Attachment, Anxiety, and Depression: A Study of Women in Residential Treatment with their Children at the Susan B. Anthony Recovery Center (SBARC) (1995–2010)

by

Gary Miles Forrest

A Dissertation Presented to the
Graduate School of Humanities and Social Sciences of Nova Southeastern University
in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University

2014

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

Nova Southeastern University

Graduate School of Humanities and Social Sciences

This dissertation was submitted by Gary Miles Forrest, under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Program of Marriage and Family Therapy at Nova Southeastern University.

Approved:

11/19/12
Date of Defense

Tommie V. Boyd, Ph.D., Chair

Christine A. Ajayi, Ph.D.

Christopher F. Burnett, Psy.D.

12/10/14
Date of Final Approval

Tommie V. Boyd, Ph.D., Chair

Acknowledgment

Leading 20th century British social worker, Clare Winnicott, once wrote in a letter to her husband, Donald Winnicott:

> If one has a good experience once—*it never ceases* to exist, it is dynamic & creative & enters so deeply into the *fabric* of the personality—that it is independent of *time* & place—& simply cannot pass like any ordinary event. It is not only made up of external reality. (Winnicott & Kanter, 2004, p. 276)

Until recently, I have not truly appreciated the simplicity, rightness, and appropriateness of Winnicott's sentiment. In some ways, the secure base provided by my family of origin provided an abundance of good experiences such that I was largely unaware of their positive effects. Because of this, perhaps I learned to expect good experiences, while at the same time, becoming inured to them? My research at the Susan B. Anthony Recovery Center (SBARC) provided stark and sad evidence that good experiences are not a universal construct. It is most fortunate, therefore, that organizations such as SBARC exist.

Although you will not find it listed anywhere in literature, or written in any of its residents' treatment plans, or even lettered on one of the many handcrafted inspirational posters that adorn the walls of the group activity rooms, a key motivator for all of the clinicians, administrators, workers, and volunteers at SBARC is a genuine desire to provide the women and children at SBARC with a good experience. I know that I certainly had one while working on this dissertation at SBARC.

I would like to acknowledge my sincere thanks and admiration for the SBARC clients, staff, and volunteers who inspired this dissertation. I dedicate this research study

to you. Finally, I want to thank Marcia Currant for her unswerving leadership of SBARC and for her years of dedication to helping scores of women and their children recover their lives.

Table of Contents

Pages

List of Tables

Pages

List of Figures

Pages

Abstract

The Susan B. Anthony Recovery Center (SBARC) in Pembroke Pines, Florida is a residential center where women live with their children while receiving treatment for a variety of co-occurring substance abuse and mental health issues and while participating in mandatory parenting classes. Unlike most women's residential treatment centers, which address only the woman and her problems, SBARC treats the mother-infant/child dyad. I designed and created a database to examine the data previously available only in the paper client records of over 800 women who received treatment at SBARC from 1995 through 2010 in a previous project. This nonexperimental, retrospective explanatory study (Johnson, 2001; Johnson & Christensen, 2014) analyzed that newly digitized historical data to examine the efficacy of the SBARC treatment with respect to three key variables: dyadic attachment, maternal anxiety, and maternal depression ($N = 268$). Correlational analysis (MANOVA) of the three variables showed significant results, which suggest that reductions in maternal anxiety and maternal depression may be related to increases in the quality of the dyadic attachment. Statistical analysis (ANOVA) found significant increases in dyadic attachment and decreases in maternal anxiety and maternal depression. The results of this nonexperimental study support the need for future research via controlled studies to determine the relationships among these key treatment variables. Grossmann, Grossmann, and Waters (2005) and others claim that improvement in dyadic attachment improves outcomes for children. Dodge, Sindelar, and Sinha (2005) and others also believe that reductions in maternal depression and maternal anxiety may result in better outcomes. The results of this study suggest that there is value in combining these

two perspectives so that measurements of dyadic attachment, maternal anxiety, and maternal depression inform future program offerings and treatment plans. The multi-disciplinary foundation of attachment theory and its rich offering of systemic and relational therapy approaches provides what I believe may be an effective blend of treatment options supported by useful empirical measures that can greatly enhance and expand professional competencies of Marriage and Family Therapists involved in clinical practice with similar at-risk populations.

CHAPTER I: INTRODUCTION

The staff of the Susan B. Anthony Recovery Center (SBARC) hear more tales of woe than most people hear in a lifetime. Fortunately, they also see more women whose lives have been renewed than most people ever get a chance to see. SBARC is a place where women can reside with their children—or while they are pregnant—and receive mental health and substance abuse treatment, learn job skills, and attend parenting classes. SBARC is unusual in that the women learn new skills and get clean and sober, while living with and caring for their children. Achieving sobriety is important, but keeping the families together is also important. Teaching women who, in many cases, have experienced unspeakable horrors of abuse and tragedy in their pasts to nurture their children is a worthwhile endeavor.

SBARC Data Collection Project (SDCP)

Since its founding in 1995, SBARC had collected reams of data (on paper) concerning the women and children enrolled in their treatment program. Trained SBARC clinicians had faithfully administered widely accepted tests for measuring dyadic attachment (Davis & Michelle, 2011; Pittman, Kerpelman, Lamke, & Sollie, 2009; van Ijzendoorn, 1995), maternal depression (Ward & Dow, 1998), and maternal anxiety (Ward & Dow, 1998) at intake and at discharge to the mother-infant/ child dyads in residence at SBARC over the years from 1995 through 2010. Unfortunately, the paper tests languished in the client files where they were buried unseen under reams of paper. Because no one had examined the results of either test for evidence of change in levels of dyadic attachment, maternal depression, or maternal anxiety, SBARC lacked an accurate statistically supported picture of its anecdotally supported success.

For two and a half years prior to the current study, I organized and entered SBARC's data (1995–2010) into a computer database that I designed as a tool for SBARC employees to track their client statistics and outcomes. The SBARC Data Collection Project (SDCP) data provided the basis for this study. See Appendix A for more information about the SDCP.

Statement of the Problem

A preponderance of behavioral and psychological developmental research has long established correlations between early childhood interactions in the child/primary-caregiver dyad and later behavioral, developmental, and mental health issues for the child (Gray, 2011; Greco, 2010; Somech & Elizur, 2012; Sonthalia & Dasgupta, 2012). The AQS (Waters, 1987) and its derivatives (Pederson et al., 1990) are established instruments for measuring levels of attachment between mother and child (Davis & Michelle, 2011; Pittman et al., 2009; van Ijzendoorn, 1995). In addition, conventional wisdom, supported by a host of outcomes research, supports the proposition that reductions in depression and anxiety over the course of treatment may be related to better outcomes, such as a lowered probability of relapse in abuse treatment programs (Grant et al., 2004; Hasin et al., 2002; Willinger et al., 2002).

In this case, the problem was that the 828 client records spanning 16 years had never been examined for evidence of anything. This study constitutes the first review and analysis of much hitherto untouched data.

Purpose of the Study

The purpose of this study was to investigate the SDCP data (that is, SBARC historical records spanning the years 1995 through 2010) for statistical evidence of

increased dyadic attachment, decreased maternal anxiety, and decreased maternal depression. (Without further research, any claims of SBARC program effectiveness would be premature.) Although most funding agencies look solely to program completion rates upon which to base their funding decisions, this study attempted to buttress SBARC's impressive program completion percentages and anecdotal reports of success with emergent analytical data.

In this study, I reviewed the newly digitized historical data of the SDCP that SBARC had collected about the 828 women who participated in their comprehensive substance abuse, mental health, and parenting program from 1995 through 2010. I examined the SDCP data through the theoretical lens of attachment with an eye to how three variables: dyadic attachment, maternal anxiety, and maternal depression changed as evidence of treatment efficacy. The SDCP data included evaluations of dyadic attachment, maternal anxiety, and maternal depression, which were measured both at the beginning of the SBARC program (at intake) and shortly before its conclusion (at discharge).

Limitations and Assumptions of the Study

Eight hundred twenty-eight women were treated at SBARC from 1995 through 2010. Only women with both complete case files and children in residence were included in this study. After excluding the case files of those women who did not fit the criteria, a total of 268 dyads were that formed the study sample ($N = 268$).

Ideally, for study purposes, the SBARC experience would remain the same throughout its existence. In the real world, however, that is rarely possible. The class offering varied from year to year as experience informed SBARC about the needs of the

resident population and as facilities changed. Furthermore, as expected, staff turnover occurred over the years. It is impossible to state with authority that any aspect of the SBARC treatment remained the same over 16 years. In fact, no institutional memory exists detailing precisely what instruction the first residents received. Luckily, every resident was evaluated for dyadic attachment, maternal depression, and maternal anxiety using the same test instruments, which are established instruments for measuring attachment: the Attachment Q-Sort (AQS) (Block, 1952, 1961) and its derivatives (Pederson, Gleason, Moran, & Bento, 1998; Pederson & Moran, 1995; Pederson, Moran, Sitko, et al., 1990; Waters, 1987; Waters, Garber, Gornall, & Vaughn, 1983); and the Functional Assessment Scale (FARS) (Ward & Dow, 1998). These test instruments are widely accepted as valid and reliable tools for measuring the strength of attachment between mother and child (Gravetter & Wallnau, 1991; Strayer, Verissimo, Vaughn, & Howes, 1995), maternal depression, and maternal anxiety. (For more information on these tests, see Test Instruments in Chapter III.) In addition, these tests are observational. Therefore, it is important to know that although the same clinician administered the tests for the most recent six years, the clinician varied during the previous nine years.

Each of the 268 dyads in this study received a treatment plan that was specifically designed for that mother-infant/child combination. As a result, we can make no representations about precisely what treatment any particular dyad received. However, because the treatment was tailored to the needs of that dyad, we can assume that the experience was generative. Similarly, we can make no representations concerning length of treatment, because each dyad was in residence at SBARC anywhere from a week or two to many months.

It is also important to remember that the population from which the study sample was drawn—and therefore the members of the study sample themselves—are very much a population at risk. These are women whose personal histories frequently include not just substance abuse and/or mental health issues, but also sexual, physical, and mental abuse of every sort. The client files for many of these women are heartbreaking. It is difficult to read of a 6-year old, so badly mutilated by a gang rape that she needed several reconstructive surgeries, or of an 8-year old whose virginity was sold by her mother for crack. These are the client details contained and hidden in the inches-thick accordion files that are reduced to dry facts in the SDCP dataset.

Each SDCP client data set included over 100 facts about each particular dyad. The vast data set "allowed for more comparisons than could reasonably be included in a single study" (Roznowski, Hong, & Reith, 2000). Therefore, I chose to examine variables for which quantitative data existed: dyadic attachment, maternal anxiety, and maternal depression.

Significance of the Study

Women who are positively attached with their children are more apt to be successful in their attempts to reenter society after treatment (Pederson et al., 1990). Martini et al. (2013) found that a growing body of research associated anxiety and depression with "adverse outcomes in mother and offspring (Andersson, Sundström-Poromaa, I., Wulff, M., Åström, M., & Bixo, 2004; Deave, Heron, Evans, & Emond, 2008; Mauri et al., 2010; Skouteris, Wertheim, Rallis, Milgrom, & Paxton, 2009)" p. 2. Furthermore, as Martini et al. (2013) assert:

> Schechter and Wilheim (2009), Feldman et al. (2009), Glasheen, Richardson, and Fabio (2010), O'Connor, Heron, Golding, Beveridge, and Glover (2002), Weinberg and Tronick (1998), and Hirshfeld et al. (1992) suggest a link between maternal anxiety and early adversities in the offspring (e.g., behavioral inhibition, mother-infant-interaction problems, insecure attachment) that are discussed to be early risk factors for later adverse child development. (p. 3)

Simply put, these and other studies have found that increased dyadic attachment is good and too much maternal anxiety and maternal depression are bad. (See Chapter II, Review of the Literature, for more information on literature associated with dyadic attachment, maternal depression, and maternal anxiety.) This study is significant in that the presence of such an inverse link would suggest that strengthening dyadic attachment might be of enormous benefit to this generation and the next (Pederson et al., 1990).

A preponderance of behavioral and psychological developmental research, such as that done by Cain and Fast (1972), Cassidy (1988), Grossmann, Grossmann, and Waters (2005), Sagi et al. (1995), Waters (1987), and Waters, Merrick, Treboux, Crowell, and Albersheim (2000), has long established correlations between early childhood interactions in the mother-infant/child dyad and later behavioral, developmental, and mental health issues for the child (Gray, 2011; Greco, 2010; Somech & Elizur, 2012; Sonthalia & Dasgupta, 2012). In addition, a host of outcome research studies, including Christophe, Dupoux, and Mehler (1994), Conners, Grant, Crone, and Whiteside-Mansell (2006), Dodge, Sindelar, and Sinha (2005), and Rounsaville, Weissman, Kleber, and Wilber (1982), support the proposition that reductions in maternal depression and maternal anxiety over the course of treatment may result in better outcomes in general

(Grant et al., 2004; Hasin et al., 2002; Willinger et al., 2002), and may lower the probability of relapse in substance abuse treatment programs in particular (Carroll, Power, Bryant, & Rounsaville, 1993; Dodge et al., 2005; Forsyth, Parker, & Finlay, 2003; Guydish, Sorensen, et al., 1999; Guydish, Werdegar, Sorensen, Clark, & Acampora, 1998; Marlatt & Gordon, 1985; Wolpe & Abrams, 1991). Clearly, an increase in dyadic attachment is desirable, as are decreases in maternal anxiety and maternal depression.

Research Summary

In this study, I explored how maternal depression and maternal anxiety affected dyadic attachment as measured at discharge from SBARC. To do this, I examined SBARC's newly organized historical data (years 1995 through 2010) for evidence of change in mean degree of dyadic attachment experienced by 268 discrete mother-infant/child dyads in residence at SBARC. Similarly, I analyzed the mean levels of maternal anxiety and maternal depression measured at intake and discharge for each of the 268 women. I also examined the data to determine if dyadic attachment were to change, would maternal depression or maternal anxiety change inversely. Finally, if positive change occurred (dyadic attachment strengthened and maternal depression and maternal anxiety lessened) more research would be necessary to make any claims of program effectiveness.

This nonexperimental, retrospective explanatory study (Johnson, 2001; Johnson & Christensen, 2014) employed two statistical analyses. The first analysis was a multivariate analysis of variance (MANOVA) in a two-group intake/discharge comparison design (Creswell, 2009; Gall, Gall, & Borg, 2007; Gay, Mills, & Airasian,

2012) that measured significance in overall mean score among the various combinations of the three variables—dyadic attachment, maternal anxiety, and maternal depression—as a result of the SBARC experience. This procedure enabled partial eta squared values to report effect sizes. A key incentive for using MANOVA was to determine whether "there are significant differences in a set of two or more dependent variables [called *criterion* variables by Belli (2009)] across two or more groups formed by one or more categorical independent variables [called *predictor* variables by Belli (2009)]" (Swanson & Holton, 2005, p. 133). (See Chapter III, Methodology, for specific information on this study design.) The second analysis employed a univariate analysis of variance (ANOVA *F* test) wherever the results of the MANOVA analysis showed significant differences as a way to discover if significant differences existed in each of the three individual dependent variables from intake to time of discharge.

By using two data analyses, I was able to show statistically significant differences among the multivariate interactions of these variables (MANOVA) and, subsequently, show the individual significance of each of the three treatment variables.

Research Questions

This study reviewed 16 years of historical data collected about women who underwent a comprehensive substance abuse and mental health treatment program at SBARC from 1995 through 2010. Intake and discharge assessments (Pederson et al., 1990; Waters, 1987) of levels of dyadic attachment were analyzed to measure changes. Intake and discharge assessments using the Functional Assessment Rating Scales (FARS) (Ward & Dow, 1998) were used to assess changes in levels of maternal anxiety. Intake

and discharge assessment using the FARS (Ward & Dow, 1998) were also used to measure changes in levels of maternal depression.

As suggested by Johnson (2001), the specific research questions (RQn) for this study were both descriptive and predictive:

RQ1. What was the relationship among dyadic attachment, maternal depression, and maternal anxiety? (Descriptive)

RQ2. What effect did dyadic attachment have on maternal anxiety and maternal depression at time of discharge from SBARC? (Descriptive)

RQ3. Does an increase in dyadic attachment predict a decrease in maternal anxiety and maternal depression at discharge? (Predictive)

Furthermore, Johnson and Christensen (2014) suggested that the overarching research question for this type of retrospective explanatory research must always be "Does the relationship we predict really exist?" (p. 82).

Organization of This Dissertation

Chapter II is a review of the literature that is pertinent to this study.

Chapter III describes the methodology used to analyze the data from this study.

Chapter IV presents the research results. This chapter concludes by answering the research questions.

Chapter V discusses the implications of the study and provides recommendations for future research.

CHAPTER II: REVIEW OF THE LITERATURE

To compile this literature review, I employed a comprehensive search of both seminal texts and online resources. I gave special attention to original writings of Bowlby and Ainsworth with respect to the underlying theory and influence of attachment theory and its relationship to the preponderance of theoretical and research literature that followed. I made extensive use of a host of online databases to locate pertinent information from peer-reviewed journals, articles from reputable research journals, and statistical and factual information from well-established web sites. For example, I used the Substance Abuse and Mental Health Services Administration website (SAMHSA.org) and the National Institute on Drug Abuse website (NIDA.gov) extensively to supplement and help elaborate on related topics in this literature review.

The core topics of attachment theory, depression, and anxiety could easily yield an overwhelming flood of information. Therefore, to maintain forward progress, I used a variety of research techniques such as reference chaining, which proved to be an efficient technique for identifying and organizing the essential threads of the topics.

To conduct extensive searches of the literature, I used the following keywords: attachment theory, attachment theory AND depression, attachment theory AND anxiety, women's substance abuse, women AND children AND residential substance abuse treatment, and the like.

Organization of This Chapter

The literature review begins with a description of two previous studies undertaken at SBARC and follows with an overview of residential treatment and the special circumstances that affect women with children. Although it is very common for women

who suffer from co-occurring disorders to be pregnant or to have young children, it is most uncommon for such women to pursue treatment for their co-occurring disorders in a residential setting without having to separate from their children. This group of relatively young, troubled women makes up the population of SBARC.

Following that is an exploration of the various aspects of attachment theory, including its surprising foundational genesis. By examining various theories and themes, Bowlby's creation of attachment theory emerges as an amalgam of such theories as control systems (McCulloch, 1965; Miller, Galanter, & Pribram, 1986; Von Bertalanffy, 1972), cybernetics (Bateson, 1971, 2000; Monk, 1997; Schwartz, 2007), and ethology (Harlow, 1959; Lorenz, 1950, 2003) that also embrace certain constructivist ideas (Miller, 2011; Shanmugam, Jowett, & Meyer, 2011).

This literature review mirrors my own investigation of attachment theory and its possible association with anxiety and depression. Consequently, it begins by describing a number of studies in which attachment measures are associated with levels of anxiety and depression. Over time, I examined the associations among dyadic attachment, maternal anxiety, and maternal depression, either directly or tangentially, in a variety of subject populations. As a result, the literature review also describes studies that involve such associations. Then, I explored the literature associated with the variety of psychometric tests that purport to measure attachment. These psychometric tests are related to the Mother-Infant Interaction Scale and the Mother-Child Interaction Scale (Pederson et al., 1990; Waters, 1987) used by SBARC in this study.

This literature review concludes with an exploration of nonexperimental quantitative research and situates this study within that body of literature.

Previous Studies at SBARC

The Susan B. Anthony Recovery Center (SBARC) has been the subject of two studies. The first (Sowers, Ellis, Washington, & Currant, 2002) analyzed treatment outcomes for 41 women who participated in a detoxification program and then were sent to SBARC for residential treatment or to a day treatment program. The study found that SBARC participants had better outcomes for three psychosocial variables: abstinence, arrest, and employment. The study also showed that SBARC participants had significant improvements on their total functional rating scores and overall customer satisfaction.

Much more recently, an applied clinical project (Winer, 2012) demonstrated that solution-focused group therapy sessions provided a strength-based family support program, which enhanced support for the women in treatment.

Co-occurring Disorder Treatment

A large scale SAMHSA study (Covington, Burke, Keaton, & Norcott, 2008) that focused on trauma- and gender-informed treatment programs for women in drug treatment, found that 55% to 99% of women with co-occurring disorders "have experienced trauma from abuse and that abused women tend to engage in self-destructive behaviors" (p. 387). This study also found that in 2006, 22.2 million individuals in the United States were classified as having a substance abuse or depressive disorder (that is, co-occurring) over the preceding year. In the same period, more than 6 million women age 18 or older met the criteria. Furthermore, Moggi, Ouimette, Moos, and Finney (1999) found that women in treatment for co-occurring disorders have among the poorest outcomes.

Research on women in treatment indicates that women are more likely than men to experience stressors, such as histories of maltreatment, mood, affective disorders, and relationship difficulties (Colman & Widom, 2004); personality disturbances (Tong, Oates, & McDowell, 1987; Wekerle & Wolfe, 2003), post-traumatic stress disorder (Schaaf & McCanne, 1998), and sexual problems (Beitchman et al., 1992; Wolfe, Wekerle, Scott, Straatman, & Grasley, 2004).

Over the years, there have been substantial barriers for women seeking treatment for co-occurring disorders. At a fundamental level, many practitioners refuse to work with clients who are actively using substances (Grella, 2003). Others have noted a bias among treatment providers that any focus on mental health issues would detract from substance abuse treatment (Osher & Drake, 1996). Another inhibiter to treatment is a lingering stigma associated with the combination of substance abuse and mental health issues (Grella & Young, 1998). In some cases, the practitioner's fear is that uncovering trauma might drive the client from sobriety and, therefore, opts to address trauma after the client has achieved 6 to 12 months of recovery. As a consequence, individuals are often not referred for mental health services until after they have completed substance abuse treatment (Kieke, Moroz, & Gort, 2007). These biases against—and inhibitors regarding—the dually diagnosed client frequently leave women seeking treatment in an unenviable position, even though a substantial body of research clearly links substance abuse with mental health issues (Brown, Read, & Kahler, 2003; Najavits, Weiss, & Shaw, 1997).

Victimization, Traumatization, and Substance Abuse

Treatment research demonstrates that there exist strong links between either victimization or traumatization in women and the propensity to abuse substances (Grella, 2003; Najavits et al., 1997). In contrast to the holistic approach toward co-occurring treatment offered at SBARC, a key limitation of many treatment programs for women is that they have a single focus (Najavits, 2004). Moggi et al. (1999) demonstrated that patients undergoing treatment for co-occurring disorders fared better when their psychological problems were dealt with directly during their substance abuse treatment. In a similar vein, Cocozza et al. (2005) found that trauma counseling for women is most effective when combined with substance abuse treatment.

Trauma associated with childhood sexual abuse is oftentimes a factor for women seeking treatment for substance use disorder (SUD). Strong empirical support suggests that women with histories of sexual abuse are more likely to suffer from SUD (Najavits, Weiss, & Shaw, 1999). One study in particular (Molnar, Buka, & Kessler, 2001) found strong support for the relationship between childhood sexual abuse and SUD.

Incarceration

The Department of Corrections (DOC) refers many women to SBARC when they are pregnant. In other instances, DOC refers women to SBARC so that they can be reunited with their children while they complete their sentences (M. L. Currant, personal communication, July 10, 2010). Studies have shown that incarcerated women frequently display the cumulative effects of sexual abuse and its attendant trauma by experiencing measurably elevated levels of emotional distress, atypical physical ailments, and ongoing patterns of substance abuse (Jordan, 2004; Jordan et al., 2002; Messina & Grella, 2006).

In addition, incarcerated women are more likely than are their male counterparts to report a history of victimization (Lewis, 2006). Studies by Chesney-Lind and Pasko (2013) and by McDaniels-Wilson and Belknap (2008) echoed Lewis's work in that both studies found that women enter prison with histories of prior trauma and abuse more frequently than do their male counterparts.

Roe-Sepowitz, Bedard, Pate, and Hedberg (2014) noted that "frequently women enter prison with problems that remain untreated during their incarceration, which leaves them profoundly unprepared to reenter their communities" (p. 191). Chesney-Lind and Pasko (2013), Kessler et al. (1995), Lewis (2006), and Zlotnick et al. (2003) believe that the mental health problems suffered by incarcerated women, which often include posttraumatic stress disorder, SUD, and longstanding emotional, sexual, or physical abuse, result from lifelong histories of abuse.

Addiction

Research has established the efficacy of gender-specific treatment for substance abusing and dependent women (Covington, 1999; Covington & Bloom, 2007; Keil & Haughton, 2007; Nelson-Zlupko, Kauffman, & Dore, 1995). The paths that women take to addiction oftentimes differ from their male counterparts in that although women require proportionally smaller quantities of substances, they progress more rapidly to addiction than do men (Grella, 1996). Women are also distinguished from men in substance abuse in that women report higher incidences of anxiety, depression, and other psychiatric disorders (Benishek, Bieschke, Stöffelmayr, Mavis, & Humphreys, 1992). An additional burden for many substance-abusing women is that incidences of rape and sexual assault are often part of their histories (Hanke & Faupel, 1993).

Addicted women also feel a great sense of guilt and shame related to their drug abuse and its impact on their families (Rosenbaum, 1979). Colten (1982) found that addicted women sometimes rationalize their substance abuse as acceptable mothering practices and believe that "staying clean while pregnant indicated . . . that they were good mothers" (p. 357). Furthermore, they tended to rationalize drugs as a way of coping with stress: "The drugs were not used to 'party,' but to maintain emotional control and physical well-being to effectively function for their children" (p. 358).

Gilbert et al. (2006) estimated that between 25% and 57% of women in treatment have been victims of intimate partner violence (IPV). Overall, women enter treatment with more co-occurring problems than men, including higher rates of mental health, family, and child-care problems (Marsh, Cao, & D'Aunno, 2004). Ongoing research indicates a strong association between substance abuse and IPV (Clark & Foy, 2000; Easton, 2006). Research also indicates that women who have a history of IPV enter treatment with multiple, complex problems that stem from the trauma and isolation that is common in abusive relationships (Gilbert et al., 2006), which further bolsters arguments for gender-specific treatment programs.

Estimates of post-traumatic stress disorder (PTSD) associated with IPV for women in substance abuse treatment run as high as 64%, compared to estimates of from 1% to 12% of non-substance-abusing women in the general population (Golding, 1999). Encouragingly enough, Golding (1999) concluded that "a majority of studies reviewed found that neither physical nor sexual abuse is predictive of change in substance abuse from pre- to post-treatment" (p. 552). Similarly, a study by Pirard, Sharon, Kang, Angarita, and Gastfriend (2005) comparing outcomes for women clients in substance

abuse treatment with and without histories of physical or sexual abuse found no differences in outcomes at a follow up one year after treatment.

Theoretical Framework: Attachment Theory

Attachment is a deep and enduring emotional bond that connects one person to another across time and space (Bowlby, 1982). Freud believed that attachment in infancy to someone who provides support, protection, and care constitutes a genuine love relationship (Ainsworth & Bowlby, 1991; Freud & Gay, 1989). This belief, which Freud's warm relationships with his own children makes easy to imagine (Freud, 1958; Young-Bruehl, 2008), is the basis of modern attachment theory.

According to Ainsworth and Bowlby (1991), attachment theory is the joint work of John Bowlby and Mary Ainsworth. John Bowlby (1907–1990), a British psycho-analyst, developed the basic tenets of attachment theory by drawing on concepts from many different disciplines, including ethology, cybernetics, information processing, developmental psychology, and psychoanalysis (Bretherton, 1992). Bowlby's colleague, Mary Ainsworth (1913–1999), operationalized Bowlby's theory by creating innovative methodologies that not only made it possible to test some of Bowlby's ideas empirically, but also helped expand the theory itself (Bretherton, 1992). (For more information on Mary Ainsworth and her work, see Mary Ainsworth (1903–1999) in this section.)

John Bowlby (1907–1990)

John Bowlby (1958) theorized that the distress that biologists had observed in infants of other mammalian species when they were separated from their parents (for example, crying, searching for the parent) could be applied to humans. Furthermore, he speculated that these behaviors, which he called attachment behaviors, might serve an

evolutionary function, in that proximity to the parent, or attachment figure, frequently made the difference in whether an infant survived to adulthood. Bowlby called this system of potentially lifesaving behaviors the attachment behavioral system. Conceptually, according to Fraley (2002), the attachment behavior system links ethological models of human development with modern theories of how emotions are regulated and how personalities are developed. In fact, Waters and Deane (1985) believed that the cornerstone of Bowlby's attachment theory actually replaced psychoanalytic drive reductions theory with a control system analysis.

Bowlby's thinking was considered revolutionary for its time because "on the basis of ethological evidence, he was able to reject the dominant 'cupboard love' theory of attachment prevailing in psychoanalysis and learning theory of the 1940s and 1950s" (van der Horst, van der Veer, & van Ijzendoorn, 2007, p. 332). Although Waters and Deane (1985) concurred with Freud's view of the mother-child relationship as one of love, they also recognized that attachment closely tracks patterns of behavior toward caregivers and that "this behavior is complexly organized, goal-corrected, and sensitive to input from the environment" (p. 41). Bowlby profoundly changed how we view the mother-child relationship today (Bretherton, 1992).

Elaborating further on this change, Waters, Hamilton, and Weinfield (2000) claimed that the real significance of Bowlby's work was that he "hypothesized that early relationship experience with the primary caregiver leads eventually to generalized expectations about the self, others, and the world" (p. 678). Bowlby (1973), Bretherton,

Ridgeway, and Cassidy (1990), and Oppenheim and Waters (1995) all confirmed that relationships emerge early in infant development and continue to evolve with attachment-related experiences during childhood and adolescence.

Security theory, as explained by Blatz (1940), posited that before infants and young children can face unfamiliar situations successfully, they need to develop a secure dependence on parents or caregivers. He coined the term *immature dependent security* to describe how infants and small children rely on their parent figure to take care of them and to be responsible for the consequences of their behavior. Echoing and expanding on this, Ainsworth and Bowlby (1991) wrote:

> If and when children become uneasy or frightened while exploring, they are nevertheless secure if they can retreat to a parent figure, confident they will receive comfort and reassurance. Thus, the parent's availability provides the child with a secure base from which to explore and learn. (p. 334)

With the secure base provided by the parent, Blatz (1940) conceptualized how the young child experiences the "thrill of insecurity, and he has overcome this insecurity through his own efforts. We may say that the child has achieved security through the acquisition of a skill . . . " (p. 185).

John Bowlby's magnum opus was three volumes (Bowlby, 1973, 1980, 1982) devoted to the many facets of attachment theory. Bowlby originally envisioned a single volume devoted to observations he made about how children respond to the temporary loss of their mother.

> However, as Bowlby noted in his second edition of Volume I (Bowlby, 1982): Events were to prove otherwise. As my study of theory progressed it was gradually borne in upon me that the field I had set out to plough so lightheartedly was no less than one that Freud had started tilling sixty years earlier, and that it contained all the same rocky excrescences and thorny entanglements that he had grappled with—love and hate, anxiety and defen[s]e, attachment and loss. (p. xxvii)

Attachment and Loss Volume 1: Attachment (Bowlby, 1982) is a 475-page detailed explanation of the origins of attachment theory. The second installment in the trilogy, *Attachment and Loss Volume 2: Separation: Anxiety and Anger* (Bowlby, 1973), expounds over 475 pages on themes introduced in Volume 1 and provides a detailed treatment of sources of security, anxiety, and distress and how these relate to the phenomenon of attachment. As Bretherton (1992) notes: "Bowlby (1973) revises Freud's theory of signal anxiety, lays out a new approach to Freud's motivational theories, and presents an epigenetic model of personality inspired by Waddington's theory of developmental pathways" (p. 767).

The last and final installment of the trilogy, *Attachment and Loss Volume 3: Loss: Sadness and Depression* (Bowlby, 1980), begins by situating mourning in the literature and then provides detailed descriptions of associations between attachment, loss, and depression in children and adults, which manifest as a consequence of loss. In this final volume, according to Bretherton (1992):

> [Bowlby] uses information processing theories to explain the increasing stability of internal working models as well as their defensive distortion. The stability of

> internal working models derives from two sources: (a) patterns of interacting grow less accessible to awareness as they become habitual and automatic, and (b) dyadic patterns of relating are more resistant to change than individual patterns because of reciprocal expectancies. (pp. 767-768)

In developing attachment theory, Waters, Crowell, Elliott, Corcoran, and Treboux (2002) assert that Bowlby created a true amalgam drawing from a variety of sources:

> [He] replaced Freud's drive reduction model of relationship motivation with one that emphasized the role relationship plays in support of exploration and competence. He also introduced concepts from control systems theory [(Monk, 1997)] to highlight and account for the complex monitoring of internal states, relationship experience, and context that shapes proximity seeking, communication across distance, and exploration away from the attachment figures. (p. 230)

Mary Ainsworth (1913–1999)

Mary Ainsworth provided empirical support for Bowlby's attachment theory (Ainsworth, Blehar, Waters, & Wall, 1978). In addition, she expanded attachment theory by contributing the concept of the attachment figure as a secure base from which an infant can explore the world (Bretherton, 1992).

Ainsworth studied under Blatz at the University of Toronto and responded enthusiastically when Blatz suggested she base her doctoral dissertation on his security theory (Ainsworth & Bowlby, 1991). In her dissertation, *An Evaluation of Adjustment Based upon the Concept of Security*, Mary Salter [Ainsworth] (1940) elaborated on the importance of security in the parenting relationship when she said, "Where familial

security is lacking, the individual is handicapped by the lack of what might be called a secure base from which to work" (p. 48).

In 1967, Ainsworth published the first observational study of secure base behavior, Infancy in Uganda: Infant Care and the Growth of Love. She followed with a longitudinal observation study of mother-infant interaction and secure-base behavior in Baltimore (Ainsworth & Bell, 1969; Ainsworth et al., 1978; Bell & Ainsworth, 1972). In addition, she formulated the concept of maternal sensitivity to infant signals and its role in the development of infant-mother attachment patterns (Bretherton, 1992).

This idea of the *secure base* dovetailed with the Bowlby and Ainsworth (1951) notion that to grow up mentally healthy, "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (p. 13). Bowlby emphasized the role of social networks, economic, and health factors in the development of strong mother-child relationships. Bowlby and Ainsworth (1951) asserted the critical role of parenting in this regard, saying:

> Just as children are absolutely dependent on their parents for sustenance, so in all but the most primitive communities, are parents, especially their mothers, dependent on a greater society for economic provision. If a community values its children it must cherish their parents. (p. 84)

Bretherton (1992) lamented that "[Bowlby's] call to society to provide support for parents is still not heeded today"(p. 759). Bowlby's belief that parents (and especially mothers) deserve the support of society is particularly pertinent today in that funding for

women's treatment centers and many charitable institutions that treat women and children face unsustainable cutbacks.

Attachment Analogy in MRI: Different Branches, Common Roots

Bowlby adapted concepts from systems theory and notions of the role of the relationship within the mother-child dyad in much the same way that Jackson and Haley (1963) did in the early conceptualization of the MRI approach. Like attachment theory, the theoretical underpinnings of MRI wed psychoanalytic (Freudian) concepts with theories from other disciplines, including relationships, context, and environment, to form a better understanding of what might be happening in the real world. Late in his career, Bowlby (1985) succinctly described both attachment theory and his world view: "I have always held the view that the internal world is a reflection of the external world and there is a constant interaction—you can't understand one without the other" (p. 20).

Attachment Patterns of Behavior

Bowlby credits Ainsworth with expanding the concepts of attachment theory and innovating empirical testing of those concepts (Bowlby, 1988). The groundbreaking Uganda infant studies (Ainsworth, 1967) and the Baltimore Study that provided replication research of the Uganda study (Ainsworth & Wittig, 1969), provided the initial extensive field observations of attachment behaviors.

Table 1 lists the four attachment patterns identified and described through empirical research. The first three patterns—*Secure, Ambivalent Resistant,* and *Avoidant*—were described in Ainsworth et al. (1971) and Piaget and Inhelder (1956). The last pattern—*Disorganized*—was identified, empirically measured, and added to the research some years later (Main & Solomon, 1986).

Table 1

Child and Caregiver Patterns of Behavior before the Age of 18 Months (Ainsworth et al., 1978; Main & Solomon, 1986)

Attachment Pattern	Child	Caregiver
Secure	Child relies on caregiver to provide a secure base from which to explore. Child will protest departure of caregiver and seek proximity and comfort upon caregiver's return, then return to exploring. Child may seek comfort from stranger but shows preference for caregiver.	Caregiver responds promptly and appropriately to child's needs. Indication that caregiver has successfully created a secure attachment to the child.
Ambivalent/ Resistant	Child not able to use caregiver as a secure base; seeks proximity before separation occurs. Child demonstrates ambivalence, anger, or reluctance to warm to caregiver. Will not explore on return of caregiver. Child is preoccupied with caregiver's availability; seeks contact but resists with anger when contact is achieved. Stranger has difficulty calming child. The child frequently feels anxious because of inconsistent availability of caregiver.	Caregiver is inconsistent in attending to child, oftentimes vacillating between appropriate and neglectful levels of response.
Avoidant	Child demonstrates little or no affective sharing with caregiver during play. Little or no distress on caregiver departure or return. Child will ignore or turn away from caregiver and make no effort to maintain contact if picked up. Treats the stranger and the caregiver similarly.	Caregiver provides little or no response to child in distress. Caregiver discourages crying and encourages independence.
Disorganized	Child demonstrates stereotyped behavior, such as freezing in place or rhythmic rocking, on return of caregiver. Child reveals the lack of coherent attachment strategy by contradictory, disoriented behaviors such as approaching caregiver but with back turned.	Caregiver withdraws or reacts negatively to the child. Often, there is role confusion, communication errors, and maltreatment. This pattern is associated with many forms of child abuse.

Ainsworth et al. (1978) make a distinction between attachment theory—the "bond, tie, or enduring relationship between a young child and his [caregiver]" (p. 17)—and attachment behaviors, ". . . through which such a bond first becomes formed and later serves to mediate the relationship" (p. 17). Ainsworth et al. (1978), Pederson et al. (1990, 1995), and Waters (1987) identify and classify attachment behaviors using various measurement instruments, such as the Mother-Infant/Child Interaction Scales (which SBARC uses) to determine the type and relative strength of dyadic attachment.

As Prior and Glaser (2006) noted, "Quantitative terms such as 'strong', 'intense' or 'weak' are not appropriate terminology in attachment theory and were very rarely used by Bowlby and Ainsworth. Instead, attachments are described and classified by their qualitative characteristics" (p. 24). The attachment patterns are classified as *organized* and *disorganized* and are a measure of the child's "strategy for gaining [organized] proximity of an attachment figure when the attachment behavioral system is activated, or the lack of collapse [disorganized] of such a strategy" (p. 24). According to Carlson (1988), disorganized attachment is associated with a number of developmental problems, including dissociation in adolescence. Lyons-Ruth (1996) and Lyons-Ruth, Alpern, and Repacholi (1993) found that disorganized attachment is also associated with anxiety, depression and other behavioral problems in childhood.

A review of the results of three meta-analyses by Levy, Ellison, Scott, and Bernecker (2011) examined the associations between attachment anxiety, avoidance, and security and psychotherapy outcome. This synthesis of 14 studies included 19 separate therapy cohorts with a combined sample size of 1,467. It contains an excellent and detailed discussion of findings and related research on the link between attachment and

the therapeutic relationship. It concluded that "Attachment theory, developed by Bowlby to explain human bonding, has profound implications for conducting and adapting psychotherapy" (p. 193).

Sroufe and Waters (1977) define attachment in the caregiver-child dyad as:

> An affective tie between infant and caregiver to a behavioral system, flexibly operating in terms of set goals, mediated by feeling, and interaction with other behavioral systems. In this view, behavior is predictably influenced by context rather than constant across situations. (p. 1185)

Turner and Bruner (1986) describe the internal working model of attachment as "conscious and/or unconscious rules for the organization of information relevant to the attachment and for obtaining or limiting access to that information, that is, to information regarding attachment-related experiences, feelings, and ideations" (pp. 66-67).

According to Waters (n.d.), "It was important to establish that infant attachment behavior is context sensitive and goal corrected in ways that only a control system model can explain" (p. 1). Ainsworth et al. (1978) developed a technique called the strange situation, which was, according to Fraley (2002), "a laboratory paradigm for studying infant-parent attachment" (p. 2). Ainsworth, Bell, and Stayton (1971) claimed that strange situation classifications could only be as valid as the classifications of the secure base behavior on which they are based. As a result, when Vaughn and Waters (1990) were able to replicate the relationship between strange-situation classifications and secure-base behavior, it, according to Waters (n.d.), "illustrated a method that can be used to test the validity of Strange Situation classifications across age, cultures, and in clinical

populations" (p. 1). In 1985, Waters adapted Block's 1961 test, called the Q-set (Block, 1961), to do just that. Waters called his test the Attachment Q-Set (AQS) (Waters & Deane, 1985). "The AQS can be seen as a valuable instrument for cross-cultural studies of mother-child relationships" (Strayer et al., 1995). (See the Q-set subsection in the Test Instruments section for more information on the Q-set.)

A 20-year longitudinal study (Waters, Merrick, et al., 2000) followed the experiences of 60 white middle-class infants seen in the Ainsworth strange situation at 12 months of age. Fifty infants from the original population (21 males, 29 females) were assessed 20 years later using the Berkeley Adult Attachment Interview (AAI) (George et al., 1985). The results of this study support Bowlby's original hypothesis:

> [I]ndividual differences in attachment security can be stable across significant portions of the lifespan and yet remain open to revision in light of experience. [The authors caution however that] The task now is to use a variety of research designs, measurement strategies, and study intervals to clarify the mechanisms underlying stability and change. (Waters, Merrick, et al., 2000, p. 684)

Obsessive Compulsive Disorder (OCD)—considered an anxiety disorder (APA, 2000)—was the focus of a study by Doron, Moulding, Kyrios, Nedeljkovic, and Mikulincer (2009) that used a student sample ($N = 446$) to examine the maladaptive beliefs associated with OCD, such as an inflated sense of responsibility and perfectionism. The study focused on the factors that led to these beliefs by examining how adult attachment orientations relate to OCD-related cognitions and OCD symptoms while controlling for depression.

Doron et al. (2009) also found that adult attachment insecurities are related to OCD in that:

> Attachment insecurities (either anxiety or avoidance) predicted dysfunctional OCD-related cognitions and OCD symptoms. Moreover, the contribution of attachment anxiety and avoidance to OCD symptoms was fully mediated by OCD-related beliefs, and remained significant, with the effect of attachment anxiety on OCD symptoms being somewhat larger than the effects of attachment avoidance. (p. 1039)

Echoing these research findings of Waters (n.d.), Doron et al. (2009) found that their findings also supported the idea that results of these and similar studies generalize across gender and cultures of origin.

Attachment and Infants

One hundred twenty-nine Dutch 15-month-old infants were assessed for attachment security using the AQS (Waters, 1987) and a short version of the Strange Situation Survey (SSS) (Ainsworth et al., 1978) in a study conducted by Kersten-Alvarez et al. in 2012. According to the results from the SSS, secure infants had significantly higher AQS scores than insecure infants and, especially, had higher AQS scores than disorganized infants who were described as "significantly more noncompliant, fussy, and angry relative to secure infants" (p. 175). The study concluded by indicating that: "The apparently unfavorable set of characteristics associated with low AQS security scores suggests such scores to predict later developmental problems" (p. 175).

Attachment and Toddlers

Pallini and Laghi (2012) sought to develop and validate the Toddler Attention Questionnaire (TAQ) by measuring the relationship between attention and attachment to a professional caregiver in toddlers age 20 to 36 months. The study used the Italian Questionnaire on Temperament (Axia, 2002) to measure attentive processes in the toddlers and attachment behaviors were measured using the AQS (Block, 1961; Waters & Deane, 1985).

Attachment and Adolescents

Sonthalia and Dasgupta (2012) state that attachment is an established clinical measure for legally sanctioned evaluation of school-age children. Furthermore, according to Sonthalia and Dasgupta (2012), Bowlby's theoretical framework posited that caregivers have "predictable, common styles that impact a child's emotion regulation, social relatedness, capability for self-reflection, and overall neurological development" (p. 54).

Gray (2011) found that binge eating and obesity in adolescents has been correlated with relative measures of attachment. A study of 525 insecurely attached children who engaged in binge eating had higher Body Mass Index (BMI) scores at age 15 than their securely attached counterparts who did not engage in binge eating.

For a study of conduct problems (CP), 136 adolescent boys (median age = 15.2) were sampled from Israeli schools for a study that examined how relative adherance to an honor code might mediate the prediction of CP. The study measured levels of insecure attachment in the adolescents and found that the level of insecure attachment was

predictive of adherance to an honor code, but was not an independent predictor of CP (Somech & Elizur, 2012).

In Lake County, IL, a 2012 study examined the attachment levels of 70 adolescents who were recruited from a local detention center and were administered the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1984, 1985, 1996). The study investigated a sample of incarcerated juveniles to examine the mediating role that parent-child attachment might have in relationship with the adolescent being exposed to community violence, maltreatment, and symptoms of psychopathology (including anxiety and depression). Insecure attachment was linked with elevated levels of psychopathology (Kokubu, Okano, & Sugiyama, 2012).

A 30-year logitudinal study of a New Zealand birth cohort found that "increased rates of early anxiety/withdrawal were associated with increased risk of later anxiety and depression. Positive parent-child attachment in adolescents was associated with a decline in the risk of later anxiety and depression" (Jakobsen, Horwood, & Fergusson, 2011, p. 303).

Attachment and Gender Differences

In 2012, McLaughlin, Zeanah, Fox, and Nelson examined the relationship between the experiences of 136 Romanian girls and boys (ages 6 to 30 months) reared in institutions. The study posited that the inability of the child to form a secure attachment to a primary caregiver when placed in foster care might be associated with the higher rates of psychiatric disorders often measured in institutionally reared children. Attachment for all children was assessed at 42 months using the Strange Situation Procedure. Internalizing disorders were assessed for all children at 54 months using the

Preschool Age Psychiatric Assessment (Egger & Angold, 2004). The findings indicated that girls in foster care had fewer internalizing disorders than their control group. However, foster care had no measureable effect on the boys in terms of ameliorating internalizing disorders. Girls in foster care, when measured at 42 months, were more likely to have secure attachment relations than girls in the control group. Boys in foster care, on the other hand, had no difference in observed attachment relationships than boys in the control group. The study had two key conclusions: first, a secure attachment relationship in both sexes was predictive of lower rates of internalized disorders in both sexes; second,

> [t]he differential effects of [foster care] on attachment security in boys and girls explained gender differences in the intervention effects on psychopathology. Findings provide evidence for the critical role of disrupted attachment in the etiology of internalizing disorders in children exposed to institutionalization. (McLaughlin et al., 2012, p. 46)

Attachment-Based Family Therapy

Attachment-Based Family Therapy (ABFT) is a brief (12 to 16 weeks) empirically based treatment intervention for working with depressed and anxious adolescents (Diamond, G. S., 2005; Diamond, G. S., Reis, Diamond, Siqueland, & Isaacs, 2002). It is based on the structural family therapy tradition (Minuchin, 1974), informed by Multidimentional Family Therapy (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009), and blends attachment theory and developmental research (Shpigel, Diamond, & Diamond, 2012). One significant finding from this study (Shpigel et al., 2012) was that "decreases in adolescents' perceived parental control during treatment were associated

with reductions in adolescents' depressive symptoms from pretreatment to 12 weeks posttreatment" (p. 271).

By 2009, three clinical trials had tested the ABFT model and found it effective in treating adolescents with suicidal ideations as well as depression and anxiety (Diamond, G. S., Wintersteen, et al., 2009).

In 2012, Shpigel, Diamond, and Diamond reported that in a test of 18 suicidal adolescents and their mothers for 12 weeks of ABFT, "decreases in adolescents' perceived parental control during the treatment were associated with reductions in adolescents' depressive symptoms from pretreatment to 12 weeks posttreatment. This [was] the first study examining the putative change mechanisms in ABFT" (p. 271).

Finally, G. S. Diamond, Diamond, and Levy (2014) added a case study illustrative of the context of adolescent depression to their previous work with ABFT. Interestingly, J. Curry (2014) stated, "Research over the past 3 decades has shown that psychotherapy can successfully address adolescent depression. Cognitive behavioral models have been most extensively and rigorously tested, with evidence also supporting interpersonal psychotherapy and attachment-based family therapy" (p. 510).

Dyads and Attachment

In its own way, focusing empirical research on the mother-child dyad was a revolutionary notion—certainly in the face of the traditional Freudian psychoanalytical tradition—as was advancing theories of psychology, psychiatry, and psychotherapy that suggested we must look at the individual within the context of relationship to understand how change might be possible (Bateson, 2000; Bowen, 1978; Keeney, 1983).

Historically, Bowlby's focus on dyads bears a striking resemblance to the contributions Don Jackson made to the discipline of family therapy. Like Bowlby, Jackson, a classically trained psychoanalyst, crossed the Rubicon from a Freudian intrapsychic framework to a much expanded one in which context (Bateson, 1979; Ruesch & Bateson, 1951), relationships (Bateson & Donaldson, 1991; Watzlawick, Bavelas, & Jackson, 1967; Watzlawick, Weakland, & Fisch, 1974), transgenerational effects (Bowen, 1978; Kerr, M. E., & Bowen, 1988), and the influence of the analyst at facilitating change (Jackson & Haley, 1963) all might be part of the magic (de Shazer, 1994) that is the "talking cure" (Posada et al., 1999, p. 184). Although Jackson and Bowlby did not share the same influences, Bowlby's theoretical development from psychoanalysis to Ethology—a subdiscipline of zoology that focuses on the naturalistic study of animal behavior (Lorenz, 2003)—played a pivotal role in establishing attachment as a phenomenon that only made sense when studied as behaviors in context between a child and caregiver (McFarland et al., 2011).

Early in his career, Bowlby worked in training as a child psychoanalyst under Melanie Klein (van der Horst, 2011), the celebrated Freudian psychoanalyst who once said "analysis . . . is not concerned with the real world . . . It is concerned simply and solely with the imaginings of the childish mind" (Loper & Tuerk, 2011, pp. 376-377).

Late in life, according to Limke, Showers, and Zeigler-Hill (2010), Bowlby was still frustrated when he recounted a key moment in his training:

> One of his first patients was a young boy with many fears whom Bowlby was treating with play therapy. The boy was exceptionally anxious during one session and, after making some inquiries, Bowlby discovered that his mother had

> abandoned the son three days earlier. Bowlby, excited by this discovery, could not wait to tell Klein this important piece of information. (p. 43)

Bowlby had noticed earlier that when the mother brought the child—who was quite anxious and hyperactive—she also seemed very anxious and unhappy. Bowlby told Klein he wanted to speak with the mother to see if her anxiety and unhappiness might be related to that of her child. Klein dismissed Bowlby's theory (McFarland et al., 2011): "Dr. Bowlby," she said, "We are not concerned with reality, we are concerned only with the fantasy." Rambo and Hibel (2013) argue that Bowlby's fundamental disagreement with Klein "began his relational consideration of human development" (p. 4), which is a key tenet of the family therapy movement. While Klein believed that "all behavior was motivated by inner feelings or drives, Bowlby felt that external relationships, e.g., the way a parent treats a child, were important to consider in understanding the child's behavior" (McFarland et al., 2011, p. 20).

McLaughlin et al. (2012) examined a community sample of 763 mothers, 46% of whom rated their anxiety above the normal range. They found that mothers without a partner reported higher maternal anxiety (MA) than those with a partner. They took a subsample ($N = 98$) of mothers who were selected for low, medium, and high levels of anxiety and observed their young children (4 to 5 years old) for behavioral inhibition (BI) and attachment. Their analysis suggests, "a child with high BI may be particularly vulnerable to MA, resulting in an [a]mbivalent attachment" (p. 199).

Guttmann-Steinmetz, Shoshani, Farhan, Aliman, and Hirschberger (2012) compared a sample of 29 Palestinian mother-child dyads from the West Bank with 21 Israeli mother-child dyads to study the children's psychological symptoms—aggression

in particular—"in the context of family characteristics, exposure to political violence, and nationality" (p. 79). They found that nonsecure mothers suffered from higher levels of depression and anxiety when exposed to political violence. In addition, they found that the children's' symptoms correlated with the mothers' depression and anxiety.

M. A. Kerr (2012) assessed the mediating role that parenting and attachment security have on behavior in 51 mother-daughter dyads, where the daughters were ages 13 to 17. Of particular interest were outcomes in areas related to depression and disruptive behavior. Each mother-daughter dyad was surveyed two times at 12-month intervals. The study found that the mother's parenting practices fully mediated the connection between maternal depression and the daughter's disruptive behavior. They also found that parenting and attachment were predictive of the daughter's levels of depression at the first survey. The researchers next controlled for the influence of "the mothers' parenting, daughters' attachment, and daughters' outcomes" (p. 3) from the first survey. Finally, M. A. Kerr (2012) concluded that:

> These results suggest that maternal depression may in part impact on daughters' disruptive behaviour through its influence on mothers' parenting, which in turn helps to shape the daughters' attachment to their mothers. The fact that mothers' depressive symptoms also uniquely predict [the second survey] outcomes indicates that there might be more complex elements of the depression construct . . . that influence adolescent well-being in a more insidious manner. (p. 3)

Dyad attachment research has also been applied by Cort, Toth, Cerulli, and Rogosch (2011) to study intergenerational effects of multitype maltreatment (i.e., combinations of maltreatment such as, neglect, sexual, physical, and emotional abuse,

which manifest when the maltreated children become maltreating parents). As Cort et al. note, while much research has established a link to the intergenerational transmission of maltreatment, little or no research exists on the intergenerational transmission of multitype maltreatment. In this study, 104 mother-child dyads were examined to explore this phenomenon and found that the "mother's childhood multitype maltreatment directly predicted their children's multitype maltreatment" (p. 20).

A biologically oriented study conducted by Feldman, Gordon, and Zagoory-Sharon (2011) examined the relationship between the body's secretion of the neuropeptide oxytocin (OT)—in paternal and maternal plasma, urine, and saliva—and its relationship to attachment measures of the dyad to determine if oxytocin is implicated in the human bonding process. The researchers studied oxytocin levels of 112 mothers and fathers interacting with their 4- to 6-month-old infants. They found that plasma and saliva OT were associated with attachment relationships for both mother and father dyads. Urine OT was correlated with relationship anxiety and parenting stress only in the mothers. The suggestion is that OT is involved in human attachment. The conclusion was that "The dual role of oxytocin in stress and affiliation underscores its complex involvement in processes of social bonding throughout life" (p. 752).

A key tenet of attachment theory is the idea that early childhood care matters greatly in determining the quality of the child-caregiver attachment relationship (Posada et al., 1999): "Research findings indicate that the secure-base phenomenon is characteristic in children from different cultures and socio-economic contexts" (p. 4). They also show that rates of secure attachment are lower in families under stress than in families with lower levels of stress (Gravetter & Wallnau, 1991; Meites, Ingram, &

Siegle, 2012; Misri et al., 2010), and vary from culture to culture (Moss, Bureau, Cyr, & Dubois-Comtois, 2006; Newton, 2008; Pallini & Laghi, 2012).

Parenting Programs and Attachment

According to Scott (2012), the quality of parenting can have a considerable impact on a child's development and ongoing mental health as explicated by a review of recent literature on the relationships between the quality of parenting and a host of outcomes in the children. "Biological indices of stress, such as C-reactive protein, show that prenatal anxiety is a significant determinant of later outcomes for children, and abusive parenting of young children has lasting biological effects into adulthood" (Scott, 2012, p. 301). They also found research indicating that efficacy of parenting programs at increasing the security of the infant's attachment.

Hennessy, Deak, and Schiml-Webb (2010) examined the intergenerational transmission of attachment psychopathology by focusing on mother-child dyads, and by comparing and contrasting how the young mother related to her mother and her children. They discovered an "intergenerational pattern . . . [which is shown to improve with appropriate intervention]" (p. 292).

A longitudinal study conducted by Guttmann-Steinmetz et al. (2012) examined the attachment styles of a group of adults who as children were identified as *nonorganic failure to thrive* and received social work intervention and therapy. The study focused on assessing the internal working models of the individuals 20 years after the treatment and compared their adult attachment style with their childhood attachment to their mother. The study found that in some instances the internal working model demonstrated a change from an insecure to a secure attachment style. This study suggests that targeted

therapeutic interventions and “changes in life circumstances” (p. 179) may effect change in an individual’s internal working model.

Nylen, Moran, Franklin, and O'Hara (2006) examined postpartum depression and its effects on the mother-child relationship and concluded that infants of depressed mothers are reliably less securely attached and, therefore, “often have cognitive, emotional, and behavioral deficits that persist well into childhood” (p. 327).

Marriage and Family Therapy and Attachment

Attachment is an area of therapeutic study that is unfamiliar to many marriage and family therapists. A large body of literature, beginning with Ainsworth and Bowlby, and continuing today with the ongoing research of many devoted social scientists throughout the world, such as van Ijzendoorn and Waters, addresses aspects of the issues that were examined in this study.

Intrinsic to attachment is the implication that families and their wellbeing are important. This is demonstrated in the number of attachment books and articles that have been written about family issues. For example, in 2002, G. S. Diamond, Reis, G. M. Diamond, Siqueland, and Isaacs designed a 12-week treatment for adolescent depression using Attachment-Based Family Therapy (ABFT). G. S. Diamond adapted ABFT to working with depressed and anxious adolescents in 2005.

Most interesting to the present study was Parker, Tambling, and Campbell (2013), because it examined adult attachment as a mediator that explained “the association between dyadic adjustment and depressive symptoms” (p. 28) in 199 women and 35 men. The results showed a significant relationship between poor attachment and depression.

Anxiety, Depression, and Attachment

A study that related anxiety and depression to attachment in adults (Surcinelli, Rossi, Montebarocci, & Baldaro, 2010), assessed the attachment styles of 274 adult volunteers who were categorized into four groups—secure, preoccupied, fearful, and dismissing-avoidant—using the Bartholomew model (Puckering et al., 2011)—found that secure attachment was associated with better mental health, while insecure attachment was associated with higher levels of anxiety and depression.

A longitudinal study of 94 pregnant women who were assessed for antenatal anxiety and depression to see how it affected postpartum parenting stress found that antenatal anxiety and depression had a direct impact on postpartum parenting stress (Misri et al., 2010). In this study, the women were monitored during the third trimester of pregnancy and 3- and 6-month intervals postpartum. The findings indicated a direct relationship between measured levels of antenatal anxiety and depression and higher levels of parenting stress, which was not ameliorated by antenatal antidepressant therapy.

For information on anxiety and depression measurements, please see the Anxiety and Depression Measurements subsection in the Assessments section of this chapter.

It is estimated that 10% to 15% of new mothers experience maternal depression beyond two weeks postpartum (Onunaku, 2005). Depressed mothers have been shown to have lowered levels of responsiveness and more impaired levels of quality of care for their children when compared to their nondepressed counterparts (Barr, 2008;Gla, Fiori-Cowley, Hooper, & Cooper, 1996).

One important way maternal depressive symptoms affect development of children is by affecting the quality of mother-child interactions. Depressed mothers tend to

express fewer emotions, are more likely to show sad affect, are more intrusive, and are less involved in their interactions with infants. Depressed mothers speak less to infants and show more hostility to children. Children of depressed mothers interact differently with their mothers because children who experience maternal emotional unavailability and unresponsiveness display avoidance and lack of positive affect to their mothers, which, in turn, affects maternal behavior (van Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008).

Attachment theory posits that lowered quality of care and lack of responsiveness from the primary caregiver may later lead to social and behavioral problems in children that they carry into adulthood (Bowlby, 1988). Maternal depression, which contributes to lowered quality of care, has been shown to be related to negative outcomes for children, including higher incidences of depression in the child (Milan, Snow, & Belay, 2009). When mothers experience depression in the first year of their children's lives, infants have been shown to display higher levels of distress, negativity, and avoidance of their mothers (van Doesum et al., 2008). In addition, children of depressed mothers are more likely to develop insecure attachments to their mothers (Cicchetti, Rogosch, & Toth, 1998).

Radke-Yarrow, Cummings, Kuczynski, and Chapman (1985) found a relationship between maternal depressive diagnosis and child attachment patterns. Insecure attachments were more common among children of mothers with major depression than in children of mothers with minor depression or among nondepressed mothers.

Over the years, attachment theory-based research has expanded from its roots in studying the behaviors of the caregiver-child dyad to include outcomes research focusing

on adult attachment. One study used the Relationship Scales Questionnaire (RSQ) (Bartholomew & Horowitz, 1991) to assess attachment styles and found that "adult attachment anxiety was correlated with depressivity . . . and attachment avoidance" (Donges et al., 2012, p. 149). An intriguing facet of this study, which harkens back to Bowlby's reliance on biology and observed behavior to inform his theory (Bowlby, 1969, 1982), is its conclusion that measurements of adult attachment anxiety were found to be associated with enhanced automatic neural response to positive facial expression.

The neuroscientific literature describes a host of empirical studies relating measures of attachment to neuroanatomical structures and functioning (Burnett & Williams, 2009; Cullen & Harris, 2009; Dinur & Sherman, 2009; Nolte, Guiney, Fonagy, Mayes, & Luyten, 2011). Dinur and Sherman (2009) proposed:

> A functional neuroanatomical framework to integrate the key brain mechanisms involved in the perception and regulation of social emotional information, and their modulation by individual differences in terms of secure *versus* insecure (more specifically avoidant, anxious, or resolved *versus* unresolved) attachment traits. (p. 1)

The proposed framework focuses on two areas of the brain: the limbic cortico-subcortical areas (for affective evaluations) and the fronto-temporal areas for "cognitive mentalization and regulation" (p. 13). The authors suggest that these areas may relate dynamically with one another when functioning. Furthermore, the authors suggest that it may be possible to measure this differential functioning relative to the subject's attachment history. In much the same way that Bowlby (1982) believed that a multidisciplinary context was necessary to give rise to attachment theory, so too Dinur

and Sherman (2009) suggest that their neuroscientific framework "will be made possible by using an interdisciplinary approach based on neuroimaging, genetic, and psychological investigations in humans, as well as innovative studies on animal models of social behaviors . . ." (p. 16).

Another interesting area of research exploration relating to attachment is maternal-fetal attachment (MFA). In a study examining the effects of depression in pregnancy, McFarland et al. (2011) suggested that while there is substantial evidence that maternal depression may adversely affect the mother-infant attachment, much less is understood about "the impact of depression in pregnancy on maternal emotions and cognitions about the fetus (often termed 'maternal fetal attachment') is unclear" (p. 425). In the study, 161 pregnant women—65 of whom met the criteria for Major Depressive Disorder (MDD)—were evaluated during their second or third trimester (23 to 36 weeks gestation). The study used Cranley's Maternal Fetal Attachment Scale (Levy et al., 2011) at 26 and 36 weeks gestation to measure attachment. When compared to the scores for nondepressed mothers, the results showed that "clinically defined MDD during pregnancy negatively impacts MFA, suggesting that the basis for poor mother-to-infant attachment in postpartum MDD may have roots in pregnancy" (p. 425).

More closely related to this proposed study, researchers studied the experiences of 70 women who had diagnoses of MDD and a history of childhood sexual abuse to determine how attachment orientation (i.e., anxiety and avoidance) and the development of a working alliance affects outcomes. They found that women with a history of childhood sexual abuse were less responsive to treatment for depression and have a greater difficulty in forming and maintaining secure relationships. Greater levels of

attachment avoidance combined with weaker levels of working alliance was predictive of more severe symptoms of depression. In this study, the measured effects were found to be independent of comorbid bipolar disorder (BPD) and PTSD (Smith et al., 2011).

A group of first-time pregnant mothers were screened for depression in Goecke et al. (2012), which suggested promoting good dyadic attachment during pregnancy may positively influence later occurrences of post-partum depression.

A study that examined the relationship between secure attachment and maternal depression found that secure attachment in early childhood could have a protective, moderating effect on children exposed to chronic levels of maternal depression. Also, it found that children with disorganized attachment were most vulnerable to maternal depression (Milan et al., 2009).

Overview of Assessments

Several widely used assessments were an integral part of this study. Therefore, it is important to understand what the assessments are, how they work, and how widespread is the use of each one. This study includes intake and discharge assessments for dyadic attachment: the Mother-Infant Interactional Scale (see Appendix C) and the Mother-Child Interactional Scale (see Appendix D). Both of these assessments are adaptations of the Maternal Behavior Q-Set (MBQS) (Pederson et al., 1990) and the Attachment Q-set, Version 3.0 (AQS) (Waters, 1987). This study also includes intake and discharge assessments for maternal anxiety and maternal depression: the Functional Assessment Rating Scale (FARS) intake and discharge assessments (Ward & Dow, 1998, with Text Revisions 2004, 2005, 2006). This section describes the test instruments, their developmental histories, and their usual provenance.

Functional Assessment Rating Scale (FARS)

The Functional Assessment Rating Scale (FARS) was first used in Florida in 1995 to monitor changes in functioning in both mental health and substance abuse populations for children and adults. Its progenitor, the Colorado Client Assessment Record (CCAR) (Ellis, Wackwitz, & Foster, 1991), had been in wide use in several states, including Arizona and New York, for several years when Ward and Dow (1998) revised it for use in Florida. The FARS, like the CCAR, was intended to measure psychiatric symptoms and psychosocial impairments. Since 1995, it has been widely used and accepted as a snapshot of mental health.

The FARS is usually used for client evaluations as part of an admissions interview, as a case review, or at completion of a program to ensure that decisions made based on the assessment reflect current levels of cognitive and behavioral functioning. Because of the temporal nature of the FARS assessment, the clinician administering the FARS must focus on how the client is functioning now and how the client has been functioning for the past three weeks only. Although investigating a client's history can be useful for other purposes, it has no purpose or place in a FARS assessment. Scores on the FARS can help identify and document how well a client is functioning cognitively and behaviorally. As a result, a FARS can be a useful benchmark in developing or monitoring progress towards achieving short- or long-term goals (Ward & Dow, 1998, with Text Revisions 2004, 2005, 2006). It is important to note that the FARS is a way of documenting and standardizing impressions from clinical evaluations or mental status exams using cognitive, social, and role functioning as its focus.

The FARS assesses depression, anxiety, hyper affect, thought processes, cognitive performance, substance use, medical/physical, interpersonal relationships, family relationships, family environment, traumatic stress, socio-legal, work or school, ADL functioning, danger to self, danger to others, self-care, and security/management needs. Also, the FARS includes Global Assessment of Functioning (GAF) as an overall measure of functioning (Ward & Dow, 1998).

The FARS scales for Anxiety and Depression were used as intake and discharge assessments for all the women included in this study. The FARS has been shown to have "very good interrater reliability, test-retest reliability, construct validity, and concurrent validity" (Kiser, Medoff, Black, Nurse, & Fiese, 2010, p. 389).

Dyadic Attachment Assessments

To fully appreciate the dyadic attachment assessments used in this study (the Mother-Infant/Child Interaction Scales), it is necessary to be conversant with the Attachment Q-set (AQS), and its progenitors, the Q-set and the Q-sort. The following two subsections describe Q-sort and Q-set.

Q-sort assessment. The Q-sort is a psychometric method of rank ordering that was originally developed in 1953 by Stephenson as a personality assessment technique. The Q-sort allows a trained clinician to sort qualities and perceptual responses, which has obvious appeal in that it allows clinicians to evaluate such intangibles as maternal attachment. It has been used extensively in personality assessment and developmental research by Baumrind (1968), Bem and Funder (1978), Block (1961) (who actually refined the Q-sort), Block and Block (1980), Roberts, Block, and Block (1984), and Waters et al. (1983), and many others.

Q-sort methodology. The Q-sort methodology consists of three components: procedures for developing sets of descriptive items to which scores are to be assigned, procedures assigning scores to items by sorting them into a rank order from most characteristic to most uncharacteristic within each subject, and a wide variety of procedures for data reduction and analysis.

According to Pitt and Sube (1979), Q-sort was useful for sorting and rank ordering aspects of many different disciplines that are otherwise very difficult to test. In fact, Pitt and Sube even used Q-sort to determine which landscape designs would have near-universal appeal to a wide range of potential property buyers.

Everett Waters, an Ainsworth protégé, recognized the Q-sort as a useful way to test different aspects of attachment. To that end, he developed the Attachment Q-set (AQS) (Waters, 1987), on which, in part, the SBARC mother-infant and mother-child interaction tests are based.

Attachment Q-set (AQS). The AQS is the widely used standard for assessing secure base behavior and attachment security (Pederson et al., 1990; Waters, n.d.). Prior to the development of the AQS, the accepted way to assess attachment was the Strange Situation Procedure (SSP) (Ainsworth et al., 1978). [Note: The SSP and the Strange Situation Survey (SSS) are one and the same.]

Version 3.0 of the AQS was first published and 1987 and is used today. A meta-analysis designed to study the reliability and validity of the AQS examined 139 studies comprising 13,835 children. The AQS security scores showed convergent validity with the SSP security (r = 31) and excellent predicted validity with sensitivity measures (r = 39). The association of the AQS with measures of temperament was weaker (r = 16),

which supports discriminant validity of the AQS. Studies on the stability of the observer AQS are still relatively scarce, but they have yielded promising results (mean $r = 28$; $k = 4$, $n = 162$). I can conclude from this that the observer form of the AQS—a version of which is the standard used at SBARC in its measurements of attachment—is a valid measure of attachment (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2005).

Both the Mother-Infant Interaction Scale and the Mother-Child Interaction Scale that SBARC uses are based on the AQS, version 3.0. The AQS, which was designed by Waters in 1987, is made up of 90 items (questions or statements) that use the Q-sort method of sorting to assess secure behavior and organize information (McWey & Mullis, 2004). The information thus sorted is believed to be "consistent across all socioeconomic and cultural classes in society" (Waters, n.d., p. 1).

Waters developed the AQS for three reasons: first, to provide an economical methodology to examine relations between secure base behavior at home and SSP classifications; second, to better define (via a Q-sort) the behavioral referents of the secure base; and third, to stimulate interest in normative secure base behavior and individual differences in attachment security beyond infancy (Waters, 1987).

The AQS scores measure security on a continuum, thereby capturing information about potentially meaningful differences with each group. However, Waters recognized that it is "sometimes useful to convert continuous AQS scores to a secure/insecure dichotomy," Waters (n.d., p. 1). Waters was adamant that the AQS not be used as a value system, but rather as an informational assessment system that allows interpretation.

The AQS is an observational assessment in which a clinician observes interactions between a parent and child in a natural setting. Ideal observers are familiar

with the dyad through repeated observations. The AQS is a 90-item criterion-referenced Q-sort designed to assess characteristics of a child's behavior by looking for both the presence and absence of specific behaviors and the frequency with which behaviors occur. Observers assess parent-child interaction for 90-minute intervals or longer. The observers then rank the items that describe observed behavior. Individual correlation scores are interpreted as quality of attachment on a continuum in which 1.0 depicts the optimally securely attached child and -1.0 represents an extremely insecurely attached child (McWey & Mullis, 2004, p. 295).

Mother-Infant/Child Interaction Scales

The Mother-Infant/Child Interaction Scales are versions of the AQS designed for use with specific age groups. The Mother-Infant Interaction Scale is very similar to the Mother-Child Interaction Scale. In fact, the only real difference between the two scales is that the questions and statements (called items) on the Mother-Infant Interaction Scale are age-appropriate for infants 14 months and younger, while the items on the Mother-Child Interaction Scale are designed for children 15 months and older. In both cases, the assessments are designed to evaluate the strength of the infant or child's attachment to its mother using an assessment that allows a trained clinician to observe and, finally, to score the infant or child's quality of interaction with its mother.

In all cases, a trained Master's- or Ph.D.-level clinician[1] administered an intake assessment to the mother and infant or child. If the mother had more than one child in

[1] Most clinicians at SBARC are also licensed through the Florida Department of Health. Because SBARC is designated as a nonprofit 501(c)3 entity, the requirement for clinical members to have state licenses is waived. However, most staff members are license-eligible. The clinician who administered all the attachment intake and discharge evaluations for the last seven years has a Master's degree in Social Work, but does not have a license.

residence with her, the clinician repeated the intake procedure with each child. At the conclusion of the mother's stay at SBARC, a clinician repeated the assessment as part of the discharge process. Thus, the archived client file memorializes the assessment scores at both intake and discharge.

Nonexperimental Quantitative Research

Following the "cardinal rule of research . . . that you first determine your research questions and then select the strongest research method available to address those questions" (Johnson & Christensen, 2014), this study was nonexperimental because it was based on archival data. The definition of nonexperimental research, according to Kerlinger (1986), is as follows:

> Nonexperimental research is systematic empirical inquiry in which the scientist does not have direct control of independent variables because their manifestations have already occurred or because they are inherently not manipulable. Inferences about relations among variables are made, without direct intervention, from concomitant variation of independent and dependent variables. (p. 348)

"[N]onexperimental research cannot provide evidence for causality that is as strong as the evidence obtained in experimental research. Evidence for causality in nonexperimental research is more tentative, more exploratory, and less conclusive" (Johnson & Christensen, 2014). However, Kerlinger (1986) emphasized the importance of nonexperimental research as follows:

> It can even be said that nonexperimental research is more important than experimental research. This is, of course, not a methodological observation. It means, rather, that most social scientific and educational research problems do not

> lend themselves to experimentation, although many of them do lend themselves to controlled inquiry of the nonexperimental kind. Consider Piaget's studies of children's thinking, the authoritarianism studies of Adorno et al., the highly important study *Equality of Educational Opportunity*, and McClelland's studies of need for achievement. If a tally of sound and important studies in the behavioral sciences and education were made, it is possible that nonexperimental studies would outnumber and outrank experimental studies. (pp. 359–360)

Nonexperimental Research Categories

Johnson (2001) categorizes nonexperimental research according to a two-dimensional nonexperimental research scheme in which the first dimension "represents a characterization of the basic goal or main purpose for conducting the nonexperimental study [*research objective*] and the second dimension [*time dimension*][is classified] according to the time frame in which the data were collected" (Belli, 2009, p. 65).

Research Objective Dimension

Following his two-dimensional research categorization scheme, Johnson (2001) and Johnson and Christensen (2014) divided research objectives into the following three categories:

1. Descriptive—"Research that describes, usually in detail, phenomena as they exist. . . . contrasted with research that comes to causal conclusions or inferences" (Vogt & Johnson, 2011, p. 104).
2. Predictive—"[A]n investigation whose goal is to forecast (predict, but not explain) the values of one variable by using the values of one or more other variables. . . . In other terms, the goal in predictive research is to

estimate a future value of a dependent variable. Usually contrasted with explanatory research" (Vogt & Johnson, 2011, p. 300).

3. Explanatory—"[R]esearch that seeks to understand variables by discovering and measuring causal relations among them" (Vogt & Johnson, 2011, p. 134). "[T]he goal is to understand the causes behind relations, to test theory-based hypotheses to develop a theory, or sometimes to compare the effectiveness of two theories to explain variance in a dependent variable. . . . In other words, the goal is to estimate the partial regression coefficients that are interpreted as showing the degree of effect or causal relation for each variable, controlling for the other variables" (Vogt & Johnson, 2011, p. 300).

Given these three options, this study was Explanatory.

Time Dimension

Johnson (2001) and Johnson and Christensen (2014) further divided nonexperimental research into the following three categories with respect to when the data collection took place (that is, the time dimension):

1. Cross-sectional—Data were collected at one time.
2. Longitudinal—Data were collected in a forward direction over time.
3. Retrospective—Data were collected that represented present and past.

According to Vogt and Johnson (2011), a retrospective study is "research that uses information from the past to draw conclusions (p. 342)." In addition, Johnson and Christensen (2014) also states that in longitudinal research "data are collected at multiple

time points, and comparisons are made across time" (p. 404). As a results, the time dimension for this study was retrospective-longitudinal.

Table 2 is a matrix that illustrates the intersection of these two dimensions (research objective and time dimension), which determined the type of nonexperimental design most appropriate for this study (Johnson, 2001, Johnson & Christensen, 2014).

Table 2

Matrix of Research Types (Research Objective x Time Dimension) (Johnson & Christensen, 2014, p. 402)

Research Objective	Time Dimension		
	Retrospective*	Cross-Sectional	Longitudinal*
Descriptive	Retrospective descriptive	Cross-sectional descriptive	Longitudinal descriptive
Predictive	Retrospective predictive	Cross-sectional predictive	Longitudinal predictive
Explanatory	Retrospective explanatory	Cross-sectional explanatory	Longitudinal explanatory

*A retrospective study can also be, as in this study, longitudinal (that is, retrospective-longitudinal) (Johnson & Christensen, 2014, p. 403).

CHAPTER III: METHODOLOGY

The Susan B. Anthony Recovery Center (SBARC) is a fully accredited co-occurring disorder Level 3 residential treatment facility as defined by the American Society of Addiction Medicine (ASAM) (Stevenson-Hinde & Shouldice, 1995). As such, SBARC regularly reports on its successful outcomes to various governmental and funding sources. The purpose of this study was twofold: 1) to add to previous work on attachment and to increase knowledge and understanding of maternal depression and maternal anxiety as it related to attachment and, ultimately, to parenting; 2) to provide quantitative data that SBARC could report to funding sources as support for its impressive anecdotal success.

The women who enter the SBARC program usually live with one or more children while they are residing at SBARC. Because of this, the SBARC program was designed, in part, to strengthen parenting skills. Unfortunately, over the years, no formal study had been conducted to evaluate SBARC's parenting success. In addition, the parenting program had changed over the years of SBARC's existence, making any claims of statistical program effectiveness moot. Although everyone—community, staff, and residents—agreed that the SBARC experience was beneficial for its residents in many ways, that success was purely anecdotal. However, throughout SBARC's 16-year history, each resident was evaluated at intake and just prior to discharge to measure dyadic attachment, maternal anxiety, and maternal depression. The scores on these evaluations have formed the basis for investigating change in the key treatment variables.

Study Subjects

All subjects in this study were admitted to the SBARC residential program for treatment of a variety of substance abuse, mental health, and co-occurring disorders during the 16-year period from the beginning of 1995 through the end of 2010. The subjects in residence at this nonprofit, 501(3)c charitable institution were referred to it from a variety of sources, including: Department of Corrections, Department of Children and Family services, and many community-based mental health centers. The study subjects were all from the local community and were provided no monetary rewards to participate in the SBARC program. At intake, each SBARC participant in the residential program granted permission (i.e., each participant signed an informed consent form) for SBARC to use her de-identified data.

Active subject recruitment was not part of this study. This study relied entirely on historical data. I examined the data sets collected earlier (828 clients), applied the case exclusion criteria and, thereby, derived the total number of records that were used for the study sample ($N = 268$). All subjects in this study were admitted to SBARC for a variety of substance abuse, mental health, and co-occurring disorders during the 16-year period from the beginning of 1995 through the end of 2010.

The following three assessments were administered twice by trained SBARC clinicians: first, within two weeks of entering the program; second, shortly before discharge:

1. The Mother-Infant Interaction Scale (see Appendix C).
2. The Mother-Child Interaction Scale (see Appendix D).

3. The Functional Assessment Rating Scale (FARS) (Ward & Dow, 1998) (see Appendix E).

For more information on these three assessments, see the Assessments section in this chapter.

At discharge the SBARC staff therapist prepares a Discharge Summary and determines whether the outcome is Successful or Unsuccessful. Each Successful outcome is a story of a mother-infant/child dyad who managed to perform a series of personal improvement tasks, such as getting a GED, learning to use a computer, or learning to read, while remaining clean and sober. At this point, SBARC considers the resident to be Successful and to have graduated. (A limitation of this study is that because SBARC tailors each client's program to her unique needs, the number of weeks or months needed to complete each program varies.) A resident who leaves the SBARC program prematurely is deemed Unsuccessful and does not graduate. Although graduation rates are important to governmental or charitable funding sources, they were not considered relative to this study. However, the presence of a written Discharge Summary in the client file, whether Successful or Unsuccessful, was an essential part of the criteria for inclusion in the study sample.

Subject Inclusion Criteria

From its inception in 1995, a key prerequisite for admission to residence at SBARC was that the women either have at least one infant or child reside with them or be pregnant at the time of admission. In addition, all SBARC residents were exposed to the same parenting skills classes. Theoretically, all residents who completed treatment at SBARC may have been considered for inclusion in this study. However, as a practical

matter, since this study depends exclusively on historical data, the chief exclusion criteria for this study were those cases for which the historical records were found to be missing the requisite data.

In order to qualify for inclusion in this study, the data record collected for the client included at a minimum:

1. Intake and discharge evaluations for the Functional Assessment Rating Scales (FARS).
2. Intake and discharge evaluations for the Mother-Infant Interactional Scale (AQS), and/or
3. Intake and discharge evaluations for the Mother-Child Interactional Scale (AQS).
4. SBARC Discharge Summary.

Subject Exclusion Criteria

Women who resided at SBARC during the time period studied were excluded from this study for one of the following reasons:

1. They did not have an infant or child in residence with them. (Many women who participate in SBARC's programs have children who reside with a family member.)
2. Their files did not include SBARC Discharge Summary forms.
3. Their files did not include both intake and discharge AQS tests (that is, attachment assessment scores).
4. Their files did not include both intake and discharge FARS Anxiety scores.
5. Their files did not include both intake and discharge FARS Depression scores.

As is evident from this list, the primary exclusion criterion for any woman who had a child in residence while she completed the program was lack of documentation in the archived file. A missing evaluation score or a missing Discharge Summary was sufficient for exclusion from the sample.

Assessments

The following three assessments were administered twice by trained SBARC clinicians: first, within two weeks of entering the program; second, shortly before discharge:

4. The Mother-Infant Interaction Scale (see Appendix C).
5. The Mother-Child Interaction Scale (see Appendix D).
6. The Functional Assessment Rating Scale (FARS) (Ward & Dow, 1998) (see Appendix E).

The observational assessments that provided the data of interest in this study were:

1. The Mother-Infant Interaction Scale (see Appendix C) and the Mother-Child Interaction Scale (See Appendix D). These scales are adapted versions of two AQS assessments, which are derived from Pederson et al. (1990) and Waters (1995) Version 3.0. These instruments measured changes in attachment in the mother-infant/child dyads.
2. The Functional Assessment Rating Scale (FARS) (Ward & Dow, 1998) provided a clinical estimate of maternal anxiety at intake and discharge. (See Appendix E for more information on the FARS.)

3. The Functional Assessment Rating Scale (FARS) (Ward & Dow, 1998) provided a clinical estimate of maternal depression at intake and discharge. (See Appendix E for more information on the FARS.)

The following two subsections detail the assessments that SBARC uses to evaluate each mother and mother-infant/child dyad. These assessments were administered twice during the treatment episode. The intake evaluation was administered within the first two weeks of residential treatment; the discharge assessments was administered just before completion of the program.

Mother-Infant/Child Interaction Scales

If an infant was less than 15 months old at the time of the intake evaluation, the dyad was assessed using the Mother-Infant Interaction Scale. If the child was 15 months or older, the dyad was assessed with the Mother-Child Interaction Scale. These two assessments are very similar, but they were designed to be age appropriate for two different age groups. Also, these two assessments are both adaptations of two well-known assessments of attachment: the Maternal Behavior Q-Set (Pederson et al., 1990) and the AQS, version 3 (Waters, 1987).

Functional Assessment Rating Scales (FARS)

The FARS (Ward & Dow, 1998) is made up of a group of scales that were designed to allow a trained clinician to score each mother on a number of separate variables. These variables included anxiety and depression.

Data Collection

The data analyzed in this study were previously collected in the SBARC data collection project (SDCP) from 16 years of archival client information. The SDCP,

yielded over 100 data items concerning each of SBARC's 828 clients. (See Appendix A for more information about the SDCP.) Although the vast array of data contained in these 828 historical client records was similarly compelling, this study examined only three aspects of the clients' experiences: 1) evidence of change in dyadic attachment; 2) evidence of change in levels of maternal anxiety; and 3) evidence of change in levels of maternal depression.

As previously stated, one purpose of the current study was to add to previous work on attachment and to increase knowledge and understanding of maternal depression and maternal anxiety as they may or may not relate to attachment. Another purpose was to test a theory that as dyadic attachment increases, maternal anxiety and maternal depression will tend to decrease.

To accomplish this goal, I chose a nonexperimental quantitative research design.

Nonexperimental Quantitative Research

The research design used in this study follows the description found in Johnson and Christensen (2014) and is called Retrospective-Longitudinal Explanatory. According to Belli (2009), Johnson defined retrospective explanatory research as

> nonexperimental research in which the primary focus for the research is to explain how some phenomenon works or why it operates. The objective is often to test a theory about the phenomenon. Hypotheses derived from a given theoretical orientation are tested in attempts to validate the theory. (p. 65)

(See the Nonexperimental Research Categories section in Chapter II for more information about the Retrospective-Longitudinal Explanatory and other nonexperimental research designs suggested by Johnson & Christensen, 2014.)

Archival Data

The data used in this study are archival. These data were taken from the archived client records of women (and their resident children) who had been discharged after having participated in the SBARC program. I collected the data over a two-year period in a data-collection project that was designed, implemented, and completed by me. [See Appendix A for additional information concerning the SBARC Data Collection Project (SBCP).] Each of these archived records represented the SBARC history—from intake to discharge—of a single client mother-infant/child dyad. The record for each client dyad was contained in an expanding-width file folder wallet (that is, client record). The complete data set for each client record ranged from about 1 inch to, in some cases, 8 inches or more, depending on the client dyad's length of stay in treatment and the complexity of the services offered. Occasionally, the client record was contained in multiple expanding folders. All archived records were housed in a locked file room, stored on shelves, and ordered sequentially by client identification number. (See Appendix B for a description of the processes, database entry screens, and exemplars of the de-identified source documents used in this data collection project.)

Since this study used only archived, de-identified, historical data, which represented dyads for whom treatment services were provided from 1995 through the end of 2010, there were no live subjects and, therefore, no consent by study participants was necessary. All client records from which data was obtained for use in this study remain the property of SBARC.

Research Design

In addition to examining SBARC's archival data (hence the retrospective portion of the retrospective-longitudinal nomenclature) for evidence of change in dyadic attachment, maternal anxiety, and maternal depression, and to further previous work on attachment and increase knowledge and understanding of maternal depression and maternal anxiety, I also tested a theory concerning maternal depression and maternal anxiety with respect to dyadic attachment (the explanatory portion of the nomenclature) (Johnson, 2001). Furthermore, I compared and analyzed the results collected from intake and discharge evaluations of women who (with their children) completed the SBARC residential program treatment at SBARC (whether they were Successful or Unsuccessful). This is a two-group pretest-posttest design. The two groups are Mother-Infant and Mother-Child. The pretests are intake scores on the assessments of strength of attachment and levels of maternal anxiety and levels of maternal depression. The intervention is the SBARC experience, whatever that was at the time that a particular dyad was in residence at SBARC. (In this study, the intervention is the independent variable and dyadic attachment, maternal anxiety, and maternal depression are the dependent variables.) The posttests are the scores on same assessments for strength of attachment and levels of maternal anxiety and levels of maternal depression.

Research Procedure

The subject inclusion criteria for this study rely exclusively on the completeness of the paper files, scores on the Intake Evaluation (Pretest), evidence of the SBARC Residential Program Participation (Intervention), and scores on the Discharge Evaluation (Posttest), which were obtained from the data were collected during the SDCP, which

preceded this study. (See Appendix A for more information on the SDCP.) The following subsections describe how and when the archival SBARC data, which was originally collected in paper files, was digitized to become the SDCP data. It was the SDCP data that subsequently formed the pretest, intervention, and posttest for this study.

Pretest Source: SDCP Intake Evaluation Data

This intake evaluation measured variables before a treatment was administered (Gall et al., 2007, p. 381). The SBARC clinicians conducted a formal intake evaluation of each mother and each mother-infant/child dyad for several variables, which included an assessment of the degree of dyadic attachment, an assessment of the level of maternal anxiety, and an assessment of the level of maternal depression. Each of these assessments yielded a numerical score, which I used as the pretest.

The client record for each member of the sample population contained a complete set of intake evaluation data, which included scores for maternal depression (FARS), scores for maternal anxiety (FARS), and scores for dyadic attachment (Mother-Infant Interaction Scale or Mother-Child Interaction Scale, depending upon the age of the child). (See the Assessments section in this chapter for more information about these tests.) As part of the intake evaluation, the Mother-Infant Interaction Scale or the Mother-Child Interaction Scale was administered to all SBARC participants during their first two weeks at SBARC. This evaluation is an adaptation of two attachment Q-sort assessments: Pederson et al. (1990) and Waters (1987), Version 3.0.

The Mother-Infant Interaction Scale (see Appendix C), a 58-item assessment, was administered by a trained clinician (Master's or Ph.D. degree). The Mother-Child Interaction Scale (see Appendix D) is a similar 62-item assessment. These assessments

measure the same characteristics; the difference between the two is their age appropriateness. The infant version was given to children less than 15 months old; the child version was given to children 15 months and older. In both cases, the clinician observed interactions between mother and child and rated each question on a 3-point scale (1= Rarely or Never, 2=Sometimes, 3=Always or most of the time). After assigning point responses to each of the items, the clinician summed the scores. I used this score as the pretest.

Intervention: SBARC Residential Program Participation

For the purposes of this research design, the SBARC program as a whole—however it changed over 16 years—was considered the intervention.

At a minimum, the SBARC residential treatment program included the state-mandated, county-administered Healthy Start infant and child parenting skills training program (Teti & McGourty, 1996) as well as a customized, one-on-one parenting skills training program. All SBARC program participants were required to participate in the these classes.

Oftentimes, the Healthy Start Program was court-mandated for the participants at SBARC. These services were free of charge to pregnant woman and to those with children up to age 3. Healthy Start included services relevant to this study, such as education and support in childbirth and parenting, nutrition counseling, tobacco cessation counseling and support, and breastfeeding education and support ("Healthy Start Coalition," n.d.). Since this analysis was of archived historical records, and since program interventions have varied during the 16 years of data under analysis, evaluating specific parenting interventions at SBARC was beyond the scope of this study.

Posttest Source: SDCP Discharge Evaluation Data

The assessments performed in the intake evaluation (an assessment of the degree of dyadic attachment, an assessment of maternal anxiety, and an assessment of maternal depression) were repeated just prior to discharge. As with the Intake Evaluation, each of these assessments yielded a score, which I used as the posttest.

At the end of the SBARC program, and after each dyad had been exposed to the various parenting interventions, the dyad was evaluated by an SBARC clinician who used the Mother-Infant Interaction Scale or the Mother-Child Interaction Scale. This assessment was the same version of the AQS that they received within two weeks of beginning treatment at SBARC. In addition, the FARS assessment was repeated, which yielded final scores for maternal anxiety and maternal depression. Both types of assessments were administered by a trained Master's- or doctoral clinician and were scored in the same fashion as the intake assessment. Again, these were considered the posttest.

Also at discharge, the SBARC staff therapist prepared a Discharge Summary and determined whether the outcome was Successful or Unsuccessful. Each Successful outcome was a story of a mother-infant/child dyad who managed to perform a series of personal improvement tasks, such as getting a GED, learning to use a computer, or learning to read, while remaining clean and sober. At this point, SBARC considers the resident to be Successful and to have graduated. (A limitation of this study was that because SBARC tailored each client's program to her unique needs, the number of weeks or months needed to complete each program varied.) A resident who left the SBARC program prematurely was deemed Unsuccessful and did not graduate. Although

graduation rates are important to governmental or charitable funding sources, they were not considered relative to this study. However, the presence of a written Discharge Summary in the client file, whether Successful or Unsuccessful, was an essential part of the criteria for inclusion in the study sample.

Internal Validity

Anything that can affect outcome, other than the SBARC experience itself, is an extraneous variable. The presence of extraneous variables can jeopardize internal validity. Internal validity is the "extent to which extraneous variables have been controlled by the researcher, so that any observed effect can be attributed solely to the treatment variable" (Gall et al., 2007, p. 383). Van Bakel and Riksen-Walraven (2004) identify 12 types of extraneous variables (eight of which were originally identified by van Dam and van Ijzendoorn (1988) as follows:

1. History—Other events that may have occurred during the time that the study was underway. Because this study involved retrospective data, which could not be manipulated for this research in any way, and because many things may have changed during the 16 years being studied, history was not an extraneous variable that was subject to manipulation. Although the SBARC program has always included parenting classes, individual and group therapy, substance abuse classes, and more, those elements have not necessarily stayed the same over the 16 years of this study. For example, although the assessments have been administered by the same clinician for 6 of the 16 years under study, one (or more) different clinicians administered them during previous years. As

with any long-term study, the program evolved to include new ideas of efficacy and approaches to practice.

2. Maturation—The physical or psychological changes in the research subjects during the experimental treatment. This study assumed that each mother and each mother-infant/child dyad in this study would change; in fact, that was what was being studied. Therefore, this extraneous variable was not applicable to this study.
3. Testing—The mother or mother-infant/child dyad may become too familiar with the tests. Neither mother nor mother-infant/child dyad knew what attribute was being assessed at any given time during any of the tests. Therefore, this extraneous variable was not applicable to this study.
4. Instrumentation—Observers who assessed mothers and mother-infant/child dyads "before and after an experimental treatment might be disposed to give more favorable ratings the second time, simply because they expect—consciously or subconsciously—a change to have occurred" (Gall et al., 2007, p. 385). Given the number of assessments SBARC clinicians administered every month, it was highly unlikely that the trained clinician who administered the assessments remembered what score a particular mother or mother-infant/child dyad received some months ago. In addition, the clinician not only scored intake and discharge assessments on separate test blanks, but he or she may not have been the same assessor. Therefore, this extraneous variable was not applicable to this study.

5. Statistical regression—"The tendency for research participants whose scores fall at either extreme on a measure to score nearer the mean when the variable is measured a second time" (Gall et al., 2007, p. 385). To control for errors of statistical regression, this study simply subtracted the low score from the high score. This extraneous variable was not applicable to this study.
6. Differential selection—This study included all mothers and mother-infant/child dyads who enrolled at SBARC during a 16-year period who had complete documentation of test results and a Discharge Summary present in their client files, so this extraneous variable was not applicable to this study.
7. Mortality—This is the normal attrition of any program. A key selection criterion of this study was that it included all mothers and mother-infant/child dyads who completed treatment (with complete test results and a Discharge Summary in their client files), whether or not they were deemed Successful. Therefore, this extraneous variable was not applicable to this study.
8. Selection-maturation interaction—Similar to No. 6, this extraneous variable was not applicable to this study.
9. Treatment diffusion—This occurs only when a control group exists. In this study, no control group existed; therefore, this extraneous variable was not applicable to this study.
10. Compensatory rivalry by the control group—Because this study does not include a control group, this extraneous variable was not applicable to this study.

11. Compensatory equalization of treatments—Again, with no control group, this extraneous variable was not applicable to this study.
12. Resentful demoralization of the control group—Once again, with no control group, this was not an applicable extraneous variable for this study.

External Validity

The degree to which the findings from this study could be generalized to "individuals and setting beyond those . . . studied" is external validity (Gall et al., 2007). An assumption of this study was that its findings might be generally applicable to similar populations of mother-infant/child dyads who might receive treatment for substance abuse, mental health, or co-occurring disorders in residential treatment. In addition, because this was a nonexperimental analysis of archived historical data and not a controlled experiment, any ability to generalize findings beyond this study was assumed to be limited at best.

Statement of the Problem

A preponderance of behavioral and psychological developmental research has long established correlations between early childhood interactions in the child/primary-caregiver dyad and later behavioral, developmental, and mental health issues for the child (Gray, 2011; Greco, 2010; Somech & Elizur, 2012; Sonthalia & Dasgupta, 2012). The AQS (Waters, 1987) and its derivatives (Pederson et al., 1990) are established instruments for measuring levels of attachment between mother and child (Davis & Michelle, 2011; Pittman et al., 2009; van Ijzendoorn, 1995). In addition, conventional wisdom, supported by a host of outcomes research, supports the proposition that reductions in depression and anxiety over the course of treatment may be related to better

outcomes, such as a lowered probability of relapse in abuse treatment programs (Grant et al., 2004; Hasin et al., 2002; Willinger et al., 2002).

In this case, the problem was that the 828 client records spanning 16 years had never been examined for evidence of anything. This study constitutes the first review and analysis of much hitherto untouched data.

Research Questions

This study reviewed 16 years of historical data collected about women who underwent a comprehensive substance abuse and mental health treatment program at SBARC from 1995 through 2010. Intake and discharge assessments (Pederson et al., 1990; Waters, 1987) of levels of dyadic attachment were analyzed to measure changes. Intake and discharge assessments using the Functional Assessment Rating Scales (FARS) (Ward & Dow, 1998) were used to assess changes in levels of maternal anxiety. Intake and discharge assessment using the FARS (Ward & Dow, 1998) were also used to measure changes in levels of maternal depression.

As suggested by Johnson (2001), the specific research questions (RQn) for this study were both descriptive and predictive:

RQ1. What was the relationship among dyadic attachment, maternal depression, and maternal anxiety? (Descriptive)

RQ2. What effect did dyadic attachment have on maternal anxiety and maternal depression at time of discharge from SBARC? (Descriptive)

RQ3. Does an increase in dyadic attachment predict a decrease in maternal anxiety and maternal depression at discharge? (Predictive)

Furthermore, Johnson and Christensen (2014) suggested that the overarching research question for this type of retrospective explanatory research must always be "Does the relationship we predict really exist?" (p. 82).

Hypotheses

All hypotheses in this study were directional because each made a prediction about a particular outcome (Creswell, 2009). Gay, Mills, and Airasian (2012), p.536, stated that "All hypotheses logically follow the review of related literature and are based on the implications of previous research." Using a format suggested by Johnson and Christenson (2014), the hypotheses for this study were:

HA1: It was predicted that there would be a statistically significant ($p \geq .05$) increase in dyadic attachment as measured by the Mother-Child Interactional Scale for women who completed the SBARC treatment program (RQ1).

HA2: It was predicted that there would be a statistically significant ($p \leq .05$) decrease in maternal anxiety as measured by the FARS for women who completed the SBARC treatment program (RQ2).

HA3: It was predicted that there would be a statistically significant ($p \leq .05$) decrease in maternal depression as measured by the FARS for women who completed the SBARC treatment program (RQ3).

Data Analysis

In this study, I used two statistical analyses. First, I used a Multivariate Analysis of Variance (MANOVA) to test the overall difference between intake and discharge scores in a linear combination of the three (dyadic attachment, maternal anxiety, and

maternal depression). The MANOVA analysis provided the hypothesis testing for this study. Second, I used the univariate Analysis of Variance (ANOVA *F* test), which is part of MANOVA, to test for discrete significance when comparing the intake and discharge scores for each of the same three variables, dyadic attachment, maternal anxiety, and maternal depression.

The data collected at SBARC was contained in a Microsoft Access 2010 (version 14) database on my secure computer system. The plan was to extract the maternal anxiety, maternal depression, and dyadic attachment assessment scores from this corpus and use the Statistical Package for the Social Sciences (SPSS) Statistics Base 20 (2011) software suite to conduct statistical analyses associated with this study. To augment SPSS in the data analysis, I also used Minitab 16 (version 16) and Microsoft Excel 2013.

The approach to analyzing the data collected for this project consisted of a three-step process, the goals of which were to establish the sample population, describe key characteristics of the population, and, finally, conduct an exploratory data analysis to determine relationships between measures of dyadic attachment, maternal anxiety, and maternal depression as they relate to the treatment experience.

Step 1—Creating the Study Sample: The entire collection of 828 client records was examined to establish the sample for this study. Every file that did not indicate the presence of at least one infant or child in residence at SBARC was excluded from the study. Then, each of the included files was examined for the presence of AQS and FARS tests. Any files that did not contain both tests were excluded. Next, any files that did not contain both intake and discharge scores on the AQS and FARS tests were excluded. Then, any files that were missing intake and discharge Anxiety and Depression scores on

the FARS tests were excluded. Finally, any files that did not contain a Discharge Summary were excluded. Finally, a statistical process to identify outliers (cases to exclude) was conducted that left 268 dyads, which became the study sample.

Step 2—Once the study sample was established, a summary of the sample demographics was created, which included the following characteristics of the population:

1. Age of Mother at Intake
2. Race/Ethnicity of Mother
3. Marital Status of Mother at Intake
4. Education Level of Mother
5. Intake Reports of Violence, Abuse, and Suicide Ideations or Attempts
6. Arrests and Criminal Justice System Involvement of the Mother
7. DSM Diagnosis of Mother at Intake
8. Status of Mother at Discharge

Step 3—Significance Testing: MANOVA and ANOVA *F* tests were used to analyze the scores at intake and at discharge for the three variables (dyadic attachment, maternal anxiety, and maternal depression) of interest in this study. The paired samples were the evaluation scores for each case taken at the beginning of treatment and just prior to discharge.

Expected Findings

The treatment at SBARC includes education (GED classes, for example), parenting skills development (Healthy Start, for example), substance-abuse-related psychoeducational classes, individual psychotherapy, and other programs. As a result, I

expected to find significant changes in the measures of dyadic attachment as well as significant changes is the levels of maternal anxiety and maternal depression reported by the women in the sample.

Although the data displays and statistical tools may provide general indications of treatment effects, the chief aim of this study was to provide a quantitative recapitulation of the program outcomes at SBARC over a 16-year period concerning measures of dyadic attachment, maternal anxiety, and maternal depression. The findings may provide both foundation and direction for future experimental studies at SBARC.

Confidentiality, Privacy, and Storage

During the earlier data collection project (the SDCP), each client record was assigned a number and care was taken to de-identify all data, thereby ensuring that each subject's privacy was protected. No identifying data were taken from any client records or test results during the data collection phase of that project. Because I used the SDCP data for this subsequent study, identifying data no longer existed. (See Appendix A for more information on the SDCP.)

Although using historical data reduces the risk of disclosure, every precaution was taken to protect private information. Following the SDCP, I retained numbered data sets for each of the 828 client records. These numbered data sets resided on my personal password-protected laptop. With the exception of client records older than seven years, which SBARC destroyed after the data was collected, the actual client records remain at SBARC in their locked file room.

Written authorization to conduct this research, to identify the organization by name, and to include names of key staff members was obtained from Marsha L. Currant, the former Chief Executive Officer of SBARC. (See Appendix J for a copy of this consent letter.)

Ethical Considerations

In any research, the most important concern is the safety of the study participants. In this case, by using de-identified historical records, the risk to subjects was minimal. Also, because historical records were used, there was no need for informed consent and assurance of volunteerism documents. No identifying information was part of the data. By prior agreement, I will provide all data and findings from this study to representatives of SBARC

.

CHAPTER IV: DATA ANALYSIS AND RESEARCH FINDINGS

In this study, I used a nonexperimental retroactive-longitudinal explanatory research design to analyze an archival data sample ($N = 268$) of mother-infant/child dyads, who completed residential treatment with their children at the Susan B. Anthony Recovery Center (SBARC) from 1995 through 2010 (16 years). Specifically, this study was designed to examine changes in dyadic attachment as well as to examine changes in levels of both maternal anxiety and maternal depression. I compared scores on assessments of dyadic attachment, maternal anxiety, and maternal depression that SBARC measured at the beginning of treatment (at intake) with scores measured on the same tests at the end of treatment (at discharge).

After the SBARC Data Collection Project (SDCP) concluded, I analyzed each of the 828 SBARC case files for possible inclusion in this study. At a minimum, to be included in this study, the archived record had to contain the following for the dyad represented by the case file:

1. A completed face sheet,
2. A completed in-depth psychosocial evaluation,
3. Intake and Discharge copies of the FARS with the Depression and Anxiety ratings completed,
4. Intake and Discharge copies of completed Mother-Infant Interaction Scale (see Appendix C), or Mother-Child Interaction Scale (see Appendix D) assessments, and
5. A completed copy of the Treatment Program Discharge Summary that included the date of discharge from the program and the client's status

(Successful, Unsuccessful, or Other) at time of discharge. (Note: If a client record contained complete Intake and Discharge data, I included it in the sample, even if the client's status at discharge was Unsuccessful.)

Since the aim of the study was to analyze the archived records for change over the course of treatment in the key areas of dyadic attachment, maternal anxiety, and maternal depression, I excluded from the sample all case files that did not meet the criteria outlined in items 1 through 5. After excluding client files that contained incomplete or missing data, 274 cases remained.

Description of Study Sample Subjects

I then conducted an analysis for outliers on the remaining sample of 274 case files, which left a total of 268 dyads in the sample population ($N = 268$). (See the Cases Excluded Based on z Values Data section in this chapter for information on how I identified and eliminated these cases.) Mother-infant dyads, where the infants were under 15 months old, made up 126 cases in the sample ($n = 126$); mother-child dyads, where the children were 15 months or older, made up the remaining 142 dyads ($n = 142$). (See Appendices F and G, respectively, for summaries of the assessment scores from the mother-infant and mother-child subpopulations that made up this sample.) Note that in cases where a mother was evaluated with more than one child, I repeated her associated identification number in the results.

Age at Intake

The average age of women in the sample at intake was 28.35 years. At intake, the youngest woman was 18 and the oldest was 44, an age range of 26 years. The median age of women in the sample population was 27.

Race/Ethnicity

As shown in Figure 1, of the 268 women represented in the sample, 130 (48.51%) reported their race/ethnicity as Caucasian. Ninety-five (35.45%) women reported their race/ethnicity as African American, and 26 women (9.70%) reported themselves to be Hispanic. Of the 268 women in the sample, 15 identified themselves as Native American (5.60%). Two women in the sample (0.75%) were unidentified with regard to race or ethnicity in the archived case file.

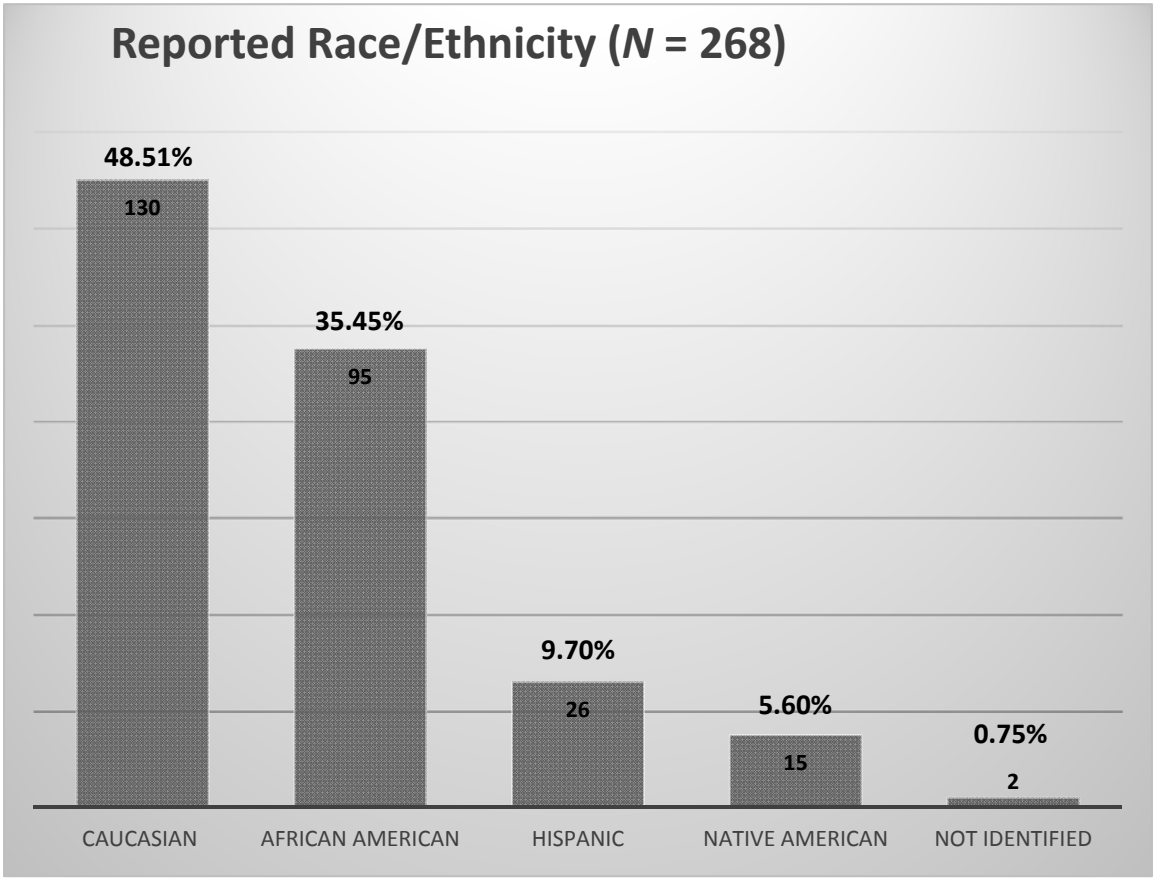


Figure 1. Reported race/ethnicity.

Marital Status at Intake

Figure 2 shows the reported marital status of the women in the study. At intake, 176 (65.67%) of the 268 women represented in the sample reported their relationship status as single. Thirty-four women (12.69%) reported they were married; 26 women (9.70%) reported being divorced; and 11 women (4.10%) reported that they were separated. Only one woman reported being a widow, and the relationship status for 22 women (7.46%) in the sample was not noted in the archived case files.

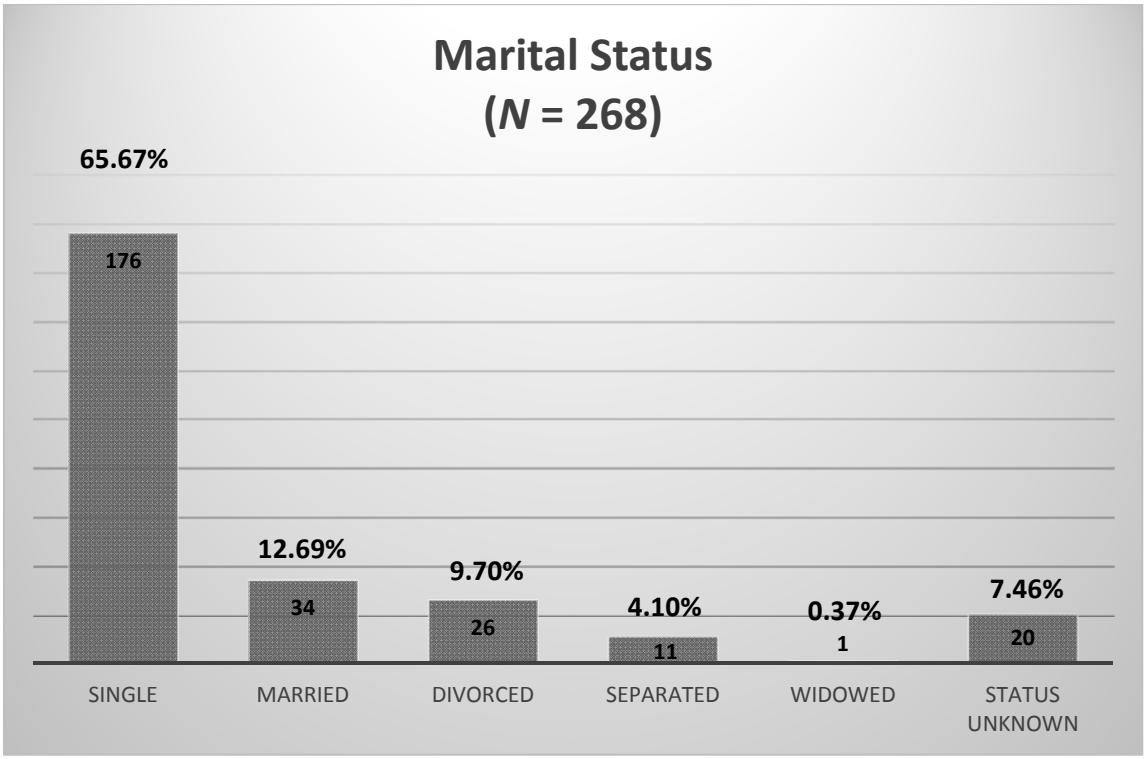


Figure 2. Marital status at intake.

Educational Level

The Referral Screening Form listed the highest level of education achieved by each of the women in the study sample. Of the 268 women in the sample, the highest

grade achieved was available in the client file for only 169 cases. The form was incomplete or missing from the file for the remaining 99 cases.

As shown in Figure 3, only 71 (42.01%) of the 169 women reported completing grade 12. Thirty-two (18.93%) reported completing grade 11, 29 (17.16%) completed grade 10, and 21 (12.43%) completed grade 9. Six (3.55%) of the 169 women reported completing grade 7 and one women (0.59%) reported completing grade 6. No information was reported on the education level of nine (5.33%) of the 169 women. Although some women reported having some college experience, none reported completing their college education.

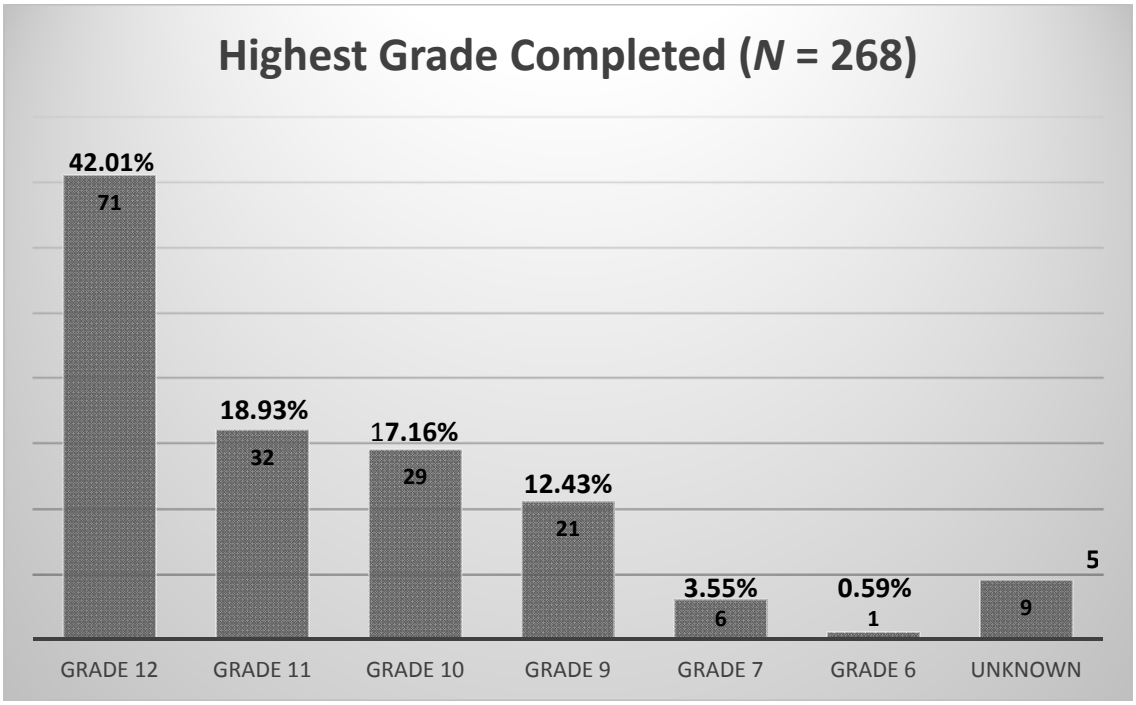


Figure 3. Highest grade completed. (Note that the archived record contained educational data on only 169 of 268 women in the study sample.)

Violence, Abuse, and Suicide Ideations or Attempts

As illustrated in Figure 4, 143 (53.28%) of the 268 women in the sample reported being involved in a relationship in which there was domestic violence. Of the 268 women in the sample, 132 (49.25%) reported being sexually abused. In fact, 98 (36.57%) of the women reported being sexually abused as a minor, and 67 (25.00%) women reported being physically abused. Finally, 193 (72.01%) of the 268 women in the sample reported prior incidents of suicidal ideations or attempts.

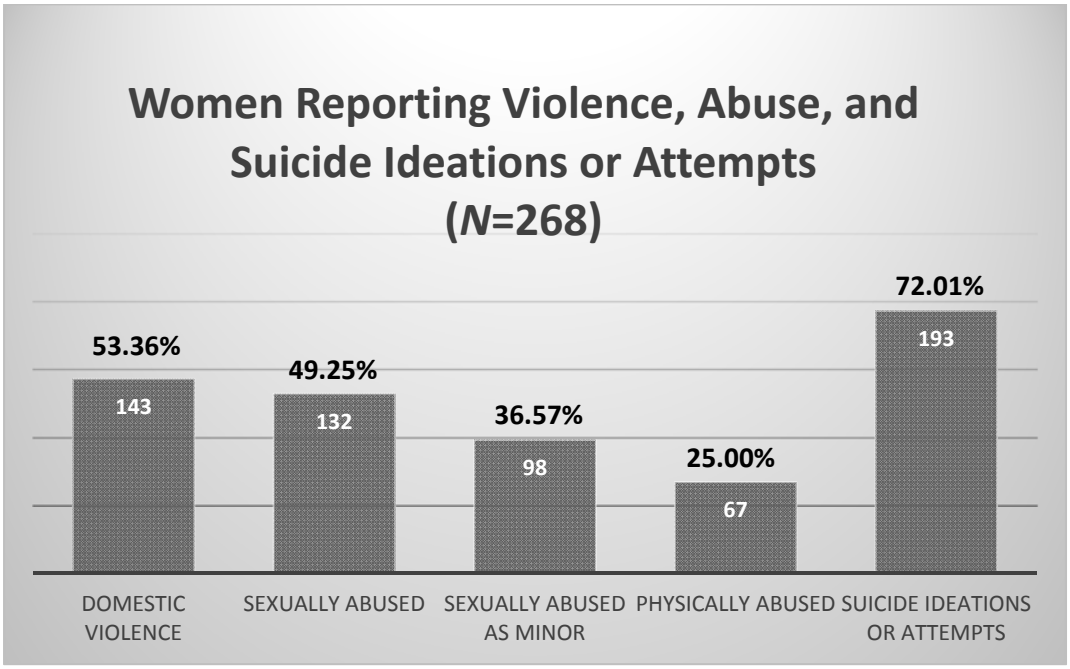


Figure 4. Violence, abuse, and suicide ideations or attempts.

Arrests and Criminal Justice System Involvement

Many of the women in the sample population reported involvement in criminal activity (see Figure 5). Of 268 women in the sample, 136 (50.75%) reported having been incarcerated prior to coming to SBARC. Questions about four types of arrests appear on

the Referral Screening Form (see Appendix L): arrests for possession or sales of drugs; behavior under the influence of drugs or alcohol; theft; and assault.

Of 268 women in the sample, 132 (49.25%) reported having been arrested for possession or sales of illicit drugs.

Of 268 women in the sample, 70 (26.12%) reported having been arrested for theft of some kind. In most cases, the theft was related to selling stolen goods to obtain drugs. Of the 268 women in the sample, 53 (19.78%) reported having been arrested for behavior under the influence of drugs or alcohol. Frequently, the arrest was associated with a driving under the influence (DUI) charge, but also included public intoxication charges. Finally, of the 268 in the sample, 41 (15.30%) reported having been arrested for assault.

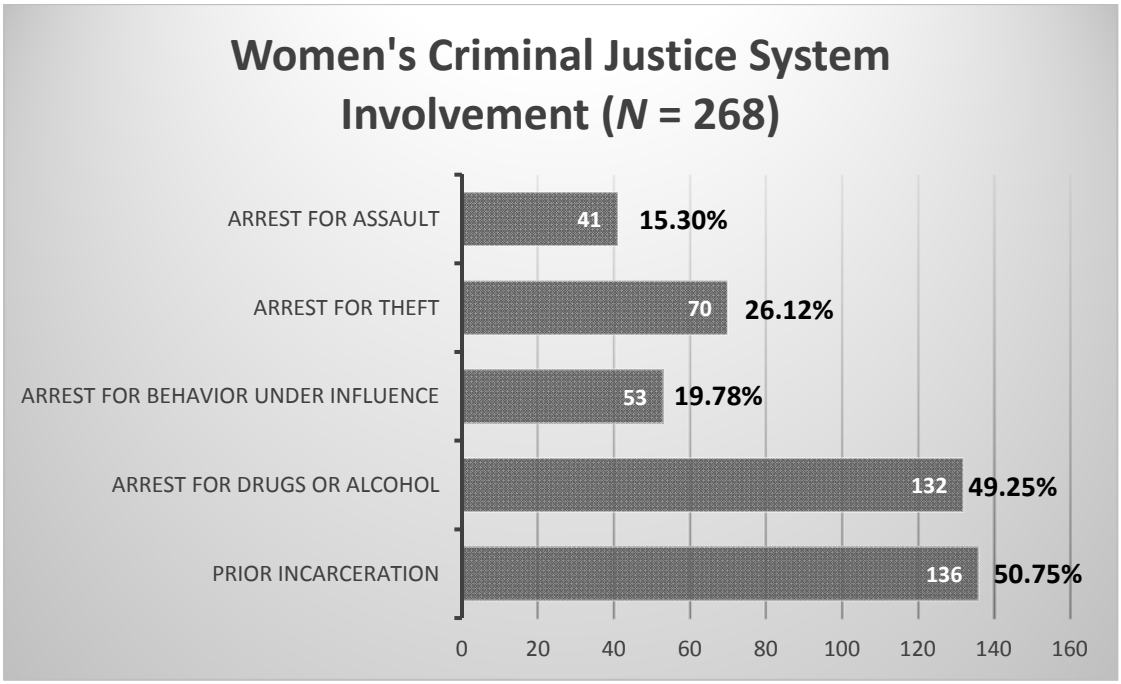


Figure 5. Criminal justice system involvement.

Mental Health Diagnosis at Intake

See Figure 6 for a breakdown of the primary diagnoses of the women in the sample. Of the 268 women in the sample, 148 (55.22%) had a primary diagnosis of substance abuse or addiction at intake. Another 53 women (19.78%) had a primary diagnosis of bipolar or major depressive disorder. Of the 268 women in the sample, 18 (6.72%) had a primary diagnosis of anxiety, and 8 (2.99%) had a primary diagnosis of adjustment disorder. The primary diagnosis for the remaining 41 women (15.30%) was not noted in the case files.

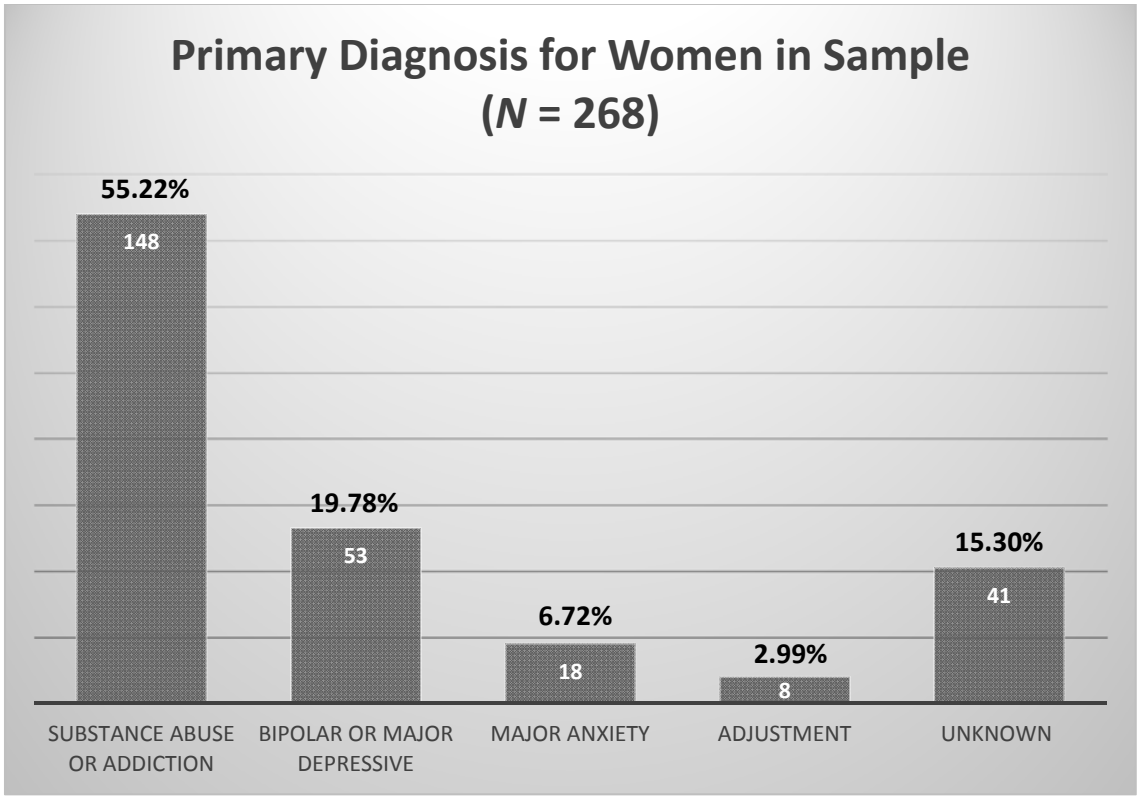


Figure 6. Primary mental health diagnoses.

Status at Discharge

Figure 7 shows the program success rate. Of the 268 dyads in the sample, 159 successfully completed the treatment program. This represents a success rate of 59.33% over the 16-year period of cases comprising the sample.

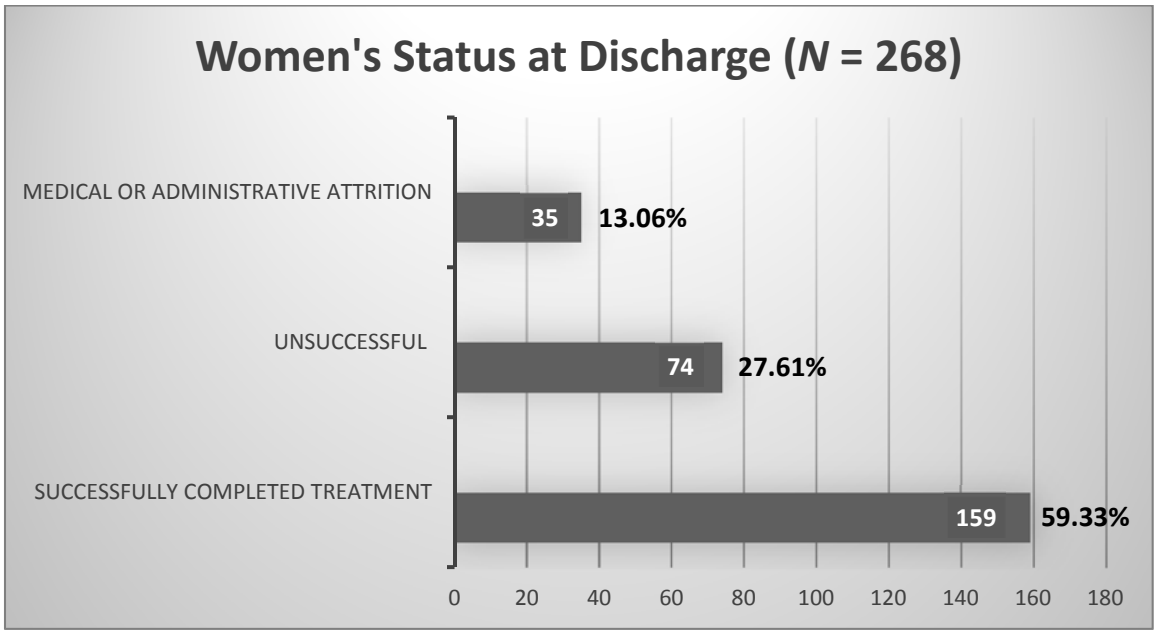


Figure 7. Study sample program success rate.

Of the 268 dyads in the sample, 74 (27.61%) were unsuccessful in completing treatment. There were myriad reasons that contributed to being unsuccessful in completing the program, such as being caught at SBARC with contraband, violent or disruptive behavior on the SBARC premises, and, in general, being noncompliant with the rules of the SBARC program.

The remaining 35 dyads (13.06%) represented cases where administrative or medical factors prevented successful completion. Examples of administrative causes included situations where the client was remanded back to the criminal justice system to

complete a sentence or the client opted to pursue treatment at another facility. Examples of medical causes included situations where the woman's need for medical treatment precluded her from fully participating in the SBARC program.

Statistical Approach

To address the research questions, this study first used IBM SPSS to perform a test procedure called Multivariate Analysis of Variance (MANOVA). (See Chapter III, for a list of the research questions.) Then, I examined MANOVA for the ANOVA *F* test statistic. The ANOVA *F* test is most appropriate for comparing the means of two or more independent groups. In addition, ANOVA is appropriate when the response variable is metric and the independent variable is categorical. This study focused the analysis on the comparison of the intake and discharge scores of three variables—dyadic attachment, maternal anxiety, and maternal depression. Furthermore, the scores for all the response variables are interval. Although both intake and discharge scores come from the same set of respondents, the response of different individuals at intake and discharge is considered independent and, therefore, the use of ANOVA is justified. ANOVA is appropriate for testing dependent variables individually (meaning a separate ANOVA is performed for each dependent variable).

In this study, there are three dependent variables: dyadic attachment, maternal anxiety and maternal depression. (Note: The treatment received by each dyad is the independent variable in this study.) Clearly, the three dependent variables may be correlated. To examine the possible correlation structure among the dependent variables, I used MANOVA.

In MANOVA, the associated multivariate *F* test and Wilks' lambda test the significance of the difference in mean scores of the combination of the three dependent variables at intake and discharge. If MANOVA shows significant difference, then univariate ANOVA *F* tests are performed to determine whether there is a significant difference in each of the three dependent variables from intake to discharge.

Before the main data analysis, however, the study sample was first examined to exclude cases on the basis of *z* values (i.e., outliers). Then, the remaining cases were subjected to assumption testing. These procedures are described in the next two sections.

Cases Excluded Based on *z* Values

Swanson and Holton (2005) stated that cases excluded on the basis of *z* values "can have a substantial influence on the results of predictive discriminant analysis and outlier detection should be a part of every discriminant analysis" (p. 130). In keeping with this view, I used the two-step method recommended by Field (2009) and Rasch, Kubinger, and Yanagida (2011) to identify cases to exclude. First, I generated a standardized score (that is, a *z* score) for each observation.

> Note: Standardized scores reflect the number of standard deviation units a given score is distant from the mean of the entire distribution (that is, from the entire group).

Second, I considered all scores that were greater than or less than 3.10 as cases to eliminate. I chose ±3.10 because both Field (200) and Rasch et al. (2011) suggested it as an acceptable and reasonable distance from the mean of the entire distribution.

Table 3 lists the cases excluded on the basis of *z* values. Based on this examination of the standardized scores, these cases were eliminated from the raw scores leaving a study sample of 268 dyads ($N = 268$).

Table 3

Cases Excluded Based on z Values

Measure	Case Number	*z*-score
Dyad Attachment (Intake)	599	(4.59)
Dyad Attachment (Discharge)	623	(4.82)
	482	(4.73)
	479	(3.97)
	487	(3.87)
Depression (Discharge)	242	(3.11)

Assumption Testing (Skew and Kurtosis)

Assumption testing for normality of distribution of scores was conducted to determine the skew and kurtosis coefficients of the three main variables (that is, the normality of the score distributions).

Table 3 shows the standardized skew and kurtosis coefficients. The typical rule for interpreting these values is that skew should not exceed ±2, while kurtosis should not exceed ±5 (Field, 2009a). However, according to Corty (2014) and Howell (2011), with relatively large sizes, minor violations are inconsequential. In the case of the current data, anxiety (discharge) and depression (discharge) have statistically moderate positive skewed scores. This could be an indication of a slight violation of the normality of

distribution score assumption for ANOVA (Field, 2009a). Considering the sample size of 268 and the nature of the ANOVA, which is relatively robust to minor violations of assumptions, this should not be an issue in the succeeding analyses (Corty, 2014).

Table 4

Mean (M), Standard Deviation (SD), Skew, and Kurtosis

Variable	M	SD	Standardized Skew	Standardized Kurtosis
Attachment (Intake)	69.97	9.58	1.35	-0.53
Attachment (Discharge)	78.74	8.96	-1.57	2.35
Anxiety (Intake)	4.35	1.80	0.05	-1.19
Anxiety (Discharge)	3.63	1.87	4.36	-0.35
Depression (Intake)	4.67	1.84	1.02	-1.94
Depression (Discharge)	3.50	1.74	2.77	-1.80

N = 268

Correlations Among Variables

Correlations among the variables were computed as part of the basic descriptive statistics. As expected, the intake and discharge scores were statistically significant when correlated across the three variables. The relationships were moderately positive, with *r* values ranging from .501 to .639. Note that there were statistically significant positive correlations between anxiety (intake and discharge) and depression (intake and discharge). Table 5 summarizes the pairwise correlations among the variables.

Table 5

Correlation Matrix

	Variables	1	2	3	4	5
1	Attachment (Intake)					
2	Attachment (Discharge)	.639**				
3	Anxiety (Intake)	.106	.075			
4	Anxiety (Discharge)	.094	-.080	.584**		
5	Depression (Intake)	.000	.037	.391**	.224**	
6	Depression (Discharge)	.003	-.097	.347**	.617**	.501**

**$p < .01$, ***$p < .001$
$N = 268$

Main Analysis

To test the three hypotheses of the study, I analyzed the overall difference between intake and discharge scores using MANOVA in a linear combination of the three dependent variables—dyadic attachment, maternal anxiety, and maternal depression. The first analysis combined both mother-child and mother-infant dyad data. Then, the second analysis separated the two dyads' data into two subgroups, mother-infant dyads and mother-child dyads.

Table 6 summarizes the results of the MANOVA analysis of the overall data.

Table 6

Mean Comparisons by MANOVA Multivariate Test (Overall Data)

	Intake		Discharge					
	N = 268		*N* = 268					Effect Size
Variables	M	SD	M	SD	Wilks'λ	*df*	*F*	η^2
Attachment	69.97	9.58	78.74	8.96	.757	(3, 532)	56.78	.243
Anxiety	4.35	1.80	3.63	8.96				
Depression	4.67	1.84	3.50	1.74				

Table 7 reports the summary of results for univariate ANOVA *F* tests of overall data.

Table 7

Mean Comparisons by MANOVA—Univariate ANOVA F Test (Overall Data)

	Intake		Discharge					
	N = 268		*N* = 268					Effect size
Variables	M	SD	M	SD	*F*	*df*	*p*	η^2
Attachment	69.97	9.58	78.74	8.96	119.698	(1, 534)	<.001	.183
Anxiety	4.35	1.80	3.63	8.96	20.715	(1, 534)	<.001	.037
Depression	4.67	1.84	3.50	1.74	56.567	(1, 534)	<.001	.096

Table 8 reports the MANOVA multivariate test for two dyads' data.

Table 8

Mean Comparisons by MANOVA Multivariate Test

		Intake		Discharge					Effect size
Group	Variables	M	SD	M	SD	*Wilks λ*	*df*	*F*	η^2
Mother-Infant (*n* = 126)	Attachment	71.01	9.46	79.28	9.69	.815	(3, 248)	18.72	.185
	Anxiety	4.19	1.70	3.63	9.69				
	Depression	4.51	1.94	3.50	1.81				
Mother-Child (*n* = 142)	Attachment	69.04	9.63	78.25	8.27	.681	(3, 280)	43.78	.319
	Anxiety	4.49	1.87	3.62	8.27				
	Depression	4.81	1.75	3.51	1.68				

Table 9 reports the summary of results for univariate ANOVA *F* tests of two dyads' data.

Results of Study

To test for differences in intake and discharge scores among overall combinations of dyadic attachment, maternal anxiety, and maternal depression, I used Multivariate Analysis of Variance (MANOVA) and Levene's test, which allowed me to determine whether the error variance remained homogeneous across time. Levene's test reported a *p* value greater than .05 for the overall data. In addition, Levene's test also reported a *p* value greater than .05 for each of the dependent variables associated with the two dyads'

data groups. Interestingly, this means that we cannot reject the null hypothesis of homogeneity of variance across time at a .05 significance level. This finding, in turn, confirms that this MANOVA analysis satisfies the assumption of homogeneity of variance.

Table 9

Mean Comparisons by MANOVA—Univariate ANOVA F Test

		Intake		Discharge					Effect size
Group	Variables	M	SD	M	SD	*F*	*df*	*p*	η^2
Mother-Infant (*n* = 126)	Attachment	71.01	9.46	79.28	9.69	46.97	(1, 250)	<.001	.158
	Anxiety	4.19	1.70	3.63	9.69	6.18	(1, 250)	<.001	.024
	Depression	4.51	1.94	3.50	1.81	18.16	(1, 250)	<.001	.068
Mother-Child (*n* = 142)	Attachment	69.04	9.63	78.25	8.27	74.82	(1, 282)	<.001	.210
	Anxiety	4.49	1.87	3.62	8.27	15.04	(1, 282)	<.001	.051
	Depression	4.81	1.75	3.51	1.68	41.08	(1, 282)	<.001	.127

MANOVA reported significant difference in overall mean score (that is, a combination of dyadic attachment, maternal anxiety, and maternal depression) between intake and discharge periods. For overall data, a multivariate test—again part of MANOVA—reported a significant result using Wilks' lambda and the associated *F* test (Wilks' $\lambda = 0.757$, $F\ (3532) = 56.78$, and $p = <.001$).

A statistically significant result was also reported for a multivariate test of two dyads' data (that is, Wilks' $\lambda = 0.815$, F (3, 248) = 18.72, and $p = <.001$ for the mother-infant group and Wilks' $\lambda = 0.681$, F (3, 280) = 43.78, $p = <.001$ for the mother-child group). In addition, effect size, as measured by partial eta squared value reports, was statistically moderate. Results of the multivariate test for the overall score indicate that there was a statistically significant difference between intake and discharge.

Hypothesis 1: Difference in Dyadic Measures of Attachment

It was hypothesized that completion of the SBARC treatment program would lead to increased attachment in the mother-infant/child dyads. Results of univariate ANOVA F test indicated that discharge attachment scores were significantly higher compared to intake scores. This was noted for the overall data (F (1, 534) = 119.698, $p = <.001$) as well as for the subgroup analysis: mother-infant dyads (F (1, 250) = 46.97, $p = <.001$) and mother-child dyads (F (1, 282) = 74.82, $p = <.001$). Thus, the findings provided support for the first hypothesis.

Hypothesis 2: Difference in Maternal Anxiety

It was hypothesized that women who completed SBARC treatment program would experience decreased levels of anxiety. The results indicated that anxiety scores were significantly lower at discharge than at intake. This was noted for the overall analysis (F (1, 534) = 20.715, $p < .001$) as well as for the subgroup analysis: mother-infant dyads (F (1, 250) = 6.18, $p = .018$) and mother-child dyads (F (1, 282) = 15.04, $p < .001$). Thus, the findings provided support for the second hypothesis.

Hypothesis 3: Difference in Maternal Depression

It was hypothesized that women who completed the SBARC treatment program would experience decreased levels of depression. Results indicated that depression scores were significantly lower during discharge when compared to the scores at intake. This was noted for the overall analysis (F (1, 534) = 56.567, $p < .001$) as well as for the subgroup analysis: mother-infant dyads (F (1, 250) = 18.16, $p < .001$) and mother-child dyads (F (1, 282) = 41.08, $p < .001$). Thus, the findings provided support for the third hypothesis.

In conclusion, the findings provided support for all three hypotheses. These results provided additional support (within the context of a nonexperimental design) that the SBARC experience may have or tended to have (Johnson & Christensen, 2014) a measurable impact on these treatment variables.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THIS STUDY

This study focused on three variables: dyadic attachment, maternal anxiety, and maternal depression. I sought to discover, through careful analysis of the archival client records, whether measurements of these three treatment variables would change by the time that the clients were discharged from treatment.

The key evaluation tools—the Mother-Infant Interaction Scale (see Appendix C), the Mother-Child Interaction Scale (see Appendix D), and the Functional Assessment Rating Scale (FARS), Florida Version (see Appendix E)—were used consistently over the 16-year period from which the sample population for this study was drawn. From the first evaluations conducted in 1995 through the end of 2010, these rating instruments were used without any revisions or modifications.

A Masters or doctoral level clinician administered each of these standard assessments within two weeks of intake to residential treatment and repeated the same assessments shortly before the end of the treatment episode. Each test was completed by the clinician and relied primarily on the clinician's judgment of functioning, based on direct observation of the mother-infant/child dyad (with regard to dyadic attachment) and of the mother (with regard to maternal depression and maternal anxiety).

Table 10 summarizes the results of this study. Furthermore, Table 10 separates the total sample ($N = 268$) into two subgroups: mothers with infants ($n = 126$) and mothers with children ($n = 142$). As shown in Table 10, the analysis measured statistically significant increases in dyadic attachment and statistically significant decreases in maternal anxiety and maternal depression in both subgroups.

Table 10

Summary of Results

Subgroup		Hypothesis	Results
Women with Infants (n = 126)	HA1:	Woman and infant dyads who completed SBARC treatment would experience increases in measures of dyadic attachment	Statistically significant difference
Women with Children (n = 142)	HA1:	Women and children dyads who completed SBARC treatment would experience increases in measures of dyadic attachment.	Statistically significant difference
Mothers of Infants (n = 126)	HA2:	Women who completed SBARC treatment would experience decreases in measured levels of anxiety.	Statistically significant difference
Mothers of Children (n = 142)	HA2:	Women who completed SBARC treatment would experience decreases in measured levels of anxiety.	Statistically significant difference
Mothers of Infants (n = 126)	HA3:	Women who completed SBARC treatment would experience decreases in measured levels of depression.	Statistically significant difference
Mothers of Children (n = 142)	HA3:	Women who completed SBARC treatment would experience decreases in levels of depression.	Statistically significant difference

The statistical analyses for the first hypothesis (HA1) dealt with measures of attachment in the mother-infant and mother-child dyads. For both subgroups, the analyses indicated that I might be seeing a positive change that could be related to the residential treatment program. In the case of the mother-infant dyads (subgroup $n = 126$), the average discharge evaluations were 8.9 points higher than the initial intake evaluations. Similarly, mother-child dyads (subgroup $n = 142$) showed an average improvement of 9.8 points when the intake evaluation score was compared with the discharge evaluation score.

The statistical analysis for the second hypothesis (HA2) was related to measures of anxiety of all women in the sample ($N = 268$). In both the overall and subgroup analyses, I found a small, but nevertheless statistically significant (d values ranged from .10 to .17), decrease in anxiety over the course of participation in the treatment program.

The statistical analysis for the third hypotheses (HA3) was related to measures of depression of all mothers in the sample ($N = 268$), as measured once at the beginning of treatment (intake) and again just before discharge. Results indicated statistically medium-to-large effect sizes (d values ranged from .54 to .76) for the overall sample and the individual subgroups, which suggested that observed levels of maternal depression were significantly lowered by the end of treatment in the program.

Finally, the correlational analyses, which examined the intercorrelations among all three variables, were moderately positive (r values ranging from .501 to .639). This suggests the possibility of a dynamic interaction among these variables that may be contributing to a better outcome and possibly to the overall success rate of the program. Since this study is a nonexperimental, retrospective explanatory analysis of the historical

case data, and since precise descriptions of the various forms of the treatment programs employed during the times when treatment was obtained were not preserved in the historical record, I can only conjecture which element of the treatment experience at SBARC most directly contributed to the treatment effects observed and analyzed in this study.

Findings and Methodological Implications

Clearly, the findings of this nonexperimental, retrospective explanatory study are very encouraging. From this analysis of the sample population taken from 16 years of case history, I conclude that maternal depression and maternal anxiety seem to have been lowered during the residential treatment, while dyadic attachment has been significantly strengthened.

Methodological Implications of Dyadic Attachment

The design and administration of the two attachment test instruments—the Mother-Infant Interaction Scale (see Appendix C) and the Mother-Child Interaction Scale (see Appendix D)—are very similar. The trained clinician observes the dyad over an extended session and rates the number and quality of generative characteristics observed. Because these scores represent ordinal data (in this case, the clinician ranks attachment characteristics on a three-point scale: 1=Rarely; 2=Sometimes; and 3=Always or most of the time), this study can only tell us that positive change (that is, an improvement) was measured when the discharge evaluation scores were compared with those of the intake scores for the sample population. I cannot make any further empirically significant claims about the value of each "point" of improvement in attachment scores. However, there is a

long and substantial history of research (see Chapter II) where these and similar instruments have been used to evaluate the quality of the dyadic attachment.

Methodological Implications of Maternal Anxiety and Maternal Depression

The analyses revealed what might be significant treatment effects for both maternal anxiety and maternal depression. Reductions in maternal anxiety showed small effect sizes (*d* values ranging from .10 to .17) when measured at the beginning of treatment and just prior to discharge. Levels of maternal depression in the sample decreased more dramatically over the course of treatment yielding medium-to-large effect sizes (*d* values ranging from .54 to .76). Again, since the treatment records contain no clear description of the treatment program as it existed throughout the 16 years, I can only speculate as to what elements of the total program may have contributed most significantly to the results presented here.

Findings Relative to the Literature

As the preponderance of literature suggests (see Chapter II), a holistic treatment milieu for women seeking treatment for co-occurring conditions ranks high in both effectiveness and outcome success. A somewhat unusual aspect of the SBARC treatment approach is that they enable women to keep their young children in residence with them while undergoing treatment.

The results of this study are encouraging in that they demonstrate the existence of a statistically positive treatment effect, which supports the anecdotal improvement in dyadic attachment observed by the clinicians in the sample population. In addition, the results indicate that women completing treatment at SBARC have experienced significant decreases in observed levels of maternal anxiety and maternal depression. Furthermore,

the results of the MANOVA analysis (see Chapter IV) point to possible evidence of a dynamic relationship among dyadic attachment, maternal anxiety, and maternal depression (that is, an increase in dyadic attachment may indicate a likelihood of decreased maternal anxiety and maternal depression and vice versa).

Public charities, such as SBARC, depend heavily on contributions and grants from various corporate and government institutions and programs. In most cases, overall program success rate is measure by the percentage of patients successfully completing the residential portion of the treatment program. This success rate percentage becomes a key performance measure upon which continued and future funding is based (M. Currant, personal communication, July 27, 2010). Based on the results of this study, I found that the women in this sample successfully completed treatment in nearly 60% of the cases.

Since it can be argued that these three treatment variables are probably closely related to treatment outcomes in general, I believe that future SBARC studies dealing more directly with attachment-theory-inspired interventions may lead to greater gains in dyadic attachment and in lowered levels of maternal anxiety and maternal depression.

Findings and the Main Question

This nonexperimental, retrospective explanatory study provided an effective and rigorous method for examining the SBARC historical record. A key motivation for doing this study was to understand whether the clinical record could provide any evidence that these key treatment variables—dyadic attachment, maternal anxiety, and maternal depression—were positively affected by the various treatment interventions provide at SBARC over the years. From a preliminary standpoint, I am encouraged that the analysis revealed the possibility of statistically significant relationships for each of the three

variable studied as well as possibly statistically significant relationships among the three variables when analyzed together.

Over the 16 years comprising this study, the SBARC treatment program (see Appendices J and K) has consisted of a rich and varied offering of therapy, effective living programs, and the like. While this outstanding offering has grown over time, I believe that infrastructural limitations, including scarce funding and lack of research personnel, have prevented the organization from performing basic empirical research activities that would greatly help them determine what types of program interventions will lead to the most beneficial results.

Conclusions and Future Implications

Much of the addiction literature—and certainly the attachment literature—closely relates the importance of increased attachment in the mother-child dyad and decreased maternal anxiety and maternal depression in the mother dealing with a co-occurring condition. I believe that future tracking of these three treatment variables would be of enormous benefit to SBARC.

One useful and cost-effective way to elevate the attention given to issues of dyadic attachment might be to use a simple self-evaluation to determine the adult attachment style of each woman at the beginning of the treatment episode. For over two years now, I have used one such evaluation, the Revised Adult Attachment Scale (Collins, 1996), in my private psychotherapy practice (see Appendix M) to determine the dominant attachment styles of the individuals and couples with whom I work. An individual can complete this easy-to-score scale in just a few minutes. In my practice, I have found this scale to be a useful tool for collaboratively identifying areas on which to

focus treatment. In addition, in family work, whether we treat the evaluated attachment style as measurement or metaphor, I have experienced how clients readily embrace and use attachment styles as a scaffolding on which to strive for more effective outcomes.

I believe that by matching measurements of adult attachment style with long-established treatment approaches informed by attachment theory (Beck, 2011; Greenberg & Johnson, 2004; Hughes, 2007; Johnson, 2001; Mikulincer & Shaver, 2010; Wallin, 2007), it may be possible to better target each woman's treatment plan in such a way as to increase attachment outcomes with the infant/child and decrease feelings of maternal anxiety and maternal depression over the course of treatment. In fact, many of the leading attachment-informed therapy approaches (especially Hughes, 2007; Johnson, 2001; and, to a somewhat lesser extent, Wallin, 2007) focus primarily on the systemic, relational, and interactional contexts of the client's experience, which makes them very well suited for use by marriage and family practitioners, thus expanding the knowledge of the therapist with regards to the treatment modality.

Over the years, SBARC has successfully helped hundreds of women and their children build healthy lives and brighter futures. The results they have achieved in serving some of the surrounding community's most desperately needy families has been and continues to be—in many instances—nothing short of miraculous. Their long-established and continuing efforts to improve the quality and effectiveness of their services ensure that they will continue to provide Help, Hope, and Healing to mothers and children in the community for many years to come.

References

Ainsworth, M. (1967). *Infancy in Uganda: Infant care and the growth of love*. Oxford, England: Johns Hopkins Press.

Ainsworth, M., & Bell, S. (1969). Some contemporary patterns of mother-infant interaction in the feeding situation. In A. Ambrose (Ed.), *Stimulation in Early Infancy* (pp. 133-170). London, England: Academic Press.

Ainsworth, M., Bell, S., & Stayton, D. (1971). Individual differences in the development of some attachment behaviors. *Merrill-Palmer Quarterly of Behavior and Development, 14*(2), 123-143. Wayne State University Press.

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: Assessed in the strange situation and at home*. Hillsdale, NJ: Erlbaum.

Ainsworth, M., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46*(4), 333. doi: 10.1037/0003066X .46.4.333

Ainsworth, M., & Wittig, B. (1969). Attachment and exploratory behavior of one-year-olds in a strange situation. In B. M. Foss (Ed.), *Determinants of infant behaviour* (Vol. IV, pp. 111-136). London, England: Methuen.

American Psychological Association (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed.). Washington, DC: American Psychological Association.

Ammer, C. (2013). *The American Heritage Dictionary of Idioms*. Chicago, IL: Houghton Mifflin Harcourt.

Andersson, L., Sundström-Poromaa, I., Wulff, M., Åström, M., & Bixo, M. (2004). Neonatal outcome following maternal antenatal depression and anxiety: A population-based study, *American Journal of Epidemiology, 159*(9), 872-881. doi: 10.1093/aje/kwh122

Axia, G. (2002). *QUIT. Questionari italiani del temperamento* [Italian questionnaire for child's temperament] (Vol. 24). Trento, Italy: Erickson.

Bakermans-Kranenburg, M., van Ijzendoorn, M., & Juffer, F. (2005). Disorganized infant attachment and preventive interventions: A review and meta-analysis. *Infant Mental Health Journal, 26*(3), 191-216. doi: 10.1002/imhj.20046

Barr, J. (2008). Postpartum depression, delayed maternal adaptation, and mechanical infant caring: A phenomenological hermeneutic study. *International Journal of Nursing Studies, 45*(3), 362-369. doi: 10.1016/j.ijnurstu.2006.10.002

Bartholomew, K., & Horowitz, L. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226-244. doi: 10.1037/0022-3514.61.2.226

Bateson, G. (1971). The cybernetics of "self": A theory of alcoholism. *Psychiatry: Journal for the Study of Interpersonal Processes*, *34*(1), 1-18. doi: 10.1037 /10112-038

Bateson, G. (1979). *Mind and nature: A necessary unity* (1st ed.). New York, NY: Dutton.

Bateson, G. (2000). *Steps to an ecology of mind*. Chicago, IL: University of Chicago Press.

Bateson, G., & Donaldson, R. (1991). *A sacred unity: Further steps to an ecology of mind* (1st ed.). New York, NY: HarperOne.

Baumrind, D. (1968). Authoritarian vs. authoritative parental control. *Adolescence, 3*(11), 255-272.

Beck, J. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.

Beitchman, J., Zucker, K., Hood, J., DaCosta, G., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect, 16*(1), 101-118. doi: 10.1016/0145-2134(92)90011-F

Bell, S., & Ainsworth, M. (1972). Infant crying and maternal responsiveness. *Child Development*, *43*(4), 1171-1190. Hoboken, NJ: Wiley. doi: 10.1111/j.14678624 .1972.tb02075.x

Belli, G. (2009). Nonexperimental quantitative research. In S. D. Lapan & M. T. Quartaroli (Eds.), *Research essentials: An introduction to designs and practices* (pp. 59-77). San Francisco, CA: Jossey-Bass.

Bem, D., & Funder, D. (1978). Predicting more of the people more of the time: Assessing the personality of situations. *Psychological Review, 85*(6), 485. doi: 10.1037 /0033-295X.85.6.485

Benishek, L., Bieschke, K., Stöffelmayr, B., Mavis, B., & Humphreys, K. (1992). Gender differences in depression and anxiety among alcoholics. *Journal of Substance Abuse, 4*(3), 235-245. doi: 10.1016/0899-3289(92)90032-S

Blatz, W. (1940). *Hostages to peace: Parents and the children of democracy*. New York, NY: Morrow.

Block, J. (1952). The Q-sort in assessment and some problems in its use. *IPAR Research Bulletin*, Department of Psychology, University of California, Berkeley.

Block, J. (1961). *The Q-sort method in personality assessment and psychiatric research*. Springfield, IL: Thomas

Block, J. (2008). The Q-sort in character appraisal: Encoding subjective impressions of persons quantitatively (pp. 45-53). Washington, DC: American Psychological Association. doi: 10.1037/11748-005

Block, J., & Block, J. H. (1980). The role of ego-control and ego-resiliency in the organization of behavior. In W. A. Collins (Ed.), *Development of cognition, affect, and social relationships: The Minnesota symposia on child psychology* (Vol. 13, pp. 39-101). Hillsdale, NJ: Erbaum.

Bowen, M. (1978). *Family therapy in clinical practice*. New York, NY: Aronson.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psycho-Analysis, 39*, 350-373.

Bowlby, J. (1969). *Attachment and loss.* London, England: Hogarth.

Bowlby, J. (1973). *Separation: Anxiety and anger* (Vol. 2*)*. New York, NY: Basic Books.

Bowlby, J. (1980). *Attachment and loss* (Vol. 3). New York, NY: Basic Books.

Bowlby, J. (1982). *Attachment* (2nd ed., Vol. 1*)*. New York, NY: Basic Books.

Bowlby, J. (1985). Interview with John Bowlby, *Bethlem and Maudsley Gazette, 32*(4), 20-23.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.

Bowlby, J., & Ainsworth, M. (1951). *Maternal care and mental health*. Geneva, Switzerland: World Health Organization.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*(5), 759-775. doi: 10.1037 /0012-1649.28.5.759

Bretherton, I., Ridgeway, D., & Cassidy, J. (1990). Assessing internal working models of the attachment relationship. In M. T. Greenberg, D. Ciccetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 273-308). Chicago, IL: University of Chicago Press.

Brown, P., Read, J., & Kahler, C. (2003). Comorbid posttraumatic stress disorder and substance use disorders: Treatment outcomes and the role of coping. In P. Ouimette & P. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 171-188). Washington, DC, US: American Psychological Association. doi: 10.1037/10460-009

Burnett, M., & Williams, J. (2009). Institutional uses of rubrics and e-portfolios: Spelman College and Rose-Hulman Institute. *Peer Review, 11*(1), 24.

Cain, A., & Fast, I. (1972). Children's disturbed reactions to parent suicide. *Survivors of Suicide*, 93-111. doi: 10.1111/j.1939-0025.1966.tb02416.x

Carlson, E. (1988). A prospective longitudinal study of disorganized/disoriented attachment. *Child Development, 69*(4), 1107-1128.

Carroll, K., Power, M., Bryant, K., & Rounsaville, B. (1993). One-year follow-up status of treatment-seeking cocaine abusers: Psychopathology and dependence severity as predictors of outcome. *Journal of Nervous and Mental Disease, 181*(2), 71-79.

Cassidy, J. (1988). Child-mother attachment and the self in six-year-olds. *Child Development*, *59*(1), 121-134. doi: 10.1111/j.1467-8624.1988.tb03200.x

Chesney-Lind, M., & Pasko, L. (2013). *The female offender: Girls, women, and crime* (3rd ed.). Thousand Oaks, CA: Sage.

Christophe, A., Dupoux, E., & Mehler, J. (1994). Do infants perceive word boundaries? An empirical study of the bootstrapping of lexical acquisition. *Journal of the Acoustical Society of America, 95,* 1570. doi:10.1121/1.408544

Cicchetti, D., Rogosch, F., & Toth, S. (1998). Maternal depressive disorder and contextual risk: Contributions to the development of attachment insecurity and behavior problems in toddlerhood. *Development and Psychopathology, 10*(2), 283-300. doi: 10.1017/S0954579498001618

Clark, A., & Foy, D. (2000). Trauma exposure and alcohol use in battered women. *Violence Against Women, 6*(1), 37-48. doi: 10.1177/10778010022181697

Cocozza, J., Jackson, E., Hennigan, K., Morrissey, J., Reed, B., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(2), 109-119. doi: 10.1016/j.jsat.2004.08.010

Collins, N. (1996). Working models of attachment: Implications for explanation, emotion, and behavior. *Journal of Personality and Social Psychology, 71*(4), 810.

Colman, R., & Widom, C. (2004). Childhood abuse and neglect and adult intimate relationships: A prospective study. *Child Abuse & Neglect, 28*(11), 1133-1151. doi: 10.1016/j.chiabu.2004.02.005

Colten, M. (1982). Attitudes, experiences, and self-perceptions of heroin addicted mothers. *Journal of Social Issues, 38*(2), 77-92.

Conners, N., Grant, A., Crone, C., & Whiteside-Mansell, L. (2006). Substance abuse treatment for mothers: Treatment outcomes and the impact of length of stay. *Journal of Substance Abuse Treatment, 31*(4), 447-456. doi:10.1016/j.jsat .2006.06.001

Cort, N., Toth, S., Cerulli, C., & Rogosch, F. (2011). Maternal intergenerational transmission of childhood multitype maltreatment. *Journal of Aggression, Maltreatment, & Trauma, 20*(1), 20-39. doi: 10.1080/10926771.2011.537740

Corty, E. (2014). *Using and interpreting statistics: A practical text for the health, behavioral, and social sciences* (2nd ed.). New York, NY: Worth.

Covington, S. (1999). *Helping women recover: A program for treating addiction, facilitator's guide*. San Francisco, CA: Jossey-Bass.

Covington, S., & Bloom, B. (2007). Gender responsive treatment and services in correctional settings. *Women & Therapy, 29*(3-4), 9-33. doi: 10.1300 /J015v29n03_02

Covington, S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, 40*(sup5), 387-398. doi: 10.1080/02791072 .2008.10400666

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Cullen, R., & Harris, M. (2009). Assessing learner-centredness through course syllabi. *Assessment and Evaluation in Higher Education, 34*(1), 115. doi: 10.1080 /02602930801956018

Currant, M. (2012). *Susan B. Anthony Recovery Center program description*. Susan B. Anthony Recovery Center. Pembroke Pines, FL. [Memorandum]

Curry, J. (May 2014). Future directions in research on psychotherapy for adolescent depression. *Journal of Clinical Child and Adolescent Psychology, 43*(3), 510-526.

Davis, C., & Michelle, C. (2011). Q methodology in audience research: Bridging the qualitative/quantitative 'divide'? *Participations: Journal of Audience and Reception Studies, 8*(2), 559-593.

Deave T, Heron J, Evans J, Emond A (2008). The impact of maternal depression in pregnancy on early child development. *BJOG International Journal of Obstetrics and Gynaecology, 115*(8):1043–1051

de Shazer, S. (1994). *Words were originally magic*. New York, NY: Norton.

Diamond, G. S. (2005). Attachment-based family therapy for depressed and anxious adolescents. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 17-41). Hoboken, NJ: Wiley.

Diamond, G. S., Diamond, G. M., & Levy, S. (2014). *Attachment-based family therapy for depressed adolescents.* Washington, DC: American Psychological Association.

Diamond, S. G., Wintersteen, M., Brown, G., Diamond, G. M., Gallop, R., Shelef, K., Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: A randomized controlled trial, *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(2), 122-131.

Diamond, G. S., Reis, B., Diamond, G. M., Siqueland, L., & Isaacs, L. (October 2002). Attachment-based family therapy for depressed adolescents: A treatment development study. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(10), 1190-1196.

Dinur, A., & Sherman, H. (2009). Incorporating outcomes assessment and rubrics into case instruction. *Journal of Behavioral and Applied Management, 10*(2), 291.

Dodge, R., Sindelar, J., & Sinha, R. (2005). The role of depression symptoms in predicting drug abstinence in outpatient substance abuse treatment. *Journal of Substance Abuse Treatment, 28*(2), 189-196. doi: 10.1016/j.jsat.2004.12.005

Donges, U., Kugel, H., Stuhrmann, A., Grotegerd, D., Redlich, R., Lichev, V., . . . Dannlowski, U. (2012). Adult attachment anxiety is associated with enhanced automatic neural response to positive facial expression. *Neuroscience, 220*(9), 149-157. doi: 10.1016/j.neuroscience.2012.06.036

Doron, G., Moulding, R., Kyrios, M., Nedeljkovic, M., & Mikulincer, M. (2009). Adult attachment insecurities are related to obsessive compulsive phenomena. *Journal of Social and Clinical Psychology, 28*(8), 1022-1049. doi: 10.1521/jscp.2009.28.8.1022

Easton, C. (2006). The role of substance abuse in intimate partner violence. *Psychiatric Times, 25*(1), 26-27.

Egger, H., & Angold, A. (2004). The preschool age psychiatric assessment (PAPA): A structured parent interview for diagnosing psychiatric disorders in preschool children. In R. DelCarmen-Wiggins & A. Carter (Eds.), *Handbook of infant, toddler, and preschool mental health assessment* (pp. 223-243). New York, NY: Oxford University Press.

Ellis, R., Wackwitz, J., & Foster, M. (1991). Uses of an empirically derived client typology based on level of functioning: Twelve years of the CCAR. *The Journal of Behavioral Health Services and Research, 18*(2), 88-100. doi: 10.1007 /bf02518603

Feldman, R., Gordon, I., & Zagoory-Sharon, O. (2011). Maternal and paternal plasma, salivary, and urinary oxytocin and parent-infant synchrony: Considering stress and affiliation components of human bonding. *Developmental Science, 14*(4), 752-761. doi: 10.1111/j.1467-7687.2010.01021.x

Feldman, R., Granat, A., Pariente, C., Kanety, H., Kuint, J., Gilboa-Schechtman, E. (2009). Maternal depression and anxiety across the postpartum year and infant social engagement, fear regulation, and stress reactivity. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(9):919–927.

Field, A. (2009). *Discovering statistics using SPSS (and sex drugs and rock 'n' roll)* (3rd ed.). Los Angeles, CA: Sage.

Forsyth, J., Parker, J., & Finlay, C. (2003). Anxiety sensitivity, controllability, and experiential avoidance and their relation to drug of choice and addiction severity in a residential sample of substance-abusing veterans. *Addictive Behaviors, 28*(5), 851-870. doi: 10.1016/S0306-4603(02)00216-2

Fraley, R. (2002). Attachment stability from infancy to adulthood: Meta-analysis and dynamic modeling of developmental mechanisms. *Personality and Social Psychology Review, 6*(2), 123-151. doi: 10.1207/S15327957PSPR0602_03

Freud, M. (1958). *Sigmund Freud: Man and father*. New York, NY: Aronson.

Freud, S., & Gay, P. (1989). *The Freud reader* (1st ed.). New York, NY: Norton.

Gall, M., Gall, J., & Borg, W. (2007). *Educational research: An introduction* (8th ed.). Boston, MA: Pearson/Allyn & Bacon.

Gay, L., Mills, G., & Airasian, P. (2012). *Educational research: Competencies for analysis and applications* (10th ed.). Boston, MA: Pearson.

George, C., Kaplan, N., & Main, M. (1984, 1985). *The Berkeley adult attachment interview*. Unpublished manuscript, Department of Psychology, University of California, Berkeley.

George, C., Kaplan, N., & Main, M. (1996). *The adult attachment interview.* Unpublished manuscript. Department of Psychology. University of California, Berkeley.

Gilbert, L., El-Bassel, N., Manuel, J., Wu, E., Go, H., Golder, S., . . . Sanders, G. (2006). An integrated relapse prevention and relationship safety intervention for women on methadone: Testing short-term effects on intimate partner violence and substance use. *Violence and Victims, 21*(5), 657-672. doi: 10.1891/vivi.21.5.657

Glasheen, C., Richardson, G., Fabio, A. (2010). A systematic review of the effects of postnatal maternal anxiety on children. *Archives of Womens Mental Health, 13*(1):61–74.

Goecke, T., Voigt, F., Faschingbauer, F., Spangler, G., Beckmann, M, & Beetz, A. (2012). The association of prenatal attachment and perinatal factors with pre- and postpartum depression in first-time mothers. *Archives of Gynecology and Obstetrics*, 1-8. doi: 10.1007/s00404-012-2286-6

Golding, J. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132.

Grant, B., Stinson, F., Dawson, D., Chou, S., Dufour, M., Compton, W., . . . Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 61*(8), 807. doi:10.1001/archpsyc.61.8.807

Gravetter, F., & Wallnau, L. (1991). *Essentials of statistics for the behavioral sciences*. St. Paul, MN: West.

Gray, C. (2011). *Binge eating and overweight in childhood from an attachment perspective.* San Francisco, CA: Alliant International University.

Greco, J. (2010). *Contextual influences on adolescents' psychosocial adjustment: Effects of exposure to community violence and child maltreatment and the role of parent-child attachment.* (Doctoral dissertation, Rosalind Franklin University of Medicine and Science, North Chicago, IL). Available from ProQuest Dissertation and Theses database.

Greenberg, L., & Johnson, S. (2004). *Emotionally focused therapy for couples* (2nd ed.). New York, NY: Guilford Press.

Grella, C. (1996). Background and overview of mental health and substance abuse treatment systems: Meeting the needs of women who are pregnant and parenting. *Journal of Psychoactive Drugs, 28*(4), 319-343. doi:10.1080/02791072 .1996.10472614

Grella, C. (2003). Effects of gender and diagnosis on addiction history, treatment utilization, and psychosocial functioning among a dually diagnosed sample in drug treatment. *Journal of Psychoactive Drugs, 35*(sup1), 169-179. doi: 10.1080/ 02791072.2003.10400512

Grella, C., & Young, N. (1998). Mental health and substance abuse treatment services for dually diagnosed clients: Results of a statewide survey of county administrators. *The Journal of Behavioral Health Services and Research, 25*(1), 83-92. doi: 10.1007/BF02287503

Grossmann, K. E., Grossmann, K., & Waters, E. (2005). *Attachment from infancy to adulthood: The major longitudinal studies*. New York, NY: Guilford Press.

Guttmann-Steinmetz, S., Shoshani, A., Farhan, K., Aliman, M., & Hirschberger, G. (2012). Living in the crossfire. *International Journal of Behavioral Development, 36*(1), 71-78. doi: 10.1177/0165025411406861

Guydish, J., Sorensen, J., Chan, M., Werdegar, D., Bostrom, A., & Acampora, A. (1999). A randomized trial comparing day and residential drug abuse treatment: 18-month outcomes. *Journal of Consulting and Clinical Psychology, 67*(3), 428. doi: 10.1037//0022-006X.67.3.428

Guydish, J., Werdegar, D., Sorensen, J., Clark, W., & Acampora, A. (1998). Drug abuse day treatment: A randomized clinical trial comparing day and residential treatment programs. *Journal of Consulting and Clinical Psychology, 66*(2), 280-289. doi: 10.1037//0022-006X.66.2.280

Hanke, P., & Faupel, C. (1993). Women opiate users' perceptions of treatment services in New York City. *Journal of Substance Abuse Treatment, 10*(6), 513-522. doi: 10.1016/0740-5472(93)90054-6

Harlow, H. (1959). Love in infant monkeys. *Scientific American*, *200*, 68-74.

Hasin, D., Liu, X., Nunes, E., McCloud, S., Samet, S., & Endicott, J. (2002). Effects of major depression on remission and relapse of substance dependence. *Archives of General Psychiatry, 59*(4), 375.

Healthy Start Coalition. (n.d.). *Broward healthy start coalition: Together, supporting mothers and babies.* Retrieved August 1, 2012, from http://www.browardhsc.org/HealthyStart/AboutTheProgram

Hennessy, M., Deak, T., & Schiml-Webb, P. (2010). Early attachment-figure separation and increased risk for later depression: Potential mediation by proinflammatory processes. *Neuroscience & Biobehavioral Reviews, 34*(6), 782-790. doi: 10.1016/j.neubiorev.2009.03.012

Hirshfeld, D., Rosenbaum, J., Biederman, J., Bolduc, E., Faraone, S., Snidman, N., Reznick, J., Kagan, J. (1992). Stable behavioral inhibition and its association with anxiety disorder. *Journal of the American Academy of Child & Adolescent Psychiatry 31*(1), 103-111.

Howell, D. (2011). *Statistical methods for psychology*: *Cengage Learning.* Belmont, CA: Wadsworth.

Hughes, D. (2007). *Attachment-focused family therapy*. New York, NY: Norton.

IBM® SPSS® Statistics 20. (2011). Armonk, NY: IBM Corporation.

Jackson, D., & Haley, J. (1963). Transference revisited. *Journal of Nervous and Mental Disease*, *137*(4), 363-371.

Jakobsen, I., Horwood, L., & Fergusson, D. (2011). Childhood anxiety/withdrawal, adolescent parent-child attachment and later risk of depression and anxiety disorder. *Journal of Child and Family Studies*, *4*, 1-8. doi: 10.1007/s10826-011-9476-x

Johnson, R. (2001). Toward a new classification of nonexperimental quantitative research. *Educational Researcher, 30*(1), 3-13.

Johnson, R., & Christensen, L. (2014). *Educational research: Quantitative, qualitative, and mixed approaches* (5th ed.). Thousand Oaks, CA: Sage.

Jordan, B., Federman, E., Burns, B., Schlenger, W., Fairbank, J., & Caddell, J. (2002). Lifetime use of mental health and substance abuse treatment services by incarcerated women felons. *Psychiatric Services, 53*(3), 317-325. doi: 10.1176/appi.ps.53.3.317

Jordan, C. (2004). Intimate partner violence and the justice system. *Journal of Interpersonal Violence, 19*(12), 1412-1434. doi: 10.1177/0886260504269697

Keeney, B. (1983). *Aesthetics of change*. New York, NY: Guilford Press.

Keil, V., & Haughton, N. (2007). Accreditation data collection requirements versus faculty loads: One college's use of self-study to balance these two realities. *The Teacher Educator, 42*(3), 209. doi: 10.1080/08878730709555403

Kerlinger, F. (1986). *Foundations of behavioral research.*. Fort Worth, TX: Harcourt Brace Jovanovich.

Kerr, M. A. (2012). *Depressed mothers and problem behaviours in their adolescent daughters: The mediating roles of parenting and attachment security.* (Doctoral dissertation, University of Ottawa, Ontario, Canada). Retrieved from https://www.ruor.uottawa.ca/bitstream/10393/30071/1/NR73898.pdf

Kerr, M. E., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen theory* (1st ed.). New York, NY: Norton.

Kersten-Alvarez, L., Hosman, C., Riksen-Walraven, J., van Doesum, K., Smeekens, S., & Hoefnagels, C. (2012). Early school outcomes for children of postpartum depressed mothers: Comparison with a community sample. *Child Psychiatry & Human Development, 43*(2), 201-218. doi: 10.1007/s10578-011-0257-y

Kessler, R., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Posttraumatic stress disorder in the national comorbidity survey, *Archives of General Psychiatry*, 52(12), 1048-1060. doi: 10.1001/archpsyc.1995. 03950240066012

Kieke, M., Moroz, K., & Gort, A. (2007). The transformation to a learner-centered community as a result of university-wide assessment. *On the Horizon, 15*(2), 107. doi: 10.1108/10748120710757343

Kiser, L., Medoff, D., Black, M., Nurse, W., & Fiese, B. (2010). Family mealtime q-sort: A measure of mealtime practices. *Journal of Family Psychology, 24*(1), 92. doi: 10.1037/a0017946

Kokubu, M., Okano, T., & Sugiyama, T. (2012). Postnatal depression, maternal bonding failure, and negative attitudes towards pregnancy: a longitudinal study of pregnant women in Japan. *Archives of Women's Mental Health*, *15*(3), 211-216. doi: 10.1007/s00737-012-0279-x

Levy, K., Ellison, W., Scott, L., & Bernecker, S. (2011). Attachment style. *Journal of clinical psychology, 67*(2), 193-203. doi: 10.1002/jclp.20756

Lewis, C. (2006). Treating incarcerated women: Gender matters. *Psychiatric Clinics of North America, 29*(3), 773-789. doi: 10.1016/J.psc.2006.04.013

Liddle, H., Rowe, C., Dakof, G., Henderson, C., & Greenbaum, P. (2009). Multidimensional family therapy for young adolescent substance abuse: Twelve-month outcomes of a randomized controlled trial. *Journal of Consulting and Clinical Psychology, 77*(1), 12. doi: 10.1037/a0014160

Limke, A., Showers, C., & Zeigler-Hill, V. (2010). Emotional and sexual maltreatment: Anxious attachment mediates psychological adjustment. *Journal of Social and Clinical Psychology, 29*(3), 347-367. doi: 10.1521/jscp.2010.29.3.347

Loper, A., & Tuerk, E. (2011). Improving the Emotional adjustment and communication patterns of incarcerated mothers: Effectiveness of a prison parenting intervention. *Journal of Child and Family Studies, 20*(1), 89-101. doi: 10.1007/s10826-010 -9381-8

Lorenz, K. (1950). The comparative method in studying innate behavior patterns. Physiological mechanisms in animal behavior (Symposium IV, Society for Experiemental Biology), pp. 221-268. Oxford, England: Academic Press.

Lorenz, K. (2003). *The foundations of ethology*. New York, NY: Springer.

Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behavior problems: The role of disorganized early attachment patterns. *Journal of Consulting & Clinical Psychology, 64*(1), 64-73.

Lyons-Ruth, K., Alpern, L., & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behaivor in the preschool classroom. *Child Development, 64*(2), 572-585.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95-124). Westport, CT: Ablex.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/ disoriented during the Ainsworth Strange Situation. In M. T. Greenberg, D. Cicchetti, & M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp 121-160). Chicago, IL: The University of Chicago Press.

Marlatt, G., & Gordon, J. (1985). *Relapse prevention: Maintenance strategies in addictive behavior change*. New York, NY: Guilford Press.

Marsh, J., Cao, D., & D'Aunno, T. (2004). Gender differences in the impact of comprehensive services in substance abuse treatment. *Journal of Substance Abuse Treatment, 27*(4), 289-300. doi: 10.1016/j.jsat.2004.08.004

Martini, J., Wittich, J., Petzolt, J., Winkel, S., Einsle, F., Siegert, J., Hoftler, M., Beesdo-Baum, K., & Wittchen, H-U (2013). Maternal anxiety disorders prior to conception, psychopathology during pregnancy and early infants' development: A prospective-longitudinal study. *Archives of Women's Mental Health Official Journal of the Section on Women's Health of the World Psychiatric Association.* Published online 21 September 2013. doi: 10.1007/s00737-013-0376-5.

Mauri, M., Oppo, A., Montagnani, M., Borri, C., Banti, S., Camilleri, V., Cortopassi, S., Ramacciotti, D., Rambelli, C., Cassano, G. (2010). Beyond "postpartum depressions": Specific anxiety diagnoses during pregnancy predict different outcomes (Results from PND-ReScU). *Journal of Affective Disorders, 127*(1-3),177-184.

McCulloch, W. (1965). *Embodiments of mind.* Cambridge, MA: The MIT Press.

McDaniels-Wilson, C. & Belknap, J. (2008). The extensive sexual violation and sexual abuse histories of incarcerated women. *Violence Against Women, 14* (10), 1090-1120. doi: 10.1177/1077801208323160

McFarland, J., Salisbury, A., Battle, C., Hawes, K., Halloran, K., & Lester, B. (2011). Major depressive disorder during pregnancy and emotional attachment to the fetus. *Archives of Women's Mental Health*, *14*(5), 425-434. doi: 10.1007 /s00737-011-0237-z

McLaughlin, K., Zeanah, C., Fox, N., & Nelson, C. (2012). Attachment security as a mechanism linking foster care placement to improved mental health outcomes in previously institutionalized children. *Journal of Child Psychology & Psychiatry*, *53*(1), 46-55. doi: 10.1111/j.1469-7610.2011.02437.x

McWey, L., & Mullis, A. (2004). Improving the lives of children in foster care: The impact of supervised visitation. *Family Relations, 53*(3), 293-300. doi: 10.1111 /j.0022-2445.2004.0005.x

Meites, T., Ingram, R., & Siegle, G. (2012). Unique and shared aspects of affective symptomatology: The role of parental bonding in depression and anxiety symptom profiles. *Cognitive Therapy and Research*, *36*(3),173-181. doi: 10.1007/s10608-011-9426-3

Messina, N., & Grella, C. (2006). Childhood trauma and women's health outcomes in a California prison population. *American Journal of Public Health, 96*(10), 1842-1848. doi: 10.2105/AJPH.2005.082016

Mikulincer, M., & Shaver, P. (2010). *Attachment in adulthood: Structure, dynamics, and change*. New York, NY: Guilford Press.

Milan, S., Snow, S., & Belay, S. (2009). Depressive symptoms in mothers and children: Preschool attachment as a moderator of risk. *Developmental Psychology, 45*(4), 1019. doi: 10.1037/a0016164

Miller, G., Galanter, E., & Pribram, K. (1986). *Plans and the structure of behavior*. New York, NY: Adams Bannister Cox.

Miller, L. (2011). *Mindfulness and self-compassion in the transition to motherhood: A prospective study of postnatal mood and attachment.* (Doctoral dissertation, New York, NY: Columbia University). Available from ProQuest Dissertations and Theses database. (UMI No. 3447974).

Minuchin, S. (1974). *Family therapy*. London, England: Tavistock.

Misri, S., Kendrick, K., Oberlander, T., Norris, S., Tomfohr, L., Zhang, H., & Grunau, R. (2010). Antenatal depression and anxiety affect postpartum parenting stress: A longitudinal, prospective study. *Canadian Journal of Psychiatry, 55*(4), 222-228.

Moggi, F., Ouimette, P., Moos, R., & Finney, J. (1999). Dual diagnosis patients in substance abuse treatment: Relationship of general coping and substance-specific coping to 1-year outcomes. *Addiction, 94*(12), 1805-1816.

Molnar, B., Buka, S., & Kessler, R. (2001). Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. *American Journal of Public Health, 91*(5), 753.

Monk, G. (1997). *Narrative therapy in practice: The archaeology of hope*. San Francisco, CA: Jossey-Bass.

Moss, E., Bureau, J., Cyr, C., & Dubois-Comtois, K. (2006). Is the maternal Q-set a valid measure of preschool child attachment behavior? *International Journal of Behavioral Development, 30*(6), 488-497. doi: 10.1177/0165025406071908

Murray, L., Fiori-Cowley, A., Hooper, R., & Cooper, P. (1996). The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. *Child Development, 67*(5), 2512-2526.

Najavits, L. (2004). Assessment of trauma, PTSD, and substance use disorder: A practical guide. In J. P. Wilson & T. Keane (Eds), *Assessing Psychological Trauma and PTSD* (2nd ed.) (pp. 466-491). New York, NY: Guilford Press.

Najavits, L., Weiss, R., & Shaw, S. (1997). The link between substance abuse and posttraumatic stress disorder in women. *The American Journal of Addictions, 6*(4), 273-283. doi: 10.3109/10550499709005058

Najavits, L., Weiss, R., & Shaw, S. (1999). A clinical profile of women with posttraumatic stress disorder and substance dependence. *Psychology of Addictive Behaviors, 13*(2), 98. doi: 10.1037//0893-164X.13.2.98

Nelson-Zlupko, L., Kauffman, E., & Dore, M. (1995). Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women. *Social Work, 40*(1), 45-54.

Newton, K. (2008). *African American women's perceptions of and experiences with mandated substance abuse treatment: Implications for counselors.* (Doctoral dissertation, Georgia State University, Atlanta). Available from ProQuest Dissertations and Theses database.

Nolte, T., Guiney, J., Fonagy, P., Mayes, L., & Luyten, P. (2011). Interpersonal stress regulation and the development of anxiety disorders: An attachment-based developmental framework. *Frontiers in Behavioral Neuroscience, 5*(55), 1-59. doi: 10.3389/fnbeh.2011.00055

Nylen, K., Moran, T., Franklin, C., & O'Hara, M. (2006). Maternal depression: A review of relevant treatment approaches for mothers and infants. *Infant Mental Health Journal, 27*(4), 327-343. doi: 10.1002/imhj.20095

O'Connor, T., Heron, J., Golding, J., Beveridge, M., Glover, V. (2002.) Maternal antenatal anxiety and children's behavioural/ emotional problems at 4 years—Report from the Avon Longitudinal Study of Parents and Children. *British Journal of Psychiatry, 180*(6), 502-508

Onunaku, N. (2005). *Improving maternal and infant mental health: Focus on maternal depression*. National Center for Infant and Early Childhood Health Policy, Los Angeles, CA. Washington, DC: Zero to Three Policy Center [Publisher]. Retrieved from WorldCat database: www.worldcat.org (OCLC Number: 67230626).

Oppenheim, D., & Waters, E. (1995). Narrative process and attachment representations: Issues of development and assessment. *Monographs of the Society for Research in Child Development, 60*(2-3), 197-215. doi: 10.2307/1166179

Osher, F., & Drake, R. (1996). Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry, 66*(1), 4-11.

Pallini, S., & Laghi, F. (2012). Attention and attachment related behavior toward professional caregivers in child care centers: A new measure for toddlers. *The Journal of Genetic Psychology, 173*(2), 158-174. doi: 10.1080/00221325. 2011.584330

Pederson, D., Gleason, K., Moran, G., & Bento, S. (1998). Maternal attachment representations, maternal sensitivity, and the infant–mother attachment relationship. *Developmental Psychology, 34*(5), 925. doi: 10.1037//0012-1649 .34.5.925

Pederson, D., & Moran, G. (1995). Maternal behavior q-set. *Monographs of the Society for Research in Child Development, 60*(2-3), 247-254. doi: 10.2307/1166182

Pederson, D., Moran, G., Sitko, C., Campbell, K., Ghesquire, K., & Acton, H. (1990). Maternal sensitivity and the security of infant-mother attachment: A q-sort study. *Child Development, 61*(6), 1974. doi: 10.2307/1130851

Piaget, J., & Inhelder, B. (1956). *The child's conception of space*. London, England: Routledge.

Pirard, S., Sharon, E., Kang, S., Angarita, G., & Gastfriend, D. (2005). Prevalence of physical and sexual abuse among substance abuse patients and impact on treatment outcomes. *Drug and Alcohol Dependence, 78*(1), 57-64. doi: 10.1016/j .drugalcdep.2004.09.005

Pitt, D., & Sube, E. (1979). The q-sort method: Use in landscape assessment research and landscape planning. *Applied Techniques for Analysis and Management of the Visual Resource, Incline Village, Nevada*.

Pittman, J., Kerpelman, J., Lamke, L., & Sollie, D. (2009). Development and validation of a q-sort measure of identity processing style: The identity processing style q-sort. *Journal of Adolescence, 32*(5), 1239-1265. doi: 10.1016/j.adolescence .2009.01.002

Posada, G., Jacobs, A., Carbonell, O., Alzate, G., Bustamante, M., & Arenas, A. (1999). Maternal care and attachment security in ordinary and emergency contexts. *Developmental Psychology, 35*(6), 1379. doi: 10.1037/0012-1649.35.6.1379

Prior, V., & Glaser, D. (2006). *Understanding attachment and attachment disorders: Theory, evidence, and practice*. London, England: Kingsley.

Puckering, C., Connolly, B., Werner, C., Toms-Whittle, L., Thompson, L., Lennox, J., & Minnis, H. (2011). Rebuilding relationships: A pilot study of the effectiveness of the mellow parenting programme for children with reactive attachment disorder. *Clinical Child Psychology and Psychiatry, 16*(1), 73-87. doi: 10.1177 /1359104510365195

Radke-Yarrow, M., Cummings, E., Kuczynski, L., & Chapman, M. (1985). Patterns of attachment in two-and three-year-olds in normal families and families with parental depression. *Child Development*, *56*(4), 884-893. doi: 10.2307/1130100

Rambo, A., & Hibel, J. (2013). What is family therapy? Underlying premises. In A. Rambo, C. West, A. Schooley & T. Boyd (Eds.), *Family Therapy Review: Contrasting Contemporary Models* (pp. xxix, 227). New York, NY: Routledge.

Rasch, D., Kubinger, K., & Yanagida, T. (2011). *Statistics in psychology using R and SPSS*. West Sussex, England: Wiley.

Roberts, G., Block, J. H., & Block, J. (1984). Continuity and change in parents' child-rearing practices. *Child Development*, *55*(2), 586-597. doi: 10.2307/1129970

Roe-Sepowitz, D., Bedard, L., Pate, K., & Hedberg, E. (2014). Esuba: A psychoeducation group for incarcerated survivors of abuse. *International Journal of Offender Therapy and Comparative Criminology, 58*(2), 190-208. doi: 10.1177 /030662X12465410.

Rosenbaum, M. (1979). Difficulties in taking care of business: Women addicts as mothers. *The American Journal of Drug and Alcohol Abuse, 6*(4), 431-446. doi: 10.3109/00952997909007054

Rounsaville, B., Weissman, M., Kleber, H., & Wilber, C. (1982). Heterogeneity of psychiatric diagnosis in treated opiate addicts. *Archives of General Psychiatry, 39*(2), 161. doi: 10.1001/archpsyc.1982.04290020027006

Ruesch, J., & Bateson, G. (1951). *Communication, the social matrix of psychiatry* (1st ed.). New York, NY: Norton.

Roznowski, M., Hong, S., & Reith, J. (May, 2000). A further look at youth intellectural giftedness and its correlates: Values, interests, performance, and behavior, *Intelligence, 28*(2), 87-113.

Sagi, A., van Ijzendoorn, M., Aviezer, O., Donnell, F., Koren-Karie, N., Joels, T., & Harel, Y. (1995). Attachments in a multiple-caregiver and multiple-infant environment: The case of the Israeli kibbutzim. *Monographs of the Society for Research in Child Development, 60*(2-3), 71-91. doi: 10.2307/1166171

Salter, M., & Study, A., (1940). *An evaluation of adjustment based upon the concept of security*: Ontario, Canada: University of Toronto Press.

Schaaf, K., & McCanne, T. (1998). Relationship of childhood sexual, physical, and combined sexual and physical abuse to adult victimization and posttraumatic stress disorder. *Child Abuse & Neglect, 22*(11), 1119-1133.

Schechter, D., Willheim, E. (2009). Disturbances of attachment and parental psychopathology in early childhood. *Child and Adolescent Psychiatric Clinic of North America 18*(3), 665–686.

Schwartz, R. (2007). Concurrent validty of the global assessment of functioning scale for clients with schizophrenia. *Psychological Reports, 100*(2), 571-574.

Scott, S. (2012). Parenting quality and children's mental health: Biological mechanisms and psychological interventions. *Current Opinion in Psychiatry, 25*(4), 301-306.

Shanmugam, V., Jowett, S., & Meyer, C. (2011). Eating psychopathology among athletes: Links to current attachment styles. *Eating Behaviors, 13*(1), 5-12.

Shpigel, M., Diamond, G. M., & Diamond, G. S. (2012). Changes in parenting behaviors, attachment, depressive symptoms, and suicidal ideation in attachment-based family therapy for depressive and suicidal adolescents. *Journal of Marital and Family Therapy, 38*(s1), 272-283.

Skouteris, H., Wertheim, E., Rallis, S., Milgrom, J., & Paxton, S. (2009). Depression and anxiety through pregnancy and the early postpartum: An examination of prospective relationships. *Journal of Affective Disorders, 113*(3), 303-308.

Smith, P., Gamble, S., Cort, N., Ward, E., He, H., & Talbot, N. (2011). Attachment and alliance in the treatment of depressed, sexually abused women. *Depression and Anxiety, 29*(2), 123-30. doi: 10.1002/da.20913

Somech, L., & Elizur, Y. (2012). Anxiety/depression and hostility/suspiciousness in adolescent boys: Testing adherence to honor code as mediator of callousness and attachment insecurity. *Journal of Research on Adolescence*, *22*(1), 89-99. doi: 10.1111/j.1532-7795.2011.00745.x

Sonthalia, S., & Dasgupta, S. (2012). Attachment styles and their implication for adolescents. *Journal of the Indian Academy of Applied Psychology, 38*(1), 54-62.

Sowers, K., Ellis, R., Washington, T., & Currant, M. (2002). Optimizing treatment effects for substance-abusing women with children: An evaluation of the Susan B. Anthony Center. *Research on Social Work Practice, 12*(1), 143-158. doi: 10.1177/104973150201200110

Sroufe, L. (1979). The coherence of individual development: Early care, attachment, and subsequent developmental issues. *American Psychologist , 34*(10), 834-841. doi: 10.1037//0003-066X.34.10.834

Sroufe, L. (1997). *Emotional development: The organization of emotional life in the early years.* Melbourne, Australia: Cambridge University Press.

Sroufe, L., & Rutter, M. (1984). The domain of developmental psychopathology. *Child Development, 55,* 17-29. doi: 10.2307/1129832

Sroufe, L., & Waters, E. (1977). Attachment as an organizational construct. *Child Development, 48*(4), 1184-1199. doi: 10.2307/1128475

Stephenson, W. (1953). *The study of behavior: Q-technique and its methodology*. Chicago, IL: University of Chicago Press.

Stevenson-Hinde, J., & Shouldice, A. (1995). Maternal interactions and self-reports related to attachment classifications at 4.5 years. *Child Development, 66*(3), 583-596. doi: 10.1111/j.1467-8624.1995.tb00891.x

Strayer, F., Verissimo, M., Vaughn, B., & Howes, C. (1995). A quantitative approach to the description and classification of primary social relationships. *Monographs of the Society for Research in Child Development, 60*(2-3), 49-70. doi: 10.2307 /1166170

Surcinelli, P., Rossi, N., Montebarocci, O., & Baldaro, B. (2010). Adult attachment styles and psychological disease: Examining the mediating role of personality traits. *The Journal of Psychology, 144*(6), 523-534. doi: 10.1080/00223980.2010.508082

Swanson, R., & Holton, E. (Eds.) (2005). *Research in organizations: Foundations and methods in inquiry*. San Francisco, CA: Berrett-Koehler.

Teti, D., & McGourty, S. (1996). Using mothers versus trained observers in assessing children's secure base behavior: Theoretical and methodological considerations. *Child Development, 67*(2), 597-605. doi: 10.2307/1131834

Tong, L., Oates, K., & McDowell, M. (1987). Personality development following sexual abuse. *Child Abuse & Neglect, 11*(3), 371-383. doi: 10.1016/0145-2134(87) 90011-1

Turner, V., & Bruner, E. (1986). *The anthropology of experience*. Urbana, IL: University of Illinois Press.

van Bakel, H., & Riksen-Walraven, J. (2004). AQS security scores: What do they represent? A study in construct validation. *Infant Mental Health Journal, 25*(3), 175-193. doi: 10.1002/imhj.20001

van Dam, M., & van Ijzendoorn, M. (1988). Measuring attachment security: Concurrent and predictive validity of the Parental Attachment Q-set. *The Journal of Genetic Psychology: Research and Theory on Human Development*, *149*(4), 447-457. doi: 10.1080/ 00221325. 1988.10532172

van der Horst, F. (2011). *John Bowlby—From psychoanalysis to ethology*: *Unraveling the Roots of Attachment Theory.* Chichester, England: Wiley-Blackwell. doi: 10.1002/jhbs.21620

van der Horst, F., van der Veer, R., & van Ijzendoorn, M. (2007). John Bowlby and ethology: An annotated interview with Robert Hinde. *Attachment & Human Development, 9*(4), 321-335. doi: 10.1080/14616730601149809

van Doesum, K., Riksen-Walraven, J., Hosman, C., & Hoefnagels, C. (2008). A randomized controlled trial of a home-visiting intervention aimed at preventing relationship problems in depressed mothers and their infants. *Child Development, 79*(3), 547-561. doi: 10.1111/j.1467-8624.2008.01142.x

van Ijzendoorn, M. (1995). Adult attachment representations, parental responsiveness, and infant attachment: a meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological Bulletin, 117*(3), 387. doi: 10.1037 /0033-2909.117.3.387

Vaughn, B., & Waters, E. (1990). Attachment behavior at home and in the laboratory: Q-sort observations and strange situation classifications of one-year-olds. *Child Development, 61*(6), 1965-1973. doi: 10.1111/j.1467-8624.1990.tb03578.x

Vogt, W., & Johnson, R. (2011*). Dictionaryl of statistics & methodology: A nontechnical guide for the social sciences (4th ed.).* Thousand Oaks, CA: Sage

Von Bertalanffy, L. (1972). The history and status of general systems theory. *The Academy of Management Journal, 15*(4), 407-426. doi: 10.2307/255139

Wallin, D. (2007). *Attachment in psychotherapy*. New York, NY: Guilford Press.

Ward, J., & Dow, M. (1998, with Text Revisions 2004, 2005, 2006). *The functional assessment rating scale.* Tampa: Florida Mental Health Institute, University of South Florida.

Waters, E. (n.d.). *Assessing secure base behavior and attachment security: Using the q-sort method.* Unpublished work. Stony Brook: State University of New York, Department of Psychology. Retrieved August ,1, 2012, from www.psychology.sunysb.edu/attachment/measures/content/aqs_method.html

Waters, E. (1987). *Attachment behavior q-set (version 3.0)*. Unpublished work. Stony Brook: State University of New York, Department of Psychology.

Waters, E. (1995). Appendix A: The attachment q-set (version 3.0). *Monographs of the Society for Research in Child Development, 60*(2-3), 234-246. doi: 10.1111/j.1540-5834.1995.tb00214.x

Waters, E., Crowell, J., Elliott, M., Corcoran, D., & Treboux, D. (2002). Bowlby's secure base theory and the social/personality psychology of attachment styles: Work(s) in progress. *Attachment & Human Development, 4*(2), 230-242. doi: 10.1080/14616730210154216

Waters, E., & Deane, K. (1985). Defining and assessing individual differences in attachment relationships: Q-methodology and the organization of behavior in infancy and early childhood. *Monographs of the Society for Research in Child Development*, *50*(1-2), 41-65. doi: 10.2307/3333826

Waters, E., Garber, J., Gornall, M., & Vaughn, B. (1983). Q-sort correlates of visual regard among preschool peers: Validation of a behavioral index of social competence. *Developmental Psychology, 19*(4), 550. doi: 10.1037/0012-1649.19.4.550

Waters, E., Hamilton, C., & Weinfield, N. (2000). The stability of attachment security from infancy to adolescence and early adulthood: General introduction. *Child Development, 71*(3), 678-683. doi: 10.1111/1467-8624.00175

Waters, E., Merrick, S., Treboux, D., Crowell, J., & Albersheim, L. (2000). Attachment security in infancy and early adulthood: A twenty-year longitudinal study. *Child Development, 71*(3), 684-689. doi: 10.1111/1467-8624.00176

Watzlawick, P., Bavelas, J., & Jackson, D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes* (1st ed.). New York, NY: Norton.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution* (1st ed.). New York, NY: Norton.

Weinberg, M., & Tronick, E. (1998). The impact of maternal psychiatric illness on infant development. *Journal of Clinical Psychiatry, 59*(S2), 53–61.

Weinberg, M., & Tronick, E. (1999). *Infant and caregiver engagement phases (ICEP)*. Boston, MA: Harvard Medical School.

Wekerle, C., & Wolfe, D. (2003). Child maltreatment: Risk of adjustment problems and dating violence in adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(3), 282-289. doi: 10.1097/00004583-200103000-00007

Willinger, U., Lenzinger, E., Hornik, K., Fischer, G., Schönbeck, G., Aschauer, H., & Meszaros, K. (2002). Anxiety as a predictor of relapse in detoxified alcohol-dependent patients. *Alcohol & Alcoholism, 37*(6), 609-612.

Winer, A. (2012). *Solution-oriented support group for families of substance abuse recovering mothers* (Doctoral applied clinical project, Nova Southeastern University, Fort Lauderdale, FL). Available from ProQuest Dissertations and Theses database.

Winnicott, C., & Kanter, J. (2004). *Face to face with children: The life and work of Clare Winnicott*. London, England: Karnac.

Wolfe, D., Wekerle, C., Scott, K., Straatman, A., & Grasley, C. (2004). Predicting abuse in adolescent dating relationships over 1 year: The role of child maltreatment and trauma. *Journal of Abnormal Psychology, 113*(3), 406-415. doi: 10.1037/0021-843X.113.3.406

Wolpe, J., & Abrams, J. (1991). Post-traumatic stress disorder overcome by eye-movement desensitization: A case report. *Journal of Behavior Therapy and Experimental Psychiatry, 22*(1), 39-43. doi: 10.1016/0005-7916(91)90032-Z

Young-Bruehl, E. (2008). *Anna Freud: A biography* (2nd ed.). London, England: Taylor & Francis.

Zlotnick, C., Rohsenow, D., & Johnson, D. (September 2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*(2), 99-105. doi: 10.1016/S0740-5472(03)00106-5

Appendices

Appendix A

Susan B. Anthony Recovery Center (SBARC) Data Collection Project

In February of 2009, I embarked upon a voluntary research project that, unbeknownst to me, was the beginning of an odyssey that would last for over two years. It would consume most of my weekends and free time. It would take me into a world in which I would otherwise never have had the opportunity (and as I later realized, the privilege) to spend time. The project, which many times seemed daunting and most of the time seemed without end, was to create a strategy whereby I would examine the paper records of over 800 women had that been created by Susan B. Anthony Recovery Center (SBARC) clinicians over a 15-year period. In addition, I would carefully and systematically collect over 100 items from each case.

Each case represented the story of a woman's journey through residential treatment with her children—from intake to discharge—at SBARC, where women were able to reside with their minor children while they were in treatment. A key mission of SBARC, therefore, was to provide a treatment service milieu that kept mothers and their children together during the treatment episode. This data collection project concluded in May of 2011.

In 1994, SBARC received its charter and opened its doors to its first families in late 1995. The first clients (called *persons served* or *P/S*) graduated from treatment in 1996. That year, there were six graduates. Over the years, SBARC experienced significant growth in the number of persons served and, consequently, its physical plant underwent significant expansion, as did the array of services offered. By the end of 2010 (the final year of the data collection project), SBARC had graduated 92 women. I

remember our initial meeting in early 2009. I met with then head of SBARC, Marsha Currant, Chief Executive Officer. We discussed the work that we might do to collect and organize the data they had collected in all the years since 1995. After our sit-down meeting, Marsha provided a tour of the main administrative building located in the center of the 5-acre campus. Near the main entrance to this building, she unlocked a room containing the archived records for all persons served since SBARC opened its doors.

The records archive was a room about 12 feet wide, 20 feet deep, and 15 feet high. In front of the wall at the far end of the room stood a high-end photocopier and sorter. Next to it was an industrial-strength paper shredder. These machines were dwarfed by floor-to-ceiling bookcases containing the case folders for each of the clients seen and discharged over the years. The shelves were constructed of rough pine boards supported on the ends by two-by-fours. Each set of bookcases, which fully covered the left and right long walls of the room, contained six shelves. All shelves were jammed packed with dark brown accordion folders, each one containing the complete paper record memorializing the entire treatment experience for an individual mother and her children. Depending on the length of stay and extensiveness of the treatment, the accordion case files ranged in width from an inch or two to eight inches thick. Some clients—especially those who had relapsed and returned for treatment—consumed two or three accordion files.

On entering the room, I looked up toward the left top shelf. I noticed the outward facing surface of each accordion file contained a self-stick file folder tag on which was written the number for that client. I noticed that the file folder numbers started at 04 on the left side of the left-hand side of shelves and ended at 800 and something on the bottom right side of the shells located to my right.

Earlier in our meeting, we discussed with Marsha and her clinical team how useful it would be to go through over a decade's worth of client files and to make sense of the data contained in them. At the time, we did not discuss overarching research questions, long-term study design, or really anything to do with making sense of the data. I think we were all somewhat cowed by the enormity of the data collection task that lay ahead. I remember at the time staring at the hundreds of archived files to my left and to my right in that very small room and wondering indeed what sense we might make of all of this data. Admittedly, I found the challenge of the project both exciting and intimidating (see Figure A-1).

Data Collection

I started visiting SBARC regularly in January of 2009. I spent the first few months poring over the contents of these brown accordion files to get a sense of what data was contained in each. My approach to designing the data collection project was to first start making lists of the kind of data contained in the record. I knew that I would not be interviewing live subjects in any part of this project. It was, therefore, important to me to choose data to collect that would help me to see each case as a multidimensional human being and not just a story reduced to numbers.

After a number of sessions spent reviewing client files and familiarizing myself with their contents, I began to chart a course for the data collection. At one point in the project, my university advisor and I had discussed the idea of bringing in a team of graduate students to assist in transferring the data from each client file to a Microsoft

Figure A-1. Archived case files at Susan B. Anthony Recovery Center.

Access database that I designed to contain the data. In support of this, and as a way for me to understand better the challenges of the project, I created a manual that contained redacted samples of each the common paper records with callouts showing the location of the data to be collected. In addition, each callout, for example, contained the same sequence number located on the access database input field.

Data Entry Instruction Manual

In the first iteration of the database, the data entry instruction manual showed 27 facsimile pages from the file and required 96 separate data items. Subsequent iterations of the database made small alterations to this original collection scheme, but ultimately collected the same data. (See Appendix B for the manual that describes the data

collection project and shows the data entry screens and facsimiles of the actual paper records from which the data was taken.)

The first 81 items identified in the manual and the database extracted key data from the:

1. Face Sheet (questions 1 through 4),
2. Bio-psychosocial (questions 5 through 40),
3. Referral Screening Form (questions 41 through 62),
4. In-Depth Assessment (questions 63-81).

Questions 82 through 96 were extracted from a variety of other documents in the client record including:

1. Mother-Infant/Child Interactional Scale, Pretest (question 82),
2. Mother-Infant/Child Interactional Scale, Posttest (question 83),
3. Parenting Skills Rating Scale, Mother-Infant/Child, Pretest (question 84),
4. Parenting Skills Rating Scale, Mother-Infant/Child, Posttest (question 85),
5. FARS Pretest Depression Score (question 86),
6. FARS Pretest Anxiety Score (question 87),
7. FARS Pretest GAF Score (question 88),
8. FARS Posttest Depression Score (question 89),
9. FARS Posttest Anxiety Score (question 90),
10. FARS Posttest GAF Score (question 91),
11. Treatment Program Discharge Summary (questions 92 through 95), and
12. ASAM Adult 65D-16 (question 96: Discharge Date).

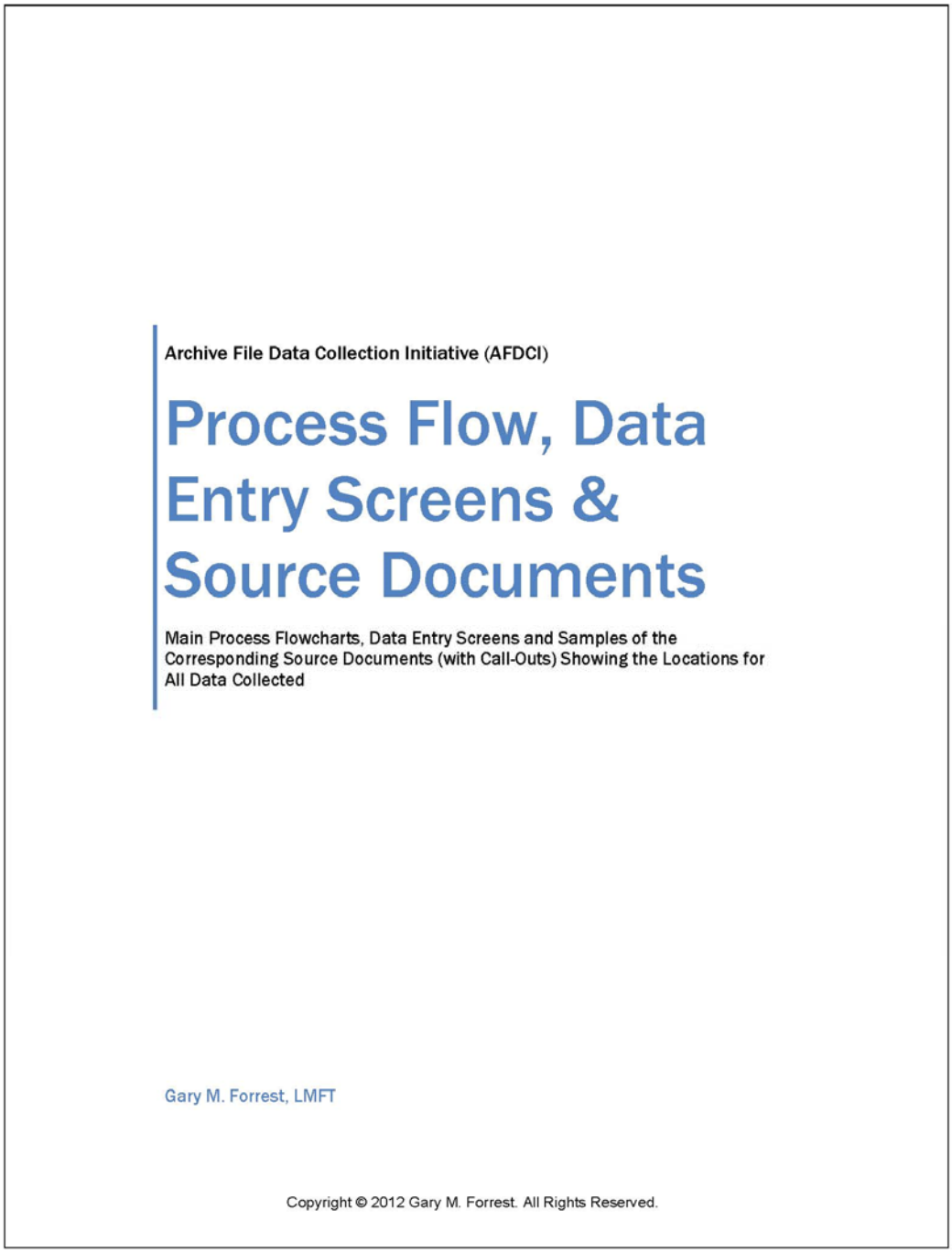
Depending on the length of stay and the complexity of the treatment, the accordion file for a client could range from one half inch thick to, in some cases, over eight inches thick when fully extended. This presented a significant challenge during the data collection process. Our collection protocol dictated that we find 20 or 25 pages that contained the key data in a file that sometimes contained hundreds of pages. The protocol for the processing of each client folder was to separate and inventory the pages that contain the data to be entered into the Microsoft Access database at a later time. In order to ensure quality and accuracy, we established a single page cover sheet. (See Appendix B for a copy of the Cover Sheet.) This cover sheet served as a checklist guide for quickly determining whether or not the key pages containing data were present in the client file. In addition to providing a quality control point, the cover sheet provided the person entering data into the access database with a convenient summary of all intake and discharge evaluation scores for the client.

My original design for the Microsoft Access database was based on the idea that multiple two-person teams would identify, organize, and provide data entry for all the relevant client data in the archive. I envisioned using the multiuser capabilities of the Microsoft Access 2007—and ultimately Microsoft Access 2010—database software, which would enable the data entry person on each team to take the client packet that the data collector had prepared and enter the key data into the database. The Susan B. Anthony Recovery Center had a multiuser network of Windows operating system-based workstations on which it provided GED classes and vocational training for residents during the week. I originally estimated that we might use six or eight two-person teams so as to complete the data collection relatively quickly. However, because our access to

the computer systems was restricted to evenings and weekends, because of the difficulties associated with attracting volunteer labor for protracted project such as this, and because of technical issues I ran into associated with implementing the multiuser version of the software, I ultimately abandoned the idea of performing the data collection using multiple teams. Instead, we completed the bulk of this project using myself and another volunteer—my wife, Robin. The data collection project concluded in May of 2011.

Appendix B

Process Flow, Data Entry Screens, and Source Documents



Archive File Data Collection Initiative (AFDCI)

Process Flow, Data Entry Screens & Source Documents

Main Process Flowcharts, Data Entry Screens and Samples of the Corresponding Source Documents (with Call-Outs) Showing the Locations for All Data Collected

Gary M. Forrest, LMFT

Table of Contents

Introduction

In February 2009, I embarked upon a research project of my design to collect useful information from the paper records of hundreds of women who had been treated at a local women's residential treatment center.

Each of these archived records represented the treatment history – from intake to discharge — of a single client. The record for each client was contained in an expanding width, file folder wallet ("client record"). Each client record ranged from about 1 inch to, in some cases, 8 inches or more, depending on the client's length of stay in treatment and the complexity of the services offered. Occasionally, the client record would be contained in multiple expanding folders. All archived records were housed in a locked file room, stored on shelves, and ordered sequentially by client identification number.

The data collection project, which ran from February 2009 through May 2011, consisted of two processes:

- Packet Assembly
- Source Data Entry

Packet Assembly – This was the first process in the project (see flowchart on page 4). During Packet Assembly, each client record was unpacked and examined to identify and extract key source documents from the client record. The extracted documents were then placed in a particular order in a separate pile ("packet"). A document clip placed at the top of each packet kept the documents together. We used a custom cover sheet (see sample on page 9) as the first page for each packet. The cover sheet provided the following:

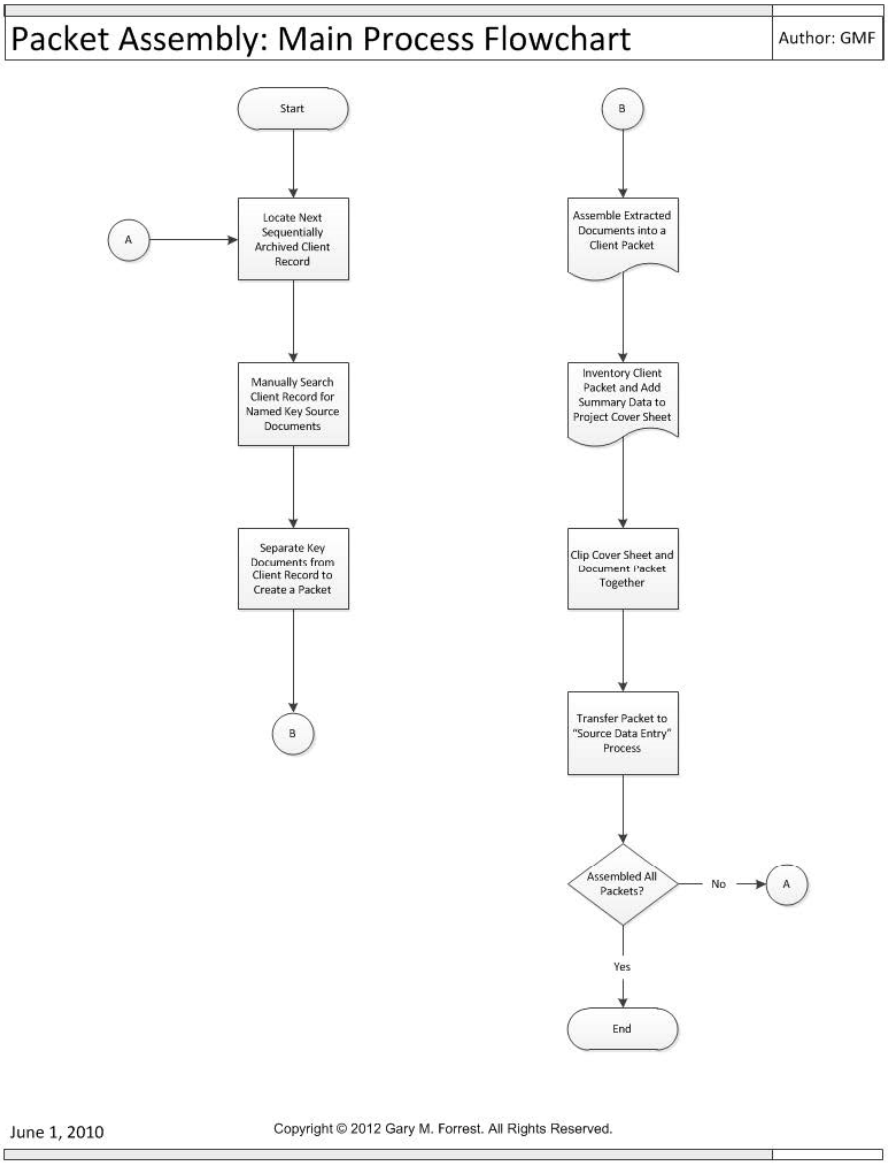
- Client identification number and basic client demographic data
- A checklist by which each packet was inventoried to ensure that key documents had been located.
- Locations to enter key pre- and post-test scores associated with the client

Once the packet was assembled, it could proceed to the second process in the project:

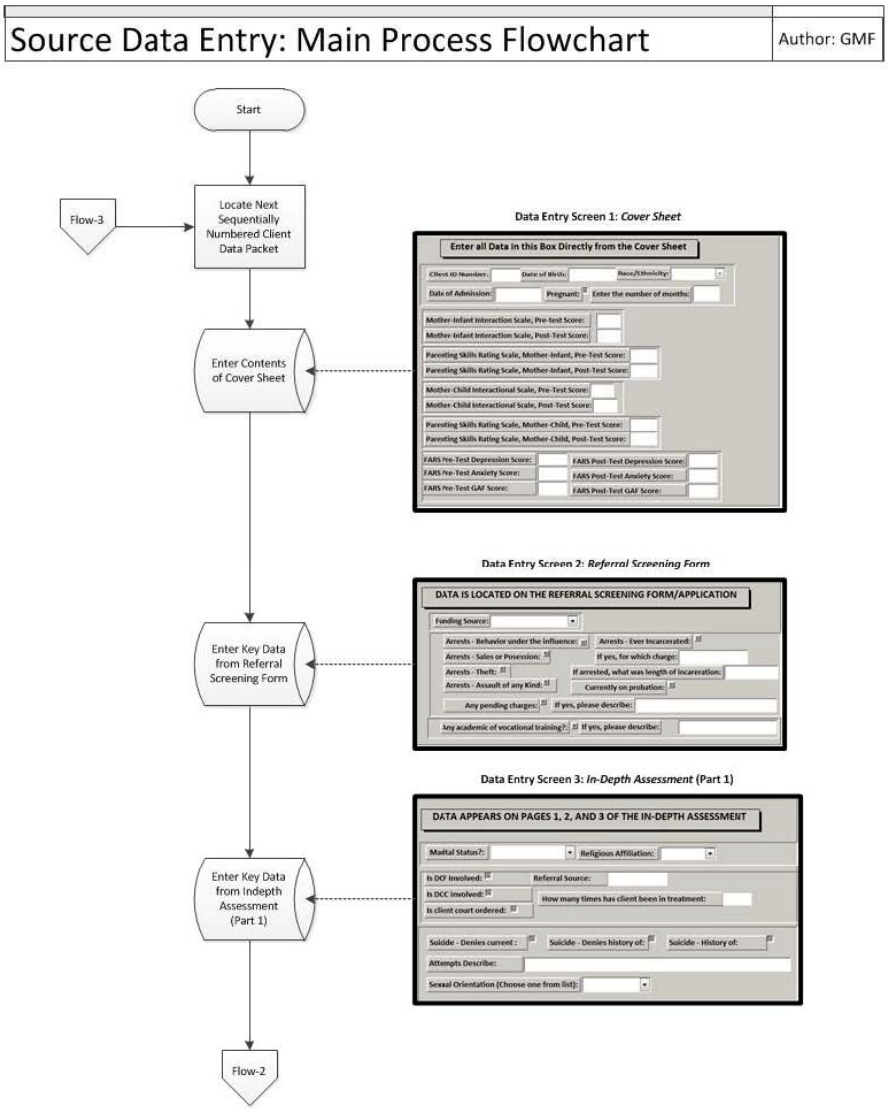
Source Data Entry – During this process (see flowchart on pages 5-7), each packet was scanned by the data entry technician and key data was copied from the packet into the research database. The **Source Data Entry** flowchart lists the physical documents from which the data was copied during data entry. It also shows the eight actual data entry screens used in the database program.

The remainder of this document presents the eight data entry screens (used in the database) and the physical source documents (from the client packet). Note that each of the sample source documents contains callouts, which show the exact location of the data item that was copied into the research database.

Packet Assembly: Main Process Flowchart



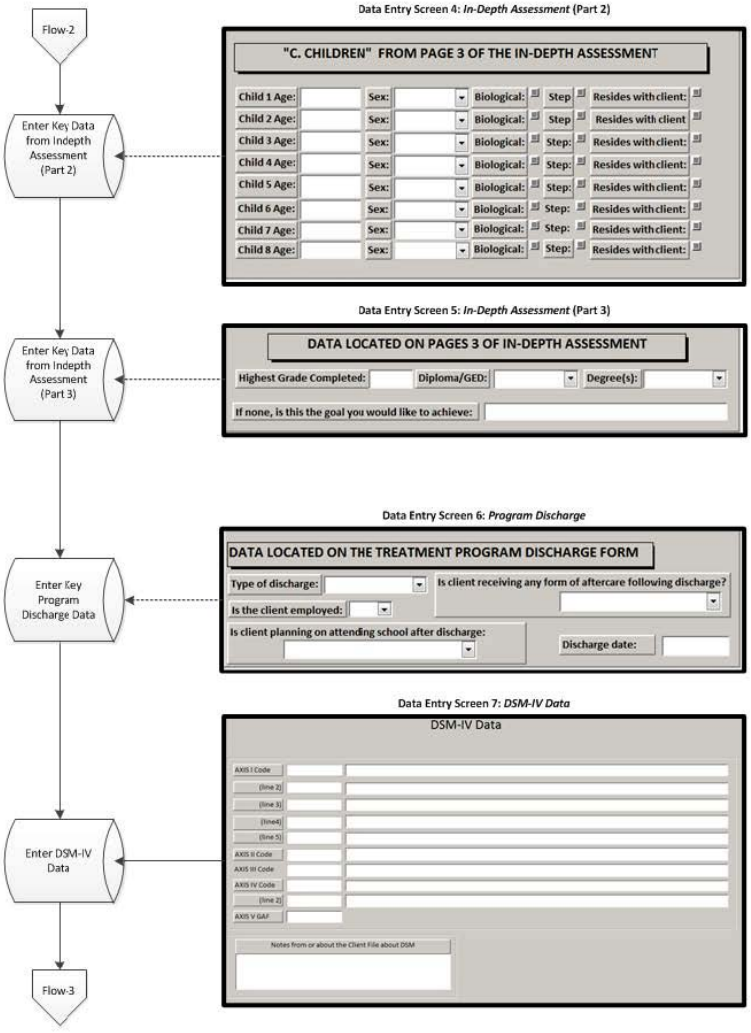
Source Data Entry: Main Process Flowchart



Page | 5

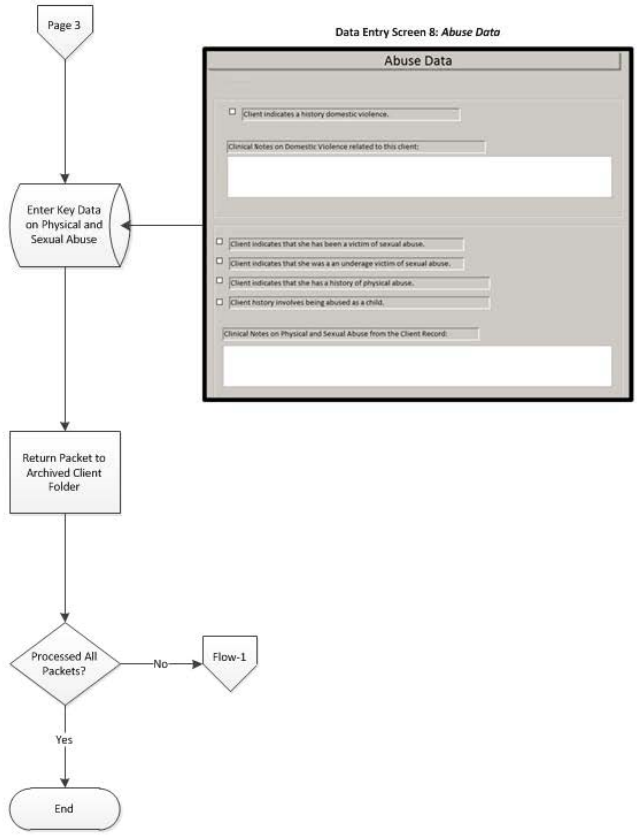
Source Data Entry: Main Process Flowchart

Author: GMF



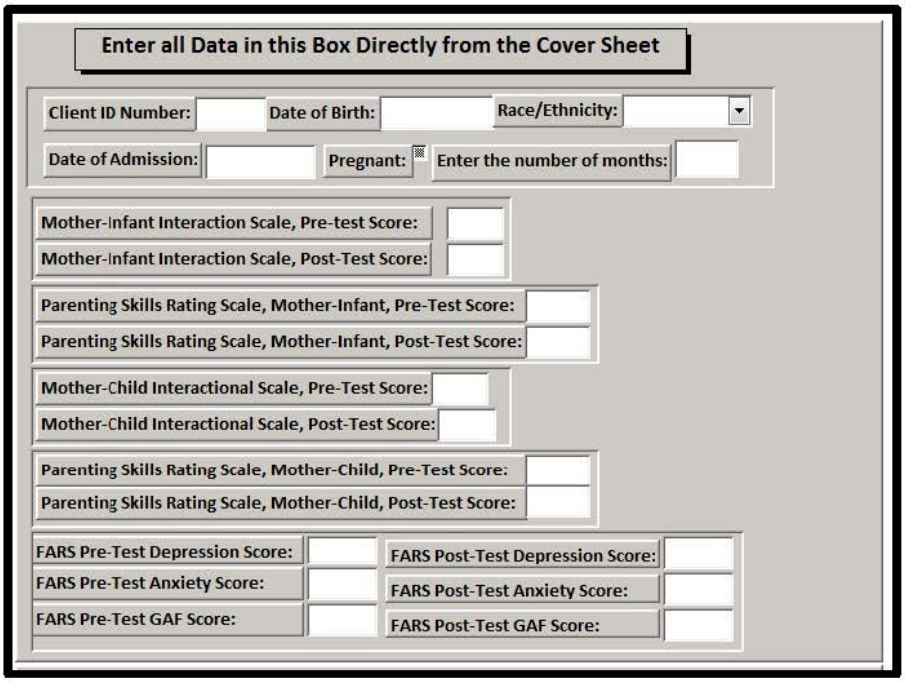
June 1, 2010

Source Data Entry: Main Process Flowchart	Author: GMF



June 1, 2010

Data Entry Screen 1: *Cover Sheet*



The data entry screen shown above is the first database screen used to collect data from the client record. As shown in the *Packet Assembly: Main Process Flowchart* (page 4), the client record is searched for the key documents used for collecting the data. The sample *Cover Sheet* (see page 9) contains all of the data copied from certain documents.

Client ID Number, **Date of Birth**, **Race/Ethnicity**, and **Date of Admission**, are all data taken from the client *Face Sheet* (see page 10).

Pregnant and **Enter the number of months** (if pregnant) are taken from page 1 of the *Bio-Psychosocial Evaluation* (see page 11).

The data values for all pre- and post-test scores are taken from their respective forms, as follows: *Mother-Infant (Child) Interactional Scale* (see pages 12-13, 16-17), *Parenting Skills* (see pages 14-15, 18-19) and FARS Depression & Anxiety (pages 20 & 21), and FARS GAF scores (pages 22 & 23)

Source Document: *Cover Sheet*

Packet Type ____

COVER SHEET

Client File # _____

[redacted]

This file was audited on _____ and contains the aforementioned documents from which data will be entered into the archived client database.

DOB:_____ Race:_____ Admission Date:_____

Pregnant? How many months:_____

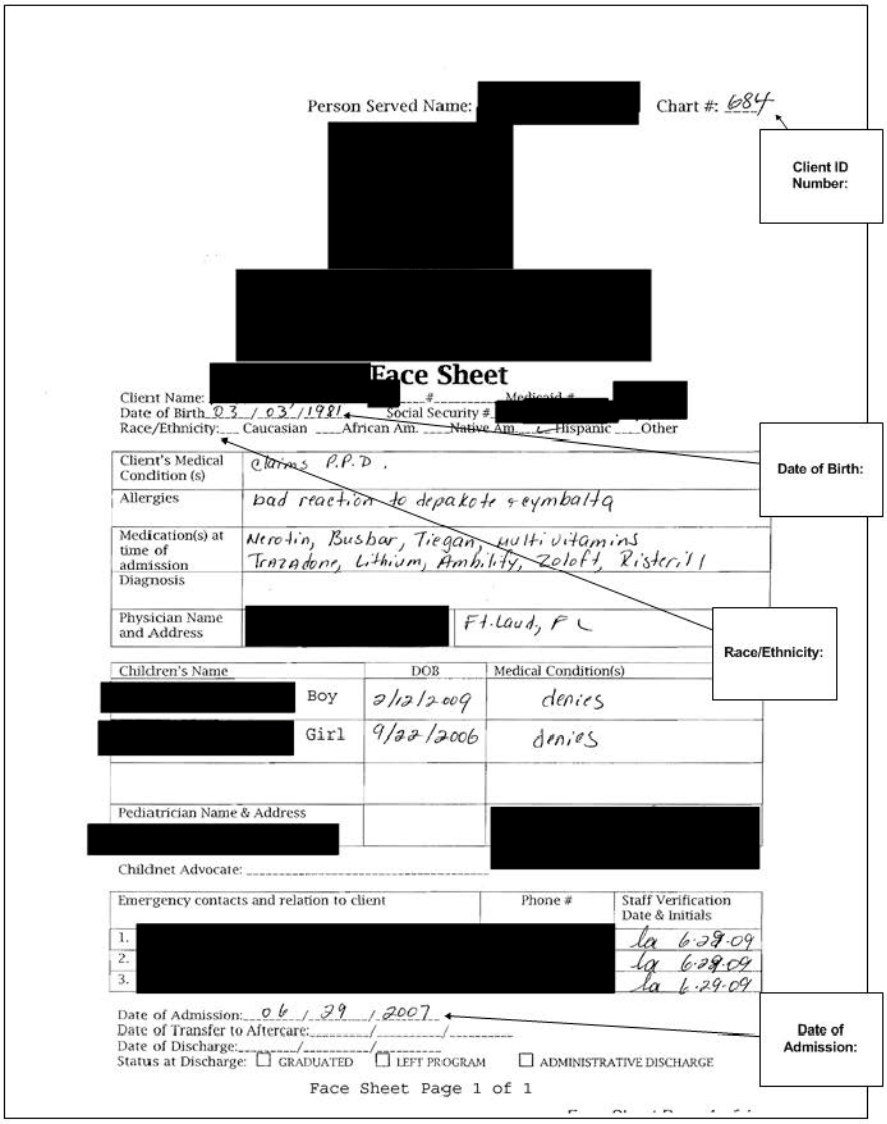
NOW ENTER DATA FROM THE FOLLOWING DOCUMENTS IN THIS PACKAGE:

- ☐ Treatment Program Discharge Summary
- ☐ Indepth Assessment or Bio-Psychosocial
- ☐ Referral Screening Form/Application

Assessment	SCORES:
☐ Mother-Infant Interaction Scale (Pre-Test)	_____
☐ Mother-Infant Interaction Scale (Post-Test)	_____
☐ Parenting Skills Rating Scale, Mother-Infant (Pre-Test)	_____
☐ Parenting Skills Rating Scale, Mother-Infant (Post-Test)	_____
☐ Mother-Child Interaction Scale (Pre-Test)	_____
☐ Mother-Child Interaction Scale (Post-Test)	_____
☐ Parenting Skills Rating Scale, Mother-Child (Pre-Test)	_____
☐ Parenting Skills Rating Scale, Mother-Child (Post-Test)	_____

- ☐ FARS Pre-Test – Depression:_____ Anxiety:_____ GAF:_____
- ☐ FARS Post-Test – Depression:_____ Anxiety:_____ GAF:_____

Source Document: *Face Sheet*



Person Served Name: [redacted] Chart #: 684

Client ID Number:

[redacted]

Face Sheet

Client Name: [redacted] #_____ Medicaid #_____

Date of Birth: 03 / 03 / 1981 Social Security # [redacted]

Race/Ethnicity: ___ Caucasian ___African Am. ___Native Am. _L_Hispanic ___Other

Date of Birth:

Client's Medical Condition (s)	Claims P.P.D.
Allergies	bad reaction to depakote + eymbalta
Medication(s) at time of admission	Nerotin, Busbar, Tiegan, multivitamins Trazadone, Lithium, Ambilify, Zoloft, Risteril
Diagnosis	
Physician Name and Address	[redacted] Ft. Laud, FL

Race/Ethnicity:

Children's Name		DOB	Medical Condition(s)
[redacted]	Boy	2/12/2009	denies
[redacted]	Girl	9/22/2006	denies

Pediatrician Name & Address: [redacted]

Childnet Advocate: _____

Emergency contacts and relation to client	Phone #	Staff Verification Date & Initials
1. [redacted]		la 6.29.09
2.		la 6.29.09
3.		la 6.29.09

Date of Admission: 06 / 29 / 2007

Date of Transfer to Aftercare: ____/____/____

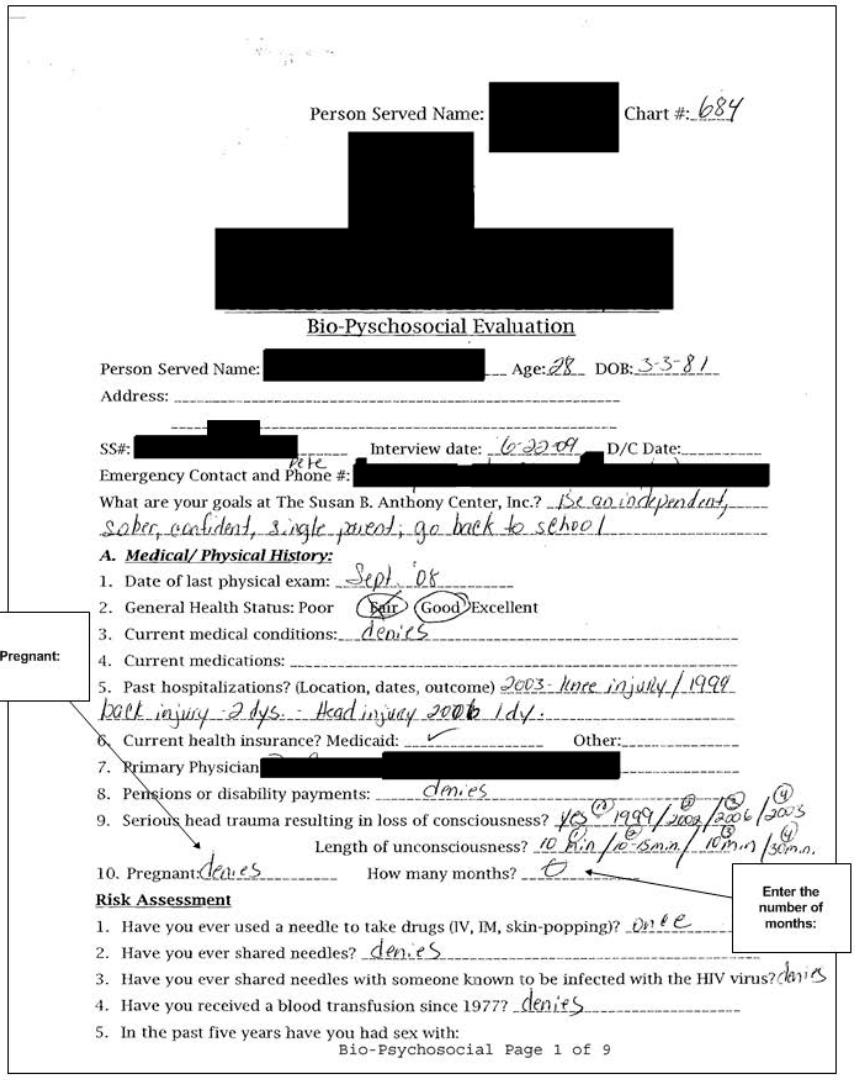
Date of Discharge: ____/____/____

Status at Discharge: ☐ GRADUATED ☐ LEFT PROGRAM ☐ ADMINISTRATIVE DISCHARGE

Date of Admission:

Face Sheet Page 1 of 1

Source Document: *Biopsychosocial* Page 1



Person Served Name: [redacted] Chart #: 684

[redacted]

Bio-Pyschosocial Evaluation

Person Served Name: [redacted] Age: 28 DOB: 3-3-81

Address: _____

SS#: [redacted] Interview date: 6-22-09 D/C Date: _____

Emergency Contact and Phone #: [redacted]

What are your goals at The Susan B. Anthony Center, Inc.? Be an independent, sober, confident, single parent, go back to school

A. *Medical/ Physical History:*

1. Date of last physical exam: Sept. '08
2. General Health Status: Poor Fair Good Excellent
3. Current medical conditions: denies
4. Current medications: _____
5. Past hospitalizations? (Location, dates, outcome) 2003- knee injury / 1999 back injury - 2 dys. - Head injury 2006 1 dy.
6. Current health insurance? Medicaid: ✓ Other: _____
7. Primary Physician [redacted]
8. Pensions or disability payments: denies
9. Serious head trauma resulting in loss of consciousness? Yes ① 1999 / ② 2004 / ③ 2006 / ④ 2008
   Length of unconsciousness? ① 10 min / ② 10-15 min / ③ 10 min / ④ 30 min.
10. Pregnant: denies How many months? 0

Pregnant:

Enter the number of months:

Risk Assessment

1. Have you ever used a needle to take drugs (IV, IM, skin-popping)? Once
2. Have you ever shared needles? denies
3. Have you ever shared needles with someone known to be infected with the HIV virus? denies
4. Have you received a blood transfusion since 1977? denies
5. In the past five years have you had sex with:

Bio-Psychosocial Page 1 of 9

Source Document: *Mother-Infant Interaction Scale* Pre-Test

[redacted]

Mother-Infant Interaction Scale*

Circle one: (Pre-Test) Post-Test

*This scale is an adaptation of the Maternal Behavior Q-Set (Pederson, Moron, Sitko, Campbell, Ghesquire, & Acton, 1990) and the attachment Q-Set, Version 3.0 (Waters, 1987)

Person Served Name: [redacted]

Person Served Number: 702

Infant's Name: [redacted]

Infant's DOB: 9/9/09 Age: 1wk

Completed By: [redacted]

Date: 9/22/09

Mother-Infant Interaction Scale, Pre-Test Score:

Score: 130/174

Percent: 75%

Source Document: *Mother-Infant Interaction Scale* Post-Test

[redacted]

Mother-Infant Interaction Scale*

Circle one: (Pre-Test) Post-Test

*This scale is an adaptation of the Maternal Behavior Q-Set (Pederson, Moron, Sitko, Campbell, Ghesquire, & Acton, 1990) and the attachment Q-Set, Version 3.0 (Waters, 1987)

Person Served Name: [redacted]

Person Served Number: 702

Infant's Name: [redacted]

Infant's DOB: 9/9/09 Age: 1w1k

Completed By: [redacted]

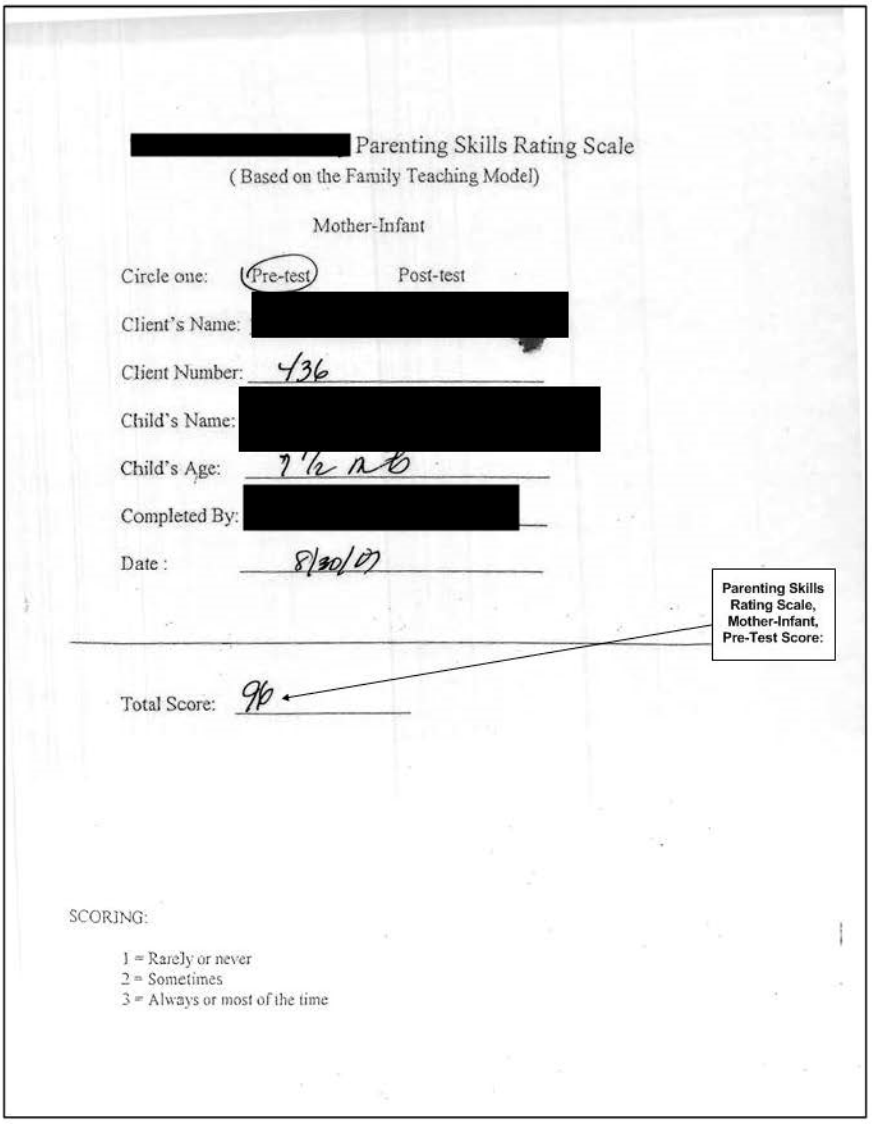
Date: 9/22/09

Mother-Infant Interaction Scale, Pre-Test Score:

Score: 130 /174

Percent: 75%

Source Document: *Parenting Skills Rating Scale, Mother-Infant* Pre-Test



[redacted] Parenting Skills Rating Scale

(Based on the Family Teaching Model)

Mother-Infant

Circle one: (Pre-test) Post-test

Client's Name: [redacted]

Client Number: 436

Child's Name: [redacted]

Child's Age: 7 1/2 mo

Completed By: [redacted]

Date : 8/30/07

Parenting Skills Rating Scale, Mother-Infant, Pre-Test Score:

Total Score: 90

SCORING:

1 = Rarely or never
2 = Sometimes
3 = Always or most of the time

Source Document: *Parenting Skills Rating Scale, Mother-Infant* Post-Test

[redacted] Parenting Skills Rating Scale

(Based on the Family Teaching Model)

Mother-Infant

Circle one: Pre-test Post-test

Client's Name: [redacted]

Client Number: 436

Child's Name: [redacted]

Child's Age: 12 mos

Completed By: [redacted]

Date : 2/3/08

Parenting Skills Rating Scale, Mother-Infant, Post-Test Score:

Total Score: 105

SCORING:

1 = Rarely or never
2 = Sometimes
3 = Always or most of the time

Source Document: *Mother-Child Interactional Scale* Pre-Test

[redacted]

Mother-Child Interactional Scale

Circle One: (Pre-Test) Post-Test

This scale is an adaptation of the Maternal Behavior Q-Set (Pederson, Moron, Sitko, Campbell, Ghesquire, & Acton, 1990) and the Attachment Q-Set, Version 3.0 (Waters, 1987).

Client's Name: [redacted]

Child's Name: [redacted] Boy

Child's Age: 6 months

Completed By: [redacted]

Date: 5/20/07

Mother-Child Interactional Scale, Pre-Test Score:

Score: 75%

Source Document: *Mother-Child Interactional Scale* Post-Test

[redacted]

Mother-Child Interactional Scale

Circle One: Pre-Test (Post-Test)

This scale is an adaptation of the Maternal Behavior Q-Set (Pederson, Moran, Sitko, Campbell, Ghesquire, & Acton, 1990) and the Attachment Q-Set, Version 3.0 (Waters, 1987).

Client's Name: [redacted]

Child's Name: [redacted]

Child's Age: DOB 11/17/06 1yr 3mos

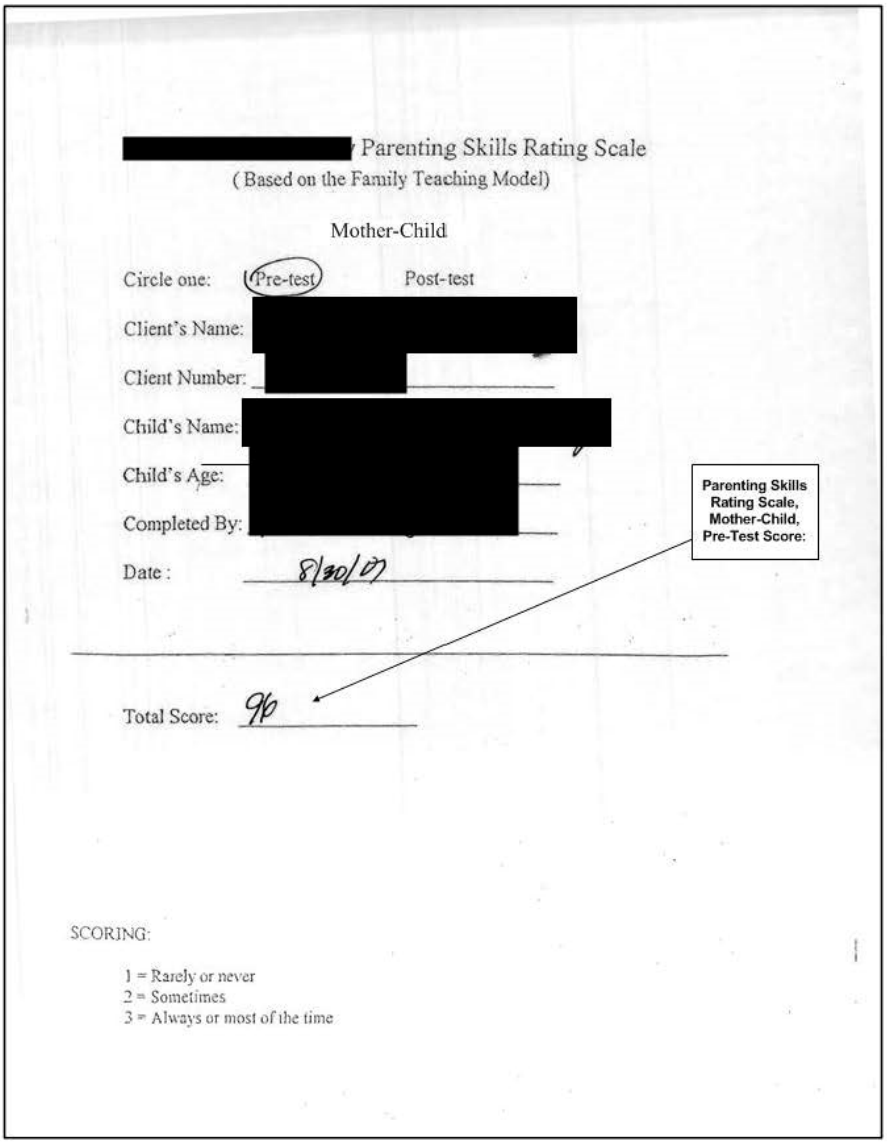
Completed By: [redacted]

Date: 2/3/08

Mother-Child Interactional Scale, Post-Test Score:

Score: 160/184 = 87%

Source Document: *Parenting Skills Rating Scale, Mother-Child* Pre-Test



[redacted] Parenting Skills Rating Scale

(Based on the Family Teaching Model)

Mother-Child

Circle one: (Pre-test) Post-test

Client's Name: [redacted]

Client Number: [redacted]

Child's Name: [redacted]

Child's Age: [redacted]

Completed By: [redacted]

Date : 8/30/07

Total Score: 96

Parenting Skills Rating Scale, Mother-Child, Pre-Test Score:

SCORING:

1 = Rarely or never
2 = Sometimes
3 = Always or most of the time

Page | 18

Source Document: *Parenting Skills Rating Scale, Mother-Child* Post-Test

[redacted] Parenting Skills Rating Scale

(Based on the Family Teaching Model)

Mother-Child

Circle one: Pre-test Post-test

Client's Name: [redacted]

Client Number: 436

Child's Name: [redacted]

Child's Age:

Completed By:

Date : 2/3/08

Parenting Skills Rating Scale, Mother-Child, Post-Test Score:

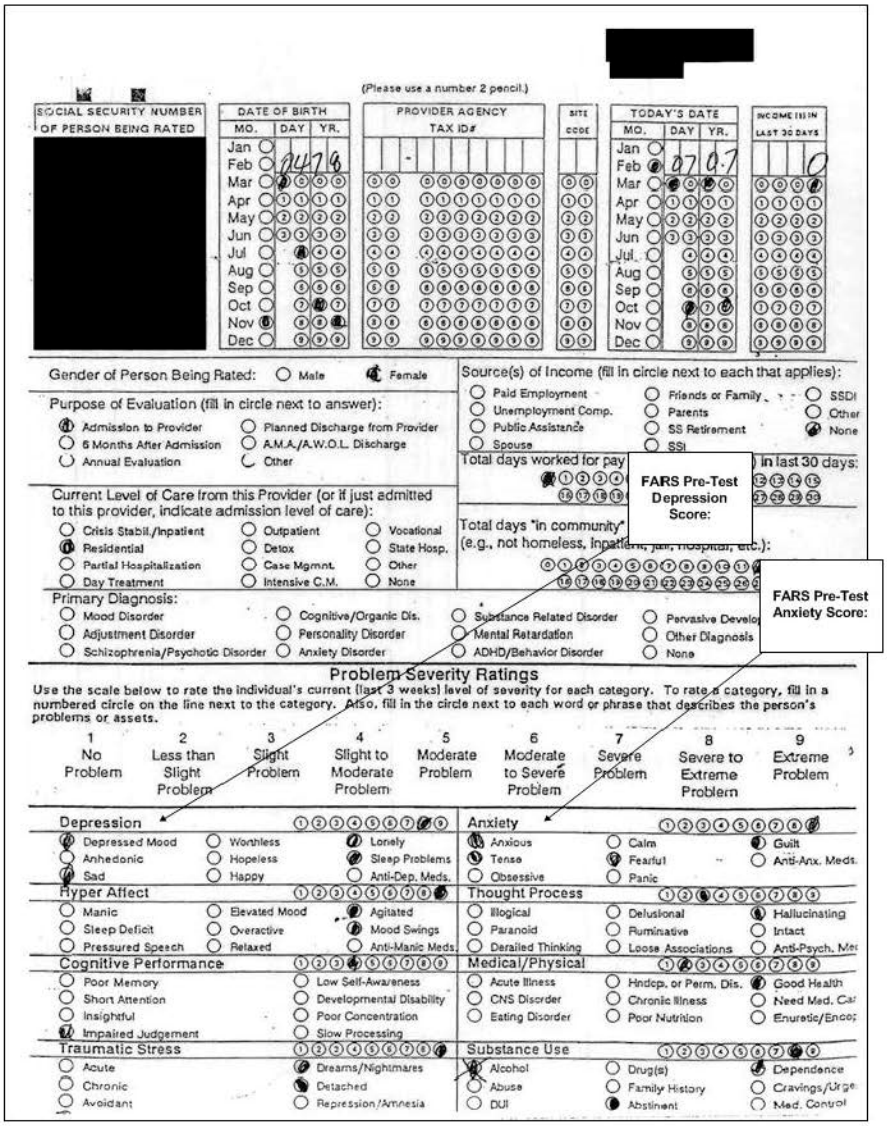
Total Score: 105

SCORING:

1 = Rarely or never
2 = Sometimes
3 = Always or most of the time

Page | 19

Source Document: *Functional Assessment Rating Scale,* Pre-Test, Page 1



(Please use a number 2 pencil.)

SOCIAL SECURITY NUMBER OF PERSON BEING RATED: [redacted]

DATE OF BIRTH: MO. Feb | DAY 24 | YR. 76

PROVIDER AGENCY TAX ID#:

SITE CODE:

TODAY'S DATE: MO. Feb | DAY 07 | YR. 07

INCOME (\$) IN LAST 30 DAYS: 10

Gender of Person Being Rated: ○ Male ● Female

Purpose of Evaluation (fill in circle next to answer):
- ● Admission to Provider
- ○ 6 Months After Admission
- ○ Annual Evaluation
- ○ Planned Discharge from Provider
- ○ A.M.A./A.W.O.L. Discharge
- ○ Other

Source(s) of Income (fill in circle next to each that applies):
- ○ Paid Employment
- ○ Unemployment Comp.
- ○ Public Assistance
- ○ Spouse
- ○ Friends or Family
- ○ Parents
- ○ SS Retirement
- ○ SSI
- ○ SSDI
- ○ Other
- ● None

Total days worked for pay ... in last 30 days: 04

FARS Pre-Test Depression Score:

Current Level of Care from this Provider (or if just admitted to this provider, indicate admission level of care):
- ○ Crisis Stabil./Inpatient
- ● Residential
- ○ Partial Hospitalization
- ○ Day Treatment
- ○ Outpatient
- ○ Detox
- ○ Case Mgmnt.
- ○ Intensive C.M.
- ○ Vocational
- ○ State Hosp.
- ○ Other
- ○ None

Total days "in community" (e.g., not homeless, Inpatient, Jail, Hospital, etc.): 26

FARS Pre-Test Anxiety Score:

Primary Diagnosis:
- ○ Mood Disorder
- ○ Adjustment Disorder
- ○ Schizophrenia/Psychotic Disorder
- ○ Cognitive/Organic Dis.
- ○ Personality Disorder
- ○ Anxiety Disorder
- ○ Substance Related Disorder
- ○ Mental Retardation
- ○ ADHD/Behavior Disorder
- ○ Pervasive Develop
- ○ Other Diagnosis
- ○ None

Problem Severity Ratings

Use the scale below to rate the individual's current (last 3 weeks) level of severity for each category. To rate a category, fill in a numbered circle on the line next to the category. Also, fill in the circle next to each word or phrase that describes the person's problems or assets.

1 No Problem | 2 Less than Slight Problem | 3 Slight Problem | 4 Slight to Moderate Problem | 5 Moderate Problem | 6 Moderate to Severe Problem | 7 Severe Problem | 8 Severe to Extreme Problem | 9 Extreme Problem

Depression ①②③④⑤⑥⑦●⑨
- ● Depressed Mood
- ○ Anhedonic
- ● Sad
- ○ Worthless
- ○ Hopeless
- ○ Happy
- ● Lonely
- ● Sleep Problems
- ○ Anti-Dep. Meds.

Anxiety ①②③④⑤⑥⑦●⑨
- ● Anxious
- ● Tense
- ○ Obsessive
- ○ Calm
- ● Fearful
- ○ Panic
- ● Guilt
- ○ Anti-Anx. Meds.

Hyper Affect ①②③④⑤⑥⑦⑧●
- ○ Manic
- ○ Sleep Deficit
- ○ Pressured Speech
- ○ Elevated Mood
- ○ Overactive
- ○ Relaxed
- ● Agitated
- ● Mood Swings
- ○ Anti-Manic Meds.

Thought Process ①②●④⑤⑥⑦⑧⑨
- ○ Illogical
- ○ Paranoid
- ○ Derailed Thinking
- ○ Delusional
- ○ Ruminative
- ○ Loose Associations
- ● Hallucinating
- ○ Intact
- ○ Anti-Psych. Me

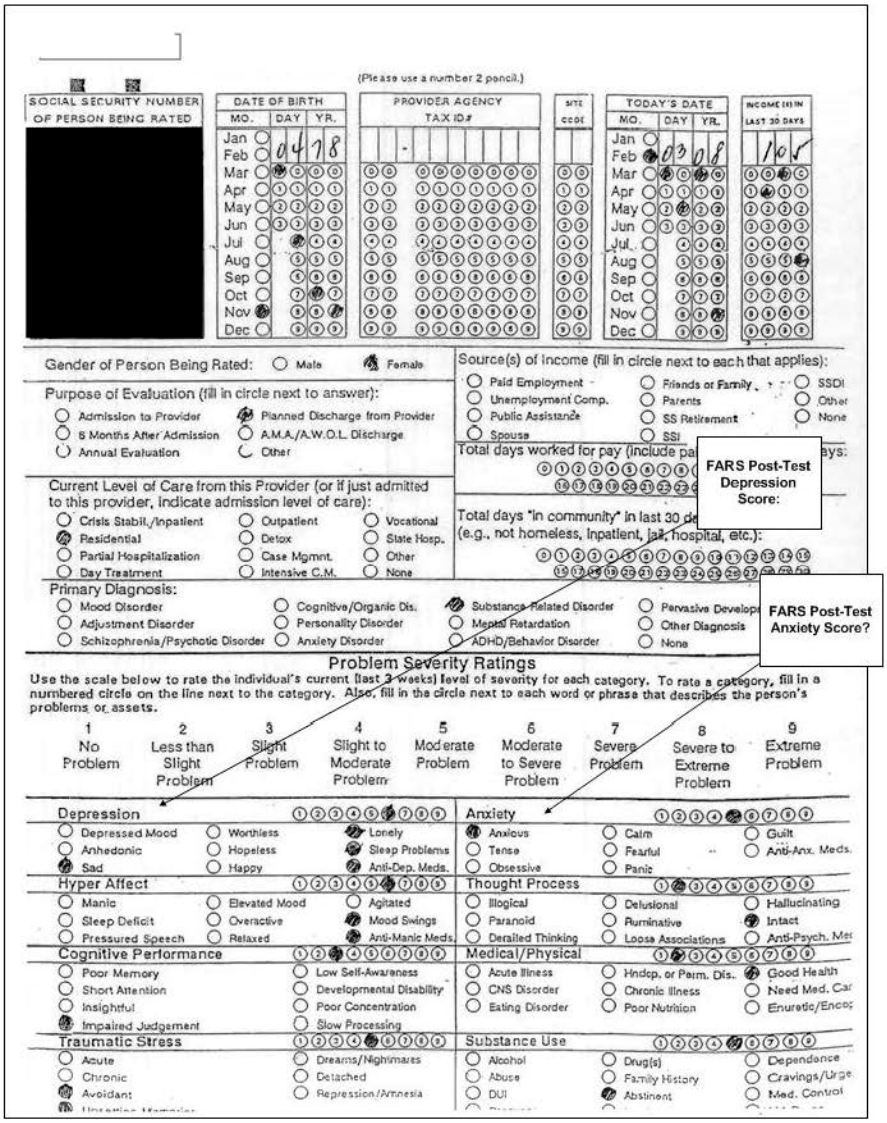
Cognitive Performance ①②③●⑤⑥⑦⑧⑨
- ○ Poor Memory
- ○ Short Attention
- ○ Insightful
- ● Impaired Judgement
- ○ Low Self-Awareness
- ○ Developmental Disability
- ○ Poor Concentration
- ○ Slow Processing

Medical/Physical ①●③④⑤⑥⑦⑧⑨
- ○ Acute Illness
- ○ CNS Disorder
- ○ Eating Disorder
- ○ Hndcp. or Perm. Dis.
- ○ Chronic Illness
- ○ Poor Nutrition
- ● Good Health
- ○ Need Med. Ca
- ○ Enuretic/Encop

Traumatic Stress ①②③④⑤⑥⑦⑧●
- ○ Acute
- ○ Chronic
- ○ Avoidant
- ● Dreams/Nightmares
- ● Detached
- ○ Repression/Amnesia

Substance Use ①②③④⑤⑥⑦●⑨
- ● Alcohol
- ○ Abuse
- ○ DUI
- ○ Drug(s)
- ○ Family History
- ● Abstinent
- ● Dependence
- ○ Cravings/Urge
- ○ Med. Control

Source Document: *Functional Assessment Rating Scale*, Post-Test, Page 1



(Please use a number 2 pencil.)

SOCIAL SECURITY NUMBER OF PERSON BEING RATED: [redacted]

DATE OF BIRTH MO. DAY YR.: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec — 04 18

PROVIDER AGENCY TAX ID#:

SITE CODE:

TODAY'S DATE MO. DAY YR.: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec — 03 08

INCOME (in) IN LAST 30 DAYS: 10 5

Gender of Person Being Rated: ○ Male ● Female

Purpose of Evaluation (fill in circle next to answer):
○ Admission to Provider ● Planned Discharge from Provider
○ 6 Months After Admission ○ A.M.A./A.W.O.L. Discharge
○ Annual Evaluation ○ Other

Source(s) of Income (fill in circle next to each that applies):
○ Paid Employment ○ Friends or Family ○ SSDI
○ Unemployment Comp. ○ Parents ○ Other
○ Public Assistance ○ SS Retirement ○ None
○ Spouse ○ SSI

Total days worked for pay (include pa... ays:

Current Level of Care from this Provider (or if just admitted to this provider, indicate admission level of care):
○ Crisis Stabil./Inpatient ○ Outpatient ○ Vocational
● Residential ○ Detox ○ State Hosp.
○ Partial Hospitalization ○ Case Mgmnt. ○ Other
○ Day Treatment ○ Intensive C.M. ○ None

Total days "in community" in last 30 d...
(e.g., not homeless, inpatient, jail, hospital, etc.):

FARS Post-Test Depression Score:

Primary Diagnosis:
○ Mood Disorder ○ Cognitive/Organic Dis. ● Substance Related Disorder ○ Pervasive Develop...
○ Adjustment Disorder ○ Personality Disorder ○ Mental Retardation ○ Other Diagnosis
○ Schizophrenia/Psychotic Disorder ○ Anxiety Disorder ○ ADHD/Behavior Disorder ○ None

FARS Post-Test Anxiety Score?

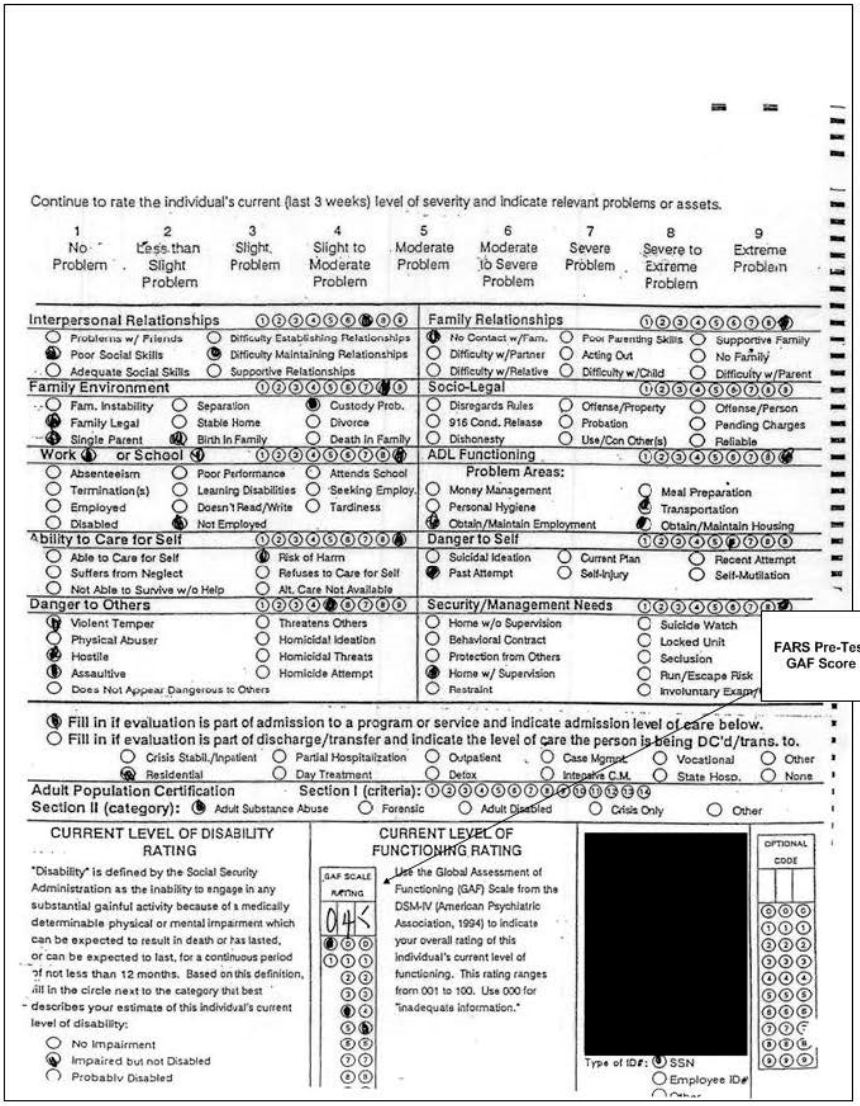
Problem Severity Ratings

Use the scale below to rate the individual's current (last 3 weeks) level of severity for each category. To rate a category, fill in a numbered circle on the line next to the category. Also, fill in the circle next to each word or phrase that describes the person's problems or assets.

1 No Problem | 2 Less than Slight Problem | 3 Slight Problem | 4 Slight to Moderate Problem | 5 Moderate Problem | 6 Moderate to Severe Problem | 7 Severe Problem | 8 Severe to Extreme Problem | 9 Extreme Problem

Depression			Anxiety		
○ Depressed Mood	○ Worthless	● Lonely	● Anxious	○ Calm	○ Guilt
○ Anhedonic	○ Hopeless	● Sleep Problems	○ Tense	○ Fearful	○ Anti-Anx. Meds.
● Sad	○ Happy	● Anti-Dep. Meds.	○ Obsessive	○ Panic	
Hyper Affect			**Thought Process**		
○ Manic	○ Elevated Mood	○ Agitated	○ Illogical	○ Delusional	○ Hallucinating
○ Sleep Deficit	○ Overactive	● Mood Swings	○ Paranoid	○ Ruminative	● Intact
○ Pressured Speech	○ Relaxed	● Anti-Manic Meds.	○ Derailed Thinking	○ Loose Associations	○ Anti-Psych. Me
Cognitive Performance			**Medical/Physical**		
○ Poor Memory		○ Low Self-Awareness	○ Acute Illness	○ Hndcp. or Perm. Dis.	● Good Health
○ Short Attention		○ Developmental Disability	○ CNS Disorder	○ Chronic Illness	○ Need Med. Ca
○ Insightful		○ Poor Concentration	○ Eating Disorder	○ Poor Nutrition	○ Enuretic/Enco
● Impaired Judgement		○ Slow Processing			
Traumatic Stress			**Substance Use**		
○ Acute		○ Dreams/Nightmares	○ Alcohol	○ Drug(s)	○ Dependance
○ Chronic		○ Detached	○ Abuse	○ Family History	○ Cravings/Urge
● Avoidant		○ Repression/Amnesia	○ DUI	● Abstinent	○ Med. Control

Source Document: *Functional Assessment Rating Scale*, Pre-Test, Page 2



Continue to rate the individual's current (last 3 weeks) level of severity and indicate relevant problems or assets.

1 No Problem | 2 Less than Slight Problem | 3 Slight Problem | 4 Slight to Moderate Problem | 5 Moderate Problem | 6 Moderate to Severe Problem | 7 Severe Problem | 8 Severe to Extreme Problem | 9 Extreme Problem

Interpersonal Relationships
- Problems w/ Friends
- Poor Social Skills
- Adequate Social Skills
- Difficulty Establishing Relationships
- Difficulty Maintaining Relationships
- Supportive Relationships

Family Relationships
- No Contact w/Fam.
- Difficulty w/Partner
- Difficulty w/Relative
- Poor Parenting Skills
- Acting Out
- Difficulty w/Child
- Supportive Family
- No Family
- Difficulty w/Parent

Family Environment
- Fam. Instability
- Family Legal
- Single Parent
- Separation
- Stable Home
- Birth In Family
- Custody Prob.
- Divorce
- Death in Family

Socio-Legal
- Disregards Rules
- 916 Cond. Release
- Dishonesty
- Offense/Property
- Probation
- Use/Con Other(s)
- Offense/Person
- Pending Charges
- Reliable

Work or School
- Absenteeism
- Termination(s)
- Employed
- Disabled
- Poor Performance
- Learning Disabilities
- Doesn't Read/Write
- Not Employed
- Attends School
- Seeking Employ.
- Tardiness

ADL Functioning

Problem Areas:
- Money Management
- Personal Hygiene
- Obtain/Maintain Employment
- Meal Preparation
- Transportation
- Obtain/Maintain Housing

Ability to Care for Self
- Able to Care for Self
- Suffers from Neglect
- Not Able to Survive w/o Help
- Risk of Harm
- Refuses to Care for Self
- Alt. Care Not Available

Danger to Self
- Suicidal Ideation
- Past Attempt
- Current Plan
- Self-Injury
- Recent Attempt
- Self-Mutilation

Danger to Others
- Violent Temper
- Physical Abuser
- Hostile
- Assaultive
- Does Not Appear Dangerous to Others
- Threatens Others
- Homicidal Ideation
- Homicidal Threats
- Homicide Attempt

Security/Management Needs
- Home w/o Supervision
- Behavioral Contract
- Protection from Others
- Home w/ Supervision
- Restraint
- Suicide Watch
- Locked Unit
- Seclusion
- Run/Escape Risk
- Involuntary Exam

FARS Pre-Test GAF Score

- Fill in if evaluation is part of admission to a program or service and indicate admission level of care below.
- Fill in if evaluation is part of discharge/transfer and indicate the level of care the person is being DC'd/trans. to.

Crisis Stabil./Inpatient | Partial Hospitalization | Outpatient | Case Mgmnt. | Vocational | Other
Residential | Day Treatment | Detox | Intensive C.M. | State Hosp. | None

Adult Population Certification — **Section I (criteria):**

Section II (category): Adult Substance Abuse | Forensic | Adult Disabled | Crisis Only | Other

CURRENT LEVEL OF DISABILITY RATING

"Disability" is defined by the Social Security Administration as the inability to engage in any substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than 12 months. Based on this definition, fill in the circle next to the category that best describes your estimate of this individual's current level of disability:
- No Impairment
- Impaired but not Disabled
- Probably Disabled

CURRENT LEVEL OF FUNCTIONING RATING

Use the Global Assessment of Functioning (GAF) Scale from the DSM-IV (American Psychiatric Association, 1994) to indicate your overall rating of this individual's current level of functioning. This rating ranges from 001 to 100. Use 000 for "inadequate information."

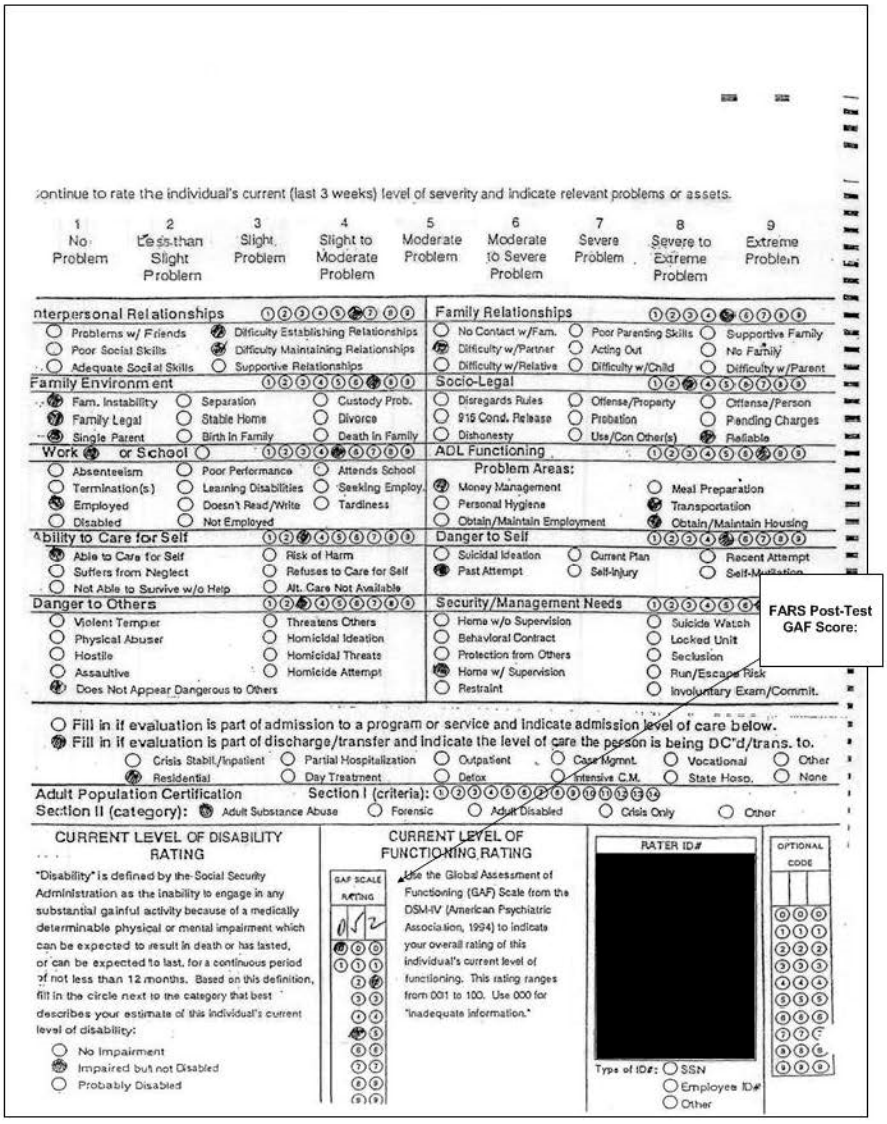
GAF SCALE RATING: 045

[redacted]

Type of ID#: SSN | Employee ID# | Other

OPTIONAL CODE

Source Document: *Functional Assessment Rating Scale*, Post-Test, Page 2



ontinue to rate the individual's current (last 3 weeks) level of severity and indicate relevant problems or assets.

1 No Problem	2 Less-than Slight Problem	3 Slight Problem	4 Slight to Moderate Problem	5 Moderate Problem	6 Moderate to Severe Problem	7 Severe Problem	8 Severe to Extreme Problem	9 Extreme Problem

nterpersonal Relationships
- Problems w/ Friends
- Poor Social Skills
- Adequate Social Skills
- Difficulty Establishing Relationships
- Difficulty Maintaining Relationships
- Supportive Relationships

Family Relationships
- No Contact w/Fam.
- Difficulty w/Partner
- Difficulty w/Relative
- Poor Parenting Skills
- Acting Out
- Difficulty w/Child
- Supportive Family
- No Family
- Difficulty w/Parent

Family Environment
- Fam. Instability
- Family Legal
- Single Parent
- Separation
- Stable Home
- Birth in Family
- Custody Prob.
- Divorce
- Death in Family

Socio-Legal
- Disregards Rules
- 916 Cond. Release
- Dishonesty
- Offense/Property
- Probation
- Use/Con Other(s)
- Offense/Person
- Pending Charges
- Reliable

Work or School
- Absenteeism
- Termination(s)
- Employed
- Disabled
- Poor Performance
- Learning Disabilities
- Doesn't Read/Write
- Not Employed
- Attends School
- Seeking Employ.
- Tardiness

ADL Functioning

Problem Areas:
- Money Management
- Personal Hygiene
- Obtain/Maintain Employment
- Meal Preparation
- Transportation
- Obtain/Maintain Housing

Ability to Care for Self
- Able to Care for Self
- Suffers from Neglect
- Not Able to Survive w/o Help
- Risk of Harm
- Refuses to Care for Self
- Alt. Care Not Available

Danger to Self
- Suicidal Ideation
- Past Attempt
- Current Plan
- Self-Injury
- Recent Attempt
- Self-Mutilation

Danger to Others
- Violent Temper
- Physical Abuser
- Hostile
- Assaultive
- Does Not Appear Dangerous to Others
- Threatens Others
- Homicidal Ideation
- Homicidal Threats
- Homicide Attempt

Security/Management Needs
- Home w/o Supervision
- Behavioral Contract
- Protection from Others
- Home w/ Supervision
- Restraint
- Suicide Watch
- Locked Unit
- Seclusion
- Run/Escape Risk
- Involuntary Exam/Commit.

FARS Post-Test GAF Score:

- Fill in if evaluation is part of admission to a program or service and indicate admission level of care below.
- Fill in if evaluation is part of discharge/transfer and indicate the level of care the person is being DC'd/trans. to.

Crisis Stabil./Inpatient; Partial Hospitalization; Outpatient; Case Mgmnt.; Vocational; Other
Residential; Day Treatment; Detox; Intensive C.M.; State Hosp.; None

Adult Population Certification — Section I (criteria):
Section II (category): Adult Substance Abuse; Forensic; Adult Disabled; Crisis Only; Other

CURRENT LEVEL OF DISABILITY RATING

"Disability" is defined by the Social Security Administration as the inability to engage in any substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than 12 months. Based on this definition, fill in the circle next to the category that best describes your estimate of this individual's current level of disability:

- No Impairment
- Impaired but not Disabled
- Probably Disabled

CURRENT LEVEL OF FUNCTIONING RATING

GAF SCALE RATING: 0 5 2

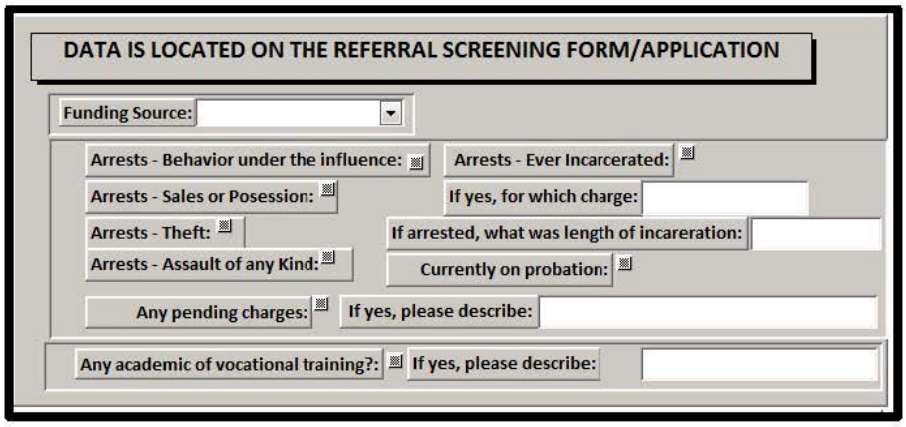
Use the Global Assessment of Functioning (GAF) Scale from the DSM-IV (American Psychiatric Association, 1994) to indicate your overall rating of this individual's current level of functioning. This rating ranges from 001 to 100. Use 000 for "inadequate information."

RATER ID#: [redacted]

Type of ID#: SSN; Employee ID#; Other

OPTIONAL CODE

Data Entry Screen 2: *Referral Screening Form*



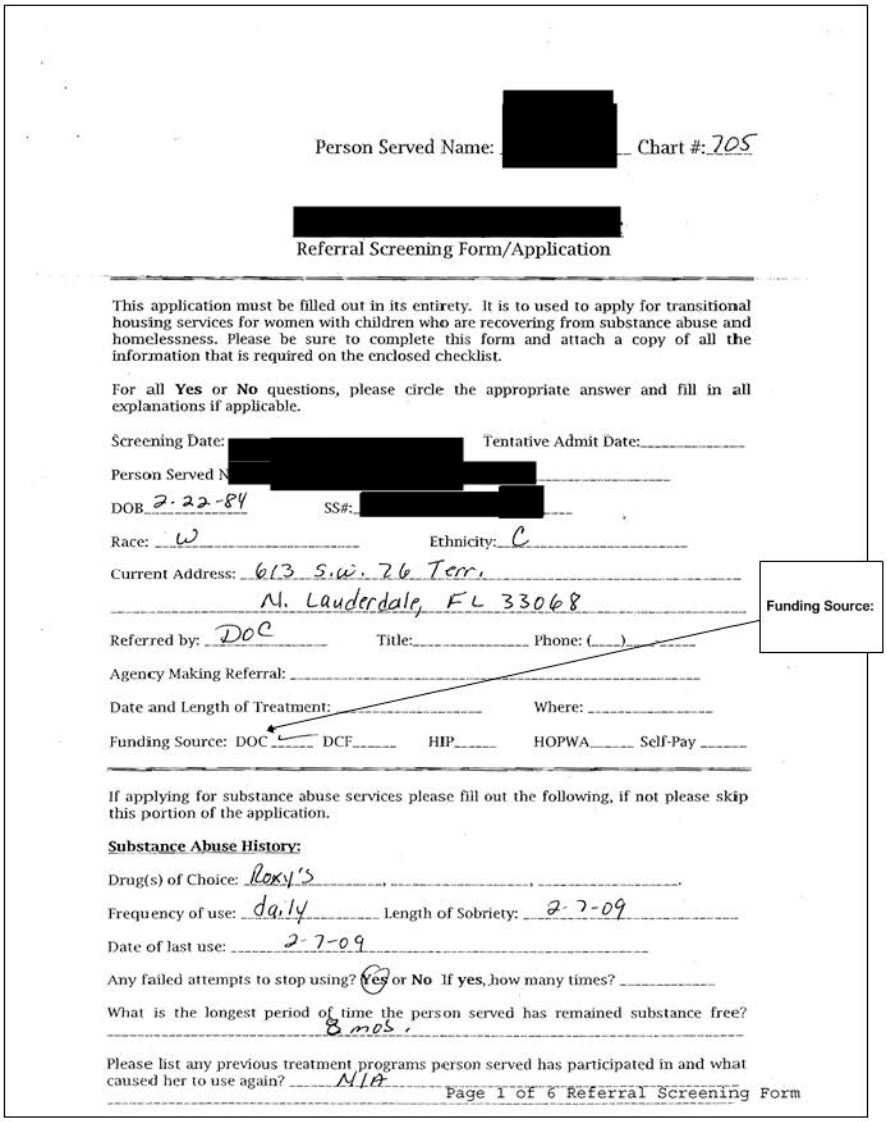
Locating the data in the client's paper file:

Funding Source data is taken from page 1 of the *Referral Screening Form* (see page 25).

All **Arrests** data is taken from page 4 of the *Referral Screening Form* (see page 26).

Any academic or vocational training and **If yes, please describe** data is taken from page 6 of the *Referral Screening Form* (see page 27).

Source Document: *Referral Screening Form*, Page 1



Person Served Name: [redacted] Chart #: 705

[redacted]

Referral Screening Form/Application

This application must be filled out in its entirety. It is to used to apply for transitional housing services for women with children who are recovering from substance abuse and homelessness. Please be sure to complete this form and attach a copy of all the information that is required on the enclosed checklist.

For all **Yes** or **No** questions, please circle the appropriate answer and fill in all explanations if applicable.

Screening Date: [redacted] Tentative Admit Date: _____

Person Served N[redacted] _____

DOB 2-22-84 SS#: [redacted]

Race: W Ethnicity: C

Current Address: 613 S.W. 26 Terr.
N. Lauderdale, FL 33068

Referred by: DOC Title: _____ Phone: (___) _____

Agency Making Referral: _____

Date and Length of Treatment: _____ Where: _____

Funding Source: DOC _____ DCF _____ HIP _____ HOPWA _____ Self-Pay _____

Funding Source:

If applying for substance abuse services please fill out the following, if not please skip this portion of the application.

Substance Abuse History:

Drug(s) of Choice: Roxy's _____, _____, _____.

Frequency of use: daily Length of Sobriety: 2-7-09

Date of last use: 2-7-09

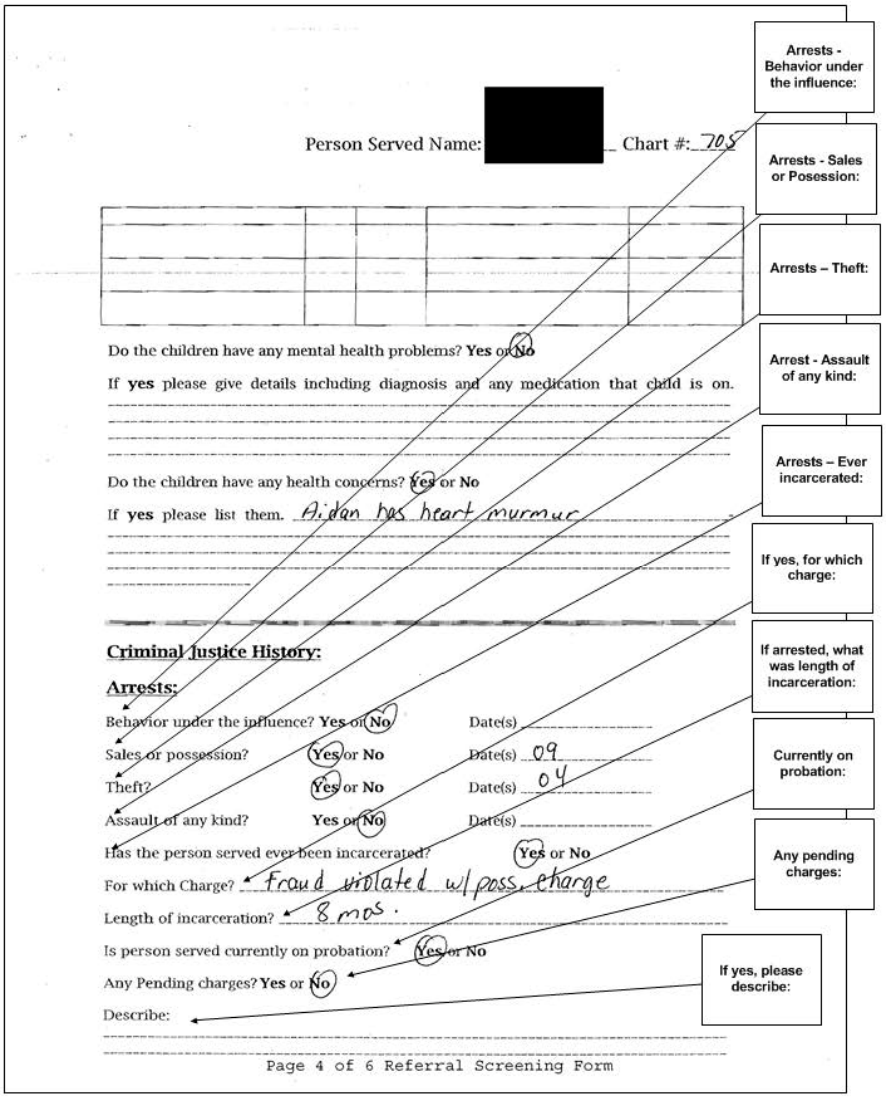
Any failed attempts to stop using? (Yes) or **No** If **yes**, how many times? _____

What is the longest period of time the person served has remained substance free?
8 mos.

Please list any previous treatment programs person served has participated in and what caused her to use again? N/A

Page 1 of 6 Referral Screening Form

Source Document: *Referral Screening Form*, Page 4



Person Served Name: [redacted] Chart #: 705

Do the children have any mental health problems? Yes or No

If yes please give details including diagnosis and any medication that child is on.

Do the children have any health concerns? Yes or No

If yes please list them. Aidan has heart murmur

Criminal Justice History:

Arrests:

Behavior under the influence? Yes or No Date(s)

Sales or possession? Yes or No Date(s) 09

Theft? Yes or No Date(s) 04

Assault of any kind? Yes or No Date(s)

Has the person served ever been incarcerated? Yes or No

For which Charge? Fraud violated w/ poss. charge

Length of incarceration? 8 mos.

Is person served currently on probation? Yes or No

Any Pending charges? Yes or No

Describe:

Page 4 of 6 Referral Screening Form

Arrests - Behavior under the influence:

Arrests - Sales or Posession:

Arrests – Theft:

Arrest - Assault of any kind:

Arrests – Ever incarcerated:

If yes, for which charge:

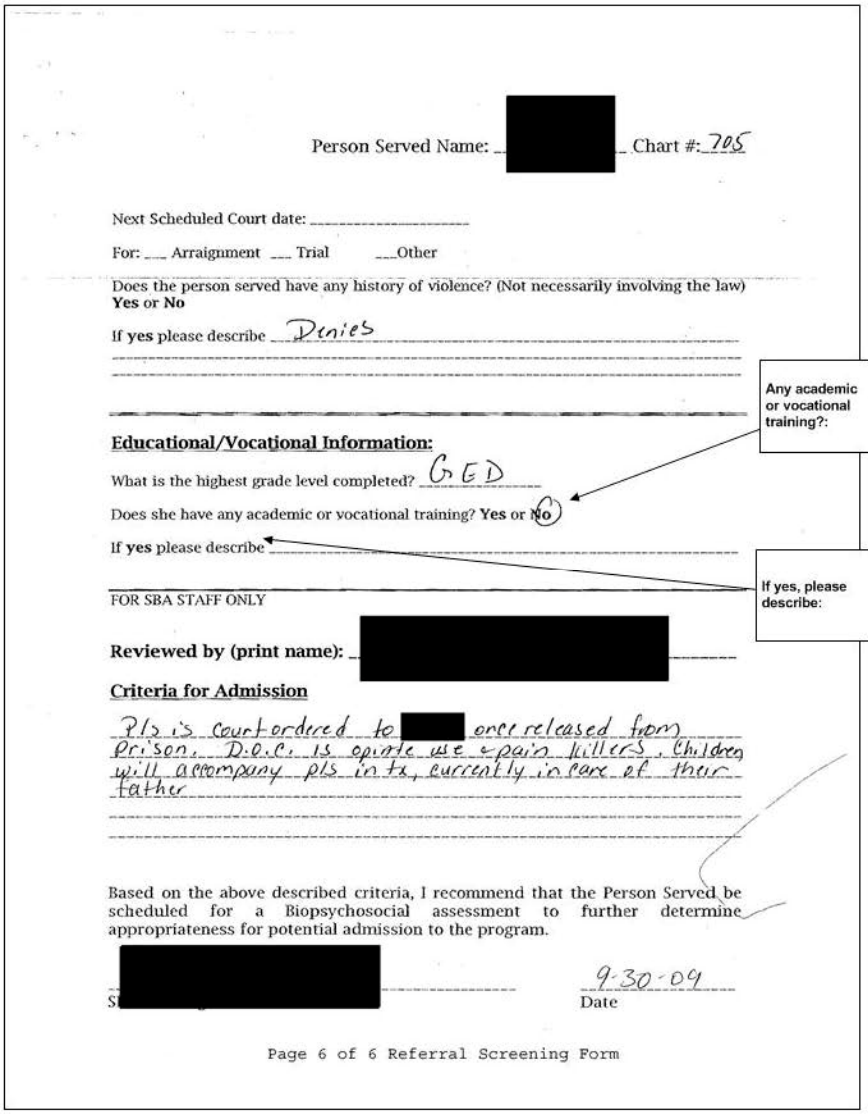
If arrested, what was length of incarceration:

Currently on probation:

Any pending charges:

If yes, please describe:

Source Document: *Referral Screening Form*, Page 6



Person Served Name: [redacted] Chart #: 705

Next Scheduled Court date: _____

For: ___ Arraignment ___ Trial ___Other

Does the person served have any history of violence? (Not necessarily involving the law)
Yes or **No**

If **yes** please describe Denies

Any academic or vocational training?:

Educational/Vocational Information:

What is the highest grade level completed? GED

Does she have any academic or vocational training? **Yes** or **No** (No)

If **yes** please describe _____

If yes, please describe:

FOR SBA STAFF ONLY

Reviewed by (print name): [redacted]

Criteria for Admission

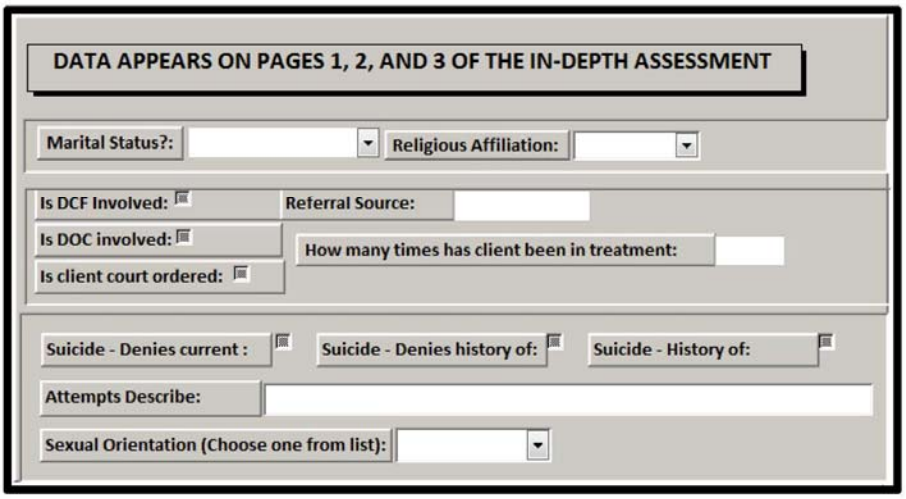
Pt's is court ordered to [redacted] once released from prison. D.O.C. is opiate use + pain killers. Children will accompany pts in tx, currently in care of their father

Based on the above described criteria, I recommend that the Person Served be scheduled for a Biopsychosocial assessment to further determine appropriateness for potential admission to the program.

S[redacted] 9-30-09
Date

Page 6 of 6 Referral Screening Form

Data Entry Screen 3: *In-Depth Assessment* (Part 1)



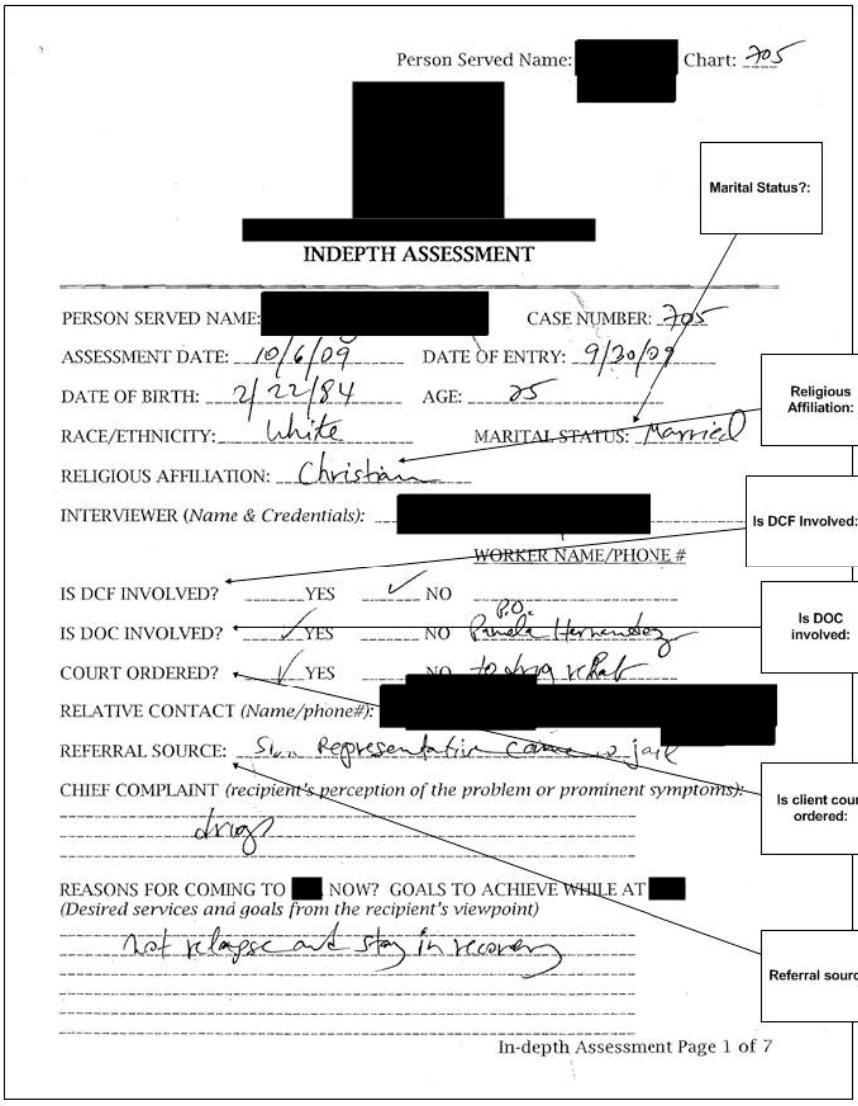
Locating the data for this form in the client's paper file:

Marital Status?, Religious Affiliation, DCF, DOC, Is client court ordered?, and **How many times has client been in treatment:** data is taken from page 1 of *Indepth Assessment* (see page 29).

All **Suicide** data is taken from page 2 of *Indepth Assessment* (see page 30).

Sexual Orientation data is taken from page 3 of *Indepth Assessment* (see page 31).

Source Document: *Indepth Assessment*, Page 1



Person Served Name: [redacted] Chart: 705

[redacted]

INDEPTH ASSESSMENT

PERSON SERVED NAME: [redacted] CASE NUMBER: 705

ASSESSMENT DATE: 10/6/09 DATE OF ENTRY: 9/20/09

DATE OF BIRTH: 2/22/84 AGE: 25

RACE/ETHNICITY: White MARITAL STATUS: Married

RELIGIOUS AFFILIATION: Christian

INTERVIEWER (*Name & Credentials*): [redacted]

WORKER NAME/PHONE #

IS DCF INVOLVED? ____YES ✓ NO

IS DOC INVOLVED? ✓ YES ____ NO P.O. Pamela Hernandez

COURT ORDERED? ✓ YES ____ NO to drug rehab

RELATIVE CONTACT (*Name/phone#*): [redacted]

REFERRAL SOURCE: Sh... Representative came 2 jail

CHIEF COMPLAINT (*recipient's perception of the problem or prominent symptoms*):

drugs

REASONS FOR COMING TO [redacted] NOW? GOALS TO ACHIEVE WHILE AT [redacted]
(*Desired services and goals from the recipient's viewpoint*)

not relapse and stay in recovery

In-depth Assessment Page 1 of 7

Marital Status?:

Religious Affiliation:

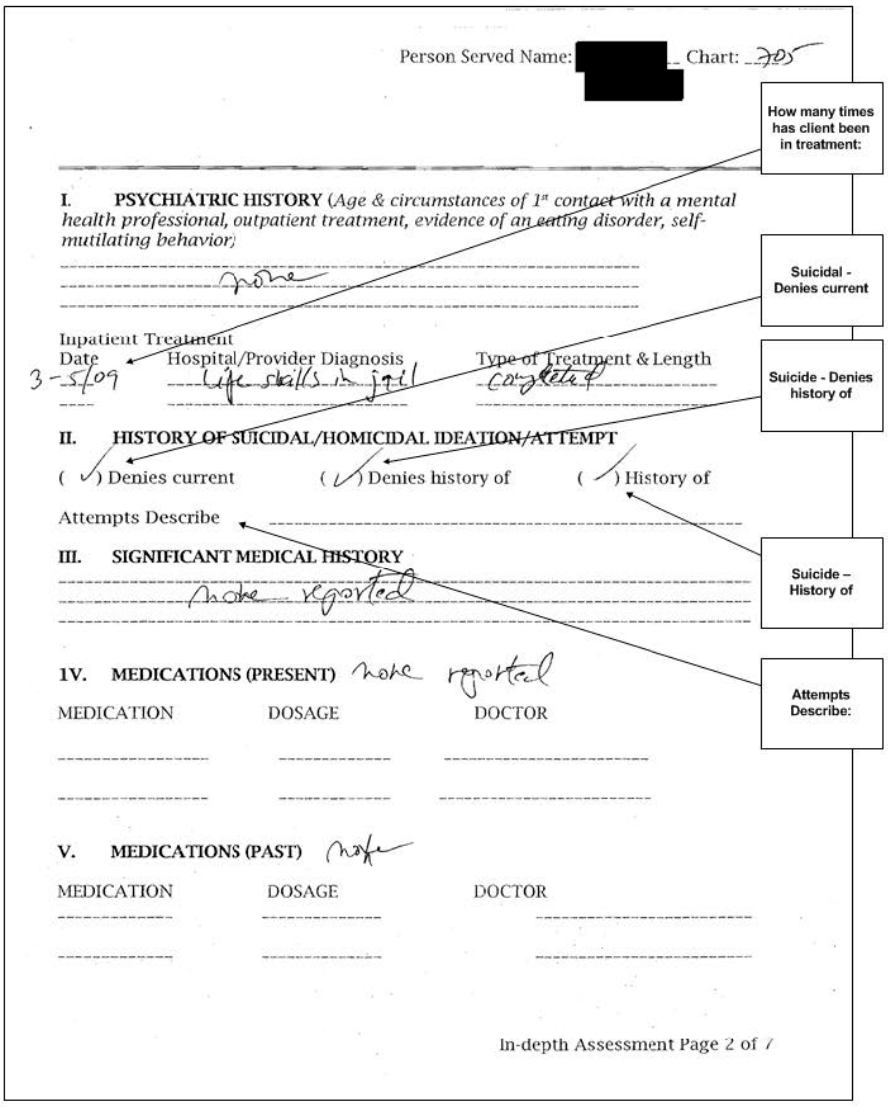
Is DCF Involved:

Is DOC involved:

Is client court ordered:

Referral source:

Source Document: *Indepth Assessment*, Page 2



Person Served Name: [redacted] Chart: 705

I. **PSYCHIATRIC HISTORY** (*Age & circumstances of 1st contact with a mental health professional, outpatient treatment, evidence of an eating disorder, self-mutilating behavior)*

none

Inpatient Treatment

Date	Hospital/Provider Diagnosis	Type of Treatment & Length
3-5/09	Life skills in jail	completed

II. **HISTORY OF SUICIDAL/HOMICIDAL IDEATION/ATTEMPT**

(✓) Denies current (✓) Denies history of ( ) History of

Attempts Describe

III. **SIGNIFICANT MEDICAL HISTORY**

none reported

1V. **MEDICATIONS (PRESENT)** none reported

MEDICATION	DOSAGE	DOCTOR

V. **MEDICATIONS (PAST)** none

MEDICATION	DOSAGE	DOCTOR

In-depth Assessment Page 2 of 7

How many times has client been in treatment:

Suicidal - Denies current

Suicide - Denies history of

Suicide – History of

Attempts Describe:

Source Document: *Indepth Assessment*, Page 3

Person Served Name: [redacted] Chart: 705

VI. SUBSTANCE ABUSE HISTORY

(Age of first use, how much, progression of use, current abstinence period, past abstinence (how long), drug of choice, prior substance abuse treatment, overdose, legal problems associated with use, peer involvement)

Age 13 – alcohol couple of beers till got drunk every weekend till age 16
Age 13 – marijuana everyday 1 joints initially then 2-4 till age 20
Age 21 – Roxies (opiates) 1/ 1-2x month then 20-30 day until got arrested 2/09
drug of choice – Roxies Clean date: 2/2/09

VII. PSYCHOSOCIAL HISTORY

loner, hung out w/ brother and his friends
spent time w/ husband

Sexual Orientation (Choose one from the list):

A. DEVELOPMENTAL MILESTONES NORMAL ✓ DELAY ____

RAISED BY: Mother & father
RESIDED WITH: parents until age 16 since parents divorced when she was 13. Mom left @ B/s was 16 and left house for her & siblings

SIBLINGS (sex & ages)
Age 29 Brother Bruce – close relationship (in Prison).
Age 23 Sister Brittany – fought as child, close relationship now in Ft. Lauderdale

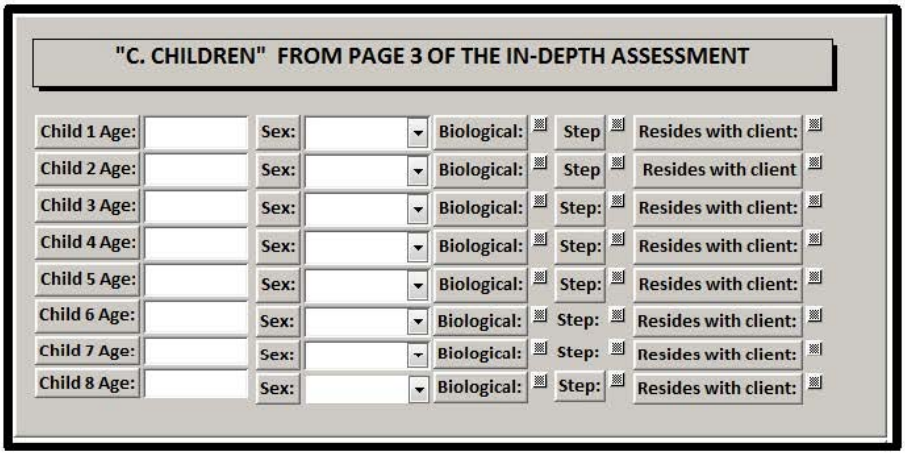
B. SEXUAL ORIENTATION ✓ Heterosexual ____ Gay ____ Lesbian ____ Bisexual ____ Transgender

C. CHILDREN Specify if Biological (B), Step-Children (S), or Adoptive (A) [redacted]
Age 4 Sex F Biological ✓ Step ____ Resides [redacted]
Age 8 months Sex M Biological ✓ Step ____ Resides [redacted]

D. EDUCATION HISTORY:
Highest Grade Completed 9th Diploma (GED) Degree(s) ____
If none, is this a goal you would like to achieve? not sure about what would like to do but wants to go back to school.

In-depth Assessment Page 3 of 7

Data Entry Screen 4: *In-Depth Assessment* (Part 2)



Locating the data for this form in the client's paper file:

All data for this form is taken from page 3 of the *Indepth Assessment* (see page 33).

Source Document: ***Indepth Assessment*****, Page 3**

Person Served Name: [redacted] Chart: 705

VI. SUBSTANCE ABUSE HISTORY

(Age of first use, how much, progression of use, current abstinence period, past abstinence (how long), drug of choice, prior substance abuse treatment, overdose, legal problems associated with use, peer involvement)

Age 13 – alcohol couple of beers till got drunk every weekend till age 16

Age 13 – marijuana everyday 1 joints initially then 2-4 till age 20

Age 21 – Roxies 1/ 1-2x month then 20-30 day until got (opiates) arrested 2/09

drug of choice – Roxies Clean date: 2

Child n Age:

VII. PSYCHOSOCIAL HISTORY

Lower living out w/ brother and his friend

spent time w/ husband

Child n Sex:

Child n Biological:

A. DEVELOPMENTAL MILESTONES NORMAL ✓ DELAY ______

RAISED BY: Mother & father

RESIDED WITH: parents until age 16 since parents divorced she was 13 mom left @ 8/s was 16 and for her & sibling

Child n Step:

SIBLINGS (sex & ages)

Age 29 Brother Bruce – close relationship (in prison)

Age 23 Sister Brittney – fought as child, close relat now in Ft. Lauderdale

B. SEXUAL ORIENTATION ✓ Heterosexual ____ Gay ____ Lesbian ____ Bisexual ____ Transgender

C. CHILDREN Specify if Biological (B), Step-Children (S), or Adoptive (A) [redacted]

Age 4 Sex F Biological ✓ Step ______ Resides

Age 8 months Sex M Biological ✓ Step ______ Resides

D. EDUCATION HISTORY:

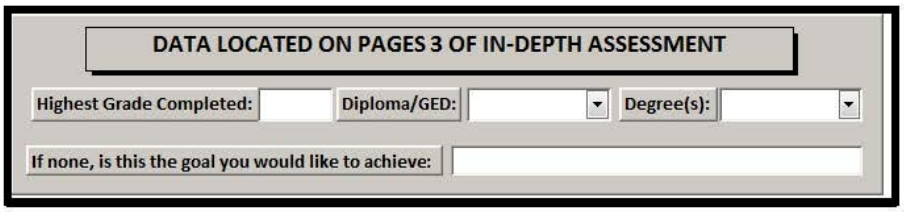
Highest Grade Completed 9th Diploma (GED) Degree(s) ____

If none, is this a goal you would like to achieve? not sure about what would like to but wants to go back to school.

Child n Resides with Client:

In-depth Assessment Page 3 of 7

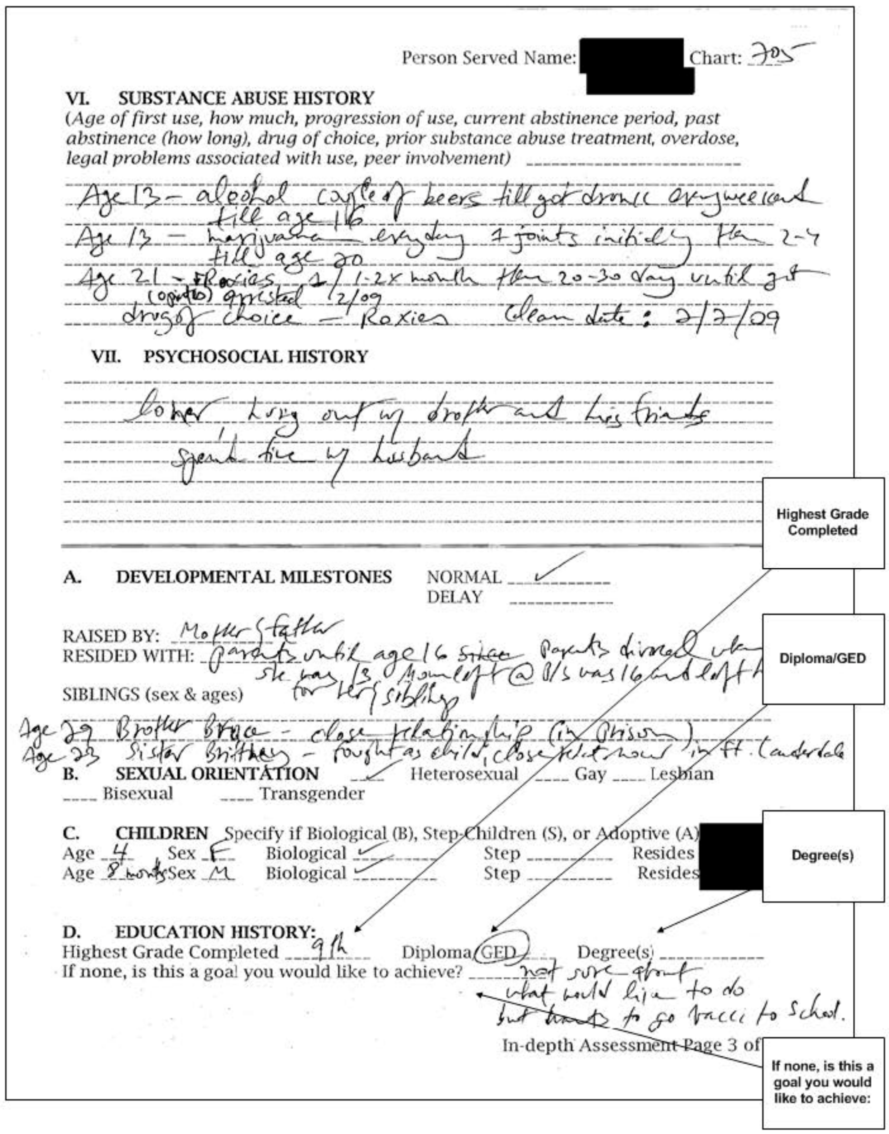
Data Entry Screen 5: *In-Depth Assessment* (Part 3)



Locating the data for this form in the client's paper file:

All data from this form is taken from page 3 of the *Indepth Assessment* (see page 35).

Document Source: *Indepth Assessment*, Page 3



Person Served Name: [redacted] Chart: 705

VI. SUBSTANCE ABUSE HISTORY

(Age of first use, how much, progression of use, current abstinence period, past abstinence (how long), drug of choice, prior substance abuse treatment, overdose, legal problems associated with use, peer involvement)

Age 13 – alcohol couple of beers till got drunk every weekend till age 16
Age 13 – marijuana everyday 1 joints initially then 2-4 till age 20
Age 21 – Roxies (opiates) 1/1-2x month then 20-30 day until got arrested 2/09
drug of choice – Roxies Clean date: 2/7/09

VII. PSYCHOSOCIAL HISTORY

loner, hung out w/ brother and his friends
spend time w/ husband

A. DEVELOPMENTAL MILESTONES NORMAL ✓ DELAY ____

RAISED BY: Mother & father
RESIDED WITH: parents until age 16 since parents divorced when she was 13, Mom left @ b/s was 16 and left her for her siblings

SIBLINGS (sex & ages)
Age 29 Brother Bruce – close relationship (in prison)
Age 23 Sister Brittney – fought as child, close but now in Ft. Lauderdale

B. SEXUAL ORIENTATION ✓ Heterosexual ____ Gay ____ Lesbian ____ Bisexual ____ Transgender

C. CHILDREN Specify if Biological (B), Step-Children (S), or Adoptive (A) [redacted]

Age 4 Sex F Biological ✓ Step ____ Resides
Age 8 months Sex M Biological ✓ Step ____ Resides

D. EDUCATION HISTORY:

Highest Grade Completed 9th Diploma (GED) Degree(s) ____
If none, is this a goal you would like to achieve? not sure about what would like to do but wants to go back to school.

In-depth Assessment Page 3 of

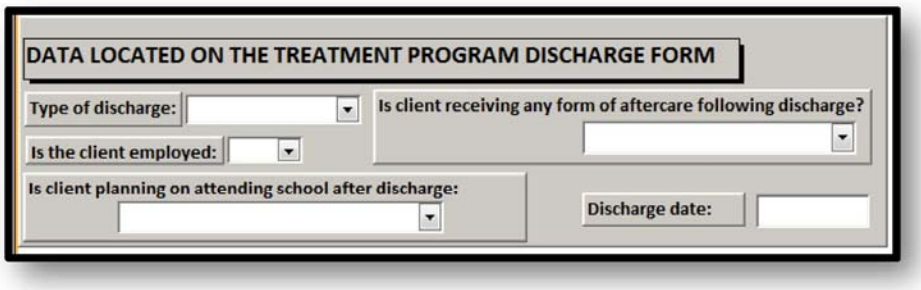
Highest Grade Completed

Diploma/GED

Degree(s)

If none, is this a goal you would like to achieve:

Data Entry Screen 6: *Program Discharge*

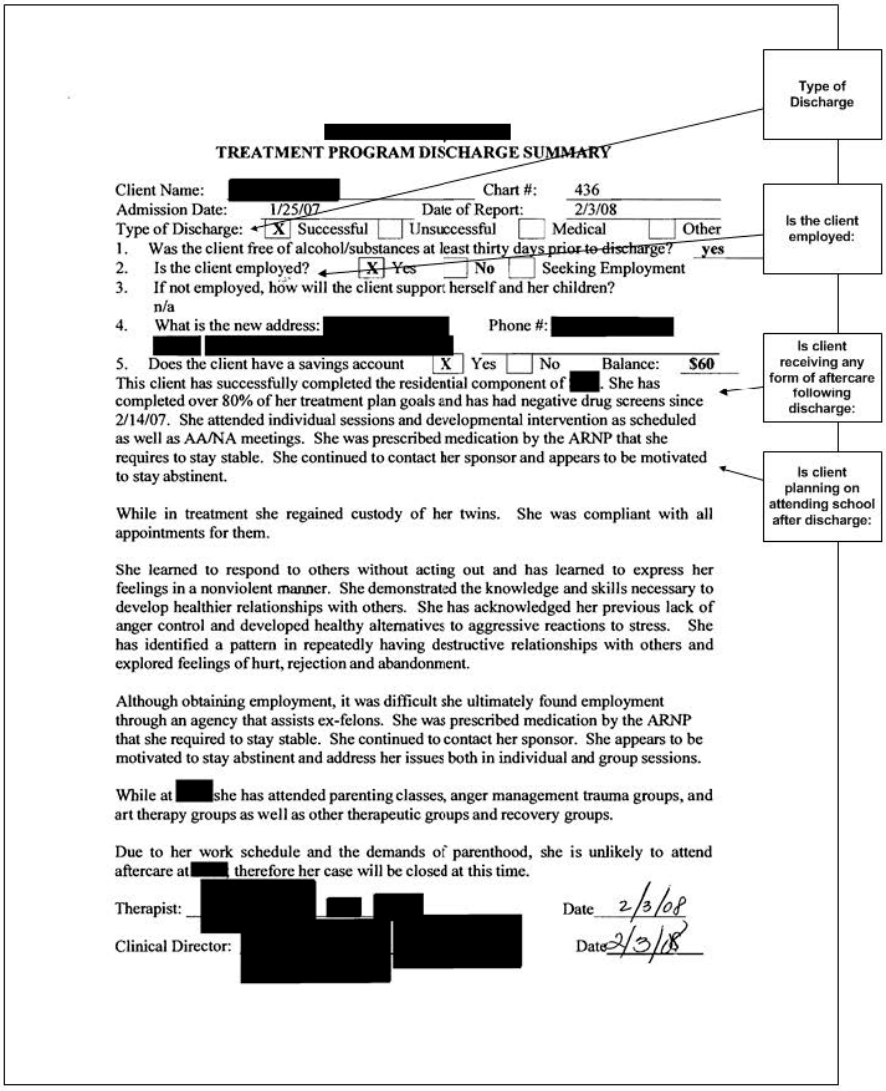


Locating the data for this form in the client's paper file:

Type of Discharge, Is client receiving any form of aftercare following discharge?, and **Is client planning on attending school after discharge:** were taken from the *Treatment Program Discharge Summary* (see page 37)

Discharge date: was taken from the *Adult 65-D* (see page 38).

Source Document: ***Treatment Program Discharge Summary***



[redacted]

TREATMENT PROGRAM DISCHARGE SUMMARY

Client Name: [redacted] Chart #: 436
Admission Date: 1/25/07 Date of Report: 2/3/08
Type of Discharge: [X] Successful [ ] Unsuccessful [ ] Medical [ ] Other
1. Was the client free of alcohol/substances at least thirty days prior to discharge? yes
2. Is the client employed? [X] Yes [ ] No [ ] Seeking Employment
3. If not employed, how will the client support herself and her children?
n/a
4. What is the new address: [redacted] Phone #: [redacted]
[redacted]
5. Does the client have a savings account [X] Yes [ ] No Balance: $60

This client has successfully completed the residential component of [redacted]. She has completed over 80% of her treatment plan goals and has had negative drug screens since 2/14/07. She attended individual sessions and developmental intervention as scheduled as well as AA/NA meetings. She was prescribed medication by the ARNP that she requires to stay stable. She continued to contact her sponsor and appears to be motivated to stay abstinent.

While in treatment she regained custody of her twins. She was compliant with all appointments for them.

She learned to respond to others without acting out and has learned to express her feelings in a nonviolent manner. She demonstrated the knowledge and skills necessary to develop healthier relationships with others. She has acknowledged her previous lack of anger control and developed healthy alternatives to aggressive reactions to stress. She has identified a pattern in repeatedly having destructive relationships with others and explored feelings of hurt, rejection and abandonment.

Although obtaining employment, it was difficult she ultimately found employment through an agency that assists ex-felons. She was prescribed medication by the ARNP that she required to stay stable. She continued to contact her sponsor. She appears to be motivated to stay abstinent and address her issues both in individual and group sessions.

While at [redacted] she has attended parenting classes, anger management trauma groups, and art therapy groups as well as other therapeutic groups and recovery groups.

Due to her work schedule and the demands of parenthood, she is unlikely to attend aftercare at [redacted] therefore her case will be closed at this time.

Therapist: [redacted] Date 2/3/08

Clinical Director: [redacted] Date 2/3/08

Type of Discharge

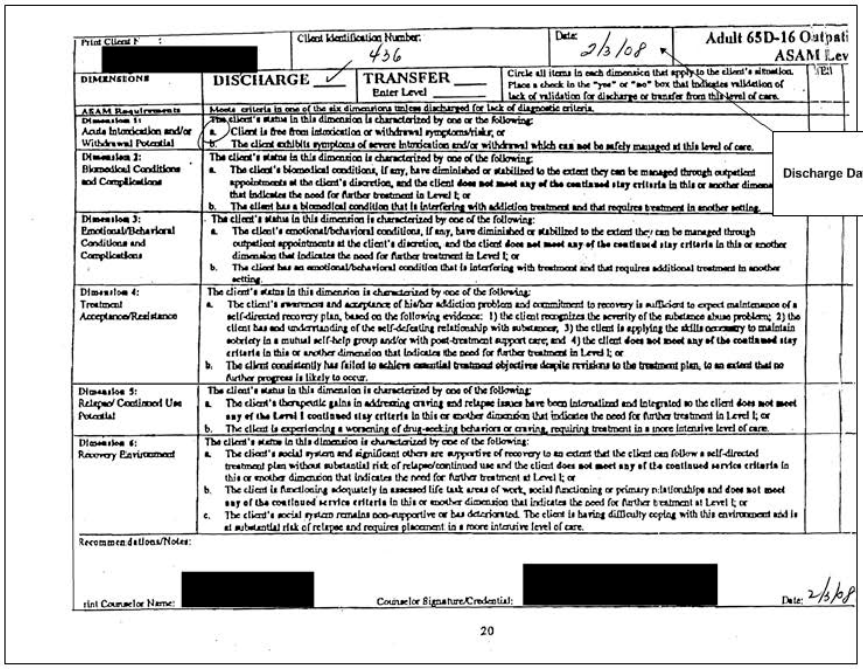
Is the client employed:

Is client receiving any form of aftercare following discharge:

Is client planning on attending school after discharge:

Page | 37

Source Document: *Adult 65D*



Print Client N: [redacted] | Client Identification Number: 436 | Date: 2/3/08 | Adult 65D-16 Outpati ASAM Lev

DIMENSIONS	DISCHARGE ✓ / TRANSFER ___ Enter Level ___ — Circle all items in each dimension that apply to the client's situation. Place a check in the "yes" or "no" box that indicates validation of lack of validation for discharge or transfer from this level of care.	Yes	No
ASAM Requirements	Meets criteria in one of the six dimensions unless discharged for lack of diagnostic criteria.		
Dimension 1: Acute Intoxication and/or Withdrawal Potential	The client's status in this dimension is characterized by one or the following: a. Client is free from intoxication or withdrawal symptoms/risks; or b. The client exhibits symptoms of severe intoxication and/or withdrawal which can not be safely managed at this level of care.		
Dimension 2: Biomedical Conditions and Complications	The client's status in this dimension is characterized by one of the following: a. The client's biomedical conditions, if any, have diminished or stabilized to the extent they can be managed through outpatient appointments at the client's discretion, and the client does not meet any of the continued stay criteria in this or another dimens that indicates the need for further treatment in Level I; or b. The client has a biomedical condition that is interfering with addiction treatment and that requires treatment in another setting.		
Dimension 3: Emotional/Behavioral Conditions and Complications	The client's status in this dimension is characterized by one of the following: a. The client's emotional/behavioral conditions, if any, have diminished or stabilized to the extent they can be managed through outpatient appointments at the client's discretion, and the client does not meet any of the continued stay criteria in this or another dimension that indicates the need for further treatment in Level I; or b. The client has an emotional/behavioral condition that is interfering with treatment and that requires additional treatment in another setting.		
Dimension 4: Treatment Acceptance/Resistance	The client's status in this dimension is characterized by one of the following: a. The client's awareness and acceptance of his/her addiction problem and commitment to recovery is sufficient to expect maintenance of a self-directed recovery plan, based on the following evidence: 1) the client recognizes the severity of the substance abuse problem; 2) the client has and understanding of the self-defeating relationship with substance; 3) the client is applying the skills necessary to maintain sobriety in a mutual self-help group and/or with post-treatment support care; and 4) the client does not meet any of the continued stay criteria in this or another dimension that indicates the need for further treatment in Level I; or b. The client consistently has failed to achieve essential treatment objectives despite revisions to the treatment plan, to an extent that no further progress is likely to occur.		
Dimension 5: Relapse/ Continued Use Potential	The client's status in this dimension is characterized by one of the following: a. The client's therapeutic gains in addressing craving and relapse issues have been internalized and integrated so the client does not meet any of the Level I continued stay criteria in this or another dimension that indicates the need for further treatment in Level I; or b. The client is experiencing a worsening of drug-seeking behaviors or craving, requiring treatment in a more intensive level of care.		
Dimension 6: Recovery Environment	The client's status in this dimension is characterized by one of the following: a. The client's social system and significant others are supportive of recovery to an extent that the client can follow a self-directed treatment plan without substantial risk of relapse/continued use and the client does not meet any of the continued service criteria in this or another dimension that indicates the need for further treatment at Level I; or b. The client is functioning adequately in assessed life task areas of work, social functioning or primary relationships and does not meet any of the continued service criteria in this or another dimension that indicates the need for further treatment at Level I; or c. The client's social system remains non-supportive or has deteriorated. The client is having difficulty coping with this environment and is at substantial risk of relapse and requires placement in a more intensive level of care.		

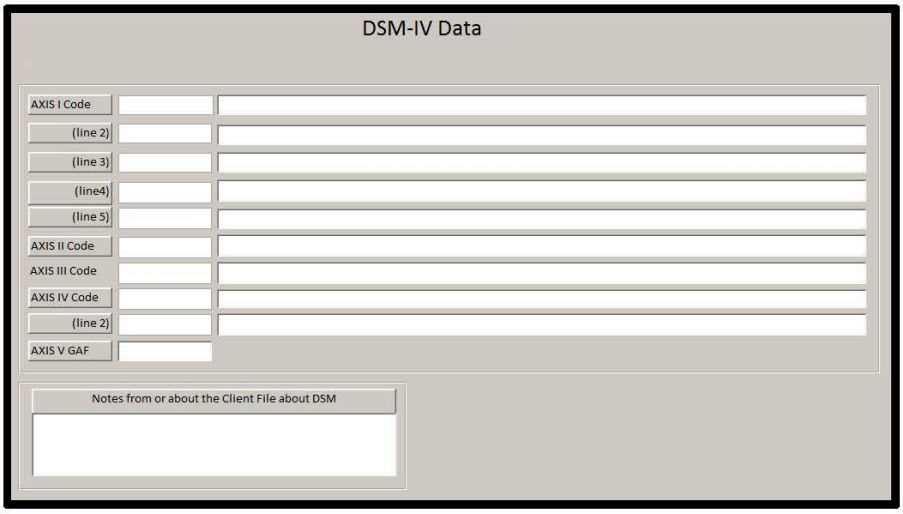
Recommendations/Notes:

rint Counselor Name: [redacted] Counselor Signature/Credential: [redacted] Date: 2/3/08

20

Discharge Date

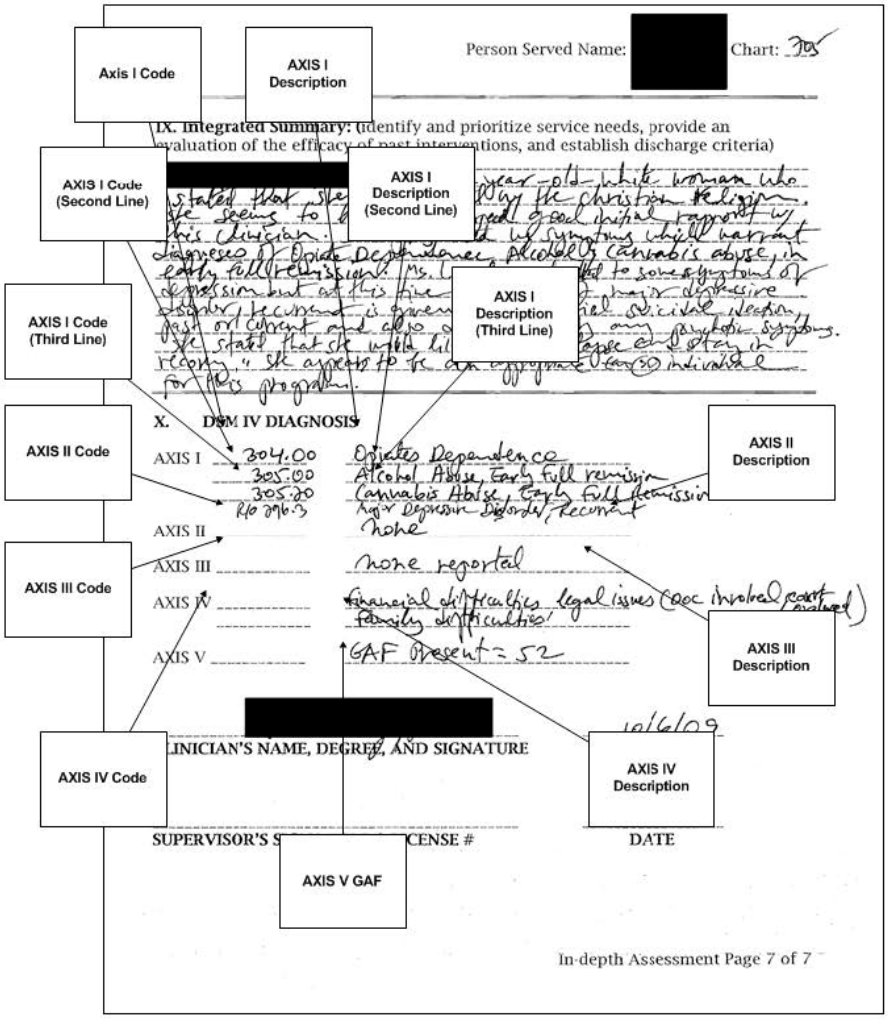
Data Entry Screen 7: ***DSM-IV Data***



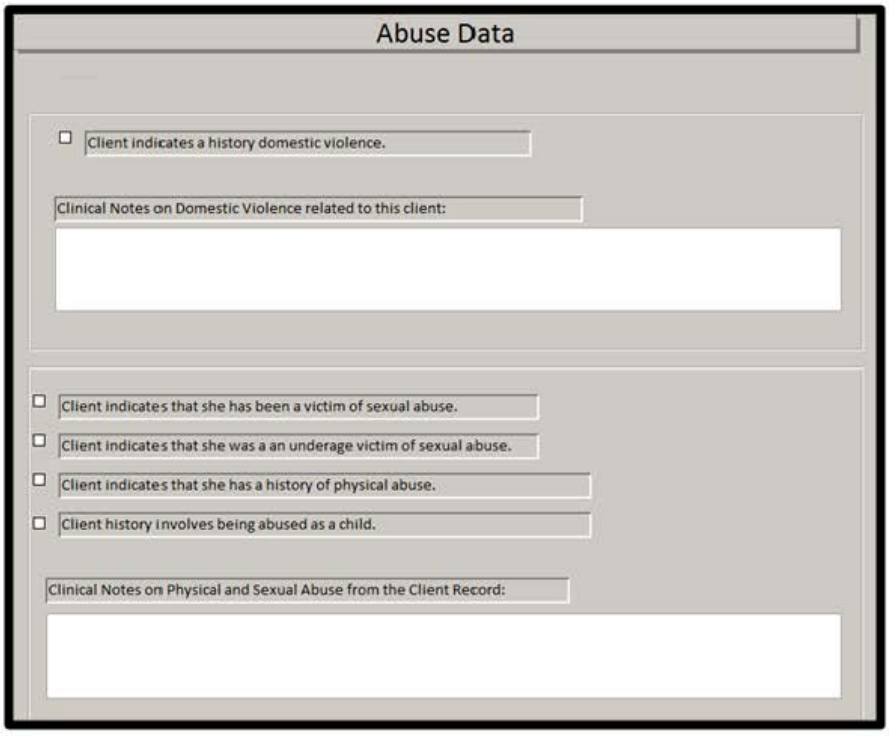
Locating the data for this form in the client's paper file:

All data on this form was taken from page 7 of the *Indepth Assessment.* (see page 40).

Source Document: *Indepth Assessment*, Page 7



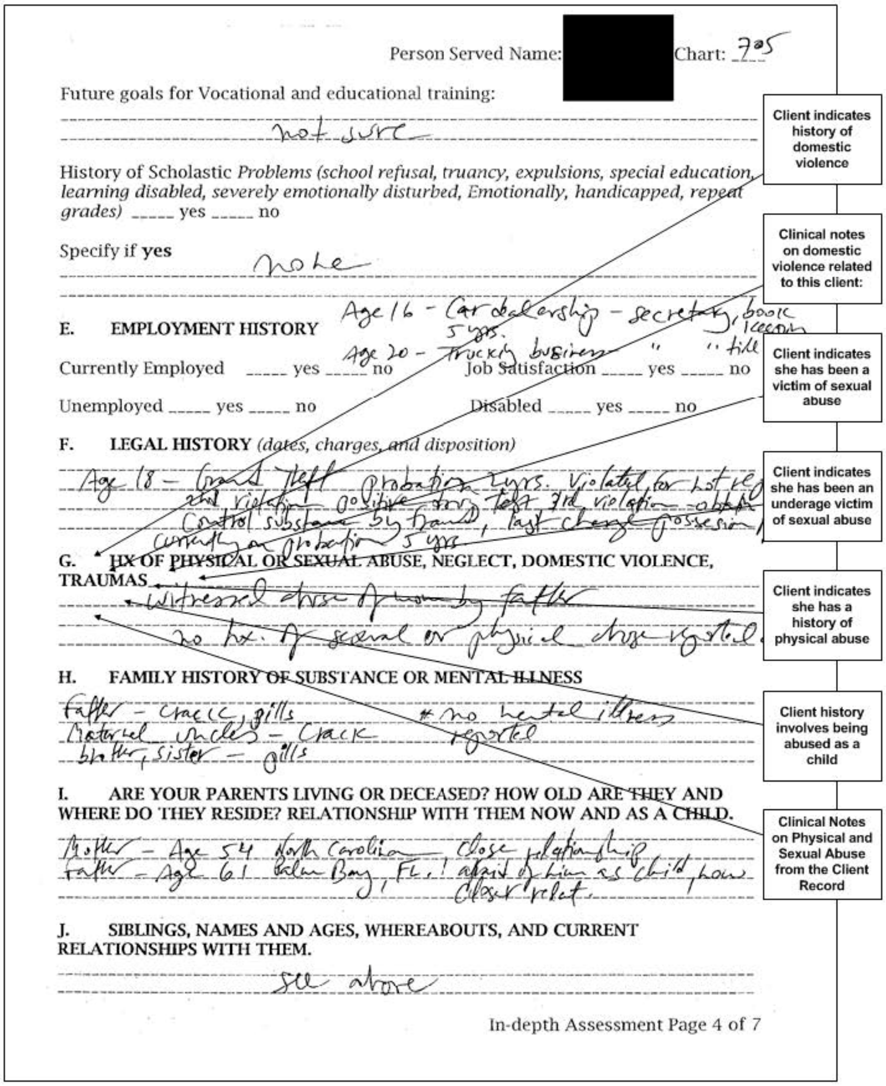
Data Entry Screen 8: ***Abuse Data***



Locating the data for this form in the client's paper file:

All data for this form was taken from page 4 of the *Indepth Assessment*.

Source Document: *Indepth Assessment*, Page 4



Person Served Name: [redacted] Chart: 705

Future goals for Vocational and educational training:

not sure

History of Scholastic *Problems (school refusal, truancy, expulsions, special education, learning disabled, severely emotionally disturbed, Emotionally, handicapped, repeat grades)* _____ yes _____ no

Specify if **yes**

none

E. EMPLOYMENT HISTORY Age 16 - Car dealership - secretary, book keeping 5 yrs. Age 20 - Trucking business " " till

Currently Employed _____ yes _____ no Job Satisfaction _____ yes _____ no

Unemployed _____ yes _____ no Disabled _____ yes _____ no

F. LEGAL HISTORY *(dates, charges, and disposition)*

Age 18 - Grand Theft probation 2 yrs. violated for lost re… 2nd violation positive drug test 3rd violation obtain Control substance by fraud, last charge possession / currently on probation 5 yrs

G. HX OF PHYSICAL OR SEXUAL ABUSE, NEGLECT, DOMESTIC VIOLENCE, TRAUMAS

witnessed abuse of mom by father

no hx. of sexual or physical abuse reported.

H. FAMILY HISTORY OF SUBSTANCE OR MENTAL ILLNESS

father - crack, pills # no mental illness reported

Maternal uncles - crack

brother, sister - pills

I. ARE YOUR PARENTS LIVING OR DECEASED? HOW OLD ARE THEY AND WHERE DO THEY RESIDE? RELATIONSHIP WITH THEM NOW AND AS A CHILD.

Mother - Age 54 North Carolina, close relationship

father - Age 61 Palm Bay, FL. afraid of him as child, now closer relat.

J. SIBLINGS, NAMES AND AGES, WHEREABOUTS, AND CURRENT RELATIONSHIPS WITH THEM.

see above

In-depth Assessment Page 4 of 7

Appendix C

Mother-Infant Interaction Scale

Mother–Infant Interaction Scale*

Check one: ❑Pre–Test ❑Post–Test

*This scale is an adaptation of the Maternal Behavior Q–Set (Pederson, Moron, Sitko, Campbell, Ghesquire, & Acton, 1990) and the attachment Q–Set, Version 3.0 (Waters, 1987)

Person Served's Name: _____

Person Served's Chart #: _____

Child's Name: _____

Child's Age: _____

Completed By: _____

Date: _____

Cumulative total divided by 174 (the maximum score a person can achieve)

Qualitative analysis of results = Total Percent: _____

Mother-Infant Interaction Scale Rev. 11-03-11

Mother–Infant Interaction Scale

Place a rating from 1 – 3 on each statement, using the following as a guide:

1 = Rarely or never
2 = Sometimes
3 = Always or most of the time

- **Reverse scoring**

_____ 1. Mother notices when her baby smiles and vocalizes.

_____ 2. * Mother is unaware of or is insensitive to her baby's signs of distress.

_____ 3. Mother notices when the baby is distressed, cries, fusses or whimpers.

_____ 4. * Mother responds only to frequent, prolonged, or intense signals.

_____ 5. Mother responds consistently to baby's signals.

_____ 6. Mother greets baby when re–entering a room

_____ 7. * Mother is sometimes aware of baby's signals of distress, but ignores or does not respond immediately to these signals.

_____ 8. * Mother is irritated by demands of the baby.

_____ 9. Mother is aware of how her moods affect the baby.

_____ 10. * Mother perceives the baby's negative behavior as rejection of her.

_____ 11. * Mother seems to resent the baby's signals of distress of bids for attention.

_____ 12. Infant smiles easily with a lot of different people.

_____ 13. Mother resolves negative feelings about the baby; that is, has some negative feelings about baby but can set these aside in interacting with the baby.

_____ 14. Mother respects baby as an individual, that is, she is able to accept baby's behavior even if it is not consistent with her ideal.

_____ 15. * Mother idealizes baby– does not acknowledge negative aspects.

_____ 16. * Mother is critical in her description of her baby.

_____ 17. Mother plays games with baby such as peek–a–boo or patty cake.

_____ 18. Mother provides age appropriate toys.

_____ 19. When upset or injured, infant will accept comforting from adults other than mother.

_____ 20. Mother seeks face-to-face interactions.

_____ 21. Mother makes an effort to take baby on "outings" such as shopping, visiting friends.

_____ 22. * Mother uses flat affect when interacting with baby.

_____ 23. Mother waits for cues form baby before feeding.

_____ 24. Mother has a predominantly positive attitude about her baby.

_____ 25. Mother points to and identifies interesting things in the baby's environment.

_____ 26. infant cries when mother leaves him/her with another adult.

_____ 27. Mother displays affection by touching.

_____ 28. * Mother kisses baby on head as the most frequent means of expressing affection.

_____ 29. Comments are generally positive when the mother speaks about the baby.

_____ 30. Mother is aware of baby's mood.

_____ 31. When holding, mother cuddles baby as a typical mode of interaction.

_____ 32. * When baby is in a bad mood or cranky, mother often will place him/her in another room so that she will not be disturbed.

_____ 33. * Mother seems overwhelmed or depressed.

_____ 34. Mother is animated in social interaction with baby.

_____ 35. * Mother responds accurately and promptly to signals of distress, but often ignores (is unresponsive to) signals of positive affect.

_____ 36. When infant is in a happy mood, he/she is likely to stay that way all day.

_____ 37. When baby is distressed, mother is able to quickly and accurately identify the source.

_____ 38. Praise is directed to toward baby.

_____ 39. * Mother will sometimes break off from her child mid-interaction to speak with a visitor or attend to some other activity that suddenly comes up.

_____ 40. Mother/infant's room is safe and baby proofed.

_____ 41. * Mother is very concerned that baby is well dressed and attractive at all times.

_____ 42. Infant tried to get mother to imitate him/her or quickly .notices and enjoys when mom imitate him/her on her own.

_____ 43. Mother seems to be aware of the baby even when not in the same room.

Mother-Infant Interaction Scale Rev. 11-03-11

_____ 44. * Mother is not skillful in dividing her attention between baby and competing demands; thus, she misses baby's cues.

_____ 45. * Nap times are determined by the mother's convenience rather than the immediate needs of the baby.

_____ 46. Mother encourages interaction of the baby with visitors, for example, she may invite visitor to hold the baby.

_____ 47. Mother monitors and responds to baby even when engaged in some other activity such as cooking or having a conversation with a visitor.

_____ 48. * Mother seldom speaks of the baby directly.

_____ 49. Mother leaves the room without any sort of "signal" or "explanation" to the baby (i.e.: "I'll be back in just a minute").

_____ 50. Mother responds immediately to cries/whimpers.

_____ 51. Mother is very alert to "dirty diapers"; she seems to change diapers as soon as indication of need.

_____ 52. If held in mother's arms, baby stops crying and quickly recovers after being frightened or upset.

_____ 53. Mother often brings a toy or other object within baby's reach and attempt to interest him/her in it.

_____ 54. * Mother seems awkward and ill at ease when interacting directly with the baby face to face.

_____ 55. Mother arranges her location so that she can perceive the baby's signals.

_____ 56. * Mother often seems to forget that her baby is present in the room during interaction with a visitor.

_____ 57. Infant is strongly attracted to new activities and new toys.

_____ 58. Infant enjoys being hugged or help by people other than his/her mother.

Areas of strength: _____

_____

Areas of special attention:

Observations:

Staff signature and Credentials

Appendix D

Mother-Child Interaction Scale

Mother–Child Interaction Scale

Place a rating from **1 – 3** on each statement, using the following as a guide:

1 = Rarely or never
2 = Sometimes
3 = Always or most of the time

- **Reverse scoring**

_____ 1. Child readily shares with mother or lets her hold things if she asks to.

_____ 2. * When he/she is upset or injured, child will accept comforting from adults other than mother.

_____ 3. Child is careful and gentle with toys and infants.

_____ 4. Child laughs and smiles easily with a lot of different people.

_____ 5. Child is lighthearted and playful most of the time.

_____ 6. * Child often cries or resists when mother takes him/her to bed for naps or at night.

_____ 7. Child often hugs mother without her asking or inviting him/her to do so.

_____ 8. Child quickly gets used to people or things that initially made him/her shy or frightened.

_____ 9. * Mother is irritated by demands of her child.

_____ 10. Mother is aware of how her moods affect her child.

_____ 11. Child is willing to talk to new people, show them toys, or shows them what he/she can do if mother asks him/her to.

_____ 12. When mother tells child to bring or give her something, he/she obeys. (Do not count refusals that are playful or part of a game unless they clearly become disobedient).

_____ 13. * Mother perceives child's negative behavior as a rejection of her.

_____ 14. Child follows mother's suggestions readily, even when they are clearly suggestions rather than orders.

_____ 15. Child keeps track of mother's location when he/she plays around the house. Calls to her now and then; notice her go from room to room; notices if she changes activities.

_____ 16. Child acts like an affectionate parent toward dolls or infants.

_____ 17. Mother resolves negative feelings about her child; that is, has some negative feelings about him/her, but can set these aside in interacting with the child.

_____ 18. * When mother sits with other family members or is affectionate with them, child tries to get mom's affection for himself/herself.

_____ 19. Mother respects her child as an individual, that is, she is able to accept child's behavior even if it is not consistent with her ideal.

_____ 20. * Mother idealizes child - does not acknowledge negative aspects.

_____ 21. * Mother is critical in her description of her child.

_____ 22. Child cries when mother leaves him/her at home with another adult.

_____ 23. Mother provides age-appropriate toys.

_____ 24. * Child wants to be the center of mother's attention. If mom is busy or talking to someone, he/she interrupts.

_____ 25. Mother plays games with the child.

_____ 26. When mother says "no", or punishes him/her, child stops misbehaving (at least at that time). Doesn't have to be told twice.

_____ 27. Child is independent with mother. Prefers to play on his/her own; leaves mother easily when he/she wants to play.

_____ 28. Mother makes an effort to take child on "outings", such as shopping, visiting friends.

_____ 29. Mother has a predominantly positive attitude about her child.

_____ 30. Child clearly shows a pattern of using mother as a base from which to explore. Moves out to play; returns or plays near her; moves out to play again, etc.

_____ 31. Mother displays affection by touching.

_____ 32. Comments are generally positive when the mother speaks about her child.

_____ 33. * Child is often serious and businesslike when playing away from mother or alone with his/her toys.

_____ 34. * Child is demanding and impatient with mother. Fusses and persists unless she does what he/she wants right away.

_____ 35. Child recognizes when mother is upset. Becomes quiet or upset himself. Tries to comfort her; asks what is wrong.

_____ 36. Child asks for mother and enjoys having her hold and hug him/her.

_____ 37. Praise is directed toward her child.

_____ 38. Child readily lets new adults hold or share things he/she has, if they ask to

_____ 39. * Mother kisses/pats/rubs child on head as the most frequent means of expressing affection.

_____ 40. Child runs to mother with a shy smile when new people visit the home.

_____ 41. When child finishes with an activity or toy, he/she generally finds something else to do without returning to mother between activities.

_____ 42. * Mother is very concerned that child is well-dressed and attractive at all times.

_____ 43. When child is in a happy mood, he/she is likely to stay that way all day.

_____ 44. * Child is easily upset when mother makes him/her change from one activity to another.

_____ 45. Mother is aware of child's moods.

_____ 46. When the family has visitors, child wants them to pay a lot of attention to him/her.

_____ 47. Child easily grows fond of adults who visit his/her home and are friendly to him/her.

_____ 48. * Child rarely asks mother for help.

_____ 49. Mother monitors and responds to child even when engaged in some other activity, such as cooking or having a conversation with a visitor.

_____ 50. Child quickly greets his mother with a big smile when she enters the room. (Shows her a toy, gestures or says "Hi Mommy.")

_____ 51. If held in mother's arms, child stops crying and quickly recovers after being frightened or upset.

_____ 52. * When given a choice, child would rather play with toys than with adults.

_____ 53. When mother asks child to do something, he/she readily understands what she wants. (May or may not obey).

_____ 54. * Mother seems overwhelmed or depressed.

_____ 55. * Child easily becomes angry at mother.

_____ 56. Child is strongly attracted to new activities and new toys.

_____ 57. * Mother responds accurately and promptly to signals of distress, but often ignores (is unresponsive to) signals of positive affect.

_____ 58. When child is bored, he/she goes to mother looking for something to do.

_____ 59. * Mother will sometimes break off from her child in mid-interaction to speak to a visitor or attend to some other activity that suddenly comes to mind.

_____ 60. Child makes at least some effort to be clean and tidy around the house.

_____ 61. * Child cries as a way of getting mother to do what he/she wants.

_____ 62. * When mother doesn't do what child wants right away, he/she behaves as if mom were not going to do it at all. (Fusses, gets angry, walks off to other activities, etc.)

Pederson, D.R., Moran G., Sako, C., Campbell, K., Ghesquire, K., & Acton, H. (1990). Maternal sensitivity and the security of the infant-mother attachment: A Q-Sort study. Child development, 61, 1974-1988.

Waters, E. (1987). Attachment Behavior Q-Set (Revision 3.0). Unpublished instrument, State University of New York at Stony Brook. Department of Psychology.

Areas of strength:

_____
_____
_____
_____
_____
_____

Areas of special attention:

_____
_____
_____
_____
_____

Observations:

_____

_____

_____

_____

_____

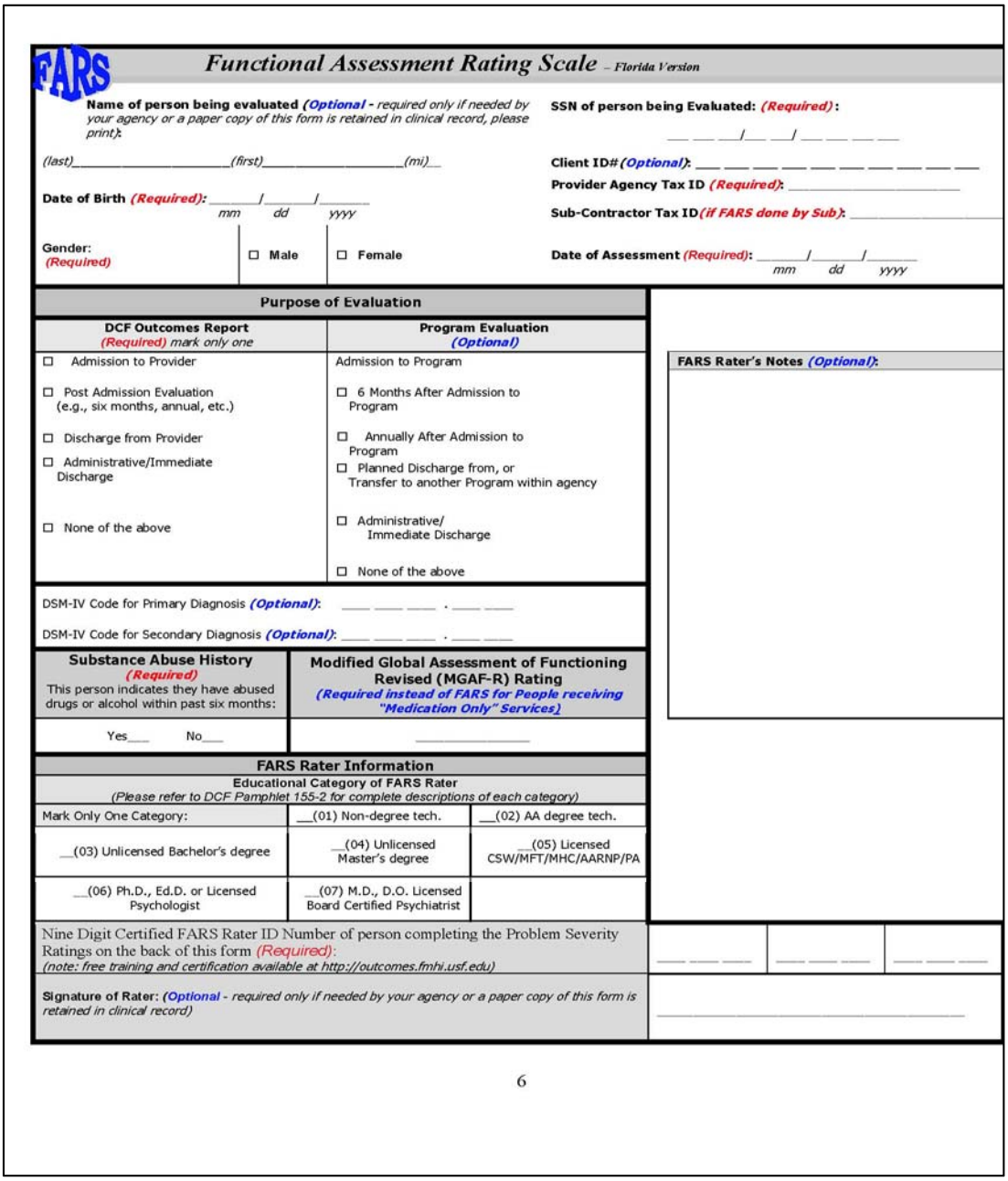
_____

Staff signature and Credentials

Appendix E

Functional Assessment Rating Scale, Florida Version

(Nelson-Zlupko et al., 1995, p. 6)



FARS

Functional Assessment Rating Scale – Florida Version

Name of person being evaluated *(Optional - required only if needed by your agency or a paper copy of this form is retained in clinical record, please print)*:

(last)_____(first)_____(mi)__

SSN of person being Evaluated: *(Required)*:

___ ___ ___/___ ___/ ___ ___ ___ ___

Client ID# *(Optional)*: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Provider Agency Tax ID *(Required)*: _____

Date of Birth *(Required)*: _____/_____/_____ (mm dd yyyy)

Sub-Contractor Tax ID *(if FARS done by Sub)*: _____

Gender: *(Required)* ☐ Male ☐ Female

Date of Assessment *(Required)*: _____/_____/_____ (mm dd yyyy)

Purpose of Evaluation

DCF Outcomes Report *(Required) mark only one*	Program Evaluation *(Optional)*
☐ Admission to Provider	Admission to Program
☐ Post Admission Evaluation (e.g., six months, annual, etc.)	☐ 6 Months After Admission to Program
☐ Discharge from Provider	☐ Annually After Admission to Program
☐ Administrative/Immediate Discharge	☐ Planned Discharge from, or Transfer to another Program within agency
☐ None of the above	☐ Administrative/ Immediate Discharge
	☐ None of the above

DSM-IV Code for Primary Diagnosis *(Optional)*: ___ ___ ___ . ___ ___

DSM-IV Code for Secondary Diagnosis *(Optional)*: ___ ___ ___ . ___ ___

FARS Rater's Notes *(Optional)*:

Substance Abuse History *(Required)*	Modified Global Assessment of Functioning Revised (MGAF-R) Rating *(Required instead of FARS for People receiving "Medication Only" Services)*
This person indicates they have abused drugs or alcohol within past six months:	
Yes___ No___	_____

FARS Rater Information

Educational Category of FARS Rater

(Please refer to DCF Pamphlet 155-2 for complete descriptions of each category)

Mark Only One Category:	__(01) Non-degree tech.	__(02) AA degree tech.
__(03) Unlicensed Bachelor's degree	__(04) Unlicensed Master's degree	__(05) Licensed CSW/MFT/MHC/AARNP/PA
__(06) Ph.D., Ed.D. or Licensed Psychologist	__(07) M.D., D.O. Licensed Board Certified Psychiatrist	

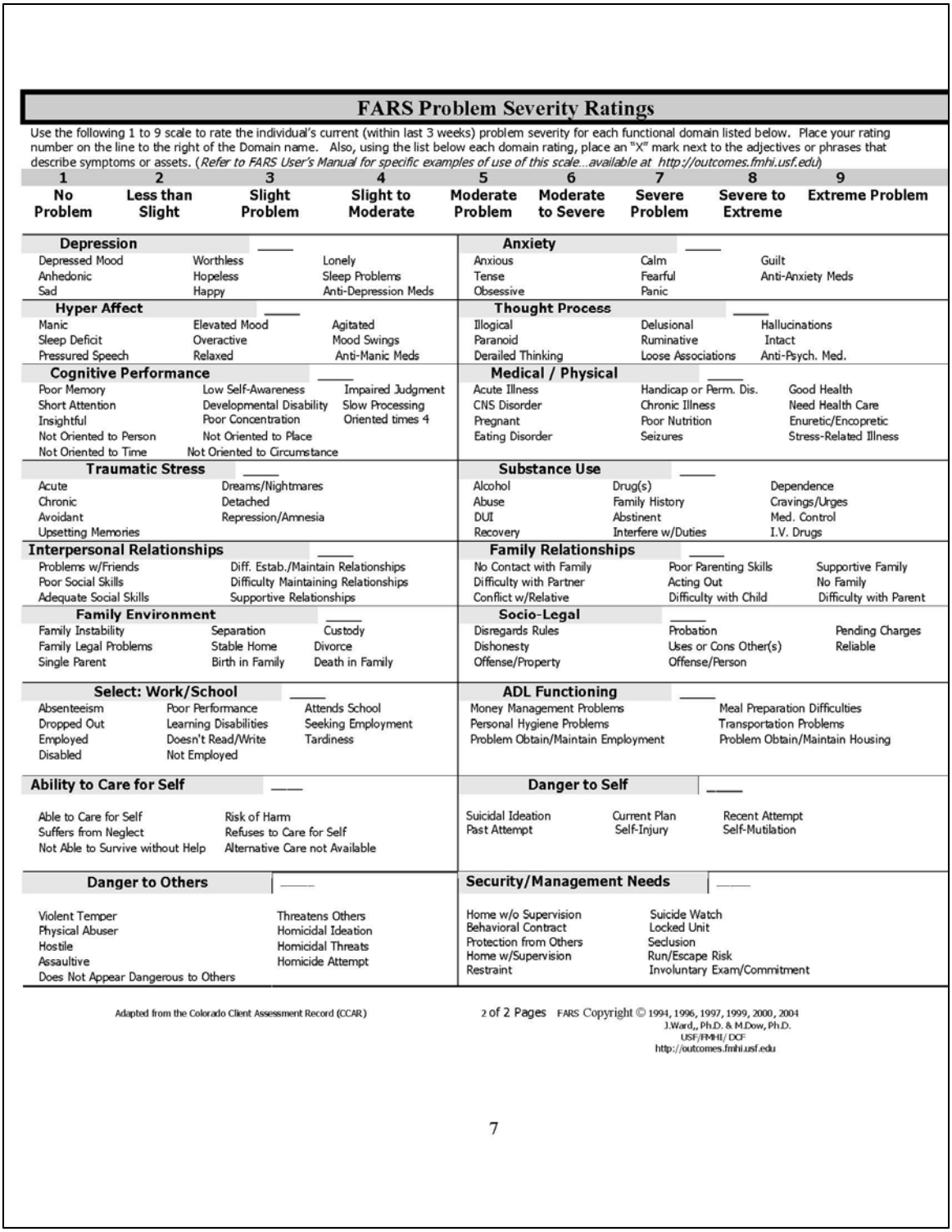
Nine Digit Certified FARS Rater ID Number of person completing the Problem Severity Ratings on the back of this form *(Required)*:
(note: free training and certification available at http://outcomes.fmhi.usf.edu)

___ ___ ___ | ___ ___ ___ | ___ ___ ___

Signature of Rater: *(Optional - required only if needed by your agency or a paper copy of this form is retained in clinical record)*

_____

6



FARS Problem Severity Ratings

Use the following 1 to 9 scale to rate the individual's current (within last 3 weeks) problem severity for each functional domain listed below. Place your rating number on the line to the right of the Domain name. Also, using the list below each domain rating, place an "X" mark next to the adjectives or phrases that describe symptoms or assets. (*Refer to FARS User's Manual for specific examples of use of this scale...available at http://outcomes.fmhi.usf.edu*)

1	2	3	4	5	6	7	8	9
No Problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression ____

Depressed Mood	Worthless	Lonely
Anhedonic	Hopeless	Sleep Problems
Sad	Happy	Anti-Depression Meds

Anxiety ____

Anxious	Calm	Guilt
Tense	Fearful	Anti-Anxiety Meds
Obsessive	Panic	

Hyper Affect ____

Manic	Elevated Mood	Agitated
Sleep Deficit	Overactive	Mood Swings
Pressured Speech	Relaxed	Anti-Manic Meds

Thought Process ____

Illogical	Delusional	Hallucinations
Paranoid	Ruminative	Intact
Derailed Thinking	Loose Associations	Anti-Psych. Med.

Cognitive Performance ____

Poor Memory	Low Self-Awareness	Impaired Judgment
Short Attention	Developmental Disability	Slow Processing
Insightful	Poor Concentration	Oriented times 4
Not Oriented to Person	Not Oriented to Place	
Not Oriented to Time	Not Oriented to Circumstance	

Medical / Physical ____

Acute Illness	Handicap or Perm. Dis.	Good Health
CNS Disorder	Chronic Illness	Need Health Care
Pregnant	Poor Nutrition	Enuretic/Encopretic
Eating Disorder	Seizures	Stress-Related Illness

Traumatic Stress ____

Acute	Dreams/Nightmares
Chronic	Detached
Avoidant	Repression/Amnesia
Upsetting Memories	

Substance Use ____

Alcohol	Drug(s)	Dependence
Abuse	Family History	Cravings/Urges
DUI	Abstinent	Med. Control
Recovery	Interfere w/Duties	I.V. Drugs

Interpersonal Relationships ____

Problems w/Friends	Diff. Estab./Maintain Relationships
Poor Social Skills	Difficulty Maintaining Relationships
Adequate Social Skills	Supportive Relationships

Family Relationships ____

No Contact with Family	Poor Parenting Skills	Supportive Family
Difficulty with Partner	Acting Out	No Family
Conflict w/Relative	Difficulty with Child	Difficulty with Parent

Family Environment ____

Family Instability	Separation	Custody
Family Legal Problems	Stable Home	Divorce
Single Parent	Birth in Family	Death in Family

Socio-Legal ____

Disregards Rules	Probation	Pending Charges
Dishonesty	Uses or Cons Other(s)	Reliable
Offense/Property	Offense/Person	

Select: Work/School ____

Absenteeism	Poor Performance	Attends School
Dropped Out	Learning Disabilities	Seeking Employment
Employed	Doesn't Read/Write	Tardiness
Disabled	Not Employed	

ADL Functioning ____

Money Management Problems	Meal Preparation Difficulties
Personal Hygiene Problems	Transportation Problems
Problem Obtain/Maintain Employment	Problem Obtain/Maintain Housing

Ability to Care for Self ____

Able to Care for Self	Risk of Harm
Suffers from Neglect	Refuses to Care for Self
Not Able to Survive without Help	Alternative Care not Available

Danger to Self ____

Suicidal Ideation	Current Plan	Recent Attempt
Past Attempt	Self-Injury	Self-Mutilation

Danger to Others ____

Violent Temper	Threatens Others
Physical Abuser	Homicidal Ideation
Hostile	Homicidal Threats
Assaultive	Homicide Attempt
Does Not Appear Dangerous to Others	

Security/Management Needs ____

Home w/o Supervision	Suicide Watch
Behavioral Contract	Locked Unit
Protection from Others	Seclusion
Home w/Supervision	Run/Escape Risk
Restraint	Involuntary Exam/Commitment

Adapted from the Colorado Client Assessment Record (CCAR)

2 of 2 Pages FARS Copyright © 1994, 1996, 1997, 1999, 2000, 2004 J.Ward,, Ph.D. & M.Dow, Ph.D. USF/FMHI/DCF http://outcomes.fmhi.usf.edu

7

(Ward & Dow, 1998, p. 7)

Appendix F

Test Results from Mother-Infant Study Sample (*n* = 126)

Mother-Infant Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
5	60	72	7	7	7	7
8	56	75	5	6	3	5
12	74	83	6	4	4	3
13	61	63	3	1	1	3
21	69	76	5	5	4	4
22	67	83	1	2	1	2
25	60	67	5	3	5	5
26	58	67	3	3	5	3
50	68	83	6	2	4	4
53	51	59	5	1	4	3
57	55	68	3	3	2	2
58	55	68	3	3	2	2
77	53	56	6	5	4	4
89	78	89	3	2	1	3
93	48	52	1	3	2	4
95	76	80	3	2	3	2
96	76	76	6	5	4	3
97	64	80	4	3	3	1
99	68	68	6	4	4	5
100	67	71	5	5	6	5
102	62	71	3	2	2	1
103	64	75	2	5	4	7
104	75	87	1	1	1	1
106	75	82	1	1	5	1
107	76	79	3	1	4	1
120	73	82	5	3	4	3
123	53	64	5	3	4	2
125	66	74	6	2	6	3
127	67	76	4	4	9	9
131	69	80	7	4	4	4
134	60	67	8	6	6	5
135	62	75	1	2	5	6
137	67	84	5	2	3	3

Mother-Infant Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
155	**55**	**71**	**7**	**5**	**6**	**6**
157	60	81	5	5	5	4
162	82	93	2	1	6	3
166	76	79	3	1	4	1
182	83	92	4	3	4	3
184	71	78	5	5	5	4
187	70	85	8	5	6	5
188	68	87	3	3	5	3
189	61	70	4	3	4	3
192	63	74	5	5	1	1
202	72	85	6	3	5	3
205	67	79	1	1	5	1
207	75	75	3	3	4	3
208	83	87	6	3	5	3
209	73	88	7	8	2	4
218	54	68	5	4	4	3
220	70	82	4	3	4	3
224	73	85	2	1	5	2
231	76	80	3	1	2	1
232	75	78	2	1	1	1
241	69	76	4	4	3	4
245	75	81	4	3	2	4
250	71	86	5	2	4	1
251	61	70	7	6	5	5
264	72	89	5	4	3	2
269	75	91	2	1	2	1
273	76	83	6	6	5	2
274	71	74	6	6	8	6
280	74	85	5	2	3	2
298	67	68	4	2	6	3
304	78	88	4	2	6	5
316	62	86	8	5	5	4
322	70	86	7	2	3	1
327	66	92	4	3	4	3
340	87	91	6	2	2	3
347	90	91	7	1	1	1
350	80	87	5	3	4	3
369	78	90	7	4	5	4

Mother-Infant Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
370	77	94	6	6	6	6
374	**76**	**76**	**6**	**3**	**2**	**1**
380	**67**	**83**	**3**	**1**	**4**	**3**
387	80	88	2	2	4	3
391	76	84	6	5	6	4
403	66	92	4	3	4	3
415	69	90	4	1	7	1
419	64	91	7	6	4	4
425	72	75	8	8	7	8
431	62	83	5	4	4	3
440	74	81	4	4	4	4
442	74	80	7	7	6	7
446	61	77	8	6	7	5
447	85	92	2	3	3	3
448	67	64	3	5	5	6
450	55	60	8	7	6	4
451	79	81	5	4	5	5
461	71	73	6	6	7	9
463	76	64	4	5	4	4
465	88	92	1	2	2	1
467	77	69	3	4	4	4
468	93	91	5	3	7	4
472	73	80	4	3	2	3
473	69	92	1	1	2	2
478	97	83	5	7	7	7
479	62	121	5	3	3	3
480	86	91	3	2	4	3
482	69	129	3	2	6	1
484	68	63	4	4	5	5
485	68	63	4	4	5	5
486	86	84	4	4	5	5
487	85	120	5	4	3	4
488	73	92	8	2	4	2
489	74	82	4	3	4	4
490	79	68	6	5	5	5
491	77	82	4	4	5	7
493	75	86	1	1	3	3
494	79	68	1	3	5	7

Mother-Infant Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
497	56	87	4	1	4	3
498	76	85	6	3	7	6
500	**74**	**82**	**3**	**6**	**3**	**5**
506	**81**	**95**	**4**	**2**	**5**	**4**
508	**92**	**92**	**5**	**3**	**4**	**4**
510	**77**	**77**	**3**	**2**	**1**	**3**
527	**75**	**83**	**7**	**7**	**5**	**7**
529	**54**	**77**	**7**	**5**	**5**	**3**
534	**89**	**91**	**3**	**3**	**3**	**3**
535	**64**	**72**	**6**	**6**	**4**	**5**
543	**64**	**48**	**1**	**5**	**1**	**7**
545	**72**	**73**	**7**	**8**	**5**	**7**
548	**65**	**76**	**5**	**2**	**6**	**2**
551	**76**	**68**	**6**	**3**	**7**	**4**
564	**85**	**97**	**6**	**4**	**6**	**3**
571	**70**	**82**	**4**	**2**	**3**	**2**
585	**84**	**84**	**4**	**4**	**6**	**5**
599	**116**	**83**	**6**	**6**	**5**	**5**
617	**71**	**81**	**8**	**5**	**1**	**1**
619	**67**	**83**	**1**	**1**	**3**	**2**
623	**85**	**130**	**5**	**3**	**4**	**3**
626	**80**	**79**	**4**	**4**	**5**	**5**

Appendix G

Test Results from Mother-Child Study Sample (*n* = 142)

Mother-Child Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
5	63	70	7	7	7	7
9	59	73	6	4	2	2
11	68	75	6	6	6	6
14	57	73	3	2	2	3
15	72	74	1	1	1	2
16	57	72	5	3	4	1
19	55	63	3	4	3	4
20	65	74	6	1	4	2
24	58	72	3	2	3	2
28	60	72	4	1	5	1
30	60	61	6	2	3	3
33	62	73	6	5	5	2
37	54	77	4	2	1	1
42	72	78	2	5	1	2
43	72	82	4	2	4	3
47	65	77	4	3	2	1
48	65	77	4	3	2	1
49	58	78	5	4	1	2
54	69	81	4	3	5	2
57	57	78	3	3	2	2
74	56	70	3	3	3	2
75	62	70	5	5	6	6
79	69	81	1	1	3	1
80	59	61	3	1	3	1
83	69	77	8	8	5	5
84	59	67	5	2	5	2
88	72	83	3	2	4	2
89	75	85	3	2	1	3
92	63	75	3	3	2	3
94	61	67	1	1	2	1
98	76	78	5	1	4	2
101	72	75	5	4	5	4
103	60	68	2	5	4	7

Mother-Child Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
104	70	75	1	1	1	1
105	63	66	4	1	3	7
109	81	88	5	2	4	4
110	56	69	3	1	1	2
111	71	77	8	4	8	5
115	74	81	6	6	7	7
122	66	76	5	4	4	3
125	96	106	6	2	6	3
126	68	73	5	2	5	2
127	84	110	4	4	9	9
128	84	87	7	4	7	7
132	76	78	3	3	1	1
136	69	80	5	2	5	1
138	63	82	1	1	4	1
139	65	79	3	7	5	6
143	67	78	3	6	3	5
148	58	69	3	2	4	3
149	67	76	4	3	3	2
152	49	70	7	5	6	5
156	54	73	6	5	5	2
158	75	78	3	3	5	7
159	62	66	7	1	5	2
161	58	72	4	1	6	3
165	69	88	4	6	6	6
167	71	77	8	4	8	5
169	81	88	5	2	4	4
170	56	69	3	1	1	2
172	72	82	7	2	5	1
176	74	81	6	6	7	7
185	51	67	7	3	7	5
186	60	66	5	3	4	3
190	55	63	4	4	5	5
193	64	77	5	2	5	3
194	69	79	5	2	5	3
197	69	88	4	6	6	6
198	78	90	6	6	7	7
199	67	67	6	5	4	4

Mother-Child Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
200	**62**	**78**	**6**	**3**	**5**	**3**
202	**72**	**81**	**6**	**3**	**5**	**3**
204	86	88	4	4	8	5
206	72	74	6	6	4	4
210	53	63	7	4	3	3
213	64	53	5	4	6	5
214	70	81	4	5	4	4
215	82	86	8	4	5	2
217	59	61	7	6	7	7
230	69	73	7	6	6	5
234	60	75	4	2	3	3
240	72	78	5	2	2	3
242	76	82	8	9	8	8
246	68	74	7	7	6	6
247	69	78	6	2	6	3
256	69	86	5	3	7	5
262	67	81	7	6	5	5
271	75	77	6	4	5	4
277	72	86	4	2	5	4
286	78	87	5	4	7	8
289	74	75	6	2	4	2
292	70	82	5	4	3	3
295	64	80	4	5	1	1
296	74	82	7	4	2	2
297	73	84	7	7	5	6
299	64	75	5	4	5	2
308	73	80	1	1	9	3
328	85	87	7	6	6	7
330	67	85	7	5	3	2
331	84	88	4	4	4	3
335	72	80	8	5	7	3
341	81	93	6	3	3	2
351	81	83	7	3	7	4
357	81	80	5	5	4	4
363	70	77	5	4	5	6
373	90	92	4	3	5	3
374	85	86	6	3	2	1

Mother-Child Dyad Identifier	Attachment Pretest	Attachment Posttest	Mother Depression Pretest	Mother Depression Posttest	Mother Anxiety Pretest	Mother Anxiety Posttest
375	57	92	4	3	6	4
376	**68**	**77**	**2**	**2**	**3**	**2**
382	50	77	3	6	6	7
389	79	91	6	2	4	3
404	85	87	7	6	6	7
406	67	85	7	5	3	2
407	84	88	4	4	4	3
411	72	80	8	5	7	3
412	57	90	8	1	1	3
416	72	86	7	3	8	3
422	76	83	6	4	4	3
423	56	78	5	3	6	3
433	65	76	1	1	3	3
435	59	75	5	2	6	4
440	66	79	4	4	4	4
441	75	85	2	5	6	8
449	75	68	5	2	3	3
455	82	82	4	4	3	3
457	74	75	3	3	5	5
460	67	79	3	4	3	3
469	91	88	4	4	3	4
475	78	84	3	2	6	4
481	79	77	6	7	6	8
483	69	86	4	3	5	4
499	77	77	4	3	5	4
508	83	86	5	3	4	4
512	63	80	8	3	8	4
514	68	79	3	2	6	5
518	64	82	5	6	6	2
557	66	76	5	4	4	3
570	55	71	6	4	5	4
573	68	77	3	3	3	3
603	91	93	5	4	5	4

Appendix H

Susan B. Anthony Recovery Center Letter Of Support

Susan B. Anthony
Recovery Center
HELP, HOPE AND HEALING

1633 POINCIANA DRIVE • PEMBROKE PINES, FL 33025 • PHONE 954.733.6068 • FAX 954.733.0766

July 10, 2011
Mr. Gary M. Forrest, M.S., LMFT
3011 NW 28th Lane
Fort Lauderdale, FL 33311

Re: Letter of Support for Your Doctoral Dissertation: Identifying SBARC

Dear Gary:

It is my pleasure to write this letter in support of the dissertation topic you are pursuing for your doctoral studies in Marriage and Family Therapy at Nova Southeastern University. I understand that your dissertation will be focused on the ongoing work done at the Susan B. Anthony Recovery Center (SBARC) of which I am the Chief Executive Officer.

From our conversations, you and I both agree that the research we have collaborated on to date and the information you are developing for your dissertation form a valuable set of resources from which SBARC may derive support and benefit in the future.

Because of this, you have our support in identifying the actual SBARC name and certain staff members within the dissertation itself. While we understand that it is customary to de-identify research subjects in projects of this nature, we feel that since the SBARC will be the main research subject of your dissertation—and we believe deeply in the benefits of getting the word out about the work we do—we are extending our consent for you to use the actual organization name and identifying details about SBARC in your work. Also, we will consent on a case-by-case basis to allow the names of actual staff and administration members of SBARC to be identified in your dissertation. In all cases, the appropriate individual consent will be obtained from each staff or administration member whose is identified in the final work product.

In conclusion, I fully support your identifying the name of our organization and describing details of its operation as part of your dissertation. We are proud of any research effort focused on our organization's mission, history, and ongoing work and we appreciate your efforts and commitment to tell our story.

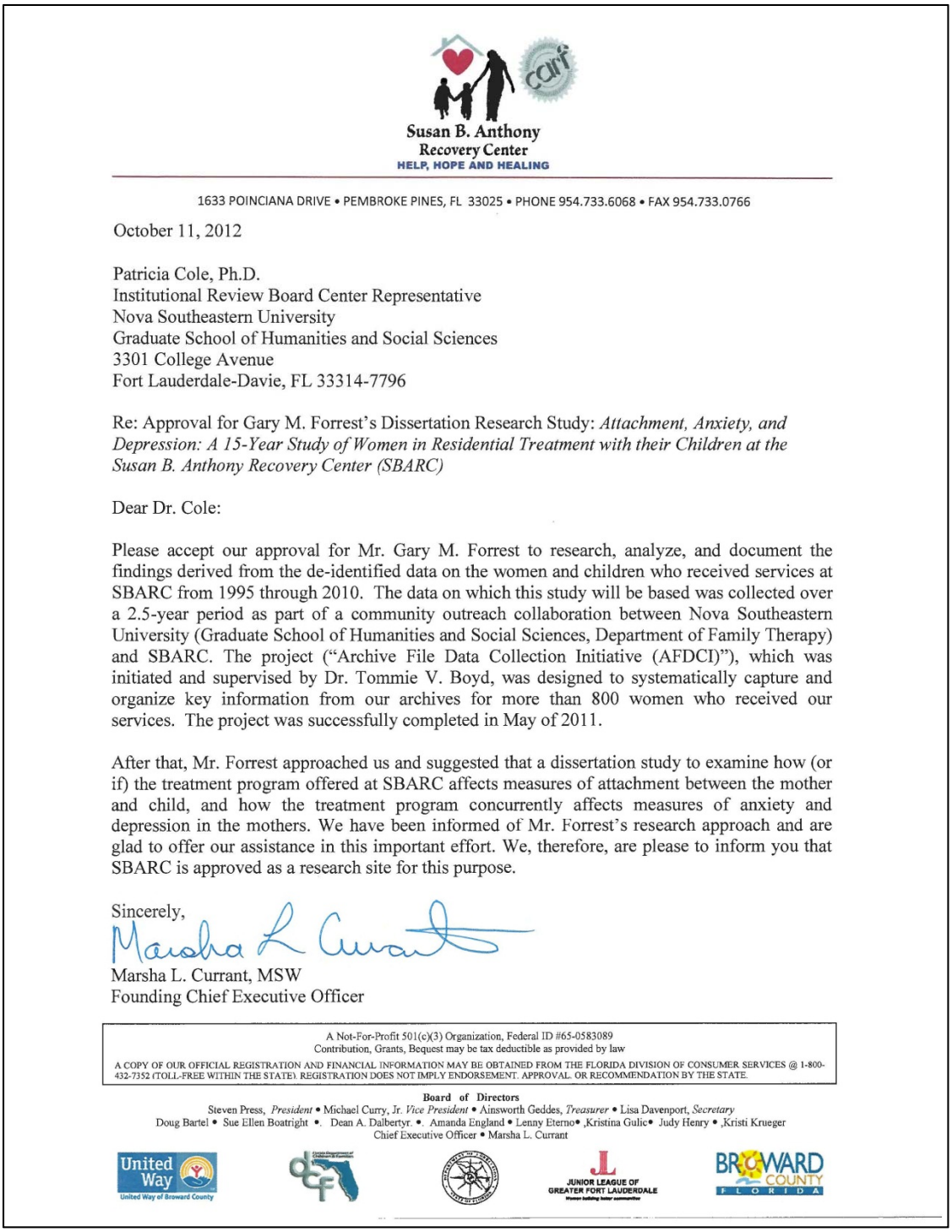
Sincerely,

Marsha L. Currant

Marsha L. Currant, MSW
Founding Chief Executive Officer

Appendix I

Susan B. Anthony Recovery Center Authorization for Research



Susan B. Anthony
Recovery Center
HELP, HOPE AND HEALING

1633 POINCIANA DRIVE • PEMBROKE PINES, FL 33025 • PHONE 954.733.6068 • FAX 954.733.0766

October 11, 2012

Patricia Cole, Ph.D.
Institutional Review Board Center Representative
Nova Southeastern University
Graduate School of Humanities and Social Sciences
3301 College Avenue
Fort Lauderdale-Davie, FL 33314-7796

Re: Approval for Gary M. Forrest's Dissertation Research Study: *Attachment, Anxiety, and Depression: A 15-Year Study of Women in Residential Treatment with their Children at the Susan B. Anthony Recovery Center (SBARC)*

Dear Dr. Cole:

Please accept our approval for Mr. Gary M. Forrest to research, analyze, and document the findings derived from the de-identified data on the women and children who received services at SBARC from 1995 through 2010. The data on which this study will be based was collected over a 2.5-year period as part of a community outreach collaboration between Nova Southeastern University (Graduate School of Humanities and Social Sciences, Department of Family Therapy) and SBARC. The project ("Archive File Data Collection Initiative (AFDCI)"), which was initiated and supervised by Dr. Tommie V. Boyd, was designed to systematically capture and organize key information from our archives for more than 800 women who received our services. The project was successfully completed in May of 2011.

After that, Mr. Forrest approached us and suggested that a dissertation study to examine how (or if) the treatment program offered at SBARC affects measures of attachment between the mother and child, and how the treatment program concurrently affects measures of anxiety and depression in the mothers. We have been informed of Mr. Forrest's research approach and are glad to offer our assistance in this important effort. We, therefore, are please to inform you that SBARC is approved as a research site for this purpose.

Sincerely,

Marsha L. Currant, MSW
Founding Chief Executive Officer

A Not-For-Profit 501(c)(3) Organization, Federal ID #65-0583089
Contribution, Grants, Bequest may be tax deductible as provided by law
A COPY OF OUR OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES @ 1-800-432-7352 (TOLL-FREE WITHIN THE STATE). REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL, OR RECOMMENDATION BY THE STATE.

Board of Directors
Steven Press, *President* • Michael Curry, Jr. *Vice President* • Ainsworth Geddes, *Treasurer* • Lisa Davenport, *Secretary*
Doug Bartel • Sue Ellen Boatright •. Dean A. Dalbertyr. •. Amanda England • Lenny Eterno• ,Kristina Gulic• Judy Henry • ,Kristi Krueger
Chief Executive Officer • Marsha L. Currant

United Way of Broward County · JUNIOR LEAGUE OF GREATER FORT LAUDERDALE · BROWARD COUNTY FLORIDA

Appendix J

Susan B. Anthony Recovery Center Program Description (Currant, 2012)

Susan B. Anthony
Recovery Center
HELP, HOPE AND HEALING

PROGRAM DESCRIPTION

Susan B. Anthony Center, Inc. (also does business as Susan B. Anthony Recovery Center), is a 501(c) (3) private non-profit organization that was founded by the Junior League of Greater Fort Lauderdale in response to the critical lack of supportive services including access and availability of essential residential substance abuse and mental health treatment services for recovering women with children in Broward County. In September of 1995 the first house was opened with five (5) mothers and six (6) children. In October of 1996, the Junior League officially turned the project over to the newly formed Susan B. Anthony Center's Board of Directors. Today, the Center has the capacity to serve sixty-two (62) families in its new facilities in Pembroke Pines, Florida.

This unique program gives the mothers an opportunity to reside with their children while receiving the comprehensive treatment services they need to enter into and remain in recovery from substance addiction and/or move into and remain in permanent housing. The families reside in our 5.5 acre campus where they also receive the comprehensive services needed to successfully move into the community. The services provided to the moms include intensive substance abuse and mental health services, nursing services, psychiatric assessments and on-going medication management, acupuncture, case management, GED preparation, educational/vocational training, job placement services, parenting skills training, and continuing care services. The services provided to the children include play and individual therapy, age appropriate group therapy, family therapy, developmental intervention services, and on-site child care. The Center has provided essential help to eight-hundred and sixteen (816) mothers and over 1100 children since opening fifteen (15) years ago.

The Center provides a warm and caring environment for women and their children to recover from the ill effects that occur from a life in addiction and/or homelessness. These mothers arrive at our doorstep impaired in their ability to take adequate care of themselves and their children due to the overwhelming stress from the consequences of the disease of addiction (HIV/AIDS, lack of adequate medical care, poverty, lack of education, involvement with the criminal justice system, etc) and/or the ill effects of homelessness. The overall goal of the Center is to help families become healthy and to stop the cycle of substance addiction, family dysfunction, and homelessness by keeping the family together and fostering healthy relationships.

Our mission: "Susan B. Anthony Recovery Center transforms families by providing help, hope and healing for mothers and their children to live responsible drug-free lives."

Susan B. Anthony Recovery Center is a replication of a "best practices model" developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the Federal Department of Human Services. The Center addresses the critical needs of the entire family through comprehensive treatment and support services for both the mothers and children. The families can reside in our residential treatment program for up to eighteen (18) months. The following is a description of primary services provided by the Center:

Residential Program: The Center provides a warm, caring, and safe environment for women and their children to recover from the ill effects of the disease of addiction and homelessness. Women and their children may remain in the residential component for a maximum of 18 months. Services include: 24 hour supervision; transportation services; 12-step meetings; spiritual groups; exercise classes; & family bonding activities.

Funding: Services are funded by DCF for moms only for housing & treatment (Level 2 at $125/day); DOC housing only for Moms ($45.25/day); HOPWA housing only (at $30 per person including the children); HIP housing and case management only ($59/day); Seminole Tribe ($300/day for moms for housing & treatment and $100/day for housing and treatment); private insurance – Residential Level 2 at the private insurance rates for Residential Treatment services for the Mom only.

1. Residence is supervised by a FT Program Supervisor who also supervises two FT Case Managers (One does Admissions and the other is a Peer who does Discharge Planning).

2. Currently staffed by Residential Managers working 12 and 24 hours shifts. They work two 24 hour shifts and two or three 12 hour shifts depending on if they work a four or five day week. We are in the process of checking to ensure this meets the Labor law requirements so it may change slightly. We currently have ___ FT staff in these positions.

3. We have two PT Overnight Awake staff who work at night at the residence and cover all 7 days of the week.

4. One PT LPN who works from 4-8 to assist in distributing medication

Adult Treatment Services: The mothers served by the Center benefit from a comprehensive approach that addresses the complex issues affecting the entire family. The vast majority of these women experienced childhood sexual or physical abuse and/or domestic violence. The goal is to prepare the whole family for successful re-entry in the community as productive citizens. These services include:

- Individual, family and group counseling for the women (up to 53 groups per week)
- Psychiatric evaluation and medication services when indicated
- Substance addiction educational groups & relapse prevention groups
- Individualized case management and discharge planning services
- Trauma, Art Therapy, Hypnotherapy, and other women focused groups

Funding: Only sources of funding currently are DCF Residential Level 2 (contract is currently $757,000 for both housing and Treatment. (We get $125.56/day/person and we apply $68.81/day/person to residential and the remainder to treatment); Seminole families (We received $300/day/Mom and $100/day/child and we apply $49/day to residential and the remainder to treatment) –we do not have Seminole clients at this time; and Private insurance (We apply $49/day to residential and the remainder to treatment). We have four women here today under this category.

1. FT Clinical Director is over the Adult Services program.

2. Currently we have three FT employees (1 Licensed Psychologist who has been here since 1998; 1 Licensed Mental Health Counselor and one Master's level Therapist who will be sitting for her licensing test very shortly.

3. Part-time Per Diem staff that fills in doing individuals and groups for both adults and children. $25 per hour for billable unit.

4. Part-time Children's Program Supervisor/Art Therapist (LMHC & Certified Art Therapist has been with the Agency since 1998).

5. We contract we Dr. D who is our Medical Director who supervises the Psychiatric ARNP who works about 6 hours a week to do the Medication services at the Center.

6. We contract with an Acupuncturist for her services three hours a day for two days a week. She provides services to the clients for 4 hours and staff for 2 hours each week.

Children's Treatment Services: The majority of the children residing in our program suffered psychological and emotional damage due to their homelessness and/or their mother's addictive lifestyle. Addressing their emotional issues gives these children an increased chance of being successful in school, establishing healthy relationships, and avoiding an addiction problem of their own. These services include:

- Assessment with the Battelle and CFARS to screen for mental health concerns.
- Individual, play, family and group counseling by a Therapist specializing in working with children
- Age appropriate play therapy utilizing the Cognitive Behavioral Therapy Model
- Parenting instruction and groups designed to meet the needs of these at risk families.

Funding: This program is funded by Jim Moran Foundation $90,000, CSB $110,000 (starting 10/2012) and by Medicaid.

1. Supervised by a PT Children's Program Supervisor who also does Art Therapy and supervises Student Interns (currently 4) who has worked for the Agency since 1998.
2. One FT Therapist and one PT Per Diem Therapist making $25/hour per billable hour.

Health Care Services: All families receive on-site health care including nursing services, psychiatric assessments, physical assessments, medication management, maternal & fetal assessments, well baby care, nutritional courses, acupuncture and linkage to other medical services.

1. Clinical Director supervises one PT Registered Nurse who works 20 hours per week at $30/hour

Funding: Funded by United Way $113,000.

Children's Developmental Intervention Program: designed to increase developmental milestones of all the children served:

- An in-depth assessment and individualized intervention plan is provided for each child that enters the program.

- A developmental intervention specialist works individually and in groups with the mothers to improve the children's developmental milestones. Mothers are also taught parenting skills that will help them parent their children successfully to adulthood.

Funding: Funded by AD Henderson grant ($40,000)

1. One FT Developmental Intervention Specialist – MSW.

Educational/Vocational Services: It is critical that the clients be readied to re-enter the workforce for their own future success. Having gainful employment assists these families to live substance free in our community. Vocational Training & Employment Services include:

- Pre-employment training classes that teach basic vocations skills including job search skills, computer job searching skills, interviewing techniques, and resume preparation.
- Educational programs including GED classes.
- Referrals to community partners such as Vocational Rehabilitation and WorkForce One that provide funding for clients to go back to school or attend vocational educational programs.
- Job Placement Services (funded by United Way).

Funding: United Way grant $60,000 pays for the Voc/Ed Coordinator (Job Coach) and JM Families grant $36,633.

1. The CEO supervises this Department
2. The Ed/Voc Coordinator – FT supervises this program. She oversees the FT Teacher who oversees the PT Workstudy students who do educational/Vocational groups. She also performs the duties of the Job Coach. We only pay the Workstudy Students $3/hr as Nova pays the other $9/hr.

Child Care Services: On-site child care services are available for all residents of the Center.

We rent the facility at this time and the Childcare Center is run by Dr. Wendi Siegel.

Continuing Care: We work diligently with the women and children to prepare them for life after Susan B. Anthony Recovery Center, but recognize that the life-line we attached to these at-risk families must be maintained as they transition to independent living. Women and their children may participate in aftercare services for up to 3 years after leaving the residential program.

1. These services are group once a week and weekly in home services of a Master's level Per Diem Therapist. We bill Medicaid for these services as the women do not fall under the IMD Issue after they move out of the facility.

Funding: Medicaid

DOC Outpatient Program: New contract starting in 2012. We provide Intake and Assessment, Develops an Individual Treatment Plan and Life skills and education groups.

Funding: DOC contract for Outpatient services

1. These services are provided at the Agency by a Per Diem Therapist at $25/hour.

The Center's capacity to provide quality services are best reflected by its receipt of a three year National Accreditation from CARF and its receipt of an Exemplary Program Award from CARF for the SURF Program that is funded by the United Way.

The Susan B Anthony Recovery Center is also the winner of the 2010 Sapphire Award of Excellence from The Blue Foundation for a Healthy Florida (philanthropic affiliate of Blue Cross and Blue Shield of Florida). The Sapphire Award is designed to recognize and promote organizations that have demonstrated excellence and impact in improving the health-related outcomes of Florida's at-risk populations. The Sapphire Award recognizes community health organizations that have demonstrated success and high merit. Award winning organizations have demonstrated effective strategies that are built on community assets, enhance organizational capacity, foster systemic change, and/or lead to lasting policy changes that improve health-related outcomes of Florida's at-risk populations and communities.

Appendix K

Weekly Meetings and Activities Offered at Susan B. Anthony Recovery Center

AA/NA
Acupuncture
Art Therapy
Art Therapy/ Psychodrama
Arts and Decorating
Big Book
C.O.D.A.
Case Load
Community Meeting
Computer Skills
Co-Occurring Disorders
Developmental Intervention
Dialectical Behavior Therapy
Domestic Violence
Emotion Regulation
Family Developmental Intervention
Family Group
Gardening and Beautification
GED Language Arts
GED Math
GED Reading
GED Science
GED Social Studies
Grief and Loss
Guilt and Shame
Healthy Brain - Healthy Mind
Healthy Relationships & Sexuality
Healthy Start
HIP Group
Individual Assessment
Individual Therapy
Individual Tutoring
Job Readiness
Jobs & Careers Exploration
Journaling
Language Arts for Success
Leadership
Let Your Garden Grow
Life Organized
Living Skills
Math for Success
Meditation/Relaxation
Mind/Body Connection
Mindful About Money
Motivation
Movement/Meditation
Newsletter
Nutrition and Wellness
Omega
On-Line
Orientation
Parenting
Parenting (pregnant - 2 months)
Parenting (3-10 months)
Parenting (11 months-2 years)
Parenting (3-4 years)
Physiology of Addiction
Positive Living
Prevention of Violence
Quilting/Art Therapy
Reading for Success
Recovery Toolbox
Reducing Stress
Relapse Prevention
Relapse Prevention
SBA Thrift
SBA Wakeup Call
Self-Expression
Self-Esteem
Sister-to-Sister
Smoking Cessation
Special Events
Spirituality
Spirituality/Process
Step Review/Inspirational
STEP Team
Storytelling for Adults
Thinking for Change
Transitional/Aftercare
Trauma
Vocational Orientation
Welcoming/Caring and Outreach
Women's Way/12 Steps
Yoga

Appendix L

Battelle Developmental Inventory, 2nd Edition: BDI-2 Screening Record Form

Battelle Developmental Inventory
2nd edition

BDI-2 Screening Record Form

Name _____ (Last / First / MI)
Sex M ❑ F ❑ ID# _____
Examiner _____
School/Program _____
Teacher _____ Classroom/Grade _____

Items Administered In: ❑ English Only ❑ Spanish Only ❑ Mixed English and Spanish
Assessment Period: ❑ Beginning of year ❑ Mid-year ❑ End of year

	Year	Month	Day
Date of Testing			
Date of Birth			
Chronological Age	*	**	
Age in Months***			

***Number of years (*) × 12 + number of months (**). Ignore all days.

Screening Score Summary

Domain	Raw Score	Standard Deviation (–2.0, –1.5, –1.0)	Cut Score	Pass/Refer
Adaptive				
Personal-Social				
Communication				
Motor				
Cognitive				
Total Screening Score				
	Age Equivalent:		Date of Report:	

Test Session Validity

Notes and Observations (Dev/Physical, Bio/Medical/Environmental)

Recommendations

RIVERSIDE PUBLISHING
a subsidiary of Houghton Mifflin Harcourt

Test Session Behavioral Observations

Provide additional information for each item under Notes & Observations (below), if needed.

Test Session Validity

❑ Yes ❑ No All test items were administered using the standard Structured, Observation, or Interview procedure, as appropriate, for the item.

❑ Yes ❑ No Only used standard administration procedures during item administration. (Accommodations were **not** used when items were administered.)

Structured Items (Items were administered directly to the child by the examiner[s].)

❑ Yes ❑ No Child's English proficiency was sufficient for testing.

❑ Yes ❑ No Child understood instructions.

❑ Yes ❑ No Child's vision was within normal range or corrected.

❑ Yes ❑ No Child's hearing was within normal range or corrected.

❑ Yes ❑ No Child's motor functioning was conducive to valid and reliable results.

❑ Yes ❑ No Child's health was good, and was conducive to valid and reliable results.

❑ Yes ❑ No Child was cooperative.

❑ Yes ❑ No Testing environment (i.e., ventilation, temperature, lighting, etc.) was satisfactory.

❑ Yes ❑ No Testing session is considered a valid representation of child's current functioning.

Observation Items (Examiner has observed the child in the relevant activities.)

Child was observed _____ times over _____ days (approximately _____ minutes total).

❑ Yes ❑ No Observations were adequate to make reliable and valid scoring judgments.

Interview Items (Parent[s], caregiver, or teacher familiar with the child was interviewed by the examiner.)

❑ Yes ❑ No Interview items were presented in English.

❑ Yes ❑ No Person understood the questions asked.

❑ Yes ❑ No Person provided information sufficient for scoring test items.

❑ Yes ❑ No Information about the child's abilities provided from Interview items is generally consistent with information obtained through Structured or Observation procedures.

❑ Yes ❑ No All test items that needed to be assessed using the Interview procedure were administered.

Notes & Observations

Child's Physical Appearance (health, nutrition, dress): _____

Testing Situation (rapport, environment, attitude toward testing): _____

Mood and Activity Level (affect, interest, off-task behaviors): _____

Attention and Concentration (focus, distractibility, sustained effort): _____

Problem-Solving Behaviors (persistence, forethought, organization): _____

Language Usage (preferred language, spontaneous verbalizations, second language): _____

Accommodations Used During Administration of Items: _____

Current Medications: _____

Other Information: _____

Basal = a score of **2** on *three consecutive* lowest-numbered items administered or the first item in the domain if a basal cannot be established

Ceiling = a score of **0** on *three consecutive* highest-numbered items administered or the last item in the domain if a ceiling cannot be established

ADAPTIVE (ADP) DOMAIN

Screener Number / Subtrial	Item Description	Score** 2	1	0	Procedure S	O	I	Comments
* 0–11 months								
ST 1	Sucks with smooth, coordinated movements.	(2)	(1)	(0)		(O)	(I)	
ST 2	Places both hands on a bottle or breast during feeding.	(2)	(1)	(0)		(O)	(I)	
12–17 months								
ST 3	Takes strained food from a spoon and swallows it.	(2)	(1)	(0)		(O)	(I)	
ST 4	Eats semisolid food when it is placed in his or her mouth.	(2)	(1)	(0)		(O)	(I)	
18–23 months								
ST 5	Helps dress himself or herself by holding out his or her arms or legs.	(2)	(1)	(0)		(O)	(I)	
ST 6	Asks for food or liquid with words or gestures.	(2)	(1)	(0)		(O)	(I)	
2 years								
ST 7	Uses a spoon or other utensil to feed himself or herself.	(2)	(1)	(0)		(O)	(I)	
ST 8	Removes his or her shoes without assistance.	(2)	(1)	(0)	(S)		(I)	
3 years								
ST 9	Feeds himself or herself with a spoon or fork without assistance.	(2)	(1)	(0)		(O)	(I)	
ST 10	Puts away toys when asked.	(2)	(1)	(0)		(O)	(I)	
4 years								
ST 11	Blows his or her nose with assistance.	(2)	(1)	(0)			(I)	
ST 12	Washes and dries his or her hands without assistance.	(2)	(1)	(0)		(O)	(I)	
5 years								
ST 13	Chooses the appropriate utensil for the food he or she is eating.	(2)	(1)	(0)	(S)			
ST 14	Responds to instructions given in a small group and initiates an appropriate task without being reminded.	(2)	(1)	(0)		(O)	(I)	
6–7 years								
ST 15	Cuts soft foods with the side of a fork.	(2)	(1)	(0)		(O)	(I)	
ST 16	Answers "what-to-do-if" questions involving personal responsibility. *You saw smoke and fire* ○ Pass ○ Fail *A stranger asked you to go for a ride* ○ Pass ○ Fail	(2)	(1)	(0)	(S)			
ST 17	Chooses clothing that is appropriate for the weather.	(2)	(1)	(0)			(I)	
ST 18	Knows his or her own phone number.	(2)		(0)	(S)			
ST 19	Goes to bed without assistance.	(2)	(1)	(0)			(I)	
ST 20	Uses emergency phone numbers.	(2)	(1)	(0)	(S)			

[ ] + [ ] = [ ] Adaptive (ADP) Domain Raw Score Total

Sum 2's Sum 1's

*Boxed ages indicate suggested starting points for typically developing students.

**Mark *one* score per item.

3

Basal = a score of 2 on *three consecutive* lowest-numbered items administered or the first item in the domain if a basal cannot be established

Ceiling a score of 0 on *three consecutive* highest-numbered items administered or the last item in the domain if a ceiling cannot be established

PERSONAL-SOCIAL (P-S) DOMAIN

Screener Number	Item Description	Score 2 1 0	Procedure S O I	Comments
0–11 months				
ST 21	Shows awareness of other people.	② ① ⓪	ⓞ ①	
ST 22	Smiles or vocalizes in response to adult attention.	② ① ⓪	Ⓢ ①	
12–17 months				
ST 23	Shows a desire for social attention.	② ① ⓪	ⓞ ①	
ST 24	Is aware of his or her feet.	② ① ⓪	ⓞ ①	
18–23 months				
ST 25	Discriminates between familiar and unfamiliar people.	② ① ⓪	Ⓢ ①	
ST 26	Displays independent behavior.	② ① ⓪	①	
2 years				
ST 27	Greets familiar adults spontaneously.	② ① ⓪	ⓞ ①	
ST 28	Initiates social contact with peers in play.	② ① ⓪	ⓞ ①	
3 years				
ST 29	Responds positively when familiar adults or adults in authority initiate social contact.	② ① ⓪	ⓞ ①	
ST 30	Responds differently to familiar and unfamiliar children.	② ① ⓪	①	
4 years				
ST 31	Allows others to participate in his or her activities.	② ① ⓪	①	
ST 32	Engages in adult role-playing and imitation.	② ① ⓪	ⓞ ①	
5 years				
ST 33	Follows adult directions with little or no resistance.	② ① ⓪	ⓞ ①	
ST 34	States his or her first and last names.	② ① ⓪	Ⓢ	
6–7 years				
ST 35	Recognizes an adult's feelings.	② ① ⓪	①	
ST 36	Cooperates in group activities.	② ① ⓪	ⓞ ①	
ST 37	Discriminates between socially acceptable and unacceptable behavior.	② ① ⓪	Ⓢ	
ST 38	Trusts familiar adults and accepts explanations from them.	② ① ⓪	ⓞ ①	
ST 39	Waits his or her turn for a teacher's or adult's attention.	② ① ⓪	ⓞ ①	
ST 40	Delays gratification until a task is completed.	② ① ⓪	①	

☐ (Sum 2's) + ☐ (Sum 1's) − ☐ = Personal-Social Domain (PS) Raw Score Total

Basal = a score of **2** on *three consecutive* lowest-numbered items administered or the first item in the domain if a basal cannot be established

Ceiling = a score of **0** on *three consecutive* highest-numbered items administered or the last item in the domain if a ceiling cannot be established

COMMUNICATION (COM) DOMAIN

Screener Number	Item Description / *Subtrial*	Score 2 1 0	Procedure S O I	Comments
0–11 months				
ST 41	Is soothed by a familiar adult's voice.	② ① ⓪	I	
ST 42	Produces differentiated cries.	② ① ⓪	O I	
12–17 months				
ST 43	Responds to different tones of a person's voice.	② ① ⓪	S I	
ST 44	Produces one or more single-syllable consonant-vowel sounds.	② ① ⓪	O I	
18–23 months				
ST 45	Identifies family members or pets when named.	② ① ⓪	S I	
ST 46	Uses variations in his or her voice.	② ① ⓪	O I	
2 years				
ST 47	Follows 3 or more familiar verbal commands.	② ① ⓪	S	
ST 48	Spontaneously initiates sounds, words, or gestures that are associated with objects in the immediate environment.	② ① ⓪	O I	
3 years				
ST 49	Responds to the prepositions *out* and *on*.	② ① ⓪	S	
	Out ○ Pass ○ Fail			
	On ○ Pass ○ Fail			
ST 50	Uses 2-word utterances to express meaningful relationships.	② ① ⓪	O I	
4 years				
ST 51	Responds to *who* and *what* questions.	② ① ⓪	S	
	Who ○ Pass ○ Fail			
	What ○ Pass ○ Fail			
ST 52	Uses words to relate information about other people, their actions, or their experiences.	② ① ⓪	S I	
5 years				
ST 53	Responds to *where* and *when* questions.	② ① ⓪	S	
	Where ○ Pass ○ Fail			
	When ○ Pass ○ Fail			
ST 54	Repeats familiar words with clear articulation.	② ① ⓪	S	
6–7 years				
ST 55	Converses on topics for more than 5 turn-taking exchanges.	② ① ⓪	S	
ST 56	Identifies a word from its definition.	② ① ⓪	S	
ST 57	Follows 3-step verbal commands.	② ① ⓪	S	

Basal = a score of **2** on *three consecutive* lowest-numbered items administered or the first item in the domain if a basal cannot be established

Ceiling = a score of **0** on *three consecutive* highest-numbered items administered or the last item in the domain if a ceiling cannot be established

COMMUNICATION (COM) DOMAIN *(Cont.)*

Screener Number	Item Description / *Subtrial*	Score 2 1 0	Procedure S O I	Comments
ST 58	Uses plural forms ending in the /ĕz/ sound.	② ① ⓪	Ⓢ	
ST 59	Recalls events from a story presented orally.	② ① ⓪	Ⓢ	
	Morning ○ Pass ○ Fail			
	Eggs, toast, and orange juice ○ Pass ○ Fail			
	Proud ○ Pass ○ Fail			
ST 60	Describes what is happening in a picture.	② ① ⓪	Ⓢ	

☐ (Sum 2's) + ☐ (Sum 1's) = ☐ Communication Domain (COM) Raw Score Total

MOTOR (MOT) DOMAIN

Screener Number	Item Description	Score 2 1 0	Procedure S O I	Comments
0–11 months				
ST 61	Maintains an upright posture at adult's shoulder without assistance for at least 2 minutes.	② ① ⓪	Ⓢ Ⓞ ①	
ST 62	Holds hands in an open, loose-fisted position when not grasping an object.	② ① ⓪	Ⓞ	
12–17 months				
ST 63	Retrieves a small object by raking it with his or her fingers and pulling it into the palm of the hand.	② ① ⓪	Ⓢ Ⓞ	
ST 64	Transfers an object from one hand to the other.	② ① ⓪	Ⓢ	
18–23 months				
ST 65	Moves from a sitting position to a standing position without support.	② ① ⓪	Ⓢ ①	
ST 66	Intentionally propels or throws an object.	② ① ⓪	Ⓢ ①	
2 years				
ST 67	Maintains or corrects his or her balance when moving from a standing position to other, nonvertical positions.	② ① ⓪	Ⓢ Ⓞ ①	
ST 68	Removes forms from a form board.	② ① ⓪	Ⓢ	
3 years				
ST 69	Runs 10 feet without falling.	② ① ⓪	Ⓢ	
ST 70	Scribbles linear and/or circular patterns spontaneously.	② ① ⓪	Ⓞ ①	
4 years				
ST 71	Walks forward 2 or more steps on a line on the floor, alternating feet.	② ① ⓪	Ⓢ	

Basal = a score of **2** on *three consecutive* lowest-numbered items administered or the first item in the domain if a basal cannot be established
Ceiling = a score of **0** on *three consecutive* highest-numbered items administered or the last item in the domain if a ceiling cannot be established

COGNITIVE (COG) DOMAIN *(Cont.)*

Screener Number	Item Description / Subtrial	Score 2 1 0	Procedure S O I	Comments
3 years				
ST 89	Finds an object hidden under one of two cups.	(2) (1) (0)	(S)	
ST 90	Nests objects inside one another.	(2) (1) (0)	(S) (O)	
4 years				
ST 91	Locates hidden items in a picture scene—Level 1. Time: _____ **min.** _____ **sec.** Items found within **3** minutes: ○ *Beach ball* ○ *Ice cream cone* ○ *Frog* ○ *Bird* ○ *Butterfly* ○ *Squirrel*	(2) (1) (0)	(S)	
ST 92	Names the colors red, green, and blue.	(2) (1) (0)	(S)	
5 years				
ST 93	Locates hidden items in a picture scene—Level 2. Time: _____ **min.** _____ **sec.** Items found within **2** minutes: ○ *Ball* ○ *Red crayon* ○ *Glue bottle* ○ *Unicorn* ○ *Eraser* ○ *Compass*	(2) (1) (0)	(S)	
ST 94	Recognizes visual differences among similar numerals and letters.	(2) (1) (0)	(S)	
6–7 years				
ST 95	Identifies the picture that is different. *Tree* ○ Pass ○ Fail *Dog* ○ Pass ○ Fail	(2) (1) (0)	(S)	
ST 96	Categorizes familiar objects by function.	(2) (1) (0)	(S)	
ST 97	Matches simple words. *No* ○ Pass ○ Fail *Blue* ○ Pass ○ Fail *Rate* ○ Pass ○ Fail	(2) (1) (0)	(S)	
ST 98	Knows the right and left sides of his or her body.	(2) (1) (0)	(S)	
ST 99	Repeats sequences of 4 and 5 objects from memory.	(2) (1) (0)	(S)	
ST 100	Groups objects by shape and color. *Shape* ○ Pass ○ Fail *Color* ○ Pass ○ Fail	(2) (1) (0)	(S)	

☐ Sum 2's + ☐ Sum 1's = ☐ Cognitive Domain (COG) Raw Score Total

RIVERSIDE PUBLISHING
a subsidiary of Houghton Mifflin Harcourt
800.323.9540

9-24596 15 16 17 18 19 20 21 22–RRD–17 16 15 14 13 12 11

Basal – a score of **2** on *three consecutive* lowest-numbered items administered or the first item in the domain if a basal cannot be established

Ceiling – a score of **0** on *three consecutive* highest-numbered items administered or the last item in the domain if a ceiling cannot be established

MOTOR (MOT) DOMAIN *(Cont.)*

Screener Number	Item Description	Score 2 1 0	Procedure S O I	Comments
ST 72	Stacks 8 cubes vertically.	② ① ⓪	Ⓢ Ⓞ	
5 years				
ST 73	Hops forward on one foot without support.	② ① ⓪	Ⓢ	
ST 74	Folds a sheet of paper.	② ① ⓪	Ⓢ	
6–7 years				
ST 75	Touches the fingertips of each hand successively with the thumb of the same hand.	② ① ⓪	Ⓢ	
ST 76	Draws a person with 6 parts.	② ① ⓪	Ⓢ	
ST 77	Walks a 6-foot line on the floor, heel-to-toe, with eyes open.	② ① ⓪	Ⓢ	
ST 78	Copies the numerals 1 through 5.	② ① ⓪	Ⓢ	
ST 79	Skips on alternate feet for 20 feet.	② ① ⓪	Ⓢ	
ST 80	Ties a single overhand knot around a crayon with a string.	② ① ⓪	Ⓢ	

__ (Sum 2's) + __ (Sum 1's) = __ Motor Domain (MOT) Raw Score Total

COGNITIVE (COG) DOMAIN

Screener Number	Item Description	Score 2 1 0	Procedure S O I	Comments
0–11 months				
ST 81	Visually attends to a light source moving in a 180-degree arc.	② ① ⓪	Ⓢ	
ST 82	Turns his or her eyes toward a light source.	② ① ⓪	Ⓢ	
12–17 months				
ST 83	Attends to an ongoing sound or activity for 15 or more seconds.	② ① ⓪	Ⓞ ①	
ST 84	Feels and explores objects.	② ① ⓪	Ⓢ	
18–23 months				
ST 85	Attends to a game of peekaboo for 1 minute.	② ① ⓪	Ⓢ	
ST 86	Uncovers a hidden toy.	② ① ⓪	Ⓢ	
2 years				
ST 87	Looks at, points to, or touches pictures in a book.	② ① ⓪	Ⓢ ①	
ST 88	Imitates simple facial gestures.	② ① ⓪	Ⓢ	

Appendix M

Revised Adult Attachment Scale

Gary M. Forrest, LMFT, CHT
Licensed Psychotherapist
120 East Oakland Park Boulevard, Suite 108
Fort Lauderdale, FL 33334
Tel: (954)308-7479 Fax: (954)337-0530 Email: gary@garymforrest.net
www.garymforrest.net

Revised Adult Attachment Scale (Collins, 1996*)

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5
Not at all characteristic of me — **Very characteristic of me**

1) I find it relatively easy to get close to people. _____
2) I find it difficult to allow myself to depend on others. _____
3) I often worry that romantic partners don't really love me. _____
4) I find that others are reluctant to get as close as I would like. _____
5) I am comfortable depending on others. _____
6) I don't worry about people getting too close to me. _____
7) I find that people are never there when you need them. _____
8) I am somewhat uncomfortable being close to others. _____
9) I often worry that romantic partners won't want to stay with me. _____
10) When I show my feelings for others, I'm afraid they will not feel the same about me. _____
11) I often wonder whether romantic partners really care about me. _____
12) I am comfortable developing close relationships with others. _____
13) I am uncomfortable when anyone gets too emotionally close to me. _____
14) I know that people will be there when I need them. _____
15) I want to get close to people, but I worry about being hurt. _____
16) I find it difficult to trust others completely. _____
17) Romantic partners often want me to be emotionally closer than I feel comfortable being. _____
18) I am not sure that I can always depend on people to be there when I need them. _____

*Collins, N. L. (1996). Working models of attachment: Implications for explanation, emotion, and behavior. *Journal of Personality and Social Psychology, 71*(4), 810-832. doi:http://dx.doi.org/10.1037/0022-3514.71.4.810

Biographical Sketch

Gary Miles Forrest is from Acton, Massachusetts. In 1976, Gary received his Bachelor of Arts degree from Norwich University in Northfield, Vermont. His first job was working as a technical writer for Digital Equipment Corporation in Marlboro, Massachusetts. This is where he developed a keen—and what would turn out to be a lifelong—interest in computer technology, systems architecture, and communications. Next, Gary became a systems programmer for a German computer manufacturer, Nixdorf Corporation. While providing technical support to a number of large-scale client installations in Germany and in the U.S., Gary became interested in applying his technical knowledge to sales and marketing.

In 1983, Gary relocated from Massachusetts to Northern Virginia where he opened the first federal sales office for Charles River Data Systems. He continued to pursue his interest in business and in leading-edge hardware, software, and communications technologies. In 1987, Gary became the Eastern Regional Sales Manager for Systech Corporation, a supplier of high-tech connectivity solutions. Soon afterward, he became National Sales Director and relocated to the company's headquarters in San Diego, California. In this position, Gary managed a diverse group of sales, marketing, and technical support professionals and was responsible for nearly 95% of the company's revenues. After Systech, Gary moved to northern California where he applied his senior business skills in the service of two Silicon Valley start-ups. In 1997, Gary and his wife, Robin, relocated to South Florida so that Robin could provide caregiver support to her ailing mother. Gary took a position as Vice President of Business Development for a San Diego-based data-mining company. Days after the terrorist

attacks of 2001, Gary joined with other high-tech professionals in the first version of the Joint Terrorist Task Force authorized by then-Attorney General John Ashcroft. This assignment took Gary back to the District of Columbia for what turned out to be a 1-year extended assignment. Later, Gary accepted a position with a small Fort Lauderdale high-tech company, Savvy Data, and eventually took the helm as its President and Chief Executive Officer. He retired from that position in 2003.

At that time, Gary became a volunteer at a friend's outpatient substance abuse practice. Although he had never experienced anything related to substance abuse treatment or psychotherapy, he found himself enchanted. Gary enrolled in Nova Southeastern University's Marriage and Family Therapy Master's program. After receiving his Master's in 2007, he enrolled in the Ph.D. program. Gary currently maintains a private practice in Fort Lauderdale, Florida, where he sees adult individuals and couples and specializes in issues surrounding communications, anxiety, depression, anger management, domestic violence, and substance abuse. In addition, Gary has performed extensive voluntary research at agencies in the area, including the Susan B. Anthony Recovery Center. He and Robin now reside in Fort Lauderdale.

%