IMPROVING BEHAVIORAL AND ACADEMIC OUTCOMES FOR STUDENTS

WITH REACTIVE ATTACHMENT DISORDER

A Dissertation

Presented in Partial Fulfillment of the Requirements for the

Degree of Doctor of Philosophy With

a

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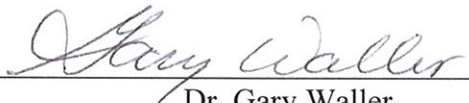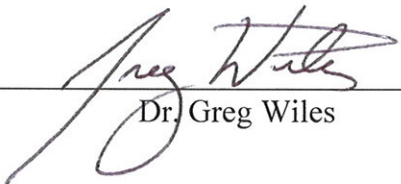
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AUTHORIZATION TO SUBMIT

DISSERTATION

This dissertation of Cynthia Cook, submitted for the degree of Doctor of Philosophy with a major in Educational Leadership and titled "Improving Behavioral and Academic Outcomes for Students with Reactive Attachment Disorder" has been reviewed in final form. Permission, as indicated by the signatures and dates given below, is now granted to submit final copies.

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DEDICATION

I would like to dedicate this dissertation to the students with the misfortune of being victims of pathogenic care in infancy. For due to this tragedy, their entire life is forever impacted. They will struggle with relationships, academic performance, and functionality if effective treatment is not implemented. School systems must become more aware and equipped to support these students. I dedicate my work to those who are diagnosed with RAD and to those who will use their time and talents to support them.

ABSTRACT

Research on Reactive Attachment Disorder (RAD) is minimal and is limited primarily to describing its nosology and clinical treatment practices. This qualitative, multi-case, case study identified school-based academic and emotional–behavioral interventions and factors which contribute to or hinder progress by conducting open-ended, semistructured interviews with high school students with a diagnosis of RAD and with school personnel who worked directly with them. Participants were from two neighboring school districts in a relatively large western state. Participants included five high school students with a diagnosis of RAD and four school personnel who worked directly them. One staff member had two students who participated in the study and thus interviewed specifically regarding both students. Data is reported holistically, as well as in paired student-staff responses to demonstrate the similarities and differences in the perceptions in relation to interventions and factors which contributed to or hindered student academic and emotional-behavioral progress. Five themes emerged in this study which led to specific implications for professional best practice including: 1) necessity for additional training, 2) development of support systems in the school setting, 3) providing a "go-to" person, 4) provide direct instruction in why and how emotional-behavioral progress will be monitored, and 5) provide direct instruction in how to build and maintain trust. As not all of these practices are currently implemented or intuitive it led to the development of a new theoretical explanation: *RAD Teaching Practice.*

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Chapter 1

Introduction

With increased early screening and assessment requirements under Child Find

(Individuals With Disabilities Education Act [IDEA], 2004), a federal mandate in which schools

are obligated to find and identify children with disabilities, children with disabilities are

identified more quickly and efficiently. It is likely a person could walk into any K–12 classroom

and find at least one to two students identified with a disability. These students are not always

identifiable upon first glance. However, if one observes long enough, one could probably

identify some students with even milder disabilities, such as language impairment, specific

learning disabilities, and attention-deficit/hyperactivity disorder (ADHD). An untrained person

would be able to identify children who demonstrate significantly different behaviors that can

accompany significant mental health disorders, like oppositional defiant disorder, obsessive

compulsive disorder, mood disorder, and attachment disorders including reactive attachment

disorder (RAD).

Kauffman (2005) relayed on average, 10% of children in schools demonstrate emotional

and behavioral problems that require professional help. Approximately 12% of children in

America have a mental health disorder (Cleary & Abbot, 2011; Davis, Kruczek, & McIntosh,

2006; Farley, Torres, Wailehua, & Cook, 2012). The 12% statistic does not necessarily appear

very dramatic until one realizes this means 12 in every 100 children will have a mental health

disorder. This can have a staggering effect in a classroom. As listed on their school district

websites in the urban school districts where this research was conducted, most elementary

classrooms consisted of 25–30 students, middle school classes consisted of 35–40 students, and

high school classes consisted of approximately 40–50 students. If percentages hold true,

approximately three students in an elementary classroom, four students in a middle school classroom, and five to six students in a high school classroom will have a mental health disorder. A mere 20% of those 12% with a mental health disorder seek and receive treatment (Cleary & Abbot, 2011; Davis et al., 2006; Farley et al., 2012; McLeod & Fettes, 2007). This suggests possibly one of those three to six students is receiving treatment. Browne, Cashin, and Graham (2012) posited a lack of appropriate intervention for children with behavior and mental health disorders can cause short- and long-term problems. Interference with the learning of others, disruption of instructional time, verbal and physical aggression, and other unsafe behaviors were a few of the specified problems Browne et al. (2012) identified. These behaviors impact other students in the classroom and persons in the community as a whole. While not exclusive to students with mental health disorders, some students with mental health disorders struggle academically, engage in destruction of school property, are caught lying, are cruel to peers, exhibit extreme anger and lack of impulse control, and demonstrate inappropriate sexual behavior in the school setting (Browne, Cashin, & Graham, 2012; Hall & Geher, 2003; Haugaard & Hazen, 2004; McLeod & Fettes, 2007; Meagher, Arnold, Doctoroff, & Fisher, 2009; O'Neill, Guenette, & Kitchenhan, 2010; Rapp-Paglicci, Stewart, & Rowe, 2011; Reid, Trout, & Schartz, 2005; Smith, Katsiyannis, & Ryan, 2011; Valdez, Lambert, & Ialongo, 2011). In the community, children with mental health disorders have demonstrated destruction of property, gorging or hoarding of food, lying, cruelty to animals, fire starting, poor impulse control, obsession with blood and death, and inappropriate sexual behavior with other children (Hall & Geher, 2003; Horner, 2008).

It would be unfair to say all children with a mental health disorder exhibit all or some of those behaviors. However, if these children are not identified and appropriate intervention

implemented, the effects can be compounded. Children not identified and, therefore, not receiving appropriate treatment for their mental health disorders are more likely to develop drug and alcohol dependencies and are at greater risk of dropping out of school (Cleary & Abbot, 2011; Dery, Toupin, Pauze, & Verlaan, 2004; McLeod, Uemura, & Rohrman, 2012; Smith et al., 2011; Strayhorn, 2002). Males in particular demonstrate more externalizing problems than females due to mental health disorders (Costello, Copeland, & Angold, 2011; Meagher et al., 2009).

Statement of the Problem

It is difficult to imagine teaching in a classroom of 30–50 students with two or three students who consistently display severe paranoia, irritability, emotional dysregulation, verbal and physical aggression, harmful behaviors to self or others, and irregular moods. This is a reality in K–12 education (Cline, 2008; Floyd, Hester, Griffin, Golden, & Canter, 2008; Hall & Geher, 2003; McLeod et al., 2012; Schwartz & Davis, 2006; Shaw & Paez, 2007). Teachers must ensure first-time instruction is implemented while managing and accommodating students identified with specific learning disabilities, as well as for those students who struggle but have not been identified with a disability. A teacher must differentiate instruction to meet the specific needs for each of these groups of students. A teacher must also provide appropriate extension activities for gifted students. How can one person manage the instructional demands for his or her students while also attending to the safety needs caused by a student with the most difficult mental health disorder, RAD? Most teachers and administrators are not prepared to manage the extreme behavior that accompanies children with mental health disorders as they do not understand trauma, attachment issues, and especially RAD (Davis et al., 2006; O'Neill et al., 2010; Schwartz & Davis, 2006).

McLeod, Uemura, and Rohrman (2012) posited teachers prefer students who approach school and its requirements with a positive attitude and demonstrate little to no disruption to the classroom routine. When atypical behaviors occur, it can cause increased stress levels in the teacher and other school staff, which may lead to punitive responses to students' escalations (Hoagwood, Olin, Kerker, Kratochwill, Crowe, & Saka, 2007; Schwartz & Davis, 2006). This leads students to believe adults are unfair and cannot to be trusted. This is a real perception of children with RAD (Becker-Weidman, 2006; Davis et al., 2006; Floyd et al., 2008; Wilson, 2009).

School teachers and administrators often respond emotionally to troubled children in ways that become negatively self-reinforcing, and they expect less from these youth (McLeod & Fettes, 2007). McLeod and Fettes (2007) stated students with mental health disorders beginning in childhood (a substantial characteristic of RAD) have more academic problems than youth without child-onset mental health. Most school personnel have not received undergraduate (Feuerborn & Chinn, 2012: Meister & Melnick, 2003; Merrett & Wheldall, 1993) or postgraduate training that would allow them to work effectively with students with mental health disorders like RAD (Davis et al., 2006; O'Neill et al., 2010; Schwartz & Davis, 2006). Typical educator training focuses on teaching content material, not mental health. Educators do not access training and make it a priority (Browne et al., 2012), possibly due to schedules, accessibility of training, and financial hardships. Training is often not provided on school campuses as administrators are typically uneducated in this area as well. Teagarden, Zabel, and Kaff (2013) asserted decreasing numbers of educators identified as working with students with an emotional–behavioral disorder as one of the challenges in providing necessary training. A systemic change in educational institutions and in state certification needs to occur. How can

school systems make effective systems changes for students with RAD without understanding trauma and its impact on the attachment patterns of children? Research has indicated teachers and other school staff must receive training in how to provide preventative intervention for students with mental health disorders if long-term impact is to be yielded in the form of academic and emotional–behavioral progress (Lowe, 2013).

Children with mental health disorders, including those with RAD, who are not identified and treated appropriately, have a significant chance of developing problems, like drug and alcohol dependency and significant behavioral problems in and out of school, and are at greater risk of dropping out of school (Browne et al., 2012; Cleary & Abbot, 2011; Dery et al., 2004; Hanley, 2003; McLeod et al., 2012; Padykula & Conklin, 2010; Smith et al., 2011; Strayhorn, 2002). Unfortunately, at this time, there is not a large body of research identifying effective school-based academic and emotional–behavioral interventions for students with RAD. An evaluation of the professional literature revealed a plethora of meta-analyses and some quantitative research conducted on the identification and characteristics of students with RAD (Buckner, Lopez, Dunkel, & Joiner, 2008; Minnis, Marwick, Arthur, & McLaughlin, 2006). However, the research has not addressed school-based interventions or the effectiveness of the current academic and emotional–behavioral interventions utilized with students who have a Diagnostic and Statistical Manual (DSM) diagnosis of RAD. This qualitative, multicase case study aimed to fill the gap in the professional literature by exploring the current school-based interventions being implemented and the perceptions of their effectiveness by high school students with a diagnosis of RAD and the school personnel who work with them.

Research Questions

This qualitative, multicase, multisite case study addressed two questions:

1. What school-based academic and emotional–behavioral interventions do staff perceive as having improved academic and emotional–behavioral outcomes in high school students with RAD?

2. What school-based academic and emotional–behavioral interventions do high school students with RAD perceive as having a positive effect on academic and behavioral outcomes?

Description of Terms

It is important to create a clear understanding of the terminology utilized in this study. Describing and assigning meaning to terms add clarity in a research study (Creswell, 2012; Marshall & Rossman, 2011; Merriam, 1998; Stake, 1995; Yin, 2014). What follows is a current list of terms used in this study.

Attachment theory. Theory which posits children who fail to form an attachment at an early age with adults develop behavioral, attachment, and communication issues (Bretherton, 1992).

Attachment therapy. Therapy consisting of family-focused counseling, the child developing an understanding of his or her own history, and intensive holding (Wimmer, Vonk & Bordnick, 2009).

Avoidant attachment. Attachment pattern that involves behaviors resembling rejection. Children with this pattern tend to ignore the caregiver's departure and return and actively avoid the caregiver's attempts to regain contact (Hardy, 2007).

Comorbid. More than one mental health disorder is present at the same time (Costello et al., 2011).

Cortisol. Hormone present in the adrenal gland helpful in mobilizing the body for protection such as flight/fight/freeze (Corbin, 2007).

Hypercortisolism. When too much cortisol is released due to early developmental stress and trauma, which can lead to affective illness later in life and, in extreme cases, death (Corbin, 2007).

Disinhibited attachment. Subtype of RAD in which children are not selective in their attachment choices and are seen as controlling or punishing (Schwartz & Davis, 2006).

Disorganized–disorientated attachment. Attachment pattern seen in infants who have been maltreated by their attachment figure, where they exhibit conflicting behavior, such as simultaneously reaching for and turning away from the caregiver (Hardy, 2007).

Dyadic developmental psychotherapy. Clinical therapy focused on attuning the relationship between the therapist and the child, the child and the foster–adoptive parent, and the foster–adoptive parent and the therapist (Becker-Weidman, 2006).

Grounded theory. Systematic, qualitative procedure used to generate a theory explaining a process, an action, or an interaction about a substantive topic; a theory grounded in the data, where existing theories do not address the problem or participants (Creswell, 2012, p. 423; Marshall & Rossman, 2011; Yin, 2014).

Heterotypic prediction. Phenomenon of one disorder predicting another over time (Costello et al., 2011).

Homotypic prediction. Phenomenon of a disorder predicting the same disorder to be present at a later stage of development (Costello et al., 2011).

Hypothalamic-pituitary adrenal axis. Pathway in the brain largely responsible for regulating the body's response to stress and helps to balance and convey neurochemical

information for the neurobiological processes of the sympathetic nervous system and is associated with the regulation of cortisol (Corbin, 2007).

Inhibited attachment. Subtype of RAD in which the child displays a persistent and pervasive failure to initiate and respond to social interactions; they are hypervigilant and highly ambivalent across social settings (Schwartz & Davis, 2006).

Pathogenic care. Maltreatment of children characterized by (a) persistent disregard for the child's emotional need for comfort, stimulation, and affections; (b) persistent disregard for the child's physical needs; and (c) repeated changes in primary caregivers (Shaw & Paez, 2007).

Perinatal encephalopathic factor. Disruption of brain development prior to birth due to maternal illness, exposure to drugs and toxins, prematurity, hypoxia, or malnutrition (Kemph & Voeller, 2007).

Psychoactive drugs or medication. Pharmacological medication used to treat symptoms of mental health disorders, such as aggression, mood swings, hallucinations, and anger (Spenrath, Clarke, & Kutcher, 2011).

Reactive attachment disorder (RAD). Markedly disturbed and developmentally inappropriate social relatedness in most contexts beginning before age 5 and is associated with grossly pathogenic care (American Psychiatric Association, 2000)

Resistant–ambivalent attachment. Attachment pattern characterized by a preoccupation or fixation on the caregiver, in which the caregiver is alternately sought out for comfort and rejected (Hardy, 2007).

Secure attachment. Attachment pattern where children typically protest when they are separated from their caregiver and attempt to regain closeness to the caregiver upon reunion (Hardy, 2007).

Semistructured interview. Interview approach consisting of several questions that define what is being explored and where the interviewer has the flexibility to pursue specific ideas in more detail and probe for better understanding of the participants' lived experiences (Gill, Stewart, Treasure, & Chadwick, 2008).

Significance of the Study

As there is no current research on effective school-based interventions for students with RAD, this study aimed to discover a theory during the data collection phase and not prove or disprove previous research, thus making this a grounded theory study (Strauss & Corbin, 1998; Walden University, n.d.). As fractured attachment is the root of this disability, using attachment theory as the theoretical frame was deemed logical.

Students who are unable to form emotional attachments or relationships have a difficult time finding meaning in relationships typical persons take for granted (Hardy, 2007). A child's future mental health is determined by the quality of care he or she receives in the early stages of life (Bowlby, 1952). This continues to be the prominent theory (Floyd et al, 2008; Hardy, 2007; Levin, 2009; Lowe, 2013; Valdez et al., 2011; Zeanah, 2000). The most extreme attachment disorder is RAD. It is one of the few applicable explicitly to young children (Zeanah & Fox, 2004).

RAD is the most misunderstood and difficult disorder to work with in the school and community setting (Breidenstine, Bailey, Zeanah, & Larrieu, 2011; Cline, 2008; Davis et al., 2006; Hall & Geher, 2003). The frequency and intensity of violence, detrimental behavior, and personality difficulties are significantly higher in students with RAD (Hall & Geher, 2003) than in students with other mental health disabilities. Children with RAD come to school with more social, emotional, behavioral, and academic challenges than do their typical peers (Schwartz &

Davis, 2006). School personnel working with students with RAD are generally not adequately trained to manage the extremes these children demonstrate (Lowe, 2013). As a result, they do not understand how trauma impacts children, the brain–behavior relationship, or about the effects of psychotropic medications (Davis et al., 2006; O'Neill et al., 2010). This lack of knowledge and training can have a great impact on teachers' abilities to manage their own frustration and emotional levels (Schwartz & Davis, 2006).

Forness, Kim, and Walker (2012) postulated students categorized with an emotional disturbance have the worst outcomes of all special education categories. Students with emotional–behavioral disorders are three times more likely to be suspended for 10 or more days than students with other disabilities (Smith et al., 2011). Smith, Katsiyannis, and Ryan (2011) also shared only 37.3% of students with emotional–behavioral disorders spent more than 80% of their time in general education. Only 20% of students with emotional–behavioral disorders ages 14–21 received diplomas in 2006–2007. Longitudinally, 55% of students with emotional–behavioral disorders dropped out of school. Smith et al. (2011) also relayed only 20% of students with emotional–behavioral disorders enrolled in postsecondary education, and only 30% were employed. Though there is not sufficient information about the effect of RAD, these numbers are representative of what could be true.

There appears to be a negative effect on communities, school systems, and children with RAD when appropriate treatment and interventions are not provided. Drug and alcohol abuse, destruction of property, cruelty to animals and persons, inappropriate sexual behavior, fire setting, and physical violence are a few of those negative effects (Hall & Geher, 2003). There are several research-based treatments for children with RAD in the clinical or residential settings, such as dyadic developmental psychotherapy, attachment therapy treatment, and medication

management. However, there are not many interventions identified as research-based for the school setting (Davis et al., 2006). Students spend an average of six-and-a-half to seven hours a day in the school setting, five days a week to meet the state requirements for student instructional time. Research has indicated school systems must find ways to intervene with students with RAD as they spend such a significant amount of time in the school setting.

The outcome of this research will shape professional development in the areas of mental health, impacts of trauma, and impacts of RAD. It will guide intervention practices that will affect both schools and the community.

Overview of Research Methods

Ainsworth and Bowlby's (1991) attachment theory is based on people's ability to emotionally attach to one another and live productively in the society. As it is based on human interaction, positive or negative, getting down to the human interaction level was imperative in order to address and answer the research questions. The gap in the literature on school-based interventions for students with RAD negated the ability to use a survey or other quantitative measure. This study, therefore, became a grounded theory study as it developed a theory from the data. The data collected will be used as the foundation for additional research in the future.

A qualitative, multicase case study emerged as the appropriate method study to answer the research questions (Creswell, 2012; Merriam, 1998; Stake, 1995; Yin, 2014). A case-study approach was used to utilize in-depth views and perceptions of high school students with a diagnosis of RAD and school personnel who worked directly with them. A multicase case-study conducted on multiple sites was utilized to add rigor and merit to the findings. The study took place in two neighboring school districts in a rural western state. The two districts were among the three largest in the state. These two districts had students from multiple ethnic and racial

backgrounds. District-wide socioeconomic status was similar. Both districts had specific programs for students with severe emotional–behavioral disorders. A purposeful, homogeneous group was selected as the study looked at a specific group of persons: high school students with a diagnosis of RAD (Creswell, 2012). Semistructured, open-ended questions allowed the participants to give their personally lived experiences, preferences, and perceptions of current school-based academic and emotional-behavioral interventions. Semistructured interviews were selected as the format where basic questions were asked of each group of participants (students and staff), but there was flexibility to probe deeper and clarify information as appropriate. With questions being open-ended, it allowed participants to give insight into other viable interventions in the school setting. All interviews were audio recorded and transcribed to help ensure accuracy of reporting (Creswell, 2012; Marshall & Rossman, 2011; Stake, 1995; Yin, 2014). Interview questions were piloted with three professionals familiar with RAD to determine validity (Stake, 1995; Yin, 2014).

Nine participants were identified for this case study: five high school students diagnosed with RAD and four school personnel who worked directly with them. One teacher had two students participate in this research study. Two 30- to 45-minute interviews were conducted with each of the participants. Some participants asked for a short break and were able to continue with a second-round interview in the same day. Interview questions were similar for the students and staff participants in order to make comparisons and determine themes and codes in the answers to the research questions.

Bowlby (1952) believed negative family experiences are the basic cause of emotional disturbance, as these negative experiences do not allow a child to grow up mentally healthy. Students with RAD are not mentally or emotionally healthy and therefore struggle in any type of

social situation, including in schools where their outcomes are significantly lacking. Looking at

attachment theory gives direction and foundation in how to determine effectiveness of academic

and emotional–behavioral interventions in the school setting.

Chapter II

Review of Literature

Introduction

Negative family experiences are one of the situations that can lead to mental health disorders in youth children (Corbin, 2007). The American Psychiatric Association (2000) lists multiple mental health disorders that occur in children and adults. Examples include ADHD, bipolar disorder, personality disorders, obsessive–compulsive disorder, autism spectrum disorders, fetal alcohol syndrome, posttraumatic stress disorder, attachment disorder, and according to Cleary and Abbot (2011), Costello, Copeland, and Angold (2011), Davis, Kruczek, and McIntosh (2006), and Wilson (2009), one of the most misunderstood disorders—RAD. Not many parents are prepared to manage and parent a child with a mental health disorder. Likewise, not many teachers have been trained to manage children with mental health disorders (Feuerborn & Chinn, 2012; Meister & Melnick, 2003; Merrett & Wheldall, 1993). Providing quality instruction for all students in the classroom, while managing students with externalizing mental health disorders, can be very difficult. This is cause for concern as many children with identified mental health disorders require specialized services and supports in order to access their education, to remain safe at school, and to reach their functional potential. Students who demonstrate noticeable externalizing or internalizing problem behaviors that require these considerations are often found eligible for special education services under the category of *other health impaired*, or more often, *emotional disturbance* as outlined in the Individuals With Disabilities Education Act of 2004 (Smith et al., 2011).

The Individuals with Disabilities Education Act (2004) mandated all children with a disability receive a free, appropriate public education; unfortunately, not all educators, including

administrators, know what it really means. There are many stipulations in the act, but put simply, school systems are required to provide (at no charge to the families) a quality education with services and supports that allow the child access to general education curriculum and instruction, academic progress, progress in social and functional skills, and access to typical peers to the degree appropriate. This may seem a simple-enough concept. However, the reality is often not simple at all. Due to the growing number of students who require intensive interventions, the need is outpacing the availability of resources necessary, leaving school systems unprepared and unable to provide necessary services (Hoagwood et al., 2007).

Teachers and school staff who are not adequately prepared and trained to work with students' mental health disorders are at a disadvantage. McLeod et al. (2012) shared the behavioral problems students demonstrate have a significant impact on their education. When behavior has been identified and a mental health diagnosis made, it can be predicted the student will require a great amount of time and energy from the teacher and the entire school system. As teachers have more than one student in their classroom, the amount of energy and time a child with a mental health disorder takes can cause the teachers to view the child through a negative lens (Dery et al., 2004; McLeod & Fettes, 2007). Children with attachment disorders, such as RAD, struggle to connect or to emotionally "attach" to adults in their environments due to the pathogenic care they received from their primary caregivers during infancy and early childhood (Breidenstine et al., 2011; Cornell & Hamrin, 2008; Hardy, 2007; Rutter, Kreppner, & Sonuga-Barke, 2009; Schwartz & Davis, 2006; Shaw & Paez, 2007; Zeanah & Smyke, 2009). Bretherton (1992) asserted Bowlby came to believe family experiences are the basic cause of emotional disturbance. Schore and Schore (2007) agreed relationships at the earliest stages shape the attachment processes during a person's lifespan as is asserted in attachment theory.

Teachers want students who are positive, organized, have good work skills, pay attention, and are not disruptive (McLeod et al., 2012). However, this is not typically the case with students with RAD. Their depressive symptoms, distractibility, poor memory, and disruptive behavior not only frustrate educators and other students, but they also contribute to the poor academic performance students with RAD demonstrate (Cleary & Abbot, 2011; Farley et al., 2012; McLeod et al., 2012; Rapp-Paglicci et al., 2011; Smith et al., 2011). McLeod et al. (2012) discussed the significant correlations between behavioral problems due to mental health disorders and high school grade point average. Youth with more than one mental health disorder demonstrated significantly lower academic attainment and lower overall grade point average than those youth with no mental health disorders. The more complex the mental health disorders are, the greater the impact they have on educational attainment (McLeod et al., 2012; Smith et al., 2011). Smith et al. (2011) also shared a carefully planned, yet diligently delivered, system of supports and services are required for students with significant mental health needs. RAD is considered by many (Breidenstine et al., 2011; Cline, 2008; Davis et al., 2006; Hall & Geher, 2003; Haugaard & Hazen, 2004; Wilson, 2009) to be the most significant and most misunderstood of these mental health conditions. It is difficult to manage and provide appropriate interventions in schools for a significant mental health disorder teachers do not understand. Teachers and administrators need additional training to be effective (Davis et al., 2006; O'Neill et al., 2010; Schwartz & Davis, 2006).

As there are not many specific research-based interventions or strategies for use in school systems, educators need additional research and training in this area. The prevalence of mental health disorders, including RAD, continues to rise, and school systems are ill prepared to intervene in and manage the plethora of presenting symptoms (Browne et al., 2012). This has a

profound effect on the students with and without mental health disorders, the staff, and the school system as a whole. Research-based interventions and strategies for use with mental health disorders, specifically RAD, need to be identified and implemented if schools are to provide a free, appropriate public education in the least restrictive environment (IDEA, 2004).

Development of Mental Health Disorders

There are many hypotheses about how mental health disorders are developed in children. Bad parenting, not enough discipline, bad genes, chemical imbalance, and poor role models are a few of the ideas postulated (Corbin, 2007; Floyd et al., 2008; Hall & Geher, 2003; Schwartz & Davis, 2006; Thrall, Hall, Golden, & Sheaffer, 2009). It could be any or all of these and many others as well. There are just as many ways in which children demonstrate the characteristics of their mental health disorder. Distractibility, paranoia, irritability, flightiness, emotional dysregulation, neediness, cruelty to animals and other persons, harmful behavior to self and others, and irregular moods are just a few of the symptoms children with mental health disorders can display (Cline, 2008; Floyd et al., 2008; Hall & Geher, 2003; McLeod et al., 2012; Schwartz & Davis, 2006; Shaw & Paez, 2007). Though multiple children may demonstrate one or many of these symptoms, the frequency, intensity, and duration of their specific behaviors vary greatly (Costello et al., 2011; Hall & Geher, 2003; Kemph & Voeller, 2007; McLeod et al., 2012; Meagher et al., 2009; Shaw & Paez, 2007; Termini, Golden, Lyndon, & Sheaffer, 2009). While many children are given the same mental health diagnosis or diagnoses by a licensed psychologist, psychiatrist, or other mental health professional, there is much variability. This can make understanding mental health confusing and complicated. Educators must find a way to understand mental health and be prepared to respond and support these children in order to ensure their academic and emotional–behavioral success.

Children undergo a vast amount of change from the time they are born until they reach adolescence and then adulthood. Along the way, they go through multiple developmental stages, and there are multiple developmental tasks they must attain in order to move smoothly through the remaining stages and become independent and functional adults. Bowen (2005) posited when children have difficulty in the attainment of specific tasks in all three developmental stages (infancy, early childhood, and middle childhood), the pattern is often a predictor of future assaultive and threatening behaviors in the middle school years. She also described how a failure to develop an organized, secure attachment within the first two years of life has been linked to later conduct problems. Secure attachment is necessary if positive behavior changes are to be made (Shi, 2014). The inability of children to attain specific tasks can be traced back to their early attachment experiences (Bowen, 2005; Costello et al., 2011; Termini et al., 2009). Bretherton (1992) captured the thoughts of Bowlby and Ainsworth's attachment theory when recounting early familial experiences are the basic cause of later emotional disturbances. Children who have experienced trauma or pathogenic care in early childhood are more highly predisposed for maladaptive behavior and disturbances of attachment as they get older (MacDonald et al., 2008; Zeanah, 2000). Children who have been victim of sexual abuse are at greater risk of becoming offenders in later years (Tarren-Sweeney (2008). Children raised in institutional care are particularly at risk (Levin, 2009; Zeanah, 2000). Bowen explained a high percentage of children having difficulty with task attainment in early childhood display severe emotional disturbances in the middle childhood years. These same children are at a higher risk of developing mental health, behavioral, and academic problems (Valdez et al., 2011). Thus, the cycle has begun. These early experiences can have a dramatic impact on the brain development of young children (Corbin, 2007; Spenrath et al., 2011). Schore and Schore (2007) supported this

when they discussed the development of brain neurobiology and physiology can be enhanced or hindered by early family experiences.

The brain develops very rapidly during the prenatal and early childhood years, and disruptions to this development can have lasting effects on social, emotional, educational, and biological factors (Corbin, 2007; Spenrath et al., 2011). Some children are born with a genetic predisposition making them more or less vulnerable to the effects of pathogenic care (Kemph & Voeller, 2007; Termini et al., 2009). Corbin (2007) recounted resilience is acquired though secure attachments with adults. Children who are born with a genetic predisposition ripe for vulnerability and are exposed to a traumatic, neglectful, or abusive early childhood will develop insecure attachments. Insecure attachment due to trauma, neglect, and abuse can actually alter brain development and brain chemistry (Corbin, 2007; Kemph & Voeller, 2007; O'Neill et al., 2010). Males appear to be more significantly impacted by additive genetic effects than females (Minnis et al., 2007). Chronic exposure to verbal aggression can affect the development of brain regions that impact psychiatric problems in later development (Teicher, Samson, Polcare, & McGreenery, 2006). O'Neill, Guenette, and Kitchenham (2010) described a 6 year old who experienced extreme trauma and neglect. This child could not sit for more than a few moments during circle time, yelled at teachers to get his needs met, and demonstrated unsafe behavior when he did not get what he wanted, which necessitated additional staff to ensure safety.

The corpus callosum has been shown to be smaller in young boys who have a history of abuse, which can affect hemispheric lateralization (Corbin, 2007). This inability of the right side of the brain and the left side of the brain to communicate properly can complicate emotional regulation, meaning-making relationships, and memory, which all affect school performance (Corbin, 2007). Early trauma and other environmental stressors that cause insecure attachments

in early childhood also cause dysfunction in the hypothalamic-pituitary-adrenal axis due to increased cortisol levels. If this elevation of the hypothalamic-pituitary-adrenal axis is sustained for a long period of time, it can cause hypercortisolism, which can lead to emotional illness in later life (Corbin, 2007). Corbin went on to say exposure to stress hormones, like cortisol, can actually change the shape of the neurons in the hippocampus, possibly killing them. Kemph and Voeller (2007) informed readers serotonin increases the hippocampus's glucocorticoid receptor expression, which is involved in synaptic activation, long-term potentiation, and cell proliferation in many brain regions, including the hippocampus. Serotonin has been shown to be related to mood, social anxiety, and obsessive–compulsive behaviors. Children who exhibit irregular moods, anxiety, and obsessive–compulsive behaviors in the school system have difficulty forming relationships, attempting and completing tasks deemed to be difficult, and demonstrating academic growth at the rate of typical peers (Kemph & Voeller, 2007; McLeod et al., 2012). When adding the impact of psychoactive drugs, a deeper negative impact occurs in the child's mental health as well as brain development (Spenrath et al., 2011).

In their qualitative, multicase case study, Kemph and Voeller (2007) shared results of a longitudinal study on the impact of early deprivation on brain development. They posited long-term social deprivation is associated with delays in cognitive development and later psychopathology (Kemph & Voeller, 2007). Kemph and Voeller (2007) described how intrauterine or perinatal encephalopathic factors are likely to increase the negative impact on brain development. These factors include maternal illness, exposure to drugs or other toxins, hypoxia, prematurity, and malnutrition. Research has also indicated exposure to psychoactive drugs in utero during early stages in rats has led to altered development of prefrontal cortexes and behaviors related to executive functioning (Spenrath et al., 2011). Spenrath, Clarke, and

Kutcher (2011) suggested later exposure to psychoactive drugs, as well as other environmental stimuli, can inhibit or enhance brain development, resulting in improved or suppressed emotional, social, and behavioral functioning, all of which impact the child's ability to be successful in school. Many of these drugs have not been tested for long-term effects and have been shown to have a negative influence on overall brain development and functioning, causing mental illness. Once mental illness is coded into the human gene, it becomes a hereditary issue and can affect offspring who otherwise may not have experienced some of the negative experiences of their parents (Corbin, 2007). A disproportionate number of boys are identified with externalizing problem behaviors than girls (Meagher et al., 2009). Though understanding and working with children with difficult behaviors can be trying at times due to lack of cooperation or lack of good developmental records, society is doing a better job of identifying children with mental health disorders and intervening so children are able to grow up academically successful and prepared to be functional adults.

Prevalence of Major Mental Health Disorders in School-Aged Children

When looking at and considering the mental health field, it can be difficult to recognize the number of people affected by mental health disorders. There are a multitude of risk factors and stressors that can increase the prevalence of mental health disorders (Browne et al., 2012). Approximately 12% of American children have a mental health disorder (Cleary & Abbot, 2011; Davis et al., 2006; Farley et al., 2012). However, of this 12%, a mere 20% receive treatment. McLeod and Fettes (2007) added 30%–60% of people with a mental health disorder in childhood will still meet the criteria in late adolescence or adulthood. Eighty percent of maltreated children develop disorganized attachment (Zilberstein & Messer, 2010). Significant RAD symptoms are seen in 35%-45% of children in the foster care system (Shi, 2014). Drug or alcohol dependency,

anxiety disorders, depression, conduct disorder, oppositional defiant disorder, ADHD, bipolar

disorder, eating disorders, panic disorder, psychotic disorders, and posttraumatic stress disorder

are some of the mental health disorders Costello et al. (2011) found in their study. Children with

mental health disorders not identified and treated appropriately have a significant chance of

developing problems like drug and alcohol dependency and are at a greater risk of dropping out

of school (Cleary & Abbot, 2011; Dery et al., 2004; Hanley, 2003; McLeod et al., 2012;

Padykula & Conklin, 2010; Smith et al., 2011; Strayhorn, 2002). This is particularly true in

males. Externalizing problems as a result of mental health disorders is seen more often in boys

than girls. Young boys are generally more active than girls and are reported for office discipline

in the school systems at a significantly higher rate than girls (Costello et al., 2011; Meagher et

al., 2009).

Dery, Toupin, Pauze, and Verlaan (2004) conducted a quantitative study to look at the

frequency of mental health disorders in elementary school students receiving educational

supports and services for behavioral difficulties. They reported that in a Quebec elementary

school between 1985 and 2000, behavioral difficulties more than tripled. Internalizing problems

are identified in girls more often than boys but are still under identified as a whole. Children,

typically female, sufferings with internalizing problems do not call attention to themselves like

overly rambunctious boys do. Externalizing problems in early childhood, like those present in

children with mental health disorders, including RAD, are associated with the development of

oppositional defiant disorder, conduct disorders, and academic failure (Arnold & Doctoroff,

2003; Meagher et al., 2009).

This phenomenon of one disorder predicting another disorder over time is referred to as

heterotypic prediction (Costello et al., 2011). One example includes past depression predicting a

future anxiety disorder. According to Valdez, Lambert, and Ialongo (2011), first graders who reported depressive symptoms predicted academic and mental health problems in later elementary school. Early disorganized attachment is associated with later posttraumatic stress disorder (Lyon, Coffey, & Silva, 2008; MacDonald et al., 2008). There is an even stronger correlation in homotypic prediction, in which a disorder now predicts the same disorder will be present later (Costello et al., 2011; McLeod & Fettes, 2007). Current depression predicts future depression, and so on. Costello et al. (2011) shared concurrent comorbidity is not always taken into account. A focus may be put on a specific disorder, such as conduct disorder or oppositional defiant disorder, and the comorbid disorder of ADHD or anxiety disorder is forgotten. This is a disservice to children and adults. If the whole child is not given treatment and intervention for the gamut of issues they have, academic, social, and behavioral success is limited (Cleary & Abbot, 2011; Dery et al., 2004; Farley et al., 2012; Smith et al., 2011). Likewise, if educators do not know the whole story, they tend to treat the label a child has and not the specific symptoms they display, which is the root of the problem.

This is especially true in the public school setting where there is a lack of training in mental health disorders (Feuerborn & Chinn, 2012; Meister & Melnick, 2003; Merrett & Wheldall, 1993). It is difficult to intervene with something not understood. Children with multiple mental health diagnoses are very difficult to treat or intervene with due to the complex array of behaviors they display at any given time (Cleary & Abbot, 2011; Farley et al., 2012; Smith et al., 2011). Shaw and Paez (2007) gave examples of children with diagnoses of disturbed attachment or RAD as having a previous diagnosis of ADHD, mental retardation, anxiety disorder, posttraumatic stress disorder, and depression, to name a few. Socioeconomic status

level and poverty can also be comorbid factors many people do not think about, but can have a dramatic impact on mental health and functioning (Floyd et al., 2008; Horner, 2008).

Additional studies have discussed the comorbidity and misdiagnosis among ADHD, autism spectrum disorder, and fetal alcohol syndrome, fetal alcohol effect (Boris et al., 2005; Chaffin et al., 2006; Minnis et al., 2006). All of these disorders have dysfunction in the frontal lobe as a central characteristic, which can explain the misdiagnosing or comorbid diagnosis. Mood disorders, bipolar disorder, pervasive developmental disorder, posttraumatic stress disorder, and ADHD have also shown to be comorbid with attachment disorders and RAD in children with traumatic experiences and severe maltreatment (Boris, 2005; Horner, 2008; Kemph & Voeller, 2007; Minnis et al., 2006; Minnis et al., 2009; Shaw, 2007; Sheperis et al., 2003; Zilberstein & Messer, 2010).

Attachment Disorders Related to K–12 Education

Attachment disorders are disorders in the ability of a young child to emotionally attach to caregivers (Boris et al., 2005). In order for infants to develop a sense of self as valuable, the caregiver must have reliably acknowledged and attended to their need for comfort and protection (Bretherton, 1992). If this does not occur, social–emotional development may be inhibited. Boris told readers there are stages in the development of attachment, including 2–7 months of age where children are motivated to interact with a variety of persons, 7–9 months of age where they show reticence around unfamiliar adults and protest to the primary attachment figure, and 12 months of age where they discriminate attachment figures. There are multiple reasons children do not attach to their primary caregivers. Early childhood physical and sexual abuse, neglect, emotional disengagement from the caregiver, removal from the primary caregiver due to death, and the witnessing of domestic violence are all reasons children do not form secure attachments

to their caregivers (Becker-Weidman, 2006; Bretherton, 1992; Cline, 2008; Connors, 2011; Corbin, 2007; Follan & Minnis, 2010; Hardy, 2007; Minnis et al., 2009; O'Neill et al., 2010; Schore & Schore, 2007; Wilson, 2009; Wimmer, Vonk, & Bordnick, 2009). Infants and children must develop a secure dependence with parents before they are able to do so in new environments (Bretherton, 1992).

There are three major types of attachment disturbances: nonattached, disordered, and disrupted (Wilson, 2001). Children who are nonattached show non-preferred attachment to anyone (Wilson, 2001). Those who have a disordered attachment pattern do not use their caregiver for security (Wilson, 2001). Disrupted attachment occurs due to grief when the primary caregiver is lost (Wilson, 2001). If one looks at children diagnosed with an attachment disorder, it is evident there is very different symptomology within each of them. Ainsworth's (1979) work took eight identified attachment behaviors and narrowed them down into four main groups: securely attached, insecure–avoidant, insecure–ambivalent, and insecure–disorganized. Haugaard and Hazen (2004) identified three attachment patterns—secure, anxious or resistant, and avoidant attachment—and posited the latter two are connected with RAD. In their meta-analyses, Boris et al. (2005), Hardy (2007), and Wilson (2001) all discussed four distinct attachment styles: secure, avoidant, resistant–ambivalent, and disorganized–disorientated. The latter three become problematic for children as they grow and develop. These children appear to reject the attempts of others to make emotional connections, alternately seek out and then reject the comfort of the primary caregiver, seek out an unfamiliar adult for comfort, or seek out and simultaneously reject the caregiver due to maltreatment, neglect, or abuse (Boris et al., 2005; Hardy, 2007; Wilson, 2001). Through their meta-analysis, Boris et al. (2005) evaluated current literature and practice regarding assessment and clinical treatment of children with RAD. They

looked at the various developmental stages children go through and how and when disruption to attachment in those stages can affect children long term, especially if the children have disinhibited attachment (Boris et al., 2005). Boris et al. (2005) also gave suggestions for clinical treatment, some of which could be generalized to the school setting with slight modifications. Rebuilding the broken attachment patterns within these students is the key (Boris et al., 2005), not just teaching behavior management (Hardy, 2007).

In his meta-analysis of children with RAD, Wilson (2001) studied the infant–caregiver relationship. He posited RAD is one of the most severe forms of infant psychopathology in terms of attachment. The greatest risk to psychopathology is disorganized attachment (Boris et al., 2005; Breidenstine et al., 2011; Zilberstein & Messer, 2010). Children with insecure attachment patterns or styles (subtypes of disorganized attachment) are preoccupied with personal safety, and they appear more anxious in the caregiver's presence (Wilson, 2009). O'Connor, Bredenkamp, and Rutter (1999) posited children with an attachment disorder have a higher risk of developing interpersonal relationship problems with peers and adults than do typical peers (Becker-Weidman, 2006; Cline, 2008; Corbin, 2007; Follan & Minnis, 2010; Hardy, 2007; Minnis et al., 2009; O'Neill et al., 2010; Wilson, 2009; Wimmer et al., 2009). Social isolation can be detrimental to the development of friendships and to academic progress. Lack of affection, promiscuous affection, noncompliance or overcompliance, and inhibited or excessive exploration without checking in with the caregiver are some of the other behaviors seen in children with attachment disorders (Tobin, Wardi-Zonna, & Yezzi-Shareef, 2007). It is not uncommon to see extremes in behavior between children with attachment disorders and within each child with an attachment disorder, as the environment plays such a dramatic role in

attachment outcomes. There appears to be an association between the duration of childhood deprivation and the severity of the attachment disorder (O'Conner et al., 1999).

Parent or caregiver abuse of drugs and alcohol, depression or other mental health illness of the parent or caregiver, and extreme stressors such as poverty, can also cause an insecure attachment pattern (Breidenstine et al., 2011; Shaw & Paez, 2007). Breidenstine, Bailey, Zeanah, and Larrieu (2011) pointed out when a parent or caregiver has his or her own previous trauma, the child can actually serve as a trigger, which causes the caregiver to act in a frightening manner due to reliving his or her own trauma. It is important to note even though research has provided overwhelming documentation the problems with attachments are primarily due to parental abuse or neglect, there are a few instances where the inability of parents to form an attachment with their child is not directly correlated to parental choices. Attachment is a two-way reciprocal relationship. It is more difficult for parents to create an attachment with children who are irritable, chronically ill, or have a developmental disability as they may not reciprocate the relational attempts by the parent. The result may be an insecure attachment between parent and child.

Insecure attachment patterns continue to represent the risk of troubled relationships, mood disorders, and psychopathology (Wilson, 2009). When the frequency, intensity, and duration of maladaptive behaviors reach a point where they severely impair functioning across multiple settings, a child may meet the criteria for RAD (Horner, 2008). RAD is one of the most misunderstood disorders and is the most difficult to work with in school and community settings (Breidenstine et al., 2011; Cline, 2008; Davis et al., 2006; Hall & Geher, 2003; Wilson, 2009). The most severe mental health diagnosis specific to attachment is RAD (Wilson, 2001, 2009).

RAD in the K–12 Educational Environment

RAD is an uncommon mental health disorder that is important for educators to learn about and understand due to the profound impact not only on the student with RAD but also on the school system as a whole (Sheperis et al., 2003). Assessment, intervention, and education of children who have begun their lives with compromised or disrupted attachment are difficult (Chaffin et al., 2006; Pritchett, Pritchett, Marshall, Davidson, & Minnis, 2013). It is difficult to provide effective intervention for a mental health disorder not widely understood. RAD not only affects the student identified with RAD but also the other students in the classroom and building, the teaching staff and administrator, and, in some cases, law enforcement.

The DSM-IV-TR (American Psychiatric Association, 2000) defined RAD as a "markedly disturbed and developmentally inappropriate social relatedness in most contexts beginning before age 5 and is associated with grossly pathogenic care" (p. 127). This does not include a developmental disability or pervasive developmental disorder. Pathogenic care is characterized by a (a) persistent disregard for the child's emotional need for comfort, stimulation, and affection; (b) persistent disregard for the child's physical needs; and (c) repeated changes of primary caregivers (American Psychiatric Association, 2000). The mitigating factor in the difference between an attachment disorder and RAD is the presence of grossly pathogenic care. Shaw and Paez (2009) asserted a diagnosis of RAD is a specific condemnation of the caregivers, be it biological parents, foster parents, or both. Despite the significant impact children diagnosed with RAD have on the home, school, and community settings, it remains an underresearched clinical category in which prevalence rates are unknown (Buckner et al., 2008; Minnis et al., 2006). Sheperis et al. (2003) cautioned readers there is no single comprehensive tool for the diagnosis of RAD. They shared four key components that should be part of any diagnosis of

RAD: (a) differentiating cognitive and lingual aspects of RAD from other developmental disorders, (b) noting specific behaviors even if they overlap with other disorders, (c) ensuring assumed origin relates to symptomology, and (d) carefully considering all of these criteria (Sheperis et al., 2003). Children diagnosed with RAD have significantly more issues with academic, behavioral, and social issues than do typical peers (Buckner et al., 2008).

Children with RAD demonstrate destruction of property in the home, community, and school; gorging or hoarding food; lying; cruelty to animals, school peers, and other persons; fire setting; poor impulse control; obsession with blood and death; and inappropriate sexual behavior with self and other children (Hall & Geher, 2003). Children with a diagnosis of RAD have typically been removed from the direct care of biological parents, as they are the contributing factor to the diagnosis (Hardy, 2007). These children are placed in institutions, foster care, or occasionally with extended family members. Placement in institutional care presents challenges and can contribute to the development of additional negative behaviors.

In the DSM-IV, RAD is divided into two subcategories: inhibited and disinhibited (Boris et al., 2005; Buckner et al., 2008; Haugaard & Hazen, 2004 Zeanah, 2000). Schwartz and Davis (2006) described the inhibited subtype as a child with a persistent and pervasive failure to initiate and respond to social interactions. Children with inhibited RAD are also hypervigilant and highly ambivalent across social interactions (Wilson, 2009). The disinhibited subtype refers to children who are not selective in their attachment choices and are seen as controlling or punishing (Schwartz & Davis, 2006; Wilson, 2009). The inhibited type of RAD develops when caregivers do not give the emotional support and comfort the child needs, which is typical with neglect situations. In some situations, children can exhibit both subtypes of RAD (Horner, 2008). Four of the five student participants in this study were diagnosed with the DSM-IV. Only one student

participant had been diagnosed under the DSM-V, which was implemented July 1, 2014. The

researcher primarily utilized the DSM-IV criterion for this study as it was the criterion by which

students were diagnosed at the time the research began. In the DSM-V, the disinhibited subtype

of RAD from the DSM-IV is separated out into its own diagnostic category, leaving the inhibited

subtype as the sole criterion. For the remainder of the research document the researcher will refer

to the DSM and not delineate a version.

In school settings, these children can demonstrate social isolation, difficulty making

friends and difficulty with group learning. Children who expect to be rejected will avoid social

situations as a defense mechanism. These children have a greater possibility of recovery than do

children with the disinhibited subtype (Breidenstine et al., 2011).

Children with RAD are typically survivors. In Hall and Geher's 2003 study, they found

the frequency and intensity of violence, detrimental behavior, and personality difficulties were

more significant in children identified with RAD, as opposed to those not identified with RAD.

The children also had less empathy. It is difficult to care for others' well-being when living in a

state of fear. Tobin, Wardi-Zonna, and Yezzi-Shareef (2007) used interviews to help understand

the thinking process of children with RAD by asking them to recall past experiences.

Interviewers asked participants to recall three of their best memories and were probed to elicit as

much detail as they could remember. Their recollection results demonstrated 18 out of 25 felt

alone, alienated, or in trouble; 21 out of 25 felt others were absent or had abandoned them or

were hostile or punishing; and 28 out of 32 recollections revealed believing events in their life

were unfair, frustrating or confusing, and scary or overwhelming. Insight like this helps develop

an understanding of the social and emotional needs of children with RAD. Children with RAD

learn quickly what they need to do in order to stay safe in their environment and survive. This can lead to an altered sense of reality.

Balbernie (2010) believed the disinhibited subtype of RAD is actually a functional adaptation, not a mental health issue. Balbernie referred to evolutionary adaptedness when recounting life millions of years ago. She posited the behavior seen today and labeled disinhibited RAD is actually a survival skill learned to adapt to situations where caregivers are often not available. Balbernie did not take into account the descriptor of grossly pathogenic care when making her assertions. Some symptoms typically associated with RAD can also occur in other disorders, including ADHD (Minnis et al., 2006). Minnis, Marwick, Arthur, and McLaughlin (2006) posited there is a clear distinction between RAD, obsessive–compulsive disorder, and ADHD.

Though there are a few dissenting opinions, like those of Balbernie, the majority of research has supported a differential diagnosis of RAD from other mental health disorders (Hinshaw-Fuseiler, Boris, & Zeanah, 1999; Minnis et al., 2007; Mukaddes, Bilge, Alyanak, & Kora, 2000). Minnis et al. (2009), in their quantitative study, looked at the criteria for RAD in both the DSM and International Classification of Diseases—10th Edition. They asserted, "Our findings reinforce the conclusions from other literature RAD is a phenomenon different in kind from attachment specific behaviors" (p. 939). Kay and Green (2013) concluded although one study found children with RAD demonstrated greater impairment with pragmatic language skills than children with autism, students with RAD have marked social impairments that make it a distinct diagnosis. Phelps, Eisert, Schulz, and Augustyn (2012) postulated manipulation and compulsive lying are characteristics seen in children with RAD, not with autism. Breidenstine et al. (2011) concurred RAD is a phenomenon different from other attachment specific disorders.

Children with RAD enter school with more social, emotional, behavioral, and academic challenges than do typical peers (Schwartz & Davis, 2006). Davis et al. (2006) shared there is not much written about providing specific school-based interventions for students with psychopathology like RAD. As the root of RAD is trauma due to pathogenic care, teachers, administrators, and other school staff must gain knowledge and skills to work with students with these intensive needs (Davis et al., 2006; O'Neill et al., 2010; Schwartz & Davis, 2006). As school personnel currently do not possess these skills (Browne et al., 2012), educators must continue to ask the question: What are we going to do to help support and ameliorate the effect of children's RAD symptoms in our school and community settings?

Community-Based Interventions for Students With RAD

Children with RAD are generally untrusting of their environments and the persons in their environments (Becker-Weidman, 2006; Davis et al., 2006; Floyd et al., 2008; Wilson, 2009). Bretherton (1992) and Connors (2011) posited attachment theory explains the long-term negative effects on children with early experiences of neglect and abuse as occurs in children with a diagnosis of RAD. The environment or persons and events in their environment, specifically the behaviors of primary caregivers (neglect, abuse, and traumatic experiences), lead to their mental health issues. Most children with RAD have been removed from the homes of their biological parents due to this maltreatment (Becker-Weidman, 2006; Hall & Geher, 2003; Hardy, 2007; Smyke et al., 2012). Placement in institutions or foster care is typically the first response by the Department of Health and Welfare when severe maltreatment is proven. As traumatic as this separation is, the younger the children are when they begin receiving appropriate intervention, the more likely their success will be (Bowen, 2005; Kemph & Voeller,

2007; McLeod & Fettes, 2007; O'Neill et al., 2010; Spenrath et al., 2011). Some of the most widely recognized community-based interventions are attachment-based therapies.

Currently, there are no empirically supported treatments for RAD (Buckner et al., 2008; Wilson, 2009). However, therapies focusing on environmental stability, caregiver patience, consistency, sensitivity, and understanding of the child's medical and developmental needs can assist in promoting attachment in the new family unit.

Wimmer, Vonk, and Bordnick (2009) conducted a study that focused on the effectiveness of attachment therapy for children diagnosed with RAD and who had been adopted. Children in this study received a minimum of 10 hours of attachment therapy, which consisted of family-focused counseling, the child understanding his or her own history, and intensive holding (Wimmer, et al, 2009).

Using the Randolph Attachment Disorder Questionnaire and the Child and Adolescent Functional Assessment Scale, Wimmer et al. (2009) demonstrated the success of their intervention. The Randolph Attachment Disorder Questionnaire mean scores dropped from the moderate range (76–89) to the subclinical range (under 65). On the Child and Adolescent Functional Assessment Scale, means scores dropped by 30 points, from marked impairment (over 90) to the moderate range (50–90). A decrease of 20 points indicates a marked improvement (Wimmer et al., 2009).

It is important to note the "holding" portion of the therapy was administered by the parent in most instances and was conducted at the request and consent of the parent and child. An across-the-lap cradling was the technique used, and the child was never in pain or had any physical discomfort. It was solely a technique to promote nurturing from the parent. Buckner, Lopez, Dunkel, and Joiner (2008) and Shaw and Paez (2007) cautioned parents to avoid

"experts" who implement bizarre techniques like past-life regression therapy and rebirthing, which can restrict a child's movements. Wilson (2009) added being cautious of any therapies using coercion or fear or intentionally causing any type of emotional distress. Instead, he, like Wimmer et al. (2009), suggested therapies promoting attachment of child to parent and building trust through time.

Circle of Security is a 20-week, group-based intervention to help parents recognize their own responsiveness through videotaping. Parent–child interaction therapy uses in-vivo coaching in the span of 12–14 parent–child sessions, where the parent is observed through a mirror and wears an earpiece to receive cues from the therapist (Soulounias-Arriaga, 2007). Both therapies have shown increased attachment between child and parent. Dyadic developmental psychotherapy also has been shown to improve this attachment relationship (Horner, 2008).

Dyadic developmental psychotherapy was used by Becker-Weidman (2006) in an 11-month study with children in the foster care and adoption system in Williamsville, New York. These children all had histories of significant physical and sexual abuse and physical and psychological neglect, and had previously been in institutional or orphanage care. This therapy focused on attuning the relationship between the therapist and the child, the child and the foster–adoptive parent, and the foster–adoptive parent and the therapist. The Child Behavior Checklist and the Randolph Attachment Disorder Questionnaire were used to assess the effectiveness of dyadic developmental psychotherapy. Scores for both the treatment and control groups were in the clinically significant range before the psychotherapy began. At the conclusion of the treatment, the only score that did not show a significant difference between the treatment and control group was the *anxious–depressed* scale of the Child Behavior Checklist (Becker-Weidman, 2006). If caregivers learn to interpret the meaning behind their children's behaviors,

they are better able to assist their children in developing adaptive relational patterns (Hardy, 2007).

Browne et al. (2012) believed if parents or caregivers learn to manage their own relationships, it will improve the child's social, emotional, and behavioral development, which will allow the child to better handle the demands of school. Corbin (2007) stated, "Psychotherapy changes the brain by forming new neural connections through the concurrent process of attachment and new learning" (p. 546). Behavior management training for parents provides psychoeducation about behavior and skills parents can use to improve behaviors at home and at school (Buckner et al., 2008). This can be effective but is difficult at times, as not all children diagnosed with RAD live with their biological parents (Becker-Weidman, 2006; Hall & Geher, 2003; Hardy, 2007; Smyke et al., 2012).

In fact, the majority of children diagnosed with RAD have been removed from the care of their biological parents due to the neglect or abuse they suffered. Unfortunately, sometimes these children are placed into institutional care in order to receive the intensive mental health and behavioral treatment they require. In the cases where this isn't necessary, children are placed into the foster care system (Becker-Weidman, 2006; Hall & Geher, 2003; Hardy, 2007; Smyke et al., 2012).

The Bucharest Early Intervention Project took 56 foster homes and gave them specific training and continued supports in order to help ameliorate the effects of the foster children's attachment disorders due to previous home and institutional care (Smyke et al., 2012). The Disturbances of Attachment Interview demonstrated there was a significant decrease in the inhibited type of RAD, and in most cases it was eliminated completely. Children in the foster care group also showed fewer signs of disinhibited RAD than the control group, but it was not

eliminated completely. In summary, Smyke et al. (2012) concluded placement in a long-term, child-centered foster home was beneficial to children and helped reduce signs of impairing disorders like RAD (Smyke et al., 2012).

Being able to live in a stable, safe, and supportive environment for a significant length of time is the most effective strategy for children with RAD (Shaw & Paez, 2007). Most researchers have agreed community interventions for RAD should focus on attachment-based therapies, which work to build secure attachments between the child and caregiver. Boris et al. (2005) presented nine recommendations for assessment and treatment of RAD, which include

- having multiple observations of child with caregiver and gaining a history of the child's attachment behavior with the caregiver,

- using structured observational data so it is comparable across relationships,

- reporting suspicion of unreported maltreatment,

- referring to developmental therapy, speech and language therapy, or for medical screening if necessary,

- providing child with emotionally available attachment figure,

- assessing caregiver attitude and perceptions of the child,

- focusing on creating positive interactions with caregivers,

- referring to additional treatment for aggressive and oppositional behavior, and

- avoiding treatment practices that carry a serious threat of harm or death (pp. 1213–1217).

These may seem to be common sense when working with children with attachment issues; however, not all treatment options are so readily agreed upon for the treatment of RAD.

There is much controversy about the use of medication for children with RAD. While psychotropic medications can reduce anxiety, depression, and emotional regulation symptoms, it is important to remember these medications are not a cure (Shaw & Paez, 2007). Shaw and Paez shared psychotropic medications and traditional counseling have little effect for children with RAD. In a residential treatment program, most children with RAD did significantly better with lower doses or being completely void of the psychotropic medications prescribed to them previously (Levin, 2009). This is not always the finding. Kemph and Voeller (2007) discussed once a pattern of behavior has been established, it is difficult to change, even with intervention. Pharmacological and behavioral interventions together are a rational approach (DuPaul & Weyandt, 2006; Hanley, 2003; Kemph & Voeller, 2007). This is possible to control in the residential and community setting but is a struggle in the public school setting where medication management is outside their locus of control.

School-Based Interventions for Students with RAD

"RAD is one of the least researched and most poorly understood disorders is the DSM" (Chaffin et al. 2006). Davis et al. (2006) shared there is not much written about providing school-based interventions for children with psychopathology like RAD. Buckner et al. (2008) specified there had been little work done to examine treatments for the disinhibited subtype of RAD. Schwartz and Davis (2006) discussed children with RAD entering the school system come with more social, emotional, behavioral, and academic challenges than do typical peers. These challenges often make it difficult for them to make and keep friends and develop relationships with teachers. Hanley (2003) asserted school systems must develop a 3-step approach focusing on prevention and intervention, including (a) building a school-wide foundation, (b) promoting early intervention, and (c) providing intensive interventions. As schools provide more services

for more students with RAD and other disabilities, it is imperative teachers, counselors, and other school staff understand trauma and the intense impact it has on children (Davis et al., 2006; O'Neill et al., 2010; Overstreet & Mathews, 2011; Schwartz & Davis, 2006).

O'Neill et al. (2010) posited in their meta-analysis students entering school with a history of extreme and chronic trauma must develop a trusting relationship with a caring person in the educational environment if academic progress is to be made. They went on to assert traumatized children have an extremely difficult time modulating their emotions, and school personnel must develop an understanding of this fact and learn how to support these students. O'Neill et al. (2010) even suggested direct training regarding the consequences of childhood trauma and the attachment disruption it causes as a way to support traumatized students. Davis et al. (2006) concurred and added staff members working with students with RAD need knowledge of the brain–behavior relationship and the effect of psychotropic medications. Cleary and Abbot (2011) added by identifying brain-related patterns, teachers can identify why students struggle and can, therefore, choose suitable interventions. School staff, especially teachers, also need to know and understand traumatized children simply cannot regulate their own emotional arousal like typical peers can. Students with RAD typically resort to the fight/flight/freeze reaction (O'Neill et al., 2010). It is difficult for them to control their behavior when they cannot control their emotional state.

Schwartz and Davis (2006) cautioned teachers and staff members to know their own limitations as well, both emotionally and physically. Working with children with RAD is rewarding but very emotionally, mentally, and sometimes physically draining. The teacher–student relationship is tied to the parent–child relationship where the student–child is looking to the person who should be the most stable, nurturing, and supportive in his or her educational

environment to keep them safe and to ensure their needs are met. This can be very draining on a teacher with a classroom of 30 other students. School systems must develop effective supports for students to allow them to function and be successful in the school environment. Overstreet and Mathews (2011) asserted referrals to school-based mental health services have been more successful than referrals to community-based services.

A few strategies and interventions come to the forefront when looking at solid intervention. An overarching consideration is the response-to-intervention (RTI) model. The RTI model allows school systems to focus on academic and behavioral interventions by providing a multitiered approach to interventions for students (Smith et al., 2011). The multitier approach allows for varying levels of service intensity dependent on the specific needs of the student (Hoagwood et al., 2007). A caution is RTI is a system-wide model for intervention, not a model for individual students. While a child is within the RTI system in the school environment, it is beneficial to have a designated case manager to monitor the interventions and the collection of data to determine future needs (Browne et al., 2012).

Browne et al. (2012) postulated by providing a case manager, school systems can ensure appropriate, specially designed instruction and other supports are provided so problems do not escalate as time passes. Browne et al. (2012) also shared there is a growing body of research demonstrating the value of the case manager sharing effective school-based interventions beyond the school setting, allowing families and other service providers the opportunity to implement similar strategies and interventions in other settings. As previously stated, case managers help ensure the appropriate interventions are implemented and implemented with fidelity to prevent problems, such as aggressive behavior, disruption to the learning environment, and unsafe

behaviors, from occurring (Browne et al., 2012). Cognitive behavior therapy is one option often explored.

A school counselor, social worker, or school psychologist may work in small groups or individually with students to help children live a life less affected by their trauma (O'Neill et al., 2010). Therapy may focus on skills to (a) repair relationships, (b) build trust, (c) improve emotional and behavioral self-regulation, (d) recognize thinking errors, (e) promote self-advocacy, (f) identify triggers in the school environment, (g) identify replacement behaviors, and (h) increase social skills, among many others. Additionally, school social workers are in a position to help ensure multiagency collaboration and supports to give the child the best chance of success.

Applied behavior analysis is another intervention with a research basis. Harvey, Luiselli, and Wong (2009) shared the therapeutic outcomes associated with an applied behavior analysis could contribute to positive school-based outcomes of students with mental health disorders. The analysis works by focusing on specific observable behavior. Behavior is observed to determine the relationship between the behavior itself and the environmental stimuli or trigger. Part of the process of applied behavior analysis can include a functional behavioral assessment and functional analysis (Harvey, Luiselli, & Wong, 2009). Functional behavioral assessments use questionnaires, interviews, observations, checklists, and other data to determine antecedents, setting events, the specific and identifiable behavior, and the consequence for the behavior. All of this information is analyzed to determine what the function of the behavior is. In other words, why does the student exhibit this specific behavior? What do they get from it? What do they need? What would an appropriate replacement behavior be?

Harvey et al. (2009) cautioned readers to thoroughly investigate the function of the behavior before trying to extinguish it. There may be a reason students display certain behaviors. After all, children use behavior as a way to communicate an unmet need. The Alaska Staff Development Network (2015) offers a distance learning opportunity that focuses on the language of behavior. Once the function of the behavior is determined, the case manager and other school personnel can implement other interventions, such as peer-assisted learning, self-regulation, and self-management.

Peer-assisted learning has shown to improve academic achievement and behavior of students with mental health disorders (Farley et al., 2012). Teachers use mixed-ability groups to support students through the process of learning. Depending on the assignment or task, all students get to experience being both the learner and the teacher. As most students with mental health disorders are behind academically as well as socially, this gives them the opportunity to observe both good academic skills and behavioral models, as well as the opportunity to share their knowledge and experience, building confidence in themselves. Farley, Torres, Wailehua, and Cook (2012) delineated a 10-step process for setting up class-wide peer tutoring and divulged it is the most researched and effective peer-tutoring model. Peer tutoring can be a good step in the direction of teaching students' self-management or self-regulation.

Self-management and self-regulation are, in essence, the same strategy. They are interventions based on the students monitoring and recording their own behavior (Farley et al., 2012; Rapp-Paglicci et al., 2011; Reid et al., 2005). Students with attachment disorders have basic deficits in the areas of self-regulation and self-management (Zilberstein & Messer, 2010). Farley et al. (2012) discussed five different types of self-management—(a) self-monitoring, (b) self-evaluation, (c) self-instruction, (d) goal setting, and (e) strategy instruction—and stated self-

monitoring is the simplest to implement. Hayes (1997) and Rapp-Paglicci, Stewart, and Rowe (2011) stated students with good self-regulation skills have higher adaptive functioning than those with less proficient self-regulation skills. Rapp-Paglicci et al. (2011) went on to say their research had found a positive link between self-management skills and academic achievement. Students with good self-management and self-regulation skills are able to block out distracters and triggers, maintain focus, and emotionally regulate themselves, which lead to better school performance (Rapp-Paglicci et al., 2011). Solar and Mason (2013) asserted that mindfulness-based stress reduction could help empower students to control their own behavior and could be used as an extension of other self-management interventions.

Goodwyn, Hatton, Vannest, and Ganz (2013) offered video modeling and video feedback as options for student self-reflection and self-management. In video modeling, a target behavior is modeled by a student or adult. After watching the video of the target behavior, the student then practices the same skills. Goodwyn et al. (2013) hypothesized video monitoring is more efficient than video modeing. Video monitoring consists of selecting a target behavior and video recording the student in a natural environment where the target behavior is likely to occur. The student then watches the video and records data based on whether he or she observed the target behavior or not. This type of intervention may be preferable as it does not interrupt ongoing tasks. Video monitoring can be utilized with academic, social, or emotional–behavioral skills.

Effective treatment must focus on behavior, academics, and school functionality (Bruhn & Watt, 2012; Cook, Collins, Restori, & Delport, 2012). DuPaul & Weyandt, 2006). DuPaul and Weyandt shared four principles school personnel must use with students diagnosed with ADHD. These four principles could also be implemented with any child with mental health disabilities, including RAD. These four principles include (a) using a balanced approach of practice and

reactive practices, (b) involving multiple change agents, (c) driving instruction with data, and (d) evaluating and modifying intervention based on data (DuPaul & Weyandt, 2006).

Ryan, Pierce, and Mooney (2008) outlined effective evidence-based practice for schools settings. They identified cross-age tutoring, peer modeling, and peer tutoring as peer-mediated interventions with an effect size of 1.85 in both elementary and secondary school students. Self-mediated interventions with an effect size of 1.8 with both elementary and secondary school student included self-monitoring and strategy instruction. Ryan et al. (2008) also identified modeling, rehearsal, feedback, and life space interviewing as having a 1.31 effective rate with elementary and secondary students under teacher-mediated, antecedent-focused interventions.

As a result of Delaney's (2009) work in a child and adolescent psychiatric unit, she asserted there are five specific behaviors that result in reduced reactive aggression. These five staff behaviors are (a) empathically attuning, (b) maintaining positive tone, (c) decreasing perception of threat and increasing the level of control children have, (d) being predictable and, (e) setting expectations that consider a child's abilities and limits (Delany, 2009, Figure 1, p. 213). While these five behaviors were discussed in the context of a psychiatric unit, these five behaviors can and should also be implemented in public school settings to help reduce the reactive aggression of students with RAD (Hansen & Spratt, 2000). Helping students redirect attention from situations causing anxiety or frustration in an empathic manner by using a positive tone, ensuring the student does not feel physically or emotionally threatened, and providing clear and consistent expectations the student is capable of achieving are a few strategies who effective. Haugaard and Hazen (2004) posited the goal of intervention for students diagnosed with RAD should be to provide an emotionally safe environment, so the students are willing to be guided and corrected in regard to their social skills.

Above all, educators need to ensure children feel safe and supported while in schools. Safety does not refer singularly to physical safety, though it is definitely important. Emotional safety is one of the most important factors. Research has demonstrated if children are worried about their own safety and well-being, their focus absolutely will not be on their academic work. Part of ensuring children feel safe and supported in schools is to have a plan when working with children with RAD, as well as other significant mental health disorders. Nurturing the student, being consistent and predictable, maintaining realistic expectations, being patient, making sure teachers understand the unmet needs when children are exhibiting behaviors, and ensuring they interact with children at the emotional stage where they are, among others, are all key fundamentals for success in working with children with RAD (Hansen & Spratt, 2000).

Behavioral and Academic Outcomes for Students with RAD

"An unmet need becomes a compulsion that then becomes a risk" (Balbernie, 2010, p. 276). If educators think of behavior in terms of communication, this statement makes perfect sense. Babies cry because they are hungry, tired, sick, or need their diapers changed, and they have no other way to communicate. As children get older and start talking, they still are not able to communicate productively at times, as they don't have the vocabulary or contextual words that allow adults to understand them. Even adults struggle to effectively communicate their needs at times. Children who are unable to communicate effectively may resort to crying, yelling, having a tantrum, or physical aggression, to name a few. If adults are unable to understand these concepts, why difficult to understand how children, whose very brain structure and development have been compromised due to their traumatic histories, are unable to verbalize and express all they are feeling and needing in a socially appropriate way? Children who experience extreme trauma often develop disorganized attachment patterns. When infants develop disorganized

attachment patterns, they have greater difficulty coping with stressful experiences as they get older (MacDonald et al., 2008). Blair (2002) hypothesized high levels of negative emotionality leads to poor school readiness unless interventions in emotional compentence and cognitive self-regulation are utilized with the child. Though Cline's (2008) article described the behavior of several children in a residential unit in a psychiatric hospital (not children in a public school system), it was clear to see the significant impact their traumatic histories had. In this unit, the behavioral outcomes were hard to see on a day-to-day basis. It was more a matter of surviving the shift and hoping to make a difference for at least one child, for one day. The staff members in this unit came back day after day, willing to take the verbal and physical abuse from these wounded children in the hope of establishing some form of attachment so the healing could begin. In the school setting, teachers or other staff members often are not willing to purposefully endure this type of abuse. Additionally, they do not have sufficient enough training to work with students with RAD effectively.

Rapp-Paglicci et al. (2011) hypothesized students with less proficient self-regulation skills have lower adaptive skills and have insufficient coping skills to use when frustrated, anxious, or overwhelmed. Self-regulation deficits are connected to both internalizing and externalizing behavioral problems (Rapp-Paglicci et al., 2011). Students with poor self-regulation skills have a greater propensity for substance abuse, theft, disciplinary problems, and academic struggles (Padykula & Conklin, 2010; Rapp-Paglicci et al., 2011).

Smith et al. (2011) reported from 2006 to 2007, students were three times more likely to be suspended over 10 days if they had an emotional–behavioral disorder than if they had any other disability. Smith et al. (2011) also shared 80% of students with an emotional–behavioral disorder spent only 37.3% of their time in general education. The rest of the time was spent in

self-contained, special education settings. In addition to the lack of highly qualified teachers who can be present in self-contained educational settings, students with RAD face additional challenges to positive academic outcomes.

Two of these challenges involve the ineffective brain function due to environmental stressors (Corbin, 2007). Increased cortisol inhibits the ability of the hippocampus to adequately store emotional and verbal memories, which impedes academic success in students. Damage to the amygdala, which also affects memory, restricts a child's ability to self-calm and self-regulate (Corbin, 2007), causing academic and behavioral problems. Students who demonstrate high levels of externalizing problems are less likely to complete high school, and students with high levels of internalizing or externalizing behaviors are significantly less likely to enter college than typical peers (McLeod & Fettes, 2007). Only 20% of students with emotional–behavioral disorders between 2006 and 2007 received a high school diploma, and 55% dropped out, according to a study by Smith et al. (2011). These authors went on to say only 20% enrolled in postsecondary education, and only 30% were employed (Smith et al., 2011).

Browne et al. (2012) conveyed not only short- and long-term problems can and do occur without appropriate academic and behavioral interventions, but teachers in the United States are not prepared or qualified to work with students with mental health disorders. Their training is in classroom instruction, which unfortunately typically does not include training in working with students with severe emotional–behavioral disorders, which often accompany significant mental health disorders. Teachers often are not able to receive additional professional development due to the lack of financial resources in school systems. Hoagwood, Olin, Kerker, Kratochwill, Crowe, and Saka (2007) conveyed when resources are limited, school mental health programs are the likely targets for cuts.

The impact of mental health and academic interventions each has on the other is understudied (Hoagwood et al., 2007). Further research should focus on identifying effective, school-based interventions and then studying the academic outcomes of students who either receive or do not currently receive those identified interventions. Unfortunately, authors are not talking about RAD.

A review of the existing literature demonstrated the dismal future for students with mental health disorders—substance abuse, dropping out of school, social isolation, and continued abuse, to name a few (Browne et al., 2012; Cleary & Abbot, 2011; Dery et al., 2004; Hanley, 2003; McLeod et al., 2012; Padykula & Conklin, 2010; Smith et al., 2011; Strayhorn, 2002). Mental health disorders, as a whole, have received some much needed attention over the past several years, specifically ADHD, autism spectrum disorders, obsessive–compulsive disorders, and even oppositional defiant disorder. However, not much is written in regard to RAD, even though, as demonstrated previously, RAD is one of the most detrimental (Davis et al., 2006; Floyd et al., 2008).

RAD is considered by many to be the most significant and most widely misunderstood of these mental health conditions (Breidenstine et al., 2011; Cline, 2008; Davis et al., 2006; Hall & Geher, 2003; Haugaard & Hazen, 2004; Wilson, 2009). Because of this, some even doubt RAD is a singular mental health disorder. However, the majority of researchers at this time have indicated RAD is a mental health disorder specified by the pathogenic care of young children by parents or caregivers (Corbin, 2007; Cornell & Hamrin, 2008; Floyd et al., 2008; Hall & Geher, 20003; Kemph & Voeller, 2007; Schwartz & Davis, 2006: Shaw & Paez, 2009; Termini et al., 2009; Thrall et al., 2009). Still, there is not enough research available to say there are research-based interventions for school use that will positively affect behavioral and academic outcomes

for students burdened with the symptomology of RAD. Additional research is needed to specifically identify school-based interventions for students with RAD and to determine the behavioral and academic outcomes of those interventions for students. This research must involve the input of students diagnosed with RAD and those school personnel who currently work or previously have worked directly with students diagnosed with RAD.

Attachment Theory as the Theoretical Framework

Attachment theory as it relates to human development is the theoretical framework for this qualitative, multicase case study. Attachment theory is built on the foundations of ethology and developmental psychology by Bowlby and Ainsworth (Bretherton, 1992). Bowlby's early work has served as a guide for many in the field (Zilberstein, 2014). Attachment theory posits children are born preprogrammed to form attachments with others (Bowlby, 1952). Infants display behaviors to elicit attention and nurturing responses from the primary caregiver. Bowlby (1952) claimed the purpose of attachment is not food, as was previously posited by others, but is an innate desire for caring responses from the primary caregiver.

Bowlby (1952) insisted a great deal of emphasis should be put on the importance of family and the development of attachment in infants and young children. Bretherton (1992) suggested Bowlby came to believe familial experiences were the basic cause of emotional disturbances in children. Bowlby (1952) asserted,

> Among the most significant developments in psychiatry during the past quarter of a century has been the steady growth of evidence that the quality of the parental care, which a child receives in his earliest years, is of vital importance for his future mental health. (p. 11)

Bowlby (1952) went on to clarify he was referring specifically to maternal care—referring to either the biological mother or permanent mother substitute—and maternal deprivation. It was not an uncommon presumption in the time period (1952) that mothers were the primary caregivers.

Maternal deprivation comes in many forms and situations, including a mother who lives in the home but does not give nurturing and responsive care to her child, a child removed from the mother due to pathogenic care, institutional living, hospitalization, or death of the mother (Bowlby, 1952; Follan & Minnis, 2010). No matter the situation, maternal deprivation, under the lens of attachment theory, is very detrimental to the mental health and physical, intellectual, and social development of these children (Bowlby, 1952; Follan & Minnis, 2010; O'Connor, Bredenkamp, & Rutter, 1999).

The list of behaviors displayed by children who have experienced maternal deprivation or pathogenic care varies from child to child and is somewhat dependent on the time frame at which the deprivation or pathogenic care was experienced (Bowlby, 1952; Bretherton, 1992). There appears to be an association between the duration of childhood deprivation and the severity of the attachment disorder (O'Conner et al., 1999). Physical, intellectual, and social functionality can all be impaired to some degree as a result of maternal deprivation and pathogenic care (Bretherton, 1992; Hardy, 2007; O'Connor et al., 1999). Figure 1 illustrates some of the ramifications on child thinking and functioning as a result of an attachment disorder.

Figure 1

Illustration of Attachment Outcomes
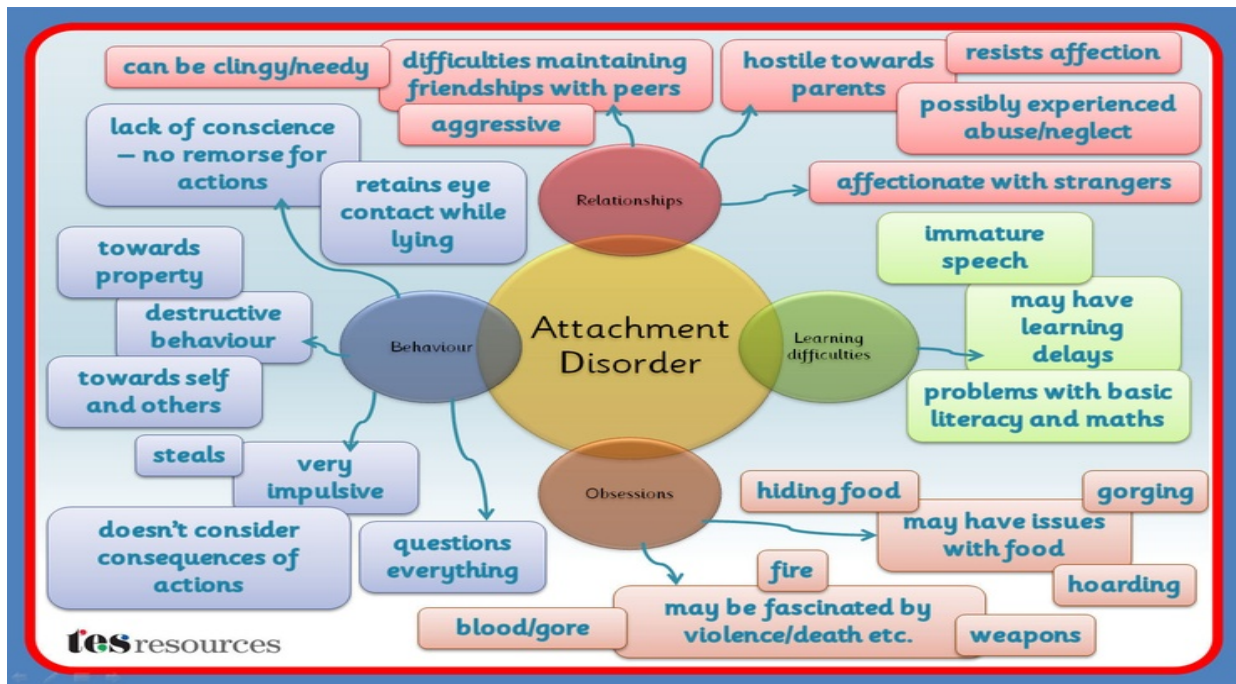
Note. Reprinted with permission from tesconnect (2015).

Ainsworth took the information from Bowlby and her own previous research and went a little further (Bretherton, 1992). Her subsequent work in 1978–1979 studied how attachment behaviors are organized in individuals, the outcome of attachment patterns, and what it means for future development (Ainsworth, 1979). Ainsworth's (1979) work took eight identified attachment behaviors and narrowed them down into four main groups: (a) securely attached, (b) insecure–avoidant, (c) insecure–ambivalent, and (d) insecure–disorganized. Table 1 identifies each of the four attachment types and offers a brief description of their characteristics.

Table 1

Patterns of Attachment in the Strange Situation Procedure

Attachment Pattern	Description
Secure attachment	Infants are typically distressed by separation from primary caregivers. Upon the caregivers' return, they greet them and return to play.
Insecure–avoidant	Children demonstrate few signs of overt distress upon separation from the caregivers, and they avoid them upon their return.
Insecure–ambivalent	Children are highly stressed when separated from the caregivers and are not easily calmed upon their return. If they do seek reunion, they may also then resist the contact by kicking or turning away. They may alternate between being clingy and being angry.
Insecure–disorganized	Children demonstrate a wide range of confusing behaviors upon reunion with the caregivers, including freezing, aggression, or other stereotypical behaviors.

Note. Adapted from "Infant–Mother Attachment," by M. D. S. Ainsworth, 1979, *American Psychologist, 34*(10), pp. 932–937.

In the Strange Situation (Ainsworth, 1979) episodes, 1 year olds were placed in episodes where the mothers were present, then left, and then returned. Ainsworth (1979) observed the interaction of the children and the mothers upon the mothers' reentry into the situation. The children's reactions ranged from brief reunion and back to playing, to ignoring the parent upon return, to physical violence toward the returning parent, or to a mix of relief, confusion, and aggression based on the attachment pattern they had developed. Like Bowlby, Ainsworth (1979) postulated maternal deprivation and behavior have a significant implication on the attachment patterns a child develops and on overall development. "When deprived of maternal care, the child's development is almost always retarded—physically, intellectually, and socially—and that

symptoms of physical and mental illness may appear….Some children are gravely damaged for life" (Bowlby, 1952, p. 15).

Bowlby (1952) posited the first year of life is the most important in developing attachment patterns and behaviors. He claimed the lengthier the period of deprivation, the greater the chance of developing an affectionless, psychopathic character that causes severely delinquent behavior, is very difficult to treat, and has far-reaching effects for the child's whole life (Bretherton, 1992; Hall & Geher, 2003; Hardy, 2007; O'Connor et al., 1999), including into adulthood and parenthood.

Conclusion

RAD can be an extremely debilitating mental health disorder with a far-reaching impact on the home, school, and community environments. RAD is set apart from other mental health disorders, including other attachment disorders, by the pathogenic care children received in the early stages of life from the people who were supposed to care for them the most, their parents. The affect RAD has on a children's education and future can be complex.

The literature highlighted most staff, general education staff members in particular, are unprepared for the intensive demands of these students. University teacher preparation programs typically do not provide training for working with students with mental health disorders for their potential general or special education teachers. While students with RAD may require much more time and effort on the part of the school staff than do typical peers or even students with less intensive disabilities, it is important to remember these students did not choose to have this disorder. They did not choose to have been neglected, abused, and traumatized as a small child.

School personnel must seek out professional development and training in mental health and specifically RAD in order to provide the supports, interventions, structures, and

understanding to help these students be successful. The purpose of this study was to provide guidance for educators surrounding interventions and factors staff and students perceive as contributing to or hindering their academic and emotional–behavioral progress.

Chapter III

Design and Methodology

Introduction

As there is not a large body of research concerning school-based interventions for high

school students with RAD, additional research is needed to identify effective interventions for

this population of students (Buckner et al., 2008; Minnis et al., 2006). By determining and

implementing effective, school-based interventions, educators will be better equipped to support

students with RAD. This is important for student success in school and in society as a whole.

The purpose of this grounded theory, qualitative, multicase case study was to explore the current

academic and emotional–behavioral interventions used in schools and to explore the school staff

and student perceptions of their effectiveness through semistructured interviews. In grounded

theory designs, the researcher uses qualitative interview data to explain a phenomenon among

the participants (Creswell, 2012) by identifying the codes that emerge from the data (Green,

2014; Yin, 2014). A multicase case study adds richness to the data by collecting from multiple

sources. A multisite, multicase case study methodology was chosen for examining the

perceptions of high school students diagnosed with RAD and school personnel on the

effectiveness of academic and emotional–behavioral interventions for high school students with

RAD (Creswell, 2000, 2012; Gill et al., 2008; Herriott & Firestone, 1983; Marshall & Rossman,

2011; Merriam, 1998; Stake, 1995; Yin, 2014). Semistructured interviews utilize commonality in

basic questions where the researcher asks additional clarifying questions where appropriate, in

order to understand lived experiences and perceptions (Gill et al., 2008).

School failure, higher dropout rates, and lack of success in the workforce are a few of the

adverse outcomes students with mental health disorders face if they are unsuccessful in school

(Farley et al., 2012; Valdez et al., 2011). Students in foster care are at higher risk of dropout than

student who live with biological family (Marcos & Sanders-Reio, 2001). Students with mental

health disorders, like RAD, who are successful in elementary, middle school, and high school are

more likely to enter postsecondary education (McLeod & Fettes, 2007; Smith et al., 2011);

conversely, those who experience a lack of academic success typically do not pursue further

academic interests (Hanley, 2003). Furthering education and training enables students to be

contributing members of society. When RAD is not diagnosed and interventions not applied,

many behavioral and academic difficulties persist into the child's future (Cain, 2006; Lowe,

2013).

  This qualitative case study used a multicase design to guide best practice and addressed

two central research questions:

1. What school-based academic and emotional–behavioral interventions do staff

  perceive as having improved academic and emotional–behavioral outcomes in high

  school students with RAD?

2. What school-based academic and emotional–behavioral interventions do high school

  students with RAD perceive as having a positive effect on academic and behavioral

  outcomes?

  Qualitative data were collected through two semistructured interview sessions with each

of five high school students with a DSM diagnosis of RAD and four school personnel. Nine total

participants were interviewed for a total of 20 interviews. Mr. Frank had two students

participating in this study; therefore, he completed two sets of interviews, one focused on each

student. Interviews were 30–45 minutes in duration. Some students elected to take a short break

and continue the second half of the interview in the same day. All interviews were audio recorded and transcribed verbatim, then coded to determine categories and themes.

Research Design

The study is a grounded theory study as it is laying the foundation for further and future study (Marshall & Rossman, 2011). Discovering emerging ideas—in this study, the effectiveness of school-based interventions for students with RAD—is the aim of grounded theory studies (Walden University, n.d). In grounded theory studies, the theory develops during the data collection process; it is not something being proven or disproven (Strauss & Corbin, 1998; Walden University, n.d).

This study was conducted with high school students with a DSM diagnosis of RAD and school personnel in two different school districts. There is power in gaining multiple views on a specific topic (Stake, 1988). Though more time consuming and intensive, evidence from multiple cases has been seen as more robust and compelling (Gill et al., 2008; Herriott & Firestone, 1983; Yin, 2014).

Marshall and Rossman (2011) posited multiple research sites allow the researcher to observe uniformity or lack of uniformity between different districts and programs. Yin (2014) added there is more power in using both multiple cases and multiple sites during a case study. Using multiple cases adds to the strength of the data, as there are multiple sources of information to determine patterns or themes in responses (Yin, 2014). It is important to note a third district agreed to participate in the study; however, no high school students with a diagnosis of RAD were identified in the district. It is also important to note two of the participants were students in the programs where the researcher was the administrator, and the researcher was the direct

supervisor for two school personnel participants in this study. Those four interviews were conducted by a proxy interviewer after the interviewer signed a confidentiality agreement.

The study consisted of multiple phases and took place over the course of six months in the fall and winter of 2014–2015. The first phase consisted of gaining all permissions, informed consent, and assent from the following groups or individuals:

- Northwest Nazarene University human research review committee

- The two school districts' superintendents or research committees

- School administrators

- Legal guardians of students diagnosed with RAD

- High school students diagnosed with RAD

- School personnel who currently or previously worked directly with students diagnosed with RAD and who were also participants in the study

Prior to the researcher conducting interviews, the specific interview questions were piloted with three professionals who were familiar with RAD to ensure validity. This not only added to the reliability of the researcher to gather data (Marshall & Rossman, 2011), but it also allowed the researcher to work out the order of questions, wording of questions, pacing, and thoughts on deepening understanding through additional probing questions (Gill et al., 2008). Another advantage of piloting interview questions with professionals with knowledge of the topic is can give feedback and provide information to make the process more effective (Jacob & Furgerson, 2012; Turner, 2010). By conducting pilot interviews, the researcher determined if the proposed questions could realistically be answered in the time frame allowed or if modifications needed to be made (Gill et al., 2008). The three individuals were a school psychologist, a school social worker, and a school counselor who was working on her school social work license. These

professionals had received specific training in mental health disorders, implications on school performance, child psychology, and school-based services and supports. Additionally, each of these professionals had worked with students diagnosed with RAD in the school setting (see Appendix A).

Data collection began in Phase 2. The four school personnel and five students took part in a face-to-face, semistructured, audio-recorded interview in the school setting. A semistructured, open-ended format was used for each of the school personnel interviews. This allowed for structure and similarity of gleaned information, while allowing for the flexibility necessary to get in-depth, rich information about the participants' lived experiences (Gill et al., 2008; Jacob & Furgerson, 2012; Marshall & Rossman, 2011). Each interview took approximately 30–45 minutes. In their research of health care, Gill, Stewart, Treasure, and Chadwick (2008) found 20- to 60-minute interviews were average. Jacob and Furgerson (2012) advocated for utilizing two or three shorter interviews rather than one interview taking over an hour and a half. They hypothesized longer interviews make it more difficult to recruit participants, and younger participants may lose interest. Student and staff participants were made aware part of this study included looking at the similarities and differences between staff and student responses.

Some of the participants chose to take a brief break and continue the second half of the interview on the same day. Follow-up questions were welcomed following transcription. Interviews were conducted face-to-face and were audio recorded to maintain accuracy (Yin, 2014). Taking extensive notes during an interview can get in the way of open communication (Jacob & Furgerson, 2012) and subsequently were not used during interviews. Using a recording device allows the researcher to maintain eye contact with the participants being interviewed and thus keep their interest and demonstrate the interviewer's interest in their experiences and

knowledge (Jacob & Furgerson, 2012). Audio recording provides a permanent record and reduces the chance of researcher bias (Gill et al., 2008). Audio recordings were transcribed verbatim to continue avoiding bias and ensure accuracy of information (Gill et al., 2008). Two student and two staff interviews were conducted by a proxy as they were in the same school as the researcher was employed. The proxy was a school counselor familiar with mental health disorders and the function and importance of confidentiality. Prior to her conducting interviews, she was required to sign a confidentiality agreement (see Appendix B) and be approved by the Northwest Nazarene University human research review committee, which was completed.

Data from all interviews were coded and categories and central themes emerged. Analysis of the phrases, expressions, and ideas (Creswell, 2012; Marshall & Rossman, 2011; Turner, 2010) that occurred among the participants was coded by hand by the researcher. This information was used to help determine follow-up questions for the second round of interviews in Phase 3. For student who chose to take a small break and continue with the interview follow up questions were asked at a later date if necessary.

Phase 3 utilized the data from the first round of interviews to drive the second round of interviews. Jacob and Furgerson (2012) asserted shorter follow-up interviews allow the researcher to clarify any questions from the first interview. Follow up interviews also allow the researcher to gather responses from the participant, based on issues arising in other first-round interviews (Jacob & Furgerson, 2012). Audio-recorded interviews were transcribed by a professional transcriber and coded by the researcher. Codes were analyzed and categories and central themes were identified.

Participants

The primary participants in the study were high school students with a DSM diagnosis of RAD in the public school setting and the school personnel who worked directly with them. The researcher used her knowledge of programs in her district of employment and surrounding districts to identify programs serving students with emotional–behavioral disorders, as these were the programs that typically support students with RAD. Contact was made with the identified school districts' administrators or research committees via letter or e-mail. Follow-up phone calls to gain permissions to conduct this study were conducted as needed School personnel were invited to participate through letters and follow-up e-mail conversations or phone conversations (see Appendix C). To ensure confidentiality, school personnel were enlisted to gain informed consent from the student's legal guardian and the high school students with RAD prior to giving any identifying information to the researcher. Students who took part were additionally asked specifically for their permission to participate in this study, to have the interviews audio recorded, and to use direct quotes as appropriate, maintaining anonymity (see Appendices E and F). Potential participants who did not return the first round of permissions were contacted again via phone. If they still did not respond, they were discontinued as participants in this study with no negative implications. Potential high school student participants whose parents or caregivers withdrew consent to participate were discontinued from further research activities with no negative implications. One student was discontinued as her parent did not give consent for her participation. The parent did not feel the student would be truthful and would skew the data.

Issues of vulnerability were a concern in this study as it involved high school students, most of whom were minors with a significant DSM diagnosis of RAD. The principal researcher

in this study was an administrator in one of the districts where the study took place. The researcher helped develop the two self-contained programs in this district for students with severe emotional–behavioral disorders, including those with a DSM diagnosis of RAD. Students in those programs were not interviewed by the researcher due to ethical issues, a concern for authenticity of information, and a potential fear or anxiety the students may have had as they were being asked about the effectiveness of interventions in place in the school setting. A proxy interviewer was utilized for the two student–staff pairs from the school in which the researcher was the administrator. Audio-recorded interviews were sent directly to the transcriber to ensure no bias occurred.

The researcher has a bachelor of arts degree in elementary education, a master's degree in special education and special education administration and related services, certification in building administration, and an endorsement as a special education consulting teacher from local universities. The researcher taught general education for one year before moving into the special education classroom. The researcher taught special education for five years before moving to the district office where she spent one year as a special education consulting teacher for her district. The researcher spent the next seven years as the administrator of multiple district-wide programs for students with emotional–behavioral disorders and developmental disabilities. The researcher was a member of the Council for Exceptional Children and the Council for Children with Behavioral Disorders, having served in multiple board positions on both councils, including as president of both councils. The researcher has designed and taught multiple courses at a local university for the education and special education departments in relation to children with exceptionalities, IEPs, negative and maladaptive behavior, and positive behavioral supports. This researcher's education and experience in working with students with severe emotional–

behavioral disorders, including RAD, assisted in minimizing the risk involved for this vulnerable

population.

The districts involved in this study were neighboring districts and had similar district-

wide socioeconomic status and total student populations. Both districts serviced students from

multiple ethnic and racial backgrounds. Additionally, both districts had special education

programs specifically for students with severe emotional–behavioral disorders at the elementary,

middle, and high school levels. Both districts had off-site programs for the middle and high

school students identified with severe emotional–behavioral disorders. Students in these

programs all had IEPs under the categories of autism spectrum disorder, other health impairment,

cognitive impairment, and emotional disturbance.

Sampling Technique

The researcher selected purposeful homogeneous sampling for this study (Creswell,

2012). The researcher acknowledged most student participants had other comorbid mental health

disorders in addition to the DSM diagnosis of RAD. However, as the focus of the study was

specific to students with a DSM mental health diagnosis of RAD, purposeful homogeneous

sampling was the most appropriate technique. Potential participants in the western United States

were identified by school personnel via e-mail or a phone conversation. School districts and

personnel were asked about the special education populations in their districts and specifically

their population of students categorized under the Individuals With Disabilities Education Act as

having an emotional disturbance, as it is typically the eligibility category for students with RAD.

A qualitative, multicase case study was deemed appropriate to address the research

questions. In order to answer the research questions, the researcher needed in-depth knowledge

of the participants' lived experiences (Gill et al., 2008; Marshall & Rossman, 2011; Merriam,

1998; Stake, 1995; Yin, 2014), which can be gained most effectively through semistructured

interviews. Interviews are an effective way to know what an individual and groups of persons

think about a particular topic, such as in this study (Aberbach & Rockman, 2002; Merriam, 1998;

Stake, 1995; Yin, 2014). As research addressing school-based interventions for students

diagnosed with RAD is minimal (Buckner et al., 2008; Schwartz & Davis, 2006), it was

important for the researcher to gain information about how both students and school personnel

perceived strategies and interventions currently in use in the school systems and whether they

perceived those strategies produced positive outcomes. Permissions from the school districts and

individual school administrators were received (see Appendix C). Informed consent was gained

from school personnel who were willing to participate in the study (see Appendix D). School

personnel consisted of special education teachers and personnel who filled a dual role of general

education teacher and special education teacher in self-contained programs for students with

emotional–behavioral disorders (EBD). Introductory letters and informed consent forms were

sent by school personnel to the legal guardians for high school students who met the study

criteria (see Appendices G and H). Once returned, potential high school student participants were

asked to give their written assent as well (see Appendices F and J) prior to giving identifying

information to the researcher. All participants gave permission to participate in the study, to

audio record the interviews, and to allow the researcher to use direct quotes with a pseudonym.

All participants were specifically informed they could withdraw from the study at any time

without any repercussion.

 School personnel and students participated in two semistructured, audio-recorded

interviews. Interviews were transcribed and coded to determine categories and themes (Taylor-

Powell & Renner, 2003) in responses. Semistructured interviews were the chosen type of

interview as the researcher wanted in-depth information in regard to the students' lived

experiences. Similar questions were asked of each group of participants with clarifications and

follow-up questions to gain better understanding of those lived experiences. Questions for

students were reworded as necessary to ensure they understood what was being asked. Gill et al.

(2008) informed readers semistructured interviews allow the interviewer to ask key questions of

all participants with the flexibility of exploring ideas and responses in more detail. Turner (2010)

and Gill et al. (2008) added standardized, open-ended interviews ensure all participants are asked

identical questions and are worded in such a way so participants contribute as much detail as

they like about their viewpoints and experiences. Sticking to the interview protocol with no

deviation or clarification does not allow for the design of the research to emerge naturally (Jacob

& Furgerson, 2012). Students were made aware their responses would be compared to responses

from the staff person in their school they were paired with in order to determine similarities and

differences.

Data Collection

Permissions were sought from school district superintendents, research review

committees, and school principals (see Appendix C) as the interviews took place on their school

campuses with a vulnerable population of students. Gill et al. (2008) posited familiarity of the

interview environment may help the participant relax and be more responsive. Informed consent

was sought from school personnel who worked directly with students diagnosed with RAD, prior

to their participation in the interviews. With the assistance of the school personnel, permissions

were obtained from legal guardians of high school students with a DSM diagnosis of RAD if

they were minors. Assent was then gained from the students. Paired permissions were then given

to the researcher in order to continue with the study, and the researcher contacted the student

participants. All permissions are noted in Appendices D, G, E, and F. All permissions were granted in written form. All participants were informed they could choose to withdraw without penalty at any time. Students whose parents or caregivers did not give or withdrew permission were discontinued from the study. Pseudonyms were used during all subsequent phases of the research to protect the confidentiality of all participants. Prior to data being collected, approval was gained from the Northwest Nazarene University's human research review committee.

Interviews of high school students diagnosed with RAD and with the school personnel who currently worked or had worked directly with RAD were scheduled in a face-to-face meeting. The interview is one of the most valuable methods of data collection in a case study (Yin, 2014). Student interviews were scheduled to occur on the school campus to help the students and school personnel feel a sense of safety in their familiar surroundings. Appendix K lists outside counseling supports, which were available if the researcher felt the necessity to refer the student during the interviews. Though available, use of this resource was not required during this study. Interviews with school personnel were conducted on school grounds and at the time agreed upon by the participant and the researcher.

Semistructured interviews were used with both the student and staff participants. Prior to beginning each interview, the researcher or proxy explained similar questions would be asked of their paired participant, as part of the research would be comparing responses for similarities and differences. Initial questions consisted of basic demographic data for both groups of participants. Questions for school personnel then addressed their knowledge base of RAD, specific training they received in regard to RAD, current academic and emotional interventions they utilized with students with a DSM diagnosis of RAD, their perceptions of the effectiveness of those interventions, and other interventions they would like to see implemented.

Questions regarding length of time lived in a given residential setting and worked in an educational setting were asked of the students following the basic demographic data. Students were also asked questions addressing their perceptions of the current academic and emotional–behavioral interventions being implemented in their educational setting and perceptions of the interventions' effectiveness on academic and emotional–behavioral outcomes. Students were asked to identify characteristics of school staff perceived as effective in working with them. Additionally, students were asked if there were other interventions they had experienced or they would like to experience to help their academic and emotional–behavioral outcomes (see Appendix J for specific questions). Interviews were audio recorded, transcribed, and coded. Categories and themes were discovered by the researcher during the analysis phase. The researcher conducted member verification checks via electronic, written, and verbal formats at the conclusion of all interviews to ensure accuracy in reporting the ideas and themes in the data from all participants.

Analytical Methods

Data collected using semistructured, open-ended interviews were analyzed with the qualitative process of hand analysis as described by Creswell (2012). The researcher analyzed responses to determine overall codes and the similarities and differences of codes between the two groups of participants. Similarities and differences of codes were also analyzed between the paired groups. Codes were further analyzed to determine a smaller number of categories and then themes. In this study, five themes emerged. Member checks (see Appendix L) were used to ensure accuracy in transcription, coding, and category and theme development (Creswell & Miller, 2000; Marshall & Rossman, 2011; Stake, 1995).

An important factor in providing validity for a research study is triangulation. Triangulation is the process of ensuring the researcher accurately received and reported the views and perspectives of the participants (Creswell, 2012; Marshall & Rossman, 2011; Stake, 1995; Yin, 2014). Case study research is considered triangulated research (Cronin, 2014). Denzin (1989) posited convergence, inconsistency, and contradiction are the three possible outcomes. In this study, the responses from the school personnel, the responses from the student participants, and the verifications of accuracy on the member-checking forms were triangulated to determine accuracy of codes, categories, and themes in the data.

Delimitations and Limitations

Several assumptions and delimitations were made in this study. It was presumed the participants who volunteered for this study gave truthful and accurate responses. One potential student participant was eliminated, as the parent did not feel she would be truthful and would, therefore, skew the data. This parent chose not to sign the consent form. Though the student participants had been in their current educational settings for a varied length of time, it was assumed their lived experiences would be similar and common themes would emerge.

Concerns about rigor, generalizability, time commitments, and validity of qualitative research over other types of research are common (Yin, 2014). Results in this study were compiled from the responses of the high school students with a DSM diagnosis of RAD and the school personnel who worked with them from two different school districts. The third district did not identify any participants for this study. Triangulation of responses from the students, staff, and member-checking data was used to ensure accuracy and validity of the reported data. A multicase case study was selected to give strength and validity to this study (Yin, 2014).

Further research should focus on (1) replicating this study on a larger scale, (2) school-based interventions in the elementary and middle school level for students with RAD, (3) quantitative research comparing the perceived effective interventions and factors in this study with assessment data to determine degrees of effectiveness, and (4) effectiveness of school-based interventions by level of stability of the home environment.

Chapter IV

Results

Introduction

In qualitative, grounded theory studies, the ideas emerge from the data itself; there is no effort to prove or disprove existing research as there is none comparable. This chapter lays out the data collected through semistructured interviews to determine codes and themes. Data will be presented to answer the two research questions:

1. What school-based academic and emotional–behavioral interventions do staff perceive as having improved academic and emotional–behavioral outcomes in high school students with RAD?

2. What school-based academic and emotional–behavioral interventions do high school students with RAD perceive as having a positive effect on academic and behavioral outcomes?

Data for each question will be presented individually followed by discussion of comparison data. Comparison data are organized in three sections: (1) side-by-side data where similarities and differences among each pair of participants are delineated, (2) side-by-side student–staff coded data demonstrating similarities and differences between all student and staff data are delineated, and (3) holistic data where the overarching themes from all of the data emerge. In this way, the data will be seen from a micro to a macro vantage point.

Results

Transcribed data were hand coded by the researcher. The coded data are delineated in the tables included in this chapter. Five tables are used to answer each of the two research questions.

Research question 1. What school-based academic and emotional–behavioral interventions do staff perceive as having improved academic and emotional–behavioral outcomes in high school students with RAD?

Table 2

Staff Perceptions of Effective and Ineffective Academic Interventions and Factors

Effective	Number of Responses	Ineffective	Number of Responses
A Person	2	Difficult	**6**
Ability	2	Emotional Regulation	**5**
Consistency	**3**	Expectations	3
Effort	1	Missed School	3
Modification	**6**	Pacing	3
Supports	**8**	Refusal	**5**
It Works	1		

Note. Items in bold denote the top three delineated codes for the data set.

The researcher identified seven codes from staff responses regarding interventions and factors that are effective in promoting student academic success. *Supports*, *modifications*, and *consistency* were the three factors they perceived as having contributed most to student academic success. *Supports* included additional help on assignments, someone checking progress, and extra time to complete assignments. *Modifications* consisted primarily of modified class schedules, taking less credits at one time, and smaller class sizes. Consistent expectations, responses, and policies encapsulated the third highest indicator, *consistency*.

Staff participants also shared the factors they perceived hindered student academic progress. *Difficulty* of work due to skills deficits or gaps in knowledge or experience, not understanding contextual cues, and limited vocabulary knowledge were included in the highest ranked code when discussing factors that impede student progress. Ability to consistently

manage *emotional regulation* and the *refusal* to accept any form of academic assistance were the other top responses delineated in Table 2. *Expectations*, *missing school*, and *pacing* each had three responses. Expectations included responses indicating if the student did not understand the work, the student would check out and the general education teacher would allow it; there were new staff persons who did not expect much due to the student's reputation; and the student chose to be off task and was not redirected. *Missing school* was obvious; students missed school for a variety of reasons, including changes in foster care and truancy. In *pacing*, the researcher found responses indicating the speed at which the instruction was delivered was too fast, the student could not keep up, and the student fell behind.

Table 3

Staff Perception of Effective and Ineffective Emotional–Behavioral Interventions and Factors

Effective	Number of Responses	Ineffective	Number of Responses
A Person	**7**	Attitude	1
Accommodations	4	Emotional Regularity	2
Attitude	1	Environment	**4**
Consistency	**10**	Expectations	**5**
Coping Skills	1	Missed School/Class	1
Maturity	3	People	**4**
Modifications	1	Consistency	1
Boundaries	1		
People	**5**		
Processing Time	1		

Note. Items in bold denote the top three delineated codes for the data set.

The student participants in this study were all on an IEP under the category of *emotional disturbance* due to the frequency, intensity, and duration of their negative behaviors. The researcher felt it important to explore the emotional–behavior interventions and factors as they are part of the whole child unit. As with the staff perceptions of effective interventions and factors contributing to academic progress, staff participants also perceived *consistency* as an important factor in the emotional–behavioral progress of the students as indicated in Table 3. However, on the behavioral side, staff perceived *consistency* as the most important factor followed by *a person* and *people*. While *consistency* appears self-evident, it is important to highlight its significance. Clear-cut directions, clear expectations, consistency between school

and group home, and "she has one go-to person" (Ms. Molly), were a few of the specific

responses revealed under this code.

While *a person* and *people* may appear to be identical, the raw data that emerged from

the staff participants demonstrated a distinct difference in the composition of responses. Items

coded as *a person* referred to a dedicated staff person, specifically a psycho–social rehabilitation

(PSR) worker or a paraprofessional who was responsible for a specific student. Most responses

fitting this code also had a component of underlying trust between the student and the dedicated

staff person. Less specific responses, such as "being around people with positive behaviors" (Mr.

Frank) and "knowing people care about her" (Ms. Nancy), were placed into the *people* category.

A case could be made to combine them as they both involve interpersonal relationships.

However, the researcher believed the specificity of one group of responses warranted separation.

Staff participants perceived *expectations* of general education teachers and staff engaging

in power struggles as the primary factor hindering emotional–behavioral progress in students

(see Table 3). This is consistent with the research regarding students with behavioral disabilities.

The *environment* was a secondary factor staff perceived as hindering emotional–behavioral

progress. Staff responses addressed home environment as a hindering factor in the majority of

responses. All of the student participants were or had been in the foster care system at some time

in their educational career. Lack of stability in living environments was found to hinder

emotional–behavioral progress in this study. When looking at *people* as the third hindering

factor, the responses surrounded removal of people supports, trauma caused by others, negative

peer influences, and trust issues. "I don't want to let you get to close; it's going to hurt when you

are out of my life" was a statement provided by Mr. Frank in relation to the paired student's

demonstrated beliefs. As the underlying cause of RAD is pathogenic care and a failure to

develop appropriate personal emotional attachments, it stands to reason these factors could

hinder emotional–behavior progress.

Table 4

Staff Perception of Supports That Contribute to Student Success

Academic Support	Number of Responses	Behavior Support	Number of Responses
A Person	**10**	A Person	**6**
Accommodations	**13**	Accommodations	5
Assistance	6	Coping Skills	2
Consistency	2	Consistency	**15**
Modifications	**15**	Instruction	**21**
Refuse	3	Modified Class/Schedule	2
		PBIS	1
		People	2

Note. Items in bold denote the top three delineated codes for the data set.

It was interesting to find *a person* among the top three factors staff perceived as supporting academic progress, considering the difficulty of appropriate emotional attachment in students with RAD (see Table 4). It is important to note staff responses were central to PSR workers, paraprofessionals, or other 1:1 people's ability to be in close proximity to the student the majority of the time in order to support academic productivity and progress. Responses that fell within the *accommodations* code consisted of providing visual schedules and graphic organizers, verbal and nonverbal prompting, test accommodations, flexibility in time constraints during classroom assignments and assessments, and the ability to correct assignments and tests under 70% correct. These accommodations may seem average to those in the field of special education; however, for new teachers or those having little experience with students with special

needs, including RAD, implementation of these accommodations may save much frustration on the part of the student and the teacher. *Modifications*, such as changing class schedules, changing the required number of classes in a given semester, ensuring placement in classrooms with smaller numbers, and adding an academic support class, were perceived as the prominent interventions and factors that led to academic progress (see Table 4).

Instruction, *consistency*, and *a person* were the three codes that emerged from the data surrounding emotional–behavioral supports as shown in Table 4. As in previous sections *a person* refers to a 1:1 person in the form of a PSR worker, a school resource officer (SRO), or behavior interventionists who provide guidance, set limits, and process difficult situations with students. *Consistency* encompassed strict behavior management programs, consistency among staff in regard to expectations and consequences, and consistent behavior tracking systems. *Consistency* has been a shared theme for all reporting perceptions discussed thus far. Among supports offered in the school setting for emotional–behavioral needs, the intervention perceived as most effective was *instruction*.

Instruction in Table 4 did not include specified curriculum taught in a specific manner. Instruction on study and learning habits, instruction on personal space and boundaries, instruction provided by school social workers and school psychologists on an array of social skills and anger management skills, and direct instruction on IEP goals were among the responses identified under *instruction*. The researcher found it interesting none of the staff participants identified a specific curriculum or strategy. Pleasingly, they did identify a number of different personnel resources who provide instruction in the emotional–behavioral realm.

Table 5

Staff Perception of Personal/Social Factors that Contribute to or Hinder Student Success

Contribute to Success	Number of Responses	Hinder Success	Number of Responses
Friends/Family	**6**	Attitude	4
Support	**12**	Building Trust	**10**
	19	External	**11**
Trust			**17**
		Interpersonal	1
		Reject	1
		Violence	

Note. Items in bold denote the top three delineated codes for the data set.

Table 5 demonstrates the personal–social factors that contribute to or hinder student academic and emotional–behavioral success as perceived by staff participants. *Family–friends*, though the smallest, was perceived as important to student success in both academic and emotional–behavioral areas. Staff responses included relationships with positive peers and family, stability of family, and positive characteristics such as wit and humor among the factors contributing to student success. As with *friends–family*, *supports* included those supports provided both inside and outside of school. Specifically, responses included positive connections with staff, having designated "go-to" persons when assistance was needed, and the ability to talk to any staff at a given time. Though these responses could have been coded under *a person* or *people* the researcher believed the context of the responses implied a support system and not a personal connection or relationship between staff and student. Likewise, the responses coded under *trust* referred to an established personal relationship where the students believe the staff members were there to support them. Specific responses included "she talks to me about her

trauma and any issue she has" (Ms. Molly), "she feels like the PSR is there to support her," (Mr. Frank), "she sees we are trying to help her" (Mr. Frank), and "staff are predictable" (Ms. Molly). Trust is not something inherent in students with RAD due to the etiology of their mental health disorder. Trust must be earned over a course of time. Therefore, the researcher believed it was important to highlight the nature of the relationship between staff and students perceived as contributing to their success.

Table 6

Academic and Emotional–Behavior Intervention Progress Indicators—Staff

Academic Indicators	Number of Responses	Emotional–Behavioral Indicators	Number of Responses
Attitude	**6**	Attitude	**4**
Grades	**15**	Data	**11**
Missed School	1	Doesn't Care	1
Skills	**7**	Inconsistent	1
		Observation	**4**
		Social	**4**

Note. Items in bold denote the top three delineated codes for the data set.

The purpose of this study was to determine not only what interventions and factors contribute to and hinder academic and emotional–behavior factors, but to determine how progress was being determined. If staff and students do not perceive progress in the same way, discussions surrounding effectiveness and success are difficult. Table 6 delineates the academic and emotional–behavioral indicators through which staff perceived progress. *Attitude* encompassed the effort the student gave during academic requirements, whether the student turned in completed work, and statements students made regarding their work. One staff reported "he'll decide if it's worth it" (Mr. Neil) and "if not, he will refuse to complete the task."

While *grades* were evidenced as the leading indicator of student academic progress, *skills* emerged as another important factor. Staff reported gaps in specific skill areas: lack of foundational skills, cognitive ability, and ability to stay caught up as factors contributing to or

hindering progress. Students' demonstrated growth in these areas were perceived as a metric of progress. Though not as definitive as grading, it was perceived important by staff participants.

Grades, as a code, was overwhelmingly the leading indicator of academic progress. Individual responses included progress in credit acquisition, staying caught up in coursework, students tracking their own academic progress, and academic grading in this code. It is not surprising there was such importance placed on course grades, as they determine credit acquisition, which determines graduation.

Concerning emotional–behavioral progress (see Table 6), one indicator emerged as the most widely used method of monitoring progress. Training in special education and behavior in particular focuses on data, data, and more data. Data drive programs. Data drive decisions. It is not surprising to the researcher *data* emerged as the leading code when exploring emotional–behavioral progress. Staff responses included behavior tracking sheets and boards, data on special behavior goals, and level of supports needed as indicators of progress. The heavy reliance on hard data was reassuring to the researcher.

Attitude, *observation*, and *social* were secondary indicators to the staff participants in this study. Appropriateness of comments and effort surfaced in staff responses under *attitude*. Making friends, being more social in the school setting, and positive relationships with staff were responses in the *social* code. While hard data are powerful indicators, observations of student behavior indicate progress as well. In this study, observation of appropriateness of student dress and generalized behavior impressions were included under *observation*.

Tables 2–6 delineate the codes identified from the staff participant data in order to answer research question 1. Attention will now focus on research question 2, where student responses and perceptions are reported.

Research question 2. What school-based academic and emotional–behavioral interventions do high school students with RAD perceive as having a positive effect on academic and behavioral outcomes?

Table 7

Student Perception of Effective and Ineffective Academic Interventions and Factors

Effective	Number of Responses	Ineffective	Number of Reponses
A Person	**6**	Difficult	**12**
Classes	3	Emotional Regulation	4
Motivation	**7**	Expectations	**9**
Supports	**8**	Lack of Understanding	1
		Missed School	1
		No Help at Home	1
		Pacing	**7**
		Personal Conflict	2
		Refusal	3

Note. Items in bold denote the top three delineated codes for the data set.

Supports were perceived as the most effective intervention by both staff and students. Unlike staff responses, students' perceived *motivation* and *a person* as the second and third most effective intervention (see Table 7). A few student responses under the *supports* code included "the support here works for me" (Val), "the math teacher teaches us individually" (Tonya), "get help from other students" (Kevin), and "if I have a low grade, the PSR helps me determine what I need to do to get that grade back up" (Val). Student responses under *motivation* revolved primarily around a desired end result, such as free time, music, and drawing, if they completed their work or were behaviorally appropriate. The third most effective intervention identified by students was *a person*. These responses identified specific persons students perceived as helping them be successful, namely a PSR worker, specific teachers, and specific friends.

While interventions and factors perceived as most effective focused on interpersonal relationships and rewards, the interventions and factors perceived as hindering progress centered around the academic work itself. As seen in Table 7, *difficult*, *expectations*, and *pacing* were perceived as hindering student success. Questions during the interview process where students were asked to identify factors hindering their academic progress brought out some intense emotions. For some of the students the researcher could see the anguish on their faces and the looks of defeat when sharing their thoughts. Responses under the code *difficult* elicited responses regarding the difficulty of assignments and admitting their academic weaknesses—"I'm a slow learner" (Val), "I don't think like other kids" (Mickie), and "all classes involve reading" (Tonya)—and their lack of ability to focus and stay on task.

Responses under *expectations* highlighted student frustration with the workload, class size, and perception where teachers expected more than the student could or would give: "Being what the teachers want me to be" (Kevin), "workload" (Val), and "amount of work" (Val) were some of the specific responses from students. It is important to note these responses were in reference to general education teachers primarily, as were the responses coded under *pacing*.

Pacing responses, as expected, revolved around the speed of instruction and task requirements. "General education teachers go too fast," "time restrictions," "time limits to complete my work," and "pushed too much at the same time" were a few of the specific responses Val shared. Tonya added, "I'm really slow," referring to her ability to process information and finish tasks. The researcher considered collapsing the responses under *difficult*, *expectations*, and *pacing* into one code but rejected this due to the specificity of answers. *Difficult* referred to skills, *expectations* referred to workload, and responses under *pacing* referred to the speed of curriculum expectations and time restrictions.

Table 8

Student Perception of Effective and Ineffective Emotional–Behavioral Interventions and Factors

Effective	Number of Responses	Ineffective	Number of Responses
A Person	**6**	Attitude	**6**
Consistency	**6**	Behavior Characteristics	1
Coping Skills	**5**	Drugs	2
Good	1	Emotional Regularity	1
Medication	2	Expectations	**7**
Modifications	1	People	**9**
Not Being Afraid	1	Perceptions	3
People	8	Violence	1

Note. Items in bold denote the top three delineated codes for the data set.

When discussing emotional–behavioral interventions and factors with students, four codes emerged as their perception of the most effective, and three emerged as the least effective and hindering. Table 8 delineates all of the codes within this set of data. Here, as in previous data sets, *a person* and *people* are within the interventions and factors perceived as most effective. As with the previous data sets, the researcher chose to list these separately as *a person* was indicative of a specifically named person and *people* referred to more general groups of persons. Thus, the researcher viewed them as distinct in their function.

A PSR worker, an EBD teacher, a boyfriend, and other special education staff were named in the responses identified under the code of *a person*. When reviewing the data placed into the *people* code, the responses did not always refer to staff or adults. "Being around friends" (Mickie), "staff is verbally uplifting" (Sarah), "talking and processing with staff" (Sarah), "less

annoying kids" (Sarah), and "teachers that understand me" (Tonya) were a few of the responses students shared as interventions and factors they perceived as contributing to their emotional–behavioral success and progress.

Another code that emerged as effective was *consistency*. Students perceived consistent expectations and consequences as effective in assisting in their emotional–behavioral progress. "They don't let people just get away with it" (referring to curse words, bullying, and physical aggression), "consistent discipline is number one," "positive behavior supports," "and being rated every day" were among the responses offered by Sarah. Knowing the expectation and consequence and knowing they would be the same every time were considered effective. Knowing and utilizing skills they had learned were also perceived as effective.

Under the code of *coping skills* responses, "ceramics-work with my hands" (Tonya), "music" (Tonya and Val), and "give me my space when I'm angry or frustrated" (Kevin) were identified specifically as interventions the students perceived as allowing them to make emotional–behavioral progress as opposed to resorting to verbal and physical aggression.

When shifting to factors that hinder emotional–behavioral progress and success, one student identified physical violence hinders progress: "Teachers don't help with my frustration and anger because they are afraid of me" (Kevin). He shared his emotional irregularity as hindering progress. One other shared her past addictions and drug use as factors that hindered her ability to make progress. Though not in the top three factors, the researcher felt it important to highlight these factors as the research has addressed violence, emotional irregularity, and drug and alcohol abuse as factors that hinder emotional–behavioral progress in school and community settings (Hall & Geher, 2003).

Students identified *people* as the primary factor they felt hindered their ability to make emotional–behavioral progress. Interestingly, *people* was in the top-two identified factors staff perceived as hindering student emotional–behavioral progress as well. Students shared "bullying" (Mickie), "people that are rude and disruptive" (Tonya), "hearing kids arguing" (Sarah), "can't deal with so many people" (Val), and "it's annoying when people get out of hand" (Tonya) as some of their specific thoughts and experiences.

Other factors students perceived as hindering their ability to make emotional–behavioral progress fell into the *expectations* code. One of the students was very adamant about the fact he did not like people watching him all the time. He didn't like "having to do what the teachers tell me to do" (Kevin). He went on to say, "Teachers expect more than I want to do." Another student struggled with expectations in the general education setting. "The general education doesn't understand the stuff that I do" (Val) in reference to her lack of focus and fidgety behaviors. This supports the need for more professional development in the arena of disabilities and mental health. The expectation of no talking in the general education classroom was another point of contention.

Student attitude was the other most identified data set as hindering students from progressing. Data were gleaned from direct student quotes regarding their own willingness to participate in school and the support there, and their shared feelings of self-worth. "I tell myself I'm stupid" (Mickie), "I'm always down on myself" (Mickie), "feeling like I'm not worth anything" (Sarah), "I'm not willing to do what they want me to do" (Kevin) were quotes from student responses. It was clear to the researcher the students had some deep-seated beliefs about themselves and what they were willing to do. This type of "fixed mindset" is highlighted in Carol Dweck's (2006) book *Mindset: The New Psychology of Success*. Dweck gave suggestions

and ideas regarding how to move students and staff from a "fixed mindset" to a "growth

mindset" in order to promote student success.

Table 9

Student Perception of Supports That Contribute to Their Success

Academic Support	Number of Responses	Behavior Support	Number of Responses
A Person	**11**	A person	**22**
Accommodations	6	Consistent	3
Assistance	**11**	Coping Skills	3
Modifications	**16**	Environment	1
Refuse	1	Instruction	**14**
		Modified Class/Schedule	3
		OK	1
		PBIS	1
		Reject	2

Note. Items in bold denote the top three delineated codes for the data set.

Modifications, *a person*, and *assistance* were perceived as contributing factors in students' academic success and progress. *Modifications* refer to changes in class schedules, changes in academic expectations, doubling up on academic support classes or content classes, and allowing oral responses as opposed to written responses on assignments and tests. As previous data indicated, these students had learning difficulties and, in many cases, were behind in credit toward graduation. Modifying schedules to support credit acquisition was perceived as helpful by students.

A person emerged as a leading code when looking at academic supports. "PSR helps" (Val), "teacher cares about my success" (Tonya), "1:1 supports" (Tonya and Sarah), and "teacher helps me with work" (Kevin) were given as responses when asked about school-based academic

supports. These responses are similar in nature to the previous responses under *a person* coding. Responses here differed from the responses under *assistance*, as *a person* responses referred to a person and *assistance* referred to more general descriptions of assistance.

IEP supports, ability to do missing work in support classes, staffing helping with understanding, getting more help, and "I get a lot of support; sometimes I don't want it" (Kevin) were among the responses coded under *assistance*. One student even talked about how the special education teacher talked to them about their IEP to ensure their understanding and what supports were determined necessary to aid in their success.

When turning to emotional–behavioral supports, *a person* and *instruction* were prominent codes (Table 9). Here again, specified persons were listed as support. A PSR worker, an EBD teacher, content teachers, and friends of the students were identified as support for emotional–behavioral needs. "PSR is always there when I feel upset or unsafe," and "PSR talks to me when I appear off," were comments shared by both Val and Tonya. "She knows what I've been through as we have a common past." "She is my go-to person" reported Sarah. "My friends (names omitted) support me" (Kevin).

Students also identified *instruction* as an intervention that supported their emotional–behavioral needs. Instruction was provided through a multitude of sources as reported by students. The school social worker, EBD teacher, and PSR worker were identified as the deliverers of instruction. Some instruction was individual and some was provided in small groups situations. One student referred to support in a content class as a factor in their emotional–behavioral success. Use of social skills games and activities were identified, as was watching episodes of the reality show *Survivor*. The EBD teacher used situations in the program to authentically provide discussion and instruction on real life skills, coping skills, and decision

making. Students also perceived goal setting instruction as a factor in their emotional–behavioral

progress.

Table 10

Student Perception of Personal/Social Factors that Contribute to or Hinder Their Progress

Contribute to Success	Number of Responses	Hinder Success	Number of Responses
Friends/Family	**18**	Attitude	**7**
Support	**15**	Building Trust	**13**
Trust	**23**	External Factors	**7**
		Interpersonal	**19**
		Reject	2
		Student Attutide	1
		Teacher Attitude	3

Note. Items in bold denote the top three delineated codes for the data set.

  Similar to the perceptions by staff, students perceived *trust*, *support*, and *friends–family* as the factors that contributed positively to their progress (see Table 10). Both groups of participants identified *trust* most prominently; *supports* and *friends–family* were in reverse order. Student responses under *trust* identified specific persons like the PSR worker or EBD teacher, or other specified teachers and staff as well as more general responses including "teachers here understand where I'm coming from" and "people here care for you," offered by Tonya. Watching the body language of the students when they discussed persons they perceived as supports for them was inspiring. Every student participant was able to identify at least one specific staff they attached to in a positive manner. Personal connections are difficult for students with RAD, which made this observation even more powerful.

  The importance of personal attachment was also identified in responses coded under *friends–family* where students shared both current family and friend connections who supported

their success and hopes for the future. "Friends and family will help me graduate" (Val), "I don't want to lose the family I have" (Mickie, referring to her foster family), "I want someone I can trust" (Tonya), "I trust my adoptive dad since he's been through the same things as me" (Kevin), and "[I] want to live with my brother and sisters" (Kevin) were included in statements from the student participants. Students appeared hopeful and nervous simultaneously as they shared their hope for family, friends, and relationships for the future.

Support consisted primarily of people supports in the school environment. Students discussed teachers who helped them gain confidence in specific content areas and staff members who helped them consider different perspectives when frustrated. "She helps me get my work done" and "she pushes me to do what I need to do" were perceptions shared by Val. Tonya shared, "The math teacher sits and helps each one of us." Kevin identified one of his supports: "[teacher's name] helped me calm down." Kevin's wish would be to have a 1:1 support staff at all times to assist him. He was also the one who admitted he often refused supports offered by the staff currently available to him. This type of behavior and thinking is not foreign to students with RAD, especially if they fall into the insecure attachment type (Ainsworth, 1979).

Many personal and social factors hinder the progress of students with RAD. Table 10 delineates the coded data in relation to hindering factors. Not surprisingly, *interpersonal* was the most prevalent set of data, followed closely by *building trust*, and then *attitude* and *external factors*. Prominent codes were identified similarly by both students and staff. Finding *interpersonal* issues as most prevalent would not be surprising to those familiar with RAD. Within the *interpersonal* code, student participants identified they did not like being around a large number of persons at one time, they were scared to get involved with peers, and too many people made them nervous. One student shared she had previously treated all of her friends like

they had to be in a sexual relationship. Multiple students identified they would rather be in a smaller school environment. One young lady shared she had lost someone who cared for her because she drove him away with her behaviors. These were visibly troubling issues for these students. Student names were purposefully omitted in the previous statement due to the sensitive nature of the content.

Building trust was the other prominent code. Trusting others is a major concern for students with RAD. "It's easier not to care, not to get close to someone," reported Mickie. Val shared, "It's hard for me to trust people….Building new trust would suck." Kevin reported he felt like he had been lied to by adults in his life, and, therefore, he did not trust people in general. Being in a number of foster homes, as many RAD students have, does not support building trust as evidenced by Mickie: "I was committed to one family, but they just kicked me out. It was the easiest thing to do, like it didn't matter. How was I supposed to take that?" Though no responses referred directly to school or school staff, the implications are the lack of trust affects students' ability to progress emotionally or behaviorally, which in turn affects academic success and progress for students with RAD.

The researcher considered combining *building trust* and *external factors* as they both comprised responses external to school but negatively affected student progress. However, the consideration was rejected as there appeared to be a distinct set of responses that revolved around trust and those that were factual information. *External factors* encompassed responses related to a student's father dying, a sibling being on the run and no one knowing where she was, extended family not wanting anything to do with the student, multiple foster home placements, and family telling the student he or she would end up in jail at some point. All of these external factors hinder a student from making progress in the school environment and can lead to

negative attitudes. "I feel like a disgrace to my family" (Mickie), "everyone has a better life than

me" (Kevin), and "I just don't care" (Mickie) were a few of the specific responses under *attitude*.

Table 11

Academic and Emotional–Behavior Intervention Progress Indicators –Student

Academic Indicators	Number of Responses	Emotional–Behavior Indicators	Number of Responses
Attitude	**5**	Attitude	**9**
Grades	**12**	Coping Skills	1
Skills	**6**	In Class/School	2
		Level	3
		No Drugs/Alcohol	**4**
		No fights	1
		Passed/Missed School	3
		Social	**4**

Note. Items in bold denote the top three delineated codes for the data set.

Grades, *skills*, and *attitude* occur in the same order in both the staff and student data sets when exploring academic progress indicators as demonstrated in Tables 11 and 6. Student responses when discussing academic success were encouraging as they reflected on the improvement in their grades from previous years to now. "Freshman year I had all 0's….Now all A's and B's—this feels great!" (Val). "I haven't gotten an F the entire season….I have all A's and B's right now" (Sarah). "I used to have straight F's but now I have straight A's" (Mickie). Student body language and tone of voice demonstrated pride in their accomplishments. Other students shared more specific information, including getting a B on the math final and being behind in credits but working to recover them. Credit acquisition was also represented in data set for *skills*.

Being behind a year in school due to skill deficit, working on lower level ninth-grade classes, and lacking growth in reading ability were included under *skills*. Sarah shared she was ahead in all of her classes, and for the first time she had a B. This piece of data was not included in the *grades* data set, as the context of the entire response was about acquisition of new skills, not the grade itself. "Math is getting easier," shared Mickie confidently. Confidence leads to better attitudes about school and progress.

When looking at the last data set, *attitude*, student attitudes were very apparent. Feeling like they were learning a lot and seeing positive outcomes when pursuing credit acquisition appeared to create positive attitudes in the majority of the student participants. Having a "take your time and finish it attitude" (Val) was very different from the "[my] 'off' button gets in the way of my academics" (Kevin). The later student showed his clear dislike for school and its structure throughout the interview sessions. He shared he would be leaving the current school at semester break and beginning online school. His attitude reflected his lack of buy-in to the current school setting due to the upcoming change. Progress was not something he was concerned about at this point unfortunately.

Table 11 also delineates the emotional–behavioral progress indicators identified by students. *Attitude*, *no drugs or alcohol*, and *social* were the three codes that emerged from the students as the most common perceptions of emotional–behavioral progress. Within the code *attitude*, student participants conveyed they measured emotional–behavioral progress by their improved attitude, having "chilled out more" (Val), "trying to do better" (Mickie), and getting confident. "I'm realizing that fighting isn't the easier way to find where you need to be and how to get there….[I'm] trying to focus on myself…not wanting to punch teachers" were thoughts

shared by Tonya. Unfortunately, Kevin shared and demonstrated he did not care about his progress.

It was interesting when students talked about progress monitoring because they referred to what they were not doing and instead of what they were doing. Indicating they had stopped doing drugs, stopped drinking, stopped partying, and stopped smoking and drinking were the central idea of responses in this data set. While the researcher would like to have seen responses indicating what they were doing, the ceasing of the mentioned negative behaviors was pleasing and positive.

The last code discussed here for emotional–behavioral progress is *social*. Responses in this data set centered around the students being less active, becoming quieter and sticking to themselves more, being more selective in their peer choices, and the positive influence of prescribed medication. Responses indicated positive changes that allowed them to make emotional–behavioral progress.

Side-by-Side Comparisons: Student–Staff Pairs

The following data tables delineate the similarities and differences of paired responses. The researcher believed these data were important in order to delineate the specific ideas and beliefs of the individuals in the pairs. The data demonstrate how well the staff and student in the pair perceive the effectiveness of interventions and factors that contribute to or hinder academic and emotional–behavioral progress for the individual student. In this way, educators can more closely explore where schools, programs, and staff may need to make some changes in order to help students be more successful. It does no good to have interventions in place for students to aid them in their success if they are ineffective. The researcher cautions readers that students with RAD can have very deep-seated beliefs and mindsets about school, staff, and interventions,

which may skew their perceptions. As the students in this study were all in high school, they had

at least eight to nine years of experience in school systems where not all of those experiences

were positive. The researcher believed the students responded honestly to the questions during

the interviews.

Table 12

Academic Data Paired Results

	Top Response Same	Top 3 Responses (Same order)	Top 3 Responses (any order)	2/3 Top Response Same
Pair 1 Total Same Responses	**5**	**1**	**4**	**5**
Academic Supports	Y	N	N	Y
Academic Not Helpful	Y	N	Y	Y
Academic Most Helpful	N	N	Y	Y
Academic Progress	Y	Y	Y	Y
Pair 2 Total Same Responses	**4**	**1**	**3**	**4**
Academic Supports	Y	Y	Y	Y
Academic Not Helpful	N	N	N	Y
Academic Most Helpful	N	N	N	N
Academic Progress	Y	N	Y	Y
Pair 3 Total Same Responses	**1**	**0**	**2**	**4**
Academic Supports	N	N	Y	Y
Academic Not Helpful	N	N	Y	Y
Academic Most Helpful	Y	N	N	N
Academic Progress	N	N	N	Y
Pair 4 Total Same Responses	**2**	**1**	**1**	**3**
Academic Supports	N	N	N	Y
Academic Not Helpful	Y	N	N	Y
Academic Most Helpful	N	N	N	N
Academic Progress	Y	Y	Y	Y
Pair 5 Total Same Responses	**3**	**2**	**4**	**4**
Academic Supports	Y	Y	Y	Y
Academic Not Helpful	N	N	Y	Y
Academic Most Helpful	Y	N	N	N
Academic Progress	N	N	Y	Y
Note. Categories in bold indicate at least 2/3 top codes the same.				
Total (out of 5)	**Top Response Same**	**Top 3 (Same order)**	**Top 3 (any order)**	**2/3 Top Same**
Academic Supports	3	2	3	5
Academic Not Helpful	2	0	3	5
Academic Most Helpful	2	0	1	1
Academic Progress	3	2	3	5
Total Paired Responses of (30)	15	5	13	20

Table 12 demonstrates the paired perceptions of staff and students regarding academic interventions and progress. As the table demonstrates, only two of the five staff–student pairs delineated the same top code for academic interventions they perceived as effective. Pair 3 and pair 5 both had *supports* as the most prominent code under effective interventions. One of the five pairs had two of the top three codes as the same (see Appendix M). All but student 2 and staff 4 had the code *supports* in the top three. Three students had *a person* as a top-three code, but only one staff participant's data set led to *a person* as a top-three code. *Supports* were the highest ranked intervention in both student and staff holistic data sets. *Motivation* and *a person* were secondary and tertiary factors for students while *modification* and *consistency* emerged from staff.

While responding to questions pertaining to interventions and factors perceived to hinder academic progress, two of the five pairs had the same top code, and all five pairs had at least two of the three top codes the same (see Appendix M). Pair 1 identified *pacing* and pair 4 delineated *emotional regulation* as the predominant factor hindering academic success. All participants except student 4 had *difficult* as a top-two code. *Difficult* pertained to the difficulty of work and the requirements of general education teachers. Student 4's data did not lead to a code of *difficult* under hindering factors. All five students and three staff participants had *expectations* as a top-three code. Only staff 2 and 3 lacked this code. *Expectations* had responses regarding what the teachers expected the students to be able to do.

When identifying supports in school contributing to student academic success, three of the five pairs had the same dominant code, and all five had at least two of the three top codes the same (see Appendix M). Pair 1 identified *a person*, pair 2 identified *modifications*, and pair 5 identified *accommodations* as the most effective support in the school setting. All participants

had responses that placed *modifications* in the top three codes. Individual responses referred to changes in class schedules, doubling up classes to achieve academic credit, and changes in class size.

Academic progress was viewed similarly by three pairs of participants. Pairs 1, 2, and 4 all delineated *grades* as the most prominent way they perceived academic progress. All five pairs identified two of three top progress codes the same (see Appendix M). Interestingly, only pair 5 did not have *grades* as an identified code. The data supported *skills* and *attitude* as codes. All participant data demarcated *attitude* as a top-three code except students 3 and 4 and staff 4.

Table 13

Behavior Data Paired Results

	Top 1 Same	Top 3 Responses (Same Order)	Top 3 Responses (Any Order)	2/3 Top Responses Same
Pair 1 Total Same	**2**	**0**	**2**	**4**
Behavior Supports	N	N	Y	Y
Behavior Not Helpful	Y	N	N	Y
Behavior Most Helpful	Y	N	N	Y
Behavior Progress	N	N	N	N
Pair 2 Total Same	**1**	**0**	**2**	**3**
Behavior Supports	Y	N	Y	Y
Behavior Not Helpful	N	N	N	N
Behavior Most Helpful	N	N	N	Y
Behavior Progress	N	N	N	N
Pair 3 Total Same	**4**	**0**	**1**	**4**
Behavior Supports	Y	N	N	Y
Behavior Not Helpful	N	N	N	N
Behavior Most Helpful	Y	N	N	Y
Behavior Progress	Y	N	N	Y
Pair 4 Total Same	**4**	**1**	**1**	**4**
Behavior Supports	N	N	N	Y
Behavior Not Helpful	Y	N	N	Y
Behavior Most Helpful	Y	N	N	N
Behavior Progress	N	N	N	N
Pair 5 Total Same	**3**	**1**	**3**	**5**
Behavior Supports	N	N	Y	Y
Behavior Not Helpful	Y	N	N	Y
Behavior Most Helpful	N	N	N	N
Behavior Progress	Y	Y	Y	Y
Note. Categories in bold indicate at least 2/3 top codes the same.				
Total (out of 5)	**Top 1 Same**	**Top 3 (Same order)**	**Top 3 (Any Order)**	**Top 2/3 Responses Same**
Behavior Supports	**2**	**0**	**3**	**5**
Behavior Not Helpful	**3**	**0**	**0**	**3**
Behavior Most Helpful	**3**	**0**	**0**	**3**
Behavior Progress	**2**	**1**	**1**	**2**
Total Same Responses of Pairings (out of 30)	**14**	**2**	**9**	**20**

As this study also looked at emotional–behavioral interventions and factors that contributed to and hindered progress, the researcher will now discuss the data in Table 13. Questions related to emotional–behavioral interventions and factors deemed effective elicited responses that led to three of the staff–student pairs having the same top code. Pair 1 delineated a *person*; pair 3, *people*; and pair 4, *consistency*. Three pairs had at least two of three similar codes in the top three. *Consistency* was a top-three code for staff 1, 2, 4, and 5, and student 4. *Coping skills* was a top-three code for students 1, 3, and 5, and staff 4. *A person*, *people*, and *consistency* were in the top three overall codes for both staff and student participants.

Three student–staff data sets found the same code when questioned about factors that hindered student emotional–behavioral progress (Table 4.12). Pair 1 identified *people*; pair 4, *expectations*; and pair 5, *attitude*. Pairs 1, 4, and 5 had two of the top three codes the same. *People* was delineated as a top-two code by all student participants and staff 1, 2, and 4. Negative peer groups, bullies, and people who are rude, people who get out of hand, and person instigated trauma were some of the specific responses. Three students and three staff had *expectations* as a top-two code. Most responses centered on general education teachers' expectations being unrealistic or inflexible (see Appendix N). Engaging in power struggles and being expected to do things they did not want to do were also found in this code. *Attitude* was another top-three code for students. Some students indicated they did not want to adhere to expectations set forth by the teachers solely because they did not want to. Others indicated they made negative comments and felt negatively toward themselves and their abilities. Both attitudes were found to hinder emotional–behavioral progress (see Appendix N. Students and staff identified other staff *supports* as important to assist in student emotional–behavioral progress. Pair 2 demonstrated *instruction* as the prominent code, while pair 3 showed *a person* to be

dominant. All five student and staff participants identified *instruction* as a top-three code. *A person* was identified by both student and staff 1, student and staff 3, student 4, and student 5. *Consistency* was identified as a top-three code by student 4 and all staff participants. Student 5 told the interviewer he rejected supports the school offered multiple times per day.

Two student–staff pairs delineated *attitude* as the prominent code in their data sets. No other pair had the same prominent code. *Attitude* was the dominant code that emerged from the combined student data sets (see Appendix N). This code referred to the students' efforts and willingness to try even when things were difficult. Only one student reported he did not care about his emotional–behavioral progress. Students also indicated they measured emotional–behavioral progress by the things they were not doing. "Stopped doing drugs…stopped drinking" (Mickie), and "not fighting" (Tonya) were a couple of the individual responses. While staff did acknowledge improved student attitudes as indicators of emotional–behavioral progress, their dominant code was *data*. This is not surprising, as educators, especially special education staff, are trained to collect large amounts of data to help in decision making, progress monitoring, and compliance.

Table 14

Positive and Negative Relationship Data Paired Results

	Top Response Same	Top 3 Responses (Same Order)	Top 3 Responses (Any Order)	2/3 Responses Same
Pair 1 Total Same	**2**	**2**	**2**	**2**
Positive Relationships	Y	Y	Y	Y
Negative Relationships	Y	Y	Y	Y
Pair 2 Total Same	**1**	**0**	**0**	**2**
Positive Relationships	N	N	N	Y
Negative Relationships	Y	N	N	Y
Pair 3 Total Same	**1**	**0**	**1**	**2**
Positive Relationships	N	N	Y	Y
Negative Relationships	Y	N	N	Y
Pair 4 Total Same	**2**	**1**	**1**	**2**
Positive Relationships	Y	N	N	Y
Negative Relationships	Y	Y	Y	Y
Pair 5 Total Same	**1**	**0**	**2**	**2**
Positive Relationships	Y	N	Y	Y
Negative Relationships	N	N	Y	Y
Note. Categories in bold indicate at least 2/3 top codes the same.				
	Top 1 Same	**Top 3 Responses (Same Order)**	**Top 3 Responses (Any Order)**	**2/3 Top Responses Same**
Positive Relationships	3	1	3	5
Negative Relationships	4	2	3	5

When working with students with mental health disorders like RAD, there is always a relationship component that can serve as a catalyst or hinder all student progress. The researcher found definite indicators of positive and negative relationships when analyzing the data in this study. Three student–staff pairs demonstrated the same dominant positive relationship code as seen in Table 14. Pair 1 delineated *support*; pair 4, *trust*, and pair 5, *family–friends* (see

Appendix O). Every student–staff pair had at least two of the top three codes the same. All participants except staff 5 delineated *trust* as a top-three factor. All but student 4 and staff 1 and 2 delineated *family–friends* in their top three codes. *Supports* was a top-three code for all participants except student 2 and staff 4. Both staff and student responses under *supports* referred to a person or people who provided academic and emotional–behavioral supports and was someone the students felt cared about them and their progress in school. While both staff and student responses warranted a code of *family–friends*, staff responses referred to friends or the desire to have friendships at school as opposed to student responses about friends, boyfriends, and family outside of the school setting. Student responses under *trust* consisted of a feeling of connection with specific staff members whom they felt understood their situations and moods, related with them due to shared life experiences, or demonstrated a caring nature. Staff responses under *trust* mirrored those ideas as well, as the thought consistency of schedule, expectations, and consequences made students feel safe because they knew what to expect on any given day, which built trust between the student and staff.

When turning the focus to negative relationships and relational issues that hinder student progress, four student–staff pairs delineated the same primary code. Pairs 1, 3, and 4 had *interpersonal* as the primary code (see Appendix O). While this is true, the researcher must note staff 3 had a co-leader in *building trust*. Pair 2 had a top code match in *building trust*. To be transparent, the researcher must also note staff 2 had co-leaders with the codes *external factors* and *attitude*. Pair 5 did not have a top code match. All five pair had at least two of the top three codes the same. All participants except staff 2 delineated *interpersonal* as a top-two code. *Interpersonal* in both staff and student responses focused on the students' inability to make and

maintain a positive relationship in the school setting, which could add to their apathy and, in turn, school success.

Summary of the Results

In this study, academic and relational perceptions of effective interventions and factors were more similar than emotional–behavioral perceptions for students with RAD and the special education staff who work directly with them. The researcher posits academic interventions and strategies are more common and are discussed more frequently than interventions and strategies for emotional–behavioral concerns. It is easier to discuss raw numerical data with students in a way they understand as it appears objective. Discussing anecdotal data and even numerical data related to emotional–behavioral areas can sometimes appear to the student to be subjective and a preference of the school and staff. The positive and negative relational factors students and staff delineated shared the top code. The top three codes were actually the same. Codes 2 and 3 were in reverse order from student to staff. This indicates staff and students saw the same relational factors affecting their learning though students referred to outside persons more than staff data sets did.

Table 15

Total Responses Paired Results—Holistic View

	Top Response Same	Top 3 Responses (Same Order)	Top 3 Responses (Any Order)	2/3 Top Responses Same
Totals (out of 10 paired responses)	6	1	7	9
Academic Supports	Y	N	Y	Y
Academic Not Helpful	Y	N	Y	Y
Academic Most Helpful	Y	N	N	N
Academic Progress	Y	Y	Y	Y
Behavior Supports	N	N	Y	Y
Behavior Not Helpful	N	N	N	Y
Behavior Most Helpful	N	N	Y	Y
Behavior Progress	N	N	N	Y
Positive Relationships	Y	N	Y	Y
Negative Relationships	Y	N	Y	Y

Note. Items in bold demonstrate codes where two of the three top codes were the same for student and staff data sets.

Table 15 demonstrates the holistic view of total student–staff responses. Codes from all students compared to codes from all staff show similarities and differences in the dominant codes that emerged from the data. Overall the student–staff pair perceptions were more closely aligned in the *academic* and *relational* areas than the *behavioral* areas. It was interesting the top three codes for *academic progress* were exactly the same and in the same order for students and staff, while *behavioral progress* showed only two of the top three codes the same, but not the top code

the same. In all areas except *academic most helpful* students and staff shared at least two of the

top three codes (see Appendix P).

Chapter V

Discussion

Introduction

Chapter 5 will summarize the results of data collected during this grounded theory study. Themes emerged during the data collection and analysis that will have implications for professional practice and provide some direction for further research. Themes that emerged from the data will be presented for each of the research questions from a macro to micro vantage point in order to help the reader understand holistic data do not represent all paired data sets. This will also lead the reader to suggestions for professional practice.

Summary of the Results

Research question 1. What school-based academic and emotional–behavioral interventions do staff perceive as having improved academic and emotional–behavioral outcomes in high school students with RAD? In this study, staff participant responses led to codes of *modification*, *accommodations*, *a person*, *supports*, and *consistency* as predominant when exploring the academic interventions, supports, and factors that led to academic success for students with RAD. *Difficulty* of skill requirements, inconsistent *emotional regulation* of students, and *refusal* to accept intervention and supports offered were the major codes delineated when discussing factors hindering academic progress and success. Staff participants predominantly identified *grades* as the way they determined academic progress, followed by individual *skill* acquisition and student *attitude* toward academic requirements and expectations.

Dominant emotional–behavioral interventions, supports, and factors staff participants perceived as effective for students with RAD were *instruction*, *consistency*, *a person*, and *people*. Staff delineated *expectations*, *people*, and *environment* as factors hindering emotional–

behavioral progress in students with RAD. *Data* was the clear leader in how staff perceived emotional–behavioral progress. *Observation*, *social*, and *attitude* were a distant second, each having the same number of responses.

Staff data sets delineated *trust* followed by *support* and *family–friends* as the positive relational factors contributing to student success. *Interpersonal* followed by *external factors* and *building trust* were the major negative relational factors staff participants perceived as hindering student overall progress.

Research question 2. What school-based academic and emotional–behavioral interventions do high school students with RAD perceive as having a positive effect on academic and behavioral outcomes? High school students with a diagnosis of RAD in this study perceived *modifications*, *a person*, *assistance*, *supports*, and *motivation* as the interventions and factors contributing most to their academic success. Difficulty of the work, *expectations* of teachers (primarily general education teachers), and *pacing* of instruction and timelines were the factors student participants perceived to hinder their academic progress. As with the staff participants, student participants delineated *grades*, *skills*, and *attitude* as the way they measured academic progress.

Student participants in this study delineated *a person*, *instruction*, *people*, and *consistency* as the interventions and factors contributing to their emotional–behavioral progress. Conversely, negative *people*, inappropriate *expectations*, and their own *attitudes* were the factors hindering their ability to make emotional–behavioral progress. Positive changes in their *attitude*s, making positive lifestyle changes such as *no drugs or alcohol*, and appropriate *social* interactions were the metrics students used to determine their own emotional–behavioral progress and success.

Student responses when discussing the positive relational factors which contributed to academic and emotional–behavioral progress were *trust*, *family–friends*, and *supports* provided at school, primarily in the form of personnel. Negative *interpersonal* skills and practices, difficulty building trust with peers and staff, and external factors including foster care, negative family experiences, and deaths in the family were the major factors students delineated as hindering their ability to make academic and emotional–behavioral progress.

Conclusions

Data analysis led the researcher to determine student and staff participants in this study perceived similarly the interventions and factors that contributed to or hindered academic progress. The interventions and factors that contributed to or hindered emotional–behavioral progress demonstrated more differences indicating a need to bridge this gap in understanding. Five prominent themes emerged in this study.

Theme 1: General education teachers need additional training in mental health disorders and their implication on learning and emotional–behavioral functioning. When responding to questions targeting academic and emotional–behavioral progress, staff and student participants both perceived the attitude and *expectations* of the general education teachers to be a major factor that hindered student progress. Very limited training is provided for teachers in relation to social and emotional–behavioral needs (Feuerborn & Chinn, 2012; Meister & Melnick, 2003; Merrett & Wheldall, 1993). Limited training can lead to power struggles with students or the habit of allowing students to "check out" and not pay attention. These were identified by staff as factors hindering student success. Students shared their frustrations in general education with the pacing of the instruction, time restriction for assignments, being pushed to do too much at the same time, and their overall ability to keep up. Teachers and

administrators must take the initiative and seek out training for working with students with intensive needs like RAD (Davis et al., 2006; O'Neill et al., 2010; Schwartz & Davis, 2006). Browne et al. (2012) posed the question, "What are we going to do to help support and ameliorate the effect of children's RAD symptoms in our school and community settings?" They went on to assert teachers in the United States are not prepared or qualified to work with students with mental health disorders (Browne et al., 2012).

Training and subsequent understanding would give general education teachers the skills and flexibility to modify schedules and provide accommodations to students with RAD. *Modification* was identified by staff as a top-three code in this study. Schwartz and Davis (2006) postulated students with RAD come to school with more social, emotional, and behavioral challenges than typical peers. Cleary and Abbott (2011) added by identifying and understanding brain-related patterns, teachers can identify why students struggle and understand traumatized children cannot regulate their own emotional arousal like typical children, which can impede their academic and emotional–behavioral functioning. Modifying class schedules, class sizes, and the number of courses required at one time were all identified in this study as contributing to student success. Browne et al. (2012) shared having a specific case manager in the school setting can ensure school-based interventions are provided for students with RAD.

Theme 2: Students with RAD need to perceive staff genuinely care about them and their success. The root of attachment theory by Ainsworth and Bowlby (1991) is a feeling of security from knowing the caretakers in the children's environment care for them and their welfare. Though their research did not focus on the school setting, it could be argued in this day and age schools do provide the care and nurture for students who do not get them elsewhere. Students with RAD have typically had a long history of traumatic experiences beginning in

infancy, where they were subjected to pathogenic care. Being denied needed emotional comfort, stimulation, and affection, and being subjected to a disregard for physical needs lead to a lack of emotional attachment and distrust. *Trust* and *building trust* were factors student and staff perceived as contributing to or hindering student success. The researcher was pleasantly surprised to find, in general, students shared they trusted the special staff they worked with currently. This was affirmed by the staff as well. However, students identified a lack of desire to try and build trusting relationships with others. The staff shared this was a concern for students as well. It was interesting to the researcher the responses in this study from student and staff participants identified *a person* and *people* as prominent codes. Ms. Nancy even specifically stated "knowing people care about her" contributed to Tonya's progress in school. Tonya said, "Teachers that understand me" help her to be successful. Professional development using Sousa's book *How the Special Needs Brain Learns* (2007) or DeBruyn and Larson's *You Can Handle Them All* (2009) would give teachers an opportunity to starting understanding students and their behavior.

Haugaard and Hazen (2004) explained the goal of intervention for students with RAD should be to provide an emotionally safe environment so they are willing to be guided in regard to social skills. O'Neill et al. (2010) posited students with a history of trauma must develop a trusting relationship with a caring person in the educational environment in order for academic progress to be made.

Theme 3: Students with RAD need designated staff to support them. While providing caring staff who are concerned about student success is important, the responses in this study by staff and students support providing one designated adult to be the go-to person. Students identified PSR staff, a paraprofessional, or a specific teacher as the person they trusted. Ms.

Molly shared, "[Sarah] has one go-to person," which helps with consistency and provides Sarah one dedicated staff person to support and advocate for her academic and emotional–behavioral needs. Student and staff responses in this study indicated a level of trust between the student and the designated staff. "She talks to me about her trauma and any issues she has" (Ms. Molly). "She feels like the PSR is there to support her" (Mr. Frank). The staff–student pairs where the student did not have a designated person indicated it would be a wish for the future. Browne et al. (2012) shared this same theory when they discussed having a specific case manager for students with RAD in the school setting.

Theme 4: Students with RAD require direct instruction regarding how and why emotional–behavioral progress is being monitored. As could be predicted, special education staff in this study relied primarily on *data* to determine emotional–behavioral progress for students. Though the staff in this study did not all use the same tracking mechanism, they all relied on the data from the tool they used. While students did offer responses regarding not missing school, not missing classes, and their progress in a level system as indicators of progress, which are measured with data, the prominent metric students identified to measure emotional– behavioral progress was *attitude*. Attitude in itself is difficult to measure objectively; this is a disconnect. Teachers are looking for objective data while students are looking for more subjective data.

Theme 5: Students with RAD require direct instruction on how to build and keep trusting relationships with peers, family, and staff. O'Neill et al. (2010) identified school counselors, school social workers, and school psychologists can provide small group or individual instruction to help students learn skills to build or repair relationships, build trust, and improve emotional–behavioral regulation.

Due to students' trauma histories, monitoring their own behavior is difficult as they have no concept of self-regulation or self-management (Zilberstein & Messer, 2010). Teaching students to monitor and record their own behavior is imperative (Farley et al., 2012; Rapp-Pagliccci et al., 2011; Reid et al., 2005). Building and keeping relationships is dependent on self-management. Rapp-Pagliccci et al. (2011) posited there is a direct link between self-management and academic achievement.

Staff responses in this study supported Farley et al. (2012), O'Neill et al. (2010), Rapp-Pagliccci et al. (2011), Reid, Trout, and Schartz (2005), and Zilberstein and Messer's (2010) assertions about specifically providing direct instruction to students on personal space and boundaries, anger management, and social skills. There are multiple curricula which address these specific issues. School social workers, school psychologists and counselors can provide a specific list to staff members.

Recommendations for Further Research

As this study was a grounded theory study, the perceptions and ideas that emerged should be used as a baseline for further research. Future research should focus on the following areas in order to prove or disprove the themes that emerged in this study:

- Conduct similar research on a larger scale
- Extend to middle school and elementary school
- Determine degree of student academic and emotional–behavioral growth through the addition of quantitative data

Implications for Professional Practice

In order to ameliorate the negative effects of RAD on student academic and emotional–behavioral progress, school staff must make changes in the way in which decisions are made and

practices are implemented. Expectations for students with RAD should be seriously discussed with all staff, including general education teachers, to ensure the rigor, pacing, and workload are appropriate. Success can be accomplished through IEP follow, through progress monitoring, and collaborative efforts focused on student success. Modifications to class schedules and structure, expectations of all course requirements, and appropriateness of coursework for individual students should be considered.

Schools and staff should provide necessary supports for students with RAD in the form of additional assistance with classwork and homework with a caring and nurturing attitude. Positive behavior supports, such as being able to earn and utilize music, drawing, and taking a break, should be incorporated into student support plans.

While not always possible or appropriate, providing a 1:1 staff or a go-to person for students with RAD should be considered. This person should assist with academic work as appropriate, provide guidance for self-management and advocacy, provide direct instruction as necessary, and be a liaison for the rest of the staff supporting the student. This person should also ensure the student is feeling supported and cared for as a person.

Due to the obvious differences in how students and staff see emotional–behavioral progress, it would behoove school staff to directly teach students the methods by which they measure emotional-behavioral progress. Schools should absolutely applaud and celebrate the positive attitudes and choices occurring in their students, especially students with RAD. Direct instruction with students on the value and purpose of consistent structure, expectations, and consequences would be helpful in order for students to understand how it aids in their progress. The negative self-attitudes expressed by some of the students can be addressed in the school setting through counseling and therapy provided by the school counselor, social worker, or

school psychologist. There are specific programs available for use in the school setting. Teaching students to understand and use objective data to self-monitor and self-manage behaviors would promote independence and may assist with self-esteem and self-worth. Staff should provide direct instruction in the emotional–behavioral realm, utilizing multiple methods of instruction and true-to-life scenarios whenever possible.

New Theoretical Explanation

The new theoretical explanation that emerged from this study for working with students with RAD in the school setting is the *RAD teaching practice*. Within this theoretical explanation there are five steps school administration and staff must follow in order to provide students with RAD the best opportunity for positive academic and emotional–behavioral outcomes. The five steps are as follows:

1. Seek training for administrators and staff on RAD and the implications on learning.

2. Develop emotional support systems for students with RAD.

3. Determine specific staff to be the "go-to" person for the student with RAD.

4. Provide direct instruction regarding how emotional–behavioral progress will be monitored and review progress frequently.

5. Provide direct instruction regarding how to build and maintain trust with others.

Steps 1 and 2, acquiring additional and specific training and developing practices and procedures to support the emotional needs of students with RAD, seem intuitive. However, steps 3–5 will require new thinking in regard to practices and procedures necessary to support students with RAD in the school setting. These, therefore, become the core of the *RAD teaching practice.*

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Appendix A

Interview Questions Pilot Group

Ashley Fowers-Coils	School Psychologist
Mindy Baze	School social Worker
Kathy Kurns	School Counselor

Appendix B

Confidentiality Agreement for Proxy Interviewer

Appendix Q
Confidentiality Agreement for Proxy Interviewer

I understand that by signing this document I agree to hold confidential any and all information gained during my participation in this study as a proxy interviewer of students with a RAD diagnosis and staff personnel that work with those students. I assert that I hold a position in the school district where I understand what confidentiality means and am aware of the sensitive nature of some of the information I may gather during the interview process. I understand that I can be held legally responsible for breaking the confidentiality of student with disabilities and school staff.

I acknowledge that I have knowledge and training in how to work with students with disabilities and with mental health disorders. I agree to receive specific training with the researcher prior to conducting interviews to ensure understanding of the questions I will ask the participants and to understand the purpose behind the questions. I understand the format of a semi-structured interview and what the parameters of the questions can be. I will refrain from asking probing or clarifying questions of students that refer to the origin of their RAD diagnosis and will focus on their school experiences in relation to supports and interventions provided in that setting and their perceived effectiveness.

I _Kathryn S. Kurns_ agree to the terms and conditions of the binding confidentiality agreement. I acknowledge that I can be held legally liable if I break the confidentiality of the participants in this study. I assert that I do not work directly with the students I will interview as the Proxy. I assert that I am not the supervisor for any staff personnel that I may interview as the Proxy.

Kathryn S. Kurns   10/31/14
Signature of Proxy Interviewer   Date

[signature]   10/31/14
Signature of Researcher   Date

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Appendix C

Site of Study Authorizations

Nampa School District:

NAMPA

School District No. 131

619 S. Canyon St. • Nampa, ID 83686
(208) 468-4600 • Fax (208) 468-4638
www.nsd131.org

February, 3, 2014

Northwest Nazarene University
Attention: HRRC Committee
Helstrom Business Center 1st floor
623 S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site Access for Mrs. Cynthia Cook

Dear HRRC Members:

This letter is to inform the HRRC that Administration at Nampa School District has reviewed the proposed dissertation research plan including subjects, intervention, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Mrs. Cook has permission to conduct her research in the district of and with students and staff of the Nampa School District. The authorization dates for this research are July 2014 to April 2015.

Respectfully,

Pete Koehler
Superintendent

Boise School District:

Ms. Cook,
I am pleased to inform you the Research Committee has approved your proposal, contingent on your securing permission from Ms. Hocevar. The Committee wishes you all the best with this research and asks that, when completed, you send a copy of your findings to my office.
Regards,
Russ

>>> "Cook, Cyndi" <ccook@nsd131.org> 2/17/2014 8:58 PM >>>
Good Evening Mr. Heller,

Please find the attached document to fulfill the BSRC requirements for a research proposal in the Boise School District. Please also find the attached letter from Dr. Mike Poe from NNU, my Dissertation Committee Chair.

Please let me know if you need any additional information.

Thank you for your time and consideration.

Cyndi Cook
Administrator

Hello Cyndi,

This sounds great. Looking forward to visiting with you.

Tracey Hocevar

Tracey L. Hocevar
School Psychologist
ASCENT Program
tracey.hocevar@boiseschools.org

Appendix D

Informed Consent for Participation in Study by Adults

INFORMED CONSENT FORM

A. PURPOSE AND BACKGROUND

Cyndi Cook, PhDc, in the Department of Graduate Education at Northwest Nazarene University is conducting a research study related to Reactive Attachment Disorder. The study will explore school-based interventions, supports, and services that are currently implemented in schools and the perceptions of their effectiveness by high school students diagnosed with RAD and school staff. We appreciate your involvement in helping us investigate how to better serve and meet the needs of Northwest Nazarene University students.

You are being asked to participate in this study because you are a healthy volunteer, over the age of 18.

B. PROCEDURES

If you agree to be in the study, the following will occur:

1. You will be asked to sign an Informed Consent Form, volunteering to participate in the study.

2. You will participate in two semistructured interviews.

3. You will be asked to reply to an e-mail at the conclusion of the study asking you to confirm the data that was gathered during the research process.

These procedures will be competed at a location mutually decided upon by the participant and principal investigator and will take a total time of about 45 minutes.

C. RISKS/DISCOMFORTS

1. Some of the discussion questions may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to stop participation at any time.

2. For this research project, the researchers are requesting demographic information. Due to the make-up of Idaho's population, the combined answers to these questions may make an individual person identifiable. The researchers will make every effort to protect your confidentiality. However, if you are uncomfortable answering any of these questions, you may decline to answer.

3. Confidentiality: Participation in research may involve a loss of privacy; however, your records will be handled as confidentially as possible. No individual identities will be used in any reports or publications that may result from this study. All data from notes, audio tapes, and disks will be kept in a locked file cabinet in the Department and the key to the

cabinet will be kept in a separate location. In compliance with the Federalwide Assurance Code, data from this study will be kept for three years, after which all data from the study will be destroyed (45 CFR 46.117).

D. BENEFITS

There will be no direct benefit to you from participating in this study. However, the information you provide may help educators to better understand the characteristics of students with Reactive Attachment Disorder. It will also help identify school-based interventions, strategies, supports and services that will provide the greatest emotional/behavior and academic outcomes possible for students with Reactive Attachment Disorder.

E. PAYMENTS

There are no payments for participating in this study.

F. QUESTIONS

If you have questions or concerns about participation in this study, you should first talk with the investigator. Cyndi Cook can be contacted via e-mail at ccook@nsd131.org , via telephone at 208-498-0557 (W) / 208-870-0618 (C) or by writing: 141 Smith Street, Nampa, ID 83619.

Should you feel distressed due to participation in this, you should contact your own health care provider.

G. CONSENT

You will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. Your decision as to whether or not to participate in this study will have no influence on your present or future status as a student at Northwest Nazarene University.

I give my consent to participate in this study:

_____   _____
Signature of Study Participant   **Date**

I give my consent for the interview and discussion to be audio taped in this study:

_____   _____
Signature of Study Participant   **Date**

I give my consent for direct quotes to be used in this study:

_____   _____
Signature of Study Participant   **Date**

Signature of Person Obtaining Consent	**Date**

THE NORTHWEST NAZARENE UNIVERSITY HUMAN RESEARCH REVIEW COMMITTE HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH.

Appendix E

Informed Consent by Adult Student for Participation in the Study

INFORMED CONSENT FORM

A. PURPOSE AND BACKGROUND

Cyndi Cook, EdDc, in the Department of Graduate Education at Northwest Nazarene University is conducting a research study related to Reactive Attachment Disorder. The study will explore school-based interventions, supports, and services that are currently implemented in schools and the perceptions of their effectiveness by high school students diagnosed with RAD and school staff. We appreciate your involvement in helping us investigate how to better serve and meet the needs of Northwest Nazarene University students.

You are being asked to participate in this study because you are a healthy volunteer, over the age of 18.

B. PROCEDURES

If you agree to be in the study, the following will occur:

4. You will be asked to sign an Informed Consent Form, volunteering to participate in the study.

5. You will participate in two, approximately 45 minute interviews either in–person or via electronic mode (Skype, Adobe Connect, Face Time, etc). Interviews will be recorded so they can be reviewed and transcribed accurately.

6. You will be asked to reply to an e-mail at the conclusion of the study asking you to confirm the data that was gathered during the research process.

These interviews will be competed at a location mutually decided upon by the participant and principal investigator and will take a total time of about 45 minutes each.

C. RISKS/DISCOMFORTS

4. Some of the discussion questions may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to stop participation at any time.

5. For this research project, the researchers are requesting demographic information. Due to the make-up of Idaho's population, the combined answers to these questions may make an individual person identifiable. The researchers will make every effort to protect your confidentiality. However, if you are uncomfortable answering any of these questions, you may decline to answer.

6. Confidentiality: Participation in research may involve a loss of privacy; however, your records will be handled as confidentially as possible. No individual identities will be used in any reports or publications that may result from this study. All data from notes, audio

tapes, and disks will be kept in a locked file cabinet in the Department and the key to the cabinet will be kept in a separate location. In compliance with the Federalwide Assurance Code, data from this study will be kept for three years, after which all data from the study will be destroyed (45 CFR 46.117).

D. BENEFITS

There will be no direct benefit to you from participating in this study. However, the information you provide may help educators to better understand the characteristics of students with Reactive Attachment Disorder. It will also help identify school-based interventions, strategies, supports and services that will provide the greatest emotional/behavior and academic outcomes possible for students with Reactive Attachment Disorder.

E. PAYMENTS

There are no payments for participating in this study.

F. QUESTIONS

If you have questions or concerns about participation in this study, you should first talk with the investigator. Cyndi Cook can be contacted via e-mail at ccook@nsd131.org , via telephone at 208-498-0557 (W) / 208-870-0618 (C) or by writing: 141 Smith Street, Nampa, ID 83619.

Should you feel distressed due to participation in this, you should contact your own health care provider.

G. CONSENT

You will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. Your decision as to whether or not to participate in this study will have no influence on your present or future status as a student at Northwest Nazarene University.

I give my consent to participate in this study:

Signature of Study Participant	**Date**

I give my consent for the interview and discussion to be audio taped in this study:

Signature of Study Participant	**Date**

I give my consent for direct quotes to be used in this study:

Signature of Study Participant	**Date**

Signature of Person Obtaining Consent   **Date**

THE NORTHWEST NAZARENE UNIVERSITY HUMAN RESEARCH REVIEW COMMITTE HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH.

Appendix F

Assent by Minor Student, After Legal Guardian Has Granted

Permission for Participation in the Study

August 23, 2014

Dear Parents & Guardians,

This year, I have the opportunity to conduct a research study with your, other children diagnosed with Reactive Attachment Disorder, and school staff as a part of my graduate program at Northwest Nazarene University. The study has been reviewed by the Research Review Committee at Northwest Nazarene University and has been successfully approved.

The benefits that may result from the research are: better understanding of Reactive Attachment Disorder by educational staff, improved school-based interventions, services, and supports for children diagnosed with Reactive Attachment disorder.

The procedures are as follows:

- The research project will take place over a period of four months.
- Data will be collected in the form of interviews with students and school personnel from August 2014-November 2014.
- Themes discovered during interviews will be reviewed with participants to ensure accuracy in reporting.

I anticipate that there is minimal risk involved for your learning over the course of the study. Interviews will take place in the school setting either in person for via electronic mode (Skype, Adobe Connect, or Face Time). The online survey for caregivers will consist of multiple choice options and a few open-ended questions at the end

Your participation in this project is completely voluntary. In addition to your legal guardian's permission, your will also be asked if you would like to take part in this project. You may stop taking part at any time without repercussion of any form. The choice to participate or not will not impact your grades or status at school.

All information that is obtained during this research project will be kept strictly secure and will not become a part of your school record. The results of this study may be used for a research paper and presentation. Pseudonyms or codes will be substituted for the names of children and the school to ensure confidentiality.

In the space at the bottom of this letter, please indicate whether you do or do not want to participate in this project. The second copy is to keep for your records. If you have any questions about this research project, please feel free to contact me either by mail, e-mail, or telephone. Please keep a copy of this form for your records.

The results of my research will be available after May 30, 2015. If you would like to have a copy of the results of my research or have any questions, please contact me at 208-870-0618 or my advisor, Dr. Mike Poe, at 208-467-8062.

Sincerely,

Cyndi Cook
Gateways Administrator
Nampa School District
208-498-0557
ccook@nsd131.org

****
I have read this form. I understand that nothing negative will happen if I do not participate. I know that I can stop participation at any time. I voluntarily agree to participate in this study as **follows:**

YES _____ **I will participate in this study.**

NO _____ **I will NOT participate in this study.**

I give my consent for the interview and discussion to be audio taped in this study:

Signature of Study Participant	**Date**

I give my consent for direct quotes to be used in this study:

Signature of Study Participant	**Date**

Student's printed name: _____

Parent/Guardian printed name: _____

Parent/Guardian signature: _____

Date: _____

Appendix G

Informed Consent for Minor Student by Legal Guardian

August 23, 2014

Dear Parents & Guardians,

This year, I have the opportunity to conduct a research study with your child, other students diagnosed with Reactive Attachment Disorder, and school staff as a part of my graduate program at Northwest Nazarene University. The study has been reviewed by the Research Review Committee at Northwest Nazarene University and has been successfully approved.

The benefits that may result from the research are: better understanding of Reactive Attachment Disorder by educational staff, improved school-based interventions, services, and supports for children diagnosed with Reactive Attachment disorder.

The procedures are as follows:

- The research project will take place over a period of six months.
- Data will be collected in the form of interviews with students and school personnel from August 2014-December 2014.
- Themes discovered during interviews will be reviewed with participants to ensure accuracy in reporting.

I anticipate that there is minimal risk involved for your child's learning over the course of the study. Interviews with your child will take place in the school setting either in person for via electronic mode (Skype, Adobe Connect, or Face Time).

Your child's participation in this project is completely voluntary. In addition to your permission, your child will also be asked if he or she would like to take part in this project. Any child may stop taking part at any time without repercussion of any form. The choice to participate or not will not impact your child's grades or status at school.

All information that is obtained during this research project will be kept strictly secure and will not become a part of your child's school record. The results of this study may be used for a research paper and presentation. Pseudonyms or codes will be substituted for the names of children and the school to ensure confidentiality.

In the space at the bottom of this letter, please indicate whether you do or do not want your child to participate in this project. The second copy is to keep for your records. If you have any questions about this research project, please feel free to contact me either by mail, e-mail, or telephone. Please keep a copy of this form for your records.

The results of my research will be available after May 30, 2015. If you would like to have a copy of the results of my research or have any questions, please contact me at 208-870-0618 or my advisor, Dr. Mike Poe, at 208-467-8062.

Sincerely,

Cyndi Cook
Gateways Administrator
Nampa School District
208-498-0557
ccook@nsd131.org

****

I have read this form. I understand that nothing negative will happen if I do not let my child participate. I know that I can stop his/her participation at any time. I voluntarily agree to let my child participate in this study as follows:

YES _____ may participate in this study.

NO _____ may NOT participate in this study.

Child's printed name: _____

Parent/Guardian printed name: _____

Parent/Guardian signature: _____

Date: _____

Appendix H

Parent/Legal Guardian Request Letter

Cyndi Cook
100 NW 16th St #105
Fruitland, ID 83619
(208) 870-0618
ckcook@nnu.edu

Dear Parent/Legal Guardian:

My Name is Cyndi Cook and I am a doctoral candidate in the Educational Leadership program at Northwest Nazarene University. I am currently the Administrator for the Gateways Programs in the Nampa School District. Previously I was a Special Education Consulting Teacher for the Nampa School District and a Special Education Teacher. I have spent a great deal of time working with students with a variety of disabilities including those with emotional/behavioral disorders. I believe we owe all of our students, especially those with disabilities the opportunity for effective instruction and intervention.

My research topic relates directly to academic and emotional/behavioral interventions, strategies, supports, and services in the school setting for students with Reactive Attachment Disorder. Reactive Attachment Disorder is a rare, but very debilitating disability that is highly misunderstood and causes students to be unsuccessful and often times unsafe in the school setting. The results of my study, "Improving Behavioral and Academic outcomes for students with Reactive Attachment Disorder" will benefit schools by helping to identify those interventions, supports, and services that are found to produce the greatest emotional/behavioral and academic outcomes, a goal of all professionals in the educational setting. I am completing this research to fulfill requirements for the degree of Doctor of Education through Northwest Nazarene University.

School personnel that work with students with Reactive Attachment Disorder (RAD) will assist in gaining Informed Consent from you and gaining assent from your student to participate in this study. Once both are received by the school personnel, only then will they be provided to the researcher.

Both students and staff personnel will be asked to participate in two semistructured interviews, approximately 45 minutes in length. The interview questions may be shared with you prior to the interview as long as they are not discussed with the student prior to the interview for the sake of validity. Interviews will be open-ended, semistructured interviews and will be conducted in person or via electronic mode (Skype, Adobe Connect, Face Time, etc.) and will be recorded to ensure accuracy of information and transcription. Questions will focus on current interventions available for students with Reactive Attachment Disorder in the school setting, which ones are perceived by staff and students to be most effective, and why. We will not be delving into the pathogenic care the students endured as we do not want to re-traumatize the students.

Your student's responses in the interviews are very important as research is limited in regard to effective school-based interventions for students with Reactive Attachment Disorder. Data is available on mental health disorders as a whole, but the etiology of Reactive Attachment Disorder is different than most mental health disorders and needs further exploration and research in order to provide these students with the best emotional/behavioral and academic supports. The results of this study will assist school staff personnel understand more about what Reactive Attachment Disorder is, how to intervene with students who have this diagnosis, and feel confident and safe in their abilities to do so.

Data gathered in the study will be presented in a doctoral dissertation. In addition, data may potentially be included in published professional journals and presented at professional conferences. Please be assured that student and staff responses will be kept confidential and anonymous. There are no other risks associated with participation in this study, which is completely voluntary. Students, their guardians, and staff personnel are free at any time to withdraw from the study without adversely affecting their standing with the investigator or Northwest Nazarene University.

In the next few weeks, I will contact you to discuss your student's participation in the study. Thank you for your consideration of my proposal. I appreciate your time. If you have any questions about the interview please feel free to contact me personally at 870-0618 (C), 498-0557 (W), or via e-mail: ckcook@nnu.edu.

Thank you for your time and consideration,
Cyndi Cook

Appendix I

Interview Questions for Minor and Adult Students

1. Give me some background information about your educational history.

2. Tell me the best / hardest thing about your current educational setting.

3. Tell me about your favorite teacher or staff person.

4. Tell me about your least favorite teacher or staff person.

5. Describe the academic supports available at your school.

6. Describe the emotional/behavioral supports available at your school.

7. What grade level are you currently in?

8. How many high school credits do you have?

9. Who do you currently live with?

10. How long have you lived in that environment?

11. Explain if and how the caregivers in the home environment support or don't support your academic and emotional/behavioral progress?

12. Tell me about your academic characteristics and progress.

13. Tell me about your emotional/behavioral characteristics and progress.

14. Tell me about your areas of need in the school environment.

15. Tell me about the academic supports that are available and implemented with you.

16. Tell me about your participation in those.

17. Tell me about the emotional/behavioral supports that are available and implement with you.

18. Tell me about your participation in those.

19. Explain what you perceive as contributing most and least to your progress or lack of progress.

20. Talk to me about your emotional/behavioral progress.

21. Explain what you perceive as contributing most and least to your progress or lack of progress.

22. If you had to choose 1 thing (school-wide factor) that contributes most to your academic success what would it be? Explain

23. If you had to choose 1 thing (school-wide factor) that impedes your academic success what would it be? Explain

24. If you had to choose 1 thing (school-wide factor) that contributes most to your emotional/behavioral success what would it be? Explain

25. If you had to choose 1 thing (school-wide factor) that impedes your emotional/behavioral success what would it be? Explain

26. If you could choose 1 new intervention/strategy to help you achieve greater academic outcomes what would it be? Explain

27. If you could choose 1 new intervention/strategy to help him/her achieve greater emotional/behavioral outcomes what would it be? Explain

28. Talk to me about how supported you feel in your educational environment.

Appendix J

Interview Questions for School Personnel

1. Give me some background about your education and work history.

2. What, if any, professional development are currently engaged in.

3. Tell me about the population of students you currently work with.

4. Tell me the best / hardest thing about your current employment.

5. Do you currently have students in your school that have a Diagnostic and Statistical Manual –version four diagnosis of Reactive Attachment Disorder?

6. How long have they been in your school and in what capacity do you work with them?

7. Tell me about any specific education or training you have in regard to mental health.

8. Tell me about any specific education or training you have in regard to Reactive Attachment Disorder.

9. How has your education or training or lack of education and training impacted your ability to support your high school students with Reactive Attachment Disorder?

10. How prepared did you feel when you started working with students with emotional/behavioral needs and specifically Reactive Attachment Disorder?

11. Describe the academic supports available for students at your school.

12. Describe the emotional/behavioral supports available students at your school.

13. Think of one student in your school that you are familiar with that has a DSM-IV diagnosis of RAD.

14. Give me some basic information about him/her.

15. Who does this student live with and how long have they been there?

16. Explain if and how the caregivers in that environment support or don't support this student's academic and emotional/behavioral progress?

17. Tell me about this student's academic and emotional/behavioral characteristics.

18. Tell me about the academic supports that are available and implemented with him/her.

19. Tell me about the emotional/behavioral supports that are available and implemented with him/her.

20. Tell me how you determine if he/she is making academic and emotional/behavioral progress.

21. Explain what you perceive as contributing most / least to his/her progress or lack of academic progress.

22. Explain what you perceive as contributing most /least to his/her progress or lack of emotional/behavioral progress.

23. If you had to choose 1 school-wide factor that contributes most /least to his/her academic success what would it be? Explain

24. If you had to choose 1 school-wide factor that contributes most / least to his/her emotional/behavioral success what would it be? Explain

25. If you could implement 1 intervention/strategy to help him/her achieve greater academic outcomes what would it be? Explain

26. If you could implement 1 intervention/strategy to help him/her achieve greater emotional/behavioral outcomes what would it be? Explain

Appendix K

Resources for Student Participants Following Interviews if Necessary

Topic and content of questions during interviews will revolve around the past and current interventions utilized in school systems for students with Reactive Attachment Disorder. Questions will not address or attempt to address the causal nature of the diagnosis. If students indicate verbally, or the researcher can determine, that the student is under any duress as a result of the interview process or questions, the interview will be terminated immediately. At this point the researcher will contact the following persons: Student's parent or legal guardian, the School Counselor, School Social Worker, and/or School Psychologist.

Additionally a list of outside resources will be given to the student and the parent/legal guardian. Resources are listed below:

All Seasons Mental Health 8030 W Emerald St. Boise, ID (208) 376-4848	**Mental Health Ctr** 1720 Westgate Dr. Ste. B1. Boise, ID (208) 334-0800
Affinity Inc 8100 W Emerald St Ste 150. Boise, ID (208) 375-0752	**R H Mental Health Svc** 1224 1st St S. Nampa, ID (208) 442-8052
All Seasons Mental Health 8050 W Rifleman St # 100. Boise, ID (208) 321-0634	**Eagle River Psychiatry** 1032 S Bridge Way Pl # 100. Eagle, ID (208) 246-0123
Aspen Mental Health 2316 N Cole Rd # B. Boise, ID (208) 342-2950	**Access Behavioral Health SVC** 3307 Caldwell Blvd. Nampa, ID (208) 465-4833
Cornerstone Psychological Associates PLLC 1755 Westgate Dr Ste 260. Boise, ID (208) 373-0790	**Allied Mental Health Pllc** 9086 Foothill Rd. Middleton, ID (208) 585-3132
Integrity Therapeutic SVC 2805 Blaine St # 120. Caldwell, ID (208) 459-4412	**Four Rivers Mental Health** 1103 Blaine St. Caldwell, ID (208) 454-2766
West Valley Mental Health Svc 1717 Arlington Ave. Caldwell, ID (208) 455-3777	**Four Rivers Mental Health** 1605 S Kimball Ave # 101. Caldwell, ID (208) 454-2766
Idaho Department of Health & Welfare Children's Mental Health Dial 211	

Appendix L

Member-Checking E-Mail

March 15, 2015

Dear Participant;

Thank you for participating in this study over the past several months. I wanted to inform you of some of the themes which emerged from the interviews of the participants, including yourself. Please let me know if these accurately depict our conversation and your thoughts. If you have any suggestions or modifications please let me know.

Tables of themes bases on data:

General Education teachers need additional training in mental health disorders and the implications on learning and emotional/behavioral functioning.
Students with RAD need to perceive staff genuinely care about them as a person and about their success.
Students with RAD need a designated staff to support them.
Students with RAD require direct instruction on how and why emotional/behavioral progress is being monitored.
Students with RAD required direct instruction on how to build and keep trusting relationships with peers, family, and staff.

Thank you again for participating in this study and I look forward to hearing from you soon.

Sincerely,

Cyndi Cook

Cyndi Cook
Doctoral Student
Northwest Nazarene University
ckcook@nnu.edu
Phone: (208) 498-0557
HRRC Approval # _____

Appendix M

Student–Staff Academic Side-by-Side Comparisons

Supports Provided

Student 1				Staff 1
A Person	6		4	A Person
Assistance	4		1	Assistance
Accommodations	2		3	Modifications
Modifications	3			

Student 2				Staff 2
Modifications	8		5	Modifications
			3	Assistance
			1	A Person

Student 3				Staff 3
Assistance	5		1	Assistance
A Person	3		2	A Person
Accommodations	1		2	Accommodations
Modifications	1		3	Modifications
Refuse	1		2	Refuse

Student 4				Staff 4
A Person	1		1	A Person
Modificaitons	3		3	Modifications
Assistance	1		6	Accommodations
Accommodations	1		2	Consistency

Student 5				Staff 5
A Person	1		1	A Person
Modifications	1		1	Modifications
Accommodations	1		5	Accommodations
Assistance	1		1	Refuse

Total Student				Total Staff
A Person	11		10	A Person
Accommodations	6		13	Accommodations
Assistance	11		6	Assistance
Modificaitons	16		2	Consistency
Refuse	1		15	Modificaitons
			3	Refuse

Not Helpful

Student 1				Staff 1
Difficult	4		1	Difficult
Pacing	6		3	Pacing
Expectations	3		1	Expectations
Lack of Understanding	1			
Emotional Regulation	2			
No Help at home	1			

Student 2				Staff 2
Difficult	1		3	Difficult
Expectations	1		2	Missed School
Missed School	1		1	Refusal
Personal Conflict	2			

Student 3				Staff 3
Difficult	4		1	Difficult
Expectations	1		2	Refuse
Refuse Assistance	1			
Emotional Regulation	1			

Student 4				Staff 4
Emotional Regulation	1		2	Emotional Regulation
Expectations	1		1	Expectations
All Good	1		1	Difficult
			1	Missed School

Student 5				Staff 5
Expectations	4		1	Expectations
Difficult	3		3	Emotional Regulation
Refusal	2		2	Refusal

Total Student				Total Staff
Difficult	12		6	Difficult
Emotional Regulation	4		5	Emotional Regulation
Expectations	9		3	Expectations
Lack of Understanding	1		3	Missed School
Missed School	1		3	Pacing
No Help at Home	1		5	Refusal
Pacing	7			
Personal Conflict	2			
Refusal	3			

Most Helpful

Student 1				Staff 1
A Person	3		2	A Person
Motivation	4		1	Support
Classes	1		2	Modifications
Support	2		1	Ability

Student 2				Staff 2
Classes	2		2	Modifications
			1	Support

Student 3				Staff 3
Support	3		5	Support
Motivation	1		1	Effort
			1	Ability

Student 4				Staff 4
A Person	2		2	Modification
Support	1		2	Consistent

Student 5				Staff 5
A Person	1		1	Support
Motivation	2		1	Consistent
Suport	2		1	It works

Total Student				Total Staff
A Person	6		2	A Person
Classes	3		2	Ability
Motivation	7		3	Consistency
Support	8		1	Effort
			6	Modification
			8	Supports
			1	It Works

Academic Progress

Student 1				Staff 1	
Grades	4		4	Grades	
Attitude	1		2	Attitude	

Student 2				Staff 2	
Grades	2		7	Grades	
Attitude	2		1	Attitude	
Skills	1		4	Skills	

Student 3				Staff 3	
Grades	3		1	Grades	
Skills	2		2	Attitude	

Student 4				Staff 4	
Grades	3		3	Grades	
Skills	2		1	Skills	
			1	Missed School	

Student 5				Staff 5	
Skills	1		2	Skills	
Attitude	2		1	Attitude	

Total Student				Total Staff	
Attitude	5		4	Attitude	
Grades	12		15	Grades	
Skills	6		1	Missed School	
			9	Skills	

Appendix N

Student–Staff Behavioral Side-by-Side Comparisons

Supports Provided

Student 1				Staff 1
A Person	12		3	A Person
Instruction	4		8	Instruction
			1	Accommodations
			2	Consistency

Student 2				Staff 2
Modified class/ schedule	2		1	Modified class/ schedule
Instruction	3		5	Instruction
			2	Consistency

Student 3				Staff 3
A Person	3		3	A Person
Environment	1		1	PBIS
Instruction	1		3	Instruction
Coping Skills	1		2	Consistency

Student 4				Staff 4
A Person	3			
Modified class/ schedule	1		1	Modified class/schedule
Instruction	5		2	Instruction
PBIS	1			
Consistency	3		7	Consistency
OK	1		4	Accommodations

Student 5				Student 5
A Person	4		2	People
Instruction	1		3	Instruction
Coping Skills	2		2	Coping Skills
Reject	2		2	Consistency

Total Student				Total Staff	
A Person	22		6	A Person	
Consistent	3		5	Accommodations	
Coping Skills	3		2	Coping Skills	
Environment	1		15	Consistency	
Instruction	14		21	Instruction	
Modified Class/Schedule	3		2	Modified Class/Schedule	
OK	1		1	Positive Behavioral Supports	
Positive Behavioral Supports	1		2	People	
Reject	2				

Not Helpful

Student 1				Staff 1	
People	4		2	People	
Behavioral Characteristics	1		1	Environment	
Expectations	2		2	Expectations	

Student 2				Staff 2	
People	4		1	People	
Drugs	2		2	Environment	
Attitude	2		1	Missed School/Class	
Perception	2		1	Emotional Regularity	

Student 3				Staff 3	
People	2		2	Expectations	
Violence	1				

Student 4				Staff 4	
Expectations	2		1	Expectations	
Attitude	1		1	Environment	
People	1		1	People	
Perception	1		1	Consistency	
			1	Emotional Regularity	

Student 5				Staff 5	
Expectations	3		1	Attitude	
Emotional Regularity	1				
Attitude	3				
People	1				

Total Student				Total Staff	
Attitude	6		1	Attitude	
Behavioral characteristics	1		2	Emotional Regularity	
Drugs	2		4	Environment	
Emotional Regularity	1		5	Expectatinos	
Expectations	7		1	Missed School/Class	
People	9		4	People	
Perceptions	3		1	Consistency	
Violence	1				
Environment	3				

Most Helpful

Student 1				Staff 1	
A Person	3		7	A Person	
Modifications	1		1	Consistency	
Medication	2				
Coping Skills	2				

Student 2				Staff 2	
A Person	2		1	People	
Not being Afraid	1		2	Maturity	
			1	Consistency	
			1	Attitude	

Student 3				Staff 3	
People	2		4	People	
Coping Skills	2		1	Processing Time	
			1	Maturity	
			1	Accommodations	

Student 4				Staff 4	
People	5		1	Coping Skills	
consistency	6		7	Consistency	
Trust	1		1	Boundaries	
Good	1		1	Modifications	

Student 5				Staff 5	
A Person	2		3	Accommodations	
Coping Skills	1		1	Consistency	

Total Student				Total Staff	
A Person	6		7	A Person	
Consistency	6		4	Accommodations	
Coping Skills	5		1	Attitude	
Good	1		10	Consistency	
Medication	2		1	Coping Skills	
Modification	1		3	Maturity	
Not Being Afraid	1		1	Modification	
People	8		1	Boundaries	
Trust	1		5	People	
			1	Processing Time	

Behavior Progress

Student 1				Staff 1
Social	4		4	Data
Coping Skills	1		1	Observation
Past Missed School	3			
Attitude	1			

Student 2				Staff 2
Attitude	3		2	Data
In Class/School	2		1	Observation
No Drugs/Alcohol	3		4	Social
			2	Attitude

Student 3				Staff 3
Attitude	3		2	Attitude
No Fights	1		1	Observation
No Drugs/Alcohol	1			

Student 4				Student 3
Attitude	1		5	Data
Level	3		1	Observation
			1	Inconsistent

Student 5				Staff 5
Attitude	1		1	Attitude

Total Student				Total Staff
Attitude	9		4	Attitude
Coping Skills	1		11	Data
In Class/School	2		1	Doesn't Care
Level	3		1	Inconsistent
No Drugs/Alcohol	4		4	Observation
No Fights	1		4	Social
Passed Missed School	3			
Social	4			

Appendix O

Positive and Negative Relationships Side-by-Side Comparisons

Positive Relations

Student 1				Staff 1	
Support	6		6	Support	
Trust	6		5	Trust	
Friends/Family	3				

Student 2				Staff 2	
Trust	2		9	Trust	
Family/Friends	5		2	Support	

Student 3				Staff 3	
Support	3		3	Support	
Trust	10		1	Trust	
Family/Friends	1		2	Family/Friends	

Student 4				Staff 4	
Support	4		1	Family/Friends	
Trust	4		4	Trust	

Student 5				Staff 5	
Support	1		1	Support	
Trust	2		3	Family/Friends	
Family/Friends	9				

Total Student				Total Staff	
Friends/Family	18		6	Friends/Family	
Support (A Person)	15		12	Support (A Person)	
Trust (A Person)	23		19	Trust (A Person)	

Negative Relations

Student 1				Staff 1
Teacher Attitude	1			
Interpersonal	5		2	Interpersonal
Building Trust	2			

Student 2				Staff 2
Building Trust	8		4	Building Trust
External Factors	6		4	External Factors
Interpersonal	6		1	Violence
Attitude	5		4	Attitude
Student Attitude	1			
Teacher Attitude	1			

Student 3				Staff 3
Interpersonal	4		3	Interpersonal
Teacher Attitude	1		3	Building Trust
			1	External Factors

Student 4				Staff 4
Interpersonal	3		10	Interpersonal
			4	External Factors
			2	Building Trust

Student 5				Staff 5
Interpersonal	1		2	Interpersonal
Attitude	2			
External Factors	1		2	External Factors
Reject	2		1	Reject
Building Trust	2		1	Building Trust

Total Student				Total Staff
Attitude	7		4	Attitude
Building Trust	13		10	Building Trust
External Factors	7		11	External
Interpersonal	19		17	Interpersonal
Reject	2		1	Reject
Student Attitude	1		1	Violence
Teacher Attitude	3			

Appendix P

Holistic Comparisons for all Categories

Academic Characteristics

Student   **Staff**

Ability	4
Effort	20
Emotional Regulation	3
Learning Difficulties	12
Missed School	1
Needs Supports	3

10	Ability
14	Effort
3	Emotional Regulation
9	Learning Difficulties
3	Learning Skills
2	Missed School
4	Needs Support

Academic Supports

Student   **Staff**

A Person	11
Accommodations	6
Assistance	11
Modifications	16
Refuse	1

10	A Person
13	Accommodations
6	Assistance
2	Consistency
15	Modifications
3	Refuse

Academic - Not Helpful

Student   **Staff**

Difficult	12
Emotional Regulation	4
Expectations	9
Lack of Understanding	1
Missed School	1
No Help	1
Pacing	7
Personal Conflict	2
Refusal	3

6	Difficult
5	Emotional Regulation
3	Expectation
3	Missed School
3	Pacing
5	Refusal

Academic Most Helpful

Student

A Person	6
Classes	3
Motivation	7
Support	8

Staff

2	A Person
2	Ability
3	Consistency
1	Effort
6	Modification
8	Support
1	It Works

Academic Grand Wishes

Student

A Person	1
Career	1
Drop Out	1
Good	1
Graduate	3
Home	1
Structure/Resources	9

Staff

4	A Person
2	Good
4	Life Skills
4	Structure/Resources

Academic Progress

Student

Attitude	6
Grades	12
Skills	7

Staff

6	Attitude
15	Grades
1	Missed School
7	Skills

Behavior Characteristics

Students

Academic Root	5
Attitude	21
Behavioral Challenges	30
Harm	5
Interpersonal	19
Medication	1
Missed School/Classes	7
Past Behavioral Challenges	6
Positive Attitude	10
Violence	10

Staff

11	Attitude
37	Behavioral Challenges
6	Cognitive/Psychological Challenge
5	Harm
19	Interpersonal
7	Missed School/Classes
3	Need Supports
2	No Violence
1	OK
1	Past Behavioral Challenges
2	Positive Attitude
5	Violence

Behavior Supports

Student			Staff	
A Person	22		6	A Person
Consistent	3		5	Accommodations
Coping Skills	3		2	Coping Skills
Environment	1		15	Consistency
Instuction	14		21	Instruction
Modified Class/Schedule	3		2	Modified Class/Schedule
OK	1		1	Positive Behavioral Supports
Positive Behavioral Supports	1		2	People
Reject	2			

Behavior -NOT Helpful

Students			Staff	
Attitude	6		1	Attitude
Behavioral Characteristics	1		1	Consistency
Drugs	2		2	Emotional Regularity
Emotional Regularity	1		4	Environment
Expectations	7		5	Expectation
People	9		1	Missed School/Classes
Perceptions	3		4	People
Violence	1			
Environment	3			

Behavior- Most Helpful

Student			Staff	
A Person	6		7	A Person
Consistency	6		4	Accommodations
Coping Skills	5		1	Attitude
Good	1		10	Consistency
Medication	2		1	Coping Skills
Modification	1		3	Maturity
Not Being Fearful	1		1	Modifications
People	8		1	Boundaries
Trust	1		5	People
			1	Processing Time

Behavior Grand Wishes

Students

			Staff	
A Person	2		9	a person
Environment	10		3	environment
Food	1		1	good
Workload	1		4	resources

Behavior Progress

Student

			Staff	
Attitude	9		4	Attitude
Coping Skills	1		11	Data
In Class/School	2		1	Doesn't Care
Level	3		1	Inconsistent
No Drugs/Alcohol	4		4	Observation
No Fights	1		4	Social
Passed Missed School	3			
Social	4			

Positive Relationships

Student

			Staff	
Friends/Family	18		6	Friends/Family
Support (A Person)	15		12	Support (A Person)
Trust (A Person)	23		19	Trust (A Person)

Negative Relationships

Student

			Staff	
Attitude	7		4	Attitude
Building Trust	13		10	Building Trust
External Factors	7		11	External
Interpersonal	19		17	Interpersonal
Reject	2		1	Reject
Student Attitude	1		1	Violence
Teacher Attitude	3			

Appendix Q

Researcher Certification

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research

certifies that **Cynthia cook** successfully completed the NIH Web-

based training course "Protecting Human Research Participants".

Date of completion: 10/23/2013

Certification Number: 1310116

Appendix R

Debrief Statement for Qualitative Interviews

Thank you for participating in this study. As you know Reactive Attachment Disorder is a very difficult mental health disorder to function with. It affects the interpersonal relationships, the academic progress, and overall functioning of the person with RAD. In order to be successful students diagnosed with RAD need intensive interventions in the community and in the school setting. As there is not much professional literature specific to school based interventions for RAD, this study will hopefully give insight into what school based interventions will be most successful and provide the best supports for students with RAD in the school environment.

After I have had a chance to analyze the data I will e-mail or bring you the results and ask for feedback. It is important that I have accurately recorded and captured our discussions and translated your thoughts correctly.

If you have any questions or concerns, Cyndi Cook can be contacted by phone at (208) 498-0557; (208) 498-0567; or e-mail at ckcook@nnu.edu.

Thank you for your participation

Cyndi Cook (signature)

Cyndi Cook
HRRC

Appendix S

Verbatim Instructions for Interviews

Hello _____

Thank you for participating in this study, I truly appreciate it.

Semistructured, Audio Recorded Interviews
Two semistructured, audio recorded interviews will be conducted with each participant in this study. These interviews will be completed in the school setting or in a public location mutually agreed upon by the participant and the investigator. Each interview will take approximately 45 minutes.

Your participation is completely voluntary and you can select to leave the study at any time. If you feel uncomfortable with any question you can choose not to answer that specific question.

Do you have questions for me?

Thank you for participating.

Appendix T

Institutional Request to Conduct Research

Cyndi Cook
100 NW 16th St #105
Fruitland, ID 83619
(208) 870-0618
ckcook@nnu.edu

Dear Administrator:

My Name is Cyndi Cook and I am a doctoral candidate in the Educational Leadership program at Northwest Nazarene University. I am currently the Administrator for the Gateways Programs in the Nampa School District. Previously I was a Special Education Consulting Teacher for the Nampa School District and a Special Education Teacher. I have spent a great deal of time working with students with a variety of disabilities including those with emotional/behavioral disorders. I believe we owe all of our students, especially those with disabilities the opportunity for effective instruction and intervention.

My research topic relates directly to behavior and emotional/behavioral interventions, strategies, supports, and services in the school setting for students with Reactive Attachment Disorder. Reactive Attachment Disorder is a rare, but very debilitating disability that is highly misunderstood and causes students to be unsuccessful and often times unsafe in the school setting. The results of my study, "Improving Behavioral and Academic outcomes for students with Reactive Attachment Disorder" will benefit your School District by helping to identify those interventions, supports, and services that are found to produce the greatest emotional/behavioral and academic outcomes, a goal of all professionals in the educational setting. I am completing this research to fulfill requirements for the degree of Doctor of Education through Northwest Nazarene University.

The plan for my research includes identifying school personnel that work(ed) with students with Reactive Attachment Disorder (RAD) and are willing to participate in the study. After their informed consent has been gained I will recruit them to help gain the consent of the student participants. School personnel participants will be provided the Informed Consent to share with the legal guardians of high school students with a DSM-IV diagnosis of RAD. Once received back by them, they will gain assent from the students themselves. Once both are received by the school personnel, only then will they be provided to the researcher. Until that time the identifying information of potential student participants will remain unknown to the researcher.

Both students and staff personnel will be asked to participate in two semistructured interviews, approximately 45 minutes in length. The interview questions may be shared with parents/legal guardians if they would prefer, as long as they are not discussed with the student prior to the interview for the sake of validity. Interviews will be open-ended, semistructured interviews and

will be conducted in person or via electronic mode (Skype, Adobe Connect, Face Time, etc) and will be recorded to ensure accuracy of information and transcription. Questions will focus on current interventions available for students with Reactive Attachment Disorder in the school setting, which ones are perceived by staff and students to be most effective, and why. We will not be delving into the pathogenic care the students endured as we do not want to re-traumatize the students.

Student and staff participation in the interviews are very important because research is limited in regard to effective school-based interventions for students with Reactive Attachment Disorder. Data is available on mental health disorders as a whole, but the etiology of Reactive Attachment Disorder is different than most mental health disorders and needs further exploration and research in order to provide these students with the best emotional/behavioral and academic supports. The majority of school staff personnel do not know what Reactive Attachment Disorder is, how to intervene with students who have this diagnosis, or feel confident or safe in their abilities to do so.

Data gathered in the study will be presented in a doctoral dissertation. In addition, data may potentially be included in published professional journals and presented at professional conferences. Please be assured that student and staff responses will be kept confidential and anonymous. There are no other risks associated with participation in this study, which is completely voluntary. Students, their guardians, and staff personnel are free at any time to withdraw from the study without adversely affecting their standing with the investigator or Northwest Nazarene University.

In the next few weeks, I will contact you to discuss your participation in the study. Thank you for your consideration of my proposal. I appreciate your time. If you have any questions about the survey or the interview please feel free to contact me personally at 870-0618 (C), 498-0557 (W), or via e-mail: ckcook@nnu.edu.

Thank you for your time and consideration,
Cyndi Cook

Appendix U

Assent Script for School Staff to Use With Students

Good afternoon _____

I am assisting Cyndi Cook in fulfilling the requirements of her doctoral program through Northwest Nazarene University. She is conducting a study entitled *Improving Behavioral and Academic outcomes for students with Reactive Attachment Disorder.* I am talking to you regarding possible participation in this study as you have a diagnosis of Reactive Attachment Disorder.

Student participants in this study will be asked to give their verbal and written assent before their name will be given to the researcher, Mrs. Cook. Your parent/legal guardian has already given their written Informed Consent for you to participate in this study.

Your participation will consist of two approximately 45 minute semistructured interviews with Mrs. Cook. Semistructured means she will have a list of some questions she wants to ask you and other questions will come along as a natural part of the conversation. A few of the staff members of the school and a few others students will be asked to participate as well. The interviews will be audio recorded in order for Mrs. Cook to ensure accuracy when transcribing them. She may also want to use some direct quotes from you if appropriate to emphasize meaning. Mrs. Cook will contact you after she transcribes your interviews in order to check with your for accuracy. Information gathered from you will remain anonymous.

Interviews will be scheduled at a time that is convenient for you, your parent/legal guardian, and the school. No one will be in the interview except you and Mrs. Cook unless you specifically make a request for an adult to accompany you.

Mrs. Cook has worked in Special Education and with students with mental health diagnosis or over 10 years and understands the vulnerable nature of Reactive Attachment Disorder. She will not be asking questions surrounding how you got the diagnosis. Questions will focus on your educational history, successes and struggles, and ways that school systems could do a better job supporting you and other students with Reactive Attachment Disorder both academically and emotionally/behaviorally.

Do you have any questions for me or that I can ask Mrs. Cook before you decide if you are willing to participate? Even if you give your verbal and written assent you have the right to withdraw from participation at a later date without any negative consequence.