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Youth aggression: The impact of attachment and passive family violence

Rosie Maria Mayzum

Doris Menoken Paxton

YOUTH AGGRESSION: THE IMPACT OF ATTACHMENT AND PASSIVE FAMILY VIOLENCE

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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Approved by:

[redacted]

Dr. Morley Glicken,
Project Advisor, Social Work

6-13-00
Date

[redacted]

Dr. Rosemary McCaslin,
Chair of Research Sequence

ASSIGNED RESPONSIBILITIES

This research was a team effort where both authors worked collaboratively in all phases of the study. However, each researcher was primarily responsible for one sample. The responsibilities were assigned as follows:

1. Data Collection

   Early School aged sample: Doris Paxton

   Adolescent sample: Rosie Mayzum

2. Data Entry and Analysis

   Rosie Mayzum & Doris Paxton

3. Report Writing and Presentation of Findings

   a. Introduction and Literature Review

      Rosie Mayzum & Doris Paxton

   b. Methods

      Rosie Mayzum & Doris Paxton

   c. Results

      Rosie Mayzum & Doris Paxton

   d. Discussion

      Rosie Mayzum & Doris Paxton

ABSTRACT

This study addresses three questions regarding the relationship of attachment to aggressive behavior in early school age children (2-6 years) who have witnessed domestic violence, and to adolescents (13-18) who have been diagnosed with Oppositional Defiant Disorder. The authors hypothesized that insecure attachment is a major cause for youth violence and that a secure attachment may lessen the negative effects of passive family violence. Data was extracted from case files; findings supported earlier attachment and domestic violence research; study limitations and social work implications were addressed.

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INTRODUCTION

On April 20, 1999, this nation heard and saw the gruesome aftermath of school violence that occurred at Columbine High School in Littleton, Colorado. Twelve students and one teacher were killed; twenty-three students were wounded. The two assailants were high school juniors who "went to work, shredding their classmates with bullets, laughing as they went, turning Columbine High School into what may be the scene of the deadliest school shooting in American history" (Press-Enterprise 4/21/99). The two young men then committed suicide. Other recent shootings occurring in the United States by young people are cited in Appendix A.

There is a great deal of evidence that children and adolescents are involved more in violence now than in times past. Wolfson (1997), Josephson Institute (1998), Office of Juvenile Justice and Delinquency Prevention cite the following confirming statistics: The juvenile rate of arrest for violent crimes increased by 38% between 1988 and 1992; 50% between 1988 and 1994, with the number of juvenile murderers tripling between 1984 and 1994. The Violent Crime Index for 1983 - 1992 for juveniles increased 57%, while the adult index increased only 50%. From 1985 to 1993, murders committed by people over age 25 dropped 20%;

but they increased 65% among 18-24-year-olds, and increased an outstanding 165% among 14-17-year-olds. During this same time frame the homicide rate for 16-year-olds increased 138%, while the rate among 18-year-olds doubled, and the rate for 24-year olds and above either remained the same or declined.

More recent data compiled by the Office of Juvenile Justice and Delinquency Prevention indicates that these increases are still occurring among juveniles in the United States and this population is becoming more violent. Also, the annual rates of firearm homicides for youths aged 15-19 increased 155% between 1989 and 1994. In 1994 law enforcement agencies made over 2.7 million arrests of persons under the age of 18. This is approximately 65% of the entire U.S. juvenile population. Based upon 1994 FBI clearance data, juveniles were responsible for: 48% of arsons, 20% of robberies, 25% of motor vehicle thefts, 14% of forcible rapes, 25% of larceny-thefts, 13% of aggravated assaults, 21% of burglaries, and 10% of murders. Juveniles were responsible for 14% of all Violent Crime Index offenses cleared in 1994 and 25% of all Property Crime Index offenses cleared. In 1994, 1 in 5 murdered juveniles were known to have been killed by a juvenile offender. The proportion of murdered juveniles killed by a

juvenile offender varied substantially with the age: 0-5 years / 6%; 6-11 years/ 18%; 12-14/ 38%; 15-17/ 22%. It is important to note that many of these statistics come from arrest records, which do not reflect the aggressive acts of juveniles who have not been caught.

On the local scene in California, the Orange County District Attorney's Office (1999) released a special report stating that juveniles committed 54% more violent crimes in a single year. Aggravated assaults were up 81% and robberies were up 32%. In Riverside County, the 1999 report for Riverside Juvenile Hall (Appendix B) shows the following: 2,908 admissions, 11 homicides, 132 robberies, 397 assaults, 300 burglaries, 317 thefts, 315 sex offenses, 229 miscellaneous felonies, 139 miscellaneous misdemeanors, 1,200 technicals (WIC).

According to T. Toch (1995) "Of the nation's eighth graders, 9% had carried some type of weapon to school in past months and one estimate was that about 270,000 guns were in the nation's schools each day. Sixteen percent of the eighth graders said they feared for their safety when they were in school. New York schools reported 5,761 violent incidents in 1992" (Newman and Newman, 1995, p.392). An article on classroom discipline in the Riverside Press-Enterprise (July 6, 1998) informs us that

"Madeline Fennell has been hit, kicked and spit at as a teacher in a public school in Omaha, Neb. One pupil tried to bite her. Her assailants were first - graders" (p. A-3).

America is not the only country experiencing this social phenomenon. Pfeiffer 1998 cites the following rising trends in juvenile violence in Europe from the early or mid-1980s to the mid-1990s (pp.1-2): In every country that studied the rate of juvenile violence it had risen sharply in the mid-1980s or early 1990s. In some countries the official figures increased between 50% and 100%. In England and Wales (counted together) in 1986, for example, approximately 360 out of every 100,000 youths aged 14 - 16 were "convicted or cautioned by the police for violent crimes; in 1994, that figure had climbed to approximately 580 per 100,000". In Germany the growth rate was even higher. In 1984, the number of 14-18-year-olds suspected of violent crime in the former West Germany was approximately 300 per 100,000; by 1995, that figure had more than doubled to approximately 760 per 100,000. Rates in the former East Germany were between 60% to 80% higher. Nonviolent crimes committed by juveniles also increased significantly. Property crimes committed by juveniles 14-17-years-old in Italy more than doubled between 1986 and 1993 (from

approximately 320 per 100,000 to approximately 650 per 100,000). In no country did an increase in the adult crime rate parallel that for juveniles (remained stable or increased moderately).

The American population is projected to reach 74 million by the year 2010 and may lead to more juvenile offenders and increased case flow into the juvenile justice system (Office of Juvenile Justice, 1999). Wolfson(1997) predicts that "If this trend continues, juvenile arrests for violent crime could double by the year 2010" (p. 5). How do we start to explain this violence in our youth? More importantly, what do we do to slow it down? Consequently, knowing why juveniles are more prone to violence would be a decidedly important thing to know as we try to understand, treat, and prevent a significant increase in violence among our youth.

Articles have been written about this increase in youth violence. Several attribute it to systemic family problems, especially family violence which has been receiving a lot of press. It is believed that family violence results in poor attachments between children and their primary caregivers. Attachment theory is being revived. Support groups, such as the recently established Inland Empire Area Support Group (first meeting on April

16, 1999) and the National Attachment Disorder Support Group are attempting to educate our society on the extreme importance of early and continued parental nurturing. As such, this study looked at attachment, domestic violence, and aggressive behavior in our youth.

Many of these aggressive young people have been diagnosed with Oppositional Defiant Disorder, an aggressive disorder. Oppositional Defiant Disorder is a more recent diagnosis which made its first appearance in the Diagnostic Statistical Manual III (DSM III 1980) and can be viewed as a lesser form of Conduct Disorder in Children and Adolescence. A diagnosis of Oppositional Defiant Disorder requires an attitude of negativism, hostility and defiant behavior lasting at least six months, along with four of the following behaviors: losing temper, arguing with authorities, denying or refusing to comply with rules or requests from adults, annoying other people, blaming others for their mistakes, easily annoyed or touchy, angry and resentful and often acts in spiteful or resentful ways. The child or adolescent must not meet the criteria for Conduct Disorder of Anti-Social Personality (eighteen years or older), their behavior must not occur during a psychotic or mood disorder and their behaviors need to cause significant impairment in their social, academic or

occupational functioning.

There is some debate over whether this diagnosis should be included in the DSM. Although the criteria for a diagnosis of Oppositional Defiant Disorder may be seen as a normal developmental process of an adolescent, and there may be a fine line between making the diagnosis and normal development; as clinicians we need to address this diagnosis. If this diagnosis is missed, a client may proceed into Conduct Disorder or Anti-Social Personality Disorder. At this point, more aggressive behaviors will be in place and positive interventions may be out of reach.

During a time when adolescents are bringing weapons to school, killing classmates and teachers they do not like, a call to understand why this is happening, instead of blaming parents, schools, or organizations, is needed. This study attempted to try to understand where the adolescent is coming from so society can begin to understand them, instead of giving up on them.

This study, therefore, looked at children two to six years old who have witnessed family violence. It also looked at adolescents thirteen to eighteen years old who may or may not have witnessed family violence but have been diagnosed with Oppositional Defiant Disorder. By observing the interaction between the primary caregiver and the child

in treatment, attachment bonding was established; as well as by the worker's evaluation of the gain in treatment, the relationship between attachment bonding and improvement in treatment was established. In other words, the better the attachment the more likely the child is to improve.

PROBLEM FOCUS

This study focused on the aggressive behavior of children between the ages of two and six years of age, early childhood, and adolescents between thirteen and eighteen that have been diagnosed with Oppositional Defiant Disorder, and the level of attachment they have with a primary caregiver. The purpose of the study was to bring together four relevant issues: (1) the impact of domestic violence on children who witness it; (2) early childhood aggression; (3) Oppositional Defiant Disorder and (4) attachment with a primary caregiver. It's almost a given that children who are maltreated will act out either passively or actively and some studies are showing that children who witness domestic violence are affected as if they were being physically abused. The question then becomes what happens when the variable of attachment is put in the equation? Will the impact be mitigated?

It is important to study this problem of youth

violence because it not only impacts heavily on the schools, the families, and counseling agencies; but also day care centers. Our society is founded on capitalism; it values money, material possessions, power, and status. Women are having children at a later age in order to establish a career and accumulate "wealth." "Mothers aren't staying at home during the early formative years of a child as in the days past. In 1991, 57% of married women with children under 3 years old were in the labor force, compared with 33% in 1975" (Newman and Newman 1995, p.336). According to Piotrowski, Rapoport & Rapoport, "rather than drop out of the labor force and return to work after their children are grown, the majority of women are now remaining in the labor force throughout the early years of parenthood" (Newman and Newman 1995, p. 536). Who then raises the children? For the most part, this task has fallen to day care centers, babysitters/nannies, and relatives, or, unfortunately, no one. The National Commission on Children reports that in 1987, roughly 28% of an estimated 7,736 three-and four- year old children of working mothers were cared for in day care centers. Children who are exhibiting aggressive behavior are not welcomed in most day care centers.

The findings of this study may serve to support

current interventions and programs that are being used in schools, social service agencies, and counseling centers to stop youth violence by stopping aggressive behavior in school age children. Research published in the American Journal of the American Medical Association cites a Second Step program developed in Seattle and used in more than 10,000 schools in the United States and Canada as being effective in quelling childhood aggression. In this program children take part in 35-minute sessions once or twice a week to learn empathy, problem solving, and anger management. Some counselors at the Youth Service Center of Riverside, use a program by Dr. Thomas W. Phelan, Ph.D. called 1-2-3 Magic: Effective Discipline for Children 2-12. Dr. Phelan mentions in his videotape that "it's better to deal with your child's outbursts and tantrums now then at 18 years of age." This study could also be used to develop interventions to be used with adolescents diagnosed with Oppositional Defiant Disorder. The more we understand why childhood aggression and Oppositional Defiant Disorder occur, the more capable we will be in developing interventions to treat them.

Not only did this study focus on the impact of children who witness domestic violence, but also on adolescents diagnosed with Oppositional Defiant Disorder.

The adolescent diagnosed with Oppositional Defiant Disorder was studied to determine if he/she lacked a secure attachment to a primary caregiver as an infant (0-2 years). A lack of positive attachment will be operationalized based on the following definitions: inaccessibility (absence), meaning that even though the primary caregiver was present they were inaccessible emotionally for the infant; separation (temporary loss), meaning that there was a temporary separation between the infant and caregiver; and loss (permanent loss), meaning that the infant was separated from the primary caregiver or vice versa for good.

Specifically, this research study sought to answer the following questions:

1) Does a poor or insecure attachment to a primary caregiver lead to Oppositional Defiant Disorder among adolescents?
2) Is there a relationship between passive family violence and attachment problems?
3) Even with family violence, if a child has a better or secure attachment to the primary caregiver will it result in a lesser degree of behavioral difficulties?

LITERATURE REVIEW

Newman and Newman (1995), in summarizing attachment research by Teti (et al. 1991), state that "children who lack attachment security are more likely to exhibit irritability, avoidance, resistance, and aggressiveness as preschoolers. These toddlers will have more difficulty calming themselves and reducing the intensity of their impulses" (p.273). Attachment to individuals that are primary caregivers, which can include parents or parent figures, is the beginning of an individual's relationships (Chase-Lansdale, Wakschlag, Brooks-Gunn, 1995). A security of attachment with a primary caregiver contributes to the child's internal sense that significant others are available, loving and trustworthy, therefore leading to relationships beyond the primary caregiver (Chase-Landsdale, Wakschlag, Brooks-Gunn, 1995). Factors leading to a positive attachment include a primary caregiver's emotional availability, and responsiveness to an infant's needs (Chase-Lansdale, Wakschag, Brooks-Gunn, 1995).

Renken, Egeland, Marvinney, Mangelsdorf, and Sroufe (1989) linked attachment history to aggressive behavior. They conducted a longitudinal study of 191 children. Predictors were selected to represent: (1) a developmental

history of insecure attachment and poor adjustment; (2) inadequate or hostile parental care; and (3) stressful or chaotic life circumstances. The study results indicate that attachment history and early social adaptation were significantly related to an aggressive outcome in boys, and the factors of harsh parental treatment and stressful life circumstances were related to aggression in both boys and girls. Prediction of passive-withdrawal was not quite as strong. This study explained the link between the antecedents and outcome by referencing Bowlby's concept of the internal working model; Ainsworth's anxious-avoidant/resistant attachment patterns; and the self-efficacy theory.

Egeland and Sroufe (1981) in their study of attachment and early maltreatment correlated a family's chaotic life-style with childhood neglect and abuse. The study involved maltreatment cases of extreme neglect and abuse of 31 infants (3-18 months) using a Child Care Rating Scale. The results were highly tentative and suggested that secure attachment within the maltreatment group was associated with the presence of a supportive family member, less chaotic life-style, and in some instances, a more robust infant. The study further showed that insecure attachments could change with infants between 12 and 18 months with the

positive social conditions listed above. This finding has great implications for aggression prevention in early childhood and for possible effective treatment and resolution for young kids diagnosed with Oppositional Defiant Disorder.

Bretherton and Waters (1985) cite the early (1978) research of Matas, Arend, and Sroufe as indicating predictive validity for early attachment patterns of behavior. This study, "The Relationship between Quality Attachment and Later Competence," examined the quality of play and problem solving behavior of 48 two year-olds who had previously been assessed at 18 months as being securely or insecurely attached. Results indicated that the children found to be securely attached attempted the problem-solving tasks with confidence and when, having difficulty, they elicited help from the mother. These children "were significantly more enthusiastic, affectively positive, and persistent; they exhibited less nontask behavior, ignoring of mother, and noncompliance" p. 553). The children assessed in infancy as being insecurely attached were frustrated, whined, and negativistic and "showed a poorer quality adaptation at two years" (p.553).

This study leads us to believe that once our early attachment relationship is established, our life's

blueprint and our behavior is predicated on it. It appears not to consider the impact of the individual's interactive environment; whereas, the Egeland and Sroufe study (1981, cited above) does. Matas (et al.) however, does inform us of their study's limitations. They believe the observed continuity could have been due to the presence or behavior of the mother in both situations. However, they further state that "since many of the competence measures used were noninteractive (e.g., enthusiasm for the task), such an interpretation does not seem likely. However, it will be important for future research to investigate continuity in competence-using situations where the mother is not present. For example, one may predict that securely-attached infants would demonstrate their greater competence with peers as well as with adults by the pre-school period" (p.556).

Main, Kaplan, and Cassidy (1985), in their chapter entitled "Security in Infancy, Childhood, and Adulthood: A Move to the Level of Representation," talk about a study they conducted in 1982 to determine individual differences in attachment relationships and the continuity of stability. Forty mothers, fathers, and their six-year-old children (24 male) participated. The children had been assessed in the Ainsworth Strange Situation at either 12

months or 18 months of age and classified accordingly. The children were observed responding to the family's photograph. The unexpected result was that "individual differences in early relationships to the mother, but not to the father, significantly predicted the six-year-old's responses to the separation interview and responses to the family photograph; …this suggests a hierarchy of internal working models in which the mother often stands foremost, a result that seems in keeping with Bowlby's suggestion of hierarchies in the organization of internal working models of attachment figures" (p. 93). This study revealed two viewpoints: (1) that the child's "internal working model of the relationship established by the end of the first year of life functions as a "template" of previously unrecognized strength and acts as a filter for the perception of all succeeding experience and directs all succeeding behavior"; and (2) "No template had been formed but rather that secure versus insecure patterns of interaction had continued over the 5 year-period" (p.94). However, the researchers interpreted the findings as follows: "We propose in contrast that patterns once established are actively self-perpetuating. This proposal is in keeping with the most basic tenets of psychoanalysis and certainly with Bowlby's proposal that internal working

models, once established, have a propensity towards stability"(p.94). However you interpret the findings, the bottom line relates to stability or continuity of infancy attachment and the representational interactions or behavioral system. The researchers state that "our data is insufficient to determine whether models acquired as a function of early attachment-related events are particularly resistant to change. The mother-child interaction pattern changed for so few children in our sample over a 5 year-period that our data cannot provide an answer"(p.101).

The above attachment theory research studies appear to agree with "Freud's view that attachment in infancy constitutes a genuine love relationship (and that) this relationship is closely tracked by patterns of behavior toward caregivers and that this behavior is complexly organized, goal-directed, and sensitive to environmental input"(Waters and Dean p. 41). These studies also support the fact that individual behavioral differences can be predicted based on one's early attachment to a primary caregiver. However, the door is open to build upon Egeland and Sroufe's and others belief that "in childhood, it is possible that internal working models of relationships can be altered only in response to changes in concrete

experience" (p.76). And Piaget's belief that "following the onset of the stage of formal operations, it is possible that the internal working models of particular relationships established earlier can be altered. This is because these operations may permit the individual to think about thought itself, that is, to step outside a given relationship system and to see it operating" (Bretherton and Waters 1985, p.75).

Much research has been done on attachment of infants. Bowlby found that the presence or absence of a mother or mother figure is a key variable in determining a child's behavior and emotional state (Bowlby, 1973). This is confirmed by research conducted by Grovtevant, McRoy, and Jenkins (1998) on adopted children and attachment. They found that adopted children are also at risk for referral to psychological treatment: "two to five times more frequently as their nonadopted peers (Grotevant, Mcroy, Jenkins, 1998, pg 4)" Grotevant, McRoy and Jenkins (1988) use a term "elbow babies" to describe adopted children who push away from their adopted mothers. They found that pre-placement history could have an effect on this phenomenon because once an attachment had been made the infant is taken to another primary caregiver. Another possible cause of "elbow babies" could be that since attachment usually

occurs between the period of six to eight months, children placed after this period could be at risk of not forming a positive attachment to the adoptive mother (Grotevant: McRoy: Jenkins, 1988). Singer el al. stated "that the older the child at the time of adoption placement the more likely he or she will display problems in socioemotional, behavioral, and school related adjustment (1985, p 1550)".

Singer et al. (1985) in their study of middle class adoptees found that the quality of caregiver-infant relations is similar to that found in non-adoptive families. Their findings suggested that psychological problems in adoptees during middle childhood and adolescence are unlikely linked to insecure attachment patterns in infancy. Brodzinsky, Singer and Braff (1984) found that psychological disturbances in school age adoptees begin to occur because an understanding of adoption and its implications is occurring. The child then starts to feel uncertain, confused, and insecure in their adoptive families (Singer et al. 1985).

Oppositional Defiant Disorder is a diagnosis that is seen in many children and adolescents that had an insecure attachment in infancy. This diagnosis may seem like normal adolescent behavior and because of this, there has been much criticism by some that do not think that this should

be classified as a mental disorder. Rutter and Schaffer (1980) have questioned whether or not Oppositional Defiant Disorder is different or distinct from normal oppositional behavior, that the description of the disorder sounds like behavior many children display and unlike a psychiatric disorder (Rey et al. 1988). Others argue that Oppositional Defiant Disorder might be over diagnosed when no other diagnosis is present. A possibility has been shown that a diagnosis of Oppositional Defiant Disorder might be given instead of Attention Deficient Disorder (Rey et al. 1988). Another argument against this diagnosis is that there is an overlap between the diagnosis of Oppositional Defiant Disorder and Conduct Disorder, or that Oppositional Defiant Disorder is just a milder form of Conduct Disorder.

Because Oppositional Defiant Disorder in children is widespread and common with the prevalence of the traits of negativism in the school age population to be between 16% and 22% (Rey et al. 1988), it is clear that further investigation needs to be done to determine whether or not Oppositional Defiant Disorder does exist as a psychiatric disorder. Rey et al. found in their study that although there is not high agreement on whether or not it should be a diagnosis, it is not any worse than other disagreements on any other psychiatric diagnosis. They also found that

those children diagnosed with Oppositional Defiant Disorder seemed to be disabled, in that they were usually referred to a psychiatric unit. Their findings did show Oppositional Defiant Disorder to be a milder form of Conduct Disorder, and in order to increase the reliability of a diagnosis of Oppositional Defiant Disorder more attention should be paid to the specific diagnosis criteria (Rey et al. 1988).

In Bowlby's work with juvenile thieves in the late 1930's, he found that many of the thieves had been separated from their mothers during infancy. These individuals grew up hating their parents and would act out in such ways as meaningless sex, theft, and aggression (Karen 1994). During this time Oppositional Defiant Disorder was not seen as a psychiatric diagnosis, although many of the behaviors are seen as criteria for the diagnosis today, such as arguing with parents, being spiteful and vindictive (stealing from parents), being angry and resentful, and losing their temper (Karen 1994; American Psychiatric Association 1996). If Oppositional Defiant Disorder had been a psychiatric disorder then, would many of Bowlby's thieves be diagnosed with it? Anna Freud also agreed, urging that mothers be admitted to hospitals with their children. She believed that

otherwise, a child's ego resources would be overwhelmed (Karen, 1994).

Glueck and Glueck (1968) conducted a study comparing delinquent boys with non-delinquent boys. This study was conducted during the 1940's-1960's, before Oppositional Defiant Disorder had become a diagnosis. If Oppositional Defiant Disorder had been a diagnosis many of the delinquents studied would have fit the criteria. The delinquents at a rate of 95.6% compared to the non-delinquents at 17.2% misconducted themselves at school. This social maladjustment expressed itself through disobedience, unruliness, defiance, stubbornness, and temper tantrums (Glueck and Glueck, 1968). Glueck and Glueck also found that these delinquents came from far less stable homes than non-delinquents and had been exposed to one or more radical household changes, with the worst being abandonment at birth or shortly after. The delinquents were exposed to hostility and indifference from their parents, and a higher percentage of the delinquent's mothers' were openly indifferent to the boys, almost to the point of rejection. These factors contributed to the fact that the delinquents were found to be less attached to their parents (Glueck and Glueck, 1968).

Other research does not see a lack of attachment as a

cause for Oppositional Defiant Disorder, but other reasons related to the family. Frick (1993) suggested a more biological approach to the development of Conduct Disorders. Frick (1993) found that children that had Conduct Disorder had higher rates of parental Anti-Social behavior than other controls. Other risk factors of Conduct Disorders included parent's marital relationships, and parental socialization practices (Frick, 1993). Kazdin (1987) stated that the risks of Conduct Disorder in children are criminal behavior and alcoholism, particularly by the father. Other factors found to lead to Anti-Social behavior or Oppositional Defiant Disorder in children are uncaring, affectionless, less warmth, and lack of parental emotional support (Kazdin 1987; Rey, Platt, 1990). Kazdin (1987) reported these youth have less attachment with a primary caregiver, but it is only a small factor in the many reasons for Anti-Social behavior.

In the late 1940's, much evidence had been accumulated that showed maternal deprivation affected the personality of many children. Bowlby specifically related maternal depravation with delinquency (Kessler, 1966). During this time, Oppositional Defiant Disorder was not yet a diagnosis, but an examination of the research of these delinquents shows many of the traits displayed by these

delinquents could be seen as criteria for a diagnosis of Oppositional Defiant Disorder today.

The following literature reviews reference the effect of domestic violence on children who witness it. Violence within the family is increasingly being recognized as a serious societal problem. Kilpatric, Litt, and Williams (1997) conducted an exploratory study entitled "Post-traumatic stress disorder in child witnesses to domestic violence." A sample of children aged 6-12 years, who had witnessed domestic violence and 15 who had not, was examined for PTSD. Study results showed witnessing domestic violence to be a significant predictor of PTSD and that " such witnessing is comparable to that of child physical and sexual abuse" (p. 643).

An abstract of an article entitled "Children who witness domestic violence: A review of empirical literature" by Kolbo, Blakely, and Engleman (1996) presents a review of the empirical literature examining the initial effects of witnessing domestic violence on children's functioning. The abstract states that although research on this subject is limited and about 10 years old, " results are still somewhat inconclusive regarding children's social, cognitive, and physical development, the findings of recently conducted investigations, when combined and

compared with the previously reviewed literature, suggest much less equivocation concerning the negative effects of witnessing domestic violence on children's emotional and behavioral development. Theoretical developments and methodological refinements appear related to the recent findings."

In their research with latency age children ranging in age from 5-12 years of age, Roseby and Johnston, (1995) conclude that children who live in high-conflict or violent divorced families, "are quite constricted and have difficulty using language to express inner experiences or their split-off of repressed feelings; when affectively aroused, they can easily regress and act out, often aggressively" (p.53).

Fantuzzo, DePaolo, Lambert, Martino, Anderson, and Sutton (1991) were concerned about the harmful effects of exposure to family violence on preschool children. The study participants were 107 young children and mothers of low income. Eighty-four were enrolled in Head Start Centers and twenty-three were temporarily residing in shelters for battered women. The researchers used the Conflict Tactics Scale, The Child Behavior Checklist, and the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children. Results indicated that "verbal conflict

only was associated with a moderate level of conduct problems; verbal plus physical conflict was associated with clinical levels of conduct problems and moderate levels of emotional problems; and verbal plus physical conflict plus shelter residence was associated with clinical levels of conduct problems, higher level of emotional problems, and lower levels of social functioning and perceived maternal acceptance" (p.258). The researchers found that "witnessing interparental physical and verbal violence is related to the type and extent of behavior problems displayed by young children" (p.263) and that "family violence disrupts the development of empathic and pro-social competencies for preschool children...and placing preschool children in shelters with their abused mothers separates them from important concrete coping mechanisms in their natural environment (e.g., familiar surroundings, toys, peers, neighbors, and relatives) and leaves them feeling more defenseless and less buffered from stress" (p.264).

The researchers inform us of the following problems that may have impacted the results: (1) failure to provide a detailed analysis of maternal functioning; (2) failure to provide pre/post shelter maternal and child functioning; and (3) study relied solely on maternal report of behavior problems.

Kashani, Daniel, Dandoy, and Holcomb (1992) in an article entitled "Family Violence: Impact on Children, conclude, "the home environment is the basis for our view of ourselves and others as well as society and the world in general. Maladaptive interactions within the family unit will thus have negative consequences on a global scale" (p. 187). This conclusion appears to be based on Systems Theory and the Social Learning Model Theory.

Lewis (1992) in her article entitled "From Abuse to Violence: Psycho-physiological Consequences of Maltreatment", talks about the effect of children being exposed to aggressive adults and stressful living conditions. She uses Bandura's theory of modeling as her framework. She also cites her study of 1979 that compared extremely aggressive delinquents to their less aggressive delinquent peers. Study results indicated, "that the exposure to extreme violence within the household, particularly between caretakers, was strongly associated with children's violent behaviors"(p.384).

Peled (1998) conducted a qualitative study of fourteen pre-adolescents, 10 - 13 years old. The study was influenced by the theories of phenomenology and resiliency and sought to determine how children responded to being exposed to domestic violence. Seventy structured

interviews were conducted and guided by a list of "Categories of Desired Information." Study results indicated that children are not only affected by their exposure to violence but manage it in different ways. Some seemed to lead a normal childhood and this "could be (the) children's stable and supportive relationships with their mothers, the support a few children received from their fathers or stepfathers, the support they received through participation in domestic violence groups, and their abilities to redefine reality in a way that facilitated their coping and adaptation" (Peled 1998,p.413-414). Others slept a lot, avoided going home, "disconnected from parts of reality", emotionally distanced themselves, or interfered when witnessing the incident. This study revealed more internal aggression than external.

Hilton (1992) conducted semi-structured interviews of 24 abused women living in a shelter. These women were asked if their children witnessed the violence, what they said or did at that time or later. A modified version of the Conflicts Tactics Scale was used. Study results found the women to be concerned with the children imitating the violence and with the psychological impact. "Although the theory was not specified by the interviewer, nine mothers (45%) made some reference to intergenerational transmission

in their parents and/or children" (p.82). Hilton believes the study provides data for future studies about domestic violence and mother-child relationships. In addition, this study appears to be the foundation for our research questions.

Cummings (1987) conducted research on "Coping with background anger in early childhood." The focus was on 4 and 5 year olds and the central processes of imitation and modeling. Eighty-five 4 and 5 year olds were subjected to verbalized anger displayed between adult models. The pre-schoolers displayed increased verbal aggressiveness in play after being exposed to the adult quarreling. Their coping styles (emotional responses) varied from showing empathy, no emotion, or ambivalence. The study gives additional evidence that background or environmental anger stresses children and challenges their adaptive capacities.

Other articles inform us that these young witnesses are becoming withdrawn, depressed, aggressive, argumentative, or hyperactive. Eth and Pynoos (1984) found that a "child witness to a parent's homicide, rape, or suicidal behavior demonstrate symptomatology fulfilling the four major DSM-III criteria for PTSD;...the symptoms are likely to persist, and the children will benefit from prompt psychiatric assistance" (p.20).

Eth and Pynoos (1984) further inform us that witnessing acts of domestic violence is psychic trauma that is distinguished from the trauma of direct victimization. "The helplessness of the child witness is determined by the passivity imposed by having to watch or listen to the sights and sounds surrounding the violence and the physical mutilation it creates. The uninjured child witness is unprotected from the full emotional impact of the violence, and may suffer immediately all of the painful symptoms of a post-traumatic stress syndrome" (p.24). Whereas, the injured child victim immediately concentrates on his/her physical pain and recovery, and may cope with the trauma by developing disassociative symptoms or even multiple personality disorders. The child witness is not so much concerned with self-harm, as with "the personal meaning of the threat of the victim's injury or loss" (p.24). Eth and Pyroos (1984) further state: "Viewing such an event can cause profound changes in the child's (witness) sense of the safety and security of future human relationships" (p. 27).

Finally, Conroy (1996), as a result of her literature review for her paper, *Child Witness to Domestic Violence*, appears to sum up our literature review on this issue by informing us that children who witness domestic violence

fall into "two groups (1) internalized problems such as withdrawn or anxious and (2) externalized problems such as aggression and delinquency" (p.1).

However, not all the studies on this subject agree with Conroy. Fantuzzo et al (1991) informs us that we need to be cautious of those studies that "found no significant relationship between witnessing interparental violence and social competence." (p.258). He cites the following major methodological issues as being the cause:

(a) They do not determine whether the child witnesses were also victims of maltreatment.

(b) The majority did not consider the age of the child witnessing as an important mediating variable.

(c) Most studies did not consider socioeconomic status when matching nonviolent comparison groups with the violence groups. The violence groups were typically from low-income families.

(d) Nearly all of the child witnesses studied were temporary residents of battered women's shelters (p.258).

With all this in mind we return to attachment. A main focus of our research is the impact of attachment, if secure attachment is the key when it comes to aggressive behavior. Attachment theory as delineated by Bowlby in the

1940's provides an encompassing framework in which to build upon previous models of some childhood behavior disorders (Greenburg M.T.; Speltz M., 1988). This is important, if we can find a theory that provides an understanding of these conduct disorders as social workers our models for treatment will be more effective. Attachment theory is a strong theory that can provide us not only with an etiological framework, but also help social workers develop new models for treating aggression and conduct disorders (Greenburg M.T.; Speltz M., 1988). With newer, more understanding models, social workers may be able to intervene with children at risk for conduct disorders at an earlier age or have a better understanding of how to treat school age children with behavior problems. The literature reviews on attachment as it relates to early childhood aggression and adolescents with Oppositional Defiant Disorder and the reviews on the behavioral effects on children who are exposed to domestic violence appear to be a foundation for the following hypothesis:

Attachment/bonding + domestic violence = early childhood behavior and Oppositional Defiant Disorder in Adolescents

METHOD

This study sought to answer the following three-part question. Does a poor or insecure attachment to a primary caregiver lead to oppositional disorders among juveniles? Is there a relationship between passive family violence and attachment problems? Even with family violence, if a child has a better or secure attachment to the primary caregiver will it result in a lesser degree of behavioral difficulties? The majority of the literature revealed that children who witnessed domestic violence were negatively affected as indicated by their externalized and internalized aggression. This study attempted to determine the affects of attachment on the aggressive behavior of two age groups: early school age children and adolescents. It further explored the relationship of four separate phenomena 1) early childhood aggression, 3) Oppositional Defiant Disorder, 3) attachment, and 4) witnessing domestic violence. These phenomena were the variables and constants for this study, based on the following operationalized definitions:

- **Domestic Violence (independent *variable)*** is most often equated with injuries resulting from the use of physical force. Sometime it is interchanged with domestic abuse, which encompasses both physical and psychological injury

and pain. For the purposes of this study we defined domestic violence as any mistreatment, injury, insulting or coarse language that explodes in the home between family members and results in physical or emotional injury (Kashani, Daniel 1985, and San Bernardino's District Attorney's Office). Using the conflicts tactics scale (Van Hasselt et al, 1988), domestic violence was broken down into categories based on the severity of the abuse. Low levels of abuse were characterized by throwing things, pushing, shoving, and grabbing. Moderate levels were characterized by slapping and threatening with a knife or gun. Severe levels were characterized by kicking, biting, hitting with a fist, and hitting or trying to hit with something. Extreme levels were characterized by beating up and using a knife or gun. Emotional abuse was characterized by verbal abuse (loud arguments, coarse language, and degrading remarks (Webb 1991).

- **Attachment *(independent variable)*** is a system of behaviors "so constituted that feelings of security and actual conditions of safety are highly correlated … the system's set-goal is to regulate behavior's designed to maintain or obtain proximity to and contact with a discriminated person or persons referred to as the

attachment figure" (Bretherton, Water 1985, p.6). A healthy or secure attachment is "an affectionate bond between two individuals that endures through space and time and serves to join them emotionally … it insures the child's physical survival … it allows him to develop both trust in others and reliance on himself" (Fahlberg, M.D. p.1) Insecure attachment was operationalized based on the following definitions: inaccessibility (absence), meaning that even though the primary caregivers were present they were inaccessible emotionally for the infant; separation (temporary loss), meaning that there was a temporary separation between the infant and caregiver; and loss (permanent loss), meaning that the infant was separated from the primary caregiver or vice versa for good.

- *Age (early childhood and adolescence), early childhood behavior, and Oppositional Defiant Disorder* were the three constants in the study; while the demographic variables of *ethnicity and gender* will describe the sample. Early Childhood Behavior was defined as externalized and internalized acts of aggression that negatively impacted a child's social functioning and emotional health.

Methodology

The study methodology was qualititative post positivist. It was used because the study was: 1) based on explanatory research, 2) was based on hypothesizes that were formulated from established theories and research, 3) it sought to identify linkages (not statistical causality) between existing phenomena/social issues in uncontrolled clinical and school environments; 4) the study was expected to generate small samples.

Data was extracted from case files, observed, and recorded. Qualitative research methodology met the study's parameters because (1) there were some variables such as the original interviewers biases that could not be controlled for, and (2) both the adolescent and school age samples were conducted in a uncontrolled clinical and school settings.

Design

Consequently, the researchers used a secondary analysis design, instead of a survey design, because of the complexity of the four issues in the study, time constraints, and the anticipated additional harm that could come to parents when confronted with the reality that their child(ren) may have been harmed by witnessing domestic

violence. In addition, the researchers determined that a secondary design would be beneficial for the study participants who had an insecure attachment or bad memories of their primary caregiver. Furthermore, this design would prevent the study participants and their parents from undergoing an interview process, which would cause them to resurrect these highly emotionally charged experiences.

Procedure

Data was extracted from case files of the Youth Service Center of Riverside and the Val Verde Unified School District based upon the study's operationalized definitions and parameters. Data regarding the adolescent age sample was collected from case files at the Val Verde School District in Riverside County. A purposive sample was used to obtain the sample. Twelve case files were collected on students between the ages of thirteen and eighteen that were diagnosed with Oppositional Defiant Disorder. All case files with this diagnosis were collected regardless of whether there had been evidence of witnessing domestic violence. This was due to the lack of cases available. From the twelve case files none were not used because of insufficient evidence for the diagnosis of Oppositional Defiant Disorder.

Data for the early school age children sample was collected from the case files at the Youth Service Center of Riverside. Purposive sampling was used to obtain the sample. The computer was queried to provide a report showing the cases of children from two to six years of age who had been seen at the Center from the time the Center automated its file system (1996) to the present. From the initial report, we excluded those cases identified as child abuse. The study is not concerned with children who have been physically maltreated; but only those who had witnessed domestic violence. We also excluded cases that involved foster parents and related adjustment issues. The computer report contained basic intake information, including type of case based on funding source (e.g., general, child abuse, substance abuse). Initially one hundred eighty three cases met the study criteria. Further review resulted in twenty-six cases being used with two cases being eliminated because of insufficient information and one case being eliminated because of indiscernible case notes. Twenty-three case files were extracted and analyzed for this sample.

The researchers evaluated the cases using a data extraction instrument they designed by using categories from the Conflict Tactic Scale (Van Hasselt, et al., 1988)

and modifying the Parent/Child Reunion Inventory (Kritzberg, Perea, 1994). The extraction instrument included the following: a measure of oppositional defiant/aggressive behavior as noted during the interview and the level of attachment to the primary caregiver as an infant as noted during the interview. All of the younger children and some of the older children had experienced a form of family violence. The data extraction instrument was designed with the help of three indicators of aggressive behavior, attachment, and domestic violence. These indicators can be seen in full in appendix C, and the data extraction instrument used for this study can be found in appendix D. The diagnostic criteria for Oppositional Defiant Disorder was also considered in designing the data extraction instrument and can be found in appendix E. Using this data extraction instrument, based on the mentioned indicators, this study evaluated the premise that the stronger the attachment to the primary caregiver the less impact family violence will have on aggressive behaviors, and a secure attachment may lessen the diagnosis of Oppositional Defiant Disorder.

Data was extracted from the case records, each researcher being initially responsible for one sample. After each researcher extracted data on their sample they

cross checked each other's cases. This was done to establish study trustworthiness through peer conformability.

RESULTS

Frequencies of mean, median, mode, and standard deviation were run on both the school age sample, adolescent sample, and both samples together. Chi squares were also ran separately for each sample and together. Analysis was ran based on the following three part question: 1) Does a poor or insecure attachment to a primary caregiver lead to Oppositional Defiant Disorder among adolescents? 2) Is there a relationship between passive family violence and attachment problems? 3) Even with family violence, if a child has a better or secure attachment to the primary caregiver will it result in a lesser degree of behavioral difficulties?

The early school age sample was 60.9% Caucasian, 17.4% Hispanic, 17.4% Bi-racial, and 4.3% African-American and was comprised of 11 males (47.8%) and 12 females (52.2%). The average age was 4.8 years. The frequency

Table 1.1-Ethnicity-Early School Age Sample

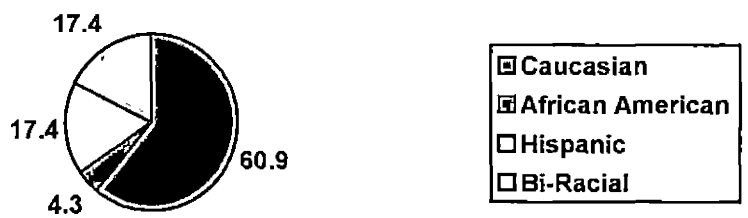
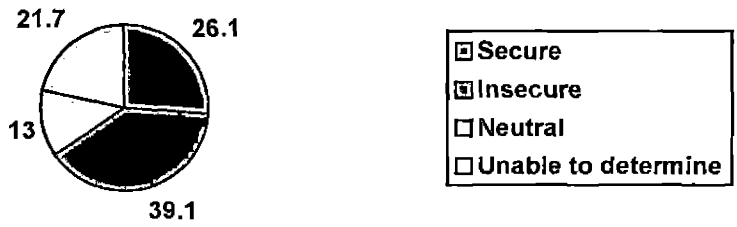


table shows that 60.9% of the sample witnessed extreme forms of domestic violence, 21.7% witnessed severe forms, and 17.4% witnessed emotional abuse. None of the children were exposed to singular incidents of either low or moderate levels of domestic violence. The mean for the level of domestic violence witnessed was 3.95 indicating the extreme level.

The frequency table further shows that the mean for the attachment variable was 2, indicating that 39.1% of the

Table 1.2-Attachment-Early School Age Sample



children had an insecure attachment to a primary caregiver; while 26.1% had a secure attachment; 13% showed signs of both an insecure and secure attachment, and 21.7% were indeterminable.

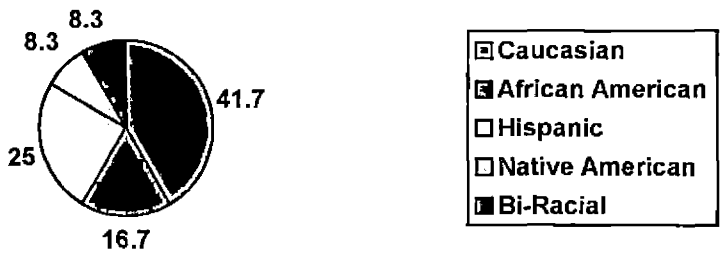
The table indicates that 52% of the sample exhibited no more than five external aggressive behaviors, 34.8% exhibited over five external aggressive behaviors, and 13% did not exhibit any external aggressiveness. The mean for

this variable of external aggression was 2.1, indicating 6.5 external aggressive behaviors. Regarding internal aggressive behaviors, the Table indicates that 43.5% of the children exhibited under three passive aggressive behaviors, 13% exhibited 3-4 behaviors, and 43.5% showed no evidence of passive aggression. The mean for this variable was 3.7, indicating almost 7 internal aggressive behaviors. Overall, 87% of the children exhibited some form of external aggressive behavior while 56.5% exhibited some form of internal or passive aggressive behavior.

Chi-squares were ran on the school aged population to determine if there was any linkage between attachment and the witnessing of domestic violence, and if there was any linkage between attachment and external aggression. These chi-squares as well as those examining the relationship between attachment, witnessing of domestic violence, age, gender, and internal aggression did not show a significant linkage. The chi-square examining the relationship between witnessing domestic violence and external aggression showed a significant relationship of .011.

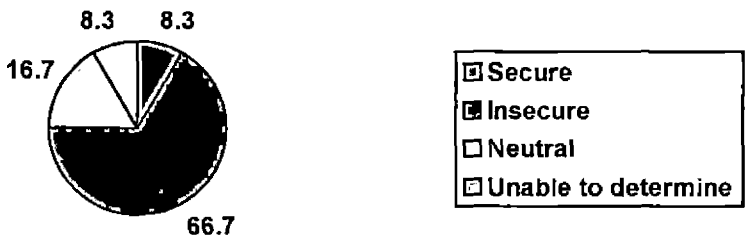
The adolescent sample was 41.7% Caucasian, 25% Hispanic, 16.7% African American, 8.3% Native American, 8.3% Bi-racial and was comprised of nine males (75%) and

Table 1.3-Ethnicity-Adolescent Sample



three females (25%). The average age was 15.25. The frequency table shows that the mean for attachment was 2.3, indicating that 66.7% of the adolescents had an insecure

Table 1.4-Attachment-Adolescent Sample



attachment to a primary caregiver; while 8.3% had a secure attachment; 16.7% showed signs of both an insecure and secure attachment, and 8.3% were indeterminable.

Frequencies also indicated that 50% exhibited no more than five external aggressive behaviors, 50% exhibited over five external behaviors. Regarding internal aggressive behaviors, the table indicates that 83.3% of the

adolescents exhibited under three internally aggressive behaviors, and 16.7% showed no evidence of internally aggressive behaviors.

Although the adolescent sample was not primarily concerned with the witnessing of domestic violence, frequencies were run on this variable because information for the variable was extracted from case files. The median level of domestic violence witnessed was 6, indicating no evidence of witnessing domestic violence. 66% had no evidence of witness to domestic violence, 8.3% witnessed extreme forms, and 25% witnessed emotional abuse.

Chi-squares were run on the adolescent sample to determine if there was any linkage between attachment and Oppositional Defiant Disorder, or aggressive behaviors. This chi-square as well as those examining the linkage between attachment, age, gender, and internal aggression did not show a significant linkage.

When frequencies were run on the school aged and adolescent samples there was a greater amount of males than females, twenty-one and fourteen respectfully. The total sample was still mostly Caucasian, but had a bigger spread of ethnicities, 20% and 14% were Hispanic and Bi-racial respectfully. The median attachment was 2, indicating that

when analsised together the total sample had an insecure attachment to a primary caregiver. Witnessing of domestic

Table 1.5-Type of Domestic Violence Witnessed-Total Sample

violence also had a bigger spread with only 37.1% of the total sample being witness to extreme forms of domestic violence. Twenty percent were witness to either severe or emotional forms of domestic violence, with 22.9% having no evidence of being witness to any forms of domestic violence.

Chi-squares were run on the total sample to determine if there was a linkage between the study's variables. Analyses were run together in hopes of finding a higher significance with a larger sample. The Chi-squares examining the linkage between gender and attachment proved significant at a level of .052, and for external aggression and attachment the level of significance was .178, close to showing a significant linkage. All the other Chi-squares ran did not show any significant linkage.

DISCUSSION

In this study we have addressed three questions regarding the relationship of attachment to aggressive behavior in early school age children who have witnessed domestic violence and to adolescents diagnosed with Oppositional Defiant Disorder. The first question posed was whether or not an insecure (poor) attachment to a primary caregiver leads to Oppositional Deviant Disorders among juveniles. Although this sample was small, and the results presented indicated that there was no linkage between these two variables, the results clearly indicated that a pattern existed between insecure attachment and both external and internal aggressive behaviors. Although it was expected that the sample would display aggressive behavior because of the diagnosis, it is interesting to note that one case had a secure attachment.

This supports Glueck and Glueck's (1968) research that studied delinquent adolescent boys. They found in their research that the delinquent boys were less attached to their primary caregiver when compared to the non-delinquent boys. In our sample of adolescents, it is apparent that this also may be true for adolescents diagnosed with Oppositional Defiant Disorder.

Other research did not see a lack of attachment as the

cause of Oppositional Defiant Disorder, but other reasons related to the family (Frick 1993). Frick (1993) in his research found that factors such as parent's behaviors, relationships, and socialization practices, contributed to the adolescent being diagnosed with Oppositional Defiant Disorder. Kazdin (1987) stated in his research that factors leading to Conduct Disorders include criminal behavior and alcoholism, particularly by the father. Other factors included uncaring, affectionless, less warmth, and lack of parental support. Kazdin (1987) reported that these youth do have a less secure attachment to a primary caregiver, but that is only a small factor. These studies also support findings in this study that deal with information obtained upon further investigation of case files. These findings speak to the many complex causes of Oppositional Defiant Disorder. One thing to keep in mind is that many of the issues discussed in Kazdin's (1987) and Frick's (1993) studies are issues that may cause an insecure attachment to a primary caregiver (Frick 1993; Kazdin 1987).

This study dealt with attachment to a primary caregiver, which in most cases we would assume to be the mother or a mother figure, but not the father or father figure. Although the adolescent sample was small it was

interesting to note that many adolescents had strong negative feelings regarding their fathers. For the cases where the father was still around and the adolescent knew him, there were many difficulties between the adolescent and the father, such as the father had died, been an alcoholic, in and out of prison, hostility toward the father, and physical abuse from the father. This accounts for six cases. In four cases, the adolescents did not know their fathers and had no contact with them. This suggests that insecure attachments may have been formed because of these issues with their fathers, leading possibly to Oppositional Defiant Disorder. This supports research done by Frick (1993) and Kazdin (1987). This is also interesting because so much of the literature focused on the primary caregiver, usually the mother, to be extremely important. From this small sample it is apparent that the phenomena of the impact of a secure attachment to both figures be studied further.

Many of the adolescents also used drugs, mostly cannabis. One student stated that he used the drug to self medicate, that is to help him "get away" from his problems at home. In reading some of the biopsycosocial assessments of these adolescents, it would not be presumptuous to assume that many may resort to drug use to deal with their

feelings. Also, some of the adolescents have a history of substance abuse in their families, this is possibly how they learned to cope. Once involved in substance use these adolescents also became involved in the drug culture, where many oppositional behaviors are encouraged. This has implications for social work practice, especially in the schools where this behavior is grounds for expulsion. Instead of punishing these adolescents and forcing the message of "just say no", without helping them find more effective ways of dealing with their emotions we are setting ourselves, and them, up for further failure.

The second question addressed in this study was whether or not a relationship existed between passive family violence and attachment problems. The results presented indicated that there was no relationship between these two variables. There was no connection between the types of family violence witnessed by early school age children and their type of attachment to a primary caregiver. We had hoped to lend additional information to Egeland and Sroufe's (1981) research that found a "highly tentative" relationship between these two variables. These researchers "suggested" that a secure attachment was associated with a less chaotic life-style.

The third and more important question relating to

aggressive behavior in early school age children was whether or not a child who witnessed family violence would exhibit a lesser degree of behavioral difficulties if he/she had a secure attachment to a primary caregiver.

The literature (Eth and Pynoos, 1984; Hilton, 1992; Conroy) reflects that witnessing acts of domestic violence is "psychic trauma", causes profound changes in the witnesses' sense of safety and security, and will cause the children to exhibit external and/or internal acts of aggression. Our study results support these research findings. Chi-square results showed that there is a significant connection (.01) between the witnessing of domestic violence and acts of external aggression exhibited by the early school age children in our study. We are not reflecting the chi-square of .01 as a valid statistically significant correlation because, due to our small sample size of 23 case files, more than 25% of the cells had an expected frequency count of less than 5. The minimum expected count was .52. However, this statistic still has face validity and significance. With the frequency counts for external/internal aggression and types of passive family violence, showing that: 1) 82% of the early school age children in our study witnessed severe and extreme forms of domestic violence that included kicking, biting,

hitting with the fist or with an object, beatings, use of a knife or gun; 2) 87% exhibited some form of external aggressive behavior; and 3) 56.5% exhibited internal or passive aggressive behaviors, the study supported Conroy's research. Conroy's article summarized the majority of research on the impact of passive family violence on children. We integrated this finding with the finding to our second research question stated above, and concluded that attachment did not play a role in mitigating the impact of family violence on children who witness it. Whether the child had a secure or insecure attachment to a primary caregiver, he or she would most likely act out aggressively. We had hoped to find that children who had a secure attachment would exhibit more passive aggressive behavior while children with an insecure attachment would act out more aggressively.

This study had many limitations, emanating from the researchers using a secondary analysis design or case records. Using secondary data sources resulted in the following: 1) limited the ability to generalize to a population that is not receiving professional counseling for a behavioral problem; 2) contained the counselor or therapist's counter transference issues and/or unconscious biases regarding domestic violence and oppositional defiant

juveniles; 3) made it difficult, in some cases, to determine the severity, type, and frequency of the domestic violence witnessed; and 4) raised reliability issues because the researchers, oftentimes, had to interpret the written observations and progress notes of the original counselor's or therapist's. Other limitations included sample size and other developmental issues of the sample. The early school aged, and adolescent samples were very small having 23 and 13 respectfully, providing a small and nearly homogenous combined sample size (54.3% Caucasian and 60% males). This study also did not indicate the pre-morbidity of the samples; thereby, opening the door for a possible validity issue and room for the following question: Were the aggressive behaviors of the sample linked to passive family violence/attachment or other developmental or social stressors.

The aggressiveness of our young people is a growing concern and future research is needed. Future studies of early school aged aggression and Oppositional Defiant Disorder should include a larger sample than was presented here. If possible a more heterogeneous sample would also be ideal, this study was greatly homogenous, with 54.3% of the total sample being Caucasian and 60% being male. Face to face interviews, surveys completed by sample subjects,

or assessment forms that capture attachment and forms of domestic violence issues may also yield more valid less subjective data than was obtained through case files. Although our overall study results did not prove to be significant, we believe that the limitations of our study can be used to design a study on youth aggression that will have generalizable results and control for the following extraneous variables that impacted out study: drug use by the study participants and the primary caregivers; emotional stability of the caregivers; loss issues relating to divorce, relocations, and adoptions; and the onset of aggressive behaviors.

It was hoped that this study's findings would contribute and support current interventions and programs being used by schools, social service agencies, and counseling centers to stop youth violence by stopping aggressive behaviors in school aged children. Although our results did not prove significant we do not think that the results of this study should not be taken into consideration. In addition, we further think that our study exposed the following red flags that social workers, educators, child welfare workers, and others working with early school age children should consider: 1) Be proactive and pay close attention to a child who lives in a chaotic

family environment. The exposure can lead to immediate and future aggressive behaviors. Dr. Phelan, in his video on child discipline, tells us that, "it's better to deal with your child's outbursts and tantrums now than at 18 years of age." 2) A chaotic family environment and loss issues can be used as a basis for treatment plans for adolescents diagnosed with Oppositional Defiant Disorders.

Although our sample was small and homogenous it indicated that having a secure attachment did not lessen the impact of witnessing domestic violence and that having an insecure attachment did not necessarily lead to Oppositional Defiant Disorder. Many other extraneous variables were found to possibly have an impact, as discussed, but this study contributes to our body of knowledge and gives us other areas in which to study the phenomena of school age aggression and Oppositional Defiant Disorder for greater understanding and more effective treatments.

Appendix A

Youth Violence Reports

The Riverside Press-Enterprise (4/21/99) cites other recent school shootings occurring in the United States by young people:

- **May 21, 1998**: Two teen-agers are killed and more than 20 people wounded when a 15 year-old boy allegedly opens fire at a high school in Springfield, Oregon. His parents are killed at their home.
- **May 19, 1998**: Three days before his graduation, an 18 year-old honor student allegedly opens fire in a parking lot at a high school in Fayetteville, Tennessee, killing a classmate who was dating his ex-girlfriend.
- **April 24, 1998**: A science teacher is shot to death by a 14 year-old student at an eighth grade dance in Edinboro, Pennsylvania.
- **April 15, 1998**: A 15-year-old at a Grand Terrace California school for children with learning disabilities fired shots at a counselor. No one was hurt.
- **March 24, 1998**: Four girls and a teacher are shot to death, 10 people wounded during a false fire alarm at a middle school in Jonesboro, Arkansas, when two boys, 11 and 13, open fire from the woods.
- **December 1, 1997**: Three students are killed and five others wounded in

a hallway at Health High School in West Paducah, Kentucky by a 14 year- old student.

- **October 1, 1997**: A 16-year-old boy in Pearl, Mississippi, is accused of killing his mother, then going to his high school and shooting nine students, two fatally.
- **January 23, 1995**: A Redlands, California Parochial School principal was shot in the face with a blast of buckshot by a 13-year-old eighth-grade boy at Sacred Heart School.

Appendix B

Monthly Activity Report
Riverside Juvenile Hall
Yearly 1999

Admissions:	2,908						Homicide:	11
Boys:	2,475						Robbery:	132
Girls:	433						Assault:	397
							Burglary:	300
Hispanic:	1,144						Theft:	317
Black:	765						Sex offense:	315
White:	914						Drug:	112
Indian:	18						Misc. felony:	229
Asian:	37						Misc. misdemeanor:	139
Other:	30						Technical (WIC):	1,200
Ages:								
12 & under:	55	13/14:	529	15/16:	1,276	17/18:	1,041	19 & over:	7
1st time detained:		1,672					Live with parents:		2,264
Releases:	2,914		State Prison:	9			Home:		745
Boys:	2,475		RM:	473			AWOL:		3
Girls:	439		Other Co:	163			CYA:		89
			IJH:	2			T.P.R.:		82
			Other state:	5			USBP:		7
			DPSS:	27			VHYC:		63
			Placement:	377			Homesup:		193
Length of stay:			Maximum				Average length		
1 day:	330		length of stay:	922			of stay:	27 days	
% of total releases:		11					Boys:	28 days	
							Girls:	17 days	
Total children days:		77,228							
Time over capacity:		223	61%						
Average daily			Highest				Lowest		
population:	204		population day:		242		population day:		165
Boys:	183		Boys:		217		Boys:		147
Girls:	24		Girls:		25		Girls:		18

Appendix C
Data Extraction Elements

- Scoring categories will be from the **Conflict Tactic Scale** (Van Hasselt et al. 1988, p. 13) except for the ones marked with an *.

-Throwing things	- Hitting or trying to hit with something
-Pushing, shoving, or grabbing	- Beating up
-Slapping	- Threatening with a knife or gun
-Kicking, biting, or hitting with the fist	- Using a knife or gun

*Verbal abuse (loud quarrels, coarse language, denigrating remarks).

These value categories will reflect nominal data measured by a yes/no response (1=Yes; 2= No) and then by an ordinal scale reflecting a progressive range of violence witnessed by the child. A frequency distribution will be run.

The construct of attachment will be measured by the following behaviors

(Kritzberger & Peria, 1994) documented in the files:

Q1	Child/adolescent seems relaxed throughout the session.
Q2	Child/adolescent shows/speaks of pleasure at being with the parent/caregiver.
Q3	Child/adolescent initiates positive interaction with parent (e.g., invites parent/caregiver to see what they are doing).
Q4	Child physically touches the parent/caregiver in an affectionate manner (kiss, hug, etc).
Q5	Child moves away from parent to engage in a playful activity but returns.
Q6	Child was engaged throughout the entire session with toys, other objects, and activities.
Q7	Child/adolescent showed/speaks of hostility toward parent/caregiver (e.g., jabbing with a toy, making a hurtful remark, or talking negative about caregiver).
Q8	Child/adolescent rejected/rejects the parent/caregiver by asking him/her to leave the room or saying, "Don't bother me."
Q9	Child/adolescent made/makes humiliating or embarrassing remarks to the parent/caregiver such as "you're really clumsy" or "I told you to keep quiet" etc.)
Q10	Child/adolescent shows extreme nervous, cheerfulness (e.g., jumping, skipping, clapping hands or "clowning").

Q11 Child asks parent to play in a "parental", eager or overprotective manner (e.g. "It's fun, isn't it, mommy? "Want to play with me, mommy?").
Q12 Child/adolescent seems very sad or depressed.
Q13 Child/adolescent seems fearful of the parent/caretaker.
Q14 Primary caregiver was emotionally inaccessible when child was an infant (0-2 yrs.)
Q15 Child/adolescent was temporarily separated from primary caregiver as an Infant (0-2)
Q16 Child/adolescent was permanently separated from primary caregiver as An infant (0-2 yrs.)

The level of measurement would be nominal and a yes/no response would be employed: 1=Yes; 2= No. A positive response to **any** of the questions 1-5 would indicate a **secure** attachment. A positive response to any of the questions 6-16 would indicate an **insecure** attachment. A frequency distribution would be run. Questions 1-5 would be combined and recoded as the variable secure with the value of 1; questions 6-16 will be combined and recoded as the variable insecure with the value of 2.

These behaviors listed above were modified from the Parent/Child Reunion Inventory used in the research study Attachment of Children in Foster Care (Kritzberger & Peria, 1994). The authors state that the "validity and reliability of this survey has been adequate. This is verified by a previous study where the Cronbach alpha was .76 for secure attachment and .77 for insecure attachment" (p. 11).

- Value categories will be taken from Aggression and Passive-Withdrawn Scales (Renkin et al. 1989); the level of measurement will be nominal with yes/no

responses: 1= Yes; 2=No. The following items will characterize *external aggression*:

Argues, defiant, bragging, cruelty, demands attention, destroys own things, teases, disobedient, disturbs others, poor peer relations, lacks guilt, fights, impulsive, lying, cheating, talks out of turn, attacks people, disrupts class, screams, acts irresponsibly, shows off, explosive, easily frustrated, stubborn, moody, sulks, suspicious, swears, talks too much, stealing, temper tantrums, threatens, loud.

The following will characterize *internal/passive aggression:*

Fails to finish things, likes to be alone, apathetic, won't talk, shy, stares blankly, fails to carry out tasks, underactive, withdrawn, avoids involvement or communication, just sits and doesn't participate, needs precise directions, anxious.

A positive response, in any combination, to the above listed behaviors would indicate aggression.

Appendix D

Diagnostic criteria of 313.81 Oppositional Defiant Disorder

A. A pattern of negativistic, hostile, and defiant behavior lasting at least six (6) months, during which four (or more) of the following are present:

   1) often loses temper

   2) often argues with adults

   3) often actively defies or refuses to comply with adults' requests or rules

   4) often deliberately annoys people

   5) often blames others for his or her mistakes or misbehaviors

   6) is often touchy or easily annoyed by others

   7) is often angry and resentful

   8) if often spiteful or vindictive

   Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Appendix E

Data Extraction Instrument

Client ID # Sex: DOB/Age: Ethnicity

Rater:

Domestic Violence Categories
(Mark all that apply)

- ☐ Throwing things
- ☐ Pushing, shoving,, or grabbing
- ☐ Slapping
- ☐ Kicking, biting, or hitting with the fist
- ☐ Hitting or trying to hit with something
- ☐ Beating up
- ☐ Threatening with a knife or gun
- ☐ Using a knife or gun
- ☐ Verbal abuse (loud quarrels, coarse language, denigrating remarks)

Attachment Behaviors

(Circle all the numbers that apply)

1. Child seems relaxed throughout the session.
2. Child shows pleasure at being with the parent/caregiver
3. Child initiates positive interaction with parent (e.g., invites parent/caregiver to see what they are doing).
4. Child physically touches the parent/caregiver in an affectionate manner (kiss, hug, etc).
5. Child moves away from parent to engage in a playful activity, but returns.
6. Child was engaged throughout the entire session with toys, other objects, activities.
7. Child showed hostility toward parent/caregiver (e.g., jabbing with a toy or making a hurtful remark).
8. Child rejected the parent/caregiver by asking him/her to leave the room or saying, "Don't bother me."
9. Child made humiliating or embarrassing remarks to the parent/caregiver such as,

"you're really clumsy" or "I told you to keep quiet" etc

10. Child shows extreme nervousness, cheerfulness (e.g., jumping, skipping, clapping hands, or clowning).
11. Child asks parent to play in a "parental", eager or overprotective manner (e.g., "It's fun, isn't it, mommy? "Want to play with me, mommy?").
12. Child seems very sad or depressed.
13. Child seems fearful of the parent/caretaker.

Early Childhood Behavioral Categories

A. External Aggression

(Mark all that apply)

- ☐ Argues
- ☐ Defiant
- ☐ Bragging
- ☐ Cruelty
- ☐ Demands attention
- ☐ Lacks guilt
- ☐ Fights
- ☐ Impulsive
- ☐ Lying
- ☐ Cheating
- ☐ Talks out of turn
- ☐ Attacks people
- ☐ Disrupts class
- ☐ Screams
- ☐ Acts irresponsibly
- ☐ Shows Off
- ☐ Explosive
- ☐ Easily frustrated
- ☐ Stubborn
- ☐ Moody
- ☐ Sulks
- ☐ Suspicious
- ☐ Swears
- ☐ Talks too much
- ☐ Teases
- ☐ Temper tantrums
- ☐ Threatens
- ☐ Loud

B. Internal/Passive Aggression

- ☐ Fails to finish things
- ☐ Likes to be alone
- ☐ Apathetic
- ☐ Won't talk
- ☐ Shy
- ☐ Stares blankly
- ☐ Fails to carry out tasks
- ☐ Underactive
- ☐ Withdrawn
- ☐ Avoids involvement or communication
- ☐ Just sits and doesn't participate
- ☐ Needs precise directions
- ☐ Anxious

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