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A Comparison of Students', Parents' and Group Leaders'
Perceptions of Attachment Disorders

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Runninghead: Attachment Disorders

Abstract

This study examined the perceptions of parents, group leaders, and students to see if the students displayed symptoms of attachment disorders. Fifty-three students, twenty-seven parents, and twelve group leaders from a private school participated. Subjects completed a Likert type scale survey including seventeen symptoms of attachment disorders. Subjects were required to answer the extent to which each symptom applied to the student (eg; very little to very much). Correlational studies of each question and descriptive statistics were used to analyze the data. Significant correlations were found for question numbers 5 (cruelty to animals), 7 (hyperactivity), 9 (does not think of consequences), 10 (Lack of conscience), 11 (Abnormal eating), and 16 (inappropriately demanding), among students, group leader, and parents. Professionals who work with Attachment Disorder suggest that if specific characteristics (superficially engaging and charming, unaffectionate on parental terms, lying about the obvious, lack of cause and effect thinking, lack of conscience) are more prevalent, the child is more likely to have Attachment Disorder. Three of the characteristics (18%) found significant in this study match the characteristics considered more prevalent by researchers (lying about the obvious, lack of cause and effect thinking, lack of conscience). The exact percentage of students with Attachment Disorders in the general population can not be determined, because it is not a direct medical diagnosis. With the information found it can be determined that there are very few students who display all of the symptoms of attachment disorder in this population of emotionally disabled students.

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A Comparison of Students' Perceptions, Group Leaders' Perceptions, and Parents' Perceptions of Attachment Disorder

Infant mental health has been a growing concern in psychiatry for the past quarter of a century. One aspect of infant mental health, the attachment process, has been researched quite thoroughly, yet still remains controversial. Research on child development can be traced to Freud, who studied such phenomena as love relations, separation anxiety, mourning, defense, anger, depression, emotional detachment, and sensitive periods early in life (Bowlby, 1988). Freud had a significant impact on Bowlby who developed an ethological approach to understanding attachment. Bowlby related the discoveries of ethologists, who studied the mating and bonding process of animals to human beings. For example, ethologists discovered that the young duckling will bond to the first thing it sees when hatched. Bowlby felt that humans also have bonding behaviors and intergenerational cues that predispose them for relationships. (Karen, 1994) Bowlby found that the quality of parental care which a child receives early in life is extremely important for future mental health. It is essential that the infant and young child have a warm, intimate, and continuous relationship with the primary caregiver in which both are satisfied. When children are given up for adoption, placed in foster homes and moved around, or abused as infants, their mental health is in danger. Bowlby believed that, although heredity played a role in neurosis, the emotional environment in which the infant lives intensifies it. Bowlby felt that the two most devastating and important environmental factors in childhood are the death or separation from the mother and the mother's emotional attitude toward the child.

Children who had lengthy separations from their mothers became cunning, unfeeling, thieving, and deceptive. Mothers with negative emotional attitudes were either hostile or neurotically guilty (Karen, 1994).

Mary Ainsworth's beliefs on attachment were similar to Bowlby's, prompting her to do some important studies of her own. In the 1960s, Ainsworth studied mothers and infants in their homes, observing how the mother responded to her infant under conditions such as feeding, crying, cuddling, eye contact, and smiling. When the infants were twelve months old, both infant and mother were taken to a lab and placed in a "strange situation". Ainsworth demonstrated that "secure attachment" between mother and infant was vital for the child's psychological development, and the mother's way of caring (e.g.-warm, sensitive, responsive, dependable) was the basis for the development (Karen, 1994).

Rene' Spitz, a chief spokesman in the United States on maternal deprivation, raised critical issues regarding the importance of attachment. His film, "Grief: A Peril in Infancy," created much emotional response and controversy as it presented scenes of several foundling homes where infants were left by their mothers and the decreasing mental and physical health of infants which resulted because of lack of care. The film suggested that if the mothers are gone longer than three months, the infants have no hope of recovery. The film further compared the foundling homes to a prison nursery where babies were allowed to spend time with their imprisoned mothers who were given time to nurture their infants. These infants, given regular access to their mothers, were much healthier and happier (Karen, 1994).

Development of Attachment Disorders

Attachment occurs during the first eighteen months of life, when an infant has a need, expresses this need, and is satisfied by the primary caregiver, most often the mother. A strong bond of trust occurs as this cycle is repeated (McKelvey & Stevens, 1994). Cline referred to this cycle as the "soul cycle", which contains four stages, from first to last: need, rage, relief, and trust. If not broken, the soul cycle will help the child to accept limits and controls. If needs are not met at the first stage, the infant may die. Moving from the stage of rage to the stage of relief is often where problems occur. The infant has a need and his cries are ignored, thus leaving the infant unrelieved from his feelings of rage. Any interruption in the cycle is called a break. If a break occurs, lasting and severe psychopathology may result (Cline, 1989). A child's relationship with his mother is the most important and crucial throughout his formative years. She feeds, comforts, keeps him warm, and establishes the basis for all relationships he will have later in life. If a child does not attach to his mother for whatever reason, the results are devastating. (Karen, 1994)

The mistreatment of children begins among the first interactions during the first months of life. The care given by the primary caregiver (early in life) has more effect on the child's development than what happens to the child later in life when exposed to the world around him. Problems that cause parents to mistreat their children most likely occur in the earliest part of the developing relationship between mother and child, often called the "attachment period" (Schmidt & Eldridge, 1989). Attached children want to spend more time with their caregivers, communicate better, and often wonder what their parents will

think of their actions (Groze, 1992). When children are mistreated or removed from their biological home, it is not unusual for them to have difficulties forming or maintaining attachments. The child does not have confidence in the caregiver to meet his/her needs if the child should require help.

Adoptive parents must have the history of their adopted child's first few years of life in order to raise him properly. Foster care must set up specialized systems to help special needs children. The parents should know if the child was moved around to several foster care homes before being adopted or of any neglect or abuse. All information from birth to the time of adoption is crucial. (Karen, 1994)

Other researchers have formed opinions of what constitutes attachment, from studying previous data of Bowlby and Ainsworth. According to Hegar (1993), attachment refers to the emotional bond between people who know and have positive feelings for each other. He stated that by the age of eighteen months children are attached to more than one individual (Hegar, 1993). Schmidt and Eldridge (1989) compared Bowlby's theory with Fraiburg's and Call's. Bowlby's theory that "attachment is an instinctive process which ensures the survival of man by maintaining a closeness between the mother and infant" is much like Fraiburg's and Call's theories. Fraiburg viewed "the attachment between mother and infant as the psychological basis for the quality of human relatedness, ego and superego development, and the binding aggression" (Schmidt & Eldridge, 1989). Call maintained that attachment "is a behavioral process that promotes development when attachment occurs and developmental failure when it does not" (Schmidt & Eldridge, p. 266). The social control theory viewed attachment as a "social bond" that influences the child's behavior (Groze, 1992).

Groze (1992) classified difficulties of attachment in two categories of anxious resistant and anxious avoidant and lists affective, behavioral, and cognitive cues for both. The affective cues for anxious resistant children are whining and crying. The affective cues for anxious avoidant children are shyness, withdrawal, and difficulty getting along with others. The behavioral cues for anxious resistant children are hyperactivity, clinging to adults, easily jealous, and dependent. The behavioral cues for anxious avoidant children are cruelty, physical attacks, and threats. The cognitive cues for anxious resistant children are complaints of loneliness and for anxious avoidant children, fear of certain animals and places and self-consciousness (Groze, 1992). Sroufe also studied anxious and avoidant relationships, with peers in attachment studies. (Karen, 1994) He alternately paired anxiously attached, avoidantly attached, and securely attached children to observe interactions. The children with avoidant attachment histories made the worst play partners. These children were often observed taunting and hurting other children. The children with secure attachment histories played well with the other children. They were persistent when the anxiously attached children were too frightened to play, and they ignored the intimidations of the avoidantly attached children. The anxiously attached children did not make attempts to get other children to play with them and often became victim to the attacks of the avoidantly attached children (Karen, 1994).

According to the philosophy of treatment at Forest Heights Lodge, a center in Evergreen, Colorado, that works with children with attachment disorders three levels of trust are involved if a child is to learn to form a normal attachment. The levels include trust of care, trust of control, and trust of self. "Trust of care" involves the infant expressing his needs and having those needs met. "Trust of control" is a toddler testing his caretakers,

discovering his limits and control, and learning right and wrong. "Trust of self" is when the child sets limits for himself, knows the difference between right and wrong, and does the right thing. With these basic elements of attachment the child is able to bond with others and form lasting relationships (Forest Heights Lodge, 1994).

Research has identified that many disruptions can occur in a child's life which may prevent normal attachment. John Stack (1987) completed a study of three pregnant women in a psychological crisis. The women were very frightened about being mothers because of the way in which they had been raised. If a mother in psychological crisis does not receive therapy, the result may be abortion, failure to attach (on mothers part), parenting disorders, and/or failure to thrive infants (Stack, 1987). A child born with birth defects that keep him in the hospital for lengthy periods of time is often not given the chance to form attachments. Sometimes a child is born with a defect that goes unnoticed, by the parents or the doctor, thereby being unintentionally neglected of the care he needs. Even if a handicap or defect is discovered, the parents do not always know how to care for the child properly or to facilitate the proper means for attachment. Learning disabilities may also prevent a normal attachment because children may perceive actions differently or may not clearly understand everything going on in the world around them. Children with physical handicaps or learning disabilities may also be unintentionally neglected by the parents because the children may not know how to or be able to express their needs (Forest Heights Lodge, 1994).

Parenting styles are also a factor in forming attachment relationships. There are several types of parenting styles which may disrupt normal attachment process. Parents who are unprepared to be a parent and anxious about parenting create an environment that

appears unsafe as perceived by the child and hard to trust. The parent may be too structured and seem rigid, caring for the infant according to a set schedule, not necessarily when the infant demands it. Trust becomes difficult because needs are not met when the infant feels and expresses the need. Other forms of inconsistent care, such as the infant coming into contact with a baby-sitter more than Mom, or a series of moves in which the infant is deprived of consistent care, can also cause a lack of trust. Many moves often occur in the foster care system (Forest Heights Lodge, 1994).

When children do not develop a normal attachment, many characteristics can appear. Infants that display symptoms of attachment disorders are often called "elbow babies", because they tend to push the mother away and do not accept attention (Berry, 1990). "Elbow babies" do not cry when their mothers leave them. Although they are feeling intense fear, they can not trust anyone because their needs were not met from the start. When children feel that no one is there to take care of their needs, they often turn inward to take care of themselves, thus blocking out others and turning to manipulation to fulfill their needs. When children turn inward and block out everyone else , they are unable to form relationships with others or to have an understanding or respect for other people's feelings. Not only do they have problems understanding differences between right and wrong, but they also have problems caring about the differences. Therefore children feel no guilt when they have done something wrong and they have a hard time feeling good when they have done something right (Berry, 1990). Although children with attachment disorders turn people away and block them out, they still have a need for closeness. This sense of isolation makes the children very sad and prone to depression. To push others away, the children hide their feelings of sadness, by masking them with other feelings and

confusing their caregivers (Karen, 1994). (See Appendix A for a list of Attachment Disorder Symptoms).

Some of the issues that trigger intensified rage in children with special needs are therapeutic progress, survival skills adaptations, and fear of loss of control. Therapeutic progress is difficult as these children work through past traumatic events. Families are put under intense strain, and mother is often the target of the child's anger, due to the intense past feelings of rejection. Children with symptoms of attachment disorders have adapted their own self-preservation survival skills with little or no regard for others. These children adapt new skills to create a more comfortable atmosphere while going through therapy. The child with symptoms of attachment disorder turns inward to gain self control and finds it difficult to comprehend giving up that control (Peterson, 1995).

Adoption, Foster Care and Attachment Disorders

In a study completed on placement disruptions in foster care and adoption (a suggested cause of attachment disorders), disrupted placements were as high as 23% (Valentine, Conway & Randolph, 1987). The children in the foster care/ adoption system five years or older are the most difficult to place. Most of these children have attachment disorders caused by random and repeated placements, lack of prenatal care, irresponsible birth parents, and an ignorant judicial system. The programs set up to reduce this growing number of children are not faring well. Problems are made more difficult by a legal system that is unaware of children with special needs and a mental health system that is unable to provide necessary therapy (McKelvey & Stevens, p.87). In a study by Rosenthal and Groze (1991), the number of adopted children were over-represented in clinical populations. Berry (1990) also stated that adopted children are over-represented in

psychological and psychiatric populations. Adoptive children are more likely to be aggressive, have low self-esteem, be hyperactive, and have learning problems. Attachment influences self-concept as equally as self-concept influences attachment (Groze, 1992). Therefore if a child has a low self-concept, his ability to attach is low and if his ability to attach is low, he will have a low self-concept.

Another study suggested that the reason children do not always adjust in their adoptive homes is related to the parents' expectations, which are often too high and the children can not meet their expectations. When this happens both parent and child end up feeling insecure with the relationship (Berry, 1992). The parents need to know the history of the child in order to know what to expect. Too many foster care/ adoption systems do not give this information to prospective homes in an effort to protect the biological family or the system. Stepelton (1987) suggested that many children, including children with emotional disorders (a suggested label for attachment disorders), could bypass residential treatment if the foster care system were more effective. Attachment disorder is not a direct medical diagnosis, yet many children are described as having the symptoms. The labels for these children are many, including emotionally disturbed, conduct disordered, oppositional defiant disordered, and others.

One center specifically designed for treating children with attachment disorders, the Forest Heights Lodge in Evergreen, Colorado, presently exists. The belief at this school is that there is a specific treatment for attachment disorders. Many researchers are aware of and study attachment disorders, yet because of the lack of a specific medical diagnosis many children with these symptoms are being treated for other disorders. Not knowing the history of the child can also lead to misdiagnosis. Attachment disorders are more obvious

in the home because the child is being forced to interact on a personal basis. In the clinical setting the child is not constantly being forced to interact, therefore the symptoms are not always evident. The Forest Heights Lodge brings the family together and teaches the child behaviors to interact appropriately with the family.

A small residential school, which does not specifically serve boys with attachment disorders but serves emotionally disturbed boys ages 11-19, exists in central Virginia. Many of these boys are diagnosed with disorders which are suggested labels for attachment disorders (eg: conduct disorder, character disorder). The school consists of 60 boys, divided into 6 groups. Each group has two group leaders who work with the boys on a consistent basis and one supervisor to oversee the group. The group leaders are not made aware of the boys' histories or labels. The philosophy is that labels will interfere with the objectivity of working with the students and they learn about the boys' past from the boys themselves. Group leaders develop students' skills by having them work together as a team, learning their strengths and weaknesses, building their self confidence, improving communication, and developing social skills.

The purpose of this study is to further the research on attachment disorders by comparing parents' perceptions with group leaders' perceptions and students' perceptions of themselves in the residential setting. The information resulting from this study may help us identify children with symptoms attachment disorders in the emotionally disabled population, therefore aiding in treatment.

Method

Sample

The sample for this study consisted of parents, group leaders, and students that currently attended a "wilderness school" in central Virginia, for at least one month.

The wilderness school consists of outdoor residential living for males ages 11-19 identified as having emotional disorders. Group Leaders are counselors who live and work with the boys on a day to day basis.

A letter requesting permission to survey the students, group leaders, and parents was sent to the Director of the school (see Appendix B). The letter stated that participation was voluntary and that no information would link the school, group leaders, children, or parents to responses. Upon obtaining permission, a letter stating the same information, was sent to the parents, along with a copy of the questionnaire, a letter from a staff member of the school, and a self-addressed, stamped envelope. To obtain information from the group leaders and students, the researcher went to the school, gave a lecture on attachment disorders to the staff, and gave them the questionnaires with directions. The staff then gave the questionnaires to the students along with the directions given by the researcher. The letters were coded by numbers so that anonymity was established.

Instrument

The questionnaire that was given to parents, students, and group leaders was developed by the researcher with information provided from the Virginia United Methodist Youth Services (VUMYS). The Virginia United Methodist Youth Services looks at the symptoms and judges how severe they are. According to Don Wilhelm of VUMYS, when certain symptoms (for example; superficially engaging and charming, unaffectionate on

parental terms, lying about the obvious, lack of cause and effect thinking, lack of conscience) are predominant, the individual is more likely to experience attachment disorder. (See Appendix A.)

The questionnaire contained two sections. The first section included general demographic questions. The questions for the group leader (how long they had been a group leader, their age, any experience working with emotionally disabled children) were asked to discover if they would be able to recognize symptoms of attachment disorders by the amount of time working with the students or if they may have had previous experience working with attachment disorders. The questions asked of the students were to find out if they had been at the school longer than a month and how old they were. The questions asked of the parents (age, gender, if their child had been adopted or in foster care, how many children they had) were asked to discover the history of the child as well as to obtain some insight on their own history as a parent. The second section included questions related to the symptoms of attachment disorders. These questions are answered by a Likert Scale ranging from 1 being "Not at All" to 4 being "Very Much". The questionnaire was field tested on special education teachers to determine if the questions could easily be understood.

Data Analysis

The data were interpreted by descriptive statistics and a correlational analysis. Correlations were obtained by translating the subjects' responses for each statement into a numerical value. Values ranged from 1 to 4, with 1 being the lowest and 4 being the highest. The total values for parents, group leaders, and students were calculated for each question and compared by using a Pearson R.

Results

Sixty-four parents were contacted. Thirty-one of these (48%) elected to participate. All of the group leaders (n=12) answered surveys for 95% (n=56) of the students. Five percent of the group leaders questionnaires were eliminated because there were no student or parent questionnaires with which to compare. Of fifty-nine students currently attending the school, 90% (n=53) were able to participate. The other 10% were either not in the group for disciplinary reasons, therefore not able to participate, or had not attended the school for at least one month.

Demographics

Twenty-five per cent of the parents who reported gender were male, 75% female. The mean number of children in each family was 2. Ages of parents who reported age ranged from 33-55. Eight per cent (n=5), of the parents responding stated their students were adopted. Forty per cent (n=2) of those adopted were previously in foster care. Three per cent (n=2) were previously in foster care, but were not adopted by the present family with whom they were living.

The mean age of the students was 16 with a range of 11-18. The mean number of months in which students attended the wilderness school was 10 with a range of 1 to 19.5

The mean age of the group leaders was 24, 17% females (n=2), 83% males (n=10). Range of time as group leaders at the wilderness school was 2 weeks to 24 months with the mean time being 7.5 months. The average group size for 2 group leaders consisted of 10 students.

Degree of Attachment Disorder Symptoms

The researcher used means to report descriptive statistics to show the degree to which students portray symptoms of attachment disorders. It is important to know the congruency of the symptoms among the population variables of interest of the student, group leader, and parent. The researcher reviewed the symptoms in attachment disorders and counted each population variable of interest which had a reported score of 3 (“pretty much”) or greater, on the Likert Scale, for each student. The following information was collected: for “superficially engaging and charming”; two students (3%) had complete (including student, group leader, and parent) population variable of interest responses with a score of 3 or above. For the symptom of “being unaffectionate on parental terms”; two students (3%) had the group leader and student responses with scores of 3 or above, and one student (2%) with group leader, student and parent response with scores of 3 or above. “Lying about the obvious” was the most common symptom with eight students (15%) who had student and group leader responses with scores of 3 or above, and five students (9%) with group leader, student, and parent responses with scores of 3 or above. “A lack of cause and effect thinking” was also common with nine students (17%) who had both group leader and student responses, one (2%) with group leader and parent, and two (3%) with group leader, student, and parent all with scores of 3 or above. The symptom of “lack of conscience”, as reported by both group leader and student responses, contained one student (2%) with scores of 3 or above. (See Table 2).

Of the students adopted or in foster care two questions had high means in the population variables of interest (group leader, student and parent surveys). Two students had high means on question of interest number 7 (“lying about the obvious”) and one

student had a high mean on question variable of interest number 1 (“superficially engaging and charming”).

Correlations

The data for correlations were obtained by translating the subject's responses for each symptom into a numerical value using a Likert Scale. Values ranged from 1 to 4, with 1 being the lowest possible score and 4 being the highest. Each symptom statement was calculated as follows according to the indicated response: not at all = 1, very little = 2, pretty much = 3, very much = 4. The total values for parents, group leaders, and students were calculated for each question and compared using the Pearson R. The questions with significant correlations between the three population variables of interest ($p=.001$) were items 5, 7, 9, 10, 11, and 16. The questions were correlated by comparing the student responses with the other population variables of interest, comparing the parent responses with the other population variables of interest, and comparing the group leader responses with the other population variables of interest. Question 5 was significant at the .01 level between the student and group leader. Question 7 was significant at the .01 level between the student and group leader. Question 9 was significant at the .01 level between the group leader and parent. Question 10 was significant at the .001 level between the group leader and student. Question 11 was significant at the .001 level between the student and parent. Question 16 was significant at the .001 level between the group leader and parent. (See Table 3).

Discussion

The purpose of this study was to discover the degree to which children with symptoms of attachment disorders are present in a population of individuals with an emotional disability. A comparison of the parents' and group leaders' perceptions of the student and the students' perceptions of themselves was made to decide if the symptoms were significantly displayed. Significant correlations were formed among student responses, parent responses, and group leader responses, related to destruction of material things, self and others; lying about the obvious; learning lags; lack of cause and effect thinking, lack of conscience and inappropriately clinging or demanding. Professionals who deal with attachment disorders suggest that when the characteristics (eg: "superficially engaging and charming", "unaffectionate on parental terms", "lying about the obvious", "lack of cause and effect thinking", "lack of conscience") are more prevalent, the individual is more likely to have attachment disorder. (D. Wilhelm, personal communication, August 25, 1995).

When the means for each student, for each population variable of interest were calculated, the only mean of 3 or greater was that of the parent response for the symptom of superficially engaging and charming. (See Table 1). Of the correlations found, only 18% (n=3) between the group leader and student were significant. Between the group leader and parent 13% (n=2) were found significant, and between the student and parent 6% (n=1) were found significant. (See Table 3). Among the symptoms considered prevalent by professionals, lack of cause and effect thinking, had the highest percentage of scores with 3 or above. This percentage was 17% among student and group leader. The next highest

percentage is 15% among student and group leader responses for the symptom of Lying about the obvious. (See Table 2).

Limitations

By reviewing the information collected it appears that attachment disorder is not prevalent in the emotionally disabled population in this residential setting. One effect the researcher did not study was the prevalence of the symptoms before the students attended the school and after they had attended for several months. The focus of this residential setting is to address characteristics such as reflected by these symptoms. If the student has already resolved some of their conflicts related to the symptoms, then the symptoms would no longer be prevalent. A significant limitation of the research is that Attachment Disorder is not a direct medical diagnosis. One reason is that researchers can not measure when bonding or attachment takes place. Another may be that many of the symptoms also apply to other disorders. Therefore the researcher can only suggest that students have symptoms of attachment disorder. Another limitation is that, although honesty is emphasized as important at the school in which the research was completed, a characteristic of attachment disorder is lying, which effects the reliability of the students responses. The study may have been stronger with a larger number of subjects to complete the questionnaire, including more parents or even another school of similar background. One of the group leaders only had 2 weeks experience, thus effecting the knowledge of students and therefore the responses.

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Appendix A

List of Attachment Disorder Symptoms

Attachment Disorder Symptoms:

1. Superficially engaging and "charming"
2. Lack of eye contact on parental terms
3. Indiscriminately affectionate with strangers
4. Not affectionate on parental terms (not cuddly)
5. Destructive to self, others, and material things (accident prone)
6. Cruelty to animals
7. Lying about the obvious (crazy lying)
8. No impulse controls
9. Learning lags
10. Lack of cause and effect thinking
11. Lack of conscience
12. Abnormal eating patterns
13. Poor peer relationships
14. Preoccupation with fire
15. Persistent nonsense questions and incessant chatter
16. Inappropriately demanding and clingy
17. Abnormal speech patterns

(The United Methodist Family Services, 1994)

Dear

I am writing to you regarding the research project that we are conducting on attachment disorders. Your participation in this project is very important to us. We will be gathering information on your child's attachment style and how it affects their behavior. This information will be used to help us understand attachment disorders better and to develop better treatments for them. Your child's participation in this project is completely voluntary and you can withdraw your child from the project at any time without any consequences. We will provide you with all the information you need to make an informed decision about your child's participation in the project.

Appendix B

Research Permission Letter

The purpose of this research is to understand attachment disorders and how they affect children's behavior. Your participation in this project is very important to us. We will be gathering information on your child's attachment style and how it affects their behavior. This information will be used to help us understand attachment disorders better and to develop better treatments for them. Your child's participation in this project is completely voluntary and you can withdraw your child from the project at any time without any consequences. We will provide you with all the information you need to make an informed decision about your child's participation in the project.

I am writing to you regarding the research project that we are conducting on attachment disorders. Your participation in this project is very important to us. We will be gathering information on your child's attachment style and how it affects their behavior. This information will be used to help us understand attachment disorders better and to develop better treatments for them. Your child's participation in this project is completely voluntary and you can withdraw your child from the project at any time without any consequences. We will provide you with all the information you need to make an informed decision about your child's participation in the project.

Wendy Foote
4 13 A Putney St.
Farmville, VA 23901
804-392-5817

Dear _____,

I am writing to gain permission to survey the group leaders and parents of _____ school. I am a graduate student at Longwood College working on my Master's thesis. The research will be gathered through a questionnaire. Participation in the study is completely voluntary and may be discontinued at any time. Results will be kept confidential. No information identifying the school, students, parents, or group leaders will be used.

Anonymity will be protected above all else.

The questionnaire focuses on the symptoms of attachment disorders and contains a few questions based on general demographics.

Your permission is needed to begin conducting research. Please return this permission sheet to me in the envelope provided. I appreciate your time.

Sincerely:

Wendy Foote
Longwood College
Graduate Student

I give Wendy Foote permission to send questionnaires to Group Leaders and parents.

Appendix C

Parent Questionnaire Cover Letter

Wendy Foote
413 A Putney St.
Farmville, Va. 23901

Dear Parent or Guardian,

I am a graduate student at Longwood College. This past fall I did my internship at _____ School. As an intern, I worked with the groups in a group leader role.

Currently, I am collecting information to write my thesis. I would like to gather information from parents about their perceptions of their son's behaviors. Enclosed please find a questionnaire. I assure you that anonymity will be established and confidentiality will be maintained. Your responses will not be linked to you, your son, or _____ School. The Director of _____ School, has given me permission to send you this questionnaire, knowing that it is voluntary.

Please return the questionnaire in the self addressed stamped envelope provided. Your time and effort are greatly appreciated.

Sincerely,

Wendy Foote

Longwood College
Graduate Student

Appendix D

Staff Letter to Parent

Dear Parent,

Enclosed you will find a questionnaire from Wendy Foote. Wendy is pursuing her Master's Degree and collecting information for her thesis. Wendy did her graduate internship at _____, for 4 months. Please consider filling out the enclosed surveys and understand that they are anonymous. Thank-you for your time.

Sincerely,

Yessy Tovar
400 A. Palmer St.
Baltimore, Va 27401
404 465-3311

Dear Group Leader,

I am a graduate student in Psychological Biology, collecting information from group leaders
on the perceptions of the students in their groups taking an attachment disorders
course. It would be great to have your input on how you feel about the course and your
responses will be included in my dissertation on the subject. I am grateful for your
input.

Appendix E

Group Leader Questionnaire Cover Letter

Yessy Tovar
400 A. Palmer St.
Baltimore, Va 27401
404 465-3311

Wendy Foote
413 A Putney St.
Farmville, Va. 23901
804-392-5817

Dear Group Leader,

I am a graduate student at Longwood College, collecting information from group leaders on their perceptions of the students in their groups relating to symptoms of attachment disorders. I assure you that the value of anonymity has been established and your responses will not be linked to you, the students, or the school. I have gained permission from _____ to send you these questionnaires to fill out for each boy in your group. Please send them back in the self-addressed stamped envelope provided. Your time and effort are greatly appreciated.

Sincerely,

Wendy Foote
Longwood College
Graduate Student

Parent Questionnaire

1. Please fill in the correct information

2. Gender: Male _____ Female _____

3. Age: _____

4. How many children do you have?

5. Age of oldest child: _____

6. Was your child ever in a residential institution? _____

7. How old was your child when they entered the institution?

Appendix F

Parent Questionnaire

8. If your child was admitted to a residential institution, please indicate the reason for admission

9. If your child was admitted to a residential institution, please indicate the date of admission

10. Please indicate the age of your child when they were admitted to a residential institution

11. How long did your child stay in the residential institution?

12. How long did your child stay in the residential institution?

13. How long did your child stay in the residential institution?

14. How long did your child stay in the residential institution?

15. How long did your child stay in the residential institution?

16. How long did your child stay in the residential institution?

17. How long did your child stay in the residential institution?

Parent Questionnaire

I. Please fill in the correct response.

1. Gender: Male _____ Female _____
2. Age: _____
3. How many children do you have? _____
4. Age of natural mother at time of birth: _____
5. Was your child, which is currently attending _____, adopted or in foster care previously? _____
6. If your child was adopted, what age was he at the time of adoption? _____
7. If your child was in foster care how long was he in foster care? _____

II. Please circle the best response which describes your child.

1=Not at all, 2=Very little, 3=Pretty Much, 4=Very Much

1. Superficially engaging and "charming" 1 2 3 4
2. Lack of eye contact on parental terms 1 2 3 4
3. Indiscriminately affectionate with strangers 1 2 3 4
4. Destructive to self, others or material things 1 2 3 4
5. Cruel to animals 1 2 3 4
6. Lies about the obvious (crazy lying) 1 2 3 4

7. No impulse controls (frequently hyperactive). 1 2 3 4
8. Learning lags (takes a while to catch on) 1 2 3 4
9. Lack of cause and effect thinking (does not think of consequences) 1 2 3 4
10. Lack of conscience 1 2 3 4
11. Abnormal eating patterns 1 2 3 4
12. Poor peer relationships 1 2 3 4
13. Not affectionate or friendly terms 1 2 3 4
14. Preoccupation with fire 1 2 3 4
15. Persistent nonsense questions and incessantly chatters 1 2 3 4
16. Inappropriately demanding and clingy 1 2 3 4
17. Abnormal speech patterns. 1 2 3 4

Group Leader
Questionnaire

1. Name of the group _____

2. Gender _____ Age _____

3. Age _____

4. What was your role in the group?

5. How long did you work with the group?

6. What was the type of the group?

7. How many sessions did you attend?

8. How did you feel about the group?

Appendix G

Group Leader Questionnaire

9. Please describe the group _____

10. Please describe the purpose of the group _____

11. How did you feel about the group?

12. How did you feel about the group?

13. How did you feel about the group?

14. How did you feel about the group?

15. How did you feel about the group?

16. How did you feel about the group?

Group Leader
Questionnaire

I. Please fill in correct response.

1. Gender: Male _____ Female _____
2. Age: _____
3. What was your major in college? _____
4. How long have you been a group leader? _____
5. What are the ages of the kids in your group? _____
6. How many students are in your group? _____
7. Have you worked with Emotionally Disturbed students before? _____

II. Please circle the best response to the question.

Please answer the question in relation to what describes the student right now.

1= Not at all, 2=Very little, 3=Pretty much, 4=Very much

1. Superficially engaging and "charming" 1 2 3 4
2. Lack of eye contact on authoritative terms 1 2 3 4
3. Student indiscriminately affectionate with strangers 1 2 3 4
4. Student destructive to self, others and material things 1 2 3 4
5. Student cruel to animals 1 2 3 4

6. Lies about the obvious (crazy lying) 1 2 3 4
7. No impulse controls (frequently hyperactive) 1 2 3 4
8. Learning lags (takes a while to catch on) 1 2 3 4
9. Lack of cause and effect thinking
(does not think of consequences) 1 2 3 4
10. Lack of conscience 1 2 3 4
11. Abnormal eating patterns 1 2 3 4
12. Poor peer relationships 1 2 3 4
13. Not affectionate with authority 1 2 3 4
14. Preoccupation with fire 1 2 3 4
15. Persistent nonsense questions and incessantly chatters 1 2 3 4
16. Inappropriately demanding and clingy 1 2 3 4
17. Abnormal speech patterns 1 2 3 4

Appendix H
Student Questionnaire

Student Questionnaire

I. Please fill in the correct response.

1. How old are you? _____
2. How long have you been at _____ ? _____

II. Please circle the best response to the question.

1=Not at all, 2=Very little, 3=Pretty much 4=Very much

1. Do you feel that you are superficial or fake? 1 2 3 4
2. Do you look into people's eyes when they are talking to you? 1 2 3 4
3. Are you affectionate with strangers? 1 2 3 4
4. Are you destructive to yourself, others and material things? 1 2 3 4
5. Are you cruel to animals? 1 2 3 4
6. Do you lie a lot? 1 2 3 4
7. Are you impulsive or hyperactive? 1 2 3 4
8. Are you a slow learner? 1 2 3 4
9. Do you think of consequences before you act? 1 2 3 4
10. Do you think of others feelings before you act? 1 2 3 4
11. Do you eat three regular meals (or do you skip meals or snack a lot) 1 2 3 4
12. Do you have close friendships? 1 2 3 4
13. Are you affectionate with authority? 1 2 3 4

14. Do you often think of starting fires? 1 2 3 4
15. Do you ask a lot of questions? 1 2 3 4
16. Are you demanding? 1 2 3 4
17. Do you have a speech problem? 1 2 3 4

Tables

TABLE 1
SYMPTOM MEANS

SYMPTOM	STUDENT	GROUP LEADER	PARENT
	N=53	N=12	N=31
1. Superficially engaging and charming	1.5	2.8	3.3
2. Lack of eye contact on authoritative terms	2.5	2.9	2.4
3. Indiscriminately affectionate with strangers	2.2	2.9	2.4
4. Destructive to self and material things	1.7	2.2	2.5
5. Cruelty to animals	1.3	1.8	1.7
6. Lies about the obvious	1.9	2.1	2.5
7. No impulse controls (hyperactive)	2.3	2.3	2.6
8. Learning lags (takes awhile to catch on)	1.9	2.2	2.6
9. Lack of cause and effect thinking	2.5	2.9	2.9
10. Lack of conscience	2.4	2.6	2.8
11. Abnormal eating patterns	2.5	1.1	1.9
12. Poor peer relationships	1.9	2.9	1.9
13. Not affectionate with authority	2.5	1.1	1.9
14. Preoccupation with fire	1.4	1.4	1.8
15. Persistent nonsense and incessant chattering	2.9	2.3	1.8
16. Inappropriately demanding and clingy	2.1	2.4	1.7
17. Abnormal speech patterns	1.3	1.5	1.5

TABLE 2
 SCORES OF THREE OR ABOVE AMONG PREVALENT CHARACTERISTICS

SYMPTOM	PERCENTAGE	VARIABLES
Superficially engaging and charming	3% n=2	student, group leader and parent
Being unaffectionate on authoritative	3% n=2 2% n=1	student and group leader student, group leader and parent
Lying about the obvious	15% n=8 9% n=5	student, group leader and parent student, group leader and parent
Lack of Cause and Effect Thinking	17% n=9 3% n=2	student and group leader student, group leader and parent
Lack of Conscience	2% n=1	group leader and student

TABLE 3
 STATISTICALLY SIGNIFICANT CORRELATIONS AMONG POPULATION
 POPULATION VARIABLES

STATEMENT	STUDENT	GROUP LEADER	PARENT
Cruelty to animals	0.01	0.01	
No impulse controls (frequently hyperactive)	0.01	0.01	
Lack of cause and effect thinking		0.01	0.01
Lack of conscience	0.001	0.001	
Abnormal eating patterns	0.001		0.001
Inappropriately demanding and clingy		0.001	0.001