

EXPERIENCES OF ATTACHMENT THERAPY:  
A FOLLOW-UP STUDY OF ADOPTIVE MOTHERS

by

JANE SHOEMAKER WIMMER

(Under the Direction of M. Elizabeth Vonk)

ABSTRACT

The purpose of this study was to explore mothers' experiences of attachment therapy as related to their current relationships with their adopted children. The therapy cited in this study was family-focused intervention which engaged the child and parents in resolving attachment difficulties. All of the children were adopted from the Georgia public child welfare system and had been diagnosed with Reactive Attachment Disorder, a serious emotional disorder of childhood that is exhibited by lack of bonding of the child to parental figures. The 16 mothers interviewed in this study had participated in state-sponsored attachment therapy and were part of an evaluation of that therapy in 2003.

This research study employed a descriptive qualitative design that used in-depth semi-structured interviews, artifacts, and a reflective research journal for data collection. The population was purposefully chosen, and all mothers who were part of the 2003 study participated. Three research questions guided this study: (1) What was the experience of attachment therapy for the participants? (2) How did the participants view their current relationship with their adopted child? (3) What were the participants' perceptions of the role attachment therapy played in their current level of functioning?

Data analysis guided by the constant comparative method revealed eight major findings. The experience of attachment therapy was (1) consistently supportive, (2) emotionally painful, and (3) physically safe. The mothers' current relationships with their adopted children were (4) continuously stressful and (5) unquestionably permanent. Attachment therapy had (6) instilled confidence in the mothers, (7) preserved family structure, and (8) offered partial solutions to the children's problems. Conclusions were that adoptive mothers exhibited extraordinary resilience, that attachment therapy had essential therapeutic components including a sense of the safety of therapy, and that families needed multi-level support from therapists, community resources, and public policy.

**INDEX WORDS:** Reactive attachment disorder, Attachment therapy, Adoption, Special needs adoption, Child welfare

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## DEDICATION

Jack was adopted when he was seven in the mid 1980s. A handsome, blond haired little boy, he was the blessing his adoptive parents had prayed for to complete their family. But Jack had been abused and neglected, and he had Reactive Attachment Disorder, a diagnosis that was unrecognized when he was placed. After 20 years his adoptive mother wrote,

*Grandchildren are really wonderful. John is 4 and Ricky is 3. They spent the weekend with us, and so we are exhausted but our hearts are filled with so much love that we will be able to exist without them until we get them for the weekend in 2 weeks. They were adopted by their biological mother's parents. The biological mom does not see the kids at all and Jack, now 27, is forbidden to see them by a court order. Fortunately, we have a good relationship with the other grandparents and although we are no longer legally grandparents they treat us as such, so we can have the kids almost as much as we want.*

*Jack is still maintaining his carefree lifestyle, sponging off anyone he can. We have come to terms with our relationship. We understand that he never really bonded with us and I think we finally accepted that it is not his fault nor was it ours. We could not penetrate the shield he built to keep from getting hurt. We see him at least twice a month and he spends the holidays with us. He does not work for longer than 1 to 2 weeks at a job, but he is going to the local tech school to study welding. Hopefully learning a trade will help. He is a handsome young man and now that he is on probation (7 years left) he is not using drugs. Jane, we will never stop hoping that*

*someday he will be able to make a life for himself that involves some responsibility and in turn provides him true happiness.*

*Our marriage is still strong (amazing as that must seem). God has blessed me with a wonderful man. (Adoptive Mother, personal communication, March 7, 2005)*

Statistically, this is a successful adoption. Jack did not disrupt from his adoptive family. He never returned to foster care. However, in spite of love, skill, patience, and professional help, Jack's parents were unable to help him attach to them. He abused drugs, and he abused his children. This dissertation is dedicated to those who seek to find help for children like Jack.

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## CHAPTER 1

### INTRODUCTION

This study focused on adoptive mothers' experiences of attachment therapy and their perception of the impact that therapy had on their relationship with their adopted children. Mothers in the study were participants in a specialized program of attachment therapy sponsored by the State of Georgia Office of Adoptions from 2000 to 2003. In each case the adopted child who was the primary client in therapy had been diagnosed with Reactive Attachment Disorder (RAD). Sixteen mothers were interviewed in 2003 as part of the evaluation of that program, and a follow-up inquiry into their experiences was chosen for this study. All of the original 16 mothers agreed to participate in in-depth interviews for this study. There were two reasons that mothers were chosen to be participants. First, Bowlby's theory of attachment places the mother as the primary attachment figure for the developing child. Children dealing with attachment difficulties have usually had problematic relationships with their mothers (Ainsworth, Bell, & Stayton, 1974; Bowlby, 1944b, 1958; Egeland, Pianta, & Ogawa, 1996). Second, anecdotal information suggests that adoptive mothers are the primary target of behavioral difficulties associated with attachment disorders (Cline & Holding, 1999; Hughes, 1999; Keck & Kupecky, 1995).

Reactive Attachment Disorder, as described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association, 2000) is a serious emotional disorder of childhood that is exhibited by lack of bonding of the child to parental figures. Behaviors most often observed include the child's indiscriminate approach to adults for attention

and affection coupled with inability to form a loving attachment to parents. Lack of bonding with parents produces secondary behavioral difficulties that make living with a child with Reactive Attachment Disorder stressful. The causes of Reactive Attachment Disorder are rooted in the experiences of the child during the first two years of life. Children who are abused, neglected, or who lack a consistent nurturing parent, fail to experience the primary relationship that develops into parent-child attachment. This attachment is the underpinning for much of the healthy emotional and relationship experiences of each person's life (Grossmann, Grossmann, & Waters, 2005; Sroufe, Egeland, Carlson, & Collins, 2005a).

There are three major areas of difficult behavior that appear frequently in adopted children with Reactive Attachment Disorder. First, the child has not internalized the love and respect for a parent, and as a result has missed the normal developmental process of internalizing a conscience, lacks the ability to feel empathy for others, and is self-centered in his desires and behaviors (Delaney & Kunstal, 1997; Magid & McKelvey, 1987). This aspect of behavior often leads to cruelty towards those weaker than the child.

Second, a defining aspect of the disorder is "indiscriminate sociability with marked inability to exhibit appropriate selective attachments" (American Psychiatric Association, 2000, p. 130). In an adoptive family, this behavior is exhibited by the child's unwillingness to give and receive love in a relationship with the mother coupled with a superficial demonstration of affection with other adults, often including the adoptive father and strangers. A child with Reactive Attachment Disorder is often uncooperative and disobedient with the adoptive mother but with other adults appears to be the model of a loving child. Extremes in the behavior can lead to inappropriate and sometimes dangerous situations in which the child would literally walk away with strangers. This ability to superficially charm makes traditional forms of therapy

ineffective for children with Reactive Attachment Disorder (Magid & McKelvey, 1987).

Unaware therapists can be convinced by the children that they are loving and obedient and are being persecuted by their cold, angry adoptive mothers.

The third area of behavioral difficulty is the child's constant need to be in control, leading to battles between the child and parents. This need develops from the child's learned distrust of caregivers and his belief that he must protect and take care of himself (Solomon & George, 1999). This over-developed coping strategy of self-reliance may have been a strength in the child's original abusive or dysfunctional home; however, in a well-functioning adoptive family the need for control blocks the child from assuming his role as a subordinate member of the family hierarchy, making him a difficult child to parent (Hughes, 1998).

The central role of the child's mother in attachment has been acknowledged continually since Bowlby's (1944b; 1958; 1966) early writings. In studying secure and insecure attachment patterns, the mother is the subject of study with her child (Ainsworth & Bell, 1970). In recent studies, the emphasis on the mother's role has continued. For example, Dozier's (Dozier & Sepulveda, 2004) work at the University of Delaware, and Marvin's (Marvin, Cooper, Hoffman, & Powell, 2002) work at the University of Virginia both focus on the mother-child attachment relationship as a method of assessing and improving child mental health. The mother appears to be both the creator of attachment difficulties in relationship to the young child, and in adoption, the parent who is most resisted as new attachments are being formed. Maxey (2004) found in a dissertation study of 39 adopted children that mothers had statistically significant higher scores than fathers on their perception of attachment disorder as measured by the Randolph Attachment Disorder Questionnaire. The importance of the mother-child relationship and the impact of attachment difficulties on the development of the relationship between an adoptive mother and

her child led to the current study's focus on the adoptive mothers' perceptions of attachment therapy.

The perceptions of mothers are central to the wellbeing of adopted children with emotional difficulties. Adoptive mothers have entered parenting with a desire to love a child, fulfilling both their own needs to nurture, and the need of mother and child for reciprocal warmth and caring. Mothers of children with Reactive Attachment Disorder discover that their dream of parenting is rebuffed by the protective shell of the emotionally damaged child. Control battles, rejection of physical affection, and unwillingness to conform as a member of the family typify the child's self-protective behavior, which was developed in previous experiences of neglect and abuse. The mothers have learned that love is not enough to achieve their parenting dreams. The family has gradually discovered truth in the saying of wise child welfare workers: "If momma ain't happy, ain't nobody happy." This underpins the importance of studying mothers' perceptions of therapy. Whether the child or the parent is the one who makes most of the shifts through the therapeutic intervention, if the adoptive mother is satisfied with the outcome of therapy, the stability of the child in the family is possible. Thus interviews with the mothers provide the most direct source of information for the area of interest.

Although the number of children with Reactive Attachment Disorder is not known, the population of children at risk of developing the disorder is large. Over 500,000 children are in foster care in the United States, most of whom entered care because of their parents' inability to provide a safe, nurturing home for them. In addition, during the past 10 years over 550,000 children with backgrounds of neglect or abuse have been placed for adoption. (U.S. Department of Health and Human Services Administration for Children Youth and Families, 2006b; U.S. Department of State, 2006). Although the *DSM-IV-TR* states that Reactive Attachment Disorder

is “very uncommon” (American Psychiatric Association, 2000, p. 129), in 2005 one Georgia county Department of Family and Children Services intake worker reported that approximately 70% of the children entering foster care in her caseload were then receiving the diagnosis (L. Hicks, personal communication, January 25, 2005).

Attachment therapy is a specialized mode of psychotherapeutic treatment that has been available only on a limited basis, primarily developed through the work of a group of therapists in Evergreen, Colorado. Attachment therapy as discussed in the current study usually involved the adopted child and his or her parents together in intensive therapy sessions with a team of two therapists. Therapy sessions usually lasted between 1 and 3 hours and included techniques of cognitive behavioral therapy, parent education, and the use of physical closeness such as cradling the child across the parent’s lap or rocking the child. The therapy was designed specifically to treat children with Reactive Attachment Disorder. It was grounded on the premise that early abuse and neglect produced the child’s lack of interpersonal connection and caring with which adoptive families struggle (Bowlby, 1988). Moving a child from an abusive birth family to the loving environment of an adoptive family is the most drastic intervention that can be imagined for a child. However, families often find their love is rejected by the child, and that parenting techniques that are effective with most children are frequently not effective with children who have Reactive Attachment Disorder (Cline & Helding, 1999; Hughes, 1999).

In 2000, the Georgia Office of Adoptions began a three-year program designed to raise public awareness about Reactive Attachment Disorder, train therapists to treat the problem, and provide therapy to children who had been placed for adoption by the Georgia Department of Family and Children Services (Wimmer, Simmons, & Dews, 2003). Sixteen mothers were interviewed as a part of the 2003 program evaluation and were the focus of the current follow-up



study. The current qualitative study engaged these mothers in individual interviews and collected related artifacts from them. Themes representing the preponderance of data are described in this report.

### Statement of the Problem

Reactive Attachment Disorder is a serious emotional difficulty that threatens the stability of adoptive placements. Untreated, it can lead to life-long difficulties in relationships, and its most serious manifestation can be the development of irresponsible and criminal adult behavior (Sroufe et al., 2005a). Research on the treatment of children with Reactive Attachment Disorder is nearly non-existent, and there is no evidence-based treatment modality available.

Lacking empirical knowledge, professionals are limited in their ability to therapeutically respond to Reactive Attachment Disorder. Attachment therapists have struggled with anecdotal examples of unethical and intrusive techniques published in the popular media. Lack of information on attachment therapy restricts the ability of public and private mental health agencies to provide treatment. In addition, public funds and private insurance companies resist payment for attachment therapy without proven techniques for achieving positive outcomes (J. Atkinson, personal communication, November 1, 2005). In particular, very little is known about mothers' experiences of therapy and perceptions of the impact of therapy on their relationships with their children. To date, no studies have been published describing these mothers' experiences.

### Purpose of the Study

This dissertation gives voice to the mothers who have participated in attachment therapy with their children and indirectly sheds light on treatment of children who were exhibiting attachment difficulties in their adoptive families. The purpose of this qualitative study was to

explore mothers' experiences of attachment therapy as related to their current relationships with their adopted children.

The research questions which guided this study were:

1. What was the experience of attachment therapy for the participants?
2. How did the participants view their current relationship with their adopted child?
3. What were the participants' perceptions of the role attachment therapy played in their current level of functioning?

#### Significance of the Study for Social Workers

The profession of social work is in a position to have both concern for and influence on children with attachment disorders. Child welfare has traditionally been claimed by social work as a field of expertise. The areas of child abuse and neglect, foster care, and adoption are taught and practiced by the profession. Pre-placement training, family assessment, placement, and post-placement services that adoptive families receive are part of the child welfare system. It is the child's case worker, most often employed by a public or private child welfare agency, who prepares the child for adoption and informs the adoptive families of the child's strengths and challenges. Beyond the arena of child welfare, social work has also developed in the past 30 years into one of the largest professions providing mental health treatment. Clinical social workers provide "mental health services for the diagnosis, treatment, and prevention of mental, behavioral, and emotional disorders in individuals, families and groups" (Clinical Social Work Federation, 2005). In this role, social workers are likely to be the therapists to whom families turn for diagnosis and treatment of Reactive Attachment Disorder.

As attachment therapy has evolved, social workers have been involved in the development of techniques, provision of services, and professional training (Infant Parent Institute, 2006; Institute for Attachment & Child Development, 2006; Kinship Center, 2006; Martha G. Welch Center, 2006; Theraplay Institute, 2006), as well as the publication of books on the subject (Keck & Kupecky, 1995; McKelvey, 1995). Of the registered clinical members of the Association for Treatment and Training in the Attachment of Children, approximately 40% have social work credentials (Association for Treatment and Training in the Attachment of Children, 2005). Unfortunately, the most widely publicized incident in therapy for Reactive Attachment Disorder involved the death of a child in 2000 who was receiving rebirthing therapy from a professional social worker (Mercer, Sarnier, & Rosa, 2003). Although the techniques in that incident were not those used in attachment therapy, the social worker was well known for her work in the area of attachment disorders of adopted children and the incident may have contributed to a public attitude of distrust for attachment therapy.

For these reasons, it is important that the experiences and effectiveness of attachment therapy are the subjects of research. There is little research on therapeutic interventions for children with attachment disorders. The journal *Attachment & Human Development* presented a special issue on “Current Perspectives on Assessment and Treatment of Attachment Disorders” which concluded that no research was available to promote empirically-based interventions for treating children with attachment disorders, and there was no current professional mandate to promote research in this area. In fact, attachment therapy was poorly understood and documented (O'Connor & Zeanah, 2003b, 2003c). The current study offers insight into the experiences of a group of adoptive mothers who received therapy from psychotherapists trained in the intervention as it is taught and practiced at this time. It is hoped that this qualitative research will

lay groundwork for the development of larger scale quantitative research into the effectiveness of the therapy.

### Definitions

The following definitions will be consistently used throughout the study.

*Adoption:* All references to adoption, adoptive parents and adopted children will mean members of a family created through the process of an adult becoming the legal parent of a child not born to him or her.

*Attachment:* The mutually satisfying, loving, reciprocal relationship between a child and his or her parent.

*Attachment disorder:* The difficulty (or range of difficulty: “attachment disorders,” “attachment difficulties”) some children have in forming an attachment with their parents.

*Attachment therapy:* Psychotherapeutic interventions specifically designed to treat children with attachment disorders. The treatment cited in this study is family-focused intervention which engages the child and family in resolving parent-child bonding difficulties. Techniques used included narrative therapy, play therapy, holding, psychodrama, Eye Movement Desensitization and Reprocessing (EMDR), neurofeedback, and parent education.

*Attachment theory:* The concepts first developed by John Bowlby that express the infant’s need for a consistent, nurturing care-giver in order to develop the emotional basis for healthy interpersonal relationships throughout a lifetime.

*Disruption:* The ending of an adoptive placement before the issuance of a final adoption decree.

*Dissolution:* The ending of an adoptive placement after the issuance of a final adoption decree, usually used when the termination of the adoptive parents' relationship with the child is requested by the parents themselves.

*Reactive Attachment Disorder (RAD):* The mental disorder indicated by the *DSM-IV-TR* as Reactive Attachment Disorder of Infancy and Early Childhood, 313.89, (American Psychiatric Association, 2000).

### Assumptions of the Study

The availability and honesty of the 16 adoptive mothers were the assumptions that supported this study. I assumed that mothers who participated in the original study would be available participants in this research. This assumption was predicated on two facts: the location of fourteen of the sixteen families had been verified through the Internet based on addresses given in the original study, and the therapy teams who treated the parents had stated their willingness to help locate families. The final information that validated this assumption was the enthusiasm for gathering and sharing information about attachment therapy that was expressed by mothers in the original study.

Based on the open communication and cooperation found from families in the original study, I also made the assumption of honesty on the part of the participants. As an outside researcher I was not a part of the system that placed their children or provided the therapy, and I anticipated that this objective status would promote the truthful expression of descriptions and attitudes.

### Organization of the Study

In Chapter 2 a review of the literature on attachment is presented from five perspectives: 1) the prevalence and description of attachment disorders, 2) the extensive research done since

the 1970s on the post-adoption needs of adoptive families, 3) attachment theory and research, 4) practice literature on treating adopted children with attachment disorders, and 5) the 2003 outcome study, *A Program Evaluation of Attachment Therapy Provided to Adopted Children with Special Needs* (Wimmer et al., 2003).

Chapter 3 presents a description of qualitative research as it relates to the study, the methods of data collection, and data analysis including issues of validity and reliability. My personal biases conclude the chapter. In Chapter 4 the research findings are presented in a qualitative format. This chapter includes profiles of the participants and presentation of categories that emerged from the preponderance of data. Chapter 5 describes the categories in relationship to previous literature and the conclusions drawn from the study. The limitations of the study are presented as are implications for theory, practice, policy, and research.

## CHAPTER 2

### REVIEW OF THE LITERATURE

This chapter introduces the literature on attachment disorder with an emphasis on the experiences of adoptive families. The prevalence and description of attachment disorders is presented as well as the research on the post-adoption needs of families and their adopted children. Attachment theory as articulated by Bowlby is reviewed as the underlying framework for understanding and treating attachment disorders. The major longitudinal study of mother-child attachment is described, presenting that study's findings on the ongoing difficulties of children who have been neglected or abused. Practice literature, written for therapists and families but lacking a research base, has played a large role in the understanding of attachment disorders by adoption professionals and adoptive families. This literature is presented as well as articles on the lack of research focused on the practice of attachment therapy. The chapter concludes with a description of attachment therapy as it is currently practiced in Georgia and with a discussion of *A Program Evaluation of Attachment Therapy Provided to Adopted Children with Special Needs* (Wimmer et al., 2003) which serves as the original study to which the current research is a follow-up.

#### Prevalence and Description of Attachment Disorders

Children who during their first years of life are abused and neglected or who are raised in orphanages are at high risk of limited success in forming healthy attachments to their caregivers (Bowlby, 1973). Based on maladaptive early attachment strategies, these children often have emotional and behavioral difficulties that become evident as the children adjust to new families

through adoption (Henry, 1999; Hughes, 1999; Randolph, 2001). There is a large population of children in the United States who have experienced inadequate attachment relationships in their earliest years. According to the U.S. Department of Health and Human Services Children's Bureau Adoption and Foster Care Analysis and Reporting System (2006b), 513,000 children were in foster care on September 30, 2005, most of whom entered care because they were neglected or abused by their birth parents. Approximately 101,000 of these had a goal of adoptive placement. During the 10 years from 1995 through 2004 approximately 426,000 children were adopted through the public child welfare system (U.S. Department of Health and Human Services Administration for Children Youth and Families, 2006a). In addition, during the 12 years from 1995 to 2006, approximately 209,500 children entered the United States for adoption from overseas (U.S. Department of State, 2006), most of whom had spent their early lives in orphanages.

There is a lack of a consensus on how to identify attachment disorders, and this has limited the data on the prevalence and the characteristics of the problem. Research on the prevalence of attachment disorders has been scarce in spite of the known risk to maltreated children. The *DSM-IV-TR* (American Psychiatric Association, 2000) stated "Epidemiological data are limited, but Reactive Attachment Disorder appears to be very uncommon" (p. 129). However, in discussing the problems of the *DSM-IV-TR* diagnosis of Reactive Attachment Disorder, Sroufe, Egeland, Carlson, and Collins (2005a) pointed out that

According to this system, if one is not excessively inhibited, hypervigilant, or ambivalent toward caregivers, or indiscriminately friendly or totally unable to form a relationship, one does not have an attachment problem. Only 2 or 3 of the 180 children we studied would have truly fit these categories; yet attachment problems, at times severe, were



common. The vast majority of children, even those who are both avoidant and disorganized as infants, do not fit this diagnosis, even though they are dramatically more likely to have a range of serious problems later.... Even many of the East European orphans, whose relational abilities are seriously compromised, do not meet diagnostic criteria. (pp. 275-276)

Several studies have explored the attachment issues of children who are served by the child welfare system, and the consensus is that difficulties are more prevalent in this population than in the general public. Ogilvie (1999) used the Randolph Attachment Disorder Questionnaire (RADQ) as one of three instruments for determining the mental health status of 285 foster children in British Columbia. Scores on RADQs for 104 children were above the clinical cut-off score of 65 for the diagnosis of Reactive Attachment Disorder. Morgan (2004) used the RADQ in evaluating the prevalence of the diagnosis of Reactive Attachment Disorder in 100 children receiving services at a community mental health agency. Of the total mental health population reviewed ( $n = 662$ ) less than 1% of the children were diagnosed with Reactive Attachment Disorder; however 23% of the 100 children included in her study had RADQ scores over 65. Morgan attributed the low percentage of Reactive Attachment Disorder diagnoses to the lack of awareness and training regarding attachment disorders in the public mental health community. Of the eleven therapists interviewed in her study, only two had ever used the diagnosis.

The current understanding of Reactive Attachment Disorder did not appear in the *DSM* until the 1994 revision. The diagnosis is based on the parent-child relationship. According to the *DSM-IV-TR*, Reactive Attachment Disorder is

the psychological disturbance of the relationship between a child and his parent(s) or primary caregiver based on pathogenic care as evidenced by at least one 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, [and/or] (3) repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care). (American Psychiatric Association, 2000, p. 128)

It is characterized by

markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):

(1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)

(2) diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures) (American Psychiatric Association, 2000, p. 130).

In addition to the *DSM* diagnosis, checklists of behaviors that characterize children who have difficulty attaching to adoptive parents have been used by therapists and parents since Cline (1979b) first proposed the “signs and symptoms of lack of attachment” (p. 87) based on his observation of children seen in therapy. Although the lists have not been studied for validity, and go beyond the characteristics of the diagnosis described in the *DSM-IV-TR*, the descriptors are often recognized by adoptive parents who are struggling with behavior problems as being

representative of their children. These lists include lack of selective attachment, indiscriminate or superficial charm, inability to give or receive affection, lack of guilt, stealing, obvious lying, and angry, frustrated parents (Cline, 1979b; Hughes, 1998; Magid & McKelvey, 1987). Wimmer et al. (2003) found that several mothers in their study described similarities between their children and the lists of behaviors. The parents' statements indicated that they were relieved to find their children depicted so clearly, and that the checklists gave them hope that someone understood their family.

Many of the behaviors listed as characteristic of attachment disorder were first noted by Bowlby (1944a; 1944b) in his description of 14 young thieves, ages 5 to 13, whom he described as "Affectionless Characters" "who had apparently never since infancy shown normal affection to anyone... [and who] responded neither to kindness nor punishment" (1944a, p. 38). Bowlby stated the Affectionless Character

is capable of neither attachment, affection nor loyalty... [and] with very few exceptions these children have suffered the complete emotional loss of their mother or foster-mother during infancy and early childhood... It is my hope that these Affectionless Characters will be studied in great detail in the future, for I believe that they form the real hard core of the problem of recidivism... I am doubtful, however, whether the law-abiding Affectionless Character exists. He does not figure amongst my controls and I have not met him elsewhere, though I have met many other Affectionless thieves besides the fourteen described here. (p. 39)

Bowlby (1944a) included lack of "warmth of feeling for anyone" (p. 38), "the feeling of social frustration" (p. 38) produced in parents, "stealing" (p. 38), lying "more frequently and in a more

brazen way” (p. 38), “superficial geniality” (p. 39), and “shamelessness” (p. 42-43) in his description of Affectionless Characters.

#### Research on the Post-Adoption Needs of Families and Their Adopted Children

Recognition that families adopting children who have been abused or neglected are dealing with difficulties rooted in the child’s past has been in the professional literature for nearly 50 years. Kadushin (1970) studied 91 intact adoptive families who had adopted older children, ages 5 to 12, from Wisconsin’s public child welfare system between 1952 and 1962. Using record reviews, parent interviews with all families, and parent surveys, he found that only 58% percent of the mothers and 63% of the fathers described their experience as “extremely satisfying” and 14% of the mothers and 11% of the fathers indicated serious problems with the adoption. Kadushin’s families described some children who “needed reiterated and repeated assurance that the adoptive parents wanted them and loved them” (p. 187). Some children showed “shallow manifestations of affection... the children, as though starved for affection, sought it indiscriminately and constantly” (p. 186). Kadushin’s study can be viewed as the first wake-up call for post-adoption services.

The realization of the need for specialized services after adoption grew in the 1980s, as children with special needs became the focus of adoption services in both public agencies and publicly contracted private agencies. Research on the need for post-adoption services was based on the extensive early work of Festinger (1986) in New York City and that of Barth and Berry (1988) in California (cf. Barth, Berry, Carson, & Goodfield, 1986; Berry, 1989, 1990; Berry & Barth, 1990). These researchers brought the issue of adoption disruption to the attention of both the academic community and child welfare professionals. Festinger (1986) studied the disruption rate of a large sample of adopted children with special needs (all age 6 or older, 87.6% non-

White), and her work was disseminated by the Child Welfare League of America. She reported on 897 children, representing the adoptive placements of all of the public and private agencies in New York City in a 12-month period in 1983-1984. The disruption rate, overall, was between 12% and 14%; children who were adopted over the age of 11 had a rate between 16% and 19%. Importantly, Festinger was the first to conclude that more intense services were universally needed to improve adoption outcomes, and that services needed to be carried out by a consistent, well-trained caseworker who was able to provide accurate family assessments and early intervention.

Following Festinger's publication, further evidence of the need for specialized services to adoptive families was supported by the work of Barth and Berry (1988; Barth, Berry, Yoshikami, & Goodfield, 1988; Berry & Barth, 1990). Their study has been widely cited over the years and remains a landmark in describing the need for post-adoption services. They reported on the outcomes of children placed from the public child welfare system of 13 northern California counties and 2 private agencies from 1980 to 1984. Of the 926 children tracked, 831 (90%) had not disrupted and 95 (10%) were verified as disrupted or dissolved. Interviews were done with a purposeful sample of adoptive parents and/or caseworkers of 120 children, 47% of whom had disrupted and 53% who had intact adoptions. This sampling method allowed families whose adoptions had failed to have an equal voice with intact families, presenting extensive information on the difficulties some families faced in attaching to their adopted children. This study found considerable stressors that impacted these adoptive families. Most frequently mentioned was mismatched expectations in which the child had a "low capacity for attachment" (Barth & Berry, 1988, p. 49) and the adoptive parents expected "instant parenthood" (p. 49). Children's behavioral problems, attachment difficulties, and family financial stresses were also noted:

Children who disrupted were significantly different than nondisrupting children in the following ways. As expected, disrupting children were older when placed for adoption and had more emotional or behavior problems and had more often been adopted before. They exhibited behaviors of cruelty, fighting, threatening, arguing, disobedience, and vandalism and showed high scores on tests of aggression and delinquency. They were less likely to increase attachment behavior over time, specifically those regarding curiosity, showing affection, caring about parental approval, and satisfaction of need for attention. (p. 142)

The advocacy by Barth and Berry (1988) for trained, adoption-sensitive, therapeutic service providers had an impact on the growth of adoptive family preservation services. They described the need for social workers to know “how to help families with children who steal, run away, lie, set fires, eat peculiarly, and have difficulty executing the basic maneuvers of reciprocal interpersonal interaction related to attachment” (p. 143). Therapy received by families in the study was most often evaluated by the parents as being of little use. The study concluded that “Therapists who are knowledgeable about adoptions and family and behavior management are scarce and valuable gems” (p. 194). Both pre-placement preparation for adoptive parents and supportive services after adoption gradually became the accepted standard of quality services for families adopting children with special needs.

In the mid-1990s data were gathered that built the case for specialized therapeutic services for adoptive families. These studies were important in keeping the issue of post-adoption services in the forefront of professional thought. Groze, Rosenthal, and Morgan (Groze, 1996; Rosenthal & Groze, 1992; Rosenthal, Groze, & Morgan, 1996) conducted several studies of adoptive families with children from public welfare departments in Illinois, Kansas, and

Oklahoma. Of the families who adopted older children, 43% used individual therapy for the child and 32% used family therapy. Fewer than 40% of all the families who used therapy responded that these services were very helpful (Rosenthal & Groze, 1992). Only 68% of the families adopting older children listed the overall impact of adoption on the family as “very” or “mostly” positive, while 32% experienced significant stress. Parents’ statements relating to attachment difficulties included: “The barrier he puts up has been very difficult to accept. He has no desire to bond with us or accept our values” (p. 66) or as another put it “He don’t like his real mother and he don’t like me” (p. 66). Parents frequently had difficulty finding a therapist who understood adoption. The study found that adoptive families “often expressed frustration with counselors who utilize traditional family therapy methods with no recognition of the uniqueness of the adoptive experience” (p. 181). The authors concluded that “families face enormous challenges and strains in adopting a special-needs child” (p. 211), and they recommended “the implementation of comprehensive services prior to and following adoptive placement” (Rosenthal et al., 1996, p. 177).

In a study of intact special needs adoptions in Iowa between 1990 and 1993 Groze (1996) reported on family stress:

During the first year about 30% of the families thought the adoption had more ups and downs than they expected, and by the fourth year this had increased to 42%. Likewise, while about 78% of the respondents reported the adoption impact to be mostly or very positive, by the fourth year 69% still felt the same way. (p. 41)

Forty percent “agreed mildly or strongly that they would advise others not to adopt” (p. 41). This discouraging level of difficulty in parenting adopted children with special needs was also noted

by Brodzinsky, Smith, and Brodzinsky (1998). In reviewing developmental and clinical issues regarding older adopted children, they found that

Unfortunately, many adoptive parents find that techniques that work with other children do not seem to be effective with special needs children... [and] ongoing social services and support are essential factors in helping parents manage the challenges of special needs adoptive parenting. (p. 62)

Adding to the survey literature cited above, research with control groups began in the mid 1980s. McRoy, Grotevant, and Zurcher (1988) studied 50 adopted adolescents with severe emotional disabilities comparing them with a sample of 50 non-adopted children receiving similar services and a control group of 115 adopted children. They concluded that special attention should be given to “children who have been abused, neglected, given negative reinforcement, or are mistrusting of others” (p. 166), and that “social workers must dispel the belief of many adoptive families that love and a positive environment will resolve all problems and must provide counseling services to help families” (p. 166). Looking at children in the same decade, Brodzinsky, Radice, Huffman, and Merkler (1987) studied non-clinical samples of adopted and non-adopted children. They found that among children age 6 to 9 years old “adoptees consistently manifested a greater prevalence of psychopathology than did their non-adopted counterparts” (p. 352).

These studies from the 1980s and 1990s helped adoption advocates present the post-adoption needs of children and families to policy makers and funders at state and Federal levels. As the family preservation movement gained momentum, adoption family preservation was recognized as a necessary service.



A number of studies examining the factors influencing the success of adoptions have been published in recent years. These studies have attempted to inform the child welfare profession of children at highest risk of adoptive placement difficulties. McDonald, Propp, and Murphy (2001); Bird, Peterson, and Miller (2002); and Leung and Erich (2002) explored the adjustment described by parents after adoption. All three studies, reflecting a total of 375 families, found that difficulties in the adoption increased with the increased age of the children at the time of adoptive placement. Adjustment was also complicated by children's behavioral problems related to early childhood "nurturing experience [that] was inadequate, intermittent, or traumatically interrupted" (Bird et al., 2002, p. 218). In describing the services needed to promote stable adoptions, Leung and Erich stated that "having available support networks is essential to achieve adoptive family stability" (p. 813) and urged that adoption agencies provide extensive post-adoption services when risk factors are present. Reilly and Platz (2004), in a survey study of 373 adopted children with special needs in 249 families, found that counseling was the greatest unmet need, and "parents with unmet counseling needs reported significantly lower quality of relationships with their children" (p. 63) than other parents. Individual counseling for the child was needed by 52% of the families and counseling for the parents and/or family needed by 45%. Reilly and Platz stated that their findings "support the notion that adoption agencies need to have specific post-adoption positions available to work with families who adopt special needs children" (p. 64).

Although many quantitative studies identified the stressors felt by adoptive families and provided statistics on their needs, qualitative research provides an intimate picture of the adjustment of children with attachment difficulties in their adoptive families. A qualitative case study of three siblings, who were ages 6, 4, and 2 when therapy began, illustrates this point (Hart

& Thomas, 2000). The children had a history of neglect and physical abuse and removal from their birth parents two years prior to adoption. Overall, behaviors were described as “smearing feces, regression to the point of not walking, prolonged night terrors, [and] the persistent seeking of physical affection from total strangers” (p. 320). The oldest child had “a frequent inability to converse without demanding food, activities, etc. from the adoptive parents” (p. 318). The middle child was described as having “an intensive period of stealing and destructive behavior” (p. 317). In addition, his “disinhibited attachment behavior was severe. It threatened his personal safety, affected his interaction with his adoptive parents and sometimes made other people feel uncomfortable” (p. 317). At the age of 12 weeks the youngest child had been hospitalized for two months for severe failure to thrive. At age four after more than two years in the adoptive home she “could still not be in a room alone without screaming in terror” (p. 318). After three years of “long-term, open-ended” (p. 320) intervention the children’s symptoms had not disappeared.

Similar needs were found for some families adopting internationally, although, as with special needs adoption, most children were functioning well (Juffer & van Ijzendoorn, 2005). In their meta-analysis of internationally adopted children, Juffer and van Ijzendoorn discovered that international adoptees had more behavioral problems than non-adopted control groups. However, in general, families were satisfied with the outcomes of their international adoptions, and would not consider adoption dissolution. Groza (formerly Groze) and Ryan (2002) found that overall internationally adopted children from Romania and those adopted from the Iowa public child welfare system were similar in their adoptive adjustment. They described a “significant association of early traumatic and stressful experiences to children’s later [difficult] behavior” (p. 195). They stated that

Although children adopted domestically and internationally enter their families after experiencing different types of trauma, their behavior is more similar than different. The sources of stress are different but the consequences may be the same. It seems that... many of the services available and used by families who adopt domestically may be appropriate for families who adopt internationally. (p. 195)

Factors that were related to significantly poorer outcomes included orphanage placement for international adoptees and multiple forms of abuse for children adopted from the Iowa public welfare system.

Romanian adoptees in Britain and Canada showed similar outcomes to those in the Groza and Ryan study. British children adopted from Romania were followed by a combined British and Romanian research team (O'Connor et al., 2003; O'Connor, Rutter, & The English and Romanian Adoptees Study Team, 2000). The Romanian adoptees showed a significant correlation between length of time in an orphanage and the total number of attachment disturbance symptoms at age 6 years. Severe attachment disorder symptoms were detected in 7% of the children who were adopted under the age of 6 months, 21% of the children adopted between 6 and 24 months of age, and 31% of the children adopted between the ages of 24 and 42 months (O'Connor et al., 2000). In a study of 130 adoptees placed in Canada from Romania, Marcovitch and Cesaroni (1995) found that 59 had developmental delays and 32 had attachment difficulties. Their research also stated that "other difficulties frequently reported included clinging behavior, hyperactivity, fear of the dark, and indiscriminate approaches to strangers" (p. 1005). In a study addressing the attachment styles of 56 adoptees from Romania, Marcovitch et al. (1997) said that 3- to 5-year-old adopted children displayed a significantly lower score on secure attachment than a control group of non-adopted 4-year-olds.

Two qualitative case studies described the extreme difficulties faced by international adoptive parents when the children exhibit lack of attachment and oppositional behaviors. Jenny, a 4-year-old adopted at 6 months from a Russian orphanage, exhibited “during her 3rd year, defiance, noncompliance, and anger [that] occurred frequently” (Stein, Faber, Berger, & Kliman, 2004, p. S26) and at age four she was described as “aloof and often angry. She [had] been asked to leave every preschool and camp she attended because of nonstop talking, severe noncompliance, and unacceptable behaviors” (p. S26). Shapiro, Shapiro, and Paret (2001) described two toddlers adopted from Russia at approximately two years old who were both severely developmentally delayed. Nikki, at five, was described as

racing around the house, seemingly guided by an internal whirlwind. His parents rushed to follow Nikki to protect him from hurting himself in his random frantic behavior.... He had only minimal ability to modulate internal feelings of anxiety and fear.... Nighttime was especially difficult, and he fiercely protested being left alone... He resisted falling asleep even if his parents stayed with him.... He was hypervigilant and frightened of many things. (p. 405)

The case of Tanya and her adopted mother, Mrs. Smith, was described shortly before Tanya’s fifth birthday:

Mrs. Smith was over-whelmed by Tanya’s poor ability to communicate, her voracious hunger for food and attention, her habit of running away and needing to be caught, and her inability to adapt even to small changes without tantrums. She did not use her adoptive mother as a social reference point, and Mrs. Smith often worried because Tanya seemed fearless and was often in danger.... [Mrs. Smith] was hurt and puzzled by

Tanya's volatile behavior toward her, especially the rapid circular changes from love to rejection to being inconsolable. (p. 410)

These qualitative studies provide insight into the experiences of adoptive parents' living with children with attachment disorder, as well as a fuller understanding of the impact of the statistics that report difficulties in the adoptions.

Taken as a whole, the literature on the post-adoption experience of families presented a strong case for the development of specialized therapy for adopted children who experience attachment and behavioral difficulties. Adoptive families expressed this need in both quantitative and qualitative research.

#### Understanding and Treating Attachment Disorders

The current therapeutic attempts to help adopted children with attachment disorders are based on attachment theory as developed by Bowlby (1966; 1973; 1982; 1988) in the mid-twentieth century. Bowlby's work was done in response to a growing concern with the psychological needs of infants and young children in hospital and orphanage settings. His core concepts were that human infants, like those of many species, are born with a need to connect to and interact with a primary caregiver, usually the biological mother. The children's developing mental health is contingent on satisfactory nurturing from the primary caregiver during the first two years of life. Children develop skills in coping with and controlling their environments based on successful strategies in engaging their primary caregivers. Through these interactions they create an inner working model of their interpersonal relationships and self concept.

Attachment theory has approached the issue of mother-child relationships directly, stating that the poor quality of the mother's care directly results in the child's difficulties in forming future healthy attachments and in the resulting emotional deficits (Sroufe et al., 2005a). When

looking at adoption through the lens of attachment theory, the professional literature includes many anecdotal accounts of individual neglected or abused children who developed attachment disorders (cf. Colin, 1996, pp. 201-204; Hart & Thomas, 2000; Shapiro et al., 2001).

Bowlby put forth several major concepts in attachment theory. He believed the human infant is born with an innate need for interaction with one primary caregiver. This human relationship begins with social interaction that can be perceived at the beginning of life with the child's tendency to respond to the human face over all other objects, the gradual development of the reciprocal smile, and the development of a strong preference for the primary parent (usually the mother) by about age seven months. This interaction is necessary for the development of mental health. Bowlby's early work was greatly influenced by the work of James Robinson (Bowlby, 1973, 1982), and Anna Freud and Dorothy Burlingham (Bowlby, 1982; Freud & Burlingham, 1967) as they observed the depression of children separated from their mothers in England in the 1940s and 1950s. Robinson in his work with hospitalized children, and Freud and Burlingham with their interest in children evacuated during the World War II bombing of London, documented the deterioration of young children and the poor emotional, physical, and cognitive development that resulted from prolonged separation from their mothers.

According to Bowlby's (1982; 1988) theory, the relationship between infant and mother is common in most species and based on instinctual survival needs. It is controlled by both the mother and the child. Bowlby was influenced by the work of Charles Darwin and of ethologist Konrad Lorenz, who described the attachment between mother and child in many species and the behavior of both in reaching out to one another. From experiencing a system of interactive control, human infants develop an internal working model which guides their relationships with their mothers and forms a basis for psychological development. The human infant's innate need

for touch and consistent nurturing is separate from, and as important as, the need for food and warmth. The work of Harlow (Blum, 2002; Bowlby, 1982; Harlow, 1986) with rhesus monkeys presented evidence of the infant's need for nurturing, as the infant monkeys in Harlow's studies clung to their cloth mother for comfort in spite of its lack of food and the abuse received from it.

Ainsworth's (Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978) work continued to refine the concepts of attachment theory and to place the mother in the center of the child's developing attachment. This work was important in understanding the impact of early mothering on the later development of the attachment between the adoptive mother and her child. Both Ainsworth and Bowlby believed that the patterns of attachment that are dependent on the interaction between the infant and his mother fully develop in the first two years of life (Bowlby, 1966). This critical period is seldom an optimal time for healthy attachments in the environment of children who are adopted through the public child welfare system or through international adoption. Beyond the difficulties of abuse and neglect during this critical period, the longitudinal work of the Minnesota Mother-Child Study has shown that the early patterns of attachment have the potential to be consistent throughout the lifespan (Sroufe et al., 2005a).

The Strange Situation devised by Ainsworth (Ainsworth et al., 1978) in the 1960s has been used to classify children, at about the age of 18 months, into styles of attachment which are either secure or insecure. Insecurely attached children were categorized by Ainsworth in two behavioral patterns: "ambivalent" and "avoidant." Securely attached children used their mothers as a comfortable base for exploration. Insecurely attached children had different behaviors. Upon brief separations from their mothers and subsequent reunions, ambivalent children resisted warming up to their mothers on reunion but reached out for them at the same time, and avoidant children did not respond to the returning mothers. These categories still are used as a basis for

describing the attachment patterns of children. Karen (1998) painted a picture of an avoidant and an ambivalent child in relation to the attempt of an adoptive mother to form a relationship:

The avoidant child doesn't want to be tempted to open himself to hope or trust when he's worked so hard to close himself down and when so much is at stake in terms of the agony of renewed rejection.... The ambivalent child, meanwhile, whose care has been inconsistent or chaotic, cannot believe that a caring gesture is any more than a passing fancy. So he is likely to keep testing and testing, keep mixing clinging with hostility and unreasonable demands. (p. 227)

Further work by Solomon and George (1999) identified a third category of insecurely attached children, describing those who had been labeled "unclassified" in the Ainsworth studies and labeling them "disorganized." Disorganized children respond with fear or confusion when reunited with their mother in the Strange Situation. Disorganized children are described as missing a "coherent attachment strategy" (p. xiv) in relation to their mothers, and lack the ability to use their mother as a safe haven for exploring the world and developing their own sense of safety. These children are more likely than those with other attachment patterns to have been abused and to exhibit Reactive Attachment Disorder (Solomon & George).

A child's temperament and a history of inadequate parenting both play a role in the inability to reciprocate in a loving relationship with the mother. The outcome is a child who has created an internal working model that rejects the mother's love. This constant rejection of love can create a cycle of action and reaction that promotes further distance between the child and mother. Karen (1998) concluded,

The behavior of the insecurely attached child – whether aggressive or cloying, all puffed up or easily deflated – often tries the patience of peers and adults alike. It elicits reactions



that repeatedly reconfirm the child's distorted view of the world. People will never love me. (p. 228)

Although Bowlby's interest in attachment theory was influenced by children with limited environmental opportunities for healthy attachment, research in the 1970s and 1980s was more concerned with attachment in family settings. Major longitudinal studies of attachment have been carried out since the 1970s, some of which are still ongoing. Grossmann, Grossmann and Waters (2005) presented a review of seven longitudinal studies, and they confirmed that early attachment patterns have an influence on later adjustment but that intervening life experiences also play a critical role.

The most extensive of the longitudinal studies is the Minnesota Mother-Child Study which was spearheaded by Sroufe and Egeland (Grossmann et al., 2005; Sroufe et al., 2005a; Sroufe, Egeland, Carlson, & Collins, 2005b). The study began with 267 high-risk expectant mothers in 1974 and has 180 subjects after 30 years. The Minnesota study looked at attachment issues from the pre-natal period up to the development of adult relationships and parenthood. The study has much detailed information to share about each stage of human development. For infants and toddlers, the "longitudinal data affirmed Bowlby's (1969/1982) hypothesis that differences in quality of care lead to differences in quality of attachment" (Sroufe et al., 2005a, p. 97). As the children grew older, success in peer relationships, school adaptation, and behavior became areas of study. Early maltreatment

affected core adaptational issues at each age... [and] our assessments of abuse history in the preschool years were indeed consistently related to adolescent behavior problems... and predicted the likelihood of some psychiatric treatment. Every form of maltreatment

was related to delinquency, with a history of psychological unavailability being the strongest predictor. (p. 189)

Sroufe and colleagues concluded “the earliest robust markers of pathogenic experience or of maladaptive developmental pathways lie in infant-caregiver relationship” (p. 285). The children who enter adoptive families from backgrounds of abuse and neglect have experienced the mistreatment that predicts these maladaptive pathways.

Although the study of patterns and outcomes of attachment has been the subject of research, little has been done to evaluate treatment that might impact the trajectory of children who have developed insecure attachments early in life. As noted, many adopted children have had experiences that produce a high probability of development of insecure attachments.

Adoption has long been claimed as a service of the social work profession, and with the advent of clinical licensure for social workers the field of mental health counseling has also become a core of the profession. However, the ability to help children and families who are dealing with severe emotional disturbance after adoption continues to be an area in which evidence-based best practice is still evolving. The family preservation services movement has included many helpful services to post-adoptive families such as supportive counseling and respite care, but finding intensive mental health intervention that can meet the needs of adopted children has been an ongoing problem (Wilson, 1992). Wimmer et al. (2003) reported in their study of attachment therapy that “most families discussed previous unsuccessful therapy experienced in their search for help for their child and family. Their experiences could be summed up in one father’s statement: ‘We wasted years with bad therapists’” (p. 28).

Social workers now understand the psychosocial dynamics and the importance of attachment, but there still remains limited knowledge of effective treatment for adopted children

who have attachment disorders. Little research has been done on attachment therapy, and the therapy is available in only a few locations across the United States. In 2003 the journal *Attachment & Human Development* devoted an issue to varying points of view on the diagnosis and treatment of Reactive Attachment Disorder. In summarizing the research, O'Connor and Zeanah (2003a) stated that there are no "established clinical guidelines for treatment or management" (p. 241) of disorders of attachment and that "no treatment method has been shown to be effective." (p. 233). In the same issue Nilsen (2003) added that children being placed for foster care and adoption are not routinely evaluated in regard to their ability to attach to parental figures. An exhaustive examination of peer-reviewed literature reveals that the only data-based research published on attachment therapy is the work of Myeroff, Mertlich, and Gross (1999), which looked at holding therapy as practiced in the mid-1990s. This study had an inadequately small sample size (11 children in the treatment posttest group and 9 in the no-treatment comparison group), an unexplained but purposeful exclusion from the sample of over 50% of the children receiving therapy in the setting of the study, and no comparison group receiving another treatment modality (Myeroff et al., 1999; Saunders, Berliner, & Hanson, 2004). Thus, the report gave no valid information on the benefit of therapy. O'Connor and Zeanah (2003a) believed that individuals engaged in holding therapy have taken on the difficult task of treating children with very severe disturbances of the kind described by the attachment disorder concept – the same kinds of children and families that are often unfortunately neglected, avoided, and misunderstood by many clinicians.... [Attachment therapists] are among the few who have sought to develop treatments for children and families who are provided few options and little reason for optimism from other clinicians. ... [However,]

rigorous clinical research is needed before this treatment is proposed as a clinical tool. (p. 238)

The need for the current study, and others exploring attachment therapy, is supported by this lack of published research.

Reviews of research on treatment best suited for children who have been exposed to physical and sexual abuse have been conducted by Hensler, Wilson, and Sadler (2004) and by Saunders, Berliner, and Hason (2004). Although these reviews did not specifically address the issues of attachment difficulties, they focused on a group of children who are at risk of Reactive Attachment Disorder. Three best practice methods were identified by Hensler et al. which primarily use a cognitive behavioral approach to therapy. Saunders et al. stated that “the theoretical foundation of one protocol [attachment therapy] was considered questionable and unacceptable” (p. 99) and “the protocol was judged to carry a significant risk for causing psychological and physical harm to children” (p. 103). Although attachment therapy is rejected in these reports as a recommended approach to treatment, there is overlap in some of the techniques used in attachment therapy and cognitive-behavioral therapy, specifically “reframing consisting of exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the abusive experience(s)” (Hensler et al.), psychoeducation with parents about child abuse and parenting techniques, and enhanced family communication (J. Turber, personal communication, April 8, 2006).

#### Practice Literature on Treatment of Attachment Disorders

Attachment therapy developed in response to the needs of the families who struggled with difficulties creating reciprocal attachments with their adopted children, regardless of whether or not mental health professionals had diagnosed the children with Reactive Attachment

Disorder. Attachment therapy was a new field in the 1980s, and it has slowly spread and changed over the past 25 years (Delaney, 1998; Hughes, 1998). In spite of the fact that most adoptive parents report satisfaction with their adoption outcomes, the extremely difficult situations faced by some parents led them to search for therapy. Thus, it is not surprising that a cadre of therapists developed interventions to treat these children.

A stream of literature since 1979 has been directed towards therapists and parents, in contrast to the academic research literature. These writings began with the series *What Shall We Do With This Kid?* written by Foster Cline (1979a; 1979b). In *Understanding and Treating the Severely Disturbed Child* (1979b) Cline discussed the severely unattached children that he was seeing in his clinical practice in Evergreen, Colorado. Describing them as like “onions,” without the core of conscience development and empathy that the emotionally healthier children exhibited (whom he posed as analogous to apples), Cline discussed the difficulties in using conventional psychotherapy with these children and proposed the model of rage reduction therapy as an intervention. His description of children with attachment difficulties preceded the *DSM* inclusion of the category of Reactive Attachment Disorder and included a list of behavioral indicators of poor attachment. Several authors and lecturers, including Fahlberg (1991), simplified Bowlby’s theory and made it accessible to caseworkers dealing with adoptive children. The diagram of “The Arousal-Relaxation Cycle” which demonstrated “a typical successful care-providing interaction between parent and child” (p. 33) was frequently presented as a model of the formation of early attachment. Cline was a prolific and engaging public speaker, and his attention to adopted children with attachment difficulties eventually led, in 1989, to the formation of the national advocacy/professional organization Association for Treatment and Training in the Attachment of Children (ATTACH).

Books that followed Cline's first series brought attention to the needs of children with attachment disorders, and to the desperation sometimes felt by their parents in their search for helpful therapy. Two were especially provocative and disturbing. The first of these was *High Risk: Children Without a Conscience* (Magid & McKelvey, 1987) which described children who murder and adult mass-murders in conjunction with childhood neglect and abuse. The second was *Conscienceless Acts: Societal Mayhem* (Cline, 1995) in which Cline interwove a discussion of society's increased violence, attachment difficulties, and rage reduction holding therapy. In the mid to late 1990s, a number of books appeared that discussed the attachment difficulties of adopted and foster children and possible therapeutic interventions to be used with them (Cline & Holding, 1999; Delaney, 1998; Delaney & Kunstal, 1997; Hughes, 1998; Keck & Kupecky, 1995; Levy & Orlans, 1998; McKelvey, 1995).

The practice-based literature and the related lectures and trainings have been both helpful and problematic to the developing area of therapy for children with attachment difficulties. Descriptions of the content of attachment therapy are varied and unclear. In part, the resulting lack of a clear treatment modality is in response to the continuing evolution of the practice of attachment therapy. The variety of treatment styles appears to also represent varied therapeutic approaches based on the training, experiences, and temperaments of the therapists who are writing.

Between 2003 and 2005 the American Professional Society on the Abuse of Children (APSAC) convened a task force to review attachment therapy in response to the 2001 death of Candace Newmaker, an 11-year-old girl in treatment for Reactive Attachment Disorder. Candace was smothered in a therapy session using pillows and a sheet in a technique called rebirthing. Critics of attachment therapy stated that it "may present a physical risk to the child" (Chaffin et

al., 2006, p. 84), and two techniques were condemned as dangerous: age regression and holding. Proponents of the therapy argued “the techniques present no physical risk to the child, parents, or therapist .... [and that] critics are misrepresenting what attachment therapy actually involves” (p. 84). The Task Force report concluded that there is a “separation between the worlds of attachment therapy and mainstream clinical science ...[and] that the ultimate benefit of children will be best served by increased dialogue and information sharing between child abuse professionals, scientific researchers, and the attachment therapy community” (Chaffin et al., 2006, pp. 85-86).

The death of Candace Newmaker was highly publicized and popularized (Rosa, 2006, n.d.). Rebirthing was characterized as attachment therapy in a book by Mercer, Sarner and Rosa (2003); however, it is not a technique used by reputable attachment therapists. In response to this publicity, ATTACH created a position statement that included “ATTACH opposes abuse in any form at any time. ATTACH opposes any intervention or activity that endangers a person’s physical or emotional wellbeing” (Association for Treatment and Training in the Attachment of Children, 2003).

Another source of confusion for therapists and parents seeking information about attachment therapy is the Internet. Most Internet information is not grounded in research, and few, if any, Internet reports would pass the scrutiny given to peer-reviewed professional literature. However, both support and warnings regarding attachment therapy can be found. Much of the information that presents attachment therapy as a dangerous practice is the work of Rosa (2006), a co-author of *Attachment Therapy on Trial* (Mercer et al., 2003) and creator of several web sites that refer to attachment therapy as “abusive” and “violent”. Similarly, there are

web sites that report without empirical support that attachment therapy is the only solution for children with attachment difficulties (Thomas, 2006).

The evolving components of attachment therapy present an additional area of complexity for practitioners and families. Practices such as coercive holding therapy and the descriptions of rage reduction therapy put forth by Cline are no longer in the mainstream of attachment therapy (Hughes, 1998, 2003). Therapy is conceptualized and practiced as family therapy, and when holding is used it is done with the child's consent and usually done by the parents rather than therapists (J. Atkinson, personal communication, November 1, 2005). Controversies have grown out of the history of attachment therapy and out of the tragedies of some children and parents who unsuccessfully dealt with attachment disorder. These controversies emphasize the need for further research on the practices, outcomes, and experiences of those who are involved in attachment therapy.

#### The Program of Attachment Therapy for Adopted Children in Georgia

*A Program Evaluation of Attachment Therapy Provided to Adopted Children with Special Needs* (Wimmer et al., 2003) that was written between August and December 2003 served as the point of departure for this study. The introduction to the program evaluation stated:

The Office of Adoptions recognized the need for intensive therapy for a limited number of adopted children who were diagnosed with Reactive Attachment Disorder, *DSM-IV-TR* 313.89 (American Psychiatric Association, 2000). These children have difficulty bonding to their adoptive families and have developed maladaptive behaviors and social interactions. Traditional psychotherapeutic interventions have proven largely ineffective for children with this disorder. The Office of Adoptions stated in its Request for Proposals: "Effective treatment for children with an attachment disorder includes a



combination of therapeutic techniques that recreate the bonding cycle between parent and child and teach parenting interventions especially helpful for children with Reactive Attachment Disorder.” With this background, the Office of Adoptions sought to create a therapeutic program that would treat these children and their families. (Wimmer et al., 2003, p. 1)

The Georgia Department of Human Resources Office of Adoptions provided funding for three years to train therapists, develop community education, and provide attachment therapy. The Attachment Network of Georgia, a non-profit organization spearheaded by adoptive parents, received the grant and managed the program from 2000 to 2003.

Licensed Georgia therapists were trained by the Attachment Center of South Carolina at Children Unlimited, Inc. in an intensive program which presented up-to-date techniques in attachment therapy. The therapists attended weekend training sessions monthly for nine months, culminating the training with attendance at the national conference of ATTACH. The training was described as follows:

Participants will learn how to apply tools and techniques to the diagnosis and treatment of children with attachment and bonding problems. These include: Assessment, Parenting Tools and Strategies, Eye Movement Desensitization and Reprocessing (EMDR), Theraplay, Narrative Therapy, Psychodrama, Regression Therapy, [and] Therapeutic Contract. (Wimmer et al., 2003, p. 5)

Twelve nationally recognized therapists working in the area of attachment provided the sessions, followed by additional training in EMDR and neurofeedback. The therapists worked in teams of two to provide attachment therapy from the completion of their training in October 2001 until June 30, 2003, at which time the grant funding ended.

The therapy consisted of family assessment and treatment focused on the trauma of abuse and neglect and the engagement of the child and parents. All families began treatment with an assessment using standardized tests (Child and Adolescent Functional Assessment Scale, Beck Depression Inventory, Randolph Attachment Disorder Questionnaire, and House-Tree-Person Drawings), a summary of a typical day with the child written by the parents, a review of previous therapy notes, and an extensive Request for Assessment form which included family composition, current medical information, and summaries of previous treatment and diagnoses. All parents were interviewed without the children as well as in a family session. All parents received extensive psycho-educational counseling regarding the effects of abuse and neglect and parenting techniques, using the *Parenting With Love and Logic* model (Cline & Fay, 1990).

Therapists used an intensive series of sessions, often meeting for 2 to 3 hours at a time, in which the children's emotions were aroused and the parents assisted providing attuned empathy to help the children recognize the emotional attachment possible in the new family. Narrative therapy which involved age regression was used, in which the therapists guided the parents in telling the children that they would have been protected and cherished in their adoptive home if they had experienced their infancy there. Narratives often continued beyond the children's current age to engage the children and parents in imagining continued growth and emotional health for the children in the future. Psychodrama created the experience of the children's past abuse as perceived by the children and allowed them and their parents to express their anger at the abuser. This was designed to empower the children to confront the abusers and have a different resolution in the safe and supportive environment of the therapy. Touch was part of the therapy process. In approximately half of the cases EMDR was used to reduce the arousal experienced with traumatic memories. During the last six months of the program, when

computer equipment became available, approximately one-third of the children participated in neurofeedback using individually designed programs. The goal of therapy was the attachment between children and their adoptive parents, and the parents were active in sessions.

The fidelity of the treatment modality could not be determined from the original program evaluation nor from the current follow-up study. Therapy was not directly observed. Holding was described by parents as a procedure in which a parent or therapist, sitting on a sofa, cradled the child while the other parent or therapist rested the child's legs across their lap. At times holding was depicted as a calm and nurturing experience, and at other times the child was portrayed as emotionally and physically volatile and holding became a physically strenuous procedure. Psychodrama, sometimes referred to as role-playing, usually involved the child's age regression into infancy or confrontation with the abusive or neglectful parents. Sometimes the child was rocked like an infant during role-playing, and in some cases they were given a baby bottle. EMDR used eye movement or tapping the child's legs moving from side to side in a regular rhythm while discussing traumatic events with the child. Neurofeedback used a diagnostic, computer generated, quantitative EEG produced by electrodes placed on the child's scalp to indicate electrical impulses reflecting brain activity. Neurological biofeedback was then prescribed for each child using a specifically designed computer game as the intervention. The intensity of use and impact of EMDR and neurofeedback interventions varied widely from family to family. Beyond these descriptions of therapy, the protocols used or how therapy varied from child to child could not be defined.

Therapy was designed to be short term, with a two-week or weekend intensive period of therapy offered in cases where parents could be available, or weekly or bi-weekly sessions. Many families had to travel in excess of two hours to attend therapy. Three months was the

average length of therapy, and most families considered occasional follow-up sessions helpful. However, the discontinuation of State funding in June 2003 left more than three-quarters of the families at an incomplete stage of therapy, and the extent to which these families continued therapy remained to be discovered in the current study.

Both the parents and children were fully informed participants, and contracted with the therapists to engage in therapy. The intervention was designed to be respectful of the child and parents, and did not use techniques promoted in the 1980s which involved shame, anger, and physical intrusiveness. All of the children had been independently diagnosed with Reactive Attachment Disorder before being accepted in the program for services, and approximately 30% of the children had comorbid diagnoses including Attention Deficit Hyperactivity Disorder, Fetal Alcohol Syndrome, and Tourette's Disorder. Approximately 80% had been previously diagnosed with other psychological disabilities, most commonly Oppositional Defiant Disorder or Adjustment Disorders.

The program evaluation was a mixed methods study that reported on 35 children in 23 families. Interviews or focus groups were held with 24 parents, of which 16 were mothers. These mothers were the participants in this follow-up study. The program evaluation found that "based on statistically significant outcomes, and perceptions of parents and therapists, this program was successful in improving the permanency and wellbeing of adopted children with special needs" (Wimmer et al., 2003, p. i).

### Conclusion

Research on the experiences and outcomes of attachment therapy is lacking in the literature. Although the theories of Bowlby and Ainsworth are well documented, Bowlby's hope that research would focus on children with attachment difficulties, the children he called

“Affectionless Characters,” has not come to fruition (Bowlby, 1944a, 1944b). Longitudinal studies of styles of attachment between mothers and children have revealed the ongoing consequences of abuse and neglect, but therapeutic interventions for individual children and families have not been included in these studies (Grossmann et al., 2005; Sroufe et al., 2005a). Peer-reviewed articles appeared in professional journals in the 1980s and 1990s discussing the difficulties of families who adopted children with special needs, but nothing was published describing successful therapeutic techniques for helping these children. The literature that focused on the treatment of children with attachment difficulties lacked an empirical base, with neither well-researched quantitative nor qualitative studies. Although a program evaluation was completed on the Georgia program of attachment therapy, many of the families had not completed therapy when the program’s funding ended (Wimmer et al., 2003), and thus the outcomes of therapy were tentative. Additionally, no long-term outcomes of therapy were measured.

This dissertation addressed the problem that there was no published research from the perspective of the mothers focused on the experiences of those who have been involved in attachment therapy. To fill this gap in the literature, the current study built on the research begun in 2003, *A Program Evaluation of Attachment Therapy Provided to Adopted Children with Special Needs* (Wimmer et al., 2003). Because mothers often are the parent most impacted by attachment difficulties of their adopted children, the mothers from the original study were chosen as participants in this research. The purpose of the study was to explore mothers’ experiences of attachment therapy as related to their current relationships with their adopted children. Particular attention was paid to the long-term effects of therapy on current family functioning. The

participants were mothers who were part of individual or couple interviews or focus groups in the 2003 study.

The research questions which guided this study were:

1. What was the experience of attachment therapy for the participants?
2. How did the participants view their current relationship with their adopted child?
3. What were the participants' perceptions of the role attachment therapy played in their current level of functioning?

## CHAPTER 3

### METHODOLOGY

The current study addressed the problem that there was no published research from the perspectives of mothers who have participated in attachment therapy. The purpose of this qualitative study was to explore mothers' experiences of attachment therapy as related to their current relationships with their adopted children. The study was a 3-year follow-up of a population of 16 mothers who originally participated in interviews or focus groups in late 2003. The mothers had been interviewed as a part of the program evaluation of attachment therapy which was provided to adopted children with special needs through a grant from the Georgia State Office of Adoptions. This chapter includes the description of the methodological perspective, methods used and rationale for their use, relation to the original study (described at the end of Chapter 2), data analysis, validity and reliability, and my personal biases.

The research questions that guided this study were as follows:

1. What was the experience of attachment therapy for the participants?
2. How did the participants view their current relationship with their adopted child?
3. What were the participants' perceptions of the role attachment therapy played in their current level of functioning?

A qualitative approach to research was chosen to gain an in-depth understanding of the mothers' perceptions of attachment therapy. Mothers were the focus of the study because they have been identified as the parent most impacted by their children's lack of attachment (Hughes,

1999; Keck & Kupecky, 1995). The goals of this research were to understand the experience of therapy and to describe its impact on the mothers' relationships with their adopted children. Thus, a qualitative rather than quantitative method was chosen to best meet the goals. My interest was in exploring therapy from the point of view of the mothers who had participated in it rather than to quantify the outcomes of therapy through the use of pre and post tests on the children. There is a scarcity of research on attachment therapy and none on the actual experiences of parents who have taken part in it. As early as Bowlby's (1944b) work in the mid-1940s, the impact of attachment difficulties on parents was noted. However, no studies on the treatment of attachment disorder have been conducted which give mothers an opportunity to have their voices heard.

The mothers and children presented a diverse population for study. Family composition varied, with 5 single mothers in the total population of 16, and children ranging in age from 8 to 18. Both Black and White mothers were included as well as families from varied socio-economic levels. Family size ranged from only children of single parents to a family of nine. The size and diversity of the population provided the opportunity to obtain rich data through qualitative inquiry.

This research was a confidential study that used semi-structured interviews, artifacts, and my own reflective journal as methods of data collection. University of Georgia Institutional Review Board approval was received for this study on February 5, 2006. Informed consent was obtained from all participants. All written and oral presentations used pseudonyms for families and children, and care has been taken to disguise identifying information. No children were interviewed.



### Description of Methodological Perspective

This dissertation was a qualitative study that described the lived experiences of a group of individuals with depth and complexity rather than quantifying the experience. In describing the literature on qualitative research, Creswell (1998) stated that “the researcher builds a complex, holistic picture, analyzes words, [and] reports detailed views of informants” (p. 15). This study used inductive analysis of data collected primarily through interviews with a small group of adoptive mothers. Interviews took place in the participants’ homes or another location deemed convenient by them. Ten of the 16 participants provided artifacts, such as family pictures and mementoes, and journal notes were made by me after each interview; these artifacts and notes added depth and triangulation to the data. Information provided by each of the participants revealed the mothers’ perceptions of their relationships with their adopted children. As themes emerged, I kept in mind Bogdan and Biklen’s (2007) statement that “it is multiple realities rather than a single reality that concern the qualitative researcher” (p. 30).

Crotty (1998) described the discussion of methods and methodology as “something that reaches into the assumptions about reality that we bring to our work” (p. 2). He listed four questions that are “basic elements of any research process” (p. 2):

- “What *methods* do we propose to use?
- What *methodology* governs our choice and use of methods?
- What *theoretical perspective* lies behind the methodology in question?
- What *epistemology* informs this theoretical perspective?” (p. 2, emphasis in original)

For purposes of clarifying the design of my study, I address these issues here in the opposite order: epistemology, theoretical perspective, methodology, and methods.

My research was approached from a social constructionist epistemology. According to Merriam (2002) “a central characteristic of qualitative research is that individuals construct reality in interaction with their social worlds” (p. 37). The mothers in this study were immersed in many social worlds, and this study focused on the world co-created by them and their adopted child. Crotty (1998) stated: “what constructionism claims is that meanings are constructed by human beings as they engage with the world they are interpreting” (p. 43). That is, “we do not create meaning. We construct meaning. We have something to work with. What we have to work with is the world and the objects in the world” (p. 44). I looked at the reality that has been constructed within the interrelatedness of the mothers, the children, and the experience of attachment therapy. We each bring our personal lens to the world and interpret its meaning individually, and this study attempted to understand the lenses and interpretations of the participants who were interviewed. As a social constructivist I was interested in exploring and representing “subjective and intersubjective social knowledge and the active construction and co-creation of such knowledge by human agents that is produced by human consciousness” (Guba & Lincoln, 2005, p. 203). My own lens, my “human consciousness,” also played a role in the construction of this knowledge in multiple ways as I approached this study, chose participants, engaged in conversation, included and rejected themes, chose what was important to report, and presented the findings using the voices of the participants. Much of our construction of knowledge is unconscious, but in the description of researcher biases later in this section I attempt to inform the reader of my personal lens.

Further explaining my approach to qualitative inquiry, within the constructionist epistemology, I used the theoretical framework of symbolic interaction. Crotty (1998) described the world-view of symbolic interaction as “a world of intersubjectivity, interaction, community

and communication, in and out of which we come to be persons and to live as persons” (p. 63). This framework synchronizes with exploring the experience of attaching to a child, and the influence of attachment therapy on that experience. Bonding to another human being involves both internal personal experience and the reciprocal emotional engagement of both people. Attachment therapy is family focused, and in the therapy settings used by this population the parents, child, and a team of two co-therapists all influenced the process. The research question “What was the experience of attachment therapy for the participants?” aims to reflect the meaning made of these multiple interactions. In addition, the experience of sharing the memories and feelings associated with therapy was influenced by the interaction of each mother and myself as researcher. Merriam (2002) stated that “the meaning of an experience is constructed by an individual interacting with other people” (p. 37). It was my goal to produce an understanding of the multiple interactions and the resulting reality as it existed for the participants at the moment in time that they were interviewed and within the context of the interview.

The methodology of this research is what Merriam (2002) called a basic interpretive qualitative study. She wrote:

Qualitative researchers conducting a basic interpretive study would be interested in (1) how people interpret their experiences, (2) how they construct their worlds, and (3) what meaning they attribute to their experiences. The overall purpose is to *understand* how people make sense of their lives and their experiences. (p. 38, emphasis in original)

The basic interpretive study is the most frequently used type of qualitative research.

The methods of data collection that I used in this study were individual interviews with each participant as well as artifacts provided by some mothers and my journal which contained my impressions of the participants. The mother’s perception of her current relationship with her

child was this study's focus because of the nature of attachment difficulties in the adoption of a child with Reactive Attachment Disorder. The mother-child bond is the connection most difficult to establish in these adoptions. A child who has experienced neglect and abuse at the hands of the birth mother often lacks the trust to establish an intimate relationship with the adoptive mother. As one mother in the study conducted by Wimmer, Simmons and Dews (2003) phrased this, "their mom was the one who abandoned them so the new mom takes all the blame" (p. B-13). Thus, interviews with the mothers most clearly reflected the progress that the child has made in attaching. The following section describes the methods in detail.

### Methods

Three methods of data collection are typically used in qualitative research: interviews, field observations, and artifacts. In this study interviews and artifacts were used, supplemented by my reflective journal with brief field notes. The use of more than one method increases the data and enhances the internal validity of the findings. The primary strategy for data collection was individual interviews which took place in April, May and June 2006. Interviews were chosen because "good interviews produce rich data filled with words that reveal the respondents' perspectives" (Bogdan & Biklen, 2007, p. 104). The subject of this research was mothers' personal, self-constructed experience. Individual interviews provided the most efficient and thorough access to this information.

Creswell (1998) described seven "series of steps" (p. 123) for interviewing. First was "identifying interviewees" (p. 123). I interviewed the population of 16 mothers whose input made up the data in the original program evaluation in 2003. I located the participants using the research records from the original study. Only two families had moved, and both were located through U.S. Postal Service mail forwarding. I contacted each mother with an introductory letter

and then by telephone, and explained the purpose and process of the study. At that point I asked the mother to participate and, upon agreement, arranged an appointment for the interview. All 16 mothers agreed to participate, and I conducted interviews with all of them.

The second step was to determine the “type of interview” (Creswell, 1998, p. 124). Although both focus groups and individual interviews were used in the initial program evaluation, face-to-face individual interviews were chosen for this study so that each participant had time to reflect on her experiences and express thoughts and emotions relating to her relationship with her child or children. Each interview lasted approximately 90 minutes. Although families were located throughout Georgia, I traveled to interview each mother on a schedule that accommodated her.

Next in my consideration was to “determine the place for conducting the interview” (Creswell, 1998, p. 124). In this study all interviews were held in a place that was convenient for the participant. Nine interviews were carried out in the participants’ homes, two in restaurants, two in a motel suite, one in the mother’s place of work, one at the child’s physical therapy setting at a recreational center, and one at my home. Interviews were scheduled at a time when privacy from the children in the family was assured and in all but three cases they were conducted in a quiet environment that permitted quality audio recording. I had a preference for interviewing in the mother’s home to increase the probability that artifacts relating to the attachment between mother and child would be shared with me in this setting. This preference proved to be valuable; only one of the participants who was interviewed outside her home brought artifacts to the interview, but all nine mothers interviewed at home produced a wide range of pictures and documents.

Creswell (1998) described two steps related to preparing for the interview process. One was to “use adequate recording procedures” (p. 124). I recorded the interviews on a digital recorder and a back-up tape recorder with a lapel microphone. I checked the voice recording in the setting at the beginning of the interview and once during the interview process when the rhythm of the conversation permitted this interruption.

I transcribed three of the first five interviews and used a professional transcription service for the remaining 13 interviews. I downloaded the data as voice files and electronically transmitted them to the transcription service immediately after each interview. They were returned electronically as typed transcripts. All transcriptions were verbatim including pauses and affect (such as crying or laughter). I reviewed all of the tapes that I did not transcribe by reading the transcripts while listening to the tape and making additions or corrections when needed. Only three tapes needed more than five corrections: one recorded outside, one in a restaurant, and one in a recreation center. As analysis of the interviews began, I used pseudonyms for every family and adopted child. Electronic versions of the interviews were stored both as files with the actual family name and the pseudonym on the hard drive and the portable file of my computer, and paper copies were filed in my dissertation notebook using the actual names. Paper and photograph artifacts were also stored in the notebook under each family’s name. Back-up tapes, my journal, and a video tape given to me as an artifact were stored in my private home office.

The other step related to interview preparation was to “design the interview protocol” (Creswell, 1998, p. 124). The interviews used a semi-structured format (Appendix A) with six questions and follow-up probes to guide the interview and cover the content of the three research questions. The semi-structured design allowed for flexibility, probes, and diversions in order to

keep “the goal of understanding how the person you are interviewing thinks ... at the center of the interview” (Bogdan & Biklen, 2007, p. 106). The setting of a home visit expanded the possibilities for inclusion of information related to observation and artifacts in the setting. Thus, each interview varied in the approach to gaining information about the current mother-child relationship. Bogdan and Biklen stated, “The researcher must always be prepared to let go of the plan and jump on the opportunities the interview situation presents” (p. 106) in order to get the most complete data. In order to assure the continued focus of the interviews on the research questions throughout the 16 interviews, a doctoral student peer who was familiar with my purpose and research questions reviewed the transcripts of the first 12 interviews.

Creswell’s (1998) final two steps relate to conducting the interview. The first of these within the interview context was to “obtain consent from the interviewee to participate in the study” (p. 124). At the time of the telephone contact, verbal agreement was required in order to schedule an appointment for the interview. Each mother read, discussed, and signed a written informed consent form (Appendix B) for participation in the research before the interview began. Creswell’s last step served as a summary of good interview technique: “stick to the questions, complete within the time specified (if possible), be respectful and courteous, and offer few questions and advice” (p. 125). My previous interview experience in research projects during the past three years and my general interviewing skills developed over many years as a social worker provided the knowledge and ability to perform this step successfully. Because of the emotional content of the interviews, I also prepared a debriefing protocol that included the names and contact information for several therapists specializing in attachment therapy who had agreed to follow up with any families in distress. I shared this information at the conclusion of one interview in which the mother’s anguish was evident to me.

In conjunction with the data collected through interviews, artifacts were also used in this study. In qualitative research “the range of what can count as useful data, and of ways of collecting them, is very wide indeed” (Punch, 1998, p. 148). Participants were told over the telephone when the interview was scheduled that I would be interested in seeing anything that they wished to share with me that reflected their relationship with their child and/or with attachment therapy. I suggested these might include pictures, children’s artwork, documents created by the therapists, or other items. One of the concluding interview questions was “Is there anything that you would like to show me that in some way represents what we have been talking about?” The home setting provided easy access to such artifacts. Photographs were taken of most artifacts, with darkened photocopies or blurred reproductions kept as data when people (such as husbands and children in family pictures) included in the photograph were not approached for their consent to use the data. Patton (2002) and Bogdan and Biklen (2007) recommended photography as a tool in their discussions of data collection strategies, and Patton stated, “Cameras have become standard accessories in fieldwork. Photographs can help in recalling things” (p. 308). Photographs displayed data in three ways: the subject of the picture, the subjectivity of the creator of the picture, and the subjectivity of the mother who considered the photograph important. In one case I had previously received from the family a video tape of their attachment therapy, and this tape was added to my artifacts with the mother’s permission. In several interviews the context in which the mother presented an artifact was audio recorded.

I kept a research journal throughout the dissertation process, and I made brief journal entries related to every interview. These included information on the mother’s affect, issues regarding my relationship with the mother and her response to me as a researcher, and observed details that were not reflected in the interviews or artifacts. In addition I added notes on analysis



during the month of July which included developing thoughts about the content and representation of the data. The journal became part of the data of the study.

### Data Analysis

Data analysis focused on identifying themes which emerged from data gathered through the interviews supplemented by artifacts and my journal entries. Merriam (2002) summarized data analysis for a basic interpretive qualitative study as follows:

Findings are a mix of these recurring patterns supported by the data from which they were derived. The overall interpretation will be the researcher's understanding, mediated by his or her particular disciplinary perspective, of the participants' understanding of the phenomenon of interest. (p. 38)

The research questions influenced the themes that came to the foreground in the study. Each interview was compared to the others as the data were collected, using the constant comparative method of Glaser and Strauss (1967). As I learned of the varied experiences of mothers I constantly compared phrases looking for patterns. Themes that were consistent across interviews gradually emerged through data analysis. In early interviews I discovered that I spent a great deal of time inquiring about the past behaviors of the children. Over the course of the first five interviews I reached redundancy in this information and this behavior became less of a focus. As this happened I focused solely on the six interview questions derived from the three research questions. Although I used the six questions from the protocol in some fashion for all of the interviews, none had identically worded questions or emphasis.

As interviews progressed, I approached the analysis of data by manipulating "chunks" of data: "comparing, contrasting, aggregating, and ordering" (LeCompte & Preissle, 1993, p. 242), and organizing the data in relation to my research questions. I developed the codes that were

used to explore all of the data by using two initial steps. First I looked at one interview and coded each segment for its content, and 60 “data-driven” codes (Ruona, 2005, p. 242) appeared out of the content of the interview. My focus was entirely on the phrases of each segment with topics such as “diagnosis” and “marriage” appearing. I repeated this process with two other interviews, producing a total of 67 codes. I then coded themes in all 16 interviews that corresponded to the research questions, using the *HyperRESEARCH* (Gaskin, 2005) computer-assisted qualitative data analysis software.

By exploring how the 67 original codes related to the research questions, I developed 17 codes, grouping some codes and dropping those that did not relate thematically (for example “medication” and “school”). These new codes represented categories in three themes: the experience of therapy (related to Research Question #1); mother-child attachment (related to Research Question #2); and the impact of therapy (related to Research Question #3). I used names for the categories that grouped concepts by the code’s first word as a secondary organizational tool, such as: “therapy hard” and “therapy not dangerous” in question #1 and “attachment child now” and “attachment mother before” in question #2. Using computer analysis I then reviewed and coded all 16 interviews, revising the 17 codes to 14. Artifacts and journal entries were analyzed in relation to the themes revealed in the interviews. Comparisons were made between the interview data and the artifacts and journal in regard to each individual family and across family data. Gradually eight categories emerged from the preponderance of both interview and artifact data. Three were related to the first interview question, two to the second, and three to the third. I renamed those categories based on the content of each.

Using a strategy referred to as “member checks” (Merriam, 2002 p. 26), I sent the themes to three of the participants with corresponding sections of their interviews to verify that I had

captured their meanings. These mothers varied in demographics and experiences and were representative of the range of participants. I followed up with telephone interviews with each. In all three cases there were no changes recommended by the participants and each of them expressed the opinion that their statements were accurately presented and fit the themes I had discovered.

My journal entries of notes on the interviews were reviewed with each mother's related interview. These notes were very brief, and served only to remind me of descriptive details, my reaction to each mother, and the mother's affect. Journal entries on analysis were reviewed several times during the process of coding interviews, and entries were added throughout data analysis up to and including the process of member checking.

#### Presentation of Findings

Data are presented in two sections in Chapter 4. First a summary of the demographics of the mothers and their adopted children is given. This is followed by a profile of each of the participants in the order in which they were interviewed. In the second section the themes derived from the data are presented through their relationship to each research question. The process of "thematic analysis" (Ezzy, 2002, pp. 86-90) was used to present categories that "are 'induced' from the data" (p. 88).

When quoting the participants I edited out extraneous verbalizations (e.g., "umm," "you know") and meaningless phrases or repetitions (e.g., "I think, you know, that," "it was like, it was like"). This editing was done for ease of reading. When these phrases were important to the understanding of the emotions or the meaning of the mother, they were retained. All other statements in original quotations that were excluded from the quotations in the study were indicated by the use of ellipses.

## Validity and Reliability

The terms validity and reliability are most closely related to quantitative research, but can be translated into useful concepts for creating and evaluating qualitative work. Punch (1998) posed three questions that should be kept in mind when considering the value of a research study: “Have the research questions been answered?” “How much confidence can we have in the answers put forward?” and “What can be concluded from the research on the basis of what was found?” (p. 259). I address the questions of confidence, which reflects internal validity, and what can be concluded, which reflects external validity first, followed by a discussion of the issue of reliability as it relates to qualitative research.

### *Internal Validity*

“Internal validity refers to the internal logic and consistency of the research” (Punch, 1998, p. 259). In the qualitative research tradition, this refers to “the extent to which the findings faithfully represent and reflect the reality which has been studied... whether all parts of the research fit together... [and] whether the findings themselves have internal consistency and coherence” (p. 260). Merriam (2002) expressed this concept by asking “How congruent are one’s findings with reality?” (p. 25). Creswell (2003) listed eight primary strategies “available to check the accuracy of the findings” (p. 196) in qualitative research and recommended that research “identify and discuss one or more strategies” (p. 196). The five strategies that I used from his list are frequently mentioned in qualitative research literature. These were triangulation; member checking; the use of rich, thick description; clarification of my biases as the researcher; and the presentation of discrepant information (Bogdan & Biklen, 2007; Creswell, 1998; Merriam, 2002; Patton, 2002; Punch, 1998).

Triangulation refers to the use of multiple sources or perspectives in data collection and analysis. In this study I used triangulation of sources through interviews with 16 participants and triangulation of methods through the inclusion of interviews, artifacts and journal entries. Member checking, as described earlier in this document, provided three participants an opportunity to review the themes that were derived from the data sources and to comment on these for further refinement. The use of rich, thick description has become the standard of quality in qualitative presentations, and I included descriptions and quotations from the mothers to provide the reader with details of the participants, their views of therapy, and their relationships with their children.

I was constantly aware of my biases as a researcher, and these were analyzed and discussed throughout the research process. I was particularly interested in the presentation of discrepant information in order to assure that I was not disregarding some of the participants' experiences or thoughts. Attachment therapy has had little examination in the academic literature, and I was open to discovering its impact on adoptive families across the entire spectrum of experiences. Guba and Lincoln (2005) captured the importance of validity when they asked,

How do we know when we have specific social inquiries that are faithful enough to some human construction that we may feel safe in acting on them, or, more important, that members of the community in which the research is conducted may act on them? (p. 207)

Issues pertaining to the relationship between the researcher and the participant and the need to consciously reflect the participants' voices are central to achieving internal validity.

### *External Validity*

In regard to the question of what can be concluded, a qualitative study purports only to present the experiences of the participants in the study. As compared with the concept in quantitative research, generalizability plays “a minor role in qualitative inquiry” (Creswell, 2003, p. 195). Merriam (2002) made the concept of generalizability useful in qualitative research when she wrote: “Probably the most common way generalizability has been conceptualized in qualitative research is as reader or user generalizability. In this view, readers themselves determine the extent to which findings from a study can be applied to their context” (p. 28-29).

Qualitative researchers accept the fact that the data gathered represents reality at one point in time for one set of participants as viewed through a particular researcher and research process. In this case, the time frame of approximately three years after the original program evaluation provided the mothers’ reflections on the completion of therapy and the continued adjustment of their family. However, I was fully aware that the adoptive family circumstances on the day of the interview impacted the construction of the data that I received. Likewise, although common themes emerged in the data analysis, the study makes no claim to the universal generalizability of the attitudes and experiences of these families. It does, however, claim to reveal information that can and should be considered by social workers in other settings as they form opinions about what attachment therapy can mean to individual families.

This claim that the study should be considered in forming opinions about attachment therapy is based on my use of two strategies recommended by Merriam (2002). The first is “providing *thick, rich description*.... that is, enough description and information that readers will be able to determine how closely their situations match, and thus whether findings can be transferred” (p. 29, emphasis in original). I accomplished this by careful analysis and writing,

and I anticipate that social workers who have experience in the public child welfare system will recognize both the themes and the family narratives that I have presented. The second strategy is “*maximizing variation*” (p. 29, emphasis in original) so that through diversity in the participants interviewed “results can be applied to a greater range of situations by readers or consumers of the research” (p. 29). Variation was accomplished by interviewing all of the 16 mothers in the population. This included mothers who established attachments with their adopted children, those who were still living with issues of attachment disorder, and one who experienced the dissolution of an adoption.

### *Reliability*

In quantitative research reliability refers to the replicability of a study’s findings. Since qualitative research is concerned with the expression of each participant’s experience, it rejects the assumption “that there is a single reality and that studying it repeatedly will yield the same results” (Merriam, 1998, p. 205). “Qualitative researchers tend to view reliability as a fit between what they record as data and what actually occurs in the setting under study” (Bogdan & Biklen, 2007, p. 40). Merriam (1998) stated that “a researcher wishes outsiders to concur that, given the data collected, the results make sense” (p. 206). Merriam also suggested strategies that produce reliable qualitative research. Three of these were used in my study: triangulation, revelation of the researcher’s position and biases in relation to the study, and an audit trail. Depth of information was obtained through triangulation of sources and methods. My position in relation to the study and participants is set forth in the following section of this chapter, “Researcher Biases.” I kept an audit trail through journaling, which “describes in detail how data were collected, how categories were derived, and how decisions were made throughout the inquiry” (Merriam, 2002, p. 27). I began the journal in the final days of my Comprehensive Examination

when the design for this study began to be formulated, and I continued it throughout the analysis process.

Additionally, I participated in a review of data with a member of my dissertation committee after the completion of five interviews and in later peer reviews with two doctoral student colleagues. One colleague, who is familiar with therapeutic issues, reviewed the transcripts of the first 12 interviews during the weeks of interviewing, and another, who is well versed in qualitative research, assisted by having many regularly scheduled discussions with me during the process of analysis. Beyond this, the reliability of the study was supported by clear interview questions, well functioning recording equipment, accurate transcription, and thoughtful data analysis.

#### Researcher Biases

My interest in adoption goes back to my earliest thoughts about choosing a career. As an undergraduate I was introduced to the writing of Anna Freud and Dorothy Burlingham on babies who were evacuated from the bombing of London during World War II. From this work I learned the importance of early mother-child relationships. I began working in adoption in 1969.

The concepts that developed for me in my early years of work remain the core of my understanding of adoption. Adoption is a child-centered service. Most children in the child welfare system can be well served by adoption; exceptions have to do with the child's tie to birth relatives, not the characteristics of the child. All children who are without families deserve the opportunity to be adopted, regardless of their age, ethnicity, or physical, mental, or emotional disabilities. Cultural continuity is in a child's best interests, and cultural competency is required for successful trans-cultural adoption. Adoption is an intra-psychic, inter-personal, systemic, and ecological life-long experience. It is often a struggle for the adoptive parents, adopted children,



and birth parents, and not all endings are happy ones. Adoption agencies have an ethical commitment to all members of the adoptive triad throughout the life cycle. Honesty is necessary to provide quality services at all times to all members of the adoption triad.

I approached this research as a White social worker specializing in adoptive placement for 35 years, as a single-parent mother and a grandmother, and as a psychotherapist who understands attachment therapy but has not been an attachment therapist. I am not a member of any part of the adoptive triad, neither an adoptive parent, an adoptee, nor a birth parent of an adopted child. I also approached the research as an inquirer. I sought knowledge about the experience of a particular group of adoptive mothers, not an objective universal truth.

My experience as a social worker directly working with adopting parents, children waiting for families, and families and children after adoption, had the most impact on my desire to study attachment therapy. I have placed hundreds of children in adoptive homes over the years, and supervised social workers placing many hundreds more. Some of these families have been loving and happy, some have struggled and stayed together with a mixture of pain and joy, and some have been devastated by the emotional chaos brought to their families by adopted children with attachment disorders. The families are diverse in race, age, culture, and composition. I have shared their joy and pain over the years.

Thus I approached attachment therapy with a deep emotional commitment to the importance of this work. However, being aware of this commitment, I was also aware of the bias I held that the intervention of attachment therapy had the potential to be successful in helping some adoptive families. For many years I was a colleague of an attachment therapist who was well regarded by his clients and by the professional adoption community. Therefore I held the bias that attachment therapy was not dangerous. I am irritated by the book (Mercer et al., 2003)

and web-sites (Rosa, 2006, n.d.) that blame attachment therapy for the death of Candace Newmaker, just as I am saddened by her death and the fact that a professional social worker performed the unethical activities that led to her death. My research process included self reflection and journaling in an attempt to monitor an awareness of these biases, and I encouraged each mother to tell me of difficult or uncomfortable situations in therapy as well as the positive experiences.

My emotional commitment was intensified by my positive personal experience as a mother and grandmother. I know the joys of parenthood that come from children who are bonded closely to their parents. As a result, I felt great sorrow for the adoptive families who were parenting children diagnosed with Reactive Attachment Disorder. I am committed to the development of services for children with Reactive Attachment Disorder, and I believe that these children and their adopted parents deserve my help, and the help of the community of child welfare social workers and psychotherapists, in understanding and treating this disability.

Being aware of my biases, I purposefully engaged the assistance of two colleagues from outside the area of child welfare as peer reviewers and discussion partners during the process of data gathering and analysis. Their insight helped keep me true to the data. In addition, early discussions with the methodologist on my committee and a course in data analysis gave me opportunities to test my findings against the interviews, artifacts, and journal entries. I was careful to encourage each participant to honestly express her thoughts about attachment therapy and about her children, without emphasizing the positive aspects of these in order to appear socially acceptable. The fact that I had not placed the children for adoption nor provided the therapy was an asset to my role as researcher. In addition, I also gave balanced weight to discrepant information regarding the experience of therapy and the current functioning of the

children. The gradual emergence of the categories over several months of analysis allowed time for me to reflect on my self-awareness and correct for biases.

## CHAPTER 4

### FINDINGS

The purpose of this qualitative study was to explore mothers' experiences of attachment therapy as related to their current relationships with their adopted children.

The research questions that guided this study were as follows:

1. What was the experience of attachment therapy for the participants?
2. How did the participants view their current relationship with their adopted child?
3. What were the participants' perceptions of the role attachment therapy played in their current level of functioning?

Ninety-minute interviews with 16 adoptive mothers were held between late April and the middle of June, 2006. The participants were the mothers who took part in the 2003 program evaluation of a State grant-funded program of attachment therapy in Georgia. The interviews were recorded and transcribed, and data were analyzed with the assistance of the *HyperRESEARCH* (Gaskin, 2005) computer program as described in Chapter 3.

This chapter is organized in three sections. First, information about the mothers and their relationships with their adopted children is presented in order to give context to the themes that follow. Pseudonyms are used for the participants and their children. This section begins with a summary of the participants followed by a profile of each. The second section focuses on the findings which are presented as they relate to the research questions. The chapter concludes with a section on the summary of the findings.

## The Participants

Sixteen mothers who had been previously interviewed as part of the program evaluation of attachment therapy in 2003 were interviewed in 2006 for this study. All of the demographics presented represent characteristics at the time of the 2006 interviews. Five participants are single parents and 11 have intact marriages. They range in age from their early 30s to their 70s. Thirteen are White and three are Black. Their home environments vary significantly, from an older townhouse apartment to an elegant, large, new home. Six live in suburban areas, five in rural areas, four in small Georgia towns, and one in an urban neighborhood. All of the adoptions are same-race with the exception of one child of multi-ethnic background whose adoptive mother is White.

The 16 participants in the study have 27 adopted children who participated in attachment therapy. There are 11 girls and 16 boys who ranged in age at the time of the study from 8 to 18. All of the children had been adopted from the Georgia Department of Family and Children Services (DFCS), and all had been diagnosed with Reactive Attachment Disorder. The mean length of time the adopted children have been in their home is 7 years with a range from 2 years to 12 years. A table of demographic data on the families is shown in Table 1 (Appendix C).

### *Mrs. Hampton*

Mrs. Hampton, the mother of 7, was the first mother interviewed in this study. She and her husband already had 5 children before adopting two children with Reactive Attachment Disorder. Mrs. Hampton is a suburban, upper middle-class woman who is active in her Mormon faith and family-centered in her values. She is the only parent who had adopted another child since our interview three years ago.

Table 1

*Summary of Participant Information*

Participant	Race	Marital Status	Number of Children	Children with RAD	Child's Age at Placement	Child's Age at Interview
Mrs. Hampton	White	Married	7	Jack	10	18
				Sara	6	8
Mrs. Compton	White	Married	1	Brittany	4	10
Mrs. Williams	Black	Married	1	Chad	3	13
Mrs. Patterson	White	Married	3	Butch	8	18
				Jimmy	5	14
Mrs. Wythe	White	Married	1	Valerie	13	18
Ms. Anderson	White	Single	5	Kenny	6	11
Mrs. Pearce	White	Married	2	Paul	8	13
				Donnie	6	11
Ms. Workman	Black	Single	2	Charnese	8	15
Ms. Smith	White	Single	1	Jose	2	8
Ms. James	Black	Single	1	Shawana	3	11
Ms. Miller	White	Single	4	Tonya	7	17
				Mark	4	9
				Missy	3	8

Table 1 continued

Participant	Race	Marital Status	Number of Children	Children with RAD	Child's Age at Placement	Child's Age at Interview
Mrs. Buckner	White	Married	4	Earl	6	18
				Edward	3	15
Mrs. McDonald	White	Married	3	Ann	6	17
				Anita	4	15
				Andrew	2	12
Mrs. Stuckey	White	Married	5	Roy	6	12
				Tommy	5	11
Mrs. Douglas	White	Married	4	Charlie	4	10
				Sue	2	8
Mrs. Cooper	White	Married	2	Cynthia	4	10
				Adam	2	9

Jack, now age 18, was adopted at age 10, and Sara, age 8, was adopted at age 6 after Jack had been in the family 6 years. Mrs. Hampton was totally unprepared for Jack's problems. In searching for a way of finding treatment for him, the family's therapist suggested that Mrs. Hampton attend a workshop on Reactive Attachment Disorder. She remembered that as soon as

she heard the description of the disorder “I was excited in one realm because we had found it, and really concerned in another realm because, ‘What do you do with it?’” She described Jack’s behavior as “lying, stealing... a lot of sexual disorders... just not caring about what anybody else felt or thought.”

Jack was 12 when the family started attachment therapy, and Mrs. Hampton credited attachment therapy with Jack’s bonding to the family. After Jack’s successful integration into the family, the Hamptons adopted Sara. Mrs. Hampton commented she and her husband felt ready to help this child, and they made the commitment on the condition that DFCS would pay for attachment therapy.

The Hampton’s children have now adjusted well. Mrs. Hampton emphatically proclaimed, “We’re just a family now. It’s so funny to even talk about this because we are so normal now, *but we were not normal back then.*”

*Mrs. Compton*

A youthful looking woman in her early thirties, Mrs. Compton is the mother of one child, 10-year-old Brittany. She owns a pet care service and is soft-spoken and pleasant in manner. Mrs. Compton cried frequently during our meeting as she described her experience as a parent, and she appeared to be the most distressed of all of the mothers whom I interviewed. She arrived late for our scheduled appointment at a motel near her home, and she explained that she and her daughter rarely make it out of the house on time in the morning because of Brittany’s oppositional behavior. Brittany was adopted when she was 4, and she has now been diagnosed with Reactive Attachment Disorder and Bi-polar Disorder.



Mrs. Compton was visibly upset when she discussed Brittany's lack of attachment. As a young, childless couple, the Comptons were thrilled when Brittany seemed to bond to them during pre-placement visits. Sadly, she described their first days:

When we first met her, we were amazed that she was just so happy to go with us, and so sweet and loving, and we thought "Wow, she really knows this is where she belongs," until we brought her home the very last time and the screaming started.... Looking back on it now I know it's because she was just, she's just that way with everybody she doesn't know - she's willing to go home. She'd be willing to go home with *you* today.

Family life has been a constant struggle for the 6 years since Brittany arrived. Attachment therapy seemed to have little impact on Brittany, but the support from the therapists was valuable to Mrs. Compton. The therapy team they used has now disbanded, and Mrs. Compton is looking for a new way of getting help. Brittany continues to be unresponsive to her parents, and Mrs. Compton described her as almost impossible to control.

*Mrs. Williams*

Presenting as an energetic, self-confident woman, Mrs. Williams exuded determination as she described the frustrations of raising her adopted son, Chad. She lives in a small city in an isolated part of the state where his intense needs for mental health intervention have been unmet. Mr. and Mrs. Williams adopted Chad, now 13, when he was 3. They have one other child, a daughter, who was born 4 years ago. Mrs. Williams has held numerous jobs during the years Chad has been with them, and she is also pursuing a college degree.

Chad has been in various types of therapy since he was 5, but Mrs. Williams explained that the therapists were not able to help him until the family entered attachment therapy. Mr. and Mrs. Williams have been investigated for child abuse several times because of incidents related

to Chad's emotional and behavioral difficulties. Attachment therapy required a 6-hour drive each way and an overnight stay in Atlanta. The family went for 6 months before the State grant-funded program ended and therapy was no longer available without charge to the family. Mrs. Williams described the difficulty of continuing because costs were approximately \$900 for each 3-hour session.

Although the family ended therapy, the attachment therapists remained supportive by telephone. During the year preceding my interview with Mrs. Williams, Chad's behavior had worsened. Mrs. Williams vividly presented the current situation when she said, "we had gotten to the point where we were sleeping with our door locked, our baby in the bed with us." With the help of the attachment therapists, and after Mrs. Williams wrote a letter of complaint to the Governor, Chad was admitted to an outdoor therapy program. Mrs. Williams was hopeful that this treatment will help.

*Mrs. Patterson*

Mrs. Patterson spoke with a slow Southern accent as she described her family, comprised of a loving husband and three adopted children, Helen, age 9, Jimmy, age 15, and Butch, age 18. Her boys were placed with the family as foster children at ages 5 and 8. Helen was adopted as a new-born infant seven months later. Mrs. Patterson is employed part time as a busy and empathetic adoptive parent advocate in her rural area. Her words were expressed with a combination of intense emotion and authority based on her extensive experience helping other adoptive families. The Patterson family was the first of the participants in this study to attend attachment therapy. They began therapy with Georgia therapists who were in practice before the State grant-funded program began, and the family also traveled to Colorado for part of their therapy.

Living with the boys was stressful from the beginning. Jimmy had daily bowel movements in his pants. Both boys lied and stole; neither responded to adult intervention. Mrs. Patterson recalled, “It was almost like they had a wall up between you and them.... It was like you weren't there.” After almost two years of counseling both boys were diagnosed with Reactive Attachment Disorder. The diagnosis was the beginning of years of treatment, travel, and expense.

Mrs. Patterson found therapy important in part because it was “just wonderful to have somebody who understood.” Therapy addressed much of the trauma in the boys’ background and gave the Pattersons new parenting skills. As Mrs. Patterson explained, “It changes the way you parent completely.... We don't react like we used to.” The boys are now a stable part of the family, although Mrs. Patterson acknowledged she will probably never feel as close to them as she does to Helen.

*Mrs. Wythe*

An attractive woman in her middle thirties, Mrs. Wythe was causally dressed for our interview and appeared to be at ease in her surroundings. She is a dog trainer by profession, and calmness permeated her house and her attitude towards the seven dogs that were part of the household on the day of our meeting. Valerie was adopted as the Wythes’ only child when she was 13 five years ago.

Motherhood, according to Mrs. Wythe, was difficult from the start. Thinking back to the first weeks with Valerie, Mrs. Wythe commented, “There was really no honeymoon at all. Valerie from the beginning was incredibly oppositional.” However, Valerie charmed Mr. Wythe, extended family and friends, and the family’s therapist. Mrs. Wythe was seen as the one with the

problem. Within her first year with the family Valerie devised a plan to murder her new mother. Mrs. Wythe was nearly suicidal because of the stress.

The attachment therapists brought relief to the family. Mrs. Wythe stated emphatically, “I owe them my life and Valerie’s life. It’s as simple as that. She *would* have killed me or I would have killed myself.” Therapy proved to be temporarily healing and for over two years Valerie was “an absolute joy to parent.... She was connected, and fun to be around.... I was just so excited for her future.” The excitement turned to heartache as Valerie’s behavior deteriorated approaching her 18<sup>th</sup> birthday. At the time of our interview Valerie had run away from home and was pregnant, and there was a warrant out for her arrest on forgery charges in another state. Mrs. Wythe fluctuated in affect as she spoke of Valerie. In tears she shared, “I miss my kid,” but with a wry laugh she remarked,

I might be able to be a grandmother and the mother of a felon by the time I’m 37.

Because you know, if you don’t laugh at it you’re going to just have to cry.... Is she doing great now? No. But, hopefully we’ll get there again.

*Ms. Anderson*

Ms. Anderson is the single adoptive parent of five, the largest number of adopted children in one family in this study. She is a social worker employed by an agency that specializes in placing older children for adoption, and both her personal and professional life focus on connecting with and advocating for children. Her children range in age from 11 to 20, and her current household consists of two sons and a daughter under age 18 and the baby of one of her older daughters. At the time of our interview the family was in the midst of a move, and we met in an almost empty room surrounded by boxes and clutter. In spite of her role as a single parent of a large and complex family, Ms. Anderson appeared well organized and unruffled as we

talked. Kenny, age 11, is the only one of her children who has been diagnosed with Reactive Attachment Disorder. He was 6 when he entered the family.

Ms. Anderson described Kenny as “a very bright kid, he's very lovable. He's got a great personality. He's very out-going. I think the most problematic piece with Kenny is that he can be very explosive and somewhat unpredictable.” Kenny has poor peer relationships and is hard to discipline. He “wants to argue everything. He still has that need to be in control, to be right about everything.”

Ms. Anderson said she was unsure whether or not Kenny's diagnosis of Reactive Attachment Disorder was accurate, even though she thought “he definitely had attachment difficulties.” Kenny and Ms. Anderson were in attachment therapy for most of a year, and Ms. Anderson believes that the therapy produced some improvement in Kenny's behavior, but that “it's hard for me to point to just one thing. I think there really have been a lot of things that made some changes.” Ms. Anderson is confident that Kenny has made progress, but she said, “I just think it's going to be a challenge to help him as he goes through the years ahead.”

*Mrs. Pearce*

Mrs. Pearce is one of the two mothers who found attachment therapy to be of no help. She is the mother of two adopted sons, Paul, age 13, and Donny, age 11, and she is employed as a personal shopper for a high-end retail store. She was gracious and engaged throughout our interview, but her speech was halting, with short answers, long empty pauses, and emphatic exclamations. Mr. and Mrs. Pearce were a childless couple who felt that they were too old to parent an infant and sought to adopt an older sibling group. The boys moved in with the family after short introductory visits at the ages of 8 and 6.

Difficulties began with the family almost immediately. Mr. and Mrs. Pearce discovered that they parented differently, and the boys fought and demanded attention constantly. Paul had been sexually abused by both his biological mother and father, and he lied, stole, soiled his underpants, and refused to conform to minimal personal cleanliness. Mrs. Pearce found relating to Paul especially hard and said, “It was kind of like having a bad date. You know, that you never really wanted to go out with again, but yet I was stuck with him.” Donny made an easier adjustment. He was small for his age and Mrs. Pearce recalled, “he looked like he was about four and very tiny. I could pick him up, carry him around, and I felt closer to him.” The Pearces tried various therapists, but nothing seemed to help. Attachment therapy for seven months when the boys were 11 and 9 proved to be no more useful.

Mrs. Pearce sounded resigned to the current family situation. Her husband shares activities with the boys such as Boy Scouts and camping, but the role of mother holds little pleasure. Mrs. Pearce revealed her solution when she explained,

I’ve gone back to work and I do my own thing. So, I don’t get a lot of enjoyment out of it. I really don’t. So, for me, I’m just trying to see that they’re in a nice school, that they are taken care of, that they are safe, you know, and those kinds of things.

*Ms. Workman*

Seven years ago Ms. Workman was the single parent of an 11-year-old daughter when she added 8-year-old Charnese to the family. She is a competent, attractive woman who had a stable professional career and felt able to offer a home to a child who needed her. Sadly, the family did not bond from the beginning. Ms. Workman described Charnese as angry and oppositional, and the two girls became enemies instead of sisters. In talking about Charnese’s first years in the family Ms. Workman said,

She didn't do anything I asked her to do from brushing her teeth to eating. Everything was a struggle. You know, getting her to take a bath, clean her room, eat whatever I put on the table. She just didn't want to do it.

Charnese would have temper fits and lock herself in her room, not responding to any attempt at discipline attempted by Ms. Workman.

Finally after three years Ms. Workman called DFCS in desperation and asked to have Charnese removed. At that time a home-based therapist who was trained in attachment therapy was assigned to the family. The therapist worked with Ms. Workman and Charnese for over three years, doing both intensive attachment interventions and ongoing supportive counseling.

Charnese's emotional problems have continued and she has recently been diagnosed with Depression and possible Bipolar Disorder. She is still antagonistic towards her older adopted sister. However, the relationship between Ms. Workman and Charnese has developed into a loving one, and Ms. Workman credits attachment therapy with the change. Describing their relationship, Ms. Workman said, "I think she attached to me as much as she could, you know. I know she loves me, and I love her, but I don't think she ever got over being given up for adoption" by the foster mother who had raised her most of her life.

*Ms. Smith*

As a single parent, Ms. Smith's activities are scheduled around the multiple needs of her only child, Jose, age 8. We talked at the noisy recreation center where Jose was having physical therapy in the pool. She arrived to meet me looking like a typical young mother bringing her child for swimming lessons. At the time of our interview Jose had diagnoses of Auditory Dyspraxia, Sensory Integration Dysfunction, Fetal Alcohol Syndrome, and Reactive Attachment

Disorder. Ms. Smith is the only trans-racial adoptive parent in this study; she is White and Jose is of Hispanic/Pacific Island ethnicity.

Jose came to Ms. Smith as a foster child with major emotional and behavioral problems when he was almost 3 years old. Looking back Ms. Smith remembered, “There was no eye contact. He had rages all the time, and they thought he was autistic.... He was very self-abusive and he'd scratch his face until it bled.” Although during the first year with Jose Ms. Smith had no intention of adopting him, he gradually won her heart. However, she was at a loss as to how to help him.

Ms. Smith learned about Reactive Attachment Disorder through a continuing education workshop she attended for her foster parent accreditation. She immediately recognized some of Jose’s symptoms, and they entered therapy with one of the State grant therapy teams. Therapy was frustrating. Jose “would not communicate anything about any of his memories, any of his emotions, nothing.” Unfortunately, after 12 months neither Ms. Smith nor the therapists saw reason to continue. Trust, empathy, and affection are unnatural for Jose, and after six years of consistency and love he is still cautious about emotionally engaging with his adoptive mother.

*Ms. James*

Ms. James was single and childless when she adopted her daughter, Shawana, then age 3, eight years ago. They live in a middle-class townhouse development in the suburbs of a major city. Ms. James proudly discussed her daughter although she expressed frustration with some behavior difficulties that make parenting stressful. Shawana’s indiscriminate attachment was evident on her first day home when she told Ms. James, “I guess you my momma now.” For years she would attach herself to everyone, even strangers, showering them with superficial



affection. Other problems included fighting with other children, and lying, stealing, and anger that was expressed as defiant behavior.

Shawana is a very bright, artistically talented child who has some of the highest test scores in her school's Gifted and Talented Program. She has been on medication for Attention Deficit Disorder during the past year, and her behavior in school has improved compared with conduct in previous grades. Ms. James commented, "I just had so many disruptions with school and everything else. It's just been unbelievable. I think some people would have probably have given up with her, but I saw a lot of potential in this little girl."

Attachment therapy and the support of the therapy team provided the help that Ms. James and Shawana needed to bond. Ms. James talks about the improvement she has seen in Shawana's behavior. Stealing and fighting have ceased, but lying continues to be a problem. Most importantly, Ms. James remarked, "I'm still hanging in there being committed to this child." Her parting words as the interview ended were, "As far as attachment, we are there. We are there."

*Ms. Miller*

Ms. Miller is the single mother of four adopted children with serious disabilities, and her life appeared to be the most stressful of all the participants. She is a middle-aged, well-spoken woman with graying hair who was interviewed in her toy-strewn living room. Her oldest three children, Tonya, 17, Mark, 9, and Missy, 8, have been diagnosed with Reactive Attachment Disorder. Matt, age 6, has life-threatening tumors that grow in his throat; he has had multiple surgeries and receives chemotherapy shots daily.

Tonya, who was placed with Ms. Miller when she was 7, is severely developmentally delayed, depressed, and prone to dangerous outbreaks directed toward the other children. She has been tentatively diagnosed with Schizophrenia, and is on Risperdal, Adderall, and Zoloft. Mark,

Missy, and Matt are half-siblings who were all placed with Ms. Miller as foster children at various times and were adopted by her four years ago. They suffered extreme physical abuse, beatings and burnings, from their drug-addicted mother before they were finally removed permanently from her care. The middle children, Mark, 9, and Missy, 8, have been diagnosed with Pervasive Developmental Disorder “on the mild end of the autism spectrum.” Mark also has Attention Deficit Disorder, and Missy has been diagnosed with Attention Deficit Hyperactivity Disorder. At the time of our interview Ms. Miller had two therapists coming regularly to the home.

Ms. Miller described her life as one of constant stress and worry, without a social outlet or support system. Her home and the abundance of toys reflected her child-centered lifestyle, but she feels “I do everything I can, and I'm still struggling with this... that everything I've done hasn't amounted to much.” She is somewhat optimistic about the future for the younger children, but is very concerned about Tonya. Meanwhile, she continues a battle with the public school system to meet the needs of all four children.

*Mrs. Buckner*

Mrs. Buckner had just finished giving a professional lecture as part of her employment in the health field when we met in a city restaurant. She is an articulate, composed, woman whose warmth and Christian faith were evident as she discussed the adoption of her two boys. She and her husband had raised his two children from a previous marriage before adopting the boys at ages 3 and 6 twelve years ago. Both boys were diagnosed with Reactive Attachment Disorder after placement.

Although to the outside world the family seemed to be functioning well, the boys had behavior problems from the beginning of placement. The family began attachment therapy when

the boys were 9 and 11. Mrs. Buckner credited therapy with maintaining the family saying, “It completely changed our understanding of the children, our approach to dealing with the children.... [Attachment therapy] made us realize we were dealing with a disease, a disorder, a severe emotional illness. That these weren't just horrible, rotten brats.” She laughingly described one of the most important lessons as “learning to keep your eyes soft and loving, even if the child was driving you up the wall, which was almost all the time.”

At the time of our interview Edward, now 15, was functioning well at home although he still has difficulties with anxiety and obsessive thoughts. Earl, at 18, had revolted against the family's discipline and was living on his own, often homeless on the streets. However, he telephones home occasionally and has not completely given up his connection to the family. After 12 years, Mrs. Buckner appeared to believe that she and her husband have given the boys the best opportunity they could for stable futures.

*Mrs. McDonald*

In her mid-seventies, Mrs. McDonald is the oldest participant in the study. Her late-in-life adoption came about when distant relatives appealed to her for help. Ann first came to live with Mr. and Mrs. McDonald when she was 5, arriving with her sister Anita who was 3. The children had several other placements, including living with their abusive parents, before settling with the family 3 years later, accompanied by their brother, Andrew, who was 2 at that time. Mrs. McDonald explained she and her husband did not plan to adopt the children. However, she remembered the children's caseworker called one day to say “we're going to take them to DFCS on such and such a date.” Mrs. McDonald was fearful that the children were being returned to their parents, and her husband shared her concern, saying to her, “We can't let those children go back.” The children were legally adopted 9 years ago, and are now 17, 15, and 12.

All three children have had ongoing behavioral problems and learning disabilities, and all three have been diagnosed with Reactive Attachment Disorder. Ann has been diagnosed with Asperger's Syndrome and Anita with Autism. All three children receive therapy from an in-home attachment therapist as well as special education services.

Mrs. McDonald conveyed a fierce determination to help the children. Mr. McDonald is now disabled with a serious illness, and Mrs. McDonald unhappily looks towards the day when she will be a single parent, but she is unwaveringly attentive to the children and diligent in her supervision and discipline. When asked about the children's current attachment to the family she said, "They know that Momma and Daddy love them and will protect them, and they know that we intend for them to do the right thing."

*Mrs. Stuckey*

Mrs. Stuckey is the only mother in the study who experienced an adoption dissolution since our interview three years previously. She is a petite, young looking mother of five, who is employed as a Special Education teacher. Her children are two adopted sons, ages 11 and 12, who have been diagnosed with Reactive Attachment Disorder and Fetal Alcohol Syndrome, a son in college, and two younger children.

Mrs. Stuckey came to my house for her interview, preferring for me not to come to her home. She expressed her sadness and disinclination to be involved in the research because Tommy, age 11, had moved out of the home a few months prior to our meeting after six years with the family. The boys were biological relatives of Mr. Stuckey, and DFCS placed them with the family after removing them from an abusive home. Their siblings were adopted by other relatives, the Douglas family, who has now taken in Tommy.

Mrs. Stuckey described her involvement in attachment therapy as “sporadic” in part because of the distance to therapy and her hectic family schedule, but also because of her lack of conviction that the therapy made sense. She was one of two mothers who did not find attachment therapy helpful in any way. Roy, who functions at a mentally retarded level, has adapted to the family routines and is a loving child. Tommy, on the other hand, was “really just out of control,” and Mrs. Stuckey sorrowfully said “he has no attachment to me at all.” The family has been much calmer since he left, and Mrs. Stuckey was gradually accepting the fact that he would not be returning home.

*Mrs. Douglas*

The word “Supermom” comes to mind in describing Mrs. Douglas. The mother of four homeschools her children and appeared immaculately groomed, calm, and relaxed. I met with her in her beautifully appointed home, and she explained her simple system of bribing the children into good behavior upstairs while we spoke.

Mrs. Douglas, like her sister-in-law, Mrs. Stuckey, adopted relatives’ children when DFCS became involved with the abusive family. Charlie and Susie, now 10 and 8, arrived 6 years ago, when the Douglas’ birth son was 7. Tommy Stuckey, age 11, had newly arrived in the family at the time of our interview. Unlike their siblings who were adopted by the Stuckeys, neither Charlie nor Susie had serious developmental delays although both were diagnosed with Reactive Attachment Disorder and Charlie has dyslexia.

Mrs. Douglas credited attachment therapy with providing stability in her family and expressed her opinion “that it should be almost a requirement for families because it made a world of difference in ours.” Susie, who was only two at placement, had already been diagnosed with Reactive Attachment Disorder and was fearful of women but would flirt and “go off with

any man that looked at her.” Like his sister, Charlie would have nothing to do with Mrs. Douglas when he arrived, and he was hypervigilant and hyperactive. Both children have developed into well-adjusted and loving members of the family. Mrs. Douglas is now committed to helping Tommy receive attachment therapy, and she said wistfully, “I don’t know how I’m going to get it for him yet, but I know he needs it.... He kind of feels like he’s on his own I think.” She anticipates that he will remain in her family and hopes to be able to help him trust and attach to them.

*Mrs. Cooper*

Mrs. Cooper and her husband were childless when they adopted siblings, Adam, age 2, and Cynthia, age 4, nearly seven years ago. The two beautiful young children seemed like the creation of a dream come true for the stable, upper middle-class couple. However, the family is in chaos, and Mrs. Cooper spoke desperately of her attempts to discipline and help the children.

Both children have now been diagnosed with Bi-Polar Disorder in addition to their diagnosis of Reactive Attachment Disorder. Although Mrs. Cooper found attachment therapy supportive for herself, the therapists discontinued their unproductive work with the children and recommended psychotropic medication. Both children receive multiple mental health and educational support services, but every day is still a struggle. Adam, at age 10, has encopresis, is defiant, and has uncontrollable fits of rage. Cynthia is so oppositional that each morning presents a battle to get her dressed and out the door to school. Like her brother, she is prone to angry outbursts that often become dangerous, although medication for Bi-Polar Disorder seems to have helped her somewhat.

Mr. Cooper works 12-hour night shifts, and Mrs. Cooper often faces the strain of parenting alone. She described her search for help for the children explaining, “We went from

one therapist to another therapist to another therapist to another therapist and we -- you know, we're still in therapy." The family seemed far from a successful resolution of the children's emotional problems. Although Mrs. Cooper is committed to raising the children, she said, "I'm having difficulty with them and they're having difficulty with me."

### *Participant Summary*

The 16 participants interviewed had a wide variety of individual characteristics and experiences. Family size ranged from an only child to seven children, and the number of adopted children ranged from one to five. Both single mothers and married couples were represented. Children were age 2 to 13 at the time of placement and 8 to 18 at the time of the mothers' interviews. The length of time the children had been in their adoptive homes ranged from 2 to 12 years. Some families felt happily bonded to their adopted children and some struggled with difficulty forming a loving, reciprocal relationship. Some of the children were succeeding in school and interpersonal relationships and others appeared out-of-control, unsuccessful, and unhappy. Some participants thought that attachment therapy had played an essential, positive role in their family adjustments and others thought the therapy had had no impact. Although there was no typical participant, eight predominant themes were supported by the data. These were representative of the participants as a group.

### Overview of Categories

The purpose of the study was to explore mothers' experiences of attachment therapy as these related to the current relationships between mothers and their adopted children. This section presents the three research questions and the corresponding categories which emerged from the data. Adoptive mothers described their experiences of attachment therapy, their views of the present relationships with their adopted children, and their perceptions of the role that

attachment therapy played in their current level of functioning. The research questions and related categories are displayed in Table 2.

Table 2

*Research Questions and Categories*

Research Question	Categories
Experience of Attachment Therapy	Consistently supportive
	Emotionally painful
	Physically safe
Current Relationship with Adopted Child	Continuously stressful
	Unquestionably permanent
Role of Attachment Therapy	Instilled confidence
	Preserved family structure
	Offered partial solutions

*Experience of Attachment Therapy*

*Consistently supportive.* Fourteen of the mothers commented on the supportive relationship they had with the attachment therapists. This relationship was often the first place that the parents encountered a sense that someone understood their families' issues. Many of the participants had become isolated from the usual support systems of friends and relatives because of the intensity of their children's problems. Difficult behaviors such as stealing, outbursts of



anger, and intrusive, inappropriate affection toward adults made people uncomfortable in the presence of the children. This isolation was compounded by feelings of failure on the part of the mothers. The ability to discuss their children's problems with attachment therapists brought a sense of relief and reaffirmation of the mothers' competency as parents.

This relief was clearly expressed by Mrs. Patterson, the mother of two teenage sons with Reactive Attachment Disorder. After many attempts to find effective therapy for the boys through public child welfare and mental health services, Mrs. Patterson had all but given up hope of finding help for the boys. In addition, she faced difficulties with her personal support system. The boys presented as perfect children outside the home, and friends and therapists had begun to believe that family dysfunction was the result of the Pattersons' poor parenting rather than problems that the boys brought to the family. The fact that the attachment therapists were aware of the behaviors of children with Reactive Attachment Disorder and knew the causes "was like the skies opened up and the sun came out and somebody truly understood what we were living in and living with." The Patterson family was in "chaos" because of the boys' behavior, and being able to share the family situation with therapists who were experienced with attachment difficulties was a great relief after two years of unsuccessful therapy. Attachment therapy brought hope that her sons would finally be able to bond with the family and that their disruptive behaviors could be controlled.

Like Mrs. Patterson, Ms. James, the single mother of Shawana, found that the connection with therapists who understood her daughter was essential. She had reached the point of considering dissolution of the adoption, and her relationship with the attachment therapists gave her the support she needed to work through Shawana's most disruptive problems. Although Shawana was placed with Mrs. James at the age of three, she was not able to accept the affection

and emotional connection that Ms. James had to offer. Their relationship deteriorated into daily battles over the first four years of placement. When traditional therapeutic interventions did not impact Shawana's oppositional behavior at age 7, her first therapist diagnosed Reactive Attachment Disorder and advised that Ms. James explore attachment therapy. Ms. James' comments describe the teamwork that was a part of attachment therapy:

The group that I had was just wonderful! We were really a team and they saw all the slickness in this little girl, the same thing that I was seeing. They could read her and she just couldn't stand it. ... We all were in the room so that everything, you know, we all were there. And then we had already made it clear that we were a team working together. In addition to collaboration in the therapy environment, the attachment therapy team supported Ms. James in the community by coming to Shawana's school for conferences and helping Ms. James explain Shawana's problems to others in the family and community. Ms. James lamented, "Everybody was just blaming me for her behavior every time she'd do something. They questioned my parenting skills and it was really rough, but like I said, I had a marvelous team that was working with me."

Although Ms. James lived close enough to the attachment therapists to have them attend school and community meetings, other parents received support and advocacy from across the state by telephone. The Williams were one of several families who obtained long-distance help at no charge after they had discontinued regularly scheduled therapy sessions. Mrs. Williams, who lived six hours from her therapists, shared one example of having a therapist participate by telephone in a community meeting. Her son Chad's need for placement in a residential treatment center was being reviewed. She described the meeting as "a big roundtable of people," but noted that it was the attachment therapist who attended by telephone who really understood Chad.

Unfortunately, the family ended up being investigated for “mental health neglect,” and Mrs. Williams emailed the attachment therapist to let him know that “they just totally ignored what you said.” With email and telephone advocacy from the therapist, and a letter to the Governor, the Williams finally were able to place Chad in the residential setting recommended by the therapist.

Similarly, several mothers received consultation from therapists for extended periods of time after actual attachment therapy ended. In spite of the cost of therapy, which often ran \$200 an hour, the attachment therapists frequently stayed available to families at no cost to them over the years. Mrs. Wythe, who dealt with her teenage daughter, Valerie, through a wide range of difficult behaviors, found the support of the therapists an ongoing part of her life. She regularly called the therapists for advice, and said she was “incredibly thankful” for their support. She explained, “We’ve chosen to pay them when we can. They have never charged us for phone work, which is great. But when we go to see them I really try to pay them.”

A different supportive situation was illustrated by Ms. Smith, the single mother of Jose who had multiple ongoing emotional, mental, and physical challenges. She reported that after the State grant ended, her therapy team “kept me for another six months, even though I could not pay them.” The therapists were concerned that Jose had not shown improvement during the time allotted by the grant funding, and they were willing to continue weekly therapy in hope of resolving some of Jose’s issues. Although attachment therapy did not improve most of Jose’s problems, Ms. Smith expressed gratitude for the concern and emotional support she received.

This emotional support was sometimes perceived by the mothers to be the most important part of therapy. Even in families where therapy seemed to have little impact on the children, the mothers reported that they, themselves, benefited. Having someone who understood the family

situation and who could offer encouragement and suggestions made a difference. Mrs. Cooper shared one example of this benefit. The Cooper children had both been diagnosed with Bi-polar Disorder and, even though they were adopted at ages 2 and 4 and had been in the home nearly 7 years, their behavior continued to be relentlessly difficult. They harmed themselves and each other, and were unwilling to follow family rules. In describing the way attachment therapy helped her Mrs. Cooper explained,

It in no way would keep the children from doing the wrong thing or whatever, but it gave me a plan on what I needed to do when that occurred. ... It allowed me to, even though I still had to be creative, to not have to constantly think, "Oh, another incident! Oh, another incident!"

Mrs. Cooper was one of three mothers who mentioned that they regularly attended parent support groups run by the therapists. She found participation crucial in her effort to survive. In her concluding remarks about what she would recommend to other parents of children with Reactive Attachment Disorder she stressed, "a support group would be something that I would highly recommend because... sometimes you still feel alone, and you need to feel like you're not a bad parent."

Some mothers, however, were not able to participate in support groups. Mrs. Patterson noted that living in a rural, isolated community did not provide her the opportunity to do so. However, the support she received from therapists lasted several years and included in-person therapy, recommended readings and videotapes, email, and telephone support. Finding the right therapists for her two boys, Butch and Jimmy, took months of searching. Eventually Butch received the diagnosis of Reactive Attachment Disorder at a local psychiatric hospital. The local therapist could offer nothing but sympathy. Mrs. Patterson related that he said, "There is not any

award big enough to give you for trying to raise this child. There is not any." Mrs. Patterson remembered that comment clearly and said she realized, "I needed a whole lot of support if I was going to deal with these kids." She believed that both her boys had benefited from attachment therapy, but that she and her husband benefited even more. Looking back she concluded, "I think, not that the therapy didn't help him [Butch] - it did, but it helped us so much, because I can tell you we would not have lived with these children. [The adoption] would have dissolved, absolutely, and my marriage probably would have [as well]." She said when they began attachment therapy "it was just wonderful to have somebody who understood and would not let these children manipulate them." In her work as an adoptive parent advocate, Mrs. Patterson has gone on to help establish adoptive parent support groups and Internet support that can benefit other parents in isolated areas.

Mrs. Hampton also referred directly to the importance of therapists who understood Reactive Attachment Disorder. Although she was an experienced parent of five children when 10-year-old Jack entered the family, she found dealing with his problems unlike anything she had experienced with her other children. She shared the relief she found "for us as parents to be able to talk to the therapists and just be honest about what was going on, and to have them understand." She added that when a family is living with children with Reactive Attachment Disorder "you feel very alone when you're doing this. Because these kids are tricking others around them into thinking *they're* OK and *you're* really not." The attachment therapists were "very helpful. It was helpful to just sort of release that 'he's doing this and he's doing that' and for them to say 'we understand' .... so that we were not alone."

In addition to emotional support, the therapists provided crisis intervention. Parents often had therapists' cell phone numbers or pager numbers. In many cases the therapists wrote letters

that the parents could carry with them to explain Reactive Attachment Disorder. These were helpful because many children caused public scenes that could be easily mistaken for child abuse. The letter included a cell phone number that the reader could use to call the therapists if the situation warranted. Mrs. Hampton shared her letter with me and described a situation in which she used it when Sara had a tantrum in a store:

[She] started hitting and spitting and biting and those sorts of things. And I finally got the child out of the store and into the car. She got out of her car seat and started to open the door while the car was moving. So I called the law enforcement officer to come and help us. And they were wonderful. They read the letter, they talked to the child, helped her calm down, and then escorted us home.

Contact with the therapists was not necessary in this incident, but Mrs. Hampton knew that she could call on them if needed.

This incident with Sara illustrated the difficult behavior with which mothers often had to cope. The preponderance of data revealed the importance of attachment therapy as a supportive experience. For most participants concern and encouragement from the therapists were consistent over time and were available both during therapy sessions and when needed by the family at other times through telephone calls and emails. In addition, therapists would make time to have families come in for emergency therapy sessions when crises arose. Follow-up sessions or referrals and suggestions made by telephone after therapy had ended provided ongoing support when the families requested further assistance.

*Emotionally painful.* Although attachment therapy had the positive aspect of being supportive, participants described a negative aspect as well: Therapy was emotionally painful for both the mothers and the children. During therapy the children's memories and emotions were

aroused, and participants described as emotionally arduous the experience of watching their children revisit unimaginable abuse and neglect. Therapy brought out the pain and anger that the children were not able to bring to the surface in everyday life. Mrs. Patterson poignantly shared her feelings:

The biggest thing with the therapy is that you have to recognize your children's sickness. ... [Therapists] brought out so much hurt from those children until you, it's like you can't take it, you know. You're already living in straight hell, but -- and you know that this is going to be helpful to the children -- at the same time, it hurts so much for those children to bring out all this stuff. It helps them to be able to talk about it, but at the same time, it's tough. If you truly care for those children, you can't sit and listen to what's happened to them and not be, uhm -- it's worse than hurt, I think, it's kind of, I don't know -- It hurts, it hurts.

As she shared her memories Mrs. Patterson was near tears, and she scratched at hives which were brought on by the emotion saying, "This makes me nervous talking about this. I mean it's-- it's weird.... If you see me scratching... you'll know why." Even years after being active in therapy her memories and emotions appeared to be intensely disturbing.

Mrs. Wythe was also open in sharing her thoughts and feelings as she described similar memories of the pain of therapy. She reflected on how emotionally draining therapy was for both herself and Valerie. When the family began attachment therapy, Mrs. Wythe was not committed to continuing to parent Valerie. She remembered, "they asked me the question: 'Can you love this child?' and I said 'I don't know, I don't know.' I felt it was useless to lie to them." In spite of her ambivalence towards Valerie, she agreed to being involved in therapy, and she explained,

The therapy was very, very hard, on all of us. I think Valerie is probably the bravest person I know. It was hard to see her suffering so much.... [She] did the incredibly difficult work they asked her to do. I did the incredibly difficult work they asked me to do.

Psychodrama, creative sand-box work, and Eye Movement Desensitization and Reprocessing (EMDR) were tools that brought to the surface Valerie's years of abuse. Mrs. Wythe described her evolving empathy for Valerie in a psychodrama episode in which one of the therapists took on the role of Valerie's abusive birth mother. She went on to add, "I think that was probably the first time I saw that terrified little girl inside, which was really hard. It was much easier being angry." The developing empathy resulted in Mrs. Wythe's gradual commitment to Valerie and, eventually, her love for her.

Another mother who described her own painful emotions that surfaced during therapy sessions was Mrs. Douglas. Her son and daughter, Charlie, age 6, and Susie, age 4, were two of the youngest children who began therapy. Graphically recalling one incident during a therapy session, Mrs. Douglas said,

I was holding Charlie and both of us started crying. I don't know what it was about it, but I couldn't -- I couldn't quit crying. I don't know why, but it was just like I was feeling his pain in what he'd been through and he was realizing I cared. I don't know. But it was -- I remember her [the attachment therapist] and my husband just sitting there kind of stunned that we both couldn't quit crying.

Susie would often scream and flail about during holding sessions, and the therapists helped her understand that her memories and anger were the "yucky stuff" that she needed to express.



Sometimes Mrs. Douglas feared therapy was causing more trauma. She vividly described some early sessions with Susie:

She thrashed and screamed and it sort of reminded you of what you would see in an -- what you would think you would see in an exorcism.... It was kind of scary.... I think what was going through my mind is, "oh my gosh, you know, are we psychologically damaging her worse? Are we -- is this going to work?" I just kept thinking this couldn't possibly work, but I'm willing to do whatever it takes.

Eventually therapy became less difficult and Mrs. Douglas would use holding at home when Susie was upset. Describing the process, she said, "I'd just sit down on the sofa and hold her for a few minutes and then she would know exactly that that was her safe place to scream and yell and kick her feet and then she would be, you know, fine." According to Mrs. Douglas, Susie benefited greatly from therapy and came to a point where she understood her past abuse, had a clear understanding of the "yucky stuff," and said at the end of a year in therapy, "I'm adjusted. I don't need any of that, I'm adjusted."

Whether or not in other children therapy led to the adjustment expressed by Susie, therapy was an intensely visceral and physical process. Mrs. McDonald, whose children continued to have complex problems, expressed the sentiments of most mothers in the study when she explained that for her therapy was

not uncomfortable as a parent, but uncomfortable having to hear them [the children] bring it all out. They move you to feelings for them. I mean, I've been to tears many a time and I probably will be again, but that's okay. When I stop crying, I guess I stop. That's not going to happen. I feel too much sometimes, I guess, but I think that you're going to feel it. You're going to hurt for them. If you don't, there's something the matter.

Mrs. McDonald described therapy as “intrusive and uncomfortable in some ways,” but she added, “these are not negative words.”

Mrs. Pearce also found therapy uncomfortable, but described it in negative terms. She spoke of using holding with the boys and said, “trying to let them get that anger out and the emotion out, that was tough, that was really tough.” Mrs. Pearce described being marginally engaged in the therapy process and uncomfortable with the therapists. She participated reluctantly in activities of therapy such as holding and psychodrama, and she appeared to struggle as she slowly explained her reaction to therapy sessions. She recalled,

I didn't like it, personally.... Some of the things that we did, I just didn't feel comfortable with. You know, I mean it was just -- it didn't really do -- I mean, I could admire my child looking at him and, you know, but it still doesn't make you *feel* -- I guess, you've got to really be able to bond. ... I felt like everything was pretty much on me, my responsibility to try to make it work. I think I was pretty defensive about it, even though I did it.

Looking back, she expressed her feeling that therapy was exhausting and “must have been awful for the children.”

Similarly, Mrs. Stuckey had disturbing memories of therapy. Describing the artificial sense of the physical closeness in using holding, Mrs. Stuckey said that one of her sons, Roy, “loved it” and the other, Tommy, “didn't want anything to do with it.” She recalled, “We tried to do some of the cuddling.... Being a Special Ed teacher... some of it made sense; some of it was kind of really off the wall for me, like giving a bottle to a 6- year-old. I mean, it was really uncomfortable.” Mrs. Stuckey explained that her training in education emphasized helping children reach their most mature level of functioning, and that she could not relate to the

regression encouraged in therapy. Roy consistently showed a willingness to become attached to Mrs. Stuckey, and she questioned whether Reactive Attachment Disorder was an appropriate diagnosis for him. Tommy retained an attitude of rejection towards Mrs. Stuckey and her husband and, at the time of our interview, had recently been placed with another family. Mrs. Stuckey believed that attachment therapy had little impact on her emotions or her relationships with the boys.

Although Mrs. Pearce and Mrs. Stuckey expressed a different point of view, empathy with the children's painful memories was expressed by the majority of mothers. The themes of the emotional difficulty of attachment therapy and the painfulness of the process were recurring topics.

*Physically safe.* In spite of the emotional stress, all participants expressed the belief that attachment therapy was safe. This was an important finding given the concern with the safety of therapy that had been presented in both the professional literature and popular media. Therapy created a safe place for children to communicate their turmoil as they tried to understand their past abuse. However, because of the anger most children felt, physical safety in therapy was a complex issue which involved both the safety of the children and the safety of parents and therapists. Most importantly, the children were safe from intrusive interventions such as harshness in restraining a child. Also, the therapists contained the physical violence that the children had often exhibited when their anger was overwhelming.

The concern that children would be violent in therapy was expressed by mothers of teenagers. Mrs. Hampton said that Jack, at 13, was

just not caring about what anybody else felt or thought,... [he] would hurt them and not care.... [He] had to get help. HAD to get help. Because the behaviors were just escalating almost daily. There was so much anger in him. A lot of anger.

In discussing her worry about her son's hostility, Mrs. Hampton described the therapists' certainty that they could safely handle Jack's outbursts of anger. She explained, "They assured us over and over that they could handle him and handle his behaviors, and, you know, those sorts of things. And they did." Although Jack was a very disturbed teenager who was in residential treatment for most of the time that the Hamptons participated in attachment therapy, Mrs. Hampton said the family felt safe within the therapy environment.

The Wythe family also found safety in the therapy office, although Valerie, who was in her mid teens, had shown herself capable of great violence. Valerie's anger was often unpredictable. Mrs. Wythe said she would "just bomb and something would blow up.... as we dealt with stuff, other stuff bubbled up." Mrs. Wythe described situations in which both she and Valerie had confidence that the therapists were in control and had the skill needed to calm Valerie down when necessary. The therapists were sensitive to Valerie's limits for closeness and did not impose beyond her ability to tolerate interventions. For example, Mrs. Wythe described Valerie as becoming violent when the family attempted holding therapy. The upsetting technique was abandoned by the therapists, and holding was used with Valerie's cooperation when she was calmer. Mrs. Wythe remembered, "They never asked us to do anything that was way outside the bounds."

Smaller children often exhibited violence in agitated, out-of-control behavior during therapy. Although Susie was only four at the time she was in therapy, her behavior was sometimes extremely aggressive. Mrs. Douglas described a situation during holding therapy in

which it took the intervention of both therapists “sitting across from us to kind of keep her from bloodying anybody’s nose.” Susie would sometimes be “screaming bloody murder” and the picture Mrs. Douglas painted was of a whirlwind of noise and motion with Susie having “fits of rage during the therapy.” Over time, Mrs. Douglas and Susie “came to realize that that was giving her a safe place to let it all out.” Mrs. Douglas noted,

After an outburst she was completely quiet and would go limp.... That was when we could start to build on our relationship with her. When she had gotten that rage out and started from there, she was real responsive from there.

Psychodrama helped build attachment between Mrs. Douglas and Susie, and Mrs. Douglas believes that “it meant a lot to her [Susie] to replace those bad memories with good memories.”

Like Mrs. Douglas, Ms. James dealt with both aggressive and responsive behavior from Shawana. Describing Shawana’s behavior in therapy, she said,

She wanted to kick and bite and spit on people.... I saw a lot of anger come out..... It was almost like two personalities within this little girl, because one was just lovable and the other one was just cunning slick. There were periods where she just hated myself and even the therapist.

However, in spite of her physical belligerence in therapy, therapeutic interventions were never perceived by Ms. James to have been unsafe. She poignantly described Shawana’s reaction after her rages as she recalled,

After they [the therapists] got a lot of the anger out of her, she really turned right--almost like a little baby. So that's when I would soothe and comfort her, just hold and comfort her and just talk to her and just reinforce that I love her.

Although Shawana's outbursts were upsetting, Ms. James expressed the belief, "The therapy was excellent...I think they can really reach the anger that's in these children."

Another aspect concerning the issue of safety related to the activities and interventions by the therapists. Some of the participants had been exposed to community attitudes that attachment therapy was unsafe. Mrs. Stuckey stated that her previous therapist warned her not to participate in attachment therapy. However, the situation with the boys was so difficult that the family was ready to try anything that might help. Mrs. Stuckey recalled the warning: "She was telling me about some extremes, I guess, that were on the news and stuff about wrapping kids up." The news of the death of Candace Newmaker, who suffocated while wrapped in a sheet in rebirthing therapy in Colorado, had been transformed into a warning against attachment therapy. Although Mrs. Stuckey was not favorably impressed by attachment therapy, she did not feel the therapy that her family had was dangerous, noting that "the bizarrest thing was the bottle feeding."

Likewise, Mrs. Williams said she believed attachment therapy was not dangerous although she had been exposed to information about the therapy based on Candace Newmaker's death through an episode of a popular television program. When Mrs. Williams was asked if she was aware of any publicity about attachment therapy, she responded with humor in her voice: "The one on *Law and Order*? Yeah, yeah. The one where they -- the rebirth or whatever it's called. I was like, 'Okay, that's different' (laughing). I have never seen *that* before, yeah." Nothing in her experience with therapy resembled the wrapping and suffocation shown on television. However, she also sympathized with all adoptive parents seeking help for children with Reactive Attachment Disorder saying, "You ask for anything to get some help for that child. Whatever -- whatever you feel like is best, we will try it." The Williams had their son, Chad, in therapy from age 5 to 8 prior to participating in attachment therapy, but Mrs. Williams saw no

evidence that he had improved during those years. She understood the concern about safety but also the need for unconventional therapy techniques to help her son.

Mrs. Compton was also dealing with a child who was unresponsive to traditional therapy, and, like Mrs. Williams, she had been exposed to popular media regarding the rebirthing death. Thinking back to the time when she and her husband were first learning about attachment therapy, she acknowledged, “We had heard about people doing the rebirthing and that kind of thing, and that was a concern.” In spite of the concern, the Comptons were one of the first families to enter therapy under the Georgia State grant funding. Mrs. Compton’s desperation for help for Brittany overcame any reluctance she felt about safety issues. Brittany had tantrums for hours at a time, and Mrs. Compton described her behavior as “just blood curdling screaming. She’d break things. If she started to get tired and couldn’t keep on she’d pinch herself to make herself still start screaming more, or keep screaming.” Totally at a loss as to how to calm their new daughter, Mrs. Compton said, “We finally would just leave her in her room, and we’d sit in the living room so if the police came they could see we were not hurting her.” When the Comptons became aware that attachment therapy was available in Georgia they did not hesitate to begin treatment. Regarding Candace Newmaker’s suffocation Mrs. Compton went on to say, “That’s not something that we ever even came close to doing in therapy. I don’t think that any of it was at all dangerous.”

Mrs. Patterson also believed that there was no danger in the techniques of attachment therapy. She was the first mother in this study to experience attachment therapy, having started before the State grant program began in Georgia. She speaks frequently with adoptive parents and professionals because of her job as an adoptive parent advocate, and she has heard distrust of attachment therapy. On the day before my interview she had a call from a DFCS caseworker who

asked for information and referral for an adoptive mother whose child had been diagnosed with Reactive Attachment Disorder. Mrs. Patterson recalled that although the worker had no direct experience with attachment therapy, she expressed concern about any treatment for attachment difficulties and said, "There's a lot of controversy about this. I don't know if we can teach her some of these things." Mrs. Patterson had to reassure her that the parenting techniques on the video tape she would be sending were not dangerous. Mrs. Patterson was emphatic as she expressed her thoughts, explaining,

What they all point to is the case in Colorado where the child died that was wrapped in a sheet. Never have they ever wrapped my child in a sheet and if they had, I probably would have said, "Get him out of the sheet!" you know what I mean? "You're gonna uncover his head right now or I'm gonna karate chop somebody," whatever I have to do, you know.

The violence of the children in their homes led some mothers to compare the issue of safety in therapy to the lack of safety if the child did not receive intervention. As Mrs. Cooper put it, "I find that the therapy is less scary than the behaviors of not being in therapy." Both Cooper children, now ages 9 and 10, have an "anger problem and both of them have a very quick temper and they're destructive.... Especially Adam.... When he's in the incident, he cannot think straight. He's out of control. He could wreck something or harm someone."

Similarly, Mrs. Buckner faced extreme violence with Earl, who was 11 when attachment therapy began. She stated, "I cooked for the first summer after the first intensive [therapy] with a butter knife. We couldn't have anything [sharp] because Earl was intent on killing me and then burning down the house or killing himself if necessary to escape the consequences." Discomfort in therapy sessions was a small price to pay to resolve the issues of safety at home. The



therapists controlled the family dynamics within therapy and gave practical suggestions for safety precautions at home.

The safety of therapy was discussed in all of the interviews. In spite of what participants perceived as the unusual techniques of age regression and holding therapy with older children, most mothers explicitly mentioned their sense of safety in therapy sessions. The responses consistently indicated that attachment therapy was perceived as a physically safe experience for both the mothers and the children.

#### *Current Relationship with Adopted Child*

*Continuously stressful.* Living with children with Reactive Attachment Disorder is difficult. Almost all of the children in the study were still having struggles, and 19 of the 27 had comorbid diagnoses that were complex to treat as well. Their problems included Fetal Alcohol Syndrome, Bi-polar Disorder, Encopresis, Attention Deficit Hyperactivity Disorder, Autism, Asperger's Syndrome, Obsessive Compulsive Disorder, Auditory Dyspraxia, Sensory Integration Dysfunction, Oppositional Defiant Disorder, and Mental Retardation. The complex emotional difficulties resulted in frequent battles between mothers and their children, and also in the absence of supportive relationships outside the family that could normally mitigate stress.

Mrs. Compton, the mother of 10-year-old Brittany who has been diagnosed with Bi-Polar Disorder, was the most emotional and distraught of all the mothers interviewed. Brittany was adopted six years ago, and even after years of adjustment Mrs. Compton described each day as filled with conflict. Mrs. Compton depicted life with Brittany as "chaos" saying "99% of the days are like that." When asked "What does chaos look like with her?" Mrs. Compton replied,

Why don't I explain it a little bit better by just telling you how our day goes? We get up in the morning and she has to get in the shower because she has wet herself during the

night. That's just a given. And that's about the most peaceful time of the day.... Then it's like I can't get her dressed. She won't put her clothes on.... I set her clothes out. There's nothing she has to do but get dressed, and it turns into a fight. She's hollering at me, and I'm like "put your clothes on." We get out the door, *if* we get out the door... usually she's not all the way dressed and I just put her in the car 'cause we've got to go. And so then she's yelling at me because the car is moving and she's trying to put her shoes on, and so then we've got that going on.... She yells at me *a lot*.

Mrs. Compton described the battles that resume after school. Her words rushed together as she continued,

[After I] pick her up I have to pull over and go through all of her stuff to make sure she has brought her homework home.... Then we go back into the classroom and get whatever it is that she has not brought home. This is a daily thing. And I find out what she did during the day, and then have to scold her for how she's acted. We get home. She starts screaming "I can't do it. I don't want to do it. I can't do it." On and on and on. And then it's supper time. And supper is *always* a battle. 'Cause it doesn't matter what we have, she doesn't want it. And then she's hungry. Then she's screaming like "I'm hungry, I'm hungry" and I'm like "You've got a plate of food right here." "I don't want that stinking food." And all this screaming, screaming, and screaming. And then we have to give her medicine to her. And then there's screaming and fighting over that. And then we put her to bed. And then we're OK again.

The breathless recital ended with an ironic laugh. As Mrs. Compton illustrated in detail her day with Brittany, the exhaustion she experienced in living with the child was evident.

In spite of Brittany's medication for Bi-Polar Disorder, there is no let-up in difficulties from morning until bedtime; screaming, fighting, and lack of cooperation marked every part of the day. According to Mrs. Compton, Brittany frequently lies and steals, and she is obsessed with blood and gore. She has harmed animals and killed her pet hamster, and Mrs. Compton must keep a watchful eye on the family dogs. Mrs. Compton and her husband remain close and both are dedicated to parenting Brittany, but they are unable to obtain relief from the responsibility of caring for her. In tears, Mrs. Compton complained,

We can't even go to the movies. We can't get a babysitter. And it's not that I'm afraid to leave her with anybody, I'm afraid for that person. We've done it. We've tried it, and it has been a disaster.... We feel guilty asking anybody to watch her, even for a few hours. But we desperately need that.

My interview with Mrs. Compton ended with a few minutes of de-briefing using the protocol which I had developed in preparation for such emotional distress. I referred her to therapists who had agreed to be available to families in the study and recommended other supportive services that might be of help. However, both Mrs. Compton and I acknowledged that life with Brittany would likely remain difficult for the foreseeable future.

Another mother dealing with extreme daily stress and whose children are diagnosed with Bi-Polar Disorder was Mrs. Cooper. The Coopers adopted Cynthia, age 10, and Adam, age 9, when they were 4 and 2 years old, respectively. Mrs. Cooper's story was similar to that of Mrs. Compton. Describing her early morning battles with Cynthia in words comparable to Mrs. Compton's, she said,

She would fail to get up in the mornings and it was always a struggle getting her up, and people would just say, "Well, you know, yeah, my kid's a sleepy head too," or something

like that. They would minimize it. But every morning, you know, I would have to literally put her feet on the floor or lift her out of the bed or spank her. That would get to the point where that's the only thing that would get her, and then she would growl at me and give me the -- I call it the look of the devil. That is no way to start your morning.... She has this passive hostility thing where she is slow about everything.... I mean she will purposely be slow on everything.... She missed the bus a lot, and Mom [Mrs. Cooper] was stressing out more than she was.... So finally, really this was at the suggestion of the counselors, let her be accountable. So I decided I was not going to stress myself out. Cynthia could just take the consequence. So I didn't get her up. She had her own alarm clock, which of course it rang for an hour. She missed the bus several times. Well, she started being truant.... Then one plan was get her up out of the bed, just tell her go directly to the car, bring her to school in her pajamas. We did that.

Mrs. Cooper was eventually threatened with court action because of Cynthia's repeated tardiness and absences from school. She revealed that she has resorted to spanking Cynthia each day as they fight their way through the morning routine.

Like his sister, Adam is also difficult to parent. He has been diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Reactive Attachment Disorder, and possible Bi-Polar Disorder. He has not bonded to Mr. or Mrs. Cooper, and his angry outbursts can endanger himself and others. An example of the tedious and unpleasant daily stresses of living with her children was illustrated by Mrs. Cooper when she shared with me a photograph she had recently taken of Adam's backpack stuffed with underwear soiled with bowel movements. Mrs. Cooper said she believes his soiling and inappropriate urination are purposeful. She appeared angry and uncomprehending as she described his behavior, telling me,

One day I went in his closet and I saw a book bag, and I looked in there and there was a book bag full of poopy underwear. Well, I got a picture of it. I said, “This is going in my memoirs because people don’t believe me.” They think I’m crazy. Well, oh, I was angry, too, because I’d been bragging on him. He was really being deceitful. Another time, I forget if it was before or after that, he had a whole bunch of poopy underwear stuffed up under his bed. I mean, he’s gross.

These behavior problems have led the Coopers to another issue that they have in common with the Compton family. They, too, have no support system and no one who is capable of providing respite care for the children. Mrs. Compton lamented, “It is not like we can just hire a babysitter. We have no life. Our life is their life.” She added sadly, “To this day I don’t think any other one person understands what’s going on. They can only see glimpses of it and especially the severity and the stress that it causes on the whole family.”

Ms. Smith has a similar full-time commitment to her 8-year-old son, Jose, and she described her life as continuously stressful as she responds to his needs. His behavior is often explosive, and her life is filled with ongoing interventions and advocacy. Jose has been diagnosed with Fetal Alcohol Syndrome, Attachment Disorder, Sensory Integration Disorder, Dyspraxia of Auditory Processing, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, and Anxiety. He has self-abusive physical behavior, for example, chewing on his hands until they bleed. He is often unable to express himself verbally, has a low tolerance for frustration, and occasionally has tantrums. Ms. Smith referred to these as mini-meltdowns and portrayed them vividly: “He will collapse on his knees like somebody has just broken his back.... Then his head goes down on the floor and he starts pounding the floor this way and he’s

crying the whole time.” Unpredictable tantrums can happen at any time, but currently last about 30 to 45 minutes, a great improvement over the 2- to 3-hour fits in earlier years.

Ms. Smith has formed her own personal understanding of Jose’s multiple difficulties: He's just a little of this and you take a little piece of about five or six different things, which makes it very difficult because you really can't say, well, this is what's wrong and this is how you deal with it.

Medication has been used to correct some of Jose’s problems, and it helped with his hyperactivity. However, Ms. Smith was unable to continue seeking medication solutions for his behavior because of reactions. As she clearly described, “He's extremely sensitive to medication. He has psychotic reactions. He cries. He gets depressed. He won't get out of bed. He has hallucinations.” Jose functions best if Ms. Smith is consistently available, and she structures each day around his needs. She said she relies on her faith and telephone contact with one close friend as her emotional support system, but she has no break from Jose’s care other than times when he is attending school. Jose is among several children in this study whose parents questioned whether they will be able to live independent lives as adults. In spite of his improvement over the years, his mother does not envision an easy path as he negotiates adolescence and adulthood.

Like Ms. Smith, Mrs. McDonald, the oldest participant in the study, worries about the future. The three McDonald children, Ann, age 17, Anita, age 15, and Andrew, age 12, all have been diagnosed with Reactive Attachment Disorder and are in Special Education classes. At one time all three were diagnosed with Autism. In talking about their development Mrs. McDonald reflected,

I've seen real progress. They have come a long way. They have come a long, long way and they still have a ways to go. And if they can get there, they're going to. They have got to be able to function.

The children need daily help with all of their school work and have problems with interpersonal communication. Mrs. McDonald cannot leave them unsupervised for more than a few minutes at a time. Speaking of the therapy visits by the counselor who comes to their home Mrs. McDonald said, "There are days I think, Oh, Lord, I need it more than the kids do."

Mrs. McDonald's high level of stress is the result of continuing difficulties with the children's behavior. Ann, the oldest, has a strong need to be in charge of her siblings and is often oppositional. Mrs. McDonald described their relationship saying, "[Ann] still shows a lack of affection, but now she is controlling. She's very controlling. There have been times when she told me, 'Why don't you leave? I can take care of this household.'" Anita has a pattern of lying and stealing, and at one point recently Mrs. McDonald reported her to law enforcement after episodes of shoplifting and stealing money. Andrew, the youngest, is the most affectionate of the children, although he, too, has behavioral and emotional difficulties. The complexity of dealing with each child's problems is multiplied by the pressure of parenting three troubled children.

Coping with multiple children, each of whom has special needs, is also stressful for Ms. Miller, the mother of four who range in age from 6 to 17. In her interview she discussed the same difficulties other families had described in controlling behavior, lack of respite and social supports, and little progress in attachment. She described herself as "operating without a net" in caring for her children as a single parent. She has no one she can call on for help with the children and has not been able to use formal respite services because of the children's difficult behavior.

Tonya, her oldest, has a history of hallucinations, is severely developmentally delayed, and is aggressive with the younger children. Currently Tonya has two therapists who come to the home and “has had at least six or seven psychiatrists.... She's had 10 years of therapy.” Trying to put into words the severity of her children’s behavior, Ms. Miller described an incident in which Tonya attacked her 9-year-old brother, Mark, when she was gone from the house for a few minutes. Her memory of the incident brought tension to her face as she said,

What it is with the sibling rivalry stuff, it almost seems that if I don't nip it in the bud early... pretty soon, there are rocks being thrown. You see another parent's not going to see that, but I do and I'm thinking [with] my kids it's a fight to the death. I mean, when Tonya choked him, it was because he moved his checker in the wrong direction.

Although Ms. Miller did not have to call for emergency help to revive Mark, the incident clearly distressed her, and Tonya’s therapists were involved in the creation of a safety plan to provide supervision for Tonya.

Ms. Miller described Mark as “full of rage.” He was born addicted to crack, and when he was removed from his mother at age four he was brought to the emergency room and his “eyes were all blackened, and he had bruises all over him on his back and face and everything.” She sadly recalled his life of abuse and neglect and said “by the time he came to me he was almost five and the damage was already done.” Missy, age 8, is the most attached of the children, but still seems emotionally distant with Ms. Miller. Mark and Missy both are prone to destructive behavior, hurting themselves, each other, their possessions, and the house. Head banging, purposely tearing clothing, and making holes in the walls were some of the specific examples Ms. Miller cited. She believed the children feel “they can dump all that nasty stuff here.” Although Matt, age 6, has fewer behavioral issues, his daily medical care and early life-



threatening neglect have created special challenges in meeting his needs. As a sad revelation of her relationship with the children, Ms. Miller reflected, “This may sound crazy but, I'm not sure sometimes if my kids know what a mother is. Or what a mother's supposed to do or not do, or say or not say, or be or not be.”

Like Ms. Miller, Mrs. Pearce did not feel that her expectation of a mother-child relationship had developed with her two boys. The boys have been disruptive and fought one another frequently, and family life has held little joy for Mrs. Pearce since the boys arrived. She summarized her feelings, saying,

I think that my husband and I, my marriage, and me wanting to be a mother, I would have been probably much more fulfilled and less, with much less of a headache, had I just gotten one. Period. Because they really were not attached to each other. They had not lived with each other. They really had not. They didn't even know they were brothers when they brought them here.... They had not and it's been -- they argue a lot. I mean, maybe that's normal for brothers.... but they -- they are so competitive and they are so wanting... You know, it makes it very tough. That's taken a lot of energy.

Mrs. Pearce has hired a live-in nanny to help with the boys and has returned to work full time. She has found that she and her husband relate differently to the children, and in discussing her lack of emotional connection with the boys she said, “My husband might tell you a completely different thing. He probably would.”

Even for families in which the participants described the children as attached, behavior problems persist. For example, although Mrs. Patterson described her two adopted sons who have been diagnosed with Reactive Attachment Disorder as now feeling settled as permanent members of the family, she stated,

It's just so strange what's happening to you in your own home. You don't feel at ease. You're never at ease because you're always having to watch. They're sneaking, they're lying, they're stealing. It's constant. Even now, I have to hide my purse. My boys haven't stolen any of my money, I don't think, in a while, but I still, every day, I have to hide my purse in my own house.

Her lack of trust in the boys, and the stress that results, was emphasized by the statement, “They still have alarms on their doors, just so we know where they're at, you know, at night, they're not wandering around.” The boys have problems with lying and appropriately expressing anger, and school achievement is a continuing concern. Mrs. Patterson credits her husband’s emotional support and his sense of humor with helping her face the boys’ challenges.

Ms. James described similar ongoing stress with her daughter, Shawana, age 11, even though their relationship has improved greatly over the years. She proudly showed me a certificate that Shawana received in school this year for “Most Improved Behavior”; however, dishonesty continues to be a major problem. Describing a recent incident, Ms. James said, “When she lies, she will stick to it and stick to it.” She brought out Shawana’s report card that had a grade change on it, obviously made by the child using White-Out on the official record. Shawana refused to acknowledge that she had made the change and created a totally implausible story “that the music teacher had quit that day, so they didn't get a grade.” Although Shawana has great potential as a bright and talented child, Ms. James remains concerned about her future behavior. She elaborated,

Right now I'm really in a thing that there still needs to be some counseling going on with her.... She needs some because she's such a compulsive little liar that I hate for her to get into something because I might not be able to help her get out of it. Because nobody can

believe anything that she says.... That compulsive lying is just, the way she's at now and it's not good at no age, but, it's not good at her age because she's getting bigger and she's just still doing it. Just lying for no reason, you know, no reason whatsoever.

Ms. James deals daily with both the promise and the challenge in helping Shawana reach her potential.

As these comments from the participants make clear, the difficulties of living with children with Reactive Attachment Disorder had not completely subsided for most of the mothers in this study, although for more than half there had been improvement in the attachment between mother and child. The problems of daily functioning remained significant, and the continuous stress was related to multiple causes and conditions.

*Unquestionably permanent.* In spite of the fact that most participants were still dealing with difficult parenting issues, commitment to the adopted children was a theme in every interview. Of the 27 children in this study, 26 were still part of their adoptive family; twenty-three were living at home, one was in residential treatment, and two were age 18 and out of the home but still emotionally connected through telephone conversations. All 16 of the mothers talked about their firm belief that their adoptions were permanent. Some verbally expressed their sense of commitment from the beginning of the placement in spite of problems. Others described times when they had rejected the children and had considered disrupting the placement before legal adoption or dissolving the finalized legal adoptive relationship. All of the mothers expressed their feeling that the children were now members of the family. An adopted child had left the family in only one case, and in that situation the child was living with adoption-related relatives; his biological brother remained in the original adoptive family.

Mrs. Patterson is one of several of the mothers who was determined from the beginning of the placement to give her children the promise that they would not move again. When the Pattersons took in Butch, age 8, and Jimmy, age 5, Mrs. Patterson knew that the boys needed a family who could permanently parent them. The boys had bounced from place to place, and their resulting behaviors were more obnoxious than other foster parents could handle. The Pattersons were experienced foster parents whose hearts went out to the boys. Mrs. Patterson spoke of the commitment she and her husband made to keep the boys although she said, "you get to the point where you really dislike these children and don't want to be around them."

The Pattersons were able to adopt Helen, the baby they had dreamed of for many years, a few months after the boys arrived. Mrs. Patterson described the tension in the house:

We waited out 10 years for a baby and then she came and was everything that we were looking for. It's kind of sad, because at that time, Jimmy and Butch were at their worse, so a lot of her babyhood we couldn't enjoy as much as we would have, but, we did make that, you know -- you know, that commitment to them.

When Helen arrived the boys had not been legally adopted, and the Pattersons could have requested that they be moved to another foster home. Instead, Mrs. Patterson maintained her dedication to parenting Jimmy and Butch and spent hours seeking treatment for the boys. She quit her job to have the time and energy for parenting.

Butch is now 18 and Jimmy 15, and Mrs. Patterson's resolve to meet their needs continues. Butch is in the tenth grade but is becoming eligible for adult disability payments. Mrs. Patterson said that she is in the process of becoming his legal representative with the hope that some time in the future he will be able to live on his own. In summarizing what commitment to the boys has meant to her Mrs. Patterson declared,

I won't say that I'll ever have the kind of relationship that I have with Helen with them because I don't think they'll allow me to, but I would hurt somebody if they hurt them, you know, and they know that. They know that I've done what I could do for them, and I think that's what's made a difference.

Another parent who had been continuously committed to permanency was Mrs. McDonald. She was in her late 60s when her three children with multiple problems arrived at the request of a distant relative. She said, "It was so bad there in the beginning that when they broke loose, I thought, 'Dear Lord, what have I got here?' We had no ideas about the sexual abuse and so many things we didn't know." When I asked her if she had ever considered disruption she said,

No, no. You don't give children back. It doesn't matter. No, all I know, and all the struggle it's been, I would do it all over again. There's not one minute I ever thought about giving them up.... I can't imagine not having them and I think about, God, what if somebody had these that - I don't feel like I do enough some times - but what if somebody had them that didn't care?

The McDonald children are 12, 15, and 17 and after 6 years in the home they still needed constant supervision and have multiple problems. Mr. McDonald is unwell, and Mrs. McDonald looks towards a future as an elderly single parent, providing support for the children even after they move into adulthood. Permanence is only limited by the reality of her advancing age and possible future health problems, and Mrs. McDonald is aware that the children sometimes worry about this. She explained, "They have this horror of something happening to us, and I try to tell them, 'You don't have to worry about that. I'm going to be around here for a while.'"

Unlike Mrs. Patterson and Mrs. McDonald, a few of the participants had seriously considered not keeping their children during the early years of the children's placement in their homes. After 6 years with Ms. Smith, Jose is now legally adopted and is the center of her life. However, when Ms. Smith took Jose into her home as her first foster child she was overwhelmed by his serious emotional disturbance. She did not develop affection for him during their first year together, and she stated that she told the caseworker, "Oh no. I'm not adopting him. No, I'm not interested." Presently, Jose is 8 years old, and he needs continuous supervision, frequent therapy visits, and special education. When explaining her intense, unending involvement in meeting his needs, Ms. Smith said, "It's my life. That's the way it is. ... There would be no other way. Sometimes I say 'What have I done?' I did a lot of praying before I adopted him." She has learned parenting skills, and has developed patience and understanding of Jose's special needs, and there is no doubt of her love for him.

Ms. Workman also described a situation in which permanence has developed in spite of difficult early years and Charnese's ongoing mental health problems. When Charnese arrived in the family at age 8 Ms. Workman described her as "a very angry little girl and, you know, almost violent sometimes, just throwing stuff and yelling, very defiant. [She] really didn't want anything to do with us." Both Ms. Workman and her other daughter, who is three years older than Charnese, suffered through disappointment and anger. Ms. Workman shared, "I just thought, in the back of my mind that, you know, any child that you love will love you back. And that's not true." She described her distressed phone call to DFCS when Charnese was 11, after she had been in the home three years. Emotionally remembering that time she said,

We were having so many problems that I called our social worker and was like, "You need to take her back. This is not working. And she doesn't want to be here. She hates us,

and you need to take her back." And they said, "No," of course, they said, "No. We can't take her back."

Ms. Workman admitted, "By that time, I didn't really like her."

The Workmans were referred to an attachment therapist who was a sustaining presence in their life for three years. During most of that time she provided therapy in the Workman's home, sometimes coming weekly after school to meet with Charnese while Ms. Workman was still at her job. She provided a support system for both Charnese and Ms. Workman, and attachment therapy helped them grow close. Ms. Workman said, "I think that brought us together.... I think she attached to me as much as she could. I know she loves me. And I love her." Ms. Workman still worries about Charnese's ability to make good decisions, and recently Charnese was hospitalized for suicidal ideation and depression; nevertheless, there is no question of Charnese's permanent status as a member of the family.

In some families the commitment to permanence for the children has continued because of a growing understanding of their difficulties, even in situations where the children are still not attached to the family. One example is the Cooper family. Adam and Cynthia Cooper have complex behavioral and emotional problems. As Mrs. Cooper elaborated,

You know something's not right, but you're not sure what it is. To this day I'm not sure if it's ADD [Attention Deficit Disorder], Bipolar, or RAD [Reactive Attachment Disorder] that's causing all this, or if it could be a comorbid condition, but the attachment therapy gives the parent tools to deal with it.

In spite of years of therapy, Adam and Cynthia continue to be argumentative, oppositional, and often out of control. Mrs. Cooper expressed her feeling that they do not feel a part of the family as she said,

I think I'm probably more attached to them than they are to me, but I'm having difficulty with them and they're having difficulty with me. There's no doubt. That doesn't really change my commitment to them, though, because I guess I'm more forgiving because I know that they can't help it.

Mrs. Pearce also described commitment to providing a permanent home for her boys in spite of her ongoing emotional ambivalence and the boys' behavioral difficulties. Her early relationship with Donny was a close one, but she hesitated to adopt Paul, her older son. She commented,

I had him for two years before it actually went through the adoption. So, they gave me enough time to know, oh my God, what have I done? But I still felt, you know -- we still went through -- through with the adoption. I was not thrilled with it, but we did it.

However, Mrs. Pearce's commitment to providing permanency for both boys was evident when she said, "We have them both and we will have them both. We're going to have them both."

It was clear from the participants' comments that commitment was not related to the pleasure of parenting nor to the progress the children were making in becoming more emotionally healthy and attached to their mothers. The commitment was a dedication to providing permanency and stability for the children.

#### *Role of Attachment Therapy*

*Instilled confidence.* One of the outcomes of attachment therapy was a sense of mastery of techniques and attitudes to control the level of stress in the home. Mothers gained confidence in their ability to parent their children as they experienced support in therapy and success at home.



The need for confidence in the role and skill as a mother was poignantly expressed by Mrs. Buckner as she described her feelings before entering attachment therapy:

I was really questioning my own ability as a mother. I felt like I was ineffective and there must be something wrong with me, and I didn't know what it was because these children are not bonding, things weren't normal. I had feelings of dislike for them and I have always been a very warm, loving person and very easily overlooked people's faults and found something to love. And it was getting harder and harder, and I really was losing my own confidence and wondering what was wrong with me that these kids weren't turning out well.

The Buckners began attachment therapy when Earl was 11 and Edward was 9. The boys had been with them for 5 years, and Mrs. Buckner said she felt like a failure as a parent. The family had been to several psychologists and Christian counselors and had been told “you’re wonderful parents, you're doing things right. This is just going to take a long time to heal. Just keep loving them, just keep loving them.” Explaining the impact of attachment therapy Mrs. Buckner continued,

Therapy with the grant made us realize we were dealing with a disease, a disorder, a severe emotional illness that these weren't just horrible, rotten brats. That their inner being was out of kilter and that it wasn't their fault, even though they were very difficult and hateful and mean. This was something that we could try to move them along with the right care.... [Therapy] was very powerful and it empowered us and they [the therapists] reassured us, as parents.

Like Mrs. Buckner, Mrs. Compton discussed the help attachment therapy gave parents in bolstering confidence. Mr. and Mrs. Compton had not been able to cope with Brittany's intense and frequent tantrums. Describing her behavior, Mrs. Compton said,

At home, if she heard the word "no" she'd start screaming, and scream for 3 and 4 hours. Nonstop. And, you know, that kind of thing we were just totally unprepared for. We didn't know how to make her stop, how to help her get through whatever. And it would be just any little thing that would start that. It wouldn't have to be anything major. It could just be a movie she was watching was over, and she'd start screaming for 3 or 4 hours. It was like, "Ok, how do we live like this"?

The local therapist in their small town said "there's nothing I can do for her.... I'm not equipped to help you with her." With the encouragement of the attachment therapists, the Comptons tried various discipline techniques. Mrs. Compton recalled,

[We] did a lot of the natural consequences. We did some limiting, we went through a phase of taking everything out of her room to where she just had nothing, and had to earn things, [but] there's nothing she cares about enough to make a difference.

Brittany's out-of-control behavior has continued in spite of attachment therapy. However, Mrs. Compton noted, "it helped my husband and I be able to deal with her. Because we had someone who knew what was going on that could kind of validate our feelings and the way we were dealing with it." In spite of the difficulty parenting Brittany, Mrs. Compton now has confidence that she understands her daughter's problems and that these are not caused by her own parenting but rather by Brittany's long-standing mental disorders.

Parents were taught to accept their own feelings of anger and frustration and to gain control over their own reactions to the children. One example of the impact of the new

confidence gained by self-awareness was given by Mrs. Cooper. She described the importance of learning new ways to react to the constant misbehavior of Cynthia and Adam when she commented,

Attachment therapy gives the parent tools to deal with it [difficult behavior] so that your home is not totally out of control.... It in no way would keep the children from doing the wrong thing or whatever, but it gave me a plan on what I needed to do when that occurred. And it, I think, taught them, I'm not sure, that Mom had a plan and that there were consequences for actions and that there was usually a reason behind it.

Attachment therapists demonstrated specific skills for parents to use in gaining confidence to cope with behavioral problems. Additionally, they modeled and supported appropriate limit setting and discipline methods. Mrs. Cooper provided an example of an effort to shift the problem of Cynthia's uncooperative early morning behavior from herself to her child:

I decided I was not going to stress myself out. Cynthia could just take the consequence. So I didn't get her up. She had her own alarm clock, which of course rang for an hour. She missed the bus several times.... And then she would get up at 9:30 or 10:00 and say, "Mom, would you take me to school?" So I said, "Well okay, but you'll have to pay me cab fare."

Although the difficult behavior has not been resolved, placing more responsibility on Cynthia for her actions has given Mrs. Cooper some peace of mind.

Often the parents were more successful in putting new techniques into practice. Ms. Smith found "strong sitting" (sitting cross-legged on the floor) helpful in dealing with her son, Jose, now age 8, who has tantrums and can be difficult to control. Ms. Smith described the technique as a process that allowed her to remain calm. She told me the story of a screaming fit

that Jose had at the grocery store a few months prior to our interview. After they returned home she told him, “Now, you sit and strong sit right here in the middle of this living room floor.” She explained, “I turned around and I walked upstairs and I closed the door, and he screamed for about half an hour, but he didn't get up. He will not get up once he's down there... which is fine with me.” Ms. Smith reported that eventually Jose will quiet down and tell her “I'm ready,” and they can then discuss his inappropriate behavior. The technique gives her a calm way of reacting to outbursts and of helping Jose increase his own self-control.

Mrs. Patterson also illustrated using new discipline techniques. She described shifting from feeling angry to being in control as she and her husband changed their parenting behaviors. She explained,

We started immediately doing the things that we learned... and we saw the reaction. We saw the children getting really mad [and] we were not mad at all. We were, like, just as sweet and talking to them just as nice. Before, I was getting really mad and didn't know why.

She added, “You learn more on how you have to deal with them.” Mrs. Patterson began using consequences that proved effective with her boys and now shares advice on parenting with other adoptive families who are struggling. Raising her boys has not been easy, but Mrs. Patterson is confident that she understands her sons and that she used the tools that were available to parent them to the best of her ability.

Likewise, Mrs. Wythe described a similar change in parenting techniques as she moved the emotion and control battles of discipline from herself to Valerie. She explained how using phrases such as “No problem” and “You can have the last word” while setting firm limits changed the family dynamics. She added that she had to choose which things to confront Valerie

about and which to let go by. Mealtime was always stressful, and this became an area where new confidence in her ability to control the situation helped Mrs. Wythe. Describing one evening, she said,

I'd say what do you want for dinner and she'd say "I want pizza." So I'd either make or order pizza, and we'd sit down to dinner and she'd say "I don't want that".... [Finally I made] a meal that wasn't her favorite, but wasn't something she hated either, and sat it in front of her. She said "We're having *this* for dinner?" I said "No problem" and I lifted her plate off the table and set it on the floor and let the dogs eat it. And she said what am I having? And I said "You're having *breakfast* if it's more to your liking." Because she literally would run me ragged over food. And Valerie never battled with me over food after that.

Fights about meals, chores, and daily activities gradually faded to the background of family life for Mrs. Wythe and Valerie as Mrs. Wythe's confidence in her parenting increased.

In several cases, as illustrated by Ms. James, the new confidence that the parents felt they gained in therapy kept them committed to parenting the children. Ms. James shared that she appreciated being understood by the therapists. She believed that the help she received from the attachment therapists made a tremendous difference in her ability to parent Shawana. She would like to return to therapy, but her insurance will not pay for attachment therapy and other counseling did not help in the past. As she explained, "That's why I'm kind of hesitant about going into other counseling because I want something that I'm going to walk away [from] and feel that it helped make a difference." She revealed,

Before I had taken her to that [attachment therapy], I was just at my wit's end. I could have just let this child go! Because it was just too much! But when I started taking that, I then started seeing a light.

Mrs. Buckner also wondered if she would have continued parenting her boys, Earl and Edward, if not for the knowledge she gained about Reactive Attachment Disorder. She emotionally commented,

It just becomes like this burden, you know, that you carry and you have to learn how to throw it off.... I was desperate for answers.... It [therapy] completely changed our understanding of the children, our approach to dealing with the children.

The confidence she gained in using consequences and choices with the boys became the core of her behavior management, and she was able to remain calm, even in difficult situations. She learned to have empathy for her sons without accepting their actions when these were in conflict with the family's values.

At 17, Earl's behavior had become unacceptable at home and Mr. and Mrs. Buckner told him,

You have to make a decision whether you're going to be following your rules, which means you're not here, or you're following ours, and you have the protection that we have to provide for you. And so he said, "Well, then I'm out of here."

Earl left home to live on the streets, although Mrs. Buckner said "at 17 he was a lot more like a 12-year-old." Despite his rebellion, she feels satisfied that "He has a full bag of tools that we've given him and he just needs a lot more time." Mrs. Buckner stated that the skills she learned in therapy and her confidence in her role as his mother gave her the ability to negotiate his rebellion from the family without destroying his tenuous attachment.

*Preserved family structure.* Of the 16 families, 13 felt attachment therapy or their relationship with an attachment therapist in ongoing, home-based therapy played a crucial role in preserving their family. Some of the participants said that they had considered legal dissolution of the adoption. Other mothers had pleaded with authorities for help. At least four of the children had been in out-of-home psychiatric hospital or residential programs. In some cases family life was so difficult that mothers considered divorce or suicide.

One of the most extreme situations was related by Mrs. Wythe. The tension between her and Valerie had been present from the beginning of the placement, but as months went by Mrs. Wythe said she became more and more distraught. Her husband had taken the role of the “good parent” and nothing Mrs. Wythe could do seemed to improve the situation. Her husband, friends, and family had identified her as the problem and Valerie as the victim in the family. Mrs. Wythe said that at this time Valerie

was just going to hunt me, and just be relentless. Like if I tried to walk away from her, she was just going to push through me. If I’d vacuum, she’d yell over the vacuum. If I went outside she’d follow me outside. If I put myself in the car she’d follow me out to the car. If, for example, the argument started and then Paul would come home she’d immediately drop it.

Mrs. Wythe said prior to entering attachment therapy her Catholic faith was probably all that saved her life. The only escape she could envision was suicide. She described her thoughts saying,

There was just no fight left in me. I mean, I had the bridge abutment picked out where I was going to go in the middle of the night, take my seat belt off and just commit suicide that way, because she didn’t have to murder me. She just had to keep doing what she was

doing, and I would have taken myself out. ... I owe them [the attachment therapists] my life and Valerie's life. It's as simple as that. She *would* have killed me or I would have killed myself.

Valerie's desire to kill her mother presented a very serious danger at the end of her first year with them. In fact, she had made a detailed plan to murder Mrs. Wythe. After an argument over her sexual behavior with men in the neighborhood, Valerie became enraged over the discipline imposed. With agitation in her voice, Mrs. Wythe recalled:

Eventually she went upstairs and brought down a hand-written plan of how she was going to murder me and make it look like a suicide.... So we called the therapist and he said "You need to transfer her to the emergency room. She's had a psychotic break."... She was saying "I'm just going to kill myself."... So we took her to the emergency room and the psychologist there evaluated her.

When questioned by the psychologist about the plan, Valerie's response was, "Hell, yeah, I wrote it and I'm going to do it." Mrs. Wythe shared the note with me, and it describes in detail Valerie's preparations to stab her and how to react to the police. She also shared the fake suicide note Valerie had written.

Other mothers similarly shared the fear that they would be killed by their children. Mrs. Buckner said that both of her boys spoke in therapy of their desire to murder her. At age 10, her younger son, Edward, disclosed that "he was going to first kill Jim [her husband] so that he couldn't protect me and then come over and kill me." Earl, the older brother, also posed a serious threat to the family. His difficult behavior as a teenager was extreme. Describing it Mrs. Buckner shared,



He would do things like strip down naked, stand on his head in the window, the full-length window in his room, naked. So that when I drove by, if I went out to a church meeting in the evening or something, I would see him naked in his window. He destroyed everything in the room.... He gouged up everything in there. Each day when I turned off the alarm [on his bedroom door] and opened it in the morning, there would be some new surprise. It might be bloody Kleenexes strewed on the floor; it might be he had rigged up something. He was so creative in having some kind of shock and surprise ready for me when I opened that door, and he would do things like, he might go on at night, maybe for a whole hour, singing hymns, words of hymns and then shift into filthy profanity.

Earl threatened Mrs. Buckner with images of attacking her with knives and “sharp bamboo spears,” or of burning the house down. Finally, when Earl was 17, Mrs. Buckner realized that she had reason to be fearful of him. She recalled the incident:

He was a big strong boy and he was out in that backyard, and he had huge body motions swinging this axe like a windmill, and hacking up the furniture and hacking up the trees and the trampoline. And I had a feeling in my heart that I had never had before, and I realized that he could come in and kill us. That he really could. And I realized that we're going to be pretty careful. I don't think he's going to do that. I think that day if he had wanted to, he would have. But, I had to take the safest, most conservative route.

Following procedures that had been discussed in attachment therapy, she called the police. She explained,

We pressed charges and everything like we'd been taught to do. He did his community service. He found out that we still meant business. You know, it was almost like his “hurrah” to see if he could take over the place.

Although Earl left home shortly after this time, he has continued to call home occasionally and obviously is invested in showing his parents that he can succeed on his own. The Buckners remain committed to their relationship with him as he grows into adulthood and still acknowledge him as part of their family; however, they are realistic about his inability to live at home without conflict.

Unlike the Buckners, Ms. Miller feels in control of her children and able to continue to keep Tonya, now 17, at home, although Tonya has aggressive and unpredictable behavior. Tonya's dangerous actions have been evident since she was much younger. Ms. Miller said, “[she] hid knives in a big pattern under my love seat in my old house. It was a frightening, frightening situation.” Ms. Miller demonstrated her perseverance when she quipped, “It was psycho. I mean, a 7-, 8-, 9- year-old who weighed less than 40 pounds. She was psychotic. She still is, but I mean, she's my psycho.” Tonya is violent with her siblings, and Ms. Miller has had to maintain constant supervision of the children and make safety plans with the help of her therapist in order to keep the family together.

Violence was not the only threat to family stability for the participants. Five of the 11 who are married specifically mentioned that they considered leaving the family. Mrs. Williams said, “This has almost caused us to get a divorce.” She described the family tensions, saying,

I told my husband, “I can't live like this no more. I'm tired of my stomach hurting.... I'm tired of my head hurting, and I'm tired of every time I get ready to come home and walk in the house, y'all are fussing at each other.”

Mrs. Williams went on to note that her loyalty to her young daughter also impacted her distress:

She starts crying and I'm like, "This is not normal. That's not fair to her," and I was really thinking about filing for a divorce. 'Cause I told him, "I can't live like this and I'm not letting her live like this." I said, "I will take her and you and Chad can have the house and tear it apart if you want to, but I can't live like this."

Mr. and Mrs. Williams approached DFCS for help in order to save their family, but services were repeatedly denied. Since attachment therapy was prohibitively far from the William's home, returning to treatment was not an option. The attachment therapists joined the family's advocacy for Chad's residential placement. While waiting several months for treatment to be approved, Mrs. Williams received support from the therapy team. She described this saying,

They [the attachment therapists] were wonderful. I mean, we could call them night or day. We had their cell numbers and since Cassandra was the main therapist we had her home number, and anytime we needed her we could call her and she'd be like, "Okay, let me talk you through. Just tell me what's going on and I'll talk you through."

At the time of our interview Chad was at an outdoor therapy program that had been recommended by the attachment therapists, and Mrs. Williams was optimistic that the family would remain intact.

Although Mrs. Patterson did not share Mrs. William's current level of stress, she remembered a time when she was also ready to leave the family. However, she realized that her plan to leave was only a daydream, and that she was firmly committed to her husband and the children. She described her reflections:

I didn't want to be here anymore. I just wanted to leave, and I actually even was looking at apartments. I was just looking in the paper, and I thought, "What are you looking for here? It's not your husband that you're trying to leave. And, if you leave, you gotta take the children 'cause he can't take care of them."

Thinking back to her own search for solutions she said, "I think that therapy has to happen if these families are going to keep these children." In her work with adoptive families Mrs. Patterson often hears stories of stress on marriages and the need for support to preserve the family.

Along with marital discord, adoption dissolution was often considered by mothers prior to attachment therapy. Although Mrs. Buckner and her husband continued to have a strong marriage and had raised two older children, they found themselves at a loss as to how to parent Earl and Edward. Looking back on the problems that the boys brought to their family at ages 6 and 3 Mrs. Buckner stated,

I would never have had any idea how to deal with those boys. I don't know if we would have disrupted, or if we would have run away from home or what we would have done. But, without that therapy, I think they would probably both be in boy's prison, because they were very criminal minded, both of them: theft, lying, arson, blood and gore, huge obsession with violence, blood, gore, things like that.

Attachment therapy was a long process, but Mrs. Buckner noted, "they began to change and over a period of a couple of years.... even the boys realized that they were changing." Now she describes their attachment to the family as positive and permanent.

Ms. Workman also described a change in the family's attachment because of therapy with her daughter who was adopted at age 8. When Charnese joined Ms. Workman and her older

daughter who was 11 at the time, Charnese was “a very angry little girl.” Ms. Workman said “[she was] almost violent sometimes. Just throwing stuff and yelling, very defiant. [She] really didn’t want anything to do with us.” Ms. Workman recalled, Charnese “had been with us for about three years, and she’d been a holy terror for three years,” driving Ms. Workman to call DFCS asking for dissolution of the adoption. Instead, the family received a DFCS referral for in-home services from a therapist trained in attachment therapy. Ms. Workman found therapy to be a positive experience and said “it made perfect sense to me... and it’s like I tell everybody this: ‘Weird as it sounds, it worked for me.’” Ms. Workman stated that attachment therapy “saved Charnese, in that I love her now as a daughter.”

For most of these families attachment therapy played a major role in the continued functioning of the family as a unit. The participants’ discussions of plans for suicide, murder, and divorce indicated the extreme gravity of their situations if there had not been significant intervention. Attachment therapy served to lower the risk of these serious outcomes and preserve the families.

*Offered partial solutions.* In spite of the helpful role that attachment therapy played for many of the families, the level of stress still existing was a clear indication that this therapy only offered partial solutions to the children’s complex problems. All of the children had at least one comorbid diagnosis when they entered therapy, and 19 of the 27 children had at least one psychiatric disorder at the time of my interviews with their mothers. Parents and therapists were aware that attachment therapy only partially resolved the challenges faced by the children and families.

Mrs. Butler believed that attachment therapy addressed a core mental health issues for her boys; however, she explained that their emotional disorders are complex and still not completely

resolved. Earl has been diagnosed with Bipolar Disorder and Edward with Tourette's Syndrome. Describing the ongoing search for solutions Mrs. Buckner said, "You keep looking for answers and you keep doing whatever you need to do to try to help these kids heal." She has seen continued progress with the boys and described the gradual change in Edward, her younger son who is now 15. As a young child he would isolate himself when in pain and withdraw from her attempts to provide comfort. Two years ago she recognized tremendous improvement in their relationship when he reached out to her:

He had an outburst, an emotional outburst, and kind of went a little psychotic. But he picked up the phone and he called me and he said, "Mom, help! I think I'm going crazy!"

I realized he called for help. He called for help!

She attributed the change to attachment therapy, but also credited medication, homeopathic remedies, consultations with specialists, extensive reading about mental illness, and her strong Christian faith with helping find solutions to the boys' difficulties. She described all of these approaches as useful in combination, and stated that attachment therapy was an important, although not exclusive, part of treatment.

Ms. Smith told a similar story of finding multiple sources of help for her child, and included attachment therapy as one of the useful interventions. Although Jose's complex disabilities made attachment therapy ineffective with him, Ms. Smith gained an understanding of the impact of Jose's background on his current functioning and new parenting techniques that were successful in controlling him. These partially resolved Jose's problems by providing tools that worked to modify his behavior. She shared with me Jose's history of therapy, which included years of occupational therapy and cognitive-based speech therapy as well as multiple adaptations in school. She described her current understanding:

He's just a little of this and you take a little piece of about five or six different things, which makes it very difficult because you really can't say, "Well, this is what's wrong and this is how you deal with it."

She believed that attachment therapy had only a small role in Jose's positive changes, but added that she believed the therapy should be available to help all adopted children who came from backgrounds of abuse and neglect.

Unlike Ms. Smith, Mrs. Patterson found attachment therapy very effective and credited it with saving her family. However, she explained that dealing with Reactive Attachment Disorder masked Butch's learning disability. Thus, although the therapy solved many problems, it left a major area of need undiscovered. She believed that the therapists' emphasis on attachment issues led to placing the blame for all misbehavior on attachment. As a result, Butch was often thought to be oppositional or lacking in empathy when he was actually dealing with cognitive deficits. Turning 18, and in the 10<sup>th</sup> grade, Butch will probably not finish high school according to his mother. She pointed out the importance of looking at the multiple disabilities a child might have: "If you have a child with an attachment disorder and learning disabilities, you have to make amendments to that -- to the rules, and I'm guilty of not doing that at times." She recognized that she would be responsible for helping Butch continue to grow for many years to come, although she stated that the boys have no further need for counseling.

Although a few participants, such as Mrs. Patterson, did not anticipate further therapy for their children, counseling continued to be part of the lives of many of the families. Most participants expressed the belief that the attachment therapy received during the State grant was helpful but only partially solved their children's attachment difficulties. Many mothers either had

remained in therapy with their children or were hoping to re-enter therapy. Ms. Workman, Mrs. McDonald, and Ms. Miller all described ongoing in-home therapy with attachment therapists.

Speaking about her three children with multiple mental health diagnoses, Mrs. McDonald noted,

[The attachment therapist] still comes to our home. It is a positive thing.... Sometimes we have group sessions. Sometimes it's just the kids or an individual kid, and so she sees them like they are. They can't snow her. Yes. Yes. She has been good.

Mrs. McDonald has received re-authorization for in-home services on a regular basis through her local community mental health program. In talking about her children at the time of our interview she said that problems continue in spite of the progress she attributes to attachment therapy: “The oldest one still shows a lack of affection, but now she is controlling. She's very controlling. There have been times when she told me, ‘Why don't you leave? I can take care of this household.’”

Similarly, Ms. Miller's four children continue to have serious multiple behavioral problems. Home-based therapy from an attachment therapist has been in place for all of the children for “few years.” Ms. Miller explained, “I've seen incremental things. I have seen improvements. I've seen some major things.” However, she added that although her relationship with the children has improved, the children's destructive acting-out and their special needs at school continue to be areas of major stress. Her disappointment was clear when she reflected,

I didn't expect miraculous results in seven days or seven visits and nobody pretended that. But I certainly expected -- I had a level of expectation that if I do the work and I do what these experts suggest when I go back home for the next week... then I thought that would



move us forward and after a period of months or a year, we'd be able to look back and say, "Okay, we've come this far."

In spite of continued challenges, she was thankful for the attachment therapist who still provided six sessions of in-home therapy each month.

Unfortunately in-home attachment therapy had recently stopped for Mrs. Workman and Charnese at the time of our interview. They had participated in home-based therapy for two years, and Ms. Workman said that attachment therapy "brought us together." However, the therapy had only partially relieved Charnese's trauma of early abuse and rejection. Her emotional adjustment continued to be tenuous, and she had recently been hospitalized for depression and suicidal ideation. Ms. Workman said she believed that continuation of therapy would have prevented this crisis, and that Charnese needed supportive counseling from a specialist in attachment issues. She hoped that the attachment therapy would be re-authorized through community mental health funding.

In summary, although attachment therapy was not the whole solution for any of the children, it played a role in stabilizing the families' functioning. Continuation of attachment therapy and implementation of other mental health and school-based services combined to provide solutions to multifaceted parenting and discipline problems and to improve the children's emotional wellbeing.

### Chapter Summary

The purpose of this study was to explore mothers' experiences of attachment therapy as related to their current relationships with their adopted children.

The research questions that guided this study were:

1. What was the experience of attachment therapy for the participants?

2. How did the participants view their current relationship with their adopted child?
3. What were the participants' perceptions of the role attachment therapy played in their current level of functioning?

The participants were 16 adoptive mothers who varied widely in age, living environments, and family composition. There were 3 Black and 13 White participants; 5 of the participants were single mothers. All had adopted through the Georgia Department of Family and Children Services and all had experienced attachment therapy under a State grant program. Each mother was interviewed individually and shared her experiences in her own words. The following sections present the findings as they related to each research question and a summary of the categories which emerged from the data.

The first research question addressed the participants' description of the experience of therapy. The categories are: "consistently supportive," "emotionally painful," and "physically safe." The first two categories bring attention to mothers' perceptions that although the therapists were supportive of the parents, therapy was emotionally difficult. Of the 16 participants, 14 described attachment therapy as consistently supportive. Therapists understood the behaviors the mothers were facing and validated their feelings. Therapists attended school meetings and other community resource conferences, and some of them ran parent support groups. They had telephone and email contact and often provided services at no charge after the State grant ended. However, despite the fact that therapists were supportive, according to the mothers the therapy itself was heart-wrenching. As the children remembered and processed abuse and neglect, their pain was shared by the mothers. Several mothers spoke of being moved to tears as they watched the children cope with their anguish.

In spite of the emotional trauma of therapy, all of the participants stated that they felt therapy was physically safe. Although some of the mothers had heard that dangerous rebirthing techniques were used in attachment therapy, none experienced any methods resembling the descriptions they had heard. All mothers expressed confidence that the therapists conducted themselves professionally and were in control of each session. No participants perceived physical danger to themselves or their children during therapy.

The second research question addressed the participants' view of their current relationship with their adopted children. "Categories are: "continuously stressful" and "unquestionably permanent." In most cases the children were still manifesting behavioral problems at the time of my interview, and living with them was difficult. Of the 27 children in the 16 families, 19 still had major psychiatric diagnoses, including Bi-polar Disorder, Fetal Alcohol Syndrome, and Asperger's Syndrome. Oppositional behavior, lying, and stealing were ongoing pervasive stressors for many families. In spite of these difficulties, the participants expressed unwavering commitment to providing permanency for the children in their families. Only one of the 27 children had been removed from his family since the end of the State grant.

The third research question explored the participants' perceptions of the role attachment therapy played in their current level of functioning. Categories that emerged from the data are "instilled confidence," "preserved family structure," and "offered partial solutions." Participants said that therapy instilled confidence in their ability to successfully parent their children. They reported that attachment therapy helped them understand Reactive Attachment Disorder and relieved the sense of failure and frustration many mothers had. The therapists were perceived to model and support appropriate limit setting and consequences. Mothers gained the confidence to respond more calmly to their children and learned specific techniques to use in disciplining their

children. This increased confidence and the support of the therapists helped preserve many of the families. Thirteen of the 16 participants shared that attachment therapy prevented family deterioration. Prior to attachment therapy 5 of the 11 mothers said they had given thought to divorce, at least four of the 27 children were considered at risk of murdering their mothers, and several families had considered legal dissolution of the adoption. Mothers gave credit to attachment therapy for averting these catastrophic family disruptions.

Nevertheless, attachment therapy only offered partial solutions to the complex challenges the children presented. None of the participants in this study advocated for attachment therapy as the sole solution for helping a child with attachment disorders and other difficulties related to neglect, abuse, and debilitating prenatal and genetic precursors. Medication, psychiatric consultation, special education, and many other interventions were needed to help these children successfully remain in their families. However, attachment therapy was seen as one of the interventions that promoted stability, parental coping, and mother/child attachment.

## CHAPTER 5

### DISCUSSION AND CONCLUSIONS

The purpose of this qualitative study was to explore mothers' experiences of attachment therapy as related to their current relationships with their adopted children. The research questions that informed this study were:

1. What was the experience of attachment therapy for the participants?
2. How did the participants view their current relationship with their adopted child?
3. What were the participants' perceptions of the role attachment therapy played in their current level of functioning?

The population of the current study was 16 mothers who participated with their children in attachment therapy and had been interviewed for a program evaluation in 2003. Data were gathered using interviews, artifacts and a research journal in a basic interpretive qualitative study (Merriam, 2002, p. 162). Analysis was conducted by reviewing the data and presenting the categories that emerged from the preponderance of data.

The findings were presented in two sections: first, a description of the mothers and their adopted children, and second, an exploration of the categories that emerged from analysis. These were organized by the three research questions: Experience of Attachment Therapy, Current Relationship with Adopted Child, and Role of Attachment Therapy. Eight categories were identified and organized through these questions. The first research question, Experience of Attachment Therapy, showed that participants found their experiences 1) consistently supportive, 2) emotionally painful, and 3) physically safe. The second question, Current Relationship with

Adopted Child, found that these relationships were 4) continuously stressful, but 5) unquestionably permanent. In Role of Attachment Therapy, the last question, participants reported that therapy 6) instilled confidence, 7) preserved family structure, and 8) offered partial solutions.

Literature on attachment therapy has discussed the categories revealed in the current study. This chapter explores the eight categories in the context of this literature. The chapter then presents the three conclusions derived from the findings; the limitations of the study; and implications for theory, practice, policy, and research.

### Categories and Literature

The current study differed from literature on attachment difficulties in that it attempted to explore treatment of children past the age of toddlerhood and who had been adopted. Recently published articles dealt with diagnostic criteria for Reactive Attachment Disorder (Zeanah et al., 2004; Zilberstein, 2006); others criticized attachment therapy as controversial and dangerous (Chaffin et al., 2006). Research on treatment has focused on infants in foster care (Dozier, Stoval, Albus, & Bates, 2001), the adoption of infants (Stams, Juffer, & van IJzendoorn, 2002), or on improving relationships between poorly attached birth parents and their children (Marvin et al., 2002; Velderman, Bakermans-Kranenburg, Juffer, & van IJzendoorn, 2006). Hanson and Spratt (2000) produced a study to “review and synthesize what is known about RAD [Reactive Attachment Disorder] and attachment disorders and to discuss implications for treatment” (p. 142). They concluded that “knowledge of interventions for attachment-disordered children is quite limited” (p. 142). No study published to date has attempted to explore the actual experience of attachment therapy for older adopted children from the point of view of the participants. In the following sections, the emergent categories are explored as they relate to existing literature.

*Consistently Supported and Instilled Confidence*

Although these two categories emerged in different research questions, they both correspond to literature that addresses the importance of the role of parents in treating children with Reactive Attachment Disorder. The relationships that were established between the adoptive mothers and the attachment therapists provided confidence and emotional support. Participants described these relationships as necessary for the continued parenting of their children. Fourteen of the sixteen mothers interviewed commented that they felt consistently supported by their therapists. Using these supportive relationships, the therapists offered parenting techniques and instilled confidence through new information, modeling, and encouragement. Early research (Festinger, 1986; Kirk, 1988) brought attention to meeting the needs of adoptive parents in order to preserve the permanency of the adoption. Because attachment therapy includes both the child and parent, the parent's emotional state must be supported to create a healthy bond (Hughes, 1998, 1999; Levy, 2000; Levy & Orlans, 1998). Hughes (2003) stated, "the parent's comfort and support around this process [facilitating the parent-child relationship] will, in turn, facilitate the attachment" (pp. 273-274). In emphasizing the need for sustaining the adoptive parents as they seek to help the child Hughes added,

The central stance of the parent is to be able to maintain a vision of the child's inner strength – or at least potential- to resolve trauma and find a more adaptive developmental pathway. If the parent loses this vision, the child will never discover it within himself. (p. 275)

Emotional support from therapists sustained the mothers when the children's behavior was difficult. An example of this support was described by Mrs. Cooper. Therapy did not change

the behavior of her children, but she felt it reduced her stress and gave her hope. She explained, “I felt like I had back-up.”

### *Emotionally Painful*

Although parents felt supported, the experience of therapy was still emotionally difficult. Several authors (Delaney, 1998; Delaney & Kunstal, 1997; Hughes, 1998; Levy & Orlans, 1998) who described attachment therapy emphasized the importance of the involvement of the parents in the therapeutic process. In their attachment therapy the adoptive parents were active team members. The mothers in this study described either being in the room with their child or watching the therapy from another part of the office as it was occurring. They were partners with the child and therapist in each therapeutic intervention. As a result, they saw the emotional trauma that was brought to the surface of their children’s consciousness. As Mrs. Patterson phrased this: “They brought out so much hurt from those children until you, it's like you can't take it.... It hurts, it hurts.”

Hughes (1999) stated, “The parents’ presence in therapy is crucial. By being present, they can provide their child with emotional support, attunement experiences, and safety during the stresses of treatment” (p. 554). Hughes (2003) discussed the importance of the “intersubjective sharing of affect” (p. 274) in which parents mirror the inner emotions of their children. This sharing of affect was reflected in the pain felt by parents as the children dealt with their past abuse and neglect. Shared emotions were graphically expressed by Mrs. Douglas when she said, “I was holding Charlie and both of us started crying.... I couldn’t quit crying. I don’t know why, but it was just like I was feeling his pain in what he’d been through and he was realizing I cared.”



*Physically Safe*

Chaffin et al. (2006), Hanson and Spratt (2000), O'Connor and Zeanah (2003a) and others have warned of the danger of attachment therapy and have recommended against its use. In light of this concern with safety, the pervasive theme that therapy was not perceived as dangerous to the child is one of the most important findings of this study. Chaffin et al. (2006) pointed out that "most critics have never actually observed any of the treatments they criticize" (p. 85) or visited any of the attachment therapists. Discussions of the risks of attachment therapy have become redundant in the literature, with references to deaths of children caused by therapy. These deaths have been alluded to without substantiation or a clear explanation of the approaches to therapy that caused them (Boris, 2003; O'Connor & Zeanah, 2003a; Zilberstein, 2006). The death of Candace Newmaker at the hands of social worker Connell Watkins, who wrapped the child in a flannel sheet and suffocated her with pillows and pressure in a "rebirthing" procedure (Mercer et al., 2003), does not resemble the experiences of the participants in this study, nor does it reflect any method of therapy approved by the Association for Treatment and Training in the Attachment of Children (ATTACH) (Minnis & Keck, 2003), the professional organization of attachment therapists.

Researchers may have avoided addressing attachment therapy because of concern about the ethics and safety of the intervention. Dozier (2003) pointed out that academic researchers were hesitant to explore attachment therapy as a consequence of the perception that it involved physically irritating, shaming, and restraining the child. The techniques described by advocates of rage reduction in holding therapy led Dozier to express her thought that no Institutional Review Board would or should approve a randomized clinical trial of the therapy. The distinction between the use of physical restraint, shame, and rage reduction, and the less extreme

positions of therapists such as those in this study is necessary if research on ethical treatment is going to be approved.

Some of the adoptive parents in this study were concerned as they approached attachment therapy. Their feelings, and the safety of the attachment therapy that they experienced, was summarized by Mrs. Compton:

We had heard about people doing the re-birthing and that kind of thing, and that was a concern. That's not something that we ever even came close to doing in therapy. I don't think that any of it was at all dangerous or even emotionally damaging.... I don't think anything that we were doing was out of line.

### *Continuously Stressful*

The finding that life with adopted children diagnosed with Reactive Attachment Disorder continued to be stressful for the adoptive mothers in this study after years of therapy and community based services was discouraging. However, in light of previous research this finding was not surprising.

When post legal adoption services were first funded by the U.S. Department of Health and Human Services, Wilson (1992) found that 40% of 325 post-finalization adoptive parents she surveyed were experiencing difficulties with their adopted children. Most of these families reported emotional and behavioral problems. Karen (1998) has written a detailed synthesis of attachment research, theory, and treatment. He stated "the problem of repair is especially thorny for abused children because the messages they get and the working models of relatedness they develop are more confused and more sealed off against intrusion" (p. 234). He addressed the issue that children who do not have secure attachment to their primary caregiver early in life "may have a hard time recognizing, may not want to recognize, that another person is able to be

steadily loving and available” (p. 205). Mrs. Miller, whose four children had lived with her for over five years, addressed this situation when she said, “I’m not sure sometimes if my kids know what a mother is.”

The difficulty in helping children overcome early lack of attachment has become a focus of study in neurobiology. Perry (2002), one of the most prolific writers on research on the neurobiology of attachment, explained,

In the development of socio-emotional functioning, early life nurturing appears to be critical. If this is absent for the first three years of life and then a child is adopted and begins to receive attention, love, and nurturing, these positive experiences may not be sufficient to overcome the malorganization of the neural systems mediating socio-emotional functioning. Disruptions of experience-dependent neurochemical signals during early life may lead to major abnormalities or deficits in neurodevelopment. (p. 87)

Many of the families in this study participated in neurofeedback using new techniques from brain science. Although some children, such as Valerie Wythe, showed improvement in EEG results after therapy, most children discontinued the use of neurofeedback without having achieved results.

Almost all of the participants had seen an increase in their child’s attachment to the family, but the majority also still lived with behavioral difficulties. Ms. Miller described disappointment that life with her children was still so difficult:

I’ve seen incremental things. I have seen improvements. I’ve seen some major things, but I haven’t seen--I guess we have so far to go that I just had hoped that things would have been a lot more.... I had a level of expectations that if I do the work and I do what

these experts suggest when I go back home for the next week.... then, I thought that would move us forward and after a period of months or a year, we'd be able to look back and say, "Okay, we've come this far."

Many mothers discussed specific improvements in their children's attachment or behavior, but only one participant, Mrs. Hampton, presented the picture of a family free of unusual stress as she said, "We're just a family now. It's so funny to even talk about this because we are so normal now."

#### *Unquestionably Permanent and Preserved Family Structure*

The mothers in the current study considered their adopted children to be permanent members of their families, and many credited attachment therapy with preserving their families. Although the needs of adopted children such as those in this study are intense, most families who adopt children with special needs remain committed to parenting the children. In the 1980s, disruption rates in special needs adoption were found to be in the range of 10% to 14% (Barth & Berry, 1988; Festinger, 1986), and more recent statistics indicate that rates have remained constant (Child Welfare Information Gateway, 2004). However, rates of dissolution after the final degree of adoption are hard to measure, and although most adoptive families view their adoptions as permanent, many can benefit from services. Groze (1996) found that none of the families in his large Iowa sample had dissolved the adoption, although 40% said they would not recommend adoption to others. Festinger (2002), in a sample of 516 adopted children, found that "there were few dissolutions, but postadoption service needs were many" (p. 515).

The importance of attachment therapy in dealing with severe difficulties was evident in the current study. Participants discussed their distress before entering therapy; they described considering legal dissolution of the adoption, possible divorce, fears of homicidal behavior on

the part of the children, and, in one case, the mother's thoughts of suicide. Thirteen of the 16 mothers said attachment therapy or their relationship with a home-based attachment therapist saved their families. The participants in this study were explicit in describing their distress before therapy. Five of the 11 married mothers discussed their consideration of divorce. One mother portrayed in detail her plan for suicide because of the anxiety induced by her adopted daughter: "I had the bridge abutment picked out where I was going to go in the middle of the night, take my seat belt off and just commit suicide."

Counseling to maintain the family has been cited as a service needed by adoptive families in previous studies. However, Rosenthal, Groze, and Morgan (1996) found in a study of 562 adoptive families that only 26% of the families who used counseling to avert placement of the child outside the home found this service very helpful. In contrast, although only 16 mothers participated in the current study, approximately 80% of these participants credited attachment therapy with helping preserve their families.

It appears that most adoptive families of children with special needs maintain a commitment to their children. This commitment was reflected in the current population in spite of the fact that several children had entered out-of-home mental health care. In the Hampton case Jack was in residential care for 3 years, the longest out-of-home placement described by any mother, and Chad Williams was in residential treatment at the time of our interview. However, with the exception of Tommy Stuckey, all of the 27 adoptions were legally stable and the parents expressed their unconditional resolve to keep the children in the family.

Three children in the study had reached the age of 18, and in all three cases the mothers' involvement in their lives continued in spite of challenges. Mrs. Patterson mentioned the need to become a legal representative for her son since he would be unable to handle his disability

payment as an adult. Both Mrs. Wythe and Mrs. Buckner were in telephone contact with their 18 year olds who were living chaotic lives outside of the family. Mrs. Cooper, whose oldest daughter was 17, summed up the attitude of the participants when she said that her commitment to the children was ongoing: “I may not see the evidence today or tomorrow, but I may see it when they’re grown.”

The current study consisted of families who remained committed to their children throughout years of stress. Families who had disrupted or dissolved their adoptions before the completion of the attachment therapy program evaluation in 2003 were not included in the population. For this reason, and because of the small size of this population, the dedication that the mothers expressed cannot be generalized to other adoptive parents.

#### *Offered Partial Solutions*

The issue of comorbid diagnoses and needed community services was closely related to the continued stress of living with the adopted children in this study. Within the group of 27 children, 19 had comorbid diagnoses at the conclusion of the study. Some of these could be clearly differentiated from Reactive Attachment Disorder and responded at least in part to medical intervention; these included Attention Deficit Hyperactivity Disorder and Bi-polar Disorder. Some were also distinct from Reactive Attachment Disorder but more difficult to treat, such as Fetal Alcohol Syndrome and Autism. These disorders complicated the daily lives of the children and the ability of attachment therapy to intervene in the children’s mental and emotional functioning.

Literature on adoptive families of children who had been abused and neglected reported that the post-adoption services needed by these families were numerous and complex. Festinger (2002) interviewed families who had adopted children from the New York City public child

welfare system. She found that four years after their legal adoption they needed “after-school services, educational services, home assistance, clinical services, health services, housing assistance, vocational services, and legal assistance” (p. 531). In a Nevada survey, Reilly and Platz (2004) found that the same 20 unmet needs were listed by over 30% of the 373 adoptive families. Financial support for medical and psychiatric care was mentioned most frequently.

Research such as the New York and Nevada studies situate the current study in the common experiences of many families who adopt older children. These children’s needs are multifaceted, and although attachment therapy or work with a home-based therapist trained in attachment therapy was helpful to 13 of the 16 participants in this study, the children still had complex struggles. An array of community services was needed to provide for the stability of these families and the wellbeing of these children. Mrs. Compton, who was coping with Brittany’s Bi-polar Disorder, Reactive Attachment Disorder, and oppositional behavior, described the challenge:

I’m concerned about Brittany’s wellbeing. I don’t know how to get her beyond these things, and to get her to the point where she can have a productive life. I mean, she is so smart, but she is still in survival mode. She won’t get beyond. She won’t see that we’re taking care of her enough to concentrate on anything else.... I don’t know what the solution is.

Brittany had been in her adoptive home for six years. She had the benefit of loving parents, attachment therapy, psychotropic medication, and other interventions, but solutions to her multiple problems were not clear.

In summary, eight categories were supported by the preponderance of data in this study. Each was related to previous literature on attachment disorders although there was no body of

currently published research with content or participants similar to those of this study. The situations described in this study varied from family to family, and no one mother could be called a typical participant. However, the information shared by the participants can be used to draw three broad conclusions from the study.

### Conclusions

Three conclusions are drawn from the findings described above. First, the resilience of the adoptive mothers was extraordinary; second, support for the parents and children was needed at multiple levels of intervention: micro, mezzo, and macro; and third, there were components of attachment therapy that were essential to the positive impact of therapy described by most participants.

### *Parental Resilience*

The adopted children described by the participants in the current study appear to represent the most difficult children to place and to parent; yet only one of the 27 children in this study had left the family and that child was in placement with relatives of the adoptive family. The mothers in the study were deeply committed to the permanence of their adoptions and engaged in getting help for their children in spite of ongoing and serious stressors. The children exhibited behaviors that disrupted family life, pitted parent against parent within the marriage, were confrontational and sometimes dangerous, and gave parents little or no reason for pride in their child or their parenting. Beyond these stresses, the children failed to return the affection that adoptive parents yearned to share with a child. Parents were vocal in describing these traits. Mrs. Patterson remarked, "It was a battle of survival. ... We lived with somebody that hated us. They showed us every day that they didn't want to be here.... And, you get to the point where you really dislike these children."



This difficulty of adjustment in adoptive families has been a focus of research since the mid-1980s. Previous literature suggested that the expected disruption rate of adoptions of older children would be between 10 and 25% (Child Welfare Information Gateway, 2004; Festinger, 1986, 2002) and between 1% and 10% would have dissolved after finalization (Child Welfare Information Gateway, 2004). Statistically, therefore, the dissolution rate in this group of families is not unusual and there can be no causal conclusion reached as to the impact of attachment therapy on the preservation of these adoptions. However, based on the severity of the behavioral problems of children with Reactive Attachment Disorder, and the reality that adoption dissolutions are difficult to track (Child Welfare Information Gateway, 2004), the permanence of these adoptions is noteworthy.

Also of note was the finding that mothers were emotionally, financially, and physically engaged in the search for therapeutic interventions for their children and in the therapy itself. Considering the lack of attachment between the children and mothers at the time the families entered therapy, their commitment was remarkable. Mrs. Patterson expressed this when she described the lack of emotional fulfillment she received from her boys saying, "It was like you weren't there." Nonetheless, her emotional engagement with them in therapy was clear when she said, "If you truly care for those children, you can't sit and listen to what's happened to them and not be, -- it's worse than hurt." Mrs. McDonald made a similar statement, "You're going to hurt for them. If you don't, there's something the matter." Mothers described long hours traveling to appointments, hundreds of dollars in expenses, and physical and emotional exhaustion in obtaining attachment therapy for their children.

In spite of the stress of participating in attachment therapy, the therapy encouraged parental resilience and family stability through the understanding and support of the therapists.

Mrs. Patterson observed that in therapy she found “somebody truly understood” the family’s issues and the parents’ desire to succeed with the children. Therapy gave the parents new tools, but it was many years before even partial improvement in family relationships was solidified for most children. Because the children were disruptive, the mothers frequently lost connections with normal support systems such as friends, family members, and church communities. Many times the choice was between connecting with these supports and meeting the needs of the children. Therapists often filled the role of the missing support system.

In spite of the extreme difficulty of parenting these children, participants were deeply committed to the permanency of the adoptive placements and expressed the belief that therapy improved the stability of their families and the permanence of their children’s adoptions.

Reflecting the theme expressed by many of the mothers Mrs. Buckner commented,

The therapy that we obtained through the grant made a huge difference in our lives. It completely changed our understanding of the children, our approach to dealing with the children, and I think it probably heightened our commitment not to give up.

In this regard, attachment therapy may be more successful in helping families than more traditional family therapy as reflected in the literature. As early as the mid-1980s Barth and Berry (1988) found in their study of nearly 1000 children placed for adoption in California that specialized therapy was needed by adoptive families. The characteristics of the children who had difficulties in family adjustment in the Barth and Berry study reflected those of many of the children with Reactive Attachment Disorder: aggression, disobedience, and lack of attachment. The study concluded that families frequently found therapy to be of little help. Groze, Rosenthal, and Morgan (Groze, 1996; Rosenthal & Groze, 1992; Rosenthal et al., 1996) found similar parental frustration with therapy in large studies of adoptees in the Midwest. Fewer than half of

the adoptive families they studied found therapy to be helpful. Although the current qualitative study reflects only a small number of participants, in contrast to the large numbers in the quantitative studies referenced above, the impact of attachment therapy on permanent placement of the children is worthy of further study.

### *Multi-Level Support*

As might be expected, the children exhibited behavioral, emotional, and psychiatric problems both before and after attachment therapy. All of these children had been adopted after the age of 2 from backgrounds of neglect and/or abuse. They had antisocial and unattached behaviors and multiple mental health diagnoses when they entered therapy. Longitudinal studies of children who were abused or neglected during the first two years of life have consistently found that these deficits have long lasting and pervasive impacts on children that are related to both behavior and mental health (Grossmann et al., 2005; Sroufe et al., 2005a).

A number of recent studies described the challenges families encountered in parenting children such as these (Bird et al., 2002; Leung & Erich, 2002; McDonald et al., 2001). In the current study many of the children required special education services and most continued to have behavioral problems such as lying, fighting, and lack of cooperation with family rules and routines. The frustration of parents who were still coping with difficult behavior as their children grew older was expressed when Ms. Compton said, "Brittany is still very defiant, if you tell her to do something she's absolutely not going to.... She will lie about everything." Children's behaviors continued to be difficult throughout the course of the adoption and complex emotional disabilities were a major part of the concerns of the participants. In order to successfully parent children diagnosed with Reactive Attachment Disorder, mothers called for multi-level,

developmentally appropriate and therapeutically sound supports to be put into place at various systems levels.

The attachment therapists provided one level of support described as important by participants. Critical input from the therapists included emotional acceptance of the mothers, an understanding of adoption issues and attachment disorder, and education on effective methods of discipline. The parents' fears and struggles in living with their children were validated. Mrs. Wythe, who was suicidal at the time the family entered therapy, began to find hope when one of the therapists said of children with Reactive Attachment Disorder, "They *shred* their mother." Mrs. Wythe continued, "And I think that's one of the best ways to say it. I just was so *shredded*." Although Mrs. Wythe entered therapy unsure if she could ever love Valerie, the therapists reinforced her motivation and provided the constant background of support that the family needed to succeed in establishing emotional bonds. For most families therapy produced increased knowledge and skills on the part of parents. Describing therapy with her boys, Mrs. Buckner said, "We were given tools on how to actually help them."

In addition to assistance from the therapists, community services were described as imperative for successful family functioning. These were required by most of the children and covered a broad range of needs. Many of the children received special education through the public schools. More than half of the children also used psychiatric services, which were often delivered through community mental health programs or paid for by Medicaid. Many of the children were on psychotropic medications. Respite service was often mentioned by mothers as an unmet need.

At the broader level, strong public policy mandates from the macro system appeared to be needed, and several systemic problems were discussed. Foremost, inadequate funding to meet

the mental health needs of the children was mentioned by many participants. The funding for attachment therapy covered by the State grant was discontinued before most families had completed therapy, and this was a difficulty for many parents. The need for skilled mental health practitioners located throughout Georgia was also mentioned. In addition, increased competency of Department of Children and Family Services (DFCS) staff at all levels and ongoing assistance from the Department was needed. Mrs. Cooper and Mrs. Pearce both described the inadequate preparation they and their husbands received before adopting. Ms. Smith shared the fact that her foster care caseworker encouraged her to adopt immediately after Jose's placement, although she was an inexperienced foster parent and Jose's multiple disabilities were not understood. Participants were concerned that the level of knowledge among DFCS staff had not seemed to increase over the years.

### *Therapeutic Essentials*

An important finding and strong conclusion was that all of the participants considered their experience of therapy to be safe and this safety was essentially to the therapeutic process. Additionally, participants frequently attributed success to four components of attachment therapy. These were parenting skills training, cognitive behavioral intervention, therapeutic relationship, and physical proximity. Each was mentioned by several mothers.

Discussions of attachment therapy in previous literature have raised issues of the safety of attachment therapy. Dozier (2003) discussed "holding therapy, sometimes known as attachment therapy" (p. 253) and commented, "It is critical that attachment researchers speak up about their objections" (p. 253). However, the descriptions of attachment therapy subjecting the child to "terrifying or traumatic conditions" (p. 254) did not reflect the experience of attachment therapy described by the 16 mothers interviewed. These mothers described therapy as controlled,

safe, and nurturing for their children. Mrs. Hampton's opinion on the safety of holding in therapy was, "You are just holding the child, you're not restraining them or anything. You're not hurting them. It's a very comfortable position. And it's so effective!"

Related to the perception of the therapy being physically safe, the physical involvement of the mothers in their children's therapy was also seen as an important component. Parents were in the room or watching therapy from an adjoining room in most therapy sessions. Touch, particularly in the form of cradling the child, was often encouraged. Although the use of touch in therapy is controversial, many mothers described the technique as emotionally engaging the child. As described by the participants, the physical contact between parent and child was consistent with Bowlby's (1982; 1988) theory of the need to develop proximity and nurturing in healthy mother-child attachment.

The mother-child relationship was also improved by parenting skills training based on the *Parenting with Love and Logic* (Cline & Fay, 1990) model. The skills employed natural and logical consequences for misbehavior, giving the parent a way to make the child more responsible for the outcomes resulting from their unacceptable behavior. Although discipline did not always result in improved conduct, mothers expressed the belief that they had more control over their children, as well as over their own angry emotions, because of their new skills. Mrs. Buckner described mastering "pro-active parenting" and "learning to keep your eyes soft and loving, even if the child was driving you up the wall." She lived with years of difficult behavior from her boys but said that the new parenting skills helped her continue her commitment. Mrs. Patterson explained that her anger was relieved: "We started immediately doing the things that we learned.... We were not mad at all. We were just as sweet and talking to them just as nice –

before, oh, my. I was getting really mad and didn't know why.” She learned to place the responsibility of misbehavior on the boys and keep herself more emotionally balanced.

Much of the intervention described by the mothers had similarities to a cognitive behavioral therapy model. Intense therapy was often done using a brief time span, sometimes meeting for 2 to 3 hours several days in succession. The therapy was focused on helping the children and parents understand the link between thoughts of shame and anger at abusive birth parents and the children’s current need for emotional isolation and control. Children were helped to internalize the belief that they were not responsible for their early neglect and abuse. They were guided in creating a healthier self image and in comprehending the difficulties in their birth families. Participants described role playing, art work, and Eye Movement Desensitization and Reprocessing (EMDR) that all used a cognitive behavioral approach. One child-focused example shared by Ms. Anderson was her son Kenny’s workbook, *Me and My Volcano*, which was used to help him be aware of and control his indiscriminate anger. Adoptive mothers were also helped to understand Reactive Attachment Disorder and the maladaptive coping behaviors of their children.

Concurrently with the parent-child work, the mothers were being strengthened by their relationships with the therapists, and the therapeutic relationship impacted the success of therapy. Several participants mentioned that they had engaged in therapy with unsuccessful results prior to attachment therapy. Parents’ trust in the therapists created a safe environment for the emotional upheaval often accompanying intervention. Some participants described their confidence in following the directions of therapists to maintain safety at home. Several mothers described the importance of the therapists’ willingness to take telephone calls outside of normal

working hours. An overarching sense that therapists were approachable and cared deeply about the family helped many of the mothers cope with extreme difficulties.

While the above conclusions drawn from the study regarding parental resilience, necessary multi-level supports, and the essential components of therapy, including physical safety are important, there are limitations inherent in the study. These are discussed in the following section.

### Limitations of the Study

This research adds to an area of currently published literature that is sparse; however, several limitations should be considered when making treatment and policy decisions based on the information presented. These include:

1. Small population size
2. Inability to determine the precise content of therapy
3. Lack of multiple interviews with each participant
4. Lack of focus groups
5. Absence of objective measurement to assess the impact of therapy
6. A population limited to intact families who had participated in therapy.

The small population of 16 mothers created a core limitation in this research. The total population was comprised of mothers from a specific geographic area who participated in one program of attachment therapy and were then further delimited by their participation in the outcome study of that therapy. Because of this restricted number of potential participants it was unnecessary to sample within the parameters of the population. However, the number of participants affected the scope of the data collected and the lack of generalizability of the study. This limitation is shared by most qualitative research.



Determining the exact content of attachment therapy was not attempted and created another important limitation. The lack of a defined treatment protocol was especially worrisome in light of the fact that critics of attachment therapy describe it as life-threatening and unethical. In most of the interviews there was an attempt to have participants describe therapy as experienced by the mothers. However, there was not a systematic inventory of the treatment techniques used or a detailed description of therapy obtained from each mother. Therapy was not observed in this study or in the original program evaluation of attachment therapy. A total of 12 therapists participated in treating these 16 families, frequently with two therapists working as a team with a family. Two families had worked with more than one team. The therapists' styles of engagement, the therapist-parent relationship, and the level of therapists' skills all had the potential to impact the content of therapy. In addition, many of the interventions were described in a manner that reflected trauma-focused cognitive behavioral therapy, and each therapist's training and experience in this therapy could be expected to impact the treatment style.

A third limitation was that the mothers were interviewed only once and data were collected at only one moment in time. This study presented data on the mothers and their relationships with their children approximately three years after the conclusion of the grant for attachment therapy in Georgia. Research on these families at other times might reveal other findings. The study contained no follow-up interviews beyond the three pertaining to member checking of themes, and there was not a detailed comparison of findings in this study with those of three years ago.

The method of individual interviewing, in contrast to conducting focus groups, also eliminated the potential stimulation and sharing of ideas. At the time of the study three years ago, most of the mothers were seen in focus groups in addition to some individual interviews. No

focus groups were added to the one-time interviews in the current study. The use of focus groups might have increased mothers' recollections or shifted the emphasis of their comments through the interplay of different memories and opinions.

A fifth limitation was the absence of objective standardized measures to gauge the change in each child's attachment. In this regard, a mixed-methods study might have had the potential to address the results of therapy. This study only explored each mother's opinion as to whether therapy had an impact on her current relationship with her child. This was an examination of therapy seen through memories and current parent-child relationships as filtered through my personal biases. Data were the thoughts of the mothers as expressed to me and then interpreted and synthesized by me.

Finally, only mothers who had consented to be part of the original 2003 program evaluation of attachment therapy were contacted to be participants in this study. Families who had disrupted or dissolved their adoption, or who were unavailable or uncomfortable with participating in the original study, were not contacted to engage their participation. It is not known if these families would have shared the experiences and characteristics of the mothers who were interviewed. However, it can be speculated that their experiences would have added different dimensions to the findings.

## Implications

### *Theory*

The findings in this study supported Bowlby's theory that unfavorable care in the first years of life has lasting detrimental effects on mental health and behavior. The emotional and behavioral disabilities of children who suffered severe stress in their early lives were focuses of Bowlby's attachment theory (1944a). The longitudinal studies of Sroufe, Egeland and others in

Minnesota (Sroufe et al., 2005a) and research on Romanian orphans (O'Connor et al., 2003; O'Connor et al., 2000) have expanded knowledge on this original theoretical issue.

Attachment therapy has been criticized as being unconnected to attachment theory, and particularly to the work of Ainsworth in classification of the types of attachment. Much of attachment theory was developed by identifying styles of attachment in infants and toddlers who had normal family relationships (Ainsworth et al., 1978). Attachment therapy was not directly concerned with this frame of reference, although some authors have suggested that children with Reactive Attachment Disorder could be diagnosed as having “Disorganized Attachment” (Solomon & George, 1999; van Ijzendoorn & Bakermans-Kranenburg, 2003). Marvin (Marvin et al., 2002; Marvin & Whelan, 2003) and Dozier (2003) have developed interventions for children with attachment difficulties that are more in keeping with Ainsworth’s work. However, their approaches differ from the interventions of attachment therapy discussed in this study, and they are primarily used with very young children. Marvin has become active in working with ATTACH, and has expressed the hope that the theoretically focused academic community and attachment therapy practitioners can work together to study and develop the therapy most effective in helping older adopted children (personal communication, September 15, 2005).

The original rage reduction holding therapy of the 1980s that was promoted by Cline (1995) to treat adopted children had no discernable relationship to Bowlby’s attachment theory. Cline’s methods have gradually been revised by most practitioners of attachment therapy, however, and some current therapists (Hughes, 2003; Minnis & Keck, 2003) have articulated a connection between their work and Bowlby’s theory. This connection is an area that would benefit from additional thoughtful theoretical exploration. Hughes discussed the appropriateness of “physical proximity in parenting to foster a secure base” (p. 273) including “nonverbal

communication through eye contact, facial expression, voice prosody, movement, gestures, touch, intensity, and timing” (p. 274) in therapy. Nonverbal communication, the importance of touch, and proximity to the mother were central to Bowlby’s (1982) early explanation of attachment and to his dismissal of the need for food as the single primary drive that established infant-mother attachment. In criticism of attachment therapy, the use of touch, age regression, and non-verbal communication such as eye contact has raised concern about the safety and ethics of therapy in relation to children as clients. (Chaffin et al., 2006; O’Connor & Zeanah, 2003a, 2003b). However, as mentioned in the comprehensive report on attachment therapy written by the American Professional Society on the Abuse of Children (Chaffin et al., 2006), most critics of attachment therapy have never been trained in specialized attachment techniques nor witnessed attachment therapy. On the other hand, clinical therapists who do attachment therapy may spend little time considering theory as they focus on interventions that can help families and children find practical solutions to their problems.

In reviewing Bowlby’s early work, his interest in helping children with attachment disorders was evident (Bowlby, 1944a, 1944b). In 1944, regarding his work with juvenile delinquents, he wrote, “It is my hope that these Affectionless Characters will be studied in great detail in the future” (1944a, p. 39). In later years he was disappointed that his theoretical work had become academic and research focused and had not lived up to its potential to treat disturbed children. In the preface to *A Secure Base: Parent-Child Attachment and Healthy Human Development* (Bowlby, 1988) he wrote, “Whereas attachment theory was formulated by a clinician for use in the diagnosis and treatment of emotionally disturbed patients and families... it has ... been disappointing that clinicians have been so slow to test the theory’s uses” (pp. ix-x).

The current study did not deal with the theoretical basis for attachment therapy, but it laid the groundwork for further study by putting forth the theme that attachment therapy was not perceived as dangerous and does not need to be avoided by researchers. Perhaps future research in the treatment of older adopted children can incorporate Bowlby's theoretical work in its design. Exploring therapeutic interventions in which the adoptive parents can re-create the missing physical and emotional bond with their older adopted child will likely remain central to treatment of children with attachment disorders. Bowlby's "key hypothesis is that variations in the way these bonds [between child to parent and parent to child] develop and become organized during the infancy and childhood of different individuals are major determinants of whether a person grows up to be mentally healthy or not" (Bowlby, 1988, p. 162). The participants in the current study described the benefits of interventions such as physical closeness, eye contact, and emotional attunement which were observed by Bowlby to be the interactions necessary for attachment. Revisiting Bowlby's theories in conjunction with research on interventions such as cradling used in attachment therapy holds the possibility of strengthening both theory and practice.

### *Practice*

Since the passage of the Adoption and Safe Families Act in 1997 the child welfare system has attempted to measure and improve the safety, permanency, and wellbeing of children who are abused and neglected. The final decree of adoption is considered the benchmark of success in achievement of permanency for children in the child welfare system. However, for many participants in this study the adoption decree was just the beginning of their years of attempts to bond as a family and to meet the needs of their children. They expressed extensive difficulties in their adoptive families even after children had been in their home an average of 7

years. This study clearly illustrates that some families live with high levels of stress after legal adoption, and that their commitment to providing permanency for their adopted children does not necessarily correlate with the children's behavior. This finding adds emphasis to recent studies on post adoption services (Barth & Miller, 2000; Reilly & Platz, 2004) and should encourage the continuation of the trend seen in the past 5 years to provide extensive post adoption services to families and children.

Current increased interest in Reactive Attachment Disorder appears to be interrelated with the more prevalent use of the diagnosis. In Georgia one of the goals of the attachment therapy program funded by the State grant was to increase awareness of the disorder. Twenty-seven trainings were given to professionals in various areas of the state during the grant period (Wimmer et al., 2003). According to anecdotal evidence there is more awareness of the diagnosis than there was in 2000 when the program began. (J. Atkinson, personal communication, November 1, 2005; L. Hicks, personal communication, January 25, 2005; J. Turber, personal communication, April 8, 2006).

One challenge, then, is to educate child welfare workers and public mental health workers, many of whom are social workers at the B.S.W. or M.S.W. level, to recognize children with Reactive Attachment Disorder and to provide services to these children and their adoptive families. At the present time, the parents who are living with these children often are used as the experts. Ms. Miller expressed frustration that she was asked to provide information to professionals in the area but seldom received information that could be helpful to her own children. Mrs. Patterson said, "Even Mental Health sends people to my house.... In fact, yesterday I had a DFCS worker call me... and she said, 'We have a family that wants to learn more about attachment disorder.'"

Attachment theory is usually taught to social work students as one theory of human development. If it is addressed beyond this introduction, it is likely to be in an elective course and then only briefly discussed. Unless child welfare workers or mental health workers seek out further information, their level of knowledge about attachment disorders is very limited. This situation was emphasized by Mrs. Compton as she said tearfully that DFCS staff “should be aware of some of this stuff.... I remember the caseworker that knew her [Brittany] saying ‘She attaches *beautifully*.’ And that haunts me.”

Beyond the need for recognition of Reactive Attachment Disorder, treatment modalities that are effective with adopted children and with maltreated children need to be taught and practiced. Trauma-focused cognitive behavioral therapy has been shown to be helpful with children who have been abused (Saunders et al., 2004). Additionally, adoption practitioners over the last 25 years have developed skills to help children and families adjust to the issues of separation, loss, and attachment that are inherent in child placement (Fahlberg, 1991). From the descriptions of attachment therapy given by mothers in the current study, the combination of trauma focused cognitive behavioral techniques and adoption sensitivity facilitated the successes of attachment therapy. Thus, another challenge to be met is the training of more mental health clinicians to be skilled and comfortable providing therapy that meets the needs of these families. Lack of trained therapists in all regions of the state was a concern for many parents and adoption sensitive therapy should be promoted in order to meet the needs of families such as those represented in this study.

Although educational classes for foster and adoptive parents touch on attachment issues, there is some question as to whether the level of knowledge of the trainers is comprehensive enough for these classes to be helpful. Nilsen (2003) was particularly critical of the information

adoptive and foster parents received in pre-approval classes. She stated that one 3-hour meeting in a class endorsed by the New York child welfare department is called “Helping Children with Attachments,” and expressed the idea that teaching foster and adoptive parents to “view the actions and emotions of the children they care for as the result of faulty attachments... obscures parental identification and recognition of the empirically-derived symptoms of attachment, which then remain untreated” (p. 303).

The current study found that for more than half of the participants, attachment therapy provided the help they needed to successfully parent their children. As Mrs. Douglas put it, attachment therapy “made a world of difference.” The issues of quality training, the availability of skilled services, and the recognition of the unique needs of adoptive parents and children are related to both practice and policy.

### *Policy*

Children who have been abused and neglected have special needs and are the responsibility of the public child welfare system. The severity of these special needs calls for public policy responses. Child welfare policy directly impacts two important adoption issues. The first of these is the responsibility of public services for adopted children both before and after placement. Second is the legally mandated drive for speedy termination of parental rights of abusive birth parents and for permanency through adoption for all children who are legally dependent on state child welfare systems.

The question of how long and to what degree the state has responsibility to children who come into care is an area of concern. For children who are never adopted this issue has led to the continuation of foster care and independent living services after their eighteenth birthday. With adoption, however, in most ways the state passes full legal and financial responsibility for



children on to the adoptive parents. Adoption assistance, a monthly financial stipend, has been encompassed in Federal law since the 1980s. However, this stipend and related Medicaid fall far short of meeting the complex needs of children with Reactive Attachment Disorder. The State's failure to meet the extensive needs of the children in the study was illustrated by many participants. This failure was typified by Mrs. Patterson's need to travel to Colorado to locate therapy for her boys and Mrs. Williams' need to write to the Governor for intervention before funding for residential treatment was approved.

Although the families who participated in this study had received attachment therapy at no cost during the Georgia grant, at the conclusion of the grant the cost of services became a barrier for continuation. The adopted children all received Medicaid, but Medicaid would not pay for attachment therapy. The therapy usually involved two therapists and lasted more than one hour and most private insurance policies did not provide full coverage. Adoption assistance payments that families received covered only a fraction of the expenses. Because of social work's commitment to serving children who have been abused and neglected, the policy issue of access to attachment therapy, as well as a full range of other services, should be addressed.

As illustrated by the current study, sometimes the needs of adopted children far exceed parents' expectations and ability to cope successfully. The limits of help from the child welfare system were met head-on by Ms. Workman when she wished to have Charnese removed from her home. She described her call to DFCS when she said, "You need to take her back'. And they said, 'No,' of course, they said, 'No. We can't take her back.'" Although all but one of the adoptions in this study were intact, the population of the study by definition excluded families who had returned their children to DFCS. The issue of family stress leads to the consideration of policies related to placement of children with special needs.

The Adoption and Safe Families Act of 1997 mandates that termination of parental rights of birth parents be considered by the courts if a child has been in foster care for 15 of the previous 22 months. Adoption then becomes the child's plan for permanency. This mandate was created with the best interests of children as its goal, but there is little room for attention to the extraordinary emotional and psychiatric needs of some abused children. There is also no provision for ongoing support for foster parents who wish to continue parenting the children with the legal protection of DFCS guardianship to meet the child's needs. Although foster and adoptive parents receive training and information in preparation for the placement of their child, participants in this study make clear the limitations of this preparation. Mrs. Compton's interview illustrated this fact when I asked, "Was the experience what you were expecting, or what you were prepared for, trying to look back?" Her response was,

No. No, absolutely not. It was very much a surprise to us.... When we first got her she was very charming, very, the *perfect* child if we were out in public. I mean, you could not ask for better behavior in a public situation. At home, if she heard the word 'no' she'd start screaming. And scream for 3 and 4 hours. Nonstop. And, you know, that kind of thing we were just totally unprepared for.

The small population of this study limits the generalizability of this problem; however, future research with larger sample sizes offers the opportunity to expand on this and other issues of concern to policy.

### *Research*

There remain many opportunities for future research on meeting the needs of parents and children such as those represented in the current study. The purpose of this study was to explore mothers' experiences of attachment therapy as related to their current relationships with their

adopted children. The study filled a gap in the literature by presenting the thoughts and voices of the participants, and by providing social workers and others in the mental health and child welfare fields an intimate look at attachment therapy. However, the study did not address the treatment outcome of therapy, issues affecting families who had disrupted or dissolved their adoptions, or attitudes towards therapy of children, fathers, or therapists.

The lack of research on the efficacy of attachment therapy is not unique in assessment of mental health treatment. In his last newsletter column as president of the Society of Child and Adolescent Psychology Thomas Ollendick stated, "I must reluctantly conclude that there has been little evaluation of evidence-based practice in most mental health settings with children and adolescents" (Ollendick, 2003, p. 2). Drisko (2005) presented a survey of successful treatment of 10 adoptive families with children ages 7 to 22 who had been diagnosed with Reactive Attachment Disorder. However, these children were treated by 15 professionals and the information presented added little to the knowledge of successful treatment interventions. In work supported by several grants from the National Institute of Mental Health, Teicher et al. (2003) found that "an important challenge that remains is the study of the impact of treatment and the potential reversibility for altered neurodevelopment" (p. 39) in children with backgrounds of severe neglect and abuse. Future research that examines the components of attachment therapy and the effectiveness of various components should be considered. Questions that might be asked include "Is the use of touch, such as cradling, a core component of successful therapy?" and "What specific knowledge and skill regarding adoption on the part of therapists promote the usefulness of cognitive behavioral therapy for adopted children with Reactive Attachment Disorder?"

In addition, data on the exact interventions used could be collected through field observations of the therapy. Information on the therapists' training and experience and their thoughts about attachment therapy could also be helpful in understanding what is happening in the therapy setting. The list of possibilities is extensive, and the finding that adoptive mothers found attachment therapy to be safe might eliminate one barrier to future research. The findings of this study presented the lived experiences of the participants. As such, the study results might be frustrating for readers wishing either to support or to disparage attachment therapy as a treatment for adopted children with Reactive Attachment Disorder. It should not be surprising that families and children are complex, and that treatment was perceived as being more effective by some participants than by others.

The qualitative study of the families participating in attachment therapy allowed for the voices of those who actually experienced therapy to be heard. As reported above, this is especially important for expansion of research on attachment therapy because of concerns about the safety of the therapeutic intervention. More qualitative studies with participants who received therapy from a variety of attachment therapists would expand this information. Responses regarding the safety of therapy would increase knowledge about the risks of therapy. These responses could be obtained from a larger population of parents, including adoptive fathers, and from adult and teenage adoptees that have experienced attachment therapy. The voices of families who began attachment therapy and withdrew from therapy or dissolved their adoptions would also add depth to the findings. Participants' views of the value of attachment therapy in preserving their adoptions would also increase knowledge. The adoptive parents' backgrounds, especially with reference to their own attachment histories, would be another area of interest.

Background characteristics of the children, such as severity of neglect or abuse, age at adoption, and number of foster home placements, would add other dimensions of knowledge.

Several therapists have developed long-standing attachment therapy programs, such as Keck (Keck & Kupecky, 1995; Minnis & Keck, 2003) in Ohio and Hughes (Hughes, 1998, 1999, 2003) in Maine, and there is a network of active therapists who maintain a commitment to ethical practices (Association for Treatment and Training in the Attachment of Children, 2005).

Academic researchers could partner with these groups to access a large population of families who have received attachment therapy. Potentially, these therapists could also open opportunities for random assignment of attachment therapy and other treatments to children needing interventions for Reactive Attachment Disorder.

The quantitative approach to the study of attachment therapy outcomes is hampered by difficulties with diagnosis and measurement. There is much debate over the usefulness of the *DSM IV-TR* diagnosis of Reactive Attachment Disorder (Sroufe et al., 2005a) and the classification has undergone major changes with new editions of the *DSM* over the past 20 years. There is not an accepted measure of Reactive Attachment Disorder or even a measure of a continuum of attachment disorders. The one tool that was specifically designed for this purpose (Randolph, 2001) measures behaviors that are closely linked to a checklist of purported behaviors that identify Reactive Attachment Disorder. The use of this checklist has been rejected by many mental health professionals as invalid in measuring attachment issues (Chaffin et al., 2006; Nilsen, 2003). Nilsen addressed the problem when she said, “The lack of attention to attachment is likely because of the dearth of validated instruments and/or empirically-supported treatments for affected youth after the preschool years to address these problems” (p.304).

Questions to be answered in quantitative research range from outcomes of therapy related to child wellbeing and family stability to issues of safety and client satisfaction. The outcomes of attachment therapy could be explored using studies of its effectiveness when compared with other interventions and placebo or no-treatment samples. Survey research might be used to gain information on parents' and therapists' perception of the physical and psychological risks in therapy.

Another approach to future research would be mixed-methods studies. This research could combine the use of quantitative tools that measure therapeutic outcomes with exploration of characteristics and experiences of families and therapists. Assuming the validity of the diagnosis of Reactive Attachment Disorder, children who received treatment of any sort for this diagnosis could be studied. This approach could be used with attachment therapy as well as more traditional methods of psychotherapeutic intervention to begin to paint the picture of successful treatment of these children.

There are still many areas of inquiry to pursue. There has been very little research on the experience or the effectiveness of treatment for adopted children with Reactive Attachment Disorder. A variety of research methods could be used to increase knowledge about ways to treat these children and their families.

### Concluding Remarks

This qualitative study has looked at the experiences of attachment therapy as described by 16 adoptive mothers whose children had all been diagnosed with Reactive Attachment Disorder. Difficulties parenting these children are hard to put into words on a page. These mothers entered adoption full of dreams of a child to love. The tears and thoughts of suicide and divorce that rocked the families after living with the children are beyond imagining. Although I

could sympathize with these mothers, it would be untruthful to say that I could fully feel or describe their pain.

In many cases attachment therapy helped these mothers cope and contributed to permanency for the child. In some cases it promoted the healing of the children. In no case was it thought to be dangerous. Three conclusions were drawn from the study: 1) mothers exhibited extraordinary parental resilience, 2) there were essential components of attachment therapy that facilitated parenting, and 3) multiple levels of support were needed by these adoptive parents and children. As with all qualitative research, and in fact with all research, the reader is left to decide the importance of this information.

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## APPENDICES

## APPENDIX A

## Interview Protocol

1. Tell me a little bit about your family.

Who is in it?

When did you adopt the child who was in attachment therapy?

What was your child like when you adopted him/her/them?

2. Tell me about your experiences with attachment therapy.

Was it helpful for your family?

How was it helpful?

How was it not helpful?

Was it an important experience for your family? Tell me why you say that.

3. Where is your family now in relation to the issues that brought you to therapy? (How are things going now?)

What changes, if any, have you seen in your child?

What changes have you seen in yourself?

What changes have you seen in your family?

Do you think that any of these were because of therapy?

4. Thinking back to the experience of attachment therapy,

Describe in what ways the therapy was “comfortable” for you.

Describe in what ways the therapy was “uncomfortable” for you.

5. Is there anything that you would like to show me that in some way represents what we have been talking about?

6. Is there anything else that you would like to tell me about?

## APPENDIX B

## Consent Form

I, \_\_\_\_\_, agree to participate in a research study titled "Adoptive Mothers' Experiences of Attachment Therapy: A 2-Year Follow-up Study" conducted by Jane S. Wimmer from the School of Social Work at the University of Georgia (770 720-3867) under the direction of Dr. Betsy Vonk, School of Social Work, University of Georgia (542-5444). I understand that my participation is voluntary. I can stop taking part without giving any reason, and without penalty. I can ask to have all of the information about me returned to me, removed from the research records, or destroyed up until the beginning of the final dissertation write-up of this data, July 1, 2006.

The purpose of this study is to explore adoptive mothers' current perceptions of the experience of attachment therapy that families received in the program "Attachment Therapy Provided for Adoptive Children with Special Needs". In addition, the study will include information on each adoptive mother's perception of her child's current attachment to the mother. This is a follow-up study involving mothers who participated in the program evaluation of this service in 2003. *This study will benefit adoptive families, adopted children, and children waiting to be adopted who are now in foster care by providing new information on the impact of attachment therapy on adoptive families and children. In addition, it will benefit therapists and policy makers who are in the position to decide on the best therapy for children with Reactive Attachment Disorder by giving them new information on attachment therapy from the point of view of the families who have received this service.*

If I volunteer to take part in this study, I will be asked to do the following things:

- 1) Participate in a 90 minute face-to-face private interview in my home or another place convenient to me with Ms. Wimmer. This interview will be audio-recorded.
- 2) Show Ms. Wimmer items of my choosing that I believe reflect my comments made during the interview. These items may be photographed by Ms. Wimmer with my verbal permission at the time.
- 3) If requested, read and review with Ms. Wimmer in a telephone conversation the information that she extracts from our interview, in order to assure that the information reflects my thoughts.

I understand that the time involved will be approximately 90 minutes for the face-to-face interview, and if requested approximately 20 minutes to review the written information derived from my interview, and approximately 45 minutes to discuss with Ms. Wimmer by telephone the content of the written information. The study will take place between March 1, 2006 and August 31, 2006.

*I understand that the content of this study might be emotionally upsetting, placing stress on me, my child, or my family through the discussion of difficulties in our family's past or current relationships. Should I become distressed during the course of the interview or subsequent contacts, Ms. Wimmer will discontinue gathering data on our family and will delete data on our family from her study if I request this. Ms. Wimmer has information on the therapists who originally treated our family, and on other attachment therapists trained in attachment therapy.*



and will make a referral for counseling for our family or give me information on mental health resources if I request this. Beyond the difficulties of discussing our family adjustment problems there are no known risks to participating in this study.

I understand that this will be a confidential study. My identity will be known to Ms. Wimmer, but she will assign a pseudo name for me and this name will be used on all information about me. No information that can specifically identify my family will be used in the results of the study. No information about my family will be shared with other participants in this study. This research will result in a Doctoral Dissertation using my pseudo name and direct quotations from me along with those of other mothers in the study. The dissertation will be publicly available and professional journal publications or conference presentations of the findings may be made. No identifying information about me, or provided by me during the research, will be shared with others without my written permission, except if it is required by law (such as the disclosure by me of child abuse). I understand that all tapes, photographs, and documents regarding this research will be kept in a secure locked file and will be destroyed five years after the final publication of data from this research.

Ms. Wimmer (770-720-3867, email: janewim@uga.edu) will answer any further questions about the research, now or during the course of the project.

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

\_\_\_\_\_  
Name of Researcher

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu