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Children who experience trauma often experience a disruption in the formation of attachment with their primary caregiver. This research aims to address how this disruption may lead to attachment disorders in children, and what developmental challenges children exposed to trauma may face. Using a qualitative interview case study of a children's mental health professional, this study examines the impact of trauma on attachment, based on the experiences of this clinician. This study set out to investigate what treatment methods are currently used to treat children with histories of trauma and attachment disorders. From the qualitative interview 4 main themes were found and are labeled as the following: *behavioral issues, reunification, awareness of attachment theory and trauma, and treatment methods*. The research findings and current literature both address the importance of the clinician being aware of attachment theory and trauma informed care within current practice and treatment methods. However, the findings reveal some gaps in service and the need for a more systematic approach in how to work with children with attachment disorders and trauma histories. Further research is needed on practices used by mental health clinicians in a wide array of treatment settings in order to generalize findings.

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Disorganized Attachment and Trauma in Children

The effects of maltreatment of children and the exposure to trauma can have a detrimental impact on the development of attachments between a child and their primary caregiver. Specifically, trauma inflicted by a primary caregiver can greatly disrupt the normal development of secure attachment, and increase the risk of developing a disorganized attachment (Becker-Weidman, 2006). “Children who have experienced maltreatment or who are at risk of abuse are more likely to have weak or abnormal attachment relationships probably because of the caring context in which abuse was able to occur” (Gough, 2002, p. 565). In a recent study of a public pediatric clinic, researchers found that of the 305 children ages 2 to 5 that were assessed, 52.5% experienced a severe traumatic stressor (Lieberman et.al, 2011). Tragically, childhood trauma is common. In the United States, approximately 3 million cases of child abuse are reported each year (van der Kolk, 2003). According to the United State Department of Health and Human Services, the first 5 years of life have the highest incidence of child maltreatment; death rates occur between birth and 12 months of age, with an overall victimization rate of 21.9 per 1000 children (Lieberman et. al., 2011). A study by Kendall –Tackett and colleagues found that 27% of women and 16% of men reported a history of childhood sexual abuse (as cited by Streeck-Fischer & van der Kolk, 2000). A pattern of repeated trauma is not limited to poor or under served children, but is a significant issue impacting the general population (Lieberman et. al., 2011). As there are many different types of trauma, this project will specifically examine the impact of physical abuse, sexual abuse, and the exposure to domestic violence on the disruption of the attachment relationship between a child and their primary caregiver.

Trauma can be defined as follows: when an individual(s) is exposed to an event where life or bodily harm is threatened; this can be a single event, ongoing events, or structural events. Trauma is experienced differently for each individual. The degree, duration, and the developmental stage all impact disruption for an individual across his or her lifespan (Lieberman, 2011). In this project I will examine the different psychological, physiological, and neurological effects that trauma can have on children based on the development of the child, the child's attachment style, and prior history.

The Impact of Trauma on Childhood Development

Trauma can affect many aspects of a child's physical and mental health. Physical abuse, sexual abuse, and domestic violence can all have an impact on the child's development (Perry, 1995). Experiencing abuse can cause high levels of emotional reactivity in early childhood and is related to numerous psychiatric problems including depression, poor school performance, impulsivity, and criminal behavior (van der Kolk, 2003). Early childhood experiences are believed to create a child's initial mental self-representations, which serve to filter stimuli (Mennen & O'Keefe, 2004). Traumatic exposure that occurs in the first 5 years of a child's life may continue to have lasting effects at later stages of development (Lieberman et. al., 2011). Relationship problems stemming from disruptions in the early attachment relationship can appear as more severe in individuals who have experienced interpersonal violence, neglect or abuse (Pearlman & Courtois, 2005). Attachment disruptions can persist throughout an individual's lifespan and may lead to later psychopathology and even criminology. Streeck-Fischer and van der Kolk (2000) assert that physical abuse and neglect are related to the highest rates of

arrest, and can also lead to the development of antisocial personality disorder. Pearlman and Courtois (2005) state that,

Studies investigating the quality of early attachment experiences between caregivers and children on neurophysiology and later mental health and emotional disturbance have found that seriously disrupted attachment without repair or intervention for the child can, in and of itself, be traumatic, as the child is left psychologically alone to cope with his or her heightened and dysregulated emotional states, thus creating additional trauma (p. 451).

Clearly, addressing these disruptions and intervening early may in fact drastically change the overall trajectory of developing psychopathology later. Insecurely attached children with high levels of infant negativity are more likely of to develop behavior problems compared to securely attached children with similar levels of infant negativity (Lieberman et. al., 2011).

In particular, trauma, specifically the exposure to interpersonal violence or exploitation can have a negative impact on the victim's ability to develop and maintain interpersonal relationships (Pearlman & Courtois, 2005). The exposure to trauma and intimate partner violence has been shown to negatively impact the development of young children and can often lead to attachment disorders. Witnessing intimate partner violence can be experienced as a form of child maltreatment and thus can impact emotional and behavioral development, including the formation of attachment patterns (Carpenter & Stacks, 2009). Children with a history of exposure to violence may struggle with responding appropriately to social situations as well as being more vulnerable to a large array of physical illnesses (van der Kolk, 2003). This early exposure to violence may

significantly impact later aspects of childhood development including further psychopathology.

The purpose of this project is to further examine the treatment practices used by clinicians to deal with trauma from physical abuse, sexual abuse, and the exposure to domestic violence on the disruption of the attachment relationship between a child and their primary caregiver. This project will examine current research and treatment practices used by mental health clinicians, the significant role that the primary caregiver has on the attachment relationship, the clinical presentation of trauma in children, current treatment methods, and implications for social work practice.

Literature Review

Attachment Theory

The three main functions that attachment serves are safety, affect regulation, and mentalization. According to van der Kolk (2003), “The security of attachment bond seems to be the most important mitigating factor against trauma-induced disorganization” (p. 293). Establishing a child’s sense of safety is an evolutionary response and is needed for optimal functioning. Traumatic experiences may negatively impact, or damage the child’s capacity to trust the reliability of the caregiver as a protective figure (Lieberman et. al., 2011). In addition to developing a child’s sense of safety, it is also important that a parent is attuned to a child’s emotional and physical needs in order to promote healthy development. “Healthy attunement therefore involves the parent’s sensitivity to the child’s signals and the collaborative, contingent communication that evokes that has been described earlier as a ‘resonance’ between two people’s states of mind: the mutual influence of each person’s state on that of the other” (Siegel, 1999, p.88). According to

Allen and colleagues (2007), “Mentalizing [is the process in which] you automatically interpret behavior as based on mental states, such a desires, beliefs, and feelings (p. 311). This ability goes beyond empathizing and includes awareness of one’s own state of mind. “The capacity of an individual to reflect upon the mental state of another person may be an essential ingredient in many forms of close, emotionally engaging relationships” (Siegel, 1999, p. 89). The quality of the caregiver and his/her ability to attune to the needs of the child, impacts the child’s response and the recovery process from a traumatic event (Lieberman et. al., 2011).

In order to examine the impact trauma can have on the attachment relationship, it is important to first understand some of the most fundamental theoretical perspectives on attachment. Attachment theory was developed by John Bowlby and validated by the work of Mary Ainsworth (Davies, 1999). Ainsworth developed the ‘Strange Situation’ procedure to examine the nature of attachment relationships whereby the mother and child are observed in a playroom as a stranger enters the room, the parent leaves and then returns. According to Bowlby (1973), as cited by Main (2000), “The procedure would be used as each infant reached twelve months of age, and was expected to demonstrate the universality of infant attachment behavior in response to natural clues of danger” (p. 1064). The experiment tests the infant’s responses to comfort from the stranger and from the parent upon return (Perry, 2001).

Ainsworth defines attachment theory as the influential relationship between the infant and his or her caregiver during infancy and classifies four different types of attachments: securely attached, insecure-avoidant (or resistant), insecure-ambivalent, and insecure-disorganized (Perry, 2001; Davies, 1999). These categories are used to address

how the infant and the primary caregiver interact, particularly in times of distress. “In the absence of such soothing presences, children are likely to demonstrate difficulties with cognition, impulse control, aggression, and emotion regulation” (van der Kolk, 2003, p. 310). According to Lieberman and colleagues (2011), the quality of attachment seems to operate in conjunction with ecological factors such as personal and contextual risk to influence child resilience to coping with trauma.

The Vital Role of the Primary Caregiver

According to attachment theory, the most influential developmental goal in infancy is forming an attachment to the primary caregiver (Mennen & O’Keefe, 2005). There are many biological, psychological, and social conditions that impact the formation of attachment; these experiences are essential for the infant as these traits can impact the development of a child across the lifespan (Corbin, 2007). Children learn how to regulate their own behavior based upon their caregiver’s responses to them, and this is the basis for a child’s construction of what Bowlby termed the “internal working model” (van der Kolk, 2006). “...Attachment is most readily observed in the intense concern that young children in unfamiliar surroundings exhibit regarding the whereabouts of parent figures” (Main, 2000, p.1060). The formations of attachment patterns happen in infancy but can be impacted by a child’s surroundings, early development, and trauma (Perry, 2001). According to Carlson and Cicchetti (1994) as cited by van der Kolk (2003), “80% of traumatized children have disorganized attachment patterns” (p. 296). Carpenter and Stacks (2009) found that the attachment relationship between an infant and his caregiver is essential in providing protection and emotional regulation for the infant in times of distress. According to van der Kolk (2006), “Early patterns of attachment affect the

quality of information processing throughout life” (p. 403). There is strong evidence that suggests it is important to implement intervention strategies and address attachment disorders as they often lead to other emotional and behavioral problems (Perry 2001).

Clinical presentation of trauma in children

Diagnosing young children exposed to trauma is very challenging and is complicated by the rapid developmental changes in the first 5 years of life, the influence of observational context on the young child’s behavior, the lack of verbal self-report capacities, and the limitations of caregivers (Lieberman et. al., 2011). According to van der Kolk (2003), the strength of the attachment bond between the child and primary caregiver is the most important factor in protecting against trauma-induced disorganization. In children that have been maltreated, emotional dysregulation is correlated with lower levels of social competence, aggression, strained peer relationships, and disruptive behavior (Shields, Cicchitti & Ryan, 1994, as cited by Carpenter & Stacks, 2009). Exposure to unmanageable levels of stress in combination with a caregiver’s failure to modulate the child’s arousal, which occurs when children are exposed to family violence, can negatively influence all levels of childhood development (Steeck-Fischer & van der Kolk, 2000; Carpenter & Stacks, 2009; Pepler et al., 2000).

This exposure to trauma can also impact future generations and in particular, impact ways of coping. A multigenerational approach is often used to understand the repetition in patterns of relationships and models of coping with conflict (Davies, 1999). According to Streeck-Fischer and van der Kolk (2000):

When trauma occurs in the presence of a supportive, yet helpless, caregiver, the child’s response will largely mimic that of the parent,

meaning the more disorganized the parent, the more disorganized the child; the security of the attachment bond mitigates against trauma-induced terror (p.903).

It has been proposed that the quality of the attachment relationship may explain the intergenerational transmission of child maltreatment as maltreated children form perceptions of their own caregivers as unresponsive and unreliable which may lead them to be unable to form a secure relationships with their own children (Mennen & O'Keefe, 2005).

Problems associated with maltreated children suffering from attachment problems include developmental delays, odd eating behaviors, immature soothing behaviors, emotional problems, inappropriate modeling, and aggression (Perry, 2001). Children exposed to unexpected violence have a heightened vulnerability to serious emotional, behavioral, physiological, cognitive and social problems (Perry, 1995). Children exposed to chronic trauma often have difficulty in social settings and tend to struggle with affect regulation and may withdraw or bully other children (Streeck-Fischer & van der Kolk, 2000). "The clinical presentation of any particular traumatized child is the result of a combination of these dissociative and disintegrated responses and their trauma-specific reactions, such as avoidance, flight/flight, freezing, compliance, behavior or affect transformation" (Streeck-Fischer & van der Kolk, 2000, p. 909). Dissociation is a way for children to compartmentalize their experienced trauma; however, it can be a strong predictor of the development of psychopathology over the lifespan (Streeck-Fischer & van der Kolk, 2000). Additionally:

Other developmental difficulties observed in persons with complex trauma adaptations have to do with the individual's sense of self, ability to identify and modulate emotions, alterations in consciousness and self-awareness (often in the form of dissociation), difficulty maintaining personal safety, somatic and medical concerns, and alterations in personal meaning or spirituality (Pearlman & Courtois, 2005, p. 450).

Presentation of behavior based on the different types of attachment classifications

The effects of different types of attachment patterns often impact the development of a child and may affect the child's attachment relationships throughout his or her lifespan. As previously mentioned, attachment patterns can be classified as secure, insecure-avoidant, insecure-ambivalent/resistant, and insecure-disorganized/disoriented. Secure attachment patterns develop from having a consistent and loving caregiver who is available and responsive in times of distress (Mennen & O'Keefe, 2005). Insecure attachments are associated with dysregulation and developmental challenges. The subtypes of insecure attachment are identified as resistant or avoidant, anxious/ambivalent, and disorganized/disoriented. Insecure-avoidant/resistant infants tend not to show distress and are often expressionless and associate attachment as aversive rather than comforting (Davis, 1999). Children with an avoidant attachment style are at higher risk of further problems than children with any other attachment classification, and three times the rate of children that are securely attached (Keller, 2005 as cited by Lieberman et. al., 2011). Children of parents who have been inconsistent in parenting techniques or abandoned their children can develop anxious/ambivalent attachment patterns and become dependent and hostile towards caregivers (Mennen & O'Keefe, 2005).

Children with disoriented/disorganized attachment patterns often display a mix of avoidance and anger but also struggle with behavior disorientation (Mennen & O'Keefe, 2005). Disoriented/disorganized attachment patterns usually result from the caregiver fearing the infant and the inability of the infant to understand what behaviors will elicit positive attention from the caregiver (Mennen & O'Keefe, 2005). According to Siegel (1999) "Disorganized attachment has been associated with serious family dysfunction, such as impaired ability to negotiate conflicts, chronic and severe maternal depression, child maltreatment, and parental controlling, helpless, and coercive behaviors" (p. 109).

According to Becker-Weidman (2006), "Trauma-attachment disordered children have internalized a negative working model of the world, adults, relationships, and themselves" (p.146). Disorganized attachment is more often associated with children who have a history of trauma. "The individuals at greatest risk of developing significant psychiatric disturbances are those with disorganized/disoriented attachments and unresolved trauma or grief" (Becker-Weidman, 2006, p.119). According to Hesse and Main (2000), infants exposed to frightening behavior by the primary caregiver and maltreated infants are very likely to have a disorganized attachment. Children that have been sexually or physically abused often display avoidant or dissociative symptoms, including lack of physical contact or eye contact. "Disorganized infant attachment has been found to have distinct and unfavorable sequel in middle childhood and a parallel form of disorganization" (Hesse & Main, 2000, p. 1098). In a study of domestic violence and attachment, Carpenter and Stacks (2009) found that 61.5% of the infants in the sample were classified as having disorganized attachment. According to Perry (2005), the duration and severity of trauma in children is dependent on many factors, one of the

most important being the availability of a healthy and supportive caregiver. However, when caregivers are inconsistent, extremely distressed, violent or neglectful, the child often becomes distressed resulting in excessive anxiety, anger and desperate need for care (van der Kolk, 2003). These children with insecure attachment patterns often have difficulty relying on others and regulating emotion, which may lead to dissociative states of aggression (van der Kolk, 2006). Trauma can have a huge impact on the development of children within many different areas of a child's life.

Chronically traumatized children tend to suffer from distinct alteration in states of consciousness, including amnesia, hypermnesia, dissociation, depersonalization, flashbacks and nightmares of specific events, school problems, difficulties in attention regulation, disorientation in time and space, and sensorimotor developmental disorders (van der Kolk, 2006, p. 405).

Complex Early Relational Trauma

“The traumatic stress field has adopted the term ‘complex trauma’ to describe the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature and early life onset” (van der Kolk, 2006, p. 402). Complex trauma can be defined as continued years of physical, emotional, or sexual abuse. These children may have a disorganized attachment and thus have difficulty forming other relationships because their internal working models were developed based on maladaptive behavior. “Deprivation of critical experiences during development may be the most destructive yet least understood area of child maltreatment” (Perry, 1995, p. 276).

Psychological Responses. Children that grow up with constant physical, sexual, and emotional abuse often experience psychological responses. Further deprivation of healthy affection, empathy, and vital learning only exacerbate this issue. “A child that is neglected early in life will exhibit profound attachment problems which are extremely insensitive to any replacement experiences later, including therapy” (Perry, 1995, p. 277). Early neglect may also lead to difficulties in affect regulation, the ability to mentalize, and difficulties with attunement. “Lack of capacity for emotional self-regulation is probably the most striking feature of chronically traumatized children” (van der Kolk, 2003, p. 298).

Physiological Responses. In response to trauma, a child may develop several physiological responses to threat, including hyperarousal, freezing, and dissociation.

The alarm reaction is characterized by a large increase in activity of the sympathetic nervous system, resulting in increased heart rate, blood pressure, respiration, a release of stored sugar, an increase in muscle tone, a sense of hyper vigilance, and tuning out of all noncritical information (Perry, 1995, p. 277).

Some children develop conditioned responses based on their experienced abuse. “When a traumatized child is in a state of alarm [because she is thinking about the trauma, for example] they will be less capable of concentrating, they will be more anxious and they will pay more attention to ‘nonverbal’ cues such as tone of voice, body posture, and facial expressions” (Perry, 1995, p. 274). This is the body’s way of defending itself to get away from the perceived threat. In children with disorganized attachments, they have learned that their caregiver is inconsistent and not always safe and as a result they must

have a heightened awareness for perceived threat. “Freezing allows better sound localization, keener visual observation—an environmental scan for potential threat” (Perry, 1995, p. 279).

Dissociation is another coping mechanism used to endure and distance oneself from trauma. “Dissociation is simply disengaging from stimuli in the external world and attending to an internal world” (Perry, 1995, p. 280). Dissociation can be a way that children learn to mentally remove themselves from the situation by allowing the mind to go somewhere else to escape the horrific experiences and protect themselves emotionally. “The nature of the trauma seems to be important to the pattern of adaptation: the more immobile, helpless, and powerless the individual feels, the more likely they are to utilize dissociative responses” (Perry, 1995, p. 282). These dismissive states can become a conditioned response to the abuse. Instead of attempting to bond with a caregiver, children may withdraw and avoid interaction all together.

Without the option to fight or flee, stuck between approach and avoidance, the infant can only ‘freeze’ into a trance-like stillness, which may be the beginnings of a tendency towards clinical dissociation—the phenomena in which consciousness, states of mind, and information processing become fragmented (Siegel, 1999, p.109).

Attachment theory relies on memory of attachment relationships as the base for internal working models (IWM) to conceptualize a sense of self and that of the caregiver (Liotti, 2004). The IWM of disorganized attachment is different than other forms of attachments because in addition to assuming negative consequences when asking for help and

comfort, it can be associated with dissociation and nonintegrated multiplicity of contradictory expectations (Liotti, 2004).

Neurological Impact. Early complex relational trauma can affect both the development and function of many vital structures in the brain (Perry, 1995). Attachment relationships are major environmental factors that shape the development of the brain during its period of maximal growth (Siegel, 1999). Traumatic experiences may cause sensitization or learning difficulties in the mature brain and may impact the functional capacity of the human brain throughout the lifespan (Perry, 1995). Unlike complex relational trauma, single episodes of mild trauma do not seem to have as significant impact on brain development. Neurological development is most vulnerable during infancy and early childhood. The main difference between the children who have not experienced early complex trauma from those who have is that the formation of the vital brain structures that impact neurological function had already been established prior to experiencing trauma (van der Kolk, 2003).

Current treatment methods

Given the scope of this problem and the impact it can have on society at large, it seems worthwhile to more carefully consider the interventions and preventative measures that will help alleviate attachment disorders and symptoms related to complex trauma. Social workers need to be conscious of the impact that the primary caregiver has on the child and must take into account the influence of attachment relationships. When treating traumatized children it is important to create safe conditions including protecting them from perpetrators, and setting clear boundaries and rules. Until children feel secure they are unlikely to give up primitive self-protective behaviors, including the habitual fight or

flight response (van der Kolk 2003). Given the tendency children have to repeat past trauma it is important to establish a safe therapeutic environment where they will not be hurt and cannot hurt others (Streeck-Fischer & van der Kolk, 2000). According to Streeck-Fischer and van der Kolk (2000), “children need to be distracted from their habitual fight/flight/freeze reactions by engaging their attention in pursuits that are not trauma-related triggers, and which give them a sense of pleasure and mastery” (p. 913). Traumatized children often struggle with hyper-arousal and need to learn about what is happening and learn to tolerate trauma-related bodily sensations and emotional states in order to, for example, participate in physical activities and obey verbal rules simultaneously. Given the disruption in trust and safety at home, it is essential for a child to be provided with patient, consistent, and attentive caregiver during childhood in order to develop a sense of interpersonal security. A major objective of therapy is to assist these children in developing their words in order for them to be seen and understood by both themselves and others around them (Streeck-Fisher & van der Kolk, 2000).

According to Becker-Weidman (2006) Dyadic Developmental Psychotherapy is an attachment-based treatment approach whereby the treatment aims to:

Remediate the negative working model of such children, using experiential methods that have several important and overlapping dimensions: modeling the healthy attachment cycle, reducing shame, safe and nurturing physical contact that is containing, re-experiencing the affect associated with trauma in order to integrate the experience and not dissociate, and the interpersonal regulation of affect (p. 151).

Becker-Weidman et al. (2006) examined the effectiveness in treating reactive attachment disorder using Dyadic Developmental Psychotherapy (DDP) compared to the usual care, including individual therapy, play therapy, family therapy, residential treatment, and intensive outpatient treatment. Findings suggest that DDP is effective in treating reactive attachment disorder, because it “facilitates a healthy attachment between child and caregiver, enables the child to actively trust the caregiver, and allows the child to secure comfort and safety from the caregiver” (p. 169). “The practice of DDP requires the clinician to become affectively attuned with the child, maintain joint attention and share congruent intentions for their time together” (Becker-Weidman & Hughes, 2008, p. 330). According to Becker-Weidman and Hughes (2008),

DDP involved the identification, regulation and integration of parallel processes (parent-child, therapist-parent and therapist-child) in a manner that changes the parent so that the parent becomes a more secure base for the child that helps the child acquire greater security (p. 335).

It is also important to consider previous treatment methods, and what has been learned since. Another form of treatment is called Holding therapy, a form of attachment therapy. This therapy consists of holding a child using a rug or a blanket to recreate the feeling of being held with the intention of making the child feel ‘comforted’. While this therapy is mostly discredited within the field of mental health, however, some clinicians still practice these methods. Cline (1992; as cited by Dozier, 2003) argues that these children need to be made to feel powerless for change in behavior to happen. “The child’s experience of powerful shame and rage while being physically restrained may well replicate for the child, terrifying or traumatic conditions (Dozier, 2003). Clearly, this

method can inflict further trauma to the child, and does not serve to work towards repairing the maladaptive internal working models between the child and the caregiver.

Implications for clinical social workers

It is important for clinicians to understand the complex impact of attachment, and more specifically how to implement effective intervention methods (Mennen & O'Keefe, 2004). Attachment research indicates that without intervention or change in circumstances, attachment patterns will persist (Karen, 1990). Experienced clinicians have observed many commonalities in maltreated children with attachment problems, including developmental delays, eating disorders, inappropriate soothing behavior, emotional problems, inappropriate modeling, and aggression (Perry, 2001). According to Mennen and O'Keefe (2005), "child welfare policy strives to use children's attachments as a guide to decisions about placement, but the demands of the system can interfere with this ideal" (p.578). As clinicians it is important to address the similarities in attachment patterns between children and their caregivers, as research has shown that parents and children's behavior tends to be complementary (Davies, 1999).

Professionals working in the mental health field and child welfare agree that when working with families it is important to regularly assess for exposure to trauma, partner violence, depression and anxiety, specifically during the prenatal period. Furthermore, professionals working with families who have experienced domestic violence and child abuse should participate in reflective supervision to talk about these traumas (Carpenter & Stacks, 2009). In conclusion, when working with children and families that have experienced domestic violence and trauma it is important for clinicians to make regular

assessments and intervene early in order to combat the effects of insecure attachments that may lead to mental health disorders.

Given the significance and scope of this topic, it is essential to further investigate treatment methodologies and examine clinicians' perspectives regarding how most effectively to work with these families. Current research explores Dyadic Developmental Psychotherapy, but fails to provide a clear or comprehensive methodology that can be implemented in group therapy or family therapy settings. Further research is needed to include current practices used by mental health clinicians in a wide array of treatment settings.

Conceptual Framework

The two theories that are used as the conceptual framework for this project are attachment theory, and psychosocial developmental theory. These theories provide the lens by which this paper will be analyzed, and provide a background and basis for the research study.

Attachment Theory (Bowlby)

Attachment theory was proposed by British psychoanalyst John Bowlby and expanded on by the work of Mary Ainsworth. Bowlby wrote about attachment, separation, and loss that had a powerful influence on practices used by primary caregivers in orphanages and pediatric hospital wards (Siegel, 1999). Attachment theory proposes that all humans have internal working models that have been adopted from the primary caregiver, and result in either a secure or insecure attachment. Bowlby (1988) found that three patterns of attachment that are present during the early years: secure attachment, anxious-resistant insecure attachment, and anxious avoidant insecure attachment. These

classifications are used to describe the attachment relationship between the primary caregiver and the child. Ainsworth developed the Infant Strange Situation to study the infant's response to the mother's return by the way he seeks proximity to the mother, and how easily he can be soothed, and how quickly he can return to play (Siegel, 1999). Ainsworth defines attachment theory as the influential relationship between the infant and his or her caregiver during infancy and added a fourth classification, disorganized attachment. Disorganized attachment is most commonly associated with children who have experienced trauma.

Attachment theory is essential in this study, as it is the lens by which the researcher will address the impact of trauma. "As they grow, children internalize their relationships with attachment figures; this gives them the ability to develop a schema or mental model of security, called a 'secure base'"(Siegel, 1999, p. 71). These internal working models are essential in understanding how children perceive threats of danger, and how easily they are comforted when the threat has decreased. When working with children that have been exposed to trauma it is essential to include the impact that this trauma can have on the relationship between the caregiver and the child. Furthermore, in order to provide effective treatment methods, parents and clinicians must be aware of the impact that the disruption of the attachment can have on the child.

Psychosocial Developmental Theory (Erikson)

Erik Erikson established a framework for understanding the typical psychosocial developmental patterns of people, and claimed that people continue to development across their lifespan. Erikson proposed that conflict arose from the individual's interaction with his or her environment, rather than from internal forces (Winter, 2001).

The Psychosocial developmental theory focuses on how internal and external forces shape life development by focusing on life stages. The main concepts are that human development occurs in defined and very distinct stages that may be universal to all individuals. This theory is useful for understanding individual growth and development across the lifespan, and useful in assessing the strengths and limitations of an individual.

This theory is helpful in addressing the problem that trauma can have across an individual's lifespan. Furthermore, it is important to focus on the strengths and limitations of the individual in order to find the most beneficial treatment methods. This theory is helpful in understanding the importance of childhood development in both typical functioning and maltreated children.

Method

Research Design

The design used for the study is a qualitative research design. The researcher planned to interview 8 respondents whereby the respondent will be asked 10 open-ended questions. Due to recruitment difficulties and limitations, one respondent participated in this research study. The respondent was chosen based on his/her current occupation and experience working with children. The criteria needed for choosing research respondents was: they must work in the field of children's mental health for at least 2 years and have direct contact with clients. The respondent was found using publicly listed websites of child welfare organizations in Minnesota. After the respondent was initially contacted, snowball sampling was used to enlist further participants. When meeting with the respondent, the respondent was asked for further recommendations of other respondents who met the criteria and may be interested in participating. The names of these contacts

were given in person based on the respondent's referral. This was completely optional and there is no benefit or reward given for the referral. The respondents referred were informed how they were referred, but the respondent's responses were kept confidential. The interview took place at a location of the respondent's place of employment. The interview was audio recorded, transcribed, and later coded for themes.

Sample

In accordance with the research design, recruitment for respondents was initiated by the researcher using publicly listed website contact information for individuals who work in children's mental health organizations in Minnesota. Initially the principle investigator made contact to these potential respondents by email. Of the 45 individuals contacted, 4 responded that they did not meet the criteria and an additional 5 declined participation but responded with referral sources. No response was received from the remaining 36 potential respondents by the researcher. Using those referrals, 2 interviews were scheduled. Due to a personal scheduling matter, 1 of the respondents was unable to meet for an interview, and had to cancel 3 days prior to meeting. One interview was conducted, shifting this research design to a single case study.

The respondent has held his/her current position for the past 4 years and currently works with children and families affected by chemical dependency, mental illness, and homelessness. The respondent has previously worked with pre-adolescent children in a day treatment setting, holds a Masters Degree in Counseling, and is currently pursuing a graduate certificate in marriage and family therapy.

Protection of Human Respondents

In order to ensure the protection of the respondent, prior to the interview the respondent was given a consent form pending approval by the University of St. Thomas/St. Catherine University Institutional Review Board (IRB) (see Appendix). The consent form addressed the steps that will be taken to protect the respondent from harm and ensure confidentiality and anonymity. Furthermore, the questions were nonthreatening and the respondent had the freedom to choose where the interview would be held. A consent form was given, and the respondent was assured that he/she could withdraw from the study at any time. The respondent was de-identified, and the data will be destroyed following its use for this research assignment.

Data Collection

After selecting the respondent, the interview was conducted to obtain data. The interview lasted approximately 30 minutes and was audio recorded for transcription. The questions were open-ended. They address exposure to violence, attachment relationship, and treatment methods as they relate to the development of attachment relationships in children. The questions were formed after completing a review of the literature and assessing the major issues being addressed in current research. The interview questions first addressed the micro-level experiences and perceptions of the respondent, and then take a more macro-level approach to address current systemic issues. The format of the questions is intentionally written this way in order to orient the respondent to address both micro and macro level issues related to this topic. The entire interview was audio recorded and transcribed for analysis purposes.

Data Analysis Plan

In order to analyze the data a qualitative coding strategy called content analysis was used. Content analysis is a systematic way of interpreting the data with the purpose of identifying similar themes (Berg, 2008). The transcript for the interview was carefully examined to find codes and themes (see Appendix). According to Berg (2008): a code is a pattern in the data; and a theme is formed after three or more of the same codes have been identified. Using an inductive grounded theory method to generate codes and themes, the researcher analyzed the data from specific information within the words of the transcript to more general themes emerging from the data. Open coding was used to identify codes in the data. Open coding was used to examine the data line-by-line, coding first for similarities then for differences (Berg, 2008). After identifying codes within the transcript, codes appearing three or more times were labeled a theme. Each theme consisted of at least three direct quotes made by the respondent.

Strengths and Limitations

When conducting a research project it is important to consider some of the possible strengths and limitations of the study. The strengths of this study are that it examines current treatment methods from a clinician working in children's mental health and that it allows the respondent to describe their experience, and the effectiveness of current treatment methods. Some limitations of this study are that the respondent was found using a convenience sample, and therefore cannot be generalized to all clinicians. Furthermore, because this study uses a qualitative research design in an interview format, not using statistical analysis to examine the data may weaken the study.

Findings

From the qualitative interview 20 codes were found, and from that, 4 main themes were found and are labeled as the following; *behavioral issues, reunification, awareness of attachment theory and trauma, and treatment methods.*

Behavioral issues

The first theme that developed from the data was the prevalence of behavioral issues that seem to be displayed in children with attachment disorders or those who have trauma histories. The exposure to violence and/or trauma often changes a child's own perceptions of his or her caregivers and may be displayed in maladaptive behavioral patterns. The following are quotations from the respondent about this theme.

I would say what I typically see in the situations I work in, there are a lot of behavioral issues, behavioral concerns. A lot of times mom is reporting that her child is not listening to her. Or, um, they're acting out, being aggressive. Things like that. In turn we will see those behaviors in the child, some of that acting out as well.

This quotation addresses the dilemma that many clinicians face, which is to address the child's behavioral concerns first even though the primary issue is either attachment or trauma-related. The respondent argues in his/her current position the mother [primary caregiver] wants to address the behavioral manifestations but in many instances, these issues are related to traumatic experiences or strain on the attachment relationship.

Wanting that immediate affection or some of the behaviors. Kids acting out, not listening to mom. Mom not understanding why. [In response to family themes common to children].

This quote, with the respondent mentioning that mom does not understand the negative behaviors, alludes to how children act out because of their attachment needs failing to get met. Also implied in this quote is that children act out based on where they are developmentally.

I don't think that many people know about it. I a lot of times it is just viewed as maybe bad parenting, or a bad kid. And I think a lot of times that part, that relationship is missed, or the lack of that relationship developing.

The respondent addressed the impact of behavior issues in reference to treatment and the relationship with the primary caregiver, the child's mother. The respondent identified the misconceptions that often arise in regard to behavioral issues in children. Often these disturbances are attributed to a lack of parental involvement rather than as a result of trauma exposure. Furthermore, there are issues related to changes in the living environment, especially with families who have been separated due to child protection involvement, incarceration, or chemical dependency issues.

Reunification

The second theme that was found addresses the impact that reunification can have on the attachment relationship between the child and the caregiver. The following quotations from the respondent are examples of this theme.

If it's a mom that's recently been reunited with the child, encouraging a lot of one on one time.

In this quotation the respondent reveals a current intervention used in treatment to help facilitate the reunification process. According to the respondent, encouraging one-on-one time between the mother and child is an intervention used to repair the separation between mother [primary caregiver] and child.

I've also seen a lot of, when moms' and children have reunified and the family has been reunified, the family often wants the child to display affection right away. And that is definitely something that doesn't come right away when they are reunified. So, um, I'd say that's been pretty hard for mom to understand.

This quotation exemplifies the impact of the attachment to the primary caregiver and how it affects the behavior of the child. It also displays the persistence of the internal working models that have developed and the impact of separation from the primary caregiver.

And to just keep the mom involved. If she's the parent, or whoever is. If they are willing to be involved, and really work on things, if they have an idea of how it will be. Just supporting them, and encouraging them to put that work in.

This theme speaks to the role that the reunification process can have on the relationship between the child and the primary caregiver, which has been disrupted when there is a separation. The respondent acknowledged the difficulty that this reunification can have on both the primary caregiver [the mother], and the child. Often times due to child protection services, incarceration, or chemical dependency treatment the child is temporarily removed from the care of the primary caregiver, which understandably disrupts the child's sense of safety and attachment.

Awareness of attachment theory and trauma

The third theme that was found addresses the importance of being aware of how attachment theory and trauma may impact working with children as observed by the respondent in his/her current position. The following quotations from the respondent are examples of this theme.

I think because our—currently it's so focused on the chemical dependency. Um, I think then that some of the other pieces are missed.

This quote is powerful because the clinician alludes to a focus on attachment being neglected at the expense of other treatment modalities. Instead the clinician argues that focus of treatment is often on chemical dependency of the mother and often misses strain in the attachment relationship between the child and primary caregiver.

Instead of looking at Mom's here because of an addiction, and her kids came with her. Looking at it as more of a family, so really taking a look at attachment, behaviors, and emotions, and that whole piece.

This quote is significant because it speaks to the issue of working with family systems during the treatment process. The respondent discusses the importance of being aware of the importance of the family component and how the attachment relationship is extremely important in understanding the presentation of behaviors and emotions.

So really keeping your eyes open, um so that you're aware of what else is going on. I think it's important to keep in mind any of the potential trauma that may have occurred. Anywhere from being homeless to more extreme trauma of abuse and things like that.

In this section the clinician argues the importance of understanding about attachment theory and how it impacts the outward interaction between the child and primary caregiver. Furthermore, the clinician emphasizes the impact of potential trauma and how important it is to be aware of the circumstances that may have brought this family into treatment.

Treatment methods

The fourth theme that was found focuses on the current treatment methods that the respondent uses in current practice when working with children and families. The following quotations from the respondent are examples of this theme.

Some skills that I think are important just to be very patient. And just to keep your eyes open, because not every, one child may be displaying the exact same behaviors as someone else but it could mean something totally different.”

“We have ways that we are aware of everything, even as early as the screening process. If there is any concern we do make referrals in the community to someone—to an, um, an agency, that typically has a bit more, um, I guess just experience working with that.

In this quotation the respondent discusses many skills that are important during the treatment process. The respondent asserts that patience and awareness are essential. Furthermore, during the assessment process it is important to be aware if a child or family needs additional support and in that case should be referred to an agency that specializes in working with child trauma or attachment disorders in children.

We do use curriculums that are specifically organized, or, um, that are specifically designed for, um, non school age children. so that zero to five. And a lot it does focus and does incorporate mom into the picture. And sometimes through that we can see if there's anything else that we might of missed, or that we need to address.

The respondent acknowledged that there could be more training and specific models used in this current position. The respondent stated that the current treatment model screens for attachment disorders, but then, if found, makes a referral to another community agency that works specifically with this population. The respondent reports that although primarily referrals are made to different agencies for treatment of attachment disorders, if the behaviors are manageable the agency will continue to work with some children and provide treatment. The respondent identifies the rationale for this is that it is where the client will receive the highest level of care. This highlights a major issue in current practice, in that although the mental health field is moving towards providing trauma informed care, currently there are gaps in service that exist.

Discussion

After reviewing the themes that were found in the interview transcript there were similarities and differences compared with the literature. The first theme, behavioral disturbances was addressed as an influential theme in both the data and in the literature. Both emphasize the disturbances in the primary caregiver relationship may be observed in maladaptive behaviors of the child. In accordance with van der Kolk (2003), the child maltreatment can cause high levels of emotional reactivity, psychiatric problems, and behavioral issues. Similarly, Pearlman and Courtois (2005) assert that the quality of

these early attachment experiences can result in the child having difficulty with self-regulation and coping abilities. In addition, Perry (2001); Perry (1995), Streeck-Fisher & van der Kolk (2000); & Pearlman & Courtois (2005), all identify that children exposed to violence may suffer from attachment problems, including developmental delays, difficulty in social settings, difficulty modulating emotions, and alterations in consciousness, specifically dissociation. Furthermore, Lieberman and colleagues (2001) argue that insecurely attached children with high levels of infant negativity are at an increased risk for behavioral problems than those securely attached children with high levels of infant negativity. In essence, the disruption in the attachment relationship can lead to many behavioral issues.

The second theme, reunification, was not extensively addressed within the literature but was a vital theme in the interview data. This finding may suggest the differences that exist between theory and practice may be specific to this clinician's current practice. In practice, clinicians must address current issues that children face including issues of separation regarding with child protection, parents being incarcerated, and those entering chemical dependency treatment. However, the reviewed literature is more narrowly focused on attachment theory and the impact that it has on the development, thus failing to incorporate the more immediate concerns of this specific population. In accordance with Mennen & O'Keefe (2005), children with parents who have been inconsistent in parenting or abandoned their children may develop anxious/ambivalent attachment patterns and may become dependent and hostile towards caregivers. This was identified in the data in relation to the child being separated and then later reunified with his or her caregiver.

The third theme, the clinician's awareness of attachment theory and trauma, was addressed in both the interview data and the literature. The data and literature indicate that it is very important for clinicians to be educated about attachment theory and how it relates to trauma. The research findings are consistent with the current literature and both address the importance of the clinician being aware of attachment theory and trauma informed care within current practice and treatment methods. In accordance with Carpenter and Stacks (2009); Steek-Fischer & van der Kolk (2000), and Pepler et al. (2000), the exposure to unmanageable levels of stress combined with a caregiver unable to modulate the child's arousal can have a negative influence on all levels of childhood development. The data identify the importance of being aware of these symptoms and how important it is to identify them in order to get these children access to the services they need. Similarly, Becker-Weidman (2006), assert that children with attachment disorders and trauma histories have a negative working model of the world associated with adults, relationships, and themselves. This suggests that due to trauma these children have significant impairment in developing relationships, and thus, clinicians need to be aware of this difficulty in order to develop rapport and provide the highest level of service possible. Perry (1995) argues that the deprivation of critical early experiences during the developmental period is arguably the most harmful and least understood area of child maltreatment.

The fourth theme found, treatment methods, focuses on the current practices used to treat and work with children with attachment disorders and those with a history of trauma. The research findings are somewhat consistent with the current literature. While the literature addresses that clinicians need to be aware of the impact that trauma and

attachment disruptions can have on the child in order to provide the needed treatment, the data fail to address specific treatments or models being used with these children. In accordance with van der Kolk (2003), when treating traumatized children it is important to create safe conditions, and until safety is established children are more likely to use primitive self-protective behaviors. The respondent emphasized how important it is to be aware of these conditioned responses, and to use current evidenced based practices. This further supports the inappropriateness of holding therapies as they are thought to be both therapeutically unethical and are not supported by empirical evidence. Further evidence by Streeck-Fisher & van der Kolk (2000) indicates the importance of a child being provided with a patient, consistent, and attentive caregiver in order to develop a sense of interpersonal security. Similarly, the data indicate that awareness is the first step in building these skills between the child and the caregiver. Becker-Weidman (2006) emphasizes Dyadic Development Psychotherapy as an attachment-based treatment approach used to rebuild the negative internal working model by modeling, reducing shame, providing safe and nurturing contact, and re-experiencing the affect associated with the trauma in order to reintegrate the experience and decrease dissociation. According to the data the therapeutic techniques of this model are readily used when working with children and caregivers.

Other notable findings include that both the literature and the data reveal that there is a significant impact that witnessing trauma can have on the development of a child. While the literature focuses more on the role that attachment has in early childhood development, the interview responses were more based on current practices and therapeutic strategies. Furthermore, the interview data focused more specifically on

generalized observations; the literature focused more on the specific attachment classifications. In addition, as noted by the respondent in the data, this specific agency does not utilize a specific attachment-focused model, and therefore does rely on referrals for children that need a higher level of care. The findings reflect a more practical approach to working with these children, incorporating multiple theories and practices in treatment methods.

Implications for future research

It is very important for clinicians to understand the interconnectedness of disorganized attachment and trauma exposure. In accordance with the research, clinicians identify many common developmental and behavioral issues related to a disturbance in attachment and trauma. Currently there has been an increase in attention, research, and funding to the field of children's mental health. Yet it is important to recognize that the implementation of these practices is still in its infancy, and there is currently not a specific model that is universally applied.

Given that this research study was condensed to a single case study it serves more as an explorative study, and further research is needed in order to make larger generalizations. The difficulty with recruitment is a notable limitation to this study, and may be related to recruitment methods. For future research it would be recommended to work specifically with an agency or organization, which may lead to higher participation and more specified findings. Furthermore, another limitation of this study is that this was a convenience sample and therefore findings cannot be generalized to all clinicians. Additionally, because this study uses a qualitative research design in an interview format, and not statistical analysis to examine the data, this may weaken the study. In order to

increase reliability a statistical analysis would be recommended. Despite the mentioned limitations this case study provides valuable research and an analysis into treatment methods and observations used in current practice.

Implications for social work practice

Based on the data collected by the respondent it is clear that the treatment of attachment disorders and trauma are both significant issues in social work practice (Mennen & O'Keefe, 2004). This case study reveals the role of attachment theory in current practice and how some clinicians are currently treating children with trauma histories. Attachment theory classifications were developed as a way to differentiate types of relationships between the primary caregiver and the child. However, while these classifications are helpful for understanding the relationship, they often are not the main focus in current practice. Instead clinicians often must address behavioral disturbances related to dysregulation. Thus the focus is often providing a reparative experience between the primary caregiver and child, and not specifically oriented to addressing attachment theory.

It is important for clinicians working in the mental health field and child welfare agencies to regularly assess for exposure to trauma, partner violence, depression and anxiety. Furthermore, when working with children and families who have experienced trauma, it is important for clinicians to make regular assessments and intervene early in order to combat the effects of insecure attachments that may lead to mental health disorders (Lieberman, 2011). After further investigating current treatment methodologies and examining the clinician's perspectives regarding how to most effectively work with these families, it is clear that there are some significant differences between current

research and current practice. Specifically, there is not a universal or systematic treatment methodology used when working with children with attachment disorders or trauma histories. The gap in service exists because not all agencies are given a recommended way to approach using trauma informed care and specifically how to address the role of attachment when working with traumatized children. Although there has been more emphasis on providing trauma informed care, some agencies have not adopted a specific protocol or systematic approach. This issue goes beyond the clinical level to a larger systemic issue. Clinicians are often expected to have received training and or education about working with children with attachment disorders and those with trauma histories. However this is not always the case. Further education and training needs to be provided so that clinicians have more universal practices and strategies for treatment. In addition it would be beneficial for employers to be required to provide this training to new employees entering the children's mental health field. Lastly, further research is needed on practices used by mental health clinicians in a wide array of treatment settings in order to generalize findings.

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Appendix A**EMAIL SENT TO POTENTIAL RESPONDENTS**

Dear _____,

My name is Anya Esch. I am currently pursuing a Masters in Social Work at the University of St. Thomas/ University of St. Catherine. I accessed your contact information on your publicly listed website, and am contacting you based on your experience working in the children's mental health field. I am conducting a research project focusing on current treatment methods and practices used when working with children with attachment disorders and/or those with trauma histories. I am looking for clinicians with 2 years experience working directly with children to volunteer to participate in a one-hour qualitative interview in the next couple weeks depending on your availability. These interviews will be audio recorded, transcribed and later coded for themes. The names of subjects will be kept confidential. There is no obligation to participate and no direct benefit associated with participation. If you are interested in getting further information or would like to participate please email back at XXXXXXXX@stthomas.edu or by phone at XXX-XXX-XXXX. Thank you very much for taking the time to read this email.

Sincerely,

Anya Esch

Appendix B

Disorganized Attachment and Trauma in Children RESEARCH INFORMATION AND CONSENT FORM

Introduction:

The focus of this study is on disorganized attachment and childhood trauma. Tragically, childhood trauma is very common in the United States and as such it is essential to continue to develop effective treatment methods. This study will use qualitative interviews of children's mental health clinicians to investigate what treatment methods are used to work with children with histories of trauma and attachment disorders, specifically focusing on disorganized attachment. Based on your current or previous occupation and experience working with children you are invited to participate in this research study. The criteria used for choosing research subjects is that participants must have 2 years experience in the field of children's mental health and have had experience with directly with children.

Background Information:

Prior research suggests that children who experience trauma often experience a disruption in the formation of attachment with his or her primary caregiver. This study aims to address how this disruption may lead to attachment disorders in children, and what developmental challenges children exposed to trauma may face. Using qualitative interviews of children's mental health clinicians, this study will examine that impact of trauma on attachment using the experiences of current children's mental health clinicians. The overall goal of this study is to increase awareness about the impact that disorganized attachment and trauma can have across a child's lifespan, to investigate current treatment methods, and examine the impact of early interventions.

Procedures:

Subjects are expected to meet at a location of his or her choosing for a one hour interview. The subject is expected to answer ten open-ended questions based on his or her experience working in the field of children's mental health, specifically focusing on disorganized attachment and trauma. These interviews will be audio-recorded and later transcribed.

Risks and Benefits:

In order to minimize risk to participants, this study does not have any direct contact with children. Instead, this research study will focus on the interpretations and perspectives of experienced mental health clinicians. The data collected will be based on the therapist's work with these children that have disorganized attachment and or those who have experienced trauma. Discussion about childhood trauma may evoke sadness, guilt, or helplessness in the mental health clinician. There are no direct benefits to you for participating in this research.

Confidentiality:

The data and records will be kept in the researcher's home office on a secure password protected external hard drive in a locked file cabinet. The researcher is the only one with a key to the file cabinet and is the only one with the password to the external hard drive. The data and records will be kept until January 1, 2014 at which point they will be completely deleted from the researchers external hard drive. The researcher and the research chair Lance T. Peterson Ph.D., LICSW will be the only people with access to the data and records.

Voluntary nature of the study:

You are free to skip any questions that may be asked and there are no exceptions.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

Researcher name: Anya Esch
 Researcher email: XXXXXXXXX@stthomas.edu
 Researcher phone: (XXX) XXX- XXXX
 Research Advisor name: Lance T. Peterson Ph., LICSW
 Research Advisor email: pete2703@stthomas.edu
 Research Advisor phone: 651-962-5811
 UST IRB Office 651-952-5341

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study and I agree to be audio recorded.

Signature of Participant

Date

Signature of Parent, Legal Guardian, or Witness
 (if applicable, otherwise delete this line)

Date

Signature of Researcher

Date

Appendix C

Interview Questions List

- 1) Please describe your responsibilities as a practitioner. How long have you served in this capacity?
- 2) Please describe the demographics of the clients you serve.
- 3) [First I will define disorganized attachment for the respondent.] Describe the individual characteristics you notice of children with disorganized attachment. Are there any family themes common to children with disorganized attachment? If so, what are they?
- 4) What has your experience been working with children with disorganized attachment? What treatment methods do you use?
- 5) Besides treatment methods, what specific approaches or skills do you find important in your work with children suffering from disorganized attachment?
- 6) What early intervention methods have you found to be successful in restoring typical social-emotional development in children with disorganized attachment?
- 7) If you were to advocate on behalf of a child with disorganized attachment, what policies would you want agencies who provide services to consider?
- 8) If you were to advocate on behalf of a child with disorganized attachment, what policies would you want policymakers to consider?
- 9) If you could, what would you want our culture to know about children with disorganized attachment?