Undersocialized Conduct and Attachment Disorders : A child psychiatric team experience with a developmental and systems approach

Christine Zsizsmann, Chatra Weerasinghe, Noelle Belcher.

Paper presented at the 11th International Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions, Paris 21–25 July, 1986.

The paper deals mainly with work undertaken at Travancore Child and Family Centre and discusses the connection between attachment disorder and Undersocialized Conduct Disorder. Clinical examples illustrate the difficulties such children present to the caregivers and workers in the systems around the child. As these children generally fail to respond readily to therapies based on the child's ability to form trusting relationships, management and treatment strategies which rely on careful assessment of the child's attachment behaviour are described.

Noelle Belcher

Christine Zsizsmann is a clinical and community psychologist at Travancore Child and Family Centre, Melbourne, a service of the Health Department Victoria for emotionally disturbed children, adolescents and their families. Her interests include mental health consultation to the child and family network and children with attachment disorders.

Dr. Chatra Weerasinghe is a child psychiatrist currently in private practice in Melbourne. She worked at Travancore as a consultant child psychiatrist for a number of years.

Noelle Belcher was the Senior Social Worker at Travancore from 1978 until her untimely death in March 1989. She had worked with children and families for nearly thirty years, the last twenty of which were within the field of child psychiatry. Noelle brought a wealth of skill and experience to her work. In particular, her knowledge of the various networks involved in helping children and families was invaluable to her colleagues. As a person and professional, she was much loved and respected for the commitment and energy she displayed in her work. Noelle was well known as an inspiring teacher and supervisor to many generations of students and workers.

Correspondence should be addressed to Christine Zsizsmann, Travancore Child and Family Centre, 50 Flemington St, Flemington 3031.

Features of Undersocialized Conduct Disorders

Using the DSM III criteria for a definition, the essential feature of a Conduct Disorder is seen as a repetitive and persistent pattern of conduct in which either the basic rights of others or age appropriate societal norms or rules are violated. (DSM III 1980). Four subtypes are described, based on the presence or absence of adequate social bonds and the presence or absence of a pattern of aggressive antisocial behaviour: Undersocialized Aggressive, Undersocialized Non-aggressive, Socialized Aggressive and Socialized Non-aggressive.

Our discussion focuses on the undersocialized types who fail to establish a meaningful degree of affection, empathy or bond with others, ie. children with a serious disturbance in attachment. Our staff have expanded the features which these children present with and include the following: (Cline 1979; Bornstein 1986).

1. Active and/or passive resistance to being controlled by adults, accompanied by extreme control battles at home and at school.
2. A repetitive and persistent pattern of aggressive, or non-aggressive conduct in which the basic rights of others are violated. This may include:-
   (a) physical aggression and destructiveness towards people including the self) and property,
   (b) unprovoked cruelty to animals,
   (c) chronic violation of a variety of rules,
   (d) lying in the face of conflicting evidence,
   (e) stealing.
3. Lack of appropriate conscience development with no display of appropriate guilt or remorse.
4. Failure to establish a normal degree of affection, empathy or relatedness with others. This pattern may include:
   (a) inability to establish long term friends,
   (b) displays of affection on the child's terms or not at all and the caregiver feels doubtful about its genuineness; the child may use affection in order to get something he wants and when the caregiver attempts to initiate touch the child withdraws or stiffens,
   (c) abnormal eye contact, especially avoidance of eye contact when the child wishes to avoid facing or doing something; this may be interspersed with a 'drop-dead' stare in which the child looks at the adult but it does not feel as if the child is making emotional contact – the child may be able to initiate such eye contact when he wants something,
   (d) initial superficial attractiveness and/or friendliness with strangers, who often cannot understand how the parents cannot handle such a charming, friendly, apparently

normal child,
(e) a sense of phoniness and sneakiness with the child engaging in unacceptable behaviour when he thinks he is not being observed.

5. Learning lags at school which may involve:
(a) developmental delays of cognition and language,
(b) resistance to being taught,
(c) resistant speech patterns in which the child may utilize the presence of immature articulation and limited vocabulary to avoid answering unpleasant questions, or may give ambiguous, unclear of 'playing dumb' answers,
(d) disturbance in cause and effect thinking.
6. Other features may include:-
(a) gorging or hoarding food,
(b) pre-occupation with aggressive, persecutory or fearful themes in speech and play,
(c) repeated running away from home or school.

Clearly, many of these features are present during certain stages of normal development and become significant only when they are not age and stage appropriate.

... the essential feature of a Conduct Disorder is seen as a repetitive and persistent pattern of conduct in which either the basic rights of others or age appropriate societal norms or rules are violated. (DSM III 1980).

We are therefore looking at a group of children who have major interpersonal difficulties that disrupt the child's relationships within the family and school in the early days and with society in general in later life. These children typically fail to respond to subsequent good parenting. Traditional supportive or psychotherapeutic interventions have also been found to be unhelpful with them. This difficulty is, no doubt, due to the fact that such interventions depend, for their effectiveness, on the child's availability to form a trusting relationship with the caregiver or therapist. It is well known (Rutter, 1981) that failure to form selective attachments in infancy due to factors present in the caregiver and/or in the infant can lead to persistent and serious problems in the child's social behaviour, often despite subsequent changes in the child's environment. Cline (1979) and Bornstein (1986) suggest that the following commonly disturb the attachment process:-

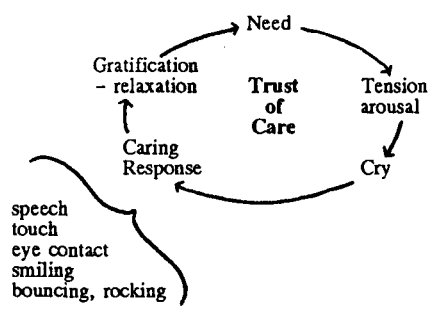
1. Lack of consistent parenting figure,
2. Physical separations from the parent figure,
3. Parental neglect with failure to attend to normal child care practices,
4. Parental rejection, emotional or physical abuse associated with psychopathology in the parent or physical abnormalities in the child,
5. Psychological absence of the parent figure through illness, including depression, stress and/or conflict,
6. Physical handicap of the child,
7. Unrelieved pain in the child,
8. Temperamental traits in the child interfering with the normal attachment process, e.g. the infant who arches his back when picked up and gives minimal cues for physical and social contact.

We have used a developmental and systems approach in an endeavour to understand the disturbances in these children and to institute effective management interventions. Bowlby's attachment theory has been particularly useful in this regard. Attachment behaviour is defined by Bowlby as any form of behaviour that results in a person attaining or retaining proximity to some differentiated and preferred individual. Bowlby conceptualizes attachment behaviour as a major and distinct behaviour system which influences and is influenced by other behaviour systems within the individual. The attachment behaviour system is described as a set of feelings, thoughts and behaviours which lead to the development of affectional bonds initially between child and parent and later between adult and adult. The forms of behaviour and the bonds to which they lead are present and active throughout life. When the child's psychosocial development follows a deviant pathway, disturbed patterns of attachment behaviour can be evident (Bowlby, 1980).

Hypothesising that the Undersocialized Conduct Disorder is significantly linked to serious disturbances in the organization of the child's attachment behaviour, we have been able to identify the critical factors responsible for the child's behaviour, and use management strategies that help the child to adaptively negotiate those early critical stages of trust development and acceptance of external controls.

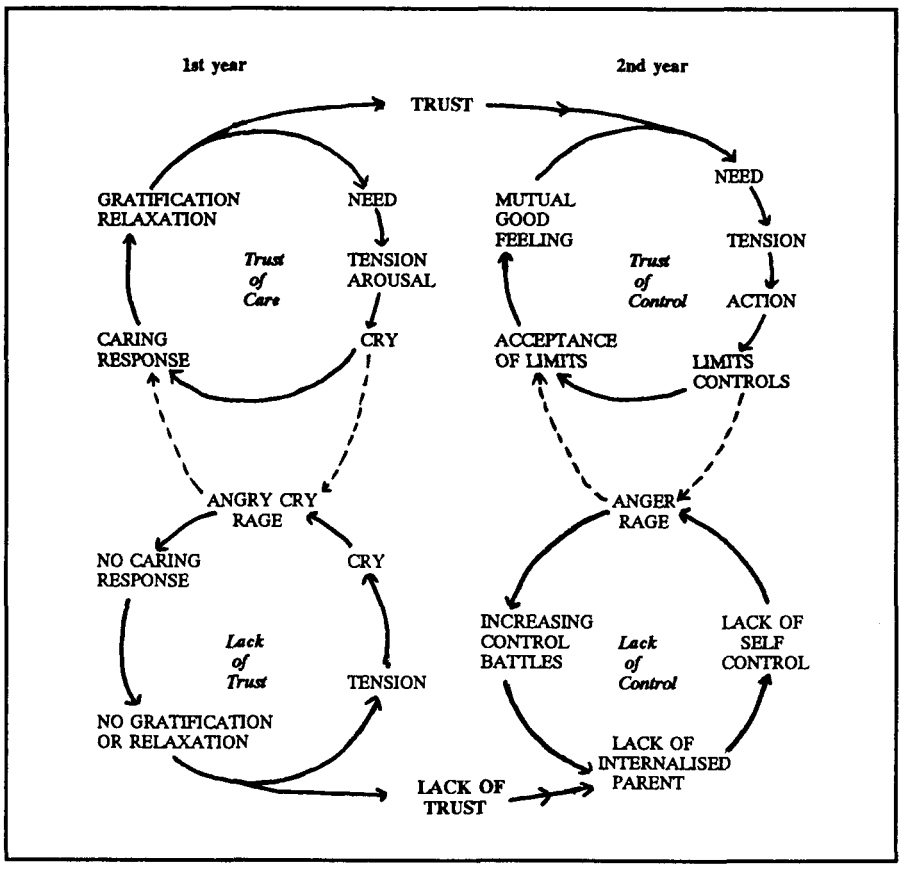
In Erikson's terms, the central task of the first year of life, is to develop trust in, and to become attached to a caregiver. This appears to occur through a cyclical repetition of mother-infant interactions which we call the **Trust-Attachment Cycle.** (Table I)

TABLE I



The way in which this interaction takes place between the infant and the caregiver has an important and a significant effect on the degree and quality of the infant's attachment behaviour. If the caregiver responds in a reliable and a predictable manner to the need-tensions or communication signals of the infant (by patterns of speech, touch, eye contact, bodily movement etc.) the scene is set for the reciprocal development of trust and secure attachment behaviour on the part of the infant. However, if the caregiver's response to the infant's signals has been insensitive, unreliable and unpredictable, the infant, unable to trust his caregiver, experiences difficulties in establishing a secure and adaptive attachment to the caregiver.

TABLE II



A major task in the second year of life as described by Erikson is the development of self control and autonomy within an environment of safe and secure limits for the child. As seen in Table II, the child's response to the caregiver's controls and limits is necessarily dependent upon the development of attachment and trust in the first year. If the establishment of trust and attachment in the first year is seriously disturbed, the basis for the child's acceptance of parental controls and in turn, for the establishment of internal controls is seriously compromised. It is not surprising therefore that such children with attachment problems frequently display in their early years evidence of poor ego integration, learning and problem solving difficulties and serious control battles with the caregiving adults (Bornstein, 1986). When presenting in their later years, these children frequently display the features outlined earlier.

It is obvious that the above features encompass many of the criteria out-lined in DSM III or Undersocialized Conduct Disorder and although the classification generally consists of descriptions of the clinical features of disorder and is generally atheoretical with regard to aetiology, our clinical experience suggests that there is a relationship between attachment disorders and the aetiology of Undersocialized Conduct Disorders.

It is appropriate to consider a range of variations in the way attachment behaviours develop in a child, and it is our observation that the most intractable Conduct Disorders are associated with the most serious disturbances in attachment behaviour. Hypothesising that the Undersocialized Conduct Disorder is significantly linked to serious disturbances in the organization of the child's attachment behaviour, we have been able to identify the critical factors responsible for the child's behaviour, and use management strategies that help the child to adaptively negotiate those early critical stages of trust development and acceptance of external controls.

The Case of Gary

This case study of an 11 year old boy Gary, illustrates the connection between the attachment disorder and Undersocialized Conduct Disorder. It will also highlight the effect of difficulties and delays in securing co-operation and co-ordination amongst the support systems involved - i.e. the family, and the welfare, educational and psychiatric services. It provides an example of the pressures to reunite separated children with their families, without first effectively dealing with the underlying issues that led to the separation. Some appropriate management strategies that take into account the difficulties such children have in utilizing traditional therapies will be presented.

Gary is the second of Sue's four children, and the only child to have been placed outside the family. Gary was first referred for help with behavioural problems at three and a half years to the local General Practitioner. His mother then described his behaviour as aggressive, defiant and sadistic. In the following year Gary was excluded from two kindergartens because of aggressive and destructive behaviour. He kicked, pushed and punched other children, stamped on and destroyed toys, demonstrated sadistic behaviour, such as cutting up caterpillars and swore when disciplined. He also sucked on dolls' bottles, dirtied his pants and threw temper tantrums. Gary was then referred for assessment to the local child psychiatric centre.

Gay has an eventful developmental and family history. Following a healthy pregnancy and normal birth, Gary developed a severe eczematous skin rash at two months of age which needed repeated hospitalisations. He was extremely distressed by these periods of separation and it was at this stage that Sue first experienced her difficulties in managing Gary. He also had a chronic bowel problem in his early months, which cleared up along with his eczema towards the end of his second year. His mother remembered the first eighteen months of Gary's life as an extremely difficult period both in her own personal life and in her relationship with Gary.

Loss of Gary's father through a gaol term, a number of moves both interstate and within the state, and the entry of Gary's stepfather into the family were stresses that preoccupied Sue, whilst Gary demanded attention through his physical problems. This critical period appears to have set the scene for problems in attachment and the subsequent mother-child relationship which has been characterised by extreme testing and acting out behaviour by Gary and rejection by his mother.

... in spite of much input from the teachers and the school counselling service, no improvement occurred... five different mothers helped the teacher ... Three weeks later four of the mothers resigned and the teacher went on sick leave ... Gary's group home parents left, retiring early because of difficulties they had with him.

Sue's own background is that, as the youngest of eight children, she grew up in a chaotic home environment with punitive and unreliable parents. There is a family history of alcoholism, violence and criminality. She spent considerable periods of her childhood in institutional care and left home in mid-adolescence. Shortly afterwards she became pregnant with her first child. Sue has had a number of short term relationships, Gary being the result of another liaison. Gary's father is described as violent and unreliable and has served heavy prison sentences for assault and larceny. There has been no contact with him since Gary was nine months old. His stepfather, on the other hand, appears to be a contrast to Sue's other men. He has a stable and supportive family background, yet Sue has not been able to develop a close, trusting relationship with him.

Psychiatric assessment showed Gary to be an immature boy with some developmental delays particularly in speech. He was easily distracted and was preoccupied with themes of aggression, punitiveness and violence. A significant degree of emotional disturbance was evident, consistent with the history given by the parents and the teacher. It also became evident that Gary's mother, unable to tolerate his behaviour, was resorting to physical abuse in an attempt to contain him. Gary was regarded as a child at risk. State Wardship was discussed with the parents who accepted the recommendation positively, and Gary was placed in a family group home. He commenced his primary schooling a day later. The placement was planned to be of twelve months duration as the social worker from the Department of Community Services was impressed by Sue's parenting abilities and was optimistic about Gary's return home.

During his initial six months in the group home, Gary proved to be extremely difficult. He continued to taunt, hit and punch other children. Some of his behaviour was of a sexual nature. He denied his behaviour even when caught in the act. At school he engaged in similar behaviours, and in spite of much input from the teachers and the school counselling service, no improvement occurred. Gary's attendance was reduced only to afternoons and five different mothers helped the teacher by taking him individually for some periods of the day. Three weeks later four of the mothers resigned and the teacher went on sick leave. The school excluded Gary until the end of the academic year. Gary's group home parents left, retiring early because of difficulties they had with him. The new group home mother, a very experienced worker, was able to control his behaviour through setting clear limits and consequences and felt she formed a relationship with him. However, when Gary was out of her control he reverted to his previous misbehaviour.

Unable to attend a school, Gary became very bored during the day and when the other children returned from school he was aggressive towards them. The strains and tensions within the group home became so unbearable that a psychiatric re-assessment of Gary and help in management was sought by the supervising Social Worker. At this point, Gary was referred to our Centre for residential treatment. Our assessment of Gary was not very optimistic. At five and a half years of age he showed many of the features outlined previously and was diagnosed as a Conduct Disordered child with serious attachment problems.

It was postulated that the inability of his mother to alleviate Gary's physical symptoms, together with her preoccupation with her problems interfered with the development of secure and adaptive attachment behaviour on the part of Gary. He was not accessible to the traditional therapeutic modes that depend on a trusting relationship for success. Admission to the Residential Unit was declined, but instead he was referred for Control of Trust-development (C.O.T.) therapy which is a confronting technique aimed at establishing an adaptive attachment between the child and his parent figure as a prelude to traditional therapies. This therapy was complemented by a very structured routine for Gary, with the therapist and the group home mother working together to maintain a consistent and secure environment.

Over the many years that Gary has been in treatment, he has made significant progress in his capacity to trust and to accept controls from significant people in his world.

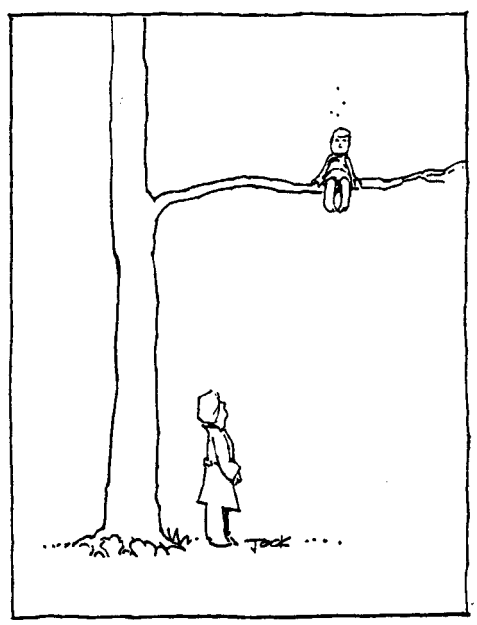
Following C.O.T. therapy Gary's aggressive and destructive behaviour decreased significantly with a corresponding improvement in his relationship with his group home mother and in his behaviour at home during holidays and weekend leave. Gary's behaviour was still too difficult for him to return to mainstream schooling and he needed to attend a social adjustment centre. He attended there for two years until he was eight years old when he was discharged home. His mother had requested this because Gary's behaviour was seen to be more settled. After this decision was made, Gary was re-referred to our Centre for day-patient treatment including attendance at the Centre's school. This was to facilitate Gary's transition from the social adjustment centre to mainstream schooling and also to support

the family during the initial phase of discharge home.

Following psychiatric re-evaluation, the referral was accepted, and in addition to the day patient programme, individual therapy was also commenced. Sue attended parent counselling sessions with another therapist with her husband joining in occasionally.

During the early weeks and months following return to his mother and admission to our Centre as a day-patient, Gary was disturbed, distressed and chaotic. His school life showed poor adjustment with severe learning difficulties. He required almost constant one to one attention for control and to secure 'on task' behaviour. Staff attitudes were at times conflicted regarding him. He aroused strong feelings, either of intense loyalty by those to whom he was becoming attached, or of ambivalence or rejection by those staff who were repulsed by his sadistic behaviour. With provision of a predictable, accepting and supportive milieu, Gary's behaviour showed some improvement, coinciding with the establishment of attachment to a few significant people of the Centre. However, his overall progress remained erratic. It was very much influenced by the way things were going between him and his mother. Our contact with Sue demonstrated that her acceptance of Gary remained entirely conditional upon his behaviour being acceptable to her and she was unable to accept Gary in the same way as she did her other children. Though manageable within the Centre's school environment, he made no progress towards schooling out. Stability, consistency and acceptance were crucial requirements for Gary and each time any of these were threatened, Gary's behaviour deteriorated markedly. During one such crisis Gary's mother requested that Gary be admitted to care.

Over the many years that Gary has been in treatment, he has made significant progress in his capacity to trust and to accept controls from significant people in his world. He has now settled into a structured school environment and takes pride in mastering skills that he should have accomplished in his earlier years. He has also internalized some controls as illustrated in a recent comment to his therapist who was late for his appointment - "Of course I feel angry, but I am able to control it now". It has been a lengthy process for Gary and those involved with him. His case illustrates some of the factors that contribute to the failure in development of normal attachment behaviour, and the difficulties encountered in attempts to manage subsequent behaviours.



The Case of Peter

The case of Peter will illustrate the importance of resolving the mourning process following prolonged separation with intermittent contact with the parent figures as commonly found in these children. Peter is an eleven year old boy who has been in care for six years. His foster placement of three and a half years duration broke down when his behaviour became uncontrollable and he asked to return to a reception centre. He saw this move as the only way in which he would be reunited with his mother. In the foster placement he had frequently refused to go on outings in case his mother visited. Her visits were unpredictable and she often failed to keep her promises to him. There was evidence that, while Peter's foster-mother had become attached to him, he had formed no attachment to her.

At a case conference it was revealed that Peter had never been told the reason for his placement away from home by his parents. It was considered that Peter's violent, anti-social behaviour was directly related to his intense anger aroused by his separation. The consultant from our Centre suggested that a meeting be held with the parents and Peter to tell him why he was in care, that he would not be returning home to live with his parents and that parental access would not necessarily be a prelude to eventual return home. Discussion of a less frequent but more realistic and thus reliable parental visiting pattern was also recommended. This meeting went ahead. Since then Peter's mother has visited him as planned. Two days after the meeting Peter had an emotional outburst saying, "How would you feel if you were told you could never go home?" A child care worker supported him in talking about how he felt and this support has continued with a corresponding decrease in his anti-social behaviour.

Children such as Gary and Peter often first come to attention in the child welfare system and, if referred to a child psychiatric service, it is usually at the point of breakdown of the child's placement. Child psychiatry is generally not perceived by other agencies as being helpful in the management of such children. The traditional therapies used by child psychiatric agencies rely on the child's capacity to relate. These are generally unsuccessful with undersocialized children who are thus frequently not accepted into the programmes offered by child psychiatric services. Sometimes the initial deceptiveness of such children in assessment, due to their apparent ability to relate in a one-to-one situation, results in them being accepted inappropriately into psychotherapy with no subsequent improvement. This does not mean child psychiatry does not have a significant role to play. We have found that the development of consultation links with child and family welfare agencies, reception centres, foster care, adoption and school counselling services can influence positively the

impact of the various systems in the child's life. Frequently these are fragmented and poorly co-ordinated. It is the Undersocialized Conduct Disordered child who tends to expose the limitations of the support systems most dramatically.

Assessment Issues

In assessing such children, we maintain an emphasis on a developmental approach. The importance of the family and other socializing influences in the child's life are also taken into account. Assessment of the child in a one-to-one situation is not enough. Observations and reports of the child in both structured and unstructured situations are valuable. We should note what prompts the referral of such children. Often it is not simply because they are conduct-disordered. Referral often occurs when caregivers realize that their attempts at genuine relationships are not reciprocated. Behaviour is always seen in a developmental context in relation to events in the child's life at the time. Detailed assessments of the child's cognitive and language skills are sometimes helpful.

A developmental and family history is necessary. Assessment of family functioning and in particular the parenting capacity of the child's caregivers is included. Detailed information is sought regarding any separations and placements, how they were handled, what the child was told and by whom and how he responded. In our experience such information regarding children when in care is often incomplete and this difficulty is compounded when there have been a number of caregivers and workers involved. The search for this information is to help to understand the nature of the undersocialized child's attachment behaviour and to identify possible intervention points to assist him to resolve his attachment difficulties.

Management Issues

A frequently encountered problem in helping these children is the failure of workers to deal adequately with the mourning process in both child and parents following separation. This is often because of the inability to tolerate the distress of the pain of the child and the parents, resulting in collusion in avoiding the work of mourning. This then leads to difficulties for the child in re-attachment with new caregivers.

A frequently encountered problem in helping these children is the failure of workers to deal adequately with the mourning process in both child and parents following separation.

Another difficulty we commonly experience is the resistance to our recommendation that long-term placement of a particular child away from the family would be in the best interests of that child. This is due to pressures to reunite the child with the family for personal, economic and political reasons. If an appropriate long term plan cannot be agreed upon, and the workers continue with unrealistic expectations of reunion of child and family, as happened in Gary's case, it will delay and complicate the child's opportunities to resolve his attachment disturbance. This situation also influences the degree of commitment that caregivers can make to the child. The importance of such commitment has been demonstrated in Tizard's (1977) follow-up study of children in care.

Due to the very nature of their psychopathology, these children arouse intense feelings of loyalty or rejection as seen in Gary, often leading to a splitting process amongst the adults who are involved with them. The child may behave well in a structured setting such as a school or in the presence of individuals who provide external controls for him, but respond less well to those who attempt to establish a close relationship with him eg. foster parents. This frequently leads to conflicted situations, eg. a teacher and a foster mother blaming and criticizing one another for what each may feel is inappropriate management by the other.

In working within the various systems and their inherent tensions, we have found it important to understand the theoretical and philosophical bases of agency policies and procedures. We believe it is important to be prepared to negotiate with those systems on behalf of the child in order to reduce the fragmentation which is all too often a repeated feature of these children. We have found the following strategies to be of value in their management and treatment.

1. **Initial clarification of the long term plan for the child with all the significant members within the systems surround the child.**
2. **Ensuring that the child receives a mutually agreed upon statement about the reasons for his placement in care, and the long term plans that are being made for him. The parent's involvement in this process is crucial.**
3. **Supporting the substitute caregivers and other involved workers to encourage and accept the verbal expression of the child's anger following separation and placement, thereby helping the resolution of the mourning process. The child's birth parents should also be supported in this way.**
4. **Providing opportunities for the child to "put the pieces of his life together" in order to establish some experience of continuity in his life, eg. use of life-books, family genograms, rituals around important events.**
5. **Assisting caregivers to institute behaviour management strategies which provide a caring, consistent and predictable environment, aimed at helping the child develop trust and control.**
6. **Provision of consultation to agencies involved with such children and families in order to educate and support their workers in the difficult task of helping the Undersocialized Conduct Disordered child.**

Bibliography

Ainsworth, M. (1982), "Attachment: Retrospect and Prospect" in Parkes, C., & Stevenson-Hinde, J. (eds.), *The Place of Attachment in Human Behaviour*, Basic Books: N.Y.

Bornstein, D. (1986), *Disorders of Attachment and Undersocialized Conduct Disorder*. Paper in preparation.

Bowlby, J. (1979), *The Making and Break-Breaking of Affectional Bonds*, Tavistock Publications: London.

Bowlby, J. (1980), *Attachment and Loss, Vol. 3, Loss: Sadness and Depression*, The Hogarth Press & the Institute of Psychoanalysis: London.

Cline, F. (1979), *What shall we do with this kid? Understanding and Treating the Disturbed Child*, Evergreen Consultants in Human Behaviour: Evergreen, Colorado.

Diagnostic and Statistical Manual of Mental Disorders (D.S.M.III), 3rd. Edition, American Psychiatric Association 1980.

Erikson, Erik H., (1950), *Childhood and Society*, W.W. Norton & Co.: N.Y.

Rutter, M., (1981), *Maternal Deprivation Reassessed*, 2nd. Edition, Penguin Books: Harmondsworth.

Steinhauer, P., (1983), "Issues of Attachment and Separation: Foster Care and Adoption," in Steinhauer, P. & Rae-Grant, Q. (eds.), *Psychological Problems of the Child in the Family*, Basic Books: N.Y.

Tizard, B., (1977), *Adoption: A Second Chance*, Open Books: London

NCBA INFORMATION SERVICE – some available material relevant to issues raised in this journal.

Wyles, Paul
Missing Children
Canberra: Aust. Institute of Criminology, 1988.

Keywords: runaways; missing children; abduction; child abuse; victims; parent responsibilities; protective behaviour programs; loss.

Glendinning, Caroline
Unshared care: parents and their disabled children
London: Routledge & Kegan Paul, 1983.

Keywords: disabled children; care in the home; child welfare; social support networks; social workers; family support services; social policy; family functioning; child health; education; family economics; stress; social interaction; working mothers.

Bowlby, John
Attachment
Harmondsworth: Penguin, 1971

Keywords: attachment; bonding; parent-child relationship.

Garbarino, James; Garbarino, Anne C.
Emotional maltreatment of children
Chicago: National Committee for Prevention of Child Abuse, 1980.

Keywords: child abuse; emotional abuse; child neglect.

Cline, Foster W.
What shall we do with this kid? understanding and treating the disturbed child
Colorado: Evergreen Consultants in Human Behaviour, 1979

Keywords: Emotionally disturbed; children; child psychotherapy; attachment; trauma; stress; adjustment; object relations; child development; psychosomatic disorders; treatment; mental disorders.

Garbarino, James; Guttmann, Edna; Seeley, Janis Wilson
The psychologically battered child : strategies for identification, assessment and intervention.
London: Jossey-Bass, 1986

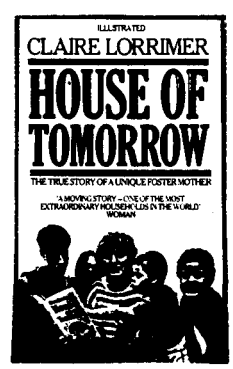
Keywords: child abuse; emotional abuse; isolation; parent-child relationship; emotionally disturbed; prevention; social work.

Paull, Thelma M.
Parenting skills program: a resource guide for parent educators
Dandenong, Vic. Dandenong Valley Family Care, 1986.

Keywords: child rearing; parent education; programs; training.

Dinkmeyer, Don; McKay, Gary D.
The parent's handbook : STEP - systematic training for effective parenting
Circle Pines, Minn.: American Guidance Service, 1982

Keywords: parent education; programs; child rearing.



Lorrimer, Claire
House of Tomorrow
London: Corgi, 1988

Keywords: child abuse; foster care; child sexual abuse; rehabilitation; disadvantaged groups; siblings; law.