Love-Seeking or Attachment Disorder?
A Holistic Review on Indiscriminate Friendliness in Adopted or Maltreated Children

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Abstract

This conceptual article provides a holistic review of literature on children's *indiscriminate friendliness* (IF), defined as excessively friendly behavior to strangers without age-appropriate screening or hesitance (Tizard, 1977), in relation to counseling. It discusses the complexity of IF, its relationship with attachment, and individually and culturally associative factors. It also broaches the pathological view on IF reflected in clinical diagnoses through various versions of *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. It highlights the need for a well-established measure for IF and offers practical implications for counseling children with IF.
Keywords: indiscriminate friendliness, attachment, adoption, foster, culture

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Indiscriminate friendliness (IF) is defined as children's excessively friendly behavior, manifested as seeking closeness and comfort from strangers without adequate screening or age-appropriate hesitance (Tizard, 1977). It has drawn attention from parents (Bennett, Espie, Duncan, & Minnis, 2009), clinical mental health counselors working with children and families (Lawler, Hostinar, Mliner, & Gunnar, 2014), and researchers in various disciplines (e.g., Bruce, Tarullo, & Gunnar, 2009; Chisholm, 1998). Previous research findings (Chisholm, 1998) as well as clinical diagnostic criteria included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-3; DSM-4; DSM-5; American Psychiatric Association [APA], 1980, 2000, 2013) have heavily emphasized the pathological nature of IF. However, some recent findings have added to discussion of the behavior and provided alternative explanations that it may be interpreted as desire to be loved and attended by newly encountered adults who have not been adequately screened (Bennett et al., 2009). This conceptual article offers a comprehensive review of IF, controversies behind its conceptualization in relation to attachment, and its measure deficiencies. It invites professional counselors and researchers to further investigate the behavior through a holistic lens, considering cultural, personal, and contextual factors that may influence children's friendliness levels.

At-Risk Populations

IF has been identified among various groups of children, including post-institutionalized children (Gleason, Fox, Drury, Smyke, Nelson, & Zeanah, 2014), international adoptees (van den Dries, Juffer, van Ijzendoorn, Bakermans-Kranenburg, & Alink, 2012), and foster youth (Pears, Bruce, Fisher, & Kim, 2010). IF was claimed to be more likely to be displayed by children who have experienced early life interruptions, neglect, or abuse (APA, 2013). For example, Gleason et al.'s (2014) longitudinal study compared 58 post-institutionalized (PI) children and 31 non-institutionalized counterparts, which showed that PI children scored higher in IF using the *Stranger at the Door* technique (an observational procedure administered by a trained researcher/assistant). Likewise, Pears et al. (2010) detected a higher level of IF in foster youth assessed by parents' reports and laboratory observations, in comparison with peers living with biological parents.

Variations exist within children with IF, as some children fail to show ability to select primary attachment figures, whereas others demonstrate secure attachment with primary caregivers yet still direct IF behavior to unfamiliar adult figures (Chisholm, 1998; van den Dries et al., 2012). The distribution of IF occurrence among these children also varies with a significantly higher ratio in the post-institutionalized population compared to foster youth (Bruce, Tarullo, & Gunnar, 2009; Pears et al., 2010). IF is typically reported in children at a young age, typically above 9 months and under 5 years old (APA, 2013); but it has also been reported as being exhibited by school-age children and adolescents (Bennett et al., 2009; Zeanah & Gleason, 2015). IF is not defined as a distinct mental health disorder, yet constitutes a primary diagnostic criterion of clinical diagnoses (APA, 2000, 2013). The diagnostic standards involving IF are reviewed, in order to provide a developmental view of IF under the clinical context.

Conceptualization of IF

IF as a diagnostic criterion. IF has been considered as a critical diagnostic criterion of attachment (APA, 2000) and trauma- and stressor-related (APA, 2013) disorders, although it does not stand out alone as a mental health diagnosis. Diagnostic criteria and conceptualization relating to IF have evolved since its first emergence within the notion of *Reactive Attachment Disorder* (RAD) in the DSM-3 (APA, 1980), in which children diagnosed as such were asserted to have had exposure to a maladaptive environment and display symptoms consistent with failure to thrive (APA, 1980). Description of RAD remained consistent throughout the DSM-4-TR (APA, 2000), where IF is treated as a primary criterion of the disinhibited type of RAD, specifically described as where "the child exhibits indiscriminate sociability or a lack of selectivity in the choice of attachment figures" (p.128). During the evolution from the DSM-4-TR to the DSM-5, *Disinhibited Social Engagement Disorder* (DSED; APA, 2013) emerged as a new category with IF specified as a salient feature and primary diagnostic criterion; meanwhile, the construct is separated from the diagnosis of RAD.

According to the DSM-5 (APA, 2013), friendliness patterns determining children's social engagement are classified as being pathological through either inhibited forms (i.e., the child withdraws from interactions with others) or disinhibited forms (i.e., the child engages in an overly friendly pattern with unfamiliar adults). IF naturally is considered an essential manifestation of a disinhibited form of social engagement, thus constitutes the core of DSED. Diagnostic criteria of DSED capturing IF (APA, 2013) include: the child's willingness to leave

with unfamiliar adults, with low levels of hesitation; violation of verbal or physical boundaries when interacting with unfamiliar adults; the child's lack of discretion during the initial interaction with unfamiliar adults; or an apparent lack of need to check in with a caregiver. Children with DSED were described as consistently, actively seeking comfort from unfamiliar adults, including but not limited to willingness to sit in the lap of unfamiliar adults (Lawler et al., 2014).

IF and caregiving. The diagnostic criteria for both RAD and DSED stressed a common theme that children who demonstrated IF have experienced pathogenic care or neglect (APA, 2000, 2013), which in the DSM-5 was reworded as "insufficient care". Forms of pathogenic care include historical social neglect, repeated changes of primary caregivers, and childrearing in a nontraditional setting (e.g., foster or group home). The relationship between IF and caregiving, however, was challenged by later studies (e.g., van den Dries et al., 2012, Zeanah & Smyke, 2008), where no significant correlation was found between the two variables. Findings of the studies suggested that post-institutionalized children's IF persisted, despite positive care received from their adoptive or foster parents.

IF and attachment. The separation of IF from the diagnosis of RAD in the DSM-5 (APA, 2013) reveals an unsettled controversy regarding the etiology of IF behavior as being an attachment issue or a separate trauma- or stressor-related disorder (APA, 2013; Lyons-Ruth, 2015). The new categorization of IF challenges the stereotypical view that IF implies children's failure to form an organized (i.e., secure or insecure) attachment. Empirical findings have offered further evidence that IF and successful attachment can co-exist within individual children; namely, children may express a high level of friendliness to strangers while maintaining secure attachment to their primary caregivers (Bruce et al., 2009; Chisholm, 1998; van den Dries et al., 2012). Similarly, Gleason, Fox, Drury, Smyke, Egger, Nelson, and Zeanah (2011) investigated the association between IF and attachment styles in 187 post-institutionalized children using parents' interviews as well as lab observations. Results of the study showed that half of the children who exhibited IF showed organized attachment. Likewise, no significant correlation was found between IF and any attachment style (i.e., organized or disorganized attachment) in another study (Zilberstein, 2006). The results challenged the classification of IF as a form of *disorganized attachment* defined as lacking of patterns in a child's attachment to the primary caregiver, with behavioral cues such as restlessness and focus deficits (Main & Solomon, 1986). Despite the controversy in classifying IF in clinical diagnoses, conceptualization of IF is intertwined with attachment. This pattern is manifested through the current literature where IF has been consistently discussed/examined along attachment, either as a type/sub-style of attachment (APA, 2000) or an independent construct distinct from attachment (e.g., Bruce, Tarullo, & Gunnar, 2009; van den Dries et al., 2012). Given such indications, it makes sense to take a further look at attachment, the attachment theory, and attachment styles, so as to develop a better understanding of IF.

Attachment and Attachment Theory

The construct of *attachment* bases itself on the Freudian psycho-analytical theory and is closely associated with *infant ego* and the *pleasure principle* (Winnicott, 1960). Winnicott proposed that the concepts of "infant" and "maternal care" are supposed to go hand in hand. The infant ego is actualized through healthy maternal care characterized by a solid *holding*

comprising not only the physical/skin-to-skin holding, but also the "total environment provision" (Winnicott, 1960, p. 589). Attachment has then been consistently examined beyond the realm of psychoanalysis. It is later defined as an affective bond between children and their primary caregivers, which involves children's seeking of proximity to a primary caregiver and showing a tendency to explore the unknown surroundings in the meantime (Bretherton, 1992). One assumption made by Sroufe and Waters (1977) was that a child gains attachment security through frequent interactions, continuous exposure, and reciprocal behavioral exchanges; and thus is able to discriminate an attachment figure from less familiar or unknown persons, and to anticipate the goals and behaviors of the primary attachment figure. Children's capability to learn from their attachment to primary caregivers and to develop reasonable expectations for future relationships are conceptualized as internal working models (Bretherton, 1995). Children with high levels of secure attachment are more likely to develop strong internal working models with salient self-efficacy, which enables them to be empathic and capable of maintaining relationships; whilst children with insecure attachment, on the other hand, are more likely to develop weak internal working models, lack self-efficacy, and view others as unresponsive (Ainsworth, 1979).

Known as the forerunner of the attachment theory, Bowlby (1973) examined the impact of children's separation from mothers on their later development when distress was found due to the interruption of maternal care. Bowlby's work laid a groundbreaking foundation for the development of attachment theory empirically supported by later empirical research (Ainsworth, Blehar, Waters, & Wall, 1978). According to the attachment theory, a steady and continuous mother-child (later expanded to caregiver-child) relationship is considered irreplaceable for a child's development. The attachment theory later became a source of reference for the diagnosis of RAD within the *International Classification of Diseases, tenth edition* (ICD-10; World Health Organization [WHO], 1994). The theory was also considered to be a significant foundation for the organization of the DSM (Zilberstein, 2006). Factors that led to inadequacy and inconsistency of maternal/parental care, such as neglect, maltreatment, separation, and loss, were regarded as the primary sources of RAD (APA, 2000).

Attachment Styles

Work on the attachment theory was later extended to classification of attachment styles by Ainsworth and colleagues (1978), which used the *Strange Situation Procedures* (SSP) to measure infant-mother attachment. Based on infants' reactions to separation and reunion episodes with mothers, they were classified into three organized attachment categories: *secure attachment*, *insecure-avoidant attachment*, and *insecure-ambivalent attachment*. Ainsworth et al. (1978) found that securely attached children utilized mothers as a secure base from which to explore the environment; those with insecure-avoidant attachment presented with a high level of anxiety and distress even in pre-separation episodes, consistently seeking proximity with mothers; and those with insecure-ambivalent attachment rarely cried when separated from their mothers and showed ambivalence in reunion episodes.

Ainsworth and colleagues' study offered insights for further consideration and expansion on attachment styles. Based on the work of Main and Solomon (1986), a fourth attachment style was added, named as disorganized attachment. Children with disorganized attachment, are characterized by low self-confidence and low self-worth, and suffer from being restless and

losing focus. These children showed an absence of an organized way to deal with stress, leading to the notion of being disorganized-attached children. As such, disorganized attachment was defined as the failure of demonstrating consistent and organized approaches to regulate emotions in stressful situations. Behavioral patterns of disorganized attachment were staying still or freezing, apprehension of parents, or indiscriminate friendliness to adult figures (Main & Solomon, 1990). The introduction of the disorganized attachment category and indicators provided a strong reference for later studies labeling IF as a form of disorganized attachment, as well as for the historical classification of IF as a type of RAD (APA, 1980, 2000, 2003).

The current literature on attachment revealed a significant lack of cultural as well as contextual considerations when it comes to children's attachment to caregivers and social engagement with unfamiliar adults. The attachment theory, as a primary conceptual framework of previous empirical research and clinical diagnosis, does not adequately address cultural influences to children's attachment and social interactions. The negligence of cultural and contextual influences remains as a limitation in conceptualizing IF and clinical diagnosis with IF as a primary criterion.

IF with Multicultural and Contextual Considerations

A cultural parameter of IF was first introduced into clinical diagnosis, through the view that the essential feature of DSED "is a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers…" (APA 2013, p. 269). However, in the absence of clear and consistently defined cultural norms regarding friendliness, this continues to be a gap in clinical practice. Further definitions, elaborations, and examples of culturally appropriate or inappropriate IF-related behaviors have yet to be included for clinical practice guidance. Consistently throughout the literature, IF-related behaviors are viewed through a lens of pathology, with the potential to contribute to the development of other psychological pathologies including *Attention Deficit Hyperactivity Disorder* (ADHD) and higher levels of aggression (Follan et al., 2011).

With new findings lending evidence that IF exists as a distinct phenomenon from attachment (Bruce et al., 2009), as well as the evolvement of DSED in DSM-5, attention was called to the complexity of IF, including potential alternatives beside the traditional pathological perspective and additional variables associated with IF other than pathogenic care. Keller (2013) pointed out that the neurophysiology of attachment is based on the assumptions such as monotropic relationships (i.e., a child selectively developing a relationship with one single caregiver), exclusive attention, and maternal sensitivity to children's needs. It can be recognized that these assumptions are largely based on Western middle-class families and do not represent more universal patterns, given that differences exist in socialization goals, parenting, and child-parent relationships (Keller, 2007).

The concept of maternal sensitivity varies significantly from culture to culture. Respecting children's autonomy and providing immediate responses to children's signals are desired in most Western cultures; however, more directing and controlling parenting is often considered desirable and culturally appropriate in many non-Western cultures (Chao, 1994; Keller, 2007). Behaviors, therefore, defined as pathological under certain cultural contexts may be considered as normative in other cultural environments (Keller, 2013). An earlier opponent of

attachment selectivity, which refers to a child's solely developing a strong attachment with the primary caregiver (i.e., mostly the mother-figure under the attachment theory), claimed that human beings would not have survived if infants selected only one attachment figure (Hrdy, 1999). Cultural dimensions have challenged some of the principles of the attachment theory in regards to the role of the primary caregiver as the hub of children's attachment and later relationship developments, which also indicate that approaching other people besides caregivers is essential to meeting human needs.

Controversies are also evident around cultural perceptions of strangers. In the many Western cultures, strangers are often readily considered potential predators of children (Keller, 2013), and the concept of "stranger danger" is often made explicit by parents (Bennett et al., 2009). However, under some cultures, particularly cultures that value collectivism, strangers are treated as neutral and even welcoming (Keller, 2013). In such contexts, children are taught to be friendly toward strangers from a very young age (Otto, Potinius, & Keller, 2014). Such cultural variations have added to the complexity of IF, as children who have been adopted from cultures that value social friendliness may have been affected by their pre-adoption environments and may have formed behavioral systems conforming to the norms of their original cultures. Based on the fact that around 272,000 children were adopted to the U.S. between 1999 and 2017, mostly from non-Western countries such as Korea, China, and Russia (U.S. Department of State, 2018), the cultural and contextual implications are of significance in regards to perceiving and treating IF-related behaviors in international adoptees. Children who were adopted at an older age are particularly more likely to be impacted by cultural norms from their birth countries (Smyke et al., 2010). The definition and diagnostic criteria under DSM may, therefore, need to be re-evaluated based on the complex nature of IF.

The complexity of IF has prompted further investigation into the underlying individual motives of the behavior. Bennett et al. (2009) first introduced the dilemma of whether the behavior should be considered as children seeking affection from unfamiliar adults and to have their needs met, or a representation of attachment or social engagement pathologies. The qualitative study of Bennett et al. (2009) offered insights into children's behavior of seeking closeness from adults, based on the fact that they may have experienced peer rejections and, thereafter, adults might seem to provide a safer space for relationship development. Bennett et al.'s findings also indicated that the IF behavior was often not absolutely indiscriminate because children initiated primary screening of strangers, even if not thoroughly, prior to approaching any unfamiliar adults. An implication brought up by Bennett et al. was that the at-risk children with IF behavior may be "seeking friendship and acceptance in the best way they know how" (p. 612). A recent mixed-method study (Liu, Li, & Xu, 2017) introduced another alternative that children's IF may partly come from their personalities, as participants (i.e., adoptive mothers) disclosed that adoptees who are extroverted naturally tended to show a higher level of friendliness to unfamiliar adults. The findings fostered the need for professional counselors to take individual contexts and characteristics into considerations in working with children displaying IF.

The cultural and contextual influences on children's behaviors prompt a further examination of to what extent IF has been assessed in the current literature, where measures of

IF stand out as a salient deficit lacking statistical rigor as well as cultural and contextual considerations.

Measures of IF

Measurements of IF have rarely been discussed in the current literature, although they certainly play a vital role in clinical diagnoses. Beforehand, including IF as a clinical diagnostic criterion has been questioned. Zeanah, Keyes, and Settles (2003) highlighted the complications of gauging IF to make a certain clinical diagnosis, due to a lack of specification on boundaries of RAD (which may be extended to DSED), because IF can encompass a wide spectrum of behaviors without well-established cut-off points or a mature measure. Clinical investigations into children exhibiting IF have revealed a range of diagnoses beyond RAD and DSED, including ADHD and *Posttraumatic Stress Disorder* (PTSD; Kočovská, et. al, 2012). Vigilance is thus needed in assessing IF as a criterion of a clinical disorder; and primary and co-occurring comorbidities should be thoroughly studied (Kocovska et al., 2012).

A key question pertains to the extent of a friendly behavior and a threshold for it to be considered truly indiscriminate or pathological. No consistent measure has been found in existing literature, the definition of IF and its role in diagnosing RAD and DSED thus remains questionable. Different IF measures have been identified in previous research, including observational scales (e.g., Bruce, Tarullo, & Gunnar, 2009), parent interviews such as the *Disturbances of Attachment Interview* (Gleason et al., 2011), and parent-reported surveys/questionnaires (Chisholm, 1998). Overlaps were detected between measurements on IF and attachment (Minnis et al., 2009), following the historical view of IF as a form of disorganized attachment.

Parent-report questionnaires have been more often used in recent studies, albeit having been challenged for responder bias impacting the results of reported children's behaviors (Lawler et al., 2014). Parent-report questionnaires invite parents' rating of their children's friendly levels based on their observation of children's interactions with unfamiliar adults on a consistent basis. Two major parents-report questionnaires designed to measure the level of IF are *Relationship Problems Questionnaire* (RPQ; Minnis et al., 2009) and the *Five-item Indiscriminate Friendliness Scale*, also called five-item IF scale (Chisholm 1998; Chisholm et al., 1995; O'Connor et al., 2000). The five-item IF scale (Chisholm et al., 1995) has been frequently used in empirical studies on IF in internationally adopted (van den Dries et al., 2012) or fostered youth (Pears et al., 2010). For each item, a respondent can select either "1" (if s/he detect IF in the child) or "0" if no IF is observed in the child. Items included assess: a) children's friendliness level with unfamiliar adults; b) level of shyness with strangers; c) "wanders off" behavior without stress; d) likelihood of going home with strangers; and e) tendency to approach strangers. The five-item scale by Chisholm et al. (1995) generates dichotomous answers (i.e., *Yes* vs. *No*), which does not capture a continuous spectrum of the behavior. Previous studies yielded low Crobach's alpha coefficient values such as .58 (Authors, 2017; Chisholm, 1998) and .65 after deleting the last two items (van den Dries et al., 2012). Chisholm's five-item IF scale is included in Appendix 1.

Similar to Chisholm et al.'s (1995) five-item measure, Follan et al. (2011) suggested using the five core DSM-4 open-ended questions targeting for assessing the level of IF. The

questions are: Does the child seek comfort from strangers? How cuddly is the child with unfamiliar adults? How likely is it for the child to wander away in a new place? How friendly is the client with newly met adults? Does the child ask strangers personal questions? The questions gauge similar behavioral areas to the five-item scale, except that they invite open-ended qualitative answers from respondents. However, the subjectivity of parents' responses may interfere with accurately gauging the behavior.

Items under both scales also seem merely to focus on children's friendliness patterns rather than on an individual as a whole. Other aspects, such as the cultural and contextual factors (e.g., cultural norms; social views toward children's attachment or social boundary), which likely contributed to the children as to who they are, were not explored. Furthermore, individual characteristics such as personality (Authors, 2017) or motivation to seek adult attention due to lack of peer support (Bennett et al., 2009), as potential alternative explanations of IF, may also be further explored. Neither were the identified aspects addressed by DSM-5, where diagnostic criteria of DSED gauge the same areas included in the five-item IF scale.

Practical and Research Implications

Implications for clinical practice. A comprehensive review of the literature generated significant implications for counselors working with children exhibiting significant IF. Counselors need to be cautious about considering IF as a primary or even mere clinical diagnostic criterion of DSED (2013). Potential cultural/contextual differences need to be considered, especially when it comes for children adopted from cultures that value socially friendly interactions, as parenting/caregiving norms vary from culture to culture (Liu & Hazler, 2015). In addition, professional counselors are also encouraged to acknowledge individual characteristics and to investigate potential underlying motives for children to approach unfamiliar adults.

A holistic approach may be taken in working with children with salient friendly behaviors, considering individual differences, the history of their development (e.g., earlier institutionalization/maltreatment experience; interruption of caregiving; change of patterns in caregiving), current developmental stage (i.e., whether or not the behavior may be considered as developmentally appropriate), their personalities (Liu et al., 2017), as well as their social relationships at school (Bennett et al., 2009). Due to the historical emphasis on the pathological nature of IF, parents and mental health practitioners' views on friendly signs and perceptions of strangers may be further examined, as adults' reactions potentially impact children's orientation to the behavior and may attenuate their self-efficacy in forming healthy relationships (Bennett et al., 2009). In addition, due to the fact that IF often co-exists with other forms of clinical diagnoses (Kocovska, et al., 2012), more attention is called to gauge IF as a primary or co-occurring symptom of a clinical diagnosis.

Implications for research. Answers to the question of whether or not IF stands as an independent construct from attachment remains unclear despite recent studies and DSM-5 that provide evidence on the lack of correlations between IF and attachment (Lyons-Ruth, Bureau, Riley, & Atlas-Corbett, 2009). More attention certainly needs to be paid to the complex nature of IF. Further research questions need to be developed in regards to components that attribute to IF,

variables that are associated with IF, potential causes beside pathogenic care contributing to the behavior, and alternative explanations of IF.

The lack of a consistent and reliable IF measures indicate a strong need for a well-established scale, with considerations of children's early-life cultural contexts and individual characteristics. A more inclusive and multiculturally sensitive measure needs to be developed, capturing aspects such as children's individual characteristics and relevant cultural and social contexts (e.g., home; school; other public settings). Based on the fact that IF may indicate in-depth motives through a child's lens beyond the prescribed pathology (Bennett et al., 2009), a child-reported measure can be beneficial, as the current measures only include parents' evaluation of the IF, which may not accurately reflect the essence of IF with potential significant difference between parents' and children's perspectives.

Conclusion

This article conceptualizes IF in children who experienced previous life difficulties through a holistic lens. It demonstrates historical conceptualization of IF following two lines: a) evolvement of DSM-3 to the latest DSM-5, using IF as a primary diagnosis criterion of RAD or DSED; and b) conceptualization of IF in association with the attachment theory and attachment styles. It explores cultural contexts and individual situations, which sparks a questions about whether IF is essentially pathological. Professional counselors working with children who exhibit IF may re-evaluate cultural, contextual, and individual aspects related to children's friendly behaviors, prior to applying a formal diagnosis based on diagnostic criteria. The article also sheds light on new research directions such as the design and development of a valid and reliable measure, potentially with involvement of children, and investigation of potential causes and associative variables of IF.

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Appendix A: Five-Item Indiscriminately Friendliness Scale
(Chisholm, Carter, Ames, & Morison, 1995)
The following questions are regarding your child's interactions with others. Please use the scale below to answer these questions.
___ 1. How friendly is your child with new adults?
0 = generally not friendly (e.g. wary, does not approach new adults, clings to parents).
0 = mixed reaction (e.g. usually friendly but sometimes cries, friendly to some strangers but not others, wary at first but then warms).
1 = very friendly, interacts freely with all new adults

___ 2. Has your child ever been shy or behaved in a strange manner?
0 = child has always been shy
0 = child did not act shy, but now does
1 = has never been shy or was initially shy, but is no longer

___ 3. What does your child do when he/she meets new adults?
0 = is upset by new adults (e.g., cries, clings to parents, covers eyes)
0 = stands back, observes, evaluates
1 = approaches adult (shows toys, speaks, asks questions)

___ 4. How willing would your child be to go home with an adult he/she had just met?
0 = no, never has been willing
0 = yes initially, currently no
1 = yes, always has been willing to

___ 5. Does your child have a tendency to wander? If yes, is your child subsequently distressed when he/she finds him/herself separated from you?
0 = no, child does not wander
0 = yes, child wanders, then is distressed at separation
1 = yes, wanders off and is not distressed at separation