

Chapter 2

Vignette of “Jorge”

(A Representative Case for Study)

Part 1: Jorge as a Toddler

Ted and Beth were childless and in their late 30s when they decided to adopt. Beth had postponed pregnancy, determined to earn an advanced degree in linguistics, to build her academic career in foreign languages, and to extend her networking possibilities as a translator. Ted transitioned to a job as an athletics coach after achieving his bachelor's in English literature, not his original aspiration, but rewarding enough in his early career. With local downsizing of the public school, he was compelled to search for new opportunity and eventually landed a job with a landscaping firm. Recently business was slow, but at least the family would not have to move. Over 10 years of marriage without dependents, Ted and Beth were financially secure with their combined salaries and were comfortable with the monthly bills. The Smiths were also happy as a couple, though Beth was aware of Ted's wish for a child and his effort at “not bringing up the subject.” Generally they handled the subject with the unwritten rule of “avoiding the subject” or at least maintaining a courteous consideration of each other's feelings. They often reflected that they were lucky as a couple, sharing, for example, their enjoyment of a rural town and many of the same friends from childhood.

Family life changed after the death of Beth's mother, and Ted became consoler and silent support in a winter of extended grieving, during which Beth appeared to lose interest in meeting friends, or even getting out for a walk. Despite the intimacy of a shared or similar experience, their relationship was marked by unaccustomed, minor squabbles, and “arguments over nothing.” Beth shared her disappointment in her family of origin; her father and brothers were even more reserved and actually shifted away emotionally despite sharing a loss. It seemed as if with the loss of her mother the family had also lost its center.

Beth and Ted strengthened ties with their church during this period and, possibly influenced by the sight of families with young children, or their new friends, they began to share the idea of a child late in life. Eventually they considered this carefully, even to the extent of meeting with a financial counselor who seemed

determined to temper their zeal with some hard figures. They responded humorously, now sharing an enthusiasm and joy, which seemed to dispel the atmosphere of Beth’s winter-long grieving. Beth, now age 39, scheduled a general checkup with their family physician to be sure that neither her age nor any other factor would stop the plan for a child.

An initial, happy anticipation waned as months passed without success in conception. A series of specialists were consulted, for both Ted and Beth, with a full infertility work-up. Gynecology consultation, examinations, and endocrine studies eventually led to diagnosis for Beth of premature ovarian failure. Prognosis was poor for fertility, even with hormone repletion; no treatment was recommended. Beth and Ted faced a new disappointment, turning over together the meaning of such an ironic, and seeming cruel, blow of fate which seemed to test their recent resolve to return to the faith of early childhood. Yet, despite the news, over time they felt stronger in faith and relationship and admonished each other not give in to despairing feelings. It was in the course of their community church activities that, separately and together, they discovered that international adoption appealed to them, based on familiarity with conditions of poverty in many countries, in contrast to their separate and combined economic success in this country.

As required by their private adoption firm, they provided full details about their home, family, and income, and specified only their criteria of a young, healthy child in need of a home. Nevertheless the wait for assignment of a child seemed endless, and after a year their agency informed them that host countries so far contacted had imposed tight restrictions for overseas adoption.

A month later, the Smiths are overjoyed to hear that a further search – extended to Guatemala – had been successful. The boy, Jorge, is “age 3, no evidence of medical problems, mother age 16 not supported.” A birth certificate and a certificate of good health can be provided to them through the agency, but there are no pediatric records apart from the medical statement. On request, further records indicate “two previous foster placements”, after the orphanage. The Smith’s case manager is responsive and wants to help, but admits to frustration reaching the orphanage, or social work authorities in charge of Jorge. Further inquiry results in the information that Jorge’s mother was “under age but had no medical problems of concern... and his birth was normal.” The case manager is then notified of “additional local fees and costs” necessary to proceed with the adoption. Wanting to have all available information in advance, Beth and Ted press their stateside adoption agency for details, receiving only a terse reply “there is no medical problem, a decision must be made within 4 weeks, not longer.” After reflection and a sharing of concerns, the Smiths decide to act: the wait has already gone on too long; they accept assignment of his care, even with the scant available background information.

Beth and Ted have pictures of their new family member, but are taken off guard by their first moments with Jorge: he is much smaller than they had expected for a child nearing his fourth birthday, and he seems much smaller and younger than expected. They reason that Jorge’s small size may be within average range in his native region, or close to it. But, even though pre-screening exam listed no abnormalities, his first examination with their family doctor shows him to be below the

fifth percentile for both height and weight. The family physician remarks low general muscle tone and asymmetry of lower deep tendon reflexes, as well as poor extensor strength. Bilateral otitis media and end-expiratory wheezing are noted. Jorge's lab reports show mild anemia and leukocytosis with a left shift. There is elevation of serum lead, but not high enough for chelation treatment. Chest x-ray is read as normal. Needed vaccinations are scheduled. The Smith's family physician recommends further consultation with pediatrics, and a "full developmental assessment."

Case Point: International Adoption

It may be reasonably asked why a couple as determined and organized as the Smiths would not have demanded and received full medical information on Jorge. Recent televised and written documentaries by John Seabrook [29, 30] highlight the risks and benefits, as well as complexities of international adoptive process. Briefly summarized, a "global migration" of orphan children to the USA began in China, Vietnam, and Korea in the 1950s and then shifted to involve primarily Latin American and Eastern Europe by the end of the 1980s. More than 226,000 children were internationally adopted into the USA between 1990 and 2005 [31].

A reasonable argument favoring international adoption, as Seabrook points out is that "poorer nations have much higher birth rates and so there is a global imbalance in children and the resources needed to raise them out of poverty" [29]. Countries with children who need homes follow a similar political path, however. According to Seabrook, "a nation opens its borders, adoptions proliferate; corruption creeps in; there is a scandal, the borders close." A Guatemalan example is depicted by Dubinsky [32]; a kidnapping of a child led to rumors of widespread trafficking in children. The rumors were evidently fueled by public sentiment about the many homeless plainly visible on the street, a sight which can inspire a kind of national shame and then culminating in restrictions on the adoption process. Similarly, Kim [33] reports that the Seoul International Olympics in 1988 attracted public interest in Korean culture, and this in turn inspired news reports which included the April 21 1988 *New York Times* article on "Babies for Export," a report which hurt Korean pride and eventually led to "systematic discouragement of international adoption" and thus to the target of zero adoptions to the USA.

The global need for stable adoptive homes continues to increase even as political factors – including the policing of human trafficking – have greatly reduced access for international adoption. UNICEF recently estimated the number of children worldwide who need homes at 163 million [29]. Yet the rate of adoptions into the USA has plummeted, from its peak in 2004 of 22,884 (from more than 90 nations) to a figure less than half this number. According to Seabrook, "the process is dwindling because no one can agree on what constitutes an ethical adoption."

During the wave of international adoption that ended in 2004, the mix of adoptees shifted dramatically from 37% Korean in 1990 with 3% Eastern Europe to 65%

Eastern Europe and just 10% Korean by 2000 [31]. This variable “country of origin” crucially affects the study of attachment because of the superior care of orphans generally provided in Korea, where foster care is in the hands of state-trained and monitored foster guardians [31, 33]. This is to compare to the care received in the notorious state-run orphanages of Romania during the Ceausescu regime, a context that is clearly associated with attachment disorder in childhood [34].

Nowadays few adoptees from overseas are “war orphans” and most have been abandoned, or given up because of poverty. Parents in the USA who seek to adopt from another country have limited ability to require particular attributes, due to diminishing numbers of children available from their country of origin. Conditions of health status can be specified, but the power to enforce these conditions is limited. Affecting this phenomenon of supply and demand is the parallel stateside adoptive process: the number of healthy infants in the USA available for adoption has also sharply declined, at least for young children not previously adopted and without special needs. Factors which influence this supply include the impact of birth control and the rise of single parenting. Most of the domestic adoptions are now relatively older children, as compared to 10 years ago, and many come from foster care.

Part 2: Jorge at Preschool Age

The Smiths are quick to set up an appointment in the nearby university Developmental Pediatric Clinic. Examinations confirm the prior findings of poor general muscle tone and poor upper and lower extensor strength. Also noted is restricted left wrist range of motion and poor balance on either leg. On careful exam, Jorge has a swinging of the left gain on ambulation, so that he has a limp, more pronounced when he attempts to ambulate rapidly. The remainder of the examination, including cardiac auscultation and pulmonary exam, is unremarkable. With help from an interpreter, the team is able to complete a range of developmental tests, leading to the conclusion that Jorge shows general delay in adaptive skills including hygiene and self-dressing. In addition to annotating these multiple delays, the team lists diagnosis of “probable attention deficit hyperactivity disorder” and “rule out neglect and/or physical abuse in early life.” Based on the observable limp, and wrist contracture, full skeletal series is recommended. Subsequent radiology results include the report of, “focal bony irregularity along the distal right tibia suggests prior remote trauma.” Jorge is scheduled with physical therapy for work on balance, ambulation, and upper extremity range of motion remediation therapy. Although psychiatry consultation is also recommended at this point, the Smiths defer on this last point, emphasizing their hope that behavioral symptoms will respond to “kindness and consistency in a good home.”

In the initial experience with Jorge, the Smiths feel confirmed about their choices in the treatment plan, and in their hopes for Jorge. Despite some physical delays, Jorge shows boundless energy and is very active in exploring his new environment.

He is “in constant motion,” and the effort to track him is greater than the Smith’s had anticipated. Mild clumsiness for age and frequent falls also do not discourage him from exploring every nook and cranny of the new home. At times he will run straight into their arms and, forcefully, a little too fast for comfort. His adoptive parents are impressed by his affection toward them and toward adult friends who visit, but begin to worry about his safety in public. Increasingly, they share their worry about his safety with strangers. They find comfort in the advice that Jorge is “making up for lost time,” perhaps compensating for early life deprivation and hearing problems, the latter possibly affecting delay of language. Privately they share their misgivings however, and guilt about their resentment of Jorge’s nonselective display of affection. They are relieved by the school recommendation to delay Jorge a year before kindergarten; this is based on the hope that he will catch up with children of his grade level in size, while advancing in a new language. Beth and Ted agree with this, but would like to put off evaluation by child psychiatry, or further psychology testing, because they are confident that “everything can improve with enough time and love.”

Case Point: Neglect, Growth, and Medical Problems

The finding of small body size in orphan children led to the theory that supports the idea that emotional deprivation directly retards growth, perhaps mediated by stress effects on the hypothalamic-pituitary-adrenal (HPA) axis. The evaluation of Failure to Thrive (FTN) is complex, however, because of frequent overlap of emotional deprivation, malnutrition, and stress in the affected families [35]. The hypothesis that emotional neglect has a direct biological effect on growth is challenged by studies showing at least a partial compensation in growth rate after provision of a fully adequate diet [36]. Stunting of growth and deficits of attachment are now recognized as separate effects of severe early childhood deprivation [37].

With regard to our case “Jorge,” the Guatemalan record is certainly benign in comparison to the costs of the Ceausescu regime to orphan children. Miller et al. [38] have assessed the children adopted from Guatemala into the USA, for comparison to US norms in case-matched design study. A growth delay is commonly found at adoption, and is generally more severe for children from Guatemalan orphanages as compared to Guatemalan children adopted from foster care. Children adopted at young age improved most quickly in their new stateside homes. The authors also report the large number of children involved: more than 17,300 in the period of 1986–2005. In addition to growth delays in height, weight, and head circumference, the children had relatively high rates of anemia (30%) and elevated serum lead levels (3%), as well as high rate for latent tuberculosis (7%). Only 28% met American Academy of Pediatrics standards for vaccine administration.

For adopted children with FTN, there is good reason to be hopeful about the trajectory toward normal physical growth in a new adoptive home that provides appropriate nutrition. In comparison, relatively more caution applies to questions

from adoptive parents about the prospect for full emotional recovery from early deprivation, neglect, or abuse. Grossly pathogenic care at critical stages of early childhood raises the risk for childhood disorders which are comorbid with RAD, including disruptive behavior disorders, post-traumatic stress disorder, depression, and anxiety [39, 40]. Counseling a family about relative risk for these conditions can help families prepare for challenges ahead, and this can be a helpful intervention even at early points of mental health assessment.

Part 3: Jorge in Kindergarten

During the time Jorge delayed from starting kindergarten, Ted and Beth have wasted no time in aligning developmental services, to include physical therapy, occupational therapy, and home tutoring. Beth is pleased to have a new use for her love of languages, and Jorge responds warmly to her Spanish. Many evenings, the two play on the rug with toys, or share picture books, English to Spanish and Spanish to English. Ted enjoys the family scene but admits half-jokingly to a feeling of exclusion: Jorge seems oblivious to his efforts at beginning Spanish. He will sometimes reply in English, but the Smiths consult a speech and language therapist about a new symptom: sometimes Jorge will not respond to either of them, in either language. With further analysis, the selective inattention is found to be related to a developing opposition to rules, such as bed times, or anything interrupting play. To curb his new, facultative, language problem, Beth is encouraged to stop trying in Spanish, and both adoptive parents are to give simple explanations of expectations in English, employing eye contact and, if necessary, applying a “consequence” (such as removal of a toy for a time) when Jorge postpones compliance.

Optimism at home is also tempered by Jorge’s behavior in public. At church he is more hyperactive, and sometimes frankly disregards instructions to stay with them, or to stay quiet. He is also too forward with strangers, abruptly giving a hug at unpredictable moments or, for example, taking the hand of an adult as if going for a walk with a complete stranger. They see the same problem at a restaurant or going to a movie; Jorge now seems uninhibited about starting conversation in English with adults unknown to the Smith household. His capacity to verbalize, and even use colloquial American speech, is remarkable, but Beth especially is hurt by the comparison to the rudimentary conversation which can be supported at home.

The start of kindergarten greatly magnifies and expands Jorge’s difficulty with social distance: his teacher is quick to identify a problem with “getting too close” with children he has not met, and parents have closely questioned Beth and Ted on this. Sometimes he runs directly into a child with arms open, in something like a hug, but he sometimes slaps the arm or head too roughly, so that the meaning of the gesture seems midway between expressing hostility or inviting friendship. Both parents have researched the library and the web for age-appropriate materials to teach Jorge about “stranger danger” and “good touch bad touch.” Results are inconclusive, though he seems to listen and attend to their gentle efforts.

Meanwhile Jorge is alternatively argumentative or over-affectionate with same-age children who Beth and Ted invite over for playmates: Jorge will sometimes share his toys but can become suddenly pushy and aggressive; his new friends tell their parents they do not wish to return because “he’s too bossy.”

Jorge does not show expected improvement in his early weeks of kindergarten but seems to grow steadily worse in offending other children and in refusal to sit in a circle or share in games. There is question about his earlier progress in English language comprehension, and he seldom replies directly to the teacher. Beth and Ted this time agree to both psychology and psychiatry consultations, as suggested by the school.

At first appointment with Jorge and his family, Ted and Beth share their chief concerns as Jorge looks on silently, and he declines to join in discussion at this point, even with gentle support. Chief complaints thus are from the parents: (1) a growing pattern of intermittent, unguarded intimacy with adults, such as importune advance and start of conversation with complete strangers, and (2) irritability and apparent hostility toward them, especially when Jorge is asked to interrupt play, to get ready for bed, or to prepare for school. What stands out from the next individual interview with Jorge is his free use of language and his casual and apparently friendly behavior. He quickly finds toy puppets and seems familiar with how to use puppets to represent a pretend conversation. He will converse freely with this device and seems to enjoy new acquaintance, smiling warmly even in his first session. Jorge falls silent however, in the face of questions about his early home, and is finally mute when problems in his life with Ted and Beth are gently approached.

Another remarkable feature of the combined interviews is Jorge’s lack of emotional expression or protest when his parents go to the waiting room to allow individual work. They try to prepare him for a possible distressing shift, but he seems too busy with toys to care at this point. Even more startling, there is no visible shift in expression, and no verbal acknowledgement of their return, at the time of reunion for discussion of preliminary findings. These are discussed with the Smiths in terms of a preliminary, differential diagnosis based on symptoms including hyperactivity and also on the history of presumed trauma and multiple placements. Attention Deficit Hyperactivity Disorder (ADHD), PTSD, and RAD are each explained in terms of understanding. In addition, the autistic spectrum disorders are reviewed as a rule out, with the caveat that Jorge has certainly shown a full range of nonverbal expression, has made progress in language, and at least sometimes will share a fun activity interactively. ADHD symptom checklists are provided to survey symptoms at home and school. The Child Behavior Checklist is to be completed at home and returned. Referral to a psychology colleague is also made at this point, for impressions on the differential diagnosis, and for further tests of aptitude and development.

Findings from psychology consultation specifically do not support Autistic Spectrum Disorder (ASD). On an observation-based diagnostic instrument, the Child Autistic Rating Scale [41], Jorge’s scores are in the nonclinical range. The report also lists Jorge’s eagerness to relate to the examiner, his reciprocal style of play behavior in the exam room, and his open expression of pleasure with the social encounter.

Also noted is the recent, remarkable advance in language, which does not seem consistent with autistic spectrum. His skillful use of facial expression and nonverbal expressiveness is also remarked. Further developmental evaluation was recommended, especially to follow the direction of learning disorder, possible improvement in language, and to rule out attachment disorder. Close pediatric care is encouraged, with the range of medical findings already identified. Jorge's social disadvantage with peers is remarked, based on his small body size. Psychology suggests that a portion of his oppositional behavior at home, and also his preference for adult company might relate to negative self-attributions and comparisons about body size, his limp, and his sense of cultural distance from peers.

Consult to orthopedics for evaluation of a limp and wrist has led to extensive evaluation of bony defects and in turn to medical evaluations which have ruled out pediatric congenital bone disease. Uneven leg length is considered a factor in the limp. Foot x-rays however reveal "metatarsal distal flaring, possibly due to early metaphysis tearing and callous reformation." No treatment is recommended except for the limp, a condition that is now obviously a problem when Jorge tries to join in play with other children when this involves running or moving rapidly. Beth brings Jorge back to his physical therapy, but he says he does not remember her and becomes immediately angry in the clinic, folding his arms and refusing to move from the waiting room. Report from the session is that he is now "too hyperactive and disruptive to engage in treatment." Beth and Ted now have a physical therapy regimen to try at home with Jorge, in hopes of improving his balance and gait. Since the family continues to decline to consider psychotropic medications, they elect to follow-up in 3 months, with the offer to come in earlier if symptoms require.

Case Point: The Retrospective Evaluation of Child Abuse

The child psychiatry clinician and radiologist seem to rarely share cases, but one example share of partnership involves the difficult assessment of infant abuse when evaluation takes place years later, as might occur in the case of international adoption. In such a case, past medical records are sparse, even missing. But even more fundamental is a special quality of the infant skeleton: it is amazingly flexible, and this, with the restructuring of growing bone, makes diagnosis by plane film especially problematic. Isolated fractures may heal in place, without a residual change in contour. Rib fractures (a common sign of severe infant trauma), for example, may be invisible years after injury.

Other reliable signs of child abuse which are familiar to emergency room clinicians are likewise less dependable when injury occurs in infancy. Cigarette burns may have healed, or morphed into vague skin discolorations. The clinical sign "wounds of different ages" will not apply assuming the child has not had subsequent, serial trauma after removal from the original setting of abuse. Displaced fractures sometimes may heal in nonalignment, however, and would then be visible on x-ray. An unfortunate example occurs when an adult, in the act of changing

diapers, becomes enraged and twists forcefully on both femoral bones; an injury of this kind could plausibly cause a limp for a child like in our case of Jorge, and could be discoverable years after injury [42]. Assaults on infants typically injure long bones and the feet are spared [43]. An exception is a grabbing and yanking injury to the feet, and severe foot fractures almost invariably involve metatarsal bones.

Physical abuse of infants may also cause bowing of either femur or tibia bones, and the fracture line may be invisible on plane film [44]. The powerful force that can produce such trauma transmits itself to the ends of long bones, with a valvular deformation at the proximal tibia, or with fracture to the growth plate. One telltale sign is called the “classic metaphyseal lesion” [44] and this is a fracture through the growth plate, best viewed with photomicrography. As the fracture spreads laterally, it flares out and separates the bony collar underlying the periosteum from the cortex of bone. With angular beaming technology, the end of the long bone may show a “bucket handle” shape, which indicates the early trauma of impact to the long bone, manifest at the “weak spot” of the growth plate. In addition to bone injuries in infancy, tendon burn injuries are an additional cause for a residual limp, as in the case of Jorge [42].

Late interpretation of infant abuse is an art as well as a science, and is rarely considered in part because it will not lead to information that guides any new medical treatment. It is also true that few children with multiple severe injuries of this kind actually survive: head trauma in combination with rib fracture, for example, is typically fatal [45]. Given the limitations of a purely medical assessment, the findings of child mental health will carry considerable weight in the interpretation of early trauma. The child psychiatry equivalent for “wounds of different ages” may be the description of post-traumatic stress disorder which is age specific in its expression and measurable by comparison to norms for age and level of development. Early trauma impacts upon multiple developmental domains, beginning with a lesion to basic trust and expanding to involve delays in emotion regulation, intellectual growth, and social relationship.

Part 4: Jorge in First Grade

Through kindergarten Jorge has gained weight quickly. There is marked improvement in expressive language, a proof for the work of his special education tutor. Now in first grade, he is roughly the same size as other children. He resembles the other children at casual glance, except that he does not share in games and often interferes when other children play together. He cannot relax his exclusive claim to his teacher, and will try to block any other child who tries to approach her. When called upon to explain himself to her, he smiles winningly, and moves closer to her side. Recently, Jorge has shown greater persistence in his effort to sit in his teacher’s lap while she is telling a story to the class, and she is increasingly uncomfortable with this behavior. In parallel with his display of affection toward the teacher, he is increasingly aggressive toward his classmates; he has been chastised for “accidentally”

kicking or tripping. Most worrisome is the increasing purposefulness of his actions, for which he offers little explanation. He is in fact silent in the face of a scolding and correction, and at time he is mute in class for no apparent cause, disregarding his teacher or others when they try to gain his attention. He also maintains a grudge, and will retaliate long after an argument. Punishment by “time out” is uniformly followed by aggressive behavior, usually a fight with another child. He has had one out of school suspension of a week, for “damage to school property, verbal aggression and out of control behavior.”

Jorge is by now assigned to a counselor at school, who is trying to understand the causes for his unpredictable hostility, while at the same time coaching him in social skills. Her preliminary impression is that Jorge has advanced in general English language skills, but lacks a sense of how to label his own emotions, and is misunderstanding the nonverbal, contextual cues he needs to comprehend the group around him. He does not, for example, easily comprehend the difference between “getting mad” as an emotional experience and actually being aggressive as in hurting another child or damaging property. He blandly denies both anger and angry behavior, at first not understanding a clear distinction. His therapist discovers that when Jorge plays a competitive game with the other first graders, he perceives them to be cheating, even conspiring together if he does not win. He is thus inclined to label laughter of a child as “laughing at him.” He also explains his problem behaviors, such as tripping or hitting other children, as necessary to maintaining his social standing with his peers, and in fact he feels those that provoke or test him are personally responsible for his violence. Counseling is now directed to both decoding and reframing the meaning of his arguments with other children, and there is consideration of expanding to a social skills group, to try out his new ideas about how to relate to children and teachers in the classroom.

Case Point: Alexythymia and Attachment

In addition to its instrumental goal of exchanging information, first use of words is profoundly personal, and in the early dyadic relationship it comprises an extension of the principle of attunement to the moment of shared experience. The relationship of language to attachment seems certain, based on empiric research; an example is the finding that the hormone oxytocin – which mediates human attachment behavior – increases when young girls (age 7–12) are comforted by the voice of their own mother, during a stress test which requires timed mathematical tasks in front of an audience [46]. Conversely, selective mutism may reveal deficits of child attachment, or may reflect the child’s perception of adult misattunement [47]. It is therefore encouraging to witness the rapid, and sometimes amazing, advance in the use of language for a child with RAD, after their transfer from conditions of emotional deprivation to a new, supportive home.

Capacity for selective attachment lags behind the general advance in language after transfer to a new home. This introduces the question of whether use of language to express personal emotion might be a specific impairment. Development of

emotions-related language can be studied in children through analysis of social measures, and scales of social competence have been applied to research on RAD [48]. Alexithymia is the term, first coined by Sifneos [49], for an evident deficit in symbolization of somatic and mental states (he applied the term to adult patients with psychosomatic disorders). In their study of alexithymia in children, Way et al. [50] redefine alexithymia as “cognitive-affective communication impairment” and a “psychological phenomenon in which individuals may experience or be aware of strong feelings but have difficulty understanding and effectively expressing their feelings to others.” They apply the term to a child who cannot identify their subjective experience of emotion and, hence, cannot convey the experience to others.

Externalizing symptoms, especially aggression, frequently correlate with impoverishment of language skills. On this basis, Way et al. [50] propose a fundamental relationship between childhood problems in communication, and delay in emotional self-regulation. Language disability is thus one element of the differential diagnosis of childhood aggression: outbursts of violence in a child may represent in part, a disability in communicating emotion by other means. Conversely, a child with language delay is at risk for academic and social problems. Of particular importance is the expressive deficit which may be specifically targeted in school even as a comorbid receptive language delay – perhaps less obvious but equally telling – continues to bar the way to normal relationship. Mixed delays are the rule rather than the exception, and many children with externalizing symptoms do not comprehend, or at least do not use nonverbal, pragmatic language cues to efficiently coordinate social intercourse. Inaccuracies in interpretation predispose to social ostracism, can lead to negative self-attributions, and hence may facilitate further use of “acting out” as the default method for expression of negative emotion [51].

The relationship between social development and use of emotional language is complex because the use of emotion words also requires motivation for emotional language and, in this sense, a matrix of attachment. Zadeh et al. [52] propose a model for language as a mediating influence between social cognition and psychopathology in externalizing children: the effective use of positive social strategies requires skillful use of language (especially syntax) because of the importance of taking perspective (representing perspective of oneself and another). These results support a dual approach to externalizing children, emphasizing both language competence and social-cognitive therapy.

Lemche et al. [48] have directly measured alexithymia in children with different levels, or subtypes of attachment. The authors assigned infants in the study at 12 months using the Strange Situation, into the categories of secure and insecure subtypes. Subsequently, at age 17, 23, 30, and 36 months, transcripts of the children’s language were collected under controlled conditions. Significant differences emerge between secure and insecure children: insecure avoidant and insecure disorganized toddlers show marked delay in use of words to express inner state of emotion, a meager vocabulary for words which pertain to emotional regulation, and rare use of words to represent internal physiological states (e.g., “thirsty”). Children classified as secure infants were more likely at 17 months to use “positive emotion words,” in addition to using more words to self-regulate, or to depict physiological state. The measures of alexithymia persist in the insecure children, as late as 3 years

into the study. The authors thus conclude that attachment status in infancy predicts the trajectory of a childhood capacity to symbolize and manage emotion.

Pivotal to our study of language and attachment is the effect of infant maltreatment on subsequent emotional expression. In an abusive or neglectful home, the young child is primarily exposed to negative affect, and receives few confirmations of positive, reciprocal communications either verbal or nonverbal. Camras et al. [53] explored the effect of maternal facial expressivity in a comparison of 20 maltreated with 20 non-maltreated children. Facial expressivity of the children was essentially proportional to maternal expressivity, for both groups. In general, children of mothers with high facial expressivity were better at interpreting emotion. Older children also scored higher than younger children. But the key finding is the consistently higher scores in emotional recognition for non-maltreated control children, for emotions ranging from pure happiness through sadness, fear, surprise, and disgust. When cognitive maturity is factored out (using the Peabody Picture Vocabulary Test), the finding holds true that maltreatment status conveys a disadvantage in accurately recognizing the emotional content of facial expressions.

Germane to a consideration of emotional intelligence in attachment-disordered children is the analysis by Wismer Fries and Pollak [54] of affect recognition abilities of post-institutionalized Eastern European children. The study group had resided in orphanages for an average of 16.6 months prior to adoption. For the 18 post-institutional children a significant handicap was discovered, in comparison to controls in interpreting test faces depicting emotion, as well as in matching standard facial expressions with emotional situation in quantitative measures of emotion discrimination.

The evidence for impoverishment of emotion recognition as a function of early emotional deprivation points to an expanded role of speech and language pathology, which is based on dyadic relationship of early life. Geller and Foley [55] advocate for expansion of the field of speech pathology to incorporate advances in the understanding of the emotional foundation for use of language in early childhood. Essentially the model involves “working from the inside out”; the authors explain that language deficits may be formulated in terms of parental understanding of the child, their hopes and wishes, as well as the child’s own state of affect and need to communicate. Geller and Foley emphasize the importance of attachment theory, and the understanding of past and present relationship of parent and child. For this expanding role of speech and language pathology, the authors emphasize applications for Stern’s theory of emotional attunement and encourage the clinician’s therapeutic use of the “self” in treatment.

Part 5: Jorge in Second and Third Grades

As the treating child psychiatrist you are invited to participate in an Individualized Education Plan for second Grade. Parents and school are united in their concern about Jorge’s disruptive behavior, his poor peer relationships, and by his apparent

insatiable hunger for adult attention. There is overt encouragement to consider medication treatment for hyperactivity. In addition to this consideration, his new education plan will include full in-school assignment of a teacher's aide. In addition to providing an adult emotional support, the aide will view and supervise relationship with other children, to encourage a pro-social trend. In addition, a new element of the education plan is "time in" for Jorge, a period of close, individual attention away from the other children and with his teacher's aide, after each incident of unruly behavior. This contingent response is intended to reverse the effect of rejection that seems implicit in the "time out" which has been used as a consequence for problem behavior.

The new plan meets with initial success; Jorge and his assigned aide seem to warm toward each other quickly, and he responds to her directions at first. But this impression shifts as he begins to test her authority, while simultaneously "demanding hugs all through the class." Adults share their dismay about a new behavior of "combined hugs and hits"; Jorge will come running into the arms of his teacher or his aide, and the forceful lunge feels hostile, even deliberately hurtful. Jorge only smiles when the effect is questioned, so that the question remains as to whether he intends to be aggressive or whether he is perhaps clumsy, even off balance because of his limp.

Medication treatment for hyperactivity in the final semester of second grade also has a hopeful beginning, and Jorge shows initial rapid improvement in listening skills, with a modest enhancement of sharing with other children. There is brief cessation of the "running hugs" of adults (hug combined with collision), which had offended several of the teachers. Report for parent-teacher conference includes the optimistic finding that "Jorge exhibits a degree of calm he has never shown before."

Success is short lived, and a new problem behavior emerges: from an initial warming of affection toward his teacher's aide, Jorge is now pressing her continuously for physical affection, and continuous, exclusive attention. After an eerie episode in which Jorge tries to kiss and stroke her arms, his teacher's aide threatens to quit, and the plan to assign an adult to Jorge in his half day of mainstream class is abandoned. Without this resource, Jorge's aggression toward other children rapidly worsens, leading to a theory of some in school that he is deliberately retaliating. Jorge is often in trouble during recess for tripping other children, a behavior he denies with a smile, but one that has been witnessed, then documented. He finally receives an out-of-school suspension for allegedly stabbing a child in the face with a pencil, during an argument at lunchtime. Jorge explains this as accidental, and though the injury is superficial, the school is under pressure from the parent of the injured child to take action.

Based on mixed or unclear results, you elect to suspend the medication treatment during summer, and you schedule reevaluation before the start of third grade. It is at this point that the parents divide in their approach to treatment. His mother would like to continue psychiatry appointments but to "try something different." His father has become interested in a form of attachment therapy which, per description of Jorge's parents, advocates strict discipline "twenty-four seven," recommends use of

“forced holds” and opposes all forms of psychiatry treatment. Ted explains to you his opinion that RAD is “not biological and not medical” and that he adds that he has learned on a web site that “symptoms get worse on a medication through kindling.” Following a discussion between Jorge’s parents at home, his mother calls to suspend appointments, she confides that marital problems have recently complicated life at home, to the extent that marital therapy will need to be prioritized, ahead of Jorge’s outpatient work for the present.

Case Point: Longitudinal Course and the Trait of Indiscriminate Friendliness

There are few studies for longitudinal course of RAD beyond early childhood. An interesting exception is a long-term study of twins, from 18 months to 8 years [56, 57]. With the effect of ongoing treatment, there was overall clinical improvement for the twins, but residual externalizing symptoms. Persistence of self-endangering behaviors suggests the early, traumatic effect of pathogenic care in this case study.

Longitudinal studies reveal persistence of attachment disorder symptoms after adoption, for children initially abandoned and then raised in a residential nursery in which personal contact was minimized, but physical stimuli – books and toys – were provided [58, 59]. Of 26 children who remained institutionalized for the first 4 years of life, eight were identified as emotionally withdrawn and unresponsive, ten were indiscriminately social, and eight were selective in attachment to their caregiver. The “over-friendly” attention-seeking trait was found to be especially persistent for these post-institutional children as observed at 4–8 years. By age 16, indiscriminate behavior toward adults was eclipsed by a related problem of superficiality toward peers, and the affected children appeared to confuse acquaintance with the terms of close friendship [60].

Large-scale studies confirm the impression that, despite the dramatic appearance of the withdrawn-inhibited form of RAD at time of diagnosis, it is the indiscriminate-disinhibited type that shows greater resistance to change after removal from pathogenic care. Social disinhibition persists, for example, in an open lack of reserve toward novel acquaintances and in “wandering off with strangers.” In the large-scale English and Romanian Adoption Study, indiscriminate sociability and disinhibition persisted from age 6 to age 11 [61]. Chisholm [62] also reports stability in Romanian orphans for the trait of indiscriminate social behavior, a clinical marker now termed “indiscriminate friendliness.”

Indiscriminate friendliness (IF) has been measured for relationship to other clinical syndromes, especially those involving externalizing disorder. Lyons-Ruth et al. [63] used the Strange Situation test to code IF behavior; children who were highly indiscriminate at 18 months also scored high on teachers rating of hyperactivity at kindergarten, independent of the effect of disorganized and avoidant attachment at the same point. Outcome studies of preschool children [60, 64, 65] and school-age children [59] suggest a moderate, inverse relationship of the “over-friendly” (IF) trait with measures of inhibitory control.

Effect of early adverse environment on the trait of indiscriminate sociability has also been examined, independent of the diagnosis of attachment disorder. Bruce et al. [31] have studied a group of 120 children age 6–7 adopted into the USA after receiving institutional or adoptive care for “most of their lives.” The authors discovered that adoptees from foreign institutional settings had relatively high levels of IF, but surprisingly this trait was also represented in international adoptees from foster care settings. The institutional care group scored relatively poorly on tests of basic emotional abilities (including tests for recognition of faces depicting emotions) and inhibitory control (including tests to inhibit reflexive response to stimuli). Based on parent reports, disinhibited social behavior was related to the duration but not the degree of general deprivation. For the children from previous institutional care, the level of disinhibited social behavior correlated with length in institutional care, prior to adoption.

In a US study, Pears et al. [64] report a direct relationship between maltreatment and level of IF in foster care children. Children with the highest number of foster care placements showed the poorest level of inhibitory control, and the highest level of IF, leading to an hypothesis for relationship of these variables to a “larger pattern of dysregulation associated with inconsistency in caregiving.”

A common finding for each outcome of the study is that disinhibited social behavior specifically corresponds to lack of consistent caregiving in an early, sensitive period of childhood, rather than to general deprivation effects like poor nutrition or lack of medical care [65, 66]. Of note however is the imperfect relationship of the trait of indiscriminate friendliness to nonselective attachment. It is now understood that children raised in institutions may show preference for a particular caregiver, but still display the trait of indiscriminate, disinhibited social behavior [67].

Part 6: Jorge in fourth and fourth Grades

New problems emerge at the start of fourth grade which, from the perspective of involved adults, now eclipse the previous worries about friendship and language delay. These are externalizing symptoms, especially lying, which is pervasive and sometimes oddly without an apparent motive. Pre-meditated or predatory behavior has occurred, such as lying in wait after school to bully smaller children; here lying serves the obvious purpose of denial and minimization. Mistruth about actual homework assignments has complicated his special education plan, and procrastination has evolved into frank opposition to school and schoolwork.

There is also some overlap of distortion with fanciful thinking and even practical jokes. On one occasion, Jorge visited a neighborhood barbecue party and told the adults presiding that Ted and Beth are secretly very poor, to the extent that they are starving him and even “punish him for going in the refrigerator”; this was so convincing that the neighbors prepared him a well-cooked meal. A graver matter is his report to the school guidance counselor that he is often whipped with a belt by his father, and this statement seemed so sincere that a case was filed with Child Protective Services. Jorge has now recanted, but will not explain his motives for the false report.

In the arena of peer relationship, Jorge has yet to find a "best friend." Yet he is often entertaining to a group and has, for example, taught his classmates how to gamble for small coins during recess. At other times he is oddly aloof, and on the playground he sits high up on a slide from which vantage he surveys the other children and the surround, seeming to act like a scout or as if standing guard. On at least one occasion he has baited another child into fighting him, and after the older boy was punished, Jorge confessed to his therapist that bruises and scratches were self-inflicted, a way of "getting him in trouble...and getting him back." This example of self-harm, and the apparent self-defeating behaviors has convinced his therapist that Jorge's best working diagnosis is atypical depression: he is defending against low self-esteem, feelings of rejection, and his earlier self-image as "unloved."

Since release of information is provided, Jorge's therapist is able to communicate her working formulation about Jorge's emerging conduct symptoms: he has not yet achieved sufficient confidence in dyadic relationship to progress to competitive activities with other children, to whom he feels inferior. For the same reason, Jorge rebels against Ted's rule-making, and is jealous of the loving relationship of his adoptive parents. Recommendation is made to Ted to adopt a softer approach, and he agrees to make time each week for positive "fun time" independent of any coaching about rules or school. In addition, both therapist and parents would like opinion about starting an antidepressant medication for Jorge, which hopefully could help his mood, and improve energy available for work and play. A commonly used SSRI is started at low dose, following your review with the family of the current evidence base, and potential risks.

Early effects of this combined approach appear positive. Ted has traded in his sedan for a brand-new off-road vehicle, and has made plans with Jorge for Saturday rides in the country. This is a prized possession for both of them, and part of the day is spent washing and waxing. Ted had to miss one weekend for a business trip, and to his dismay discovers a key or other sharp object has been run across the entire finish. Jorge protests innocence, but Ted will not fully retreat from his accusation that Jorge is somehow responsible, given the unlikelihood of vandalism in their neighborhood, and "based on his lies in the past." According to Beth, Ted now backs away from relationship with Jorge, avoids encounters before school and comes home later in the evening. By report he is opposed both to Jorge's therapy plan, and to future psychiatry appointments.

Following this reversal in relationship Jorge has become more aggressive on the playground. He is more impulsive, for example, walking away from school in plain sight of teachers. Yet he is accused of being more devious: for example putting shards of broken glass in a school mate's shoe, initially denied, and then explained "as a joke." In another apparent effort at a practical joke at home, Jorge pretends to swallow from a bottle of bleach in front of his mother. His simulation of acute illness is so convincing that he is rushed to the emergency room, where he eventually admits his deceit to medical staff, under close questioning. This naturally leads to early psychiatry appointment, and in his next session the SSRI is tapered off, because of correlation with an exacerbation of symptoms.

In the summer after fifth grade, now off medications, frank signs of conduct disorder emerge. Jorge convinces an older boy to jumpstart Ted's off-road vehicle, and the two go joy riding, apprehended only after a minor accident. Following this incident, inventory of mood symptoms is essentially negative, and Jorge has no explanation for the behavior. As the treating child psychiatrist, you again arrange for an early appointment and urge both parents to come for treatment planning. Based on past attendance it is a surprise that the family is a "no-show" to the scheduled session. It is especially unlike Beth not to call to cancel or reschedule. The answer to the mystery arrives as a telephone call from the nearby inpatient child psychiatry hospital; Jorge is an inpatient and his parents would like to arrange follow-up with you after discharge.

The inpatient social worker (with release of information) explains recent symptoms and the need for emergency hospitalization. Prior to admission Jorge elaborated a plan for slowly poisoning Beth, and he posted this on the Internet under the heading "how to murder your mother." In separate sessions he denies the plan, and next explains it as a hoax and a kind of practical joke. Further work on inpatient reveals Jorge's hope that "this will let me get close to my Dad." He seems oblivious of the ramifications of such an action, but seems convincing about his assertion that he "never would really have done it." No other formal thought disorder symptoms were discovered at admission, apart from this remarkable impairment of insight.

Provisional diagnosis from inpatient is bipolar disorder, mixed. This is based on past reckless impulsivity, the possible activation by an antidepressant earlier, and the elaborate homicidal fantasy. A neuroleptic medication has been started at low dose as a mood stabilizer, and after a few days a new antidepressant agent has been started, after psychological assessment, and the finding of an elevation of the depression scale on one of the tests used.

The inpatient record mentions that Jorge never requested calls to his family, as was his privilege. He was calm and agreeable in early family work and in fact seemed to "act as if nothing happened" according to case notes. An early inpatient problem was his frequent request for snacks, and his habit of "hanging out" at the nurse's station. A portion of the inpatient staff supported frequent snack as a necessary comfort for Jorge, helping him cope with emotions during high stress periods such as before group therapy. Others argued that acquiescing to comfort eating has supported a dysfunctional demand to "always get his own way." The complicating problem is weight gain, and even before starting medications on inpatient, the scales show Jorge to be overweight for his age and especially for his height. Weight gain on inpatient is remarkable. Jorge has assaulted another teenager who called him "fatty" and attempted to fight with another boy who imitated him. Jorge has been restrained on inpatient after striking a staff member who tried to control his aggression. The inpatient social worker who is setting up services with you confides that he "was getting worse the longer he stays here"

Test #1: Case-Related Questions

1. Suppose you are the first US physician to meet with Jorge, immediately following his move to a new home with Beth and Ted. At his appointment his case manager tells you that she is concerned about Jorge’s growth rate and he appears small for age. She has brought paperwork which includes a brief, hand-written physical examination with the remark “below the fifth percentile for height and weight. Ted and Beth are in attendance too, and add the remark that Jorge is “constantly on the go,” very restless physically. Choose the best recommendation based on these initial concerns and the information provided:
 - (a) Since small body size is likely to impair self-esteem and impede normal development of friendship, a hormonal treatment to promote rapid growth and weight gain should be started without delay.
 - (b) Since body size is compared to US children of same age, pediatric consultation is not required at this time, and poses a risk in drawing attention to a relatively unimportant child health problem.
 - (c) If not already arranged, a pediatric or family practice appointment should be scheduled without delay.
 - (d) Lack of documentation of the growth delay suggests that other medical problems also might be omitted in the paperwork provided to the Smiths, and on this basis no further psychiatry or medical evaluation should be attempted until full documentation is received from the host country.
 - (e) Since physical growth is a function of emotional nurturance, a “wait and see” approach is appropriate in the new home environment, such that a pediatric appointment could be scheduled in 6–8 months if the growth trajectory does not show improvement.
2. As you are the first psychiatrist to consult on Jorge’s care, describe your approach to others on the clinical team.
 - (a) Inform Beth and Ted that you will never discuss his treatment with his case manager or therapist unless specifically requested by one of them, in order to preserve Jorge’s privacy.
 - (b) Explain to the clinical team and the Smiths that your practice is limited to medication management, and that they should only consult you when there is reason to expect that a change in medication treatment will be helpful.
 - (c) Offer to provide opinion at any stage of treatment, and suggest availability for ongoing assessment if symptoms change even if there is no clear indication for a new medication.
 - (d) Demonstrate leadership by informing the therapist and case manager that you are in charge of the overall care plan, and instruct them that you expect to be notified of any changes in therapy, in the school plan, or in the family.
 - (e) Patiently explain to the Smiths that RAD is not a diagnosis which can be treated by psychiatry medications, so instead of consulting psychiatry they should find an expert in RAD who uses novel and specialized techniques that can repair early defects in attachment.

3. Now suppose that in Jorge's first days in kindergarten, the worry about hyperactivity appears to be confirmed by his constant motion, inattention to direction, and refusal to join in quiet group activities. Patient observation confirms that Jorge understands directions but "simply won't follow them. The school has arranged for assignment to a psychotherapist, who describes a good working alliance with Jorge. She politely disagrees with the theory that Jorge has ADHD, she reminds you that any child who has emotional trauma might become overactive in a new setting. Meanwhile, school personnel are urging the Smiths to push harder for treatment of ADHD, and there is some implication that Jorge might not be able to continue in his present kindergarten class "unless something changes." Based on this history, choose your next move in treatment:
- (a) ADHD symptom checklists can be administered for two or more settings (such as home and school) to help discern the course of symptoms and for further potential consideration of ADHD.
 - (b) Since the symptoms presented can be more accurately attributed to the diagnosis of RAD, medications designed to treat ADHD are likely to be unhelpful, and may even paradoxically worsen hyperactivity.
 - (c) If further psychological testing supports multiple diagnoses such as RAD, ADHD, and PTSD, residential treatment should be considered.
 - (d) Given the complexity of diagnosis and the uncertain origin of symptoms, a 30-day inpatient diagnostic evaluation is indicated, to include brain imaging and genetic testing.
 - (e) If Jorge's new therapist is not fluent in Spanish, you should recommend that he be transferred to a new therapist, preferably one who is culturally sensitive and bilingual.
4. You are scheduled to meet again with Jorge, who is now a first grader. The consult question from the school involves the rise in oppositional defiant behavior, such as pushing ahead in line and an incident involving foul language toward a teacher. In session with the Smiths, they reveal a separate disappointment about Jorge's failure to return their affection, and the absence of any gratitude for their efforts to make him part of the family. Their sorrow is now more acute because of the contrast with his over-affection toward his teacher, whom he often greets with hugs and kisses. Jorge's teacher however has confided that she feels increasingly uncomfortable with Jorge's physical affection, and she points out that "it makes the other children laugh at him." Which of the following represents a sound clinical recommendation for the school, supported by attachment theory?
- (a) A private conference with the school counselor would be helpful toward understanding what Jorge has learned about the meaning of touch. Once this is accomplished, he should receive further instruction to help him gauge his level of familiarity and overt affection.
 - (b) To forestall a negative developmental trajectory, a gentle but firm confrontation is indicated, and time out in a corner of the classroom should be applied at the first sign of over-affection.
 - (c) A neutral adult figure in the school should be assigned to meet and greet Jorge when he arrives at school, in order to provide a warm hug at the start

of the day. In addition to satisfying his obvious need for physical affection, this will also provide an experience at the “receiving end” and thereby can help him develop a social sense of touching.

- (d) Whenever Jorge attempts to hug or kiss his teacher, she should turn away, and deliberately show greater interest in other children.
 - (e) When Jorge tries to hug or kiss his teacher, adults should carefully abstain from any criticism or expression of concern, so as to reduce the risk of injuring Jorge’s fragile, nascent social drive and his beginning effort at attachment.
5. Now consider that Jorge is a second grader and multiple clinical assessments have culminated in diagnosis of RAD. Your mission in this appointment is to address the problem of Jorge’s violence in school toward other children, which is sometimes reactive to insult or interference, but in other cases seems to be pre-meditated. An example is tripping other children on the playground, and teachers have witnessed a careful preparation and some delight in the results of this behavior. Which of the following recommendations to the school would be most likely to enhance the development of *object constancy* for a child with delay of attachment?
- (a) Observation of Jorge in the classroom will lead to an understanding of what he looks like just before starting a fight: at the least sign of violence Jorge should stand in front of the class and apologize for his anger.
 - (b) If adults will deliberately ignore Jorge’s negative behaviors during his adaptation to school, he will internalize the belief that his acceptance into a group can be unconditional. This sense of security will become the foundation for adhering to a social code as a bona fide member of his peer group.
 - (c) In a private session with his principal, this adult should calmly explain that Jorge is not disliked, but that he unfortunately is now at risk for being expelled because of the school’s zero tolerance policy for violence.
 - (d) In a private session, a counselor or therapist may explain that Jorge can receive help in understanding the feelings that give rise to violence; while at the same time will be accountable for violating rules that apply in class to all the children.
 - (e) When correct boundaries are in place, the school’s job is to teach and the parents’ job is to discipline. The school should encourage Jorge’s adoptive parents to punish Jorge however they see fit. School personnel will refrain from any direct correction of bad behavior, but will send home daily reports of violence or rule infractions.
6. Consider that comprehensive evaluation of symptoms in third grade has led to additional diagnosis of ADHD for Jorge, and his behavior improved markedly with trial of a medication treatment for this disorder. While his compliance and cooperation have increased, initial report of academic success is favorable. You are surprised to hear from an inpatient unit, calling to request an appointment to continue outpatient care.
- An incident of “wild aggressive behavior” at school and description of mood symptoms has led to provisional diagnosis of childhood-onset bipolar disorder.

There is description of initial improvement in a neuroleptic medication and a recent inpatient trial of an SSRI antidepressant agent. The inpatient therapist who calls you relates the team consensus that Jorge is “getting worse the longer he stays here.” There is also concern about an immediate weight gain on the current medications, and some of the staff attribute this to overindulgence and “comfort eating.” Describe a best initial response to the request to resume outpatient care.

- (a) Since Jorge is gaining weight on a neuroleptic medication, you cannot accept treatment until this medication has a wash-out and a minimum of 2 weeks inpatient observation to verify both stability and maintenance of general health.
 - (b) Request explanation for start of an antidepressant on the unit and further information about any correlation with the rise in disruptive behavior. Explain that an outpatient appointment can be arranged when Jorge is stable and in control of his behavior.
 - (c) Firmly decline to accept Jorge as an outpatient while strongly encouraging referral to a residential treatment center in a nearby state, which specializes in treatments of RAD.
 - (d) Gently probe to see whether the Smiths plan to continue the adoption or would consider a return to foster care with the hope that Jorge could be accepted into a family from his home or a neighboring country.
 - (e) Inform the inpatient unit that you can accept him into outpatient treatment if you can guide the inpatient medication treatment plan for 1 week prior to his discharge.
7. In your first appointment with Jorge after discharge from inpatient, further perspective is gained from review of the records, a discussion with his therapist, and interview with each family member. Prior to hospitalization, Jorge had revealed to his therapist a partial but very troubling memory of a grown-up who touched him in his “privates,” and Jorge feels that this occurred when he was very little but “he remembers it in nightmares.” Then during the week after this came out in therapy, Jorge became much more hyperactive and frankly disruptive in class. The same week at home he experimented with building fires in the basement, and the next day his agitation at school culminated in admission to a child inpatient unit. Consider further recommendations based on this more detailed account of the pre-hospital course.
- (a) Since the time Jorge confided in his therapist about trauma, his behavior is much worse. On this basis, any further contact with the therapist may itself become traumatic, and hence he should be reassigned to a new therapist after carefully explaining the transition process to him in terms of his understanding.
 - (b) A specialized treatment center should be consulted which provides for re-birthing and “forced hugs” as potentially required when basic trust has been violated as manifest in the overlapping diagnoses of PTSD with RAD.
 - (c) Medication treatments specifically designed for post-traumatic symptoms should be considered, and all other medications should be held while monitoring the effect of medication treatment for PTSD symptoms.

- (d) Unless detrimental factors of therapy are identified, encourage Jorge and his family to continue with their current therapist but assure them that the therapist will monitor the level of stress and will not force Jorge to reveal or reexperience further troubling memories; check with the therapist about the management of PTSD symptoms in therapy.
 - (e) Schedule a sleep study for Jorge in order to ensure that problems of sleep architecture are not the actual cause for the nightmares about trauma.
8. You are asked by a pediatrician to provide a consult for another case, a girl Jane who is now age 7 and carries diagnoses of both ADHD and RAD. She was removed from her biological family in another state, “before age 2,” and soon after as a toddler Jane received diagnosis of RAD (clinical records not available). She has had four foster home placements. Your colleague in pediatrics reports that Jane is increasingly prone to episodes of rage, which include head banging and “screaming at the top of her lungs.” The consult question is to rule out early onset bipolar disorder.

Further history from her case manager and from records reveals that Jane also has social and verbal delays, which are long standing. Since transfer to her current foster home 2 years ago, Jane has yet to develop a friendship with a same-age child. She does not play and turns away from other children when approached. She enjoys a solitary activity she calls knitting, but the behavior actually involves a peculiar stretching out of napkins, and she seems content with this until repeatedly urged to shift her behavior. Rage episodes commonly begin with the request to interrupt “knitting,” but have also occurred in reaction to loud noises and to changes in daily routine. Her teacher observes that the anger is hard to predict because Jane speaks in a monotone and shows little facial expression to warn of an incipient “explosion.” Overall, the anger episodes “seem to be getting much worse.” Describe the best initial approach to diagnosis:

- (a) Both RAD, inhibited type, and autistic spectrum disorder (ASD) should be diagnosed based on the information provided.
 - (b) Since the definition of RAD, inhibited type, covers the current syndrome, no further evaluation is indicated for diagnostic purposes.
 - (c) If on evaluation all the diagnostic criteria are met for ASD, diagnosis should be changed to ASD in place of RAD.
 - (d) Since symptoms of the inhibited type of RAD are more persistent than those of the disinhibited type of RAD, continuing quasi-autistic symptoms are to be expected.
 - (e) The form and rage are evidence of childhood bipolar disorder, which can be added to the diagnostic formulation while retaining the current diagnosis of RAD, inhibited type.
9. A 5-year-old child, Timmy, is brought to you by his parents on advice of his kindergarten teacher because of his hyperactivity in school and his disruption of class when he has to share or take turns. During a separate interview with his parents Timmy plays quietly with a member of the office, but on spying his parents returning to the waiting room he pushes over the castle he has made with blocks, runs out the door, then immediately rushes back to his mother and hugs

her leg so fiercely that she is almost dragged down. When she tries to reassure and at the same time acquire her balance, Timmy responds with a look of angry resentment. Based on this limited frame of reference, which of the following best applies as a preliminary conclusion about Timmy's behavior?

- (a) This is a normal or expectable reaction to separation from parents at this age, since this essentially comprises a "strange situation" test of attachment.
 - (b) Timmy is likely to have an insecure-disorganized type of attachment.
 - (c) Reactive attachment symptoms are suggested by the ambivalent, indiscriminate and intense display of emotion.
 - (d) Timmy shows a secure attachment to his mother, and though he was distracted by play in the waiting area, he remembers his fears of separation when his parents came into view.
 - (e) ADHD symptoms were quiescent until arrival of his parents, at which point an overload of emotional stimuli caused him to lose control.
10. While waiting to see his pediatrician, Tommy, age 3, regards with interest how all the adults are absorbed in looking at magazines. He tries to grab one himself off the table but accidentally knocks over a lamp. His mother quietly sets the lamp back in place and then offers him a magazine, turning to a colorful picture. Which of the following is best represented?
- (a) The substituted gesture
 - (b) Pseudomaturity
 - (c) The facilitated gesture
 - (d) Symbiosis
 - (e) Misattunement



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