A Clinical Investigation of Attachment Theory and the Manifestation of Psychological Disturbance

Kate Eloise Holt
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School of Psychology
Faculty of Health and Behavioural Sciences
Deakin University
Melbourne, Australia

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I certify that the thesis entitled:

A Clinical Investigation of Attachment Theory and the Manifestation of Psychological Disturbance

submitted for the degree of Doctor of Psychology (Health) is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any other university or institution is identified in the text.

Full Name: Kate Eloise Holt

Signed ........................................

Date: 200605
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Abstract

The affectional bond that develops between caregiver and child during infancy can lead to the development of emotional distress and the manifestation of psychological disturbance if the relationship is severed and a sense of loss is experienced. Furthermore, the caregiver-child relationship formed during infancy can have implications for the development of interpersonal relationships in later life. The secure or insecure attachment relationships developed influence the capacity to form affectional bonds in later life and may lead to the manifestation of psychological disturbance, such as depression.

The focus of this thesis is on four case studies of three children and one adolescent who have suffered negative early life experiences. Harrison is an 8 year old Koori boy who has suffered from maternal deprivation. Diana is a 10 year old girl who has a Mild Intellectual Disability and Epilepsy. The influence of second generational trauma on the caregiver-infant attachment relationship will also be explored in the case study of Diana. The third case study focuses on Melanic who is a 9 year old girl who has suffered from paternal sexual abuse and exhibits indiscriminate attachment relationships. Finally, the fourth case study focuses on Tammie who is a 16 year girl who exhibits depressive symptomatology which may have developed as a result of early insecure attachment relationships. The case studies are described with reference to attachment theory, the language and social deficits associated with negative early life experiences, and implications for therapeutic interventions.
Chapter 1. Introduction

Whilst a variety of factors have been found to be associated with the development and maintenance of psychological disturbance, early attachment relationships are thought to play an integral role in the development of psychological disturbance, such as depression (Bowlby, 1951; Rutter, 1981). Bowlby (1952) maintained that "maternal care in infancy and early childhood is essential for mental health" and that the discovery of the importance of attachment relationships during infancy is "comparable in magnitude to that of the role of vitamins in physical health" (Bowlby, 1952, p. 59). Attachment relationships formed during infancy can impact on children's cognitive, emotional, and social development. The development of insecure attachment relationships during infancy may make children more vulnerable to the manifestation of psychological disturbance later in life. Later in 1969, Bowlby declared that any individual exhibiting psychological disturbance also possessed dysfunctional affectionate bonds. Bowlby (1969) argued that typically the social difficulties were a result of the failure to develop attachment relationships in early infancy, and consequently lead to the later development of psychological disturbance (Rutter, 1981).

The attachment relationships formed early in infancy shape future social interaction practices (Blatt & Levy, 2003; Rutter, 1981; Shaffer, 2002). Simultaneously, the attachment relationship between the caregiver and child also serves to encourage independence (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Mohr, 2001). Children aged between 7 and 9 months become primarily attached to one individual, namely the mother, and may exhibit distress when separated from the primary caregiver (Cassidy & Mohr, 2001). During this same
period, children develop exploratory behaviour whereby the attachment figure is utilised as a secure base from which to explore the surrounding environment (Bretherton, 1985; Shaffer, 2002). Attachment relationships do not, however, develop automatically between caregiver and child. Each party has to learn how to respond to and regulate the behaviour of the other (Shaffer, 2002). In addition, the quality of the caregiver-infant attachment relationship determines an infant’s reaction or response to the unfamiliar (Ainsworth et al., 1978).

Caregivers who are unresponsive to the needs of their infant develop insecure attachment relationships between caregiver and infant (Shaffer, 2002). Unresponsive caregivers may be depressed, may have had pregnancies which were unplanned or unwanted, or may have themselves been unloved, neglected, or abused as children (Ainsworth et al., 1978; David, 1992; Shaffer, 2002). In one study, David examined the long term psychosocial effects of 220 children born “wanted” and 220 children born “unwanted”. Children were assessed at age 9, again at ages 14 to 16 years and finally at 21 to 23 years. At age 9 years, David found that children categorised as “unwanted” were significantly more likely to be rejected by their peers and received lower school grades than children classified as “wanted”. At age 14 to 16 years, adolescents originally classified as “unwanted” were found to have significantly lower school performance scores than their “wanted” counterparts. Furthermore, a larger percentage of adolescents categorised as “unwanted” did not complete secondary schooling and instead began apprenticeships or found jobs. At age 21 to 23 years, young adults originally classified as “unwanted” reported significantly lower job satisfaction, more conflict with co-workers and supervisors, and problems with peer relations and romantic relationships than their “wanted” counterparts. In
addition, young adults classified as “unwanted” reported poorer mental health and
greater psychological problems (David, 1992).

The establishment of insecure attachment relationships between caregiver and
child can also be influenced by the quality of the relationship between mother and
father (Rutter, 1981; Shaffer, 2002). Parents who report that they are unhappy prior
to the birth of their baby are less sensitive caregivers, report dissatisfaction with their
parenting role and negative attitude toward the newborn and establish poor quality
and insecure attachments with their infant (Shaffer, 2002). Therefore, the broader
context in which the infant is raised can also prevent or encourage the establishment
of attachment relationships.

A child’s temperament has also been found to be associated with the
development of attachment relationships. Ainsworth et al. (1978) found that the
majority of children who were classified as having an “easy-going” temperament
were securely attached. Children classified as having a “difficult” temperament who
were resistant to change and upset by novelty were classified as insecurely attached.
In a more recent study, Van den Boom (1995) investigated the attachment
relationships between socioeconomically disadvantaged 79 Dutch mothers and their
irritable 10 day old babies. Mothers participated in an intervention designed to
improve their sensitivity and responsiveness to their infants’ difficult temperament.
At a two year longitudinal follow-up, mothers who participated in the intervention
were more accepting, accessible, co-operative, and sensitive caregivers than their
control counterparts. At a three year longitudinal follow-up, mothers who received
the intervention were more responsive to the needs of their toddler and assisted their
child in play to a greater extent than mothers in the control condition. Furthermore,
toddler of mothers who received the intervention were found to be more co-
operative during play with peers than toddlers of control mothers. Overall, mothers
who received the intervention were found to be more sensitive caregivers and infants
were found to be more securely attached than those of their control counterparts (Van
den Boom, 1995).

Longitudinal studies suggest that infants who have established secure
attachment relationships are more likely to develop positively with regards to social,
emotional, and cognitive factors than their insecure counterparts (David, 1992;
Shaffer, 2002; Van den Boom, 1995). The quality and security of attachment
relationships established during infancy can influence children as they age. This is
primarily due to the stability of attachments over time, which contributes to an
individual’s personality and emotional adjustment (Bretherton, 1985; Main &
Cassidy, 1988; Shaffer, 2002).

As infants continue to grow and interact with the primary caregiver, they
develop internal working models. Internal working models are cognitive
representations of themselves and other people which infants utilise to interpret
events and understand human behaviour (Bretherton, 1985; Main, Kaplan, &
Cassidy, 1985; Shaffer, 2002). Internal working models may be positive or negative
in nature. Positive internal working models include, caregivers are dependable.
Negative internal working models include, caregivers are not trustworthy. From
these, internal working models of the self are also developed. An infant whose
caregiver responds quickly to needs of hunger is lead to believe that “I’m lovable”.
In contrast, an infant whose caregiver ignores cries for attention perceives “I’m
unworthy”. The two models combine to influence attachment relationships and a child’s expectations with regards to future relationships with others.

Main et al. (1985) conducted a longitudinal investigation to examine how early behavioural observations of caregiver-child relations were associated with internal working models of attachment amongst caregivers and children five years later. Forty mothers, fathers, and their children participated in the study beginning with a behavioural observation of attachment relationships of infants aged 12 to 18 months. Via clinical interviews with children five years later, Main et al. was able to determine how children’s minds were organised in relation to attachment relationships rather than via behavioural observation only. In this way, Main et al. was able to gain a greater understanding of children’s internal working models of attachment. Five years later, children who were classified as securely attached during infancy were consistently categorised as secure with regards to emotional openness assessed via responses to picture cards depicting parent-child separation. Similarly, children originally classified as secure were also more likely to respond favourably to their own family photograph at long term follow-up suggesting the presence of happy family relations and secure parental attachment. Children originally classified as poorly attached during infancy typically responded negatively to their own family photograph at long term follow-up by avoiding the photograph or refusing to accept the photograph (Main et al., 1985).

In summary, attachment relationships formed during infancy between caregiver and child play an important role in the later social, emotional, and cognitive development of children. The attachment bonds created during infancy serve as a template in which other experiences are interpreted, understood and
internalised, forming internal working models of behaviour. Whilst other psychosocial factors are purported to play a role in the development of attachment relationships, such as a child’s temperament, the responsiveness of the primary caregiver has been suggested as being most influential in the development of secure attachment relationships (David, 1992; Van den Boom, 1995).
Chapter 2. Attachment Theory and Clinical Application

Perceived social support is a highly influential protective factor when considering the development and maintenance of a mental illness. Social isolation or low perceived social support can make oneself vulnerable to the development of a mental illness, such as depression or anxiety. Perceived social support can be defined as one’s own perception of degree of support from family and friends. During infancy, perceived social support is best understood via considering the attachment behavioural system introduced by Bowlby (1969, 1973, 1980). The attachment behavioural system encompasses the infant’s behaviour and the organisation of this behaviour in order to ensure close proximity between the infant and the mother or attachment figure and the on-going maintenance of this relationship (Cassidy & Mohr, 2001). Bowlby’s (1969) attachment theory, in this regard, encapsulates both normal, adaptive behaviour and abnormal, maladaptive behaviour (Sroufe, Carlson, Levy, & Egeland, 1999).

Bowlby’s (1969) attachment theory postulates that early caregiver and infant affectional bonds contribute to later psychological functioning (Bowlby, 1969; Sroufe et al., 1999). Bowlby, in his theory of attachment, defines attachment as the pattern of organised behaviour within a relationship. Bowlby states that the development of psychological disturbance results from the failure to form attachment relationships during infancy. Whilst much debate exists in the literature regarding the influential nature of caregiver-infant attachment, the later development of psychopathology may result from early experiences and contextual factors, such as social isolation or lack of social support (Rutter, 1981; Sroufe et al., 1999).
Ecologically, early experience can influence the nature of later experience and contextual or environmental factors (Sroufe et al., 1999).

Bowlby’s (1969) notions of early experience and contextual or environmental factors are best understood in his model of developmental pathways (Sroufe et al., 1999). Bowlby likens his concept of developmental pathways to branches on trees. The model emphasises greater diversity in normality with a greater number of branches in the broad centre of the tree. There are also a vast array of branches which stem from the central branches emphasising many pathways and outcomes. Extended travel along branches deviating from centrality results in greater unlikelihood that the pathway will resume to normalcy. Psychopathology results from seeking deviating pathways away from centrality. However, interventions or making positive changes towards centrality prior to adolescence, whereby one’s pathway is deemed fixed, can result in normalcy (Bowlby, 1969; Sroufe et al., 1999).

In infancy, however, Bowlby (1969, 1973, 1980) postulates that attachment behaviour is biologically based (Cassidy & Mohr, 2001). Infants’ physiological needs, for example food and temperature regulation, are met via attachment figures, primarily the mother or other biological relatives. Consistent with this notion, infants prefer to be in close proximity to attachment figures, will explore their environment whilst in their care and will seek attachment figures when alarmed or feeling unsafe (Cassidy & Mohr, 2001). Bowlby views attachment as adaptive and evolutionary in nature, suggesting that infants who engage in attachment behaviour are more likely to survive and, ecologically, reproduce and pass on genes which emphasise the importance of attachment. For an infant to feel securely attached, the mother or attachment figure must be viewed as sensitive, responsive, and available. A mother
or attachment figure who is sensitive, responsive, and available will portray to the infant that he/she is important and lovable. The opposite is also true. A mother or attachment figure who is insensitive, rejecting, and unavailable will portray to the infant that he/she is unworthy of care, unimportant, and unlovable. Infants who view their mother or attachment figure as rejecting and unavailable, likewise view themselves as unworthy of attachment and are said to be insecurely attached (Cassidy & Mohr, 2001).

2.1 The Strange Situation

One instrument that has been developed to assess the security and quality of attachments is the “Strange Situation” procedure which is designed for infants aged 12 to 18 months (Ainsworth et al., 1978). Ainsworth et al. devised an investigation of individual differences of secure attachment between mother and child. The “Strange Situation” procedure is a 20 minute laboratory based experiment whereby the infant engages in free-play during which the parent and female confederate alternatively leave the infant in a toy filled room and then return. Refer to Table 1 for a more detailed account of the “Strange Situation” procedure and break-down of the eight individual episodes. Attachment quality is determined via the infant’s response to the caregivers return on two separate occasions during the investigation.
<table>
<thead>
<tr>
<th>Number of Episode</th>
<th>Number of Persons Present</th>
<th>Duration</th>
<th>Brief Description of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mother, Baby &amp; Observer</td>
<td>30 seconds</td>
<td>Observer introduces Mother and Baby to experimental room, then leaves</td>
</tr>
<tr>
<td>2</td>
<td>Mother &amp; Baby</td>
<td>3 minutes</td>
<td>Mother is non-participant while Baby explores; if necessary, play is stimulated after 2 minutes.</td>
</tr>
<tr>
<td>3</td>
<td>Stranger, Mother &amp; Baby</td>
<td>3 minutes</td>
<td>Stranger enters. First minute: Stranger silent. Second minute: Stranger converses with Mother. Third minute: Stranger approaches Baby. After 3 minutes Mother leaves unobtrusively.</td>
</tr>
<tr>
<td>4</td>
<td>Stranger &amp; Baby</td>
<td>3 minutes or less</td>
<td>First separation episode. Stranger’s behaviour is geared to that of Baby.</td>
</tr>
<tr>
<td>5</td>
<td>Mother &amp; Baby</td>
<td>3 minutes or more</td>
<td>First reunion episode. Mother greets and/or comforts Baby, then tries to settle Baby again in play. Mother then leaves, saying “bye-bye”.</td>
</tr>
<tr>
<td>6</td>
<td>Baby alone</td>
<td>3 minutes or less</td>
<td>Second separation episode.</td>
</tr>
</tbody>
</table>
Table 1 (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Stranger &amp; Baby</th>
<th>3 minutes or less</th>
<th>Continuation of second separation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
<td></td>
<td>Stranger enters and gears behaviour to that of Baby.</td>
</tr>
<tr>
<td>8</td>
<td>Mother &amp; Baby</td>
<td>3 minutes</td>
<td>Second reunion episode. Mother enters, greets Baby, then picks Baby up. Meanwhile Stranger leaves unobtrusively.</td>
</tr>
</tbody>
</table>

(Ainsworth et al., 1978).

Ainsworth et al. describes three different forms and styles of attachment: Secure, Insecure/Avoidant, and Insecure/Resistant. Infants who exhibit interest in the caregiver’s return, contact and proximity, were classified as Secure. These infants may or may not exhibit distress when the caregiver leaves the room but upon the caregiver’s return the infant is comforted by the caregiver and either returns to exploring the toys in the room or engages in play with the caregiver (Ainsworth et al., 1978; Main & Solomon, 1986). Infants who ignored and avoided contact with the caregiver upon her return were classified as Insecure/Avoidant. These infants display no distress, fear, or anger to the caregiver’s absence and little emotion on the caregiver’s return, ignoring or moving away from the caregiver and are not willing to engage in communication with the caregiver (Ainsworth et al., 1978; Main & Solomon, 1986). Finally, infants who remained preoccupied with the caregiver and were unable to attend to the toys after the caregiver returned were classified as Insecure/Resistant. These infants display little or no security when the caregiver returns and are unable to be comforted by the caregiver (Ainsworth et al., 1978; Main & Solomon, 1986).
Ainsworth et al. (1978) reported that mothers of Secure infants were sensitive, responsive, and warm, whilst mothers of Insecure/Avoidant infants were rejecting and ignored infants’ attachment requests, shying away from physical contact with the infant. Ainsworth et al. observed that interactions between mothers and Insecure/Avoidant infants were often of short duration and unpleasant for the infant. Mothers of Insecure/Resistant infants were not rejecting of their infant, but were found to be unable to nurse the infant or respond to the infant’s cues. Furthermore, mothers of Insecure/Resistant infants were found to be unpredictable and inconsistent with regards to parenting (Cassidy & Mohr, 2001).

Consistent with Bowlby’s attachment behaviour system, Main (1990) maintains that infants devise attachment strategies to ensure close proximity to the mother or attachment figure which can be modified to encapsulate different caregiving environments. Main posits that infants utilise these attachment strategies when the mother-infant relationship is threatened, for example in the “Strange Situation” procedure. Secure infants with a sensitive, responsive, and available mother or attachment figure have learnt that in order to feel protected, they must exhibit distress. Once comforted, secure infants return to the exploration of the environment aware that their caregiver is available. For secure infants a smooth transition from attachment behaviour to exploratory behaviour takes place (Main, 1990; Main & Solomon, 1986). Insecure/Avoidant infants have learnt to suppress feelings of attachment from mothers and attachment figures who are uneasy with physical contact in order to maintain access to a protective caregiver. These infants exhibit exploratory behaviour throughout separation, detaching from the caregiver, and forming a defensive independence (Main, 1990; Main & Solomon, 1986). Lastly, Insecure/Resistant infants have learnt to exhibit distress even when threats are
deemed low risk in order to increase their chances of accessibility and availability to inconsistent and unreliable caregivers. These infants display extreme dependence on the caregiver. Despite the vast array of responses exhibited by infants when distressed or unprotected, the environments of Secure, Insecure/Avoidant and Insecure/Resistant infants are all predictable and attachment strategies can be employed and adapted to specific instances. Whilst the coping strategies employed by some infants to gain access to their protective caregiver may not be optimal for later development, for example emotion regulation, Secure, Insecure/Avoidant and Insecure/Resistant infants do receive some level of security. Some infants are faced with an unpredictable, violent, threatening, and frightening environment whereby attachment strategies to ensure access to a protective caregiver cannot be envisaged. These infants are classified as Insecure-Disorganised/Disoriented (Main & Solomon, 1986).

2.2 Insecure-Disorganised/Disoriented Infants

The Insecure-Disorganised/Disoriented infant attachment category was introduced to account for the behaviour of infants which was deemed “unclassifiable” according to Ainsworth et al.’s (1978) original study and classification system. The Insecure-Disorganised/Disoriented classification was thought to arise as a result of child neglect, abuse, or maltreatment or to describe the second generation effects of unresolved loss of an attachment figure or trauma, such as sexual abuse, experienced by a mother which transcends to the newborn infant (Main & Cassidy, 1988; Main & Hesse, 1990; Main & Solomon, 1986).
Main and Solomon (1986) reviewed video taped interactions of the "Strange Situation" procedure with 55 infants aged 12 to 20 months who were identified as "unclassifiable". The authors acknowledge that these infants display a number of features in their behaviour. Firstly, infants exhibit disordering of expected temporal sequence whereby they show strong avoidance of a caregiver following strong proximity-seeking behaviour. For example, an infant may approach the caregiver with a bright greeting then suddenly turn away presenting as dazed and avoiding the caregiver. Other infants display fear and distress upon separation from the caregiver, and then avoid the caregiver on return with an expressionless face. Secondly, infants display, simultaneously, contradictory behaviour, such as approaching the caregiver with head averted or gazing away from the caregiver when in direct contact. Main and Solomon found that one child approached the caregiver but she did so via moving backwards lying on her stomach with her face averted. These infants appear to not be able to fully approach the caregiver but cannot also shift attention away from the caregiver and move away (Main & Solomon, 1986).

A third feature identified by Main and Solomon (1986) is that infants may engage in incomplete or undirected movements and expressions, such as undirected facial expressions of fear or distress, or rocking behaviour. Main and Solomon found that an infant upon reunion with a caregiver moved away from the caregiver and proceeded to cry continuously whilst not making any attempt to gain the caregiver's attention directly by eye contact or move towards the caregiver. Infants may appear confused and apprehensive, exhibiting a hand-to-mouth gesture immediately upon a caregiver's return, which is a fourth feature of "unclassifiable" infant behaviour. An infant may be sitting erect and fall backwards with arms and legs in the air when the caregiver returns in the "Strange Situation" procedure. Finally, infants may display
behavioural stilling in which an infant may cease movement or postures indicating confusion or depression and present with dazed or disoriented expressions suggesting activation of a mutual inhibitory system. Infants may present as dazed with an unfocused dead stare with mouth and chin limp and frozen-like body. At times, infants may engage in this frozen and stilled behaviour and fall face down on the ground (Main & Solomon, 1986).

At a follow-up period five years later, children originally classified as Insecure-Disorganised/Disoriented in infancy displayed consistent insecure behaviour (Main & Solomon, 1986). Children displayed behaviour which appeared role reversed, such as punitive controlling behaviour or exaggerated caregiving behaviour towards the parent (Main & Cassidy, 1988; Main & Solomon, 1986). Interestingly, this behaviour was confined to the same parent as when originally classified as Insecure-Disorganised/Disoriented. Other measures obtained at the five year follow-up supported the notion that children classified as Insecure-Disorganised/Disoriented in infancy displayed similar disorganised or disoriented attachment related behaviour at six years. One such measure, family drawings, were often disorganised, in such that elements were scratched out or there were numerous re-starts, or were over bright, for example a family drawn standing on a row of hearts. Children were also asked to respond to a question regarding how they would react to separations. Children classified as Insecure-Disorganised/Disoriented were sometimes silent, gave bizarre answers or responded irrationally (Main & Solomon, 1986).

Children who were classified as insecure as per the Ainsworth et al. (1978) “Strange Situation” procedure during infancy were also found to be non co-
operative, non empathic, socially incompetent, have limited interest in learning and exploration, and lacked self-confidence than children who had been classified as secure (Ainsworth et al., 1978; Main & Solomon, 1986). Main and Solomon, therefore, concluded that children who were classified as insecure as per the caregiver-child attachment relationship in infancy displayed continuing psychological and behavioural problems as they progressed from infancy to early childhood (Bretherton, 1985).

2.3 Attachment Classification and Internal Working Models of Attachment

Bowlby’s (1969) proposition that attachment classifications represent internal working models of attachment is commonly conceptualised in the attachment literature (Bretherton, 1985; Zeanah, Mammen, & Lieberman, 1993). Internal working models can be defined as large memory structures which contain all of an individual’s subjective experience of others in social relationships including the formulation of social expectations of others (Zeanah & Anders, 1987). Bowlby (1969) postulates that an infant’s internal working model is constructed on the basis of infant’s caregiving experiences and evolves in the later part of the infant’s first year of life. Internal working models of attachment can therefore be influenced by the infant’s caregiving environment and also the infant’s personality characteristics. Zeanah et al. report that the attachment classification, determined by internal working models of attachment, can be generalised beyond the caregiver-infant relationship as the child grows older. However, prior to 3 years of age, the attachment behaviour is more readily relationship specific and not generalised to the formation of new relationships with others. As the child grows older, however, attachment classifications have been found to predict the quality of relationships the
child forms with the primary caregiver and others and this remains fairly stable (Main & Cassidy, 1988).

Main and Cassidy (1988) examined reunion responses reflecting attachment relationships in 33 families with children 6 years of age. All children had participated in the “Strange Situation” at 12 months of age with their mother and at 18 months of age with their father. At these times the children were classified as Secure, Insecure/Avoidant, Insecure/Resistant, or Insecure-Disorganised/Disoriented. Parents and children firstly watched a video depicting a 2 year old child being separated from parents. The parents were then instructed to leave the interview play room and complete measures regarding attachment style while the child remained in the room with the examiner completing measures pertaining to separation anxiety. Afterwards, the parents rejoined the child in the interview play room whereby reunions were examined. A judge blind to the attachment classifications determined at 12 months of age then observed and categorised caregiver-child attachment relationships at 6 years of age. Results indicated that all the children who had been classified as Secure at 12 months of age with mother were found to be classified the same five years later. Of the children classified as Insecure/Avoidant at 12 months of age with mother, 75% were classified as the same at 6 years of age. Finally, of the children classified as Insecure-Disorganised/Disoriented at 12 months of age with mother, 67% were classified as controlling at 6 years of age whereby parent-child roles were reversed. Due to small sample size, children classified as Insecure/Resistant at 12 months were not examined at the five year follow-up. Overall, attachment classifications with mother determined during infancy were found to predict 84% of the sample’s attachment relationships at five year follow-up. With regards to father-child attachments, attachment classifications determined at 12 months of age were found
to predict 61% of the sample’s attachment relationships at five year follow-up (Main & Cassidy, 1988).

In a second study, Main and Cassidy (1988) investigated reunion responses in 50 mothers and their 6 year old children and whether these were stable over a one month period. A similar design was utilised in this second study to the first in that a judge, blind to the attachment classification made at 12 months of age, in a guess-and-uncover method tried to classify children’s attachment and evaluate whether classification was consistent from 12 months to 6 years of age and at one month follow-up. There were two differences between the first study and the second study. Firstly, infants classified as Insecure/Resistant at 12 months of age were re-examined at 6 years of age, and secondly the stability of child attachment classifications were evaluated at a one month follow-up. Results indicated that at the one month follow-up, attachment classifications were found to be relatively stable and accurately predicted 62% of mother-child reunion classifications. Misclassifications existed primarily in the Insecure-Disorganised/Disoriented group whereby classifications were ambiguous at times with “unclassified” children being assigned to this group. When Insecure-Disorganised/Disoriented children were reclassified into the other “best-fitting” alternative (Secure, Insecure/Avoidant or Insecure/Resistant), one month classification consistency increased to 84% (Main & Cassidy, 1988).

One of the main aims of Main and Cassidy’s (1988) investigations was to examine the attachment behaviours of children classified as Insecure-Disorganised/Disoriented at 12 months of age in early childhood. Infants classified as Insecure-Disorganised/Disoriented at 12 months of age would present as either distressed with regards to the lack of parents’ attention and then ambivalent towards
the parent once attention was granted or the infant would engage in stilling or freezing behaviours directed towards the parent. At 6 years of age, children classified as Insecure-Disorganised/Disoriented would assume a more parental role and try to control the parents’ behaviour by either punitive (directing or embarrassing) or over-caregiving behaviour (extreme enthusiasm at reunion or protective behaviour towards the parent). Main and Cassidy report that infants classified as Insecure-Disorganised/Disoriented at 12 months of age exhibited well organised behaviour in relation to the parent at age 6 years. Main and Cassidy suggest that the child may be responding to implicit requests from the parent to act as a caregiver or a spouse in the case of severe unresolved loss or sexual abuse experienced by the parent at a young age. The effects of parental unresolved loss or trauma and subsequent parent-child attachment relationships will be considered next.

2.4 Parental Unresolved Loss or Trauma and Caregiver-Child Attachment

To examine the effects of parental unresolved loss or trauma, caregivers typically complete the Adult Attachment Interview (AAI) which examines his or her own attachment history and subsequent description and evaluation of these relationships (George, Kaplan, & Main, 1985). In the one hour interview parents are asked to provide a description of their childhood including their relationship with their parents and other important adult figures and whether any parent or important adult figure had deceased during their childhood (Main & Hesse, 1990). Parents are then classified into one of four types: Secure-Autonomous with regards to attachment, Dismissing of attachment, Pre-occupied by past attachments, or Unresolved-Disorganised in relation to attachment. Adult classifications have been found to predict children’s attachment classification in the “Strange Situation”
procedure. For example, parents classified as Secure typically have Secure children while Dismissing parents tend to have Insecure/Avoidant children (Main & Hesse, 1990). Infants of parents who experience unresolved trauma, whereby trauma can be defined as the individual’s own interpretation and perception of experiences of intense fear, terror, or helplessness, often exhibit behaviour classified as Insecure-Disorganised/Disoriented (Green & Goldwyn, 2002; Hesse & Main, 1999; Main & Hesse, 1990).

Main and Hesse (1990) proposed that parents who are themselves frightened are frightening to an infant. Frightened parents may frighten an infant because the parent’s own fearfulness may leave the infant lacking confidence in the parent’s ability to serve their role as a secure base and protector. Mothers or caregivers who experience trauma or unresolved loss of a significant attachment figure via death, rather than physical or sexual abuse, may still exhibit fear with regards to their early loss experiences (Hesse & Main, 1999; Main & Hesse, 1990). Due to this fear, the mother may present as anxious which could be interpreted as frightening to an infant. Main and Hesse found, via informal observations of infants classified as Insecure- Disorganised/Disoriented during the “Strange Situation”, that frightening or frightened behaviour, on behalf of the mother or caregiver, consisted of unusual vocal patterns, unusual movement patterns, and unusual speech content. Unusual vocal patterns include dramatic changes in tone and pitch of voice, which may be especially evident in greetings with an underlying “haunted” effect. Intonation changes may also occur in which the pitch of the mother’s voice may drop and she may subsequently sound like a male. Unusual movement patterns encompass timid handling of the infant or unpredictable invasions of the infant’s personal space by suddenly sliding hands across the infant’s face or neck. The caregiver’s body
language may also be in direct conflict with his/her verbal requests. For example, this may involve calling for an infant to approach the caregiver who is standing with his/her hands on hips and neck and jaw jutted forward (Hesse & Main, 1999; Main & Hesse, 1990). Unusual speech content includes comments which indicate that the infant's actions could have harmful consequences, such as “You’ll kill that little (stuffed) bear if you do that!”, or the sudden initiation of game playing with frightening speech content, such as “I’m gonna get you!” accompanied by frightening movement and intonation (Hesse & Main, 1999; Main & Hesse, 1990).

Mothers or caregivers who possess unresolved mourning or loss may exhibit fear and present as anxious towards a newborn infant. In this instance fear is perceived as internal to the mother and, as a consequence, the infant is confused and fearful (Hesse & Main, 1999; Main & Hesse, 1990). Due to the internal nature of the fear experienced by the mother, she may become oblivious to external environmental hazards or focus on a particular aspect of the environment which she perceives as harmful in relation to her history of loss but which is in fact not alarming. In either instance, the mother or caregiver is not adequately protecting her infant from harm. The infant will interpret the mothers’ behaviour as incomprehensible as there are no external risks or the mother may implicate the infant in her early loss experience cognitively and inadvertently lead the infant to believe that it is the source of alarm. Furthermore, a natural response to fear is flight. Therefore, the mother may indicate a desire to flee from the environment and infant or, in opposition, flee to the infant for safety. With such anxious parenting, it is no wonder infants become confused and present as disorganised and disoriented (Hesse & Main, 1999; Main & Hesse, 1990).
Retrospective analysis of mothers or caregivers’ early attachment history and experience of loss and mourning was examined in order to investigate intergenerational effects of attachment style. A six year follow-up of Insecure-Disorganised/Disoriented children revealed that 91% of mothers who were found to have unresolved mourning also had children who were classified as disorganised and disoriented in the “Strange Situation” during infancy at baseline (Main & Hesse, 1990). Main and Hesse concluded that unresolved mourning for loss of an attachment figure by a mother was associated with having a child classified as Insecure-Disorganised/Disoriented rather than death of a loved one per se. Furthermore, follow-up studies suggest that children classified as Insecure-Disorganised/Disoriented in infancy via the “Strange Situation” were found to have dysfunctional cognitive thinking regarding attachment related events at age 6 years. Children classified as Insecure-Disorganised/Disoriented exhibited fearful, disorganised, and contradictory or irrational thought processes with regards to attachment-related events (Main & Hesse, 1990).

2.5 Clinical Relevance of Attachment Theory

In this thesis, four case studies are presented which provide additional support for the notion that insecure attachments developed during infancy between mother or attachment figure and infant can contribute to the vulnerability of the infant developing maladaptive coping strategies, and consequently the manifestation of psychological disturbance in later years. The first case (Harrison) provides a description of an 8 year old Koori boy who exhibits aggressive and disruptive behaviour both in his foster care placement and at school. The case of Harrison will be explored in Chapter 3 with particular reference to maternal deprivation. In the
second case (Diana), the notion of maternal unresolved loss or trauma and
subsequent frightened and frightening behaviour exhibited by the caregiver toward
the child will be explored. This second case described in Chapter 4 involves Diana
who is a 10 year old girl who exhibits anxiety symptoms which may be related to her
mother’s unresolved loss of her parents at a young age. The third case (Melanie)
provides a description of a 9 year old girl who was sexually abused by her father and
subsequently displays indiscriminate attachment with adult figures. The inability of
Melanie’s caregivers to provide her with adequate security and safety which leads to
the development and formation of indiscriminate attachment relationships between
Melanie and other significant adult figures in her life will be described in Chapter 5.
The final case (Tammie) provides a description a 15 year old girl with a history of
sexual abuse from two different perpetrators. Tammie exhibits symptoms of
depression and low self-esteem predominantly related to familial conflict and peer
socialisation difficulties. Early childhood sexual abuse and the effects of insecure
attachment relationships during preadolescence and the later development of peer
relationships in adolescence will be described in Chapter 6. The similarities between
all four case studies of Harrison, Diana, Melanie, and Tammie, with particular
reference to language and social deficits, will be described in Chapter 7.
Chapter 3. The Case of Harrison

The case of Harrison and how early deprivation of attachment can contribute to the development of disruptive behavioural problems is described in this chapter. The case of Harrison, an 8 year old Koori boy exhibiting disruptive and aggressive behaviour will firstly be described. Literature pertinent to understanding children’s behaviour when there is a lack of a caregiver-infant attachment relationship during infancy will be outlined next. Finally, treatment options designed to manage Harrison’s disruptive and aggressive behaviour and to enable him to develop a more secure caregiver-child relationship will be explored.

3.1 Case Study- Harrison

The case of Harrison will be presented below and conceptualised within the framework of attachment theory. The assessment process occurred over four sessions involving Harrison and his foster carer Carmel.

Reason for Referral:
Harrison is an 8 year old Koori boy who was referred to a Child and Adolescent Mental Health Service (CAMHS) by a Department of Education and Training (DET) Social Worker in May 2003. The DET Social Worker reported that Harrison is well controlled in the classroom but often hurts children in the school playground. Harrison has kicked, punched, and bitten other children and, as a result, has started to lose friends. The DET Social Worker also reported that current behavioural management strategies have not been effective in the school environment and the
school were requesting further advice regarding the management of Harrison's behaviour.

*Presenting Problems:*

Harrison resided with foster carers Carmel and Bill, and his biological cousin Joshua. He has lived in this family for the last three and a half years. Carmel reported that Harrison has uncontrollable rages at home which are often of long duration and very destructive. Carmel reported that Harrison can be aggressive, defiant, and oppositional at home and she is concerned about the safety of other children Harrison interacts with due to his problematic behaviour. Carmel also stated that she believes that Harrison is confused about his aboriginality and where he “belongs” in the world. However, Carmel was primarily concerned with the violent and aggressive nature of Harrison’s behaviour.

*Personal History:*

Harrison has been in foster care from four weeks post birth to the present time. Harrison was originally cared for by his biological mother, Denise, but she was unable to cope with Harrison and he was placed in foster care. Harrison has had minimal contact with his birth mother and father since. Harrison was cared for by foster carer Lara until he was 3 years of age. Due to Lara’s old age (approximately 70 years), Harrison was then cared for by a second foster carer who Harrison refers to as “bad” Caroline. Harrison did not stay in this placement long (approximately six months) due to his violent outbursts and the carer’s inability to cope with Harrison’s behaviour. As a result, Harrison was returned to the previous carer Lara. However, as Harrison damaged Lara’s property extensively (approximately $15,000 worth damage), he only remained in this placement for three months. Harrison has been in
foster care with Carmel and Bill since approximately 4 years of age. Harrison does not have a Department of Human Services Individual Case Manager but rather a Berry Street Organisation Case Manager, Katherine.

Carmel reported that the previous carer Lara stated to her that Harrison was an angry baby who would often stiffen his body. Carmel also reported that Lara informed her that Harrison displayed “weird body movements” which Lara thought were abnormal. No other early developmental history is known by Carmel. Harrison completed two years at Kindergarten due to his inability to socialise appropriately with other children. Harrison began primary school at a local primary school but commenced grade one at another primary school, located outside the immediate district of the family home, in 2003 due to peer socialisation difficulties. Harrison exhibits emotional and behavioural difficulties including angry outbursts, lying, fighting, and temper tantrums at school, specifically in the playground, and at home.

Psychiatric History:
Harrison has had previous brief contact with another CAMHS whilst residing in Lara’s care. The Berry Street Organisation also had a private psychological assessment undertaken shortly after Harrison was placed in permanent foster care with Carmel and Bill regarding the appropriateness of the foster placement. I was not provided a copy of this psychological assessment despite requests.

Family History:
Harrison was born to Koori parents Fred and Denise in regional Victoria. Little is known about Harrison’s biological parents. Fred, Harrison’s father, is an artist who lives a transient lifestyle in country Victoria. Fred is described as an alcoholic by
Carmel. Harrison has no contact with his father but has recently begun telephone contact with Fred’s sister and Harrison’s paternal grandmother which was initiated by Carmel. Harrison’s mother, Denise, was very young when she became pregnant with Harrison, and he was an unplanned pregnancy. Denise has been described by Carmel as drug dependent. Currently, Denise is incarcerated in Adelaide on drug related charges. Harrison has no contact with his biological mother’s family.

For the first years of life, Harrison remained in the care of Lara. Little is known about Lara. Carmel stated that she believes that Lara was a spiritual lady who believed in witches and witchcraft. Prior to Harrison residing with Carmel, Carmel reported that the only toys Harrison possessed were those portraying snakes and spiders and he enjoyed movies like “The Addams Family”. Every photo that Carmel has in her possession of Harrison prior to 4 years of age, given to her by Lara, has a witch or goblin in the background, according to Carmel.

For the last three and a half years, Harrison has resided with Carmel and Bill. Carmel is a well educated woman who previously worked in local government in Canberra. Carmel advocates strongly for aboriginal rights and currently lectures in this domain at a University. Carmel has been married previously but has no biological children. Carmel fostered a young girl, prior to caring for Harrison and Joshua, who died of cancer at age 17 years. Shortly after her death, Carmel married Bill and adopted Joshua and later Harrison. Bill remains out of the parenting picture which is dominated by Carmel. Bill is a middle to late aged man who receives a disability pension due to chronic back pain. Marital discord was reported by Carmel but both Carmel and Bill had decided to stay together in order to provide joint support for their foster children Joshua and Harrison.
Joshua is a 15 year old Koori boy who has resided with Carmel and Bill for the majority of his life. Joshua is also a client of a CAMHS who has a diagnosis of Post Traumatic Stress Disorder, following early childhood sexual abuse in prior care, and a Mild Intellectual Disability. Joshua attends the local Special School. Joshua and Harrison have a conflictual and competitive relationship. Joshua has a close and enmeshed relationship with Carmel and there is evidence that Carmel portrays a preference for Joshua over Harrison in her parenting. For example, Carmel is lenient in her punishment of Joshua when he exhibits similar or worse aggressive acts, such as punching holes in walls, than Harrison.

*Genogram:*

Presented in Figure 1 is a genogram representing Harrison's family.

![Genogram of Harrison's family](image-url)

*Figure 1. Genogram of Harrison's family*
Medical History:
No known medical history.

Forensic History:
No known forensic history.

Substance Abuse:
No known substance use history.

Education:
Harrison completed two years in Kindergarten due to socialisation difficulties and also relocated to a second primary school due to the same difficulties. Harrison has recently completed the “Reading Recovery” program at his current primary school. Carmel stated that Harrison “loves school”. Harrison also reported that he likes attending school and particularly enjoys art, sport, maths, and science.

Mental State Examination:
Harrison presented as a healthy 8 year old Koori boy who was engaging and cooperative. He attended assessment sessions dressed in his school uniform and wearing pink nail polish. During the assessment sessions, Harrison played mainly with dolls and the doll house. Harrison’s mood was euthymic and normal. His affect and mood were congruent. Harrison had normal prosody of speech and utilised appropriate language. However, it was difficult to understand the content of his speech at times. Harrison currently receives speech therapy.
Harrison presented as a logical and literal thinker. He also exhibited concrete thinking and would laugh inappropriately at Carmel’s accounts of his obsessional behaviour. During the sessions, Carmel often exhibited sarcastic communication which confused Harrison and he would respond “stop talking backwards Mum”. Carmel reported that Harrison would respond similarly at home. Carmel did not make any attempt to explain her sarcastic comment and ignored Harrison’s enquiries. Harrison became pre-occupied with “telling a story” to myself and he stated that Carmel was telling a story. Harrison’s behaviour at this time was consistent with this theme. For example, Harrison pretended his hands were a movie camera/lens to view content in the interview room.

According to Carmel no formal cognitive assessment had been conducted. I enquired whether Harrison had a language disability. Harrison denied that he has angry outbursts. Harrison also denied any existence of an angry temper or engaging in aggressive acts towards others. Carmel reported that she is concerned that Harrison is not remorseful of his disruptive behaviour and fears that he lacks feelings. Carmel also reported that Harrison’s mood and angry outbursts are unpredictable. However, Harrison was reluctant to discuss his angry temper.

With regards to family interactions, an ambivalent relationship between Carmel and Harrison was observed. For example, Harrison would show his foster mother different toys in the interview room but not engage in conversation with her regarding the toys. However, further assessment and observation, including in their home environment, would be required to determine the attachment relationship between Carmel and Harrison.
Assessment History:

Information source: Clinical interview with Carmel.

Psychological assessment. According to Carmel no formal cognitive assessment had taken place previously. Carmel reported that she and the family had received psychological assessment/interventions by Berry Street Organisation. However, Carmel reported that this is mainly “band-aid” work to support her in managing Harrison’s behaviour.

Risk assessment. Harrison had not displayed any suicidal tendencies. Harrison had, however, engaged in homicidal behaviours towards Carmel and Joshua. For example, Harrison had threatened to cut Carmel’s throat with a knife. Carmel perceived Harrison’s intention to engage in these homicidal behaviours as low and had witnessed verbal threats only. Protective factors included Harrison’s supportive home and school environments.

Formulation:

Harrison is an 8 year old Koori boy who has resided in foster care since four weeks of age. Members in his biological family have a history of alcohol and drug dependency. Harrison has had minimal contact with his biological relatives in his early years. Harrison’s childhood has been chaotic and disruptive with him living in the care of four different families. Due to this disruptive lifestyle, Harrison may have suffered from maternal deprivation and an inability to form caregiver-infant attachment relationships. Harrison’s referral to a CAMHS was precipitated by an increase in Harrison’s angry outbursts and temper tantrums. Harrison is physically
violent and oppositional at home and his problematic behaviour is beginning to extend to school and the playground environment.

Harrison’s emotional and behavioural difficulties are perpetuated by his anxiety regarding a safe, secure and long term home environment. The instability in Harrison’s home life has resulted in a lack of caregiver-infant attachment relationships and Harrison’s ingrained fear of abandonment. Another perpetuating factor includes Carmel’s favouritism towards Joshua and Harrison’s perception that he is not wanted within the immediate family. Furthermore, Carmel utilises ineffective parenting techniques to manage Harrison’s problematic behaviour. Carmel’s sarcastic sense of humour may also inhibit clear communication between Harrison and herself. Bill’s lack of involvement in parenting may further perpetuate Harrison’s emotional insecurities and problematic behaviour. Protective factors include the staff at his current primary school, and Harrison’s enthusiasm for school, specifically art, sport, maths, and science. Other agencies involved include Berry Street Organisation and the Department of Human Services.

*Diagnosis:*

**Axis I:** Reactive Attachment Disorder of Infancy or Early Childhood, Inhibited Type

**Axis II:** No diagnosis

**Axis III:** No diagnosis

**Axis IV:** Educational problems, peer relational difficulties, and problems with primary support.

**Axis V:** GAF = 57
The case of Harrison and his diagnosis of Reactive Attachment Disorder of Infancy or Early Childhood, Inhibited Type, can be best understood by considering literature regarding maternal deprivation. Whilst little developmental history is known regarding Harrison, the abnormal body movements described by Harrison’s different carers suggests that Harrison developed an insecure style of attachment.

3.2 Deprivation of Early Attachment Relationships and Subsequent Behavioural Difficulties

This section provides a description of the effects associated with the deprivation of early attachment relationships, and these are used to understand the case study of Harrison. Main (1996) identified five attachment related risk factors for the later development of psychopathology. The first of these involves the failure to form an attachment between 6 months and 3 years of age, referred to as maternal deprivation. With regards to Harrison, from birth to 3 or 4 years of age, he had been primarily cared for by three different caregivers. Harrison’s inability to form attachment relationships may be due to the numerous primary caregivers. The second risk factor for the later development of psychopathology is the development of either the insecure-avoidant or the insecure-resistant styles of insecure attachment. The little developmental history known regarding Harrison suggests that he developed insecure styles of attachment, typically insecure-disorganised attachments which are discussed later in this section. Main’s third risk factor associated with the later development of psychopathology encompasses the separation or loss of an attachment figure during infancy. With regards to Harrison, he was separated from two primary caregivers during infancy and early childhood. Firstly, Harrison was
separated from his biological mother, and secondly he was separated from his foster
carer Lara.

Main (1986) also identified that evidence of insecure-disorganised
attachment, consistent with early maltreatment of the infant, was also considered a
risk factor for the later development of psychopathology. Whilst little information is
known regarding Harrison's developmental history, Harrison was placed in foster
care as a baby due to his mother's inability to care for him adequately. This may
have involved neglect, such as lack of food and nutrients. Finally, evidence of
second-generation insecure-disorganised attachment as a consequence of the parents'
own trauma may make one vulnerable to psychological illness. Due to the lack of
information regarding Harrison's biological parents and foster carer Lara, second-
generation insecure-disorganised attachment cannot be determined.

As outlined in Chapter 2, Main and Solomon (1986) describe six
characteristics for identifying disorganised infant behaviour consistent with the risk
factors identified by Main (1986). The presence of one or more of the following
characteristics represents the existence of an Insecure-Disorganised/Disoriented
attachment. Firstly, the infant may display contradictory behaviour patterns which
may be sequential or simultaneous. For example, the infant may crawl or walk
towards the mother or attachment figure backwards. Secondly, the infant may display
undirected, misdirected, incomplete, and interrupted movements or expressions.
Thirdly, the infant may exhibit odd movements and postures. The infant may also
show freezing, stilling, delayed, or slowed movements and expressions. The fifth
characteristic includes a distinct fear of a parent or attachment figure. Lastly, the
infant's behaviour will appear disorganised and disorientated. Whilst little is known
regarding Harrison's developmental history, he exhibited at least two of the defining characteristics of Insecure-Disorganised/Disoriented attachment. Firstly, Lara reported to Carmel that Harrison displayed "weird body movements" which she described as abnormal in nature. Secondly, Lara stated that Harrison often stiffened his body. Therefore, it could be proposed that Harrison exhibited behaviour consistent with Insecure-Disorganised/Disoriented attachment in his early years.

In later childhood, the effects of maternal deprivation and Insecure-Disorganised/Disoriented attachment may be expressed as developmental delay, specifically in the areas of language and socialisation (Rutter, 1981). Children who exhibit an Insecure-Disorganised/Disoriented attachment style may not display acute reactions to maternal deprivation, however, long term consequences may be apparent. Long term consequences may include a lack of linguistic stimulation and lack of socialisation (Rutter, 1981). A lack of linguistic stimulation and socialisation experiences may impede growth, resulting in developmental delay. However, the long term effects of maternal deprivation are largely influenced by the environmental context of later childhood.

The quality of family relationships, parental discord and parenting style all play a role in diminishing or ameliorating the effects of maternal deprivation (Rutter, 1981). Family relationships have been found to be most influential in terms of diminishing the effects of maternal deprivation. The formation of close family relationships, good communication systems, and role definition within the family are all important factors in determining behavioural development of children who have suffered maternal deprivation. However, parental discord and disharmony have been found to be associated with delinquent behaviours displayed by children who have
suffered from maternal deprivation (Rutter, 1981). In the case of Harrison, Carmel reported that there was marital discord and most probably parental discord with Carmel largely playing the parental figure. Inconsistency in parenting has also been found to be associated with antisocial behaviours exhibited by children who have suffered from maternal deprivation (Rutter, 1981). With regards to Harrison, Carmel’s accounts of parenting and disciplining Joshua and Harrison appear inconsistent. Carmel has not devised clear rules and boundaries and, as a result, both Joshua and Harrison engage in aggressive acts and exhibit uncontrollable rages.

3.3 The Treatment Plan of Harrison

The initial management plan included continuance with the initial assessment process to gain a better understanding of what was happening for Harrison. The initial assessment process included discussing Harrison’s behaviour with the teaching staff at his primary school and included an observation of Harrison in his school environment. Further information regarding the current parenting techniques endorsed by Carmel was also required. Specifically, the areas of concern were the following:

1) Family Environment. An individual session with Carmel was proposed to gain a better understanding of Harrison’s behaviour at home. In addition, an individual session with Carmel was suggested to clarify Carmel’s current parenting strategies and suggest the use of behavioural techniques, such as positive and negative reinforcement, to better manage Harrison’s behaviour. Due to Harrison’s literal and concrete thinking, it was also recommended that Carmel communicate with Harrison on a more basic level with no sarcasm.
2) **Aggressive Behaviour.** Observation of Harrison at school both in the classroom and playground was required to gain a better understanding of his uncontrollable behaviour. Furthermore, a series of individual sessions with Harrison to determine the underlying nature of his angry outbursts and temper tantrums were proposed. Play therapy to address Harrison's disruptive and aggressive behaviour was proposed, including role play activities, modelling, and the teaching of appropriate play strategies. It was also questioned whether Harrison was modelling inappropriate behaviour displayed by Joshua at home whereby he punches holes in walls and consequences for unruly behaviour are nonexistent.

### 3.4 Caregiver-Child Attachment

Children who fail to develop caregiver-infant attachment relationships during the first three years of life may develop "affectionless psychopathy" (Rutter, 1981). Affectionless psychopathy refers to an inability to form relationships with others and the presence of emotional difficulties, such as a lack of guilt or remorse (Rutter, 1981). Little is known about the reversibility of the affectionless psychopathy syndrome. Rutter (1981) suggested that reversal may take place only partially and only with a great deal of effort after the infancy period. With regards to the case of Harrison, Carmel has reported that she is fearful that Harrison lacks remorse for his wrong-doing. Furthermore, Rutter (1981) indicated that children who have experienced multiple caregivers during infancy are likely to develop affectionless psychopathy. Therefore, Harrison may display affectionless psychopathy and long term therapy to ameliorate his ability to form close relationships with others may be required.
Individual therapy with Harrison to improve his socialisation and communication skills was proposed. Therapy activities included role playing different scenarios and modelling of appropriate behaviour. Individual therapy also consisted of self-monitoring techniques with regards to Harrison’s emotional state. Relaxation and ‘time-out’ activities were discussed. Whilst individual therapy with Harrison was important, individual therapy with Carmel was also necessary to address her parenting and communication skills. Furthermore, individual sessions with Carmel included psychoeducation regarding attachment theory and the importance of providing Harrison with a safe and secure home environment.

3.5 Behaviour Modification Schedule Implemented At School

Harrison is a Koori boy who has experienced a number of psychosocial stressors in his eight-year life. Harrison can be a caring and fun-loving boy but can also be aggressive and oppositional, often towards those people he cares about the most. Due to Harrison’s disruptive childhood, he presents as insecure, feels that he “doesn’t fit in”, and is unsure where he belongs. As Harrison is young and a literal and concrete thinker, a behavioural reinforcement schedule within the school setting was implemented as the best solution to working with Harrison and managing his behaviour. The behaviour modification schedule implemented involved monitoring Harrison’s behaviour on a daily basis during both class-time and at play. If Harrison is well behaved or not disruptive to others, his classroom teacher can place a gold star in the relevant box of the Communication Book developed. The Communication Book is a book whereby Carmel and Harrison’s teachers can communicate with each other daily with regards to Harrison’s behaviour in written format. Harrison’s
classroom teacher, or any other teacher that is teaching him during that period, must also sign next to the gold star. The signature will reduce the likelihood of Harrison being able to manipulate the situation, as has been the case in the past. If Harrison receives four or more gold stars (maximum = 5) during one day then a negotiable reward, for example he can watch his favourite TV show or play computer games, after school will be awarded. If Harrison receives less than four stars during one day then something that Harrison perceives as positive, for example under-water hockey lessons or bike-riding with his friend, is removed from him for that day. Carmel is to sign the Communication Book daily and return it with Harrison the next day.

The premise of the behaviour modification schedule was that there needs to be clear consequences communicated to Harrison with regards to his behaviour. For example, if Harrison punches, kicks, or bites another child at school he is to be sent home immediately. If Harrison intimidates another child at school, the area that he is normally allowed to play in is reduced. This can be presented to Harrison visually via a school map. There needs to be clear structures and boundaries surrounding Harrison’s inappropriate behaviour. Harrison loves school so the worse perceived consequence for him is to have to stay at home. The rules regarding Harrison’s behaviour need to be clearly communicated to him, preferably visually presented. Harrison likes drawing and art, and would most probably attend best to information presented visually. For example, “If punch, kick or bite = HOME”, “If mean to other children = SMALLER PLAYING AREA” with visual pictures depicting these actions. To begin with Harrison will try to push the boundaries to find out where he belongs and what he can get away with, therefore, Harrison will most likely respond to firm, clear, and consistent boundaries.
The behaviour modification schedule was presented to school staff who felt positive about implementing the schedule. The school staff felt well supported to implement the schedule and appreciated conceptualising Harrison and his behaviour in a different framework, understanding that his behaviour may in part be a response to maternal deprivation.

3.6 Conclusion

Whilst Harrison's behaviour at school improved and staff felt better equipped to manage Harrison’s behaviour, Harrison’s behaviour at home unfortunately deteriorated. Carmel failed to follow through with parenting strategies discussed with her, and subsequently, Harrison exhibited a five hour rage one night which ended when Berry Street Organisation removed him from Carmel’s care at her request. Harrison was placed in a different foster care placement for six weeks and no aggressive acts or unruly behaviour was exhibited. Harrison was returned to Carmel's care at her request but with the provision that she attend a more intensive parenting program and Harrison continue with individual therapy to better manage his emotions and increase his socialisation skills. These services were provided by Berry Street Organisation and the Department of Human Services.
Chapter 4. The Case of Diana

This chapter will firstly introduce the case of Diana. Diana is a 10 year old girl with Epilepsy and a diagnosis of a Mild Intellectual Disability. Diana also presents with anxiety symptoms with an enmeshed relationship existing between Diana and her mother with regards to parent and child role reversal. Next, the effects of second generational trauma on the caregiver-infant attachment relationship will be reviewed. Emphasis will be placed on the transference of fear and anxiety in the caregiver to the infant via internal mechanisms. Finally, treatment outcomes designed to reduce Diana's anxiety and increase her mother's understanding of the transference of her anxiety onto Diana will be explored.

4.1 Case Study—Diana

The case of Diana is considered within the broader framework of attachment theory with emphasis on the effects of second generational trauma on the formation of caregiver-infant attachment relationships. Specifically, the case study examined the feelings of fear and anxiety exhibited by the caregiver which are transferred or learned via internal working models to the infant.

Reason for Referral:

Diana is a 10 year old girl with a prior diagnosis of Epilepsy and a Mild Intellectual Disability. Diana was referred to a Child and Adolescent Mental Health Service (CAMHS) after exacerbation of her anxiety symptoms consisting of frequent toilet trips and other somatic complaints, such as headaches and stomach pains.
Presenting Problems:

Diana was referred to CAMHS for the second time by her mother, Patricia, in September 2003. Diana has a six year history of epilepsy and behavioural difficulties. Diana was previously referred to CAMHS in 2000 due to her behavioural problems consisting of obsessional behaviours, hyperactivity, and poor attention and concentration. Diana’s current referral occurred in the context of increased behavioural difficulties associated with anxiety and stress experienced by Diana in relation to her epilepsy. Diana experiences sleep disturbances, frequent trips to the toilet, headaches, and stomach aches related to her anxiety and insecurity. Diana also exhibits hyperactivity in relation to her epilepsy and seizures according to her mother Patricia.

Personal History:

Diana was born to James and Patricia in June 1993. Patricia reported that Diana was an unplanned but normal pregnancy. Diana was born by caesarean section for breech presentation. Patricia described Diana as an irritable infant who experienced reflux. Early developmental milestones were normal with normal speech acquisition and walking at approximately 12 months. Diana’s parents separated when she was 3 years of age and Diana resided with her mother and still continues to do so. Diana was diagnosed with Epilepsy at age 4 years. Diana currently suffers from complex partial seizures. Diana completed two years at Kindergarten and commenced schooling at the local state primary school. Patricia reported peer relational difficulties and socialisation problems with Diana at school, such as peer teasing and exclusion. Due to these socialisation difficulties, Patricia enrolled Diana at the local Christian school. Diana stated that she “loves” her teacher and Patricia reported that Diana is much happier. Diana has been seen by several health professionals in the
past with regards to her epilepsy, behavioural difficulties, hearing and vision, cognitive ability and capacity (funding for teacher aide), and life skills (Occupational Therapist).

*Psychiatric History:*

There is no known family history of psychiatric illness.

*Family History:*

Patricia was adopted at a young age and raised in a regional country town by her adoptive parents. Patricia has had no contact with her biological parents and has no information regarding her family of origin. Currently Patricia works as a childcare worker and she has developed a romantic relationship with a male who resides in the same country town as herself.

James was born and raised in the same regional country town as Patricia. They had a romantic relationship throughout their teenage years and early 20s. After James and Patricia separated, James developed a new romantic relationship with Barbara. James and Barbara later married and had a son Toby currently aged 4 years. James and Barbara have had previous contact with a Private Psychologist with regards to Toby and his disruptive outbursts and unmanageable behaviour. James works as a builder and resides in the same country town as Patricia and Diana. James has fortnightly weekend access of Diana and she also attends for dinner every Wednesday evening at her paternal grandmother’s house.
Genogram:

Presented in Figure 2 is a genogram representing Diana’s family.

![Genogram Diagram]

Figure 2. Genogram of Diana’s family

Medical History:

Diana was diagnosed with Epilepsy at age 4 years after she experienced a generalised attack. In addition, Diana had meningococcal septicaemia in 1998 and subsequent cognitive regressions in learning, such as memory deficits. Diana also suffers from long-sightedness and wears glasses.

Medication:

Currently, Diana takes Epilium and Lamictal for her epilepsy. In the past, she has been prescribed various other medications such as Tegretol, Valproate, and Carbamazapine.

Forensic History:

No known forensic history.
Substance Abuse:

Nil. Diana reports that her father consumes "lots of" alcohol.

Education:

Diana completed two years in Kindergarten and commenced her schooling at the local state primary school. Diana is currently attending a local Christian school and she is in grade 4. Patricia enrolled Diana in a private school due to peer relational difficulties, such as being excluded and teased by peers. Patricia also reported conflict with teachers, for example a lack of perceived support by school staff, at the local state primary school. Diana has a high absentee rate and Patricia reported that this is due to Diana's stomach aches, headaches, and sleep disturbances. Diana also meets government funding prerequisites for a Teacher Aide.

Mental State Examination:

Diana arrived to the initial assessment session neatly and causally dressed with her mother. Diana presented as shy, timid, and insecure, spending the majority of the session sitting on her mother's knee. Diana portrayed poor concentration and attention towards the end of the session and engaged minimally during the session. Diana's mood was euthymic and her affect and mood were congruent. Diana had normal prosody of speech, however, her use of language was immature and there was evidence that she had a slight lisp.

Diana portrayed logical thought form predominantly. However, there was presence of some circumstantial thought. Diana was preoccupied with her mother and receiving her attention. Diana would often interrupt her mother, and continue to
do so, until she received attention from her. There was no evidence of hallucinations or delusions.

Diana displayed immature thinking and delayed cognitive functioning. Diana was aware of her medical illness of epilepsy but had limited insight with regards to early warning signs, for example physiological arousal, associated with her seizures. With regards to family interaction, Diana presented as an anxious and insecure girl and an enmeshed relationship between Patricia and Diana was evidenced with parent-child role reversal. For example, Diana dictated her mother and her behaviour and Patricia obliged. Diana was evidenced to be controlling of her mother’s attention and behaviour. Patricia presented as a devoted but over-protective mother.

Assessment History:

Information source: Clinical interview with Diana and her parents.

Psychological assessment. Diana had completed two cognitive assessments previously. Her latest results suggested that she suffers from a Moderate Intellectual Disability with a Full Scale IQ of 53. There was no significant difference between her Verbal and Performance IQ.

Risk assessment. Diana presented as a low risk of suicide or self harm with no previous history of suicidal or homicidal behaviour. She had no current suicide ideation or plan. Diana also had numerous protective factors including her parents, staff at her school, and other health professionals, such as her Paediatric Neurologist and Paediatrician.
Formulation:

Diana is a 10 year old girl with a six year history of Epilepsy and a diagnosis of a Moderate Intellectual Disability. Diana’s parents separated when she was 3 years of age and she resided with her mother Patricia in a regional country town. An enmeshed relationship exists between Patricia and Diana with parent-child role reversal. The referral of Diana was precipitated by an increase in her behavioural difficulties and anxiety symptoms believed to be related to her epileptic seizures. As a result, Diana had a high absentee rate at school. In addition, the referral of Diana was also precipitated by the increasing conflict experienced by Diana at her local state primary school by other students.

Perpetuating factors include an enmeshed relationship between Diana and her mother with Diana dictating her mother’s behaviour. The unpredictable nature of Diana’s epilepsy and her lack of understanding of her medical condition also perpetuated Diana’s current mental state. The absence of appropriate parenting techniques to manage Diana’s anxieties, specifically her sleeping and somatic complaints, contributed to the enmeshed mother-daughter relationship and Diana’s behavioural problems. Furthermore, Diana’s current mental state is perpetuated by her Moderate Intellectual Disability. Protective factors include Diana’s recent transfer to the local Christian school and the devoted relationship between mother and daughter. Other health professionals involved include her Paediatric Neurologist and Paediatrician.

Diagnosis:

Axis I: Separation Anxiety Disorder

Axis II: Moderate Intellectual Disability
Axis III: Epilepsy
Axis IV: Educational problems, problems related to peer social support
Axis V: GAF = 63

Diana's diagnosis of Separation Anxiety Disorder can be best understood in the context of the transference of fear and anxiety from Patricia to Diana with regards to Patricia's own unresolved loss resulting from early separation from her biological parents. Furthermore, Patricia may exhibit sadness and fear associated with Diana's diagnosis of Epilepsy and the unpredictability of the medical condition that may have been transferred to Diana and her internal working model.

4.2 Second-Generational Attachment Deprivation, Epilepsy and Symptoms of Anxiety

This section provides a description of the relationship between epilepsy, symptoms of anxiety and second-generational attachment deprivation in relation to the case study of Diana. The inter-relationship between these three factors will be discussed.

Children with epilepsy are reported to have a greater number of behavioural difficulties than children with other chronic illnesses or children in the general population (Oguz, Kurul, & Dirik, 2002). In addition, children with epilepsy report symptoms of depression and anxiety more often than other children. Oguz et al. examined levels of depression and anxiety in 35 children with epilepsy and 35 healthy children which made up the control group. Participants were aged 9 to 18 years and analyses were conducted separately for children aged 9 to 11 years and children aged 12 to 18 years to take into account the impact of pubertal development.
Oguz et al. reported that children with epilepsy aged 9 to 11 years were more likely to report anxiety symptoms than children from the control group. Of children aged 12 to 18 years, children with epilepsy reported greater symptoms of depression and anxiety than their control counterparts. These findings are consistent with the case study of Diana.

Whilst children with epilepsy show higher levels of psychological disturbance than other children, parents of children with epilepsy also reported poorer health outcomes. Williams et al. (2003) examined parental anxiety and quality of life of both the family and child with epilepsy with 200 parents who had a child aged 6 to 16 years who had been diagnosed with epilepsy. Results indicated that the severity of comorbid conditions, for example none, mild, moderate, or severe learning and behavioural difficulties, parental anxiety, child seizure control or seizure frequency, and pharmacological interventions were associated with the quality of life of children with epilepsy. Children who had comorbid conditions, increased parental anxiety, and lack of seizure control experienced a significantly poorer quality of life. The case study of Diana fits into this category. Williams et al. concluded that the transmission of parental anxiety to children with epilepsy regarding their health status may influence parent and child attachment and subsequent separation and the learning of independence by the child. However, Williams et al. acknowledge that further research is required to fully understand this relationship.

Consistent with Williams et al.’s (2003) notion of parental anxiety, Main and Hesse (1990) postulated that a caregiver who has suffered a loss may still be frightened and experience unresolved mourning as a result of the loss. The feelings
associated with the unresolved loss may produce anxiety in the caregiver and subsequent fear in an infant. The anxiety experienced by the caregiver may be incomprehensible to the infant. Furthermore, the frightened response of the caregiver may cause fear in the infant who fails to understand the unpredictable notion of this anxious response in the caregiver and the origin of the caregiver's response. Due to the internal fear, as opposed to an external fear, experienced by the caregiver, an infant may feel insecure because the caregiver is not keenly aware of external dangers. The caregiver may not be oriented towards typically frightening aspects of the environment, may be oriented toward an aspect of the environment which is oriented with her personal traumatic history but is not of immediate threat, and may not be equipped to offer adequate protection from danger due to three reasons.

Firstly, the caregiver's behaviour will be incomprehensible to the infant due to the prior "false alarm" behaviour exhibited by the caregiver. Secondly, in cases whereby the caregiver believes her role to be causal in the death of an attachment figure, the caregiver may intrinsically suggest to the infant that the infant is in fact the source of concern or alarm. Finally, when individuals sense fear, a natural reaction is to flee or flight. Therefore, the caregiver may indicate to the infant that she is going to flee from the environment and/or the infant itself (if the infant is lead to believe that the infant is the source of fear). The notion that the primary caregiver is going to flee from the infant may cause additional distress and intense fear in the infant. Alternatively, the caregiver may indicate to the infant that the infant is a haven of safety. This last point may relate to the enmeshed relationship between Diana and her mother. Whilst Patricia is reluctant to discuss her early childhood experiences, it may be that she has not resolved the loss associated with the early separation from her biological parents. Furthermore, Patricia may exhibit anxiety in
relation to her daughter's diagnosis of epilepsy and possible "loss of safety haven" should Diana suffer from severe epileptic seizures. The anxiety experienced by Patricia may be sensed by Diana and consequently, Diana controls her mother's behaviour and fulfils her wishes, for example by reporting headaches to her mother in order to stay home from school.

Planta, Marvan, and Morog (1999) have discussed the link between parental past experiences of loss and trauma and how this influences current caregiving behaviour due to the parents' state of mind. The child's attachment behaviour is suggested to trigger unresolved loss and trauma experiences and memories repressed by the parent. Thus, the caregiver displays disorganised attachment behaviour which may be conceptualised as frightened or frightening behaviour by the child. Due to the parent's disorganised behaviour, children present as confused with no organisational strategy to cope with fearful situations. Parents who learn of a child's diagnosis, likewise can experience a sense of loss and grief similar to that of death of a loved one. Similarly, the fact that parents who fail to come to terms with the diagnosis of a child's medical illness or disability can have a detrimental impact on the development of the caregiver-child attachment relationship. In addition, the loss and grief experienced by parents with regards to the learning of a child's medical illness or disability is a continuous or chronic stressor whereby parents are constantly reminded of their loss. Consequently, the loss experienced by caregivers can negatively influence the caregiver-child attachment relationship by distorting, filtering, ignoring, or amplifying the caregiver's perception of the child (Planta et al., 1999).
Pianta et al. (1999) examined the resolution of loss in terms of timing, past or present, the attachment relationship affected, and the child’s medical illness, cerebral palsy or epilepsy, on the attachment organisation system developed by the child. Seventy-three children aged 15 to 50 months with a diagnosis of either cerebral palsy (40 participants) or epilepsy (33 participants) and their primary caregiver were included in the study. Caregivers completed the Adult Attachment Interview (AAI) (George et al., 1985), the Reaction to Diagnosis Interview (RDI) (Pianta & Marvin, 1992) and both caregivers and children participated in the “Strange Situation” (Ainsworth et al., 1978). The RDI is an interview schedule designed to assess parents’ resolution of loss or trauma associated with their child’s diagnosis of a medical illness or disability. Caregivers are categorised as either resolved or unresolved with respect to accepting their child’s diagnosis. The findings suggested that 18% of caregivers classified as unresolved in relation to their child’s diagnosis also had children who were classified as disorganised in relation to their attachment organisation. With regards to the case study of Diana, Patricia’s unresolved grief associated with Diana’s diagnosis of epilepsy may have influenced Diana’s internal working model and subsequent insecure attachment style. A larger number of caregivers classified as resolved (36%) in relation to their child’s diagnosis had children who were classified as organised in relation to their attachment organisation. Overall, results indicated, for both disabilities, that caregivers’ resolution was associated more strongly with attachment security per se than with attachment organisation portrayed by the child (Pianta et al., 1999). These findings have treatment implications with regards to the case study of Diana.

The inter-relationship which exists between second-generational attachment deprivation, epilepsy, and symptoms of anxiety, can be both positive and problematic
in nature. Whilst Patricia’s unresolved grief regarding the early separation from her own biological parents has resulted in symptoms of anxiety exhibited by Diana, Diana’s diagnosis of epilepsy and moderate intellectual disability constantly reminds Patricia of her loss and the grief associated with learning of her daughters’ diagnosis. This in turn increases Diana’s anxiety and the vicious circle continues. However, when considering treatment options, a positive change, such as Patricia’s resolution of grief associated with Diana’s diagnosis, can result in subsequent positive changes with regards to the caregiver-child attachment relationship and the management of Diana’s anxiety symptoms related to her epilepsy. This will be discussed more fully in the next section.

4.3 Treatment Plan of Diana

The treatment plan of Diana consisted of two main objectives. The first objective consisted of individual therapy with Diana to address her underlying anxieties and insecurities related to her relationship with her mother and the management of her epilepsy symptoms. The second objective consisted of individual therapy with Patricia to address the enmeshed mother-daughter relationship, Patricia’s possible over-involvement with Diana, and psychoeducation regarding the transference of her anxiety to Diana.

In the first individual therapy session with Diana, she divulged that she did not like school contrary to her mother’s belief and reported that she did not have any friends. After a family session in which Diana’s dislike of school was discussed, it was suggested by myself that Patricia consider sending Diana to Special School part-time. With Diana’s moderate intellectual disability and limited funding available at
the Christian primary school for a teacher aide, a Special School, which helps children with special needs learn life skills and competencies, was considered the best place of learning for Diana. Diana would feel less isolated, increase her socialisation skills, and enjoy attending school, instead of staying at home with her mother, in order to reduce her mother’s and her own anxieties. After two individual sessions with Patricia and a family session with James and Barbara, a visit to the Special School was agreed upon. I contacted the Special School and arranged a guided tour for Patricia, James, and Diana. After the school visit, Patricia, James, Diana, and the Special School staff agreed that Diana would benefit from attending the Special School part-time.

Simultaneously, five individual sessions with Diana focused on understanding her medical condition and gaining greater awareness of her physiological warning signs associated with her epileptic seizures. A chart was made which resembled Diana’s own body whereby she could acknowledge changes in her body by colouring in the part of the body associated with the change (Refer to Figure 3). Diana was encouraged to reflect on any bodily changes she experienced. To increase Diana’s awareness of her epilepsy and subsequent changes in behaviour, Patricia and school staff encouraged Diana to make links between her epilepsy, physiological changes, and behavioural changes. This self-monitoring task was continued at home and at school with the help of Patricia and school staff. Due to Diana’s intellectual disability, the self-monitoring task was introduced as a long term intervention and I only witnessed small gains in the short term.
Figure 3. Body chart
With regards to parenting work with Patricia, five sessions consisted of psychoeducation regarding attachment theory, specifically second-generational attachment deprivation, and grief and loss associated with learning of Diana's diagnosis. Guided imagery was utilised to recall Diana's first epileptic fit, such as where was Diana, where was Patricia, how did Patricia feel, how long did the ambulance take to arrive, who informed Patricia of the diagnosis and so on. Patricia was also encouraged to reflect on her personal coping mechanisms for homework and make a list of these. Patricia’s coping mechanisms were discussed in individual therapy with myself and more positive coping strategies were discussed and encouraged to be implemented, such as breathing exercises. As another homework activity, Patricia kept a log book of instances in which the new coping strategies were utilised, including, the short term and long term effects of how she felt and how the coping strategy may influence Diana.

The projection of Patricia’s anxiety on to Diana and the subsequent increase in Diana’s symptoms of anxiety were also discussed in the five individual therapy sessions with Patricia. Patricia’s projection of anxiety was also considered in relation to the utilisation of more positive coping strategies, as previously outlined. To further address Patricia’s underlying insecurities she was referred to a community health centre where they offered counselling. I perceived that Patricia would require long term individual therapy to deal with her own anxieties and as CAMHS consists primarily of short term interventions to assist the positive development of psychological wellbeing of children and adolescents, Patricia was referred elsewhere for additional support. In the individual sessions with Patricia, I also focused on parenting techniques to aid in the management of Diana’s anxieties and behaviour related to epileptic seizures. Patricia was encouraged to set firm rules and boundaries
regarding sleeping arrangements and school attendance. Furthermore, Patricia was encouraged to be consistent with her parenting even though it would be likely that Diana would try to push the boundaries and test the limits in the beginning.

4.4 Conclusion

Overall, Diana’s emotional state was happier after her attendance at Special School and the formation of new friendships. Diana commenced schooling at the Special School two days a week but increased to three days a week after 6 months because she enjoyed the activities and reported that she “loved school” and had “lots of friends”. In addition, Diana’s awareness and understanding of her medical condition had increased with the help of the body chart. Likewise, Patricia had implemented parenting strategies suggested by myself and was attending counselling to discuss her own insecurities regarding her own up-bringing, loss of biological parents, and grief associated with Diana’s diagnosis.
Chapter 5. The Case of Melanie

The chapter will begin with an introduction to the case of Melanie. Melanie is a 9 year old girl with a history of paternal sexual abuse. Melanie exhibits confusion regarding her relationship with her father and displays inappropriate relationships with other significant adult figures in her life, such as invading others' personal space and exhibiting sexualised behaviour. The effects of early maltreatment, including sexual abuse, in the development of subsequent relationships with other adult figures will be explored. Finally, the treatment plan of Melanie and her relationship with her mother will be examined with respect to attachment theory.

5.1 Case Study- Melanie

The case of Melanie is presented below with emphasis on attachment patterns related to her early sexual abuse. The assessment process took place over six sessions involving the referral child, different members of the family, and other supportive agents, such as school staff.

Reason for Referral:
Melanie was referred to the Consultation Liaison Unit of a metropolitan hospital for the second time in the context of exhibiting distress and confusion in relation to her relationship with her father. Melanie disclosed sexual abuse claims regarding her father in mid 2003 and after an interrogating Department of Human Services (DHS) investigation the charges against her father were dropped in January 2004.
Presenting Problem:

Melanie is a 9 year old girl who was referred to the Consultation Liaison Unit of a metropolitan hospital after she exhibited distress and confusion regarding her relationship with her father after disclosing sexual abuse claims involving her father 12 months previously. Melanie was referred by the medical treating team on the Paediatric Ward where she was being treated for re-occurring Urinary Tract Infections (UTI’s) and Chronic Vaginitis. Melanie had previously been referred by her medical treating team in 2003 regarding management of her medical condition when she disclosed sexual abuse by her father to a psychologist. Melanie’s claims could not be substantiated, therefore no further action by DHS took place. Currently Melanie is exhibiting distress regarding her relationship with her father whereby she feels ambivalent about the father-daughter relationship.

Personal History:

Melanie is the only child of her father, Con, and her mother, Therese. Melanie’s parents separated prior to her birth and Melanie has resided predominantly with her mother. Therese reported that Melanie was an unplanned pregnancy with Therese and Con separating prior to knowledge of the pregnancy. Melanie was born two weeks prematurely and was admitted to the special care unit for jaundice and extended belly. Therese reported that she subsequently suffered from golden staff and was treated with antibiotics. Melanie was breast fed until six weeks of age when she exhibited physical effects of the antibiotics taken by Therese. Therese stated that she experienced no difficulty in changing Melanie’s dietary habits from formula milk to solids but that Melanie was difficult to settle to sleep for the first 6 to 12 months. Therese reported that Melanie was a happy and responsive baby with no mother-
child bonding difficulties. Therese reported that Melanie developed normally according to developmental milestones.

Melanie was first diagnosed with UTIs and Vaginitis at 3 years of age. As a result, Therese reported that toilet training was difficult with persistent incontinence difficulties. Up until 12 months ago, Melanie had made little progress with her incontinence difficulties despite medical and behavioural interventions. Melanie has not suffered from a UTI for the past 12 months.

According to Therese, Melanie’s transition to school was unproblematic. However, Therese and teachers described Melanie’s behaviour as immature compared to peers her own age. Melanie converses with others in “baby talk”, such as “mama”, and is preoccupied with soft-toys and writing about kittens. Therese reported that Melanie’s academic and athletic performance as “good, average to above average”. Melanie attended gymnastics and reported that she enjoys this activity.

Psychiatric History:

No known family history of psychiatric illness.

Family History:

Therese is a trained Social Worker who had, prior to the birth of Melanie, worked in the field for over 10 years. Currently, Therese is devoted to caring for Melanie and had not returned to her social work career. Therese reported that she met Con in 1990 whereby they developed an intimate but unstable relationship for five years. The relationship ended in 1995 after a period of cohabitation of six months and mutual
agreement to separate. Therese reported that Con was “too demanding” and she felt that she “was becoming his social worker”. Therese had minimal contact with Con at the time of assessment. In the past, Therese and Con had had a conflictual relationship with regards to medical treatment of Melanie’s UTIs and chronic vaginitis and the sexual abuse allegations. Melanie had had only telephone contact with her father since the court proceedings. Therese had developed a new relationship with Dave, with whom she had been friends with for a long time.

Con had three other children to a previous partner and these children attended access visits with Con and his new partner, Linda. Con and Linda had no children of their own. Melanie described her father as grumpy, tired, and aggressive.

Genogram:

Presented in Figure 4 is a genogram representing Melanie’s family.

Figure 4. Genogram of Melanie’s family
Medical History:

Melanie was diagnosed with re-occurring UTI's and Chronic Vaginitis at 3 years of age. At the time of assessment, Melanie had not suffered from a UTI’s for 12 months.

No other known medical condition.

Forensic History:

No known forensic history.

Substance Use:

No known substance use.

Education:

Melanie attended a local primary school where she was completing grade three. While teachers reported no academic concerns, Melanie was described as emotionally immature for her age and that she often conversed in a child-like manner.

Mental State Examination:

Melanie arrived to sessions punctually and presented as a 9 year-old-girl dressed appropriately in her school uniform or neat casual dress. Melanie presented as anxious, fidgeting, and rocking in her seat, on the first occasion. In subsequent sessions, Melanie would regress to infant-like behaviours, such as speaking in an immature voice or engaging in gymnastic stretches, in order to distract herself from maintaining on task. Melanie often exhibited immature behaviour with no
disciplinary action, instruction, or controlling behaviour displayed by her mother. Furthermore, Melanie exhibited precocious or sexualised behaviour at times, which included sexualised body movements or flirtatious behaviour. Melanie displayed indiscriminate attachment with adult figures, forming an inappropriately close relationship with myself instantly. For example, this included invading my personal space and inappropriately touching my legs and arms.

Melanie displayed an immature use of language at times, regressing to infant-like expression and “baby talk”, such as “me want”. At times, Melanie would also converse loudly and speak at a faster rate than normal with myself. On the other hand, Melanie exhibited no articulation or word finding difficulties. Melanie was able to express her thoughts and feelings when focused on task. Melanie reported that she was happy and the majority of her behaviour was consistent with this statement. Melanie displayed no evidence of hallucinations or delusions.

On the whole, Melanie exhibited logical thought processes. Melanie, on occasion, did, however, display circumstantial thought form when encouraged to engage in therapeutic work. During the initial assessment session there was a discrepancy regarding whether Melanie was preoccupied with her father and his behaviour and/or absence or whether her mother’s preoccupation was projected on to Melanie. In subsequent sessions, Melanie displayed some preoccupation with her father and some emphasis on her toileting behaviour.

Despite her anxious appearance and distraction-like avoidant behaviour, Melanie was able to attend to questions. Melanie was also able to recall and sequence events, thus she was well oriented to time, place, and person. It was difficult to
determine Melanie’s insight and level of understanding and comprehension of the current situation with her father due to the suspected projection of Therese’s worries and concerns on to Melanie. Melanie exhibited a limited understanding of why she had been referred to the Consultation Liaison Unit stating she attended “to play games”.

**Assessment History:**

**Information sources:** Clinical interview with Melanie and Therese

Psychometric assessment via Wechsler’s Intelligence Scale for Children- Fourth Edition (WISC-IV)

(Wechsler, 2003).

**Psychological assessment.** Melanie completed four projective drawing activities including: Good dream/bad dream, 3 wishes, people as animals, and four cards of the Children’s Apperception Test (Bellak, 1954, 1986, 1993). Melanie’s drawings were sparse with minimal use of colour and detail. Themes from drawings and verbal responses included: lack of warmth and protection in her home environments, identification with infant or baby-like characters, untrustworthiness of adults, particularly males, generalisation of males as liars, parental figures taking something away from her, view of self as a trouble-maker, social isolation, toileting behaviour, and needing protection from others but having to fend for herself.

**Cognitive assessment.** The WISC-IV is an individually administered test of cognitive ability and relative strengths and weaknesses consisting of 15 subtests. Five of the subtests measure verbal comprehension skills, for example children’s understanding of vocabulary, and four of the subtests measure perceptual reasoning
skills, for example children's visual-motor co-ordination and ability to construct
designs with blocks. Three of the subtests measure working memory skills, such as
children's attention and memory abilities to recall digits, and three of the subtests
measure processing speed skills, such as children's visual memory and co-ordination
to recall and identify constructs.

Assessment with the WISC-IV indicated that Melanie performed in the High
Average Range of overall intellectual functioning with a Full Scale IQ of 116. There
is a 95% chance that Melanie's true IQ lies within the range of 111 and 120. Melanie
could be expected to perform better than 86 out of 100 peers her age for overall
intellectual functioning. The Full Scale IQ can also be divided and considered as four
factor scores which assess a range of cognitive abilities. With regards to Melanie's
verbal skills, she performed in the High Average Range of verbal functioning with a
Verbal Comprehension IQ of 114. There is a 95% chance that Melanie's true IQ lies
within the range of 106 and 120. Melanie could be expected to perform better than
82 out of 100 peers her own age for verbal comprehension. Melanie demonstrated a
sound knowledge of vocabulary and comprehension. For example, Melanie could
define "ancient" as being "very old" and she could also explain how anger and joy
are alike, stating that both are "feelings". On the Perceptual Reasoning Index,
Melanie performed in the High Average Range with a Perceptual Reasoning IQ of
110. There is a 95% chance that Melanie's true IQ lies within the range of 102-117.
Melanie could be expected to perform better than 75 out of 100 peers her own age
for perceptual reasoning ability. Melanie was able to accurately place blocks together
to form complex designs and to correctly identify pictures which have something in
common, for example, Melanie identified a plant, chick, and baby as "all living".
With regards to Melanie's working memory skills, she performed in the High Average Range of memory functioning with a Working Memory IQ of 113. There is a 95% chance that Melanie's true IQ lies within the range of 104 and 120. Melanie could be expected to perform better than 81 out of 100 peers her own age for memory and concentration skills. For example, Melanie could correctly recall a string of seven digits in forward sequence. Finally, on the Processing Speed Index, Melanie performed in the Average Range with a Processing Speed IQ of 109. There is a 95% chance that Melanie's true IQ lies within the range of 99 and 117. Melanie could be expected to perform better than 73 out of 100 peers her own age on tasks requiring visual-motor co-ordination, processing speed, and planning ability. For example, Melanie was able to correctly identify whether specified designs were present in a string of five constructs.

There was a significant difference between Melanie's performance on verbal comprehension and working memory tasks. This discrepancy indicated that Melanie performed better on tasks that required verbal conceptualisation, general knowledge, and verbal expression than on tasks that require attention, concentration, short-term memory, and planning ability. There was also a significant difference between Melanie's Verbal Comprehension Index Score and Processing Speed Index Score. This result suggested that Melanie performed better on tasks requiring verbal conceptualisation, general knowledge, and verbal expression than on tasks that required processing speed, visual memory, visual motor co-ordination, and planning ability. On the remaining index discrepancy comparisons, Melanie's cognitive abilities appeared comparable and evenly developed.
Despite the discrepancy between Melanie's scores on the Verbal Comprehension Index and Working Memory Index, Melanie demonstrated a relative strength on the Digit Span Subtest. Melanie could accurately verbally recall strings of digits both in forward sequence and backward sequence. Melanie was able to accurately encode and chunk the verbally presented digits and correctly recall and vocally express the digits. Melanie was able to remain focused on task and actively attend to information presented to her without being distracted on this subtest.

*Risk assessment.* Melanie exhibited no suicidal or homicidal thoughts or behaviours.

*Formulation:*

Melanie is a 9 year old girl who was referred by her medical treating team on the Paediatric Renal Unit following an escalation in Melanie's distress and confusion regarding her relationship with her father. One year previously, Melanie had disclosed sexual abuse by her father to a psychologist from the Consultation Liaison Unit. Melanie presented in June 2004 with long standing medical problems, incontinence difficulties, and ambivalent feelings toward her father. Melanie also displayed socialisation and attachment difficulties, forming an indiscriminate attachment with myself instantly. Furthermore, Melanie would often regress and behave in an infant-like or immature fashion. Another predisposing factor included the conflictual relationship that existed between Therese and Con with regards to the treatment of Melanie's medical conditions and Melanie's subsequent sexual abuse allegations.
Melanie's referral to the Consultation Liaison Unit was precipitated by Melanie's confusion of the father-daughter relationship after an intensive DHS investigation of sexual abuse allegations made by herself against her father in 2003. Melanie's ambivalent feelings toward her father may have contributed to her emotional difficulties. At the time of referral, Melanie had had no face-to-face contact with her father and limited telephone contact. Melanie reported ambivalent feelings toward her father whereby she would like to maintain contact with him and her half-siblings but also reported that she felt frightened and unsafe in his care.

Melanie's emotional difficulties appear to be largely perpetuated by the father-daughter relationship and her limited contact with her father and half-siblings, and by Therese's concerns and worries regarding Melanie's sexual abuse claims and subsequent DHS investigation. Melanie's indiscriminate attachment style and regression to infant-like behaviours are perpetuated by her ambivalent feelings regarding her parental figures and sense of powerlessness. Furthermore, Melanie's medical and incontinence difficulties may be maintained by her sense of hopelessness and helplessness to change her environment and consequently manage her symptoms.

Protective factors include the loving and supportive relationship which exists between Therese and Melanie and other socially supportive relationships which exist between Melanie and her extended family, classroom teacher, and peers. Melanie's WISC-IV results suggest that Melanie is a bright and competent young girl who has a thirst for knowledge and enjoys learning. Melanie also enjoys gymnastics and is an active participant in the sport.
**Diagnosis:**

Axis I: Sexual Abuse of Child resulting in disturbed attachment and social relatedness (Unsubstantiated by DHS)

Axis II: No diagnosis

Axis III: Urinary Tract Infections, Chronic Vaginitis and Incontinence

Axis IV: Problems with primary support with estrangement from father and half-siblings and disclosure of sexual abuse by father, and socialisation difficulties

Axis V: GAF = 67

The diagnosis of Melanie can be understood by considering attachment theory, sexual abuse, and the presence of sexualised behaviour or the development of indiscriminate attachment relationships.

5.2 *Childhood Sexual Abuse and the Development of Indiscriminate Attachment*

Bowlby (1982) reported that infants aged 8 to 10 months of age exhibit sexualised behaviour, such as pelvic thrusting, but it is not until this sexualised behavioural system becomes integrated with other systems does this act become functional. Therefore, when sexualised behaviour is displayed by infants, the movement typically occurs in the wrong context or in the wrong place in a sequence of events. For example, sexualised acts may be exhibited towards parental figures. Sexualised acts of humans become functional when they are organised into a
sequence of events determined by internal conditions, such as hormone levels, and external stimuli, for example the presence of a mating partner (Bowlby, 1982). Once a sequence of events becomes organised it remains fairly stable even if it has developed pathologically (Bowlby, 1982; Shapiro & Levendosky, 1999). Therefore, the sequence of first sexual activity and the organisation of this behaviour can predict all future sexual acts as humans typically regress to the first experience of sexual activity. Via learning, humans may learn to engage in sexual acts without completing the sequence of events that leads to sexual gratification or take “short cuts” resulting in the re-organisation of the sequence of events to a plan with a set goal (Bowlby, 1982).

Sexual abuse during childhood can therefore lead to the development of atypical sexual behaviour and abnormal social interaction (Bowlby, 1982; Liem & Boudewyn, 1999). With regards to the case study of Melanie, sexual abuse by her father may have contributed to the development of atypical sexual behaviour whereby she engages in sexualised behaviour towards adults, particularly males, because this is what she has learnt.

Children who have been victims of sexual abuse often exhibit sexualised behaviour or sexual offending behaviour (Kaufman & Henrich, 2000). However, whether children exhibit sexualised behaviour or offending behaviour can be influenced by other mediating factors, such as child, family, social, and trauma-related factors (Kaufman & Henrich, 2000). Children’s response to trauma can be influenced by the child’s age, the pre-existence of psychopathology, level of cognitive functioning or IQ, and coping styles (Kaufman & Henrich, 2000; Liem & Boudewyn, 1999; Shapiro & Levendosky, 1999). With regards to the case study of
Melanie, the age at which she was first abused is not known, however, abuse prior to 3 years of age is considered a vulnerable period of development (Bowlby, 1982; Kaufman & Henrich, 2000). Whilst Melanie is a cognitively bright young girl her coping style of avoidance may inhibit her long term prognosis (Shapiro & Lovendosky, 1999).

Another mediating factor is family. Family factors include: parental psychopathology, parent-child relationships, and familial support received after trauma (Higgins, 2003; Kaufman & Henrich, 2000). With regards to the case study of Melanie, she has accused her father of being the perpetrator of sexual abuse towards her. However, Melanie also reports close relationships with her mother and other extended family members. Social factors, such as socioeconomic status, also influence the impact of trauma on a child. Other social context and environmental factors include the availability of community resources, social support, and psychotherapeutic interventions (Kaufman & Henrich, 2000). With regards to the case study of Melanie, she is of middle socioeconomic status and currently receives psychotherapy.

Trauma-related factors also mediate the effect of a child’s outcome. Trauma-related factors encompass the level of traumatic exposure, duration of trauma, closeness of the relationship with the perpetrator, the need to testify in court, and losses associated with the traumatic experience (Kaufman & Henrich, 2000; Liem & Boudewyn, 1999). With regards to the case study of Melanie, the perpetrator was her father with whom she reported having a close relationship with prior to court proceedings. Currently, she exhibits ambivalent feeling towards her father whereby she is confused about what kind of relationship she wants with him. In addition,
Melanie reports that the sexual abuse took place on more than one occasion, however, her claims were unsubstantiated by DHS leaving her feeling a sense of worthlessness and lack of trust in health professionals.

One of the most important factors that can influence the outcome of the traumatic experience on a child is the availability of a supportive parent (Kaufman & Henrich, 2000; Shapiro & Levendosky, 1999). This finding is consistent with the case study of Melanie who has a close and supportive mother-daughter relationship. The availability of a supportive parent can dramatically improve the developmental outcome, particularly with regards to the socialisation of traumatised children (Kaufman & Henrich, 2000).

5.3 Treatment Plan of Melanie

After six sessions, Therese and Melanie decided to focus their attention on Melanie’s incontinence difficulties and cease psychotherapeutic intervention. The following recommendations were made:

1) Long term individual therapy for Melanie to address underlying issues regarding her allegations of sexual abuse by Con in 2003 and subsequent court proceedings.

I encouraged Therese to notify health professionals in 6 to 12 months time if Melanie still presented with infant-like immature behaviour or if formation of indiscriminate attachment relationships with adults fails to dissipate.
2) With regards to Melanie's WISC-IV results, I suggested encouraging Melanie to maintain on task and focused by positively reinforcing appropriate and non-distracting behaviour exhibited by Melanie. I also encouraged the use of a behaviour modification schedule with clear structure and goals to maintain Melanie's attention and concentration. In addition, Melanie should be asked to repeat back specific instructions and given a time-frame to complete tasks. Consequences for not completing set tasks or engaging in distraction or avoidance behaviour should be made clear to Melanie and consistently reinforced.

5.4 Conclusion

Whilst individual therapy to address Melanie's sexual abuse allegations was ceased, the supportive and caring mother-daughter relationship between Therese and Melanie is of great importance. Melanie also receives strong support from extended family members from Therese's family and this is also important in the therapeutic process after intrafamilial abuse (Kaufman & Henrich, 2000). Long term therapy with Melanie would have involved strengthening the mother-daughter dyad and the learning of appropriate socialisation skills to reduce Melanie's sexualised behaviour and the formation of indiscriminate attachment relationships with adults, particularly males, which may be detrimental to her safety.
Chapter 6. The Case of Tammie

This chapter will begin with an introduction of Tammie. Tammie is a 16 year old girl with a history of sexual abuse. Tammie expresses depressive symptomatology, low self-esteem, and peer conflict. Literature pertinent to attachment theory, early experiences of sexual abuse, and the later development of psychopathology will be examined. Finally, treatment options with regards to ameliorating Tammie’s affect and mood and improving her social relationships with reference to attachment theory will be explored.

6.1 Case Study- Tammie

The case of Tammie is presented below with specific emphasis on the quality and nature of Tammie’s social relationships which reflect early attachment patterns. The assessment process occurred over four sessions involving the referral adolescent, different members of the family, and other supportive agents, such as the Department of Education and Training (DET) Social Worker and School Welfare Co-ordinator.

Reason for Referral:
Tammie was referred to a Child and Adolescent Mental Health Service (CAMHS) in the context of expressing depressive symptomatology, suicidal thoughts, and exhibiting other psychosocial stressors.

Presenting Problems:
Tammie is a 16 year old girl who was referred to CAMHS by the DET Social Worker Maxine. Maxine reported that she was concerned about Tammie’s level of
depression which had escalated since residing in a regional country town with her father. Tammie was previously living with her parents and siblings in metropolitan Melbourne prior to her parents' separation in June 2003. Tammie had a history of sexual abuse both as a 6 year old and later as a 15 year old. In addition, Tammie had displayed suicidal thoughts and attempts in the past by cutting her wrists and an attempted hanging. Tammie stated to Maxine that the suicidal thoughts were returning. Tammie exhibited a sense of hopelessness and helplessness and her depressed affect was exacerbated by familial discord, particularly between Tammie and her mother, and peer relational difficulties.

**Personal History:**

Tammie was the first child of her father Ken and mother Liz. Ken reported a normal pregnancy and a long labour. Ken reported that Tammie suffered from reflux as a baby and would cry frequently as a result. Tammie learnt to walk and talk at an early age. Ken stated that Tammie was a bright baby who was dearly loved by both her parents. However, Tammie felt that she had been “pushed away” by her parents, particularly by her mother, after the birth of her sister Molly. The family resided in regional Victoria during Tammie's early childhood where she attended the local primary school. According to Tammie she spent two years in her first year of primary school due to her inability to socialise with other children. Concurrently, Tammie reported that she was sexually abused at the age of 6 years whilst in daytime childcare. However, she did not disclose the sexual abuse until she was 12 years of age. Due to the early childhood abuse, Tammie remembered that she was an unhappy child who infrequently smiled.
After the birth of Tammie’s brothers, Andrew (9 years) and Sean (6 years), the family re-located to metropolitan Melbourne. Tammie reported that she was “popular” at her old high school and that she found school “okay”. Tammie enjoyed opera singing at her old school and had auditioned for Australian Idol. It was during this time that Tammie was sexually abused for the second time by a friend’s housemate. Tammie did not report the abuse to the authorities. As a result of the abuse, Tammie became pregnant but suffered a subsequent miscarriage. Tammie missed a month of school due to morning sickness and abdominal pain associated with the miscarriage.

Tammie reported that she became sexually active at a young age, approximately 12 years of age, with her first boyfriend who was five years her senior. Tammie reported having had other boyfriends in the past, however, her parents reported that they were strict with Tammie about dating and having boyfriends and that they have no knowledge of Tammie ever having had a boyfriend. Tammie has a best friend, Christine, with whom she has been friends with for 10 years. They attended primary school together and keep in regular contact. It was when Tammie was staying with Christine in the school holidays that she was sexually assaulted by a lodger in Christine’s home.

When Tammie’s parents separated, Tammie decided to reside with her father in a regional country town whilst her siblings stayed with her mother in metropolitan Melbourne. Since moving to the country, Tammie stated that she is “not settling in at school” and is experiencing the return of suicidal thoughts.
Psychiatric History:

Tammie’s brother, Andrew, has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and her father, Ken, is currently taking anti-depressant medication prescribed by his General Practitioner since separation from his wife. There is no other known family history of psychiatric illness.

Family History:

Liz, the mother of Tammie, is described by Tammie as having an “addictive personality”, being a gambler and addicted to internet chat rooms. Tammie stated that her mother believes her to be manipulative with regards to the sexual abuse claims and described Tammie as a “psycho-head”. At the time of assessment there was familial discord between Tammie and her mother with regards to the parents’ separation whereby Tammie stated that her mother blames her for the separation. Tammie also reported that her mother persistently encouraged her to lose weight and always commented that she was overweight.

Ken, the father of Tammie, decided to move to a regional country town after the recent separation from his wife to be close with his extended family. Ken was unemployed at the time of assessment but was keen to find a job. Ken was supportive of Tammie and was concerned about all of his children’s wellbeing.

Tammie reported a conflictual relationship with her sister Molly. Tammie reported that the discord is a result of her mothers’ detachment from herself when Molly was born. Tammie also reported that Molly and Sean were favoured by her parents because they were perceived as being “good” children who were easy to
manage. At the time of assessment, Tammie had had little contact with her mother and siblings.

**Genogram:**

Presented in Figure 5 is a genogram representing Tammie's family.

![Genogram of Tammie's family](image)

Figure 5. Genogram of Tammie's family

**Medical History:**

Tammie reported no medical complaints at the time of assessment. Tammie stated that she had experienced morning sickness symptoms for a period of three months prior to her miscarriage. Tammie said she was unaware that she was pregnant until the subsequent miscarriage. She had not sought professional medical advice for the three month period when she was experiencing vomiting, hot flushes, bloating, and weight gain.
Forensic History:

No known forensic history.

Substance Use:

Tammie reported recreational alcohol use only.

Education:

At the time of assessment, Tammie attended the local high school and the School Welfare Co-ordinator reported that she had poor academic performance. Tammie also said that she was socially isolated at school and stated that she had no friends and spent most of her school time by herself. The School Welfare Co-ordinator reported a high level of school absenteeism.

Mental State Examination:

Tammie presented as a physically well developed and overweight 16 year old girl. Tammie arrived to the interview sessions punctually and dressed appropriately in her school uniform. Tammie was co-operative and engaging, maintaining good eye contact. Tammie described her mood as dysphoric, stating a sense of hopelessness and helplessness. However, Tammie presented as mildly depressed in affect. Tammie presented with normal prosody of speech with appropriate rate and tone. However, there was evidence that Tammie's language development was delayed. For example, her sentence structure was not always grammatically correct with confusion regarding the use of plurals and past tense.

Tammie displayed logical thought form, however, she displayed confusion regarding the timeline of events in her personal history. Tammie expressed suicidal
ideation in the form of cutting herself with a knife or hanging herself with a dressing gown cord. However, Tammie also stated that she considers the consequences of her behaviour and rationalises her thoughts or engages in distraction behaviour to inhibit her thoughts. There was no evidence of hallucinations or delusions.

Tammie presented as an expressive teenager who was in-tuned to her thoughts, feelings, and behaviour. Tammie presented as mature for her age in some respects, taking on adult roles, whilst also immature in her ability to socialise with adolescents her own age. Tammie displayed good insight with regards to deterioration in her mental state. She also exhibited good judgement with regards to her low mood and depressed affect by seeking the assistance of school staff.

Tammie presented as a caring girl who is considerate of those she cares for, such as her father Ken and close friend Christine. A positive relationship was observed between Tammie and her father. Ken displayed concern regarding his daughter's unhappiness, lack of motivation, and inability to socialise with others.

Assessment History:

*Information source:* Clinical interview with Tammie and Ken and telephone calls with Liz and the DET Social Worker, Maxine.

*Psychological assessment.* Tammie had had no formal cognitive assessment, however, she reported consulting numerous counsellors after disclosure of her first incident of sexual abuse when she was 12 years of age.
Risk assessment. Tammie presented as a medium risk of suicide and self-harming behaviour due to her reported previous self-harming behaviours and stated low mood. However, Tammie presented with a stable mental state with no fixed plan. Tammie also had a number of support resources, such as her father, school staff who she felt she could approach, and her friend of 10 years, Christine who she was spending the weekend with.

Formulation:

Tammie is a 16-year-old girl who was referred to CAMHS with a previous history of suicidal attempts and depressed affect. Tammie grew up in regional Victoria with her parents and three younger siblings, attending the local primary and high school. According to Tammie, this period of her life was happy. It was, however, during her early childhood that Tammie was repeatedly sexually abused whilst in daytime childcare. The abuse occurred when Tammie was 6 years of age. She disclosed the abuse when she was 12 years of age. After the birth of her youngest sibling, the family relocated to metropolitan Melbourne. Tammie was popular at her new high school, where she learnt opera singing, and reported that school was “okay”. Tammie described her family life at this time as hectic and chaotic as her brother was diagnosed with ADHD and her parents were often in conflict.

Whilst residing in Melbourne, Tammie, aged 15 years, was sexually abused for the second time by a friend’s housemate. As a result of the second sexual abuse incident, Tammie became pregnant and experienced a subsequent miscarriage. Soon afterwards, in June 2003, Tammie’s parents separated and she chose to reside with her father in country Victoria. Tammie’s referral to CAMHS was precipitated by her parents’ separation, conflict with her mother whereby Tammie reported that her
mother blames her for her marriage break-up, recent re-location to country Victoria and peer adjustment issues, and subsequent deterioration in mood and affect.

Tammie’s low mood and depressed affect are perpetuated by familial discord, particularly between Tammie and her mother, and her reported low self-esteem and self-concept. Other perpetuating factors included Tammie’s history of sexual abuse and trauma associated with being pregnant and suffering from a miscarriage.

Tammie also exhibits a language difficulty. Protective factors for Tammie included her motivation to seek help, her commitment to schooling (e.g. Singing), and her close relationships with her father, Ken, and friend, Christine. Other social supports included the DET Social Worker, Maxine, and the School Welfare Co-ordinator.

**Diagnosis:**

- **Axis I:** Reactive Depression
- **Axis II:** No diagnosis
- **Axis III:** Pregnancy and miscarriage
- **Axis IV:** Familial discord, history of sexual abuse, peer relational difficulties and social isolation.
- **Axis V:** GAF = 67

Tammie’s diagnosis can be best understood by considering attachment theory, her history of sexual abuse and manifestation of psychological disturbance. Furthermore, Tammie’s lack of perceived familial support may explain her social skills deficits and peer relational difficulties. The inter-relationship that exists between these psychosocial factors will be discussed in the next section.
6.2 Attachment Patterns and the Development of Psychopathology

Victims of trauma, including childhood sexual abuse, exhibit deficits in three main areas. These problems include: interpersonal relationships, affect regulation, and self-development (Kaufman & Henrich, 2000). Traumatised children have been found to exhibit insecure attachment relationships with caregivers (Kaufman & Henrich, 2000; Schneider-Rosen, Braunwald, Carlson, & Cicchetti, 1985). With regards to the case study of Tammie, she reported that she felt unwanted and unloved by her parents during childhood. In addition, at the time of assessment, Tammie reported that she had a conflictual relationship with her mother. The availability of a supportive parent is one of the most important factors that can influence the outcome of a traumatic experience, such as child abuse (Kaufman & Henrich, 2000; Shapiro & Levendosky, 1999). Unfortunately, in the case of Tammie, she perceived a lack of parental support during childhood and after she disclosed allegations of sexual abuse in early adolescence. Furthermore, traumatised children have been found to exhibit peer socialisation difficulties, such as aggressive acts towards peers or a lack of communication skills (Kaufman & Henrich, 2000). With regards to the case study of Tammie, she completed two years of kindergarten due to poor socialisation skills. Furthermore, at the time of assessment, she exhibited peer relational difficulties.

With regards to affect regulation, traumatised children have been found to exhibit greater negative affect, including sadness, and display less interest in free-play than control counterparts (Kaufman & Henrich, 2000). Adult victims of childhood sexual abuse have also been found to report depressive symptomatology, such as sadness and sense of helplessness (Higgins, 2003). Higgins examined childhood family characteristics and depression among 133 adults. Higgins found
that adults who reported early childhood sexual abuse also reported symptoms of depression. Furthermore, maltreatment and family dysfunction, such as role conflict and lack of emotional bonding between family members, in childhood were also found to be related to depressive symptomatology in adulthood. In reference to the case study of Tammie, she reported long standing depressive symptoms and low mood. Tammie also reported conflictual relationships with family members, particularly her mother and sister, Molly.

Low self-esteem, a lack of self-understanding and poor self-efficacy have also been found to be associated with the formation of self in traumatised children (Kaufman & Henrich, 2000; Liem & Boudewyn, 1999; Peleikis, Mykletum, & Dahl, 2004; Shapiro & Levendosky, 1999). With regards to the case study of Tammie, low self-esteem was acknowledged by Tammie as problematic and I observed that she also lacked a sense of self-identity. Tammie also exhibited role conflict whereby she was confused whether she was an adult or adolescent figure.

Problems with interpersonal relationships, affect regulation, and self-development have all been found to be associated with psychopathology, such as depression, in traumatised children during late childhood or adolescence (Kaufman & Henrich, 2000; Shapiro & Levendosky, 1999). In a study by Peleikis et al. (2004) of 56 women with a history of childhood sexual abuse and 56 non-abused counterparts, a larger proportion of abused women than non-abused women met the criteria for major depression. Furthermore, a larger proportion of women who had experienced early childhood abuse reported greater engagement in self-harming behaviour than their non-abused counterparts. Findings also indicated that 55% of abused women reported having few or no friends. With regards to the case study of
Tammine, she exhibited depressive symptomatology, such as depressed affect and low motivation, and she reported previous self-harming behaviour. Tammine also reported peer relational difficulties and had few friends at school.

Bowlby (1982) argued that an individual’s current functioning or adaptation is determined via developmental history or prior experiences and the current context. Bowlby’s (1969, 1973, 1980) Theory also stated that a cumulative history of maladaptation rather than a period of poor functioning would be more detrimental to long term mental health status. Sroufe et al. (1999) tested this hypothesis among 180 children in a longitudinal investigation. Participants were tested during infancy, childhood, and adolescence. Results indicated that children with a cumulative history of unsupportive care were significantly more likely to exhibit symptoms of psychopathology in adolescence. Furthermore, on-going peer relational difficulties and quality of attachment relationships formed in infancy were found to predict symptoms of psychopathology in adolescence. The findings reported by Sroufe et al. reflect the personal history of the case study of Tammine. Tammine reported a history of familial discord, a history of peer socialisation difficulties and, at the time of assessment, she had few close friends.

Children who develop insecure styles of attachment typically exhibit deficits in two main domains: language development and social skills (Rutter, 1981). These deficits can be further hindered if the child is a victim of childhood sexual abuse. Furthermore, if the child’s perceived level of social support post trauma is low, additional negative consequences on outcome are envisioned (Kaufman & Henrich, 2000; Rutter, 1981; Sroufe et al., 1999). Insecure attachment relationships and low social support may influence internal working models and the development of poor
socialisation and communication skills (Bretherton, 1985; Kaufman & Henrich, 2000; Rutter, 1981; Sroufe et al., 1999). The case study of Tammie is consistent with this view.

6.3 Treatment Plan of Tammie

The treatment plan of Tammie is outlined below. The main objectives of psychotherapy included:

1) Ameliorate affect, increase self-esteem and reduce depressive symptomatology.

2) Reduce familial discord and encourage positive and supportive relationships between Tammie and her parents, particularly between Ken and Tammie.

3) Improve social skills and consequently improve peer relations.

Five individual therapy sessions with Tammie focused on ameliorating her affect, increasing her self-esteem, and reducing her depressive symptomatology. The individual therapy sessions consisted primarily of cognitive behavioural therapy and included the monitoring of Tammie’s affect by completing a mood diary and pleasant event scheduling. In the beginning, Tammie received psychoeducation regarding cognitive behavioural therapy and the inter-relationship between cognitions, behaviour, and emotions. Next, Tammie was introduced to the mood diary. The mood diary consists of a daily rating scale assessing mood. Mood is assessed along a continuum from 1 (low mood) to 10 (good mood). As a homework activity Tammie was encouraged to keep a daily record of her mood. At the next
session, Tammie’s mood was reviewed. The mood diary can be graphed visually so as to discuss troughs and peaks.

Pleasant event scheduling emphasises the importance of engaging in positive activities to improve cognitions and emotions. Tammie and I devised a list of activities that Tammie could engage in to make her feel better. These activities had to be of low cost and acts that she could engage in on a daily basis. Tammie’s list of positive activities included: going for a walk, having a bath, having a make-over (experimenting with make-up), listening to music, and painting her nails. For the next week Tammie was set the homework task of engaging in at least one positive activity per day and keeping a record of which activities and how many she completed per day. At the same time, Tammie had to also keep a record of her mood and rate her mood daily.

In the third session, the record of pleasant event scheduling and the mood diary were discussed. A relationship between mood and the number of positive activities engaged in was found. Tammie reported a better mood on days in which she had completed more than one positive activity. Tammie was encouraged to continue with her homework and as time lapsed, Tammie was able to add to her list of positive activities and better understand the link between her cognitions, behaviour, and emotions.

The fourth session included a family session with Ken and Tammie present. Tammie’s progress was reviewed and the therapeutic work between Tammie and I was explained to Ken, with Tammie’s permission. Tammie had mentioned in previous sessions that she felt that her father didn’t understand why she felt the way
she did so a family session was scheduled. In addition, the importance of the father-daughter relationship was discussed with Ken in order to provide a more supportive environment for Tammie at home. Whilst Ken was eager to support his daughter, I also acknowledged that Ken’s own depressed mental state, in terms of coping with his recent separation from his wife and other children, may have also been contributing to Tammie’s depression.

With regards to peer relations, after a few weeks Tammie reported that she had made new friends at school and the teasing and social isolation had subsided. In individual sessions, Tammie would reflect on instances of peer relational difficulties at school and I would discuss with Tammie different scenarios and role play different outcomes to make her less vulnerable to being teased and picked on at school. Tammie also spoke to the DET Social Worker, Maxine, about peer related problems.

6.4 Conclusion

Whilst Tammie made several psychological gains, peer relational difficulties and Tammie’s poor academic performance lead her to the decision to relocate back to Melbourne where she was offered accommodation with her maternal grandparents. Tammie was eager to complete a Beauticians course and enjoy closer proximity to her high school friends. However, with regards to her depressive symptomatology, Tammie reported greater positive affect and no suicide ideation. At the time of closure Tammie had also recommenced communication with her mother. Ken continued to support Tammie despite his initial concerns regarding her relocation.
The case studies presented in this thesis emphasise the importance of early attachment relationships, particularly in the development of language and social skills (Rutter, 1981). Early childhood experiences can impact on the development of self-esteem, self-confidence, and self-identity and can contribute to the later manifestation of psychological disturbance, such as depression (Shaffer, 2002). The case studies presented provide a description of the effects of maternal deprivation (case of Harrison), the impact of second generational trauma on parenting and attachment (case of Diana), childhood sexual abuse and the development of indiscriminate attachment relationships (case of Melanie), and the later development of psychopathology as a consequence of early childhood experiences (case of Tammie). The case studies illustrated how negative early life experiences can impede the development and functioning of children and adolescents.

All four clients suffered from negative early life childhood experiences and all four clients presented with language difficulties and socialisation problems. Deficits in language development and socialisation are typically observed in children who have suffered from negative early life childhood experiences (Rutter, 1981). In the first case study, Harrison exhibited both language and social deficits. Harrison’s speech and language was difficult to understand and comprehend. Harrison was receiving speech therapy to assist him with his language and communications skills. Harrison also exhibited a lack of socialisation skills and an inability to socialise appropriately with peers. He found it difficult to relate to children his own age and completed two years at kindergarten and changed primary schools due to this
difficulty. Harrison’s treatment plan consisted of behavioural techniques, such as role plays, to ameliorate his social skills.

In the second case study, Diana also exhibited both language and social deficits. Diana was of low intellectual functioning, exhibiting an immature use of language, and she had a slight lisp making her hard to understand at times. With regards to her social skills, Diana found it hard to relate and converse with peers her own age. Diana experienced peer related teasing and her subsequent relocation from a public primary school to a Christian primary school occurred in the context of unresolved peer relational difficulties. Diana’s treatment plan included attendance at special school part-time to increase her life skills, socialisation with children exhibiting similar difficulties to herself, and decrease her social isolation.

In the third case study, Melanie was found to exhibit both language and social deficits. Whilst Melanie exhibited a Full Scale IQ of 116, she often conversed in a child-like manner regressing to “baby talk” and exhibited an immature use of language. This was noted by her mother, school teachers, and myself. Melanie was also found to exhibit indiscriminate attachment relationships with adult figures, particularly males. Melanie exhibited inappropriate sexualised behaviour and formed an inappropriately close relationship with myself in my first meeting with her, invading my personal space and touching my legs and arms.

In the fourth case study, Tammie also presented with language and social deficits. Tammie exhibited language difficulties with incorrect use of plurals and the past tense. Tammie also reported peer relational difficulties. Tammie reported that she felt she was socially isolated at school and teased by other students. Tammie’s
treatment plan consisted of role play activities and discussion of different scenarios to increase Tammie’s communication skills and subsequent socialisation.

In all four cases, the treatment plans have included two common objectives. These include the development of caregiver-child attachment relationships to provide a secure home environment and therapeutic intervention (Kaufman & Henrich, 2000; Shapiro & Levendosky, 1999). The development of a supportive and caring parent-child relationship is one of the most important protective factors in ameliorating a child’s developmental outcome after negative early life experiences (Kaufman & Henrich, 2000; Shapiro & Levendosky, 1999).

Therapeutic interventions have also been found to improve the long term outcomes of children who have suffered from negative early life experiences (Kaufman & Henrich, 2000). The therapeutic interventions implemented have included play therapy techniques, such as role play activities, and cognitive behavioural therapy, such as self-monitoring techniques. Play therapy techniques and cognitive behavioural therapy have both been effective at reducing psychological disturbance, improving self-esteem and self-awareness, and increasing socialisation. In particular, role play activities were found to be beneficial at increasing Harrison’s and Tammio’s socialisation skills whereby basic communication skills, such as turn taking, could be practised and rehearsed. Furthermore, individual long term therapy with Melanie could have also included play therapy techniques. Via play therapy techniques, Melanie may have been able to learn basic rules of interaction with others, for example not invading others’ personal space, and increasing her social skills.
Cognitive behavioural therapy was also effective in ameliorating the self-esteem, self-confidence, and self-awareness of Diana and Tammie. Self-monitoring techniques, including the use of the body chart for Diana and the mood diary and positive event scheduling for Tammie, were effective at reducing depressive symptoms and boosting self-esteem. Both Diana and Tammie were able to record their symptoms and with psychoeducation understand the inter-relationship between cognitions, emotions, and behaviour.

Other interventions implemented with children and adolescents after trauma and a disruption to attachment relationships, may focus on coping mechanisms. Like Melanie, children and adolescents who have had negative early life experiences may exhibit avoidant coping strategies which have been found to be maladaptive in the long term (Shapiro & Levendosky, 1999). Therapeutic interventions may focus on developing more positive coping approaches and reducing the negative consequences that may be associated with early traumatic experiences.

7.1 Critique of Attachment Theory

Whilst attachment theory can be utilised as a framework to consider the presentations of Harrison, Diana, Melanie, and Tammie, attachment theory has been criticised in terms of its application for clinical assessment and treatment (Carlson, Sampson, & Sroufe, 2003; Thompson & Rakes, 2003). Beyond infancy, assessment of attachment relationships is problematic and poses many challenges (Carlson et al., 2003; Thompson & Raikes, 2003). Firstly, it is difficult to activate the caregiver-child attachment relationship in a laboratory setting unlike in infancy with the “Strange Situation” (Ainsworth et al., 1978). Secondly, children’s behaviour
becomes increasingly diverse and complex with additional factors to consider, such as, affect regulation and open-communication (Carlson et al., 2003; Thompson & Raikes, 2003). Therefore, children's behaviour is not easily categorised and classified. Thirdly, in many cases assessment of early attachment relationships relies heavily on retrospective self-report or parent-report which may not be accurate (Thompson & Raikes, 2003). Finally, few psychometric measures for children exist which are efficacious (Carlson et al., 2003; Thompson & Raikes, 2003). Until psychometric measures of attachment in childhood, adolescence, and adulthood have been empirically tested, it is difficult to determine factors associated with attachment and the stability and changeability of attachment over the lifespan (Thompson & Raikes, 2003).

The need for human contact, as an underlying premise of attachment theory, is critical across the human lifespan. Therefore, it could be argued that the current problems experienced by Harrison, Diana, Melanie, and Tammie may not be a result of negative early life experiences, but by current non-supportive caregiver-child relationships (Carlson et al., 2003). For example, in the first case study, Harrison may have perceived that Carmel and Joshua had a close relationship and he may have believed that Carmel favoured Joshua. As a result, Harrison may not have perceived Carmel as supportive and available to meet his needs. In addition, Harrison's disruptive behavioural problems may have also arisen from a lack of parenting skills exhibited by Carmel and Bill. With consistent parenting skills and rules and boundaries, Harrison's disruptive behavioural difficulties may be better managed. Furthermore, Harrison's disruptive behavioural problems may be related to a variety of other concerns, including the nature of Harrison's first foster care placement and the timing associated with his placement with Carmel and Bill.
Harrison may have experienced a sense of separation and loss when removed from Lara's care and thought he was being punished for causing damage to her private property. Harrison's lack of understanding and comprehension associated with his foster care placement with Carmel and Bill may have resulted in Harrison exhibiting emotional and behavioural difficulties (Carlson et al., 2003).

In the second case, Diana may have perceived that her mother was unable to support her and meet her needs due to Patricia's maladaptive coping strategies, which may have resulted from a variety of factors, such as her divorce from James or stressors associated with returning to employment as a childcare worker (Thompson & Raikes, 2003). Other early life events for Diana, such as the divorce of her parents, her first epileptic attack, the introduction of Barbara, and the birth of Toby, may have also impacted on Diana and played a role in her current presentation. Due to Diana's intellectual disability, she may lack an understanding of her early life events, such as the divorce of her parents, and exhibit a sense of separation and loss which may also account for her symptoms of anxiety. Furthermore, Patricia's inability to enforce parenting structure and boundaries may also account for Diana's current behavioural difficulties, including sleep disturbances, frequent trips to the toilet, headaches, and stomach aches. A combination of these factors may have influenced Diana's current concerns.

In the third case, Melanie may have perceived that her mother was unable to support her and meet her needs due to Therese's maladaptive coping strategies, which may have resulted from the impact of stressful life events. For Therese these may include the emotional turmoil and stress that she experienced as a result of her unstable relationship with Con, an unplanned pregnancy, separation from Con,
treatment of Melanie’s medical problems, and sexual abuse allegations made by Melanie against Con. An interaction of these influences may have contributed to Therese’s maladaptive coping strategies and the development of Melanie’s language and social deficits. Furthermore, the lack of a father figure and the perceived unavailability of Therese emotionally may also account for Melanie’s indiscriminate attachment.

In the fourth case, Tammie may have perceived that her mother had closer relationships with her siblings, particular Molly, and she may have believed that Liz cared more for her siblings than for her. Tammie may have felt abandoned and rejected by her mother. Furthermore, at the time of referral, Tammie may have perceived her father as having maladaptive coping strategies and unable to support her emotionally. Ken had recently experienced separation from his wife, had limited access to his remaining three children and was concerned about their wellbeing, and was prescribed anti-depressant medication. As a result, Tammie may not have perceived Liz or Ken as supportive and available to meet her needs. However, a number of different factors, such as sexual abuse on two occasions by different perpetrators, the separation of her parents, birth order, sibling conflict and house relocations may have contributed to Tammie’s current presentation.

Insecure attachment relationships developed in infancy between caregiver and child may place an individual at risk of psychological disturbance when combined with environmental stressors, such as, separation of parents, and other psychosocial stressors, such as, birth order (Carlson et al., 2003). However, environmental and psychosocial stressors alone may also lead to children’s emotional and behavioural difficulties. For example, children who have developed a
secure caregiver-child attachment relationship may exhibit emotional and behavioural difficulties, such as, aggressive or defiant behaviour, when their parents separate or divorce.

Whilst negative early life experiences may play a role in the development and manifestation of psychological disturbance, it is not clear whether the factors that initially contribute to insecure attachment relationships are also risk factors for the development of later emotional and behavioural difficulties (Thompson & Raikes, 2003). For example, it is difficult to determine whether Melanie’s sexualised behaviour and indiscriminate attachment style reflects current psychological stress associated with prior sexual abuse, insecure caregiver-child attachment relationships, Therese’s maladaptive coping strategies to deal with Melanie’s sexual abuse claims, poor quality care, inadequate parenting skills, or an interaction of these factors.

Negative early life experiences may play a role in the development and manifestation of psychological disturbance, however, this role may be dependent on other environmental factors and social supports (Sroufe et al., 1999; Thompson & Raikes, 2003).

Treatment or interventions designed to improve caregiver-child relationships for individuals diagnosed with an Attachment Disorder range from caregiver education to specialised emotional or behavioural interventions (Carlson et al., 2003). There are few clinical interventions which target children or adolescents with severe psychological disturbances of attachment and these often lack empirical support (Carlson et al., 2003; Thompson & Raikes, 2003). Although the findings from clinical interventions to treat insecure attachment relationships is mixed (Carlson et al., 2003), overall early intervention that encompasses teaching of
parenting principles, building working relationships with caregivers, and aims to create a supportive environment, has been found to ameliorate caregiver-child attachment relationships (Carlson et al., 2003).

Whilst a number of other factors, such as sexual abuse or lack of parenting skills, may have contributed to the negative early life experiences of Harrison, Diana, Melanie, and Tammie and the subsequent development of psychological disturbance, all presented with a history of insecure caregiver-child attachment relationships. Harrison suffered from maternal deprivation, while Diana exhibited anxiety as a result of second generational trauma. Melanie suffered from early childhood sexual abuse and developed indiscriminate attachment relationships, and Tammie exhibited depressive symptomatology as a result of early childhood experiences. Furthermore, Harrison, Diana, Melanie, and Tammie also exhibited language deficits, such as evidence of a lisp, and social deficits, such as peer relational difficulties including being teased and excluded. However, environmental influences also play an important role in the reversibility of these language and socialisation deficits during late childhood and early adolescence (Rutter, 1981). Environmental improvements, such as the development of a secure caregiver-child attachment relationship and therapeutic interventions, can dramatically ameliorate the psychological wellbeing of children and lead to a sense of normalcy (Rutter, 1981). Longitudinal research, however, is required to better understand the effects of negative early life experiences on the formation of attachment relationships not only in infancy but across the lifespan (Carlson et al., 2003).
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