Attachment-Based Therapeutic Interventions with Research Support

The following reviews of therapeutic interventions related to Attachment are copied from the website of the California Evidence-Based Clearinghouse for Child Welfare (CEBC). An explanation of the rating scales may be accessed on their website: http://www.cebc4cw.org/

Two additional interventions that focus on attachment introduced earlier are Attachment, Self-Regulation, & Competency (ARC) and Trust-Based Relational Intervention (TBRI).

Attachment and Biobehavioral Catch-up (ABC)

Scientific Rating:

1

Well-Supported by Research Evidence

Child Welfare System Relevance Level:

High

About This Program

The information in this program outline is provided by the program representative and edited by the CEBC staff. ***Attachment and Biobehavioral Catch-up (ABC)*** has been rated by the CEBC in the areas of: Infant and Toddler Mental Health Programs (Birth to 3) and Parent Training Programs.

Target Population: Caregivers of infants 6 months to 2 years old who have experienced early adversity

For parents/caregivers of children ages: 0 – 2

Brief Description

ABC targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push caregivers away. The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the intervention helps caregivers provide nurturing care even if it does not come naturally. Second, many children who have experienced early adversity are dysregulated behaviorally and biologically. The second intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities. The intervention helps caregivers follow their children's lead with delight. The third intervention component helps caregivers decrease behaviors that could be overwhelming or frightening to a young child.

Program Goals:

The program goals of ***Attachment and Biobehavioral Catch-up (ABC)*** are:

- Increase caregiver nurturance, sensitivity, and delight
- Decrease caregiver frightening behaviors

- Increase child attachment security and decrease disorganized attachment
- Increase child behavioral and biological regulation

Essential Components

The essential components of ***Attachment and Biobehavioral Catch-up (ABC)*** include:

- Targets three key issues:
  - Child behaves in ways that push caregiver away: The caregiver is helped to override tendencies to respond “in kind” and to provide nurturance regardless.
  - Child is dysregulated at behavioral and biological levels: Caregiver is helped to provide environment that helps child develop regulatory capabilities. This includes parent following child's lead and showing delight in child.
  - Caregiver is helped to decrease behaviors that may be frightening or overwhelming to the child.
- While ***ABC*** is a manualized intervention that also incorporates video-feedback and homework, the most crucial aspect of the intervention is the parent coach’s use of “In the Moment” comments that target the caregiver behaviors of nurturance, following the lead, delight, and non-frightening behaviors. These are used throughout the home visiting session while working with the parent.

Child/Adolescent Services

Attachment and Biobehavioral Catch-up (ABC) does not directly provide services to children/adolescents.

Parent/Caregiver Services

Attachment and Biobehavioral Catch-up (ABC) directly provides services to parents/caregivers and addresses the following:

- Has child that pushes caregivers away or has difficulty being soothed; has child with behavioral and biological dysregulation; difficulty in providing parental nurturance, following the lead, or delighting; tendency to be frightening or overwhelming; and own history of care that may interfere with parenting

Services Involve Family/Support Structures:
This program involves the family or other support systems in the individual's treatment: The child is involved in the home visits to show the parents new skills and the parents are expected to observe and note the child's behavior and practice new skills them with between sessions.

Recommended Parameters

Recommended Intensity:
Weekly one-hour sessions

Recommended Duration:
10 sessions

Delivery Settings

This program is typically conducted in a(n):

- Adoptive Home
- Birth Family Home
- Foster/Kinship Care

Homework

Attachment and Biobehavioral Catch-up (ABC) includes a homework component:

Parents make observations over the week and record observations. For most weeks, daily activities are suggested.

Languages

Attachment and Biobehavioral Catch-up (ABC) has materials available in a language other than English:

Spanish

For information on which materials are available in this language, please check on the program's website or contact the program representative (contact information is listed at the bottom of this page).

Resources Needed to Run Program

The typical resources for implementing the program are:

A/V:

- Laptop computer
- Video camera
- Webcam for supervision

Personnel:

- Clinician with excellent interpersonal skills

Space:

- Must be conducted at caregivers' homes; this can include shelters or other temporary living situations

Minimum Provider Qualifications

There is no educational level requirement for parent coaches. Potential parent coaches participate in a screening prior to training. If they pass the short screening, coaches attend a 2-3 day training and a year of supervision.

Education and Training Resources

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contact:

- **Caroline Roben**
  croben@psych.udel.edu

Training is obtained:
Training at University of Delaware with Supervision through videoconferencing

Number of days/hours:
3 days training to become a Parent Coach then followed by 1 year supervision (1.5 hours weekly, including group supervision and individual supervision in In the Moment commenting) to become a Certified Parent Coach

Implementation Information

Since ***Attachment and Biobehavioral Catch-up (ABC)*** is rated a 1, 2, or 3 on the CEBC Scientific Rating Scale, information was requested from the program representative on available pre-implementation assessments, implementation tools, and/or fidelity measures.

Show Implementation information...

Relevant Published, Peer-Reviewed Research

This program is rated a "**1 - Well-Supported by Research Evidence**" on the Scientific Rating Scale based on the published, peer-reviewed research available. The program must have at least two rigorous randomized controlled trials with one showing a sustained effect of at least 1 year. The article(s) below that reports outcomes from an RCT showing a sustained effect of at least 1 year has an asterisk (*) at the beginning of its entry. Please see the Scientific Rating Scale for more information.

Child Welfare Outcome: Child/Family Well-Being

Show relevant research...

References

Dozier, M., Dozier, D., & Manni, M. (2002). Recognizing the special needs of infants' and toddlers' foster parents: Development of a relational intervention. *Zero to Three Bulletin, 22*, 7-13.

Dozier, M., Lindhiem, O., & Ackerman, J. (2005). Attachment and biobehavioral catch-up. In L. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), *Enhancing early attachments*. New York: Guilford (pp. 178-194).

Lewis, E., Dozier, M., Knights, M., & Maier, M. (In press). Intervening with foster infants' foster parents: Attachment and biobehavioral catch-up. In R. E. Lee & J. Whiting (Eds.), *Handbook of relational therapy for foster children and their families.* Washington, DC: Child Welfare League of America.

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Child-Parent Psychotherapy (CPP)

Scientific Rating:

2

Supported by Research Evidence

Child Welfare System Relevance Level:

High

About This Program

The information in this program outline is provided by the program representative and edited by the CEBC staff. ***Child-Parent Psychotherapy (CPP)*** has been rated by the CEBC in the areas of: Domestic/Intimate Partner Violence: Services for Victims and their Children, Infant and Toddler Mental Health Programs (Birth to 3) and Trauma Treatment (Child & Adolescent).

Target Population: Children age 0-5, who have experienced a trauma, and their caregivers.

For children/adolescents ages: 0 – 5

For parents/caregivers of children ages: 0 – 5

Brief Description

CPP is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. ***CPP*** examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.

Program Goals:

The program representative did not provide information about the program's goals.

Essential Components

- Focus on the parent-child relationship as the primary target of intervention.
- Focus on safety: a) Focus on safety issues in the environment as needed; b) Promote safe behavior; c) Legitimize feelings while highlighting the need for safe/appropriate behavior; d) Foster appropriate limit setting; e) Help establish appropriate parent-child roles.
- Affect regulation: a) Provide developmental guidance regarding how children regulate affect and emotional reactions; b) Support and label affective experiences; c) Foster parent's ability to respond in helpful, soothing ways when child is upset; d) Foster child's ability to use parent as a secure base; e) Develop/foster strategies for regulating affect.
- Reciprocity in Relationships: a) Highlight parent's and child's love and understanding for each other; b) Support expression of positive and negative feelings for important people; c) Foster ability to understand the other's perspective; d) Talk about ways that parent and child are different and autonomous; e) Develop interventions to change maladaptive patterns of interactions.

- Focus on the traumatic event: a) Help parent acknowledge what child has witnessed and remembered; b) Help parent and child understand each other's reality with regards to the trauma; c) Provide developmental guidance acknowledging response to trauma; d) Make linkages between past experiences and current thoughts, feelings, and behaviors; e) Help parent understand link between her own experiences and current feelings and parenting practices; f) Highlight the difference between past and present circumstances; g) Support parent and child in creating a joint narrative; h) Reinforce behaviors that help parent and child master the trauma and gain a new perspective.
- Continuity of Daily Living: a) Foster prosocial, adaptive behavior; b) Foster efforts to engage in appropriate activities; c) Foster development of a daily predictable routine.
- Reflective supervision

Child/Adolescent Services

Child-Parent Psychotherapy (CPP) directly provides services to children/adolescents and addresses the following:

- Exposure to trauma, internalizing and externalizing symptoms, and/or symptoms of posttraumatic stress disorder (PTSD).

Parent/Caregiver Services

Child-Parent Psychotherapy (CPP) directly provides services to parents/caregivers and addresses the following:

- Negative attributions about the child, problems in the parent-child relationship, and maladaptive parenting strategies. In addition, when appropriate, the program targets parental symptoms including PTSD symptoms (avoidance, intrusion, and hyperarousal), depression, and anxiety.

Recommended Parameters

Recommended Intensity:
Weekly 1 to 1.5-hour sessions

Recommended Duration:
52 weeks (one year)

Delivery Settings

This program is typically conducted in a(n):

- Adoptive Home
- Birth Family Home
- Community Agency
- Foster/Kinship Care
- Outpatient Clinic
- School

Homework

This program does not include a homework component.

Languages

Child-Parent Psychotherapy (CPP) does not have materials available in a language other than English.

Resources Needed to Run Program

The typical resources for implementing the program are:

No specific room requirements are needed as the program is often implemented through a home-visiting model.

Minimum Provider Qualifications

- Practitioners: Master's level training.
- Supervisors: Master's degree plus minimum of 1 year training in the model.

Education and Training Resources

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contact:

- **Chandra Ghosh Ippen, PhD**
  Chandra.ghosh@ucsf.edu

Training is obtained:
There are a number of different training models. Training occurs can be arranged through the Child Trauma Research Program by contacting the individual above. Training also occurs through the Learning Collaborative model of the National Child Traumatic Stress Network. In general, training is tailored to the needs of the organization.

Number of days/hours:
Typically training involves an initial 3-day workshop and then quarterly (3 more times in a year) 2-day additional workshops. In addition, training involves bi-monthly telephone-based case consultation of ongoing treatment cases involving children aged 0-5 who have experienced a trauma.

Implementation Information

Since ***Child-Parent Psychotherapy (CPP)*** is rated a 1, 2, or 3 on the CEBC Scientific Rating Scale, information was requested from the program representative on available pre-implementation assessments, implementation tools, and/or fidelity measures.
Show Implementation information...

Relevant Published, Peer-Reviewed Research

This program is rated a "**2 - Supported by Research Evidence**" on the Scientific Rating Scale based on the published, peer-reviewed research available. The program must have at least one rigorous randomized controlled trial with a sustained effect of at least 6 months. The article(s) below that reports outcomes from an RCT showing a sustained effect of at least 6 months has an asterisk (*) at the beginning of its entry. Please see the Scientific Rating Scale for more information.

Child Welfare Outcomes: Safety and Child/Family Well-Being

Show relevant research...

References

Lieberman, A. F., Compton, N. C., Van Horn, P., & Ghosh Ippen, C. (2003). *Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy.* Washington D.C.: Zero to Three Press.

Lieberman, A. F., & Van Horn, P. (2004). *Don't hit my mommy: A manual for child parent psychotherapy with young witnesses of family violence*. Zero to Three Press: Washington, D.C.

Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York: The Guilford Press.

Contact Information

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Circle of Security-Home Visiting-4 (COS-HV4)

Scientific Rating:

3

Promising Research Evidence

Child Welfare System Relevance Level:

Medium

Brief Description

COS-HV4 is a version of Circle of Security that includes a mandatory home visiting component consisting of 4 home visits. The overall Circle of Security protocol focuses on:

- Teaching caregivers the fundamentals of attachment theory (i.e., children's use of the caregiver as a secure base from which to explore and a safe haven in times of distress) by introducing a user-friendly graphic to the caregivers that they can refer to throughout the program
- Exploring not only parenting behaviors but also internal working models
- Presenting caregivers with a simple structure for considering the ways in which their internal working models influence their cognitive, affective, and behavioral responses to their children, thus helping caregivers gain awareness and understanding of the nonconscious, problematic responses they sometimes have to their children's needs

The Circle of Security approach provides caregivers with the skills to understand their children's behavior, and the skills to understand and regulate their own cognitive, affective, and behavioral responses to their children.

Program Goals:

The goals of ***Circle of Security- Home Visiting – 4 (COS-HV4)*** are:

- Increase security of attachment of the child to the parent
- Increase parent's ability to read child's cues
- Increase empathy in the parent for the child
- Decrease negative attributions of the parent regarding the child's motivations
- Increase parent's capacity to self-reflect
- Increase parents capacity to pause, reflect, and choose security promoting caregiving behaviors
- Increase parent's capacity to regulate stressful emotional states triggered by the child's behavior

Essential Components

The essential components of ***Circle of Security- Home Visiting – 4 (COS-HV4)*** include:

- Individualized treatment plans for each caregiver are developed by reviewing videos of parent/child interaction.
- The video is used to formulate the *linchpin issue* for each participant. A linchpin issue is defined as the single, most problematic pattern related to attachment and caregiving, which, if changed successfully, is expected to have the greatest positive impact on the child's attachment pattern.
- Carefully edited clips from the videos of the interactional assessments are used in the home visitation.
- Over the course of the program, each caregiver is the focus for three video review sessions, during which clips of the caregiver interacting with his or her own child are used to enhance individual strengths and address linchpin struggles.

- The caregiver is taught the Circle of Security as a map to understand the child's needs as described below:
  - When the parent acts as a secure base to explore, the parent is taught to provide:
    - Support for exploration
    - "Watch over me" as the child explores
    - "Help me" when the child cue for help
    - "Enjoy with me" when the child engages in play with the parent
    - "Delight" as the child plays
  - When the child's attachment behavioral system is activated and the child needs to seek proximity to the parent, the parent is taught to provide:
    - "Welcome" when the child seeks proximity
    - "Protection" when needed
    - "Comfort me" when the child is distressed
    - "Organize my feelings" when the child is not easily comforted and may seem angry
    - "Delight in me" when the child comes close for intimate contact
- Once the parent understands the "Circle," the parent is asked to notice moments during the week and recall those "circle stories" at the beginning of each visit.
- The intervener (home visitor) should help the parent see the "Circle" happening with her child during the home visit.
- The intervener should help the parent identify which needs on the circle the parent feels and acts comfortable providing and which needs create discomfort in the parent.
- The intervener should help the parent identify both positive and negative attributions they may have about each need on the circle.
- The intervener should introduce the idea that meeting the needs on the circle increases the likelihood that his/her child will feel and act secure.

Parent/Caregiver Services

Circle of Security-Home Visiting-4 (COS-HV4) directly provides services to parents/caregivers and addresses the following:

- Parent who has an insecure attachment or is at risk of having an insecure attachment with a child under 6 years old that may result in child being difficult to calm after a stressful event or having difficulty in emotional regulation

Recommended Parameters

Recommended Intensity:

One 3-hour assessment session followed by a 1.5-hour session every two to three weeks

Recommended Duration:

Four home visits (after an out-of-home assessment) over a period of three months

Delivery Settings

This program is typically conducted in a(n):

- Birth Family Home

- Foster/Kinship Care
- Hospital

Homework

Circle of Security-Home Visiting-4 (COS-HV4) includes a homework component:

Parents are asked to notice “Circle Moments” between sessions. These are moments where their child shows a need on the Circle. Each meeting starts with asking the parent to share what they noticed that week.

Languages

Circle of Security-Home Visiting-4 (COS-HV4) does not have materials available in a language other than English.

Resources Needed to Run Program

The typical resources for implementing the program are:

- Room for conducting initial evaluation with video equipment to film parent/child interaction, one-way glass for filming is best but not absolutely needed
- Laptop computer for editing tape and presenting to parent during home visit

Minimum Provider Qualifications

Interveners (who work with the parent throughout the whole intervention) are mental health professionals with a Master’s level degree and must have completed the advanced 10-day Circle of Security training, passed the competency exam, and received supervision from a Circle-of-Security-approved supervisor for 5 complete interventions (each intervention consists of an evaluation and four home visits).

Education and Training Resources

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contact:

- **Gretchen Cook**
  gretchen@circleofsecurity.org

Training is obtained:
Offered several times a year at different locations. A site can sponsor training.

Number of days/hours:

10 day (70 hours)

Implementation Information

Since ***Circle of Security-Home Visiting-4 (COS-HV4)*** is rated on the Scientific Rating Scale, information was requested from the program representative on available pre-implementation assessments, implementationtools, and/or fidelity measures.

Show Implementation information...

Relevant Published, Peer-Reviewed Research

This program is rated a "**3 - Promising Research Evidence**" on the Scientific Rating Scale based on the published, peer-reviewed research available. The practice must have at least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) establishing the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. Please see the Scientific Rating Scale for more information.

Child Welfare Outcome: Child/Family Well-Being

Show relevant research...

References

Cassidy, J., Woodhouse, S., Cooper, G., Hoffman, K., & Powell, B. (2005). Examination of the precursors of infant attachment security: Implications for early intervention and intervention research. In L. J. Berlin, Y. Ziv, L. M. Amaya-Jackson, & M. T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy.* New York: Guilford Press.

Powell, B., Cooper, G., Hoffman, K., & Marvin, R. (2009). The Circle of Security. In Zeanah, C. H. (Ed.), *Handbook of infant mental health* (3rd ed.), Guilford Press.

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Dyadic Developmental Psychotherapy (DDP)

Scientific Rating:

3

Promising Research Evidence

Child Welfare System Relevance Level:

High

About This Program

Target Population: Families with children/teens with disorders of attachment and trauma. Typically adopted and foster children, those who meet the *DSM-V* criteria for Reactive Attachment Disorder, and trauma-related diagnoses, and those who meet the clinical criteria for Complex Trauma (aka Developmental Trauma Disorder)

Brief Description

DDP is a model of treatment and parenting for children with problems secondary to abuse, neglect, and multiple placements. When a child's early attachment history consists of abuse, neglect, and/or multiple placements, he/she has failed to experience the dyadic (reciprocal) interaction between a child and parent that are necessary for normal development and he/she often has a reduced readiness and ability to participate in such experiences. Many children, when placed in a foster or adoptive home that provides appropriate parenting, are able to learn, day-by-day, how to engage in and benefit from the dyadic experiences provided by the new parent. Other children, who have been much more traumatized and compromised in those aspects of their development that require these dyadic experiences, have much greater difficulty responding to their new parents. For these children, specialized parenting and treatment is often required.

Within this model, the foundation of these interventions--both in home and in treatment--must incorporate attitude based on playfulness, acceptance, curiosity, and empathy. It must never involve coercion, threat, intimidation, and the use of power to force submission.

Note: There has been controversy regarding Dyadic Developmental Psychotherapy as an appropriate treatment. Based on the available literature, there is no evidence of harm from the use of DDP as described by the developers. For more information on this issue, please refer to the Attachment Interventions definition and to the following references:

Becker-Weidman, A., & Hughes, D., (2008) Dyadic Developmental Psychotherapy: An evidence-based treatment for children with complex trauma and disorders of attachment. *Child & Family social Work, 13*, pp. 329-337.

Becker-Weidman, A., (2011-2012). Dyadic Developmental Psychotherapy: Effective Treatment for Complex Trauma and Disorders of Attachment. *Illinois Child Welfare, 6*(1), pp 119-129.

Becker-Weidman, A., & Hughes, D. (2010). Dyadic Developmental Psychotherapy: an effective and evidence-based treatment–comments in response to Mercer and Pignotti. *Child & Family Social Work, 15*(1), 6-11.

Chaffin, M., Hanson, R., & Saunders, B. E. (2006). Reply to Letters. *Child Maltreatment, 11*(4), 381-386.

Mercer, J., Pennington, R. S., Pignotti, M., & Rosa, L. (2010). Dyadic Developmental Psychotherapy is not 'evidence-based': comments in response to Becker-Weidman and Hughes. *Child & Family Social Work, 15*(1), 1-5.

Pignotti, M., & Mercer, J. (2007). Holding therapy and dyadic developmental psychotherapy are not supported and acceptable social work interventions: A systematic research synthesis revisited. *Research on Social Work Practice, 17*(4), 513-519.

Program Goals:

The goals of ***Dyadic Developmental Psychotherapy*** are different for the child and the caregiver as listed below.

Goals of Treatment for the Child:

- Develop a more secure pattern of attachment
- Resolve trauma symptoms
- Secure a more permanent connection and relationship with the committed caregiver

Goals of Treatment for Caregivers:

- Increase attunement with their child
- Develop reflective function
- Use attachment-facilitating parenting approaches
- Increase sensitivity

Essential Components

The essential components of ***Dyadic Developmental Psychotherapy (DDP)***include:

- **General Principles:** Eye contact, voice tone, touch, movement, and gestures are actively employed to communicate safety, acceptance, curiosity, playfulness, and empathy, and never threat or coercion. These interactions are reciprocal, not coerced. The following guidelines demonstrate this:
  - Opportunities for enjoyment and laughter, play and fun, are provided unconditionally throughout every day with the child.
  - Decisions are made for the purpose of providing success, not failure.
  - Successes become the basis for the development of age-appropriate skills.
  - The child's symptoms or problems are accepted and contained. The child is shown how these simply reflect his/her history. They are often associated with shame which must be reduced by the adult's response to the behavior.
  - The child's resistance to parenting and treatment interventions is responded to with acceptance, curiosity, and empathy.
  - Skills are developed in a patient manner, accepting and celebrating "baby-steps" as well as developmental plateaus.
  - The adult's emotional self-regulation abilities must serve as a model for the child.
  - The child needs to be able to make sense of his/her history and current functioning. The understood reasons for the behavior are not excuses, but rather they are realities necessary to understand the developing self and current struggles.
  - The adults must constantly strive to have empathy for the child and to never forget that, given his/her history, he/she is doing the best he/she can.
  - The child's avoidance and controlling behaviors are survival skills developed under conditions of overwhelming trauma. They will decrease as a sense of safety increases, and while they may need to be addressed, this is not done with anger, withdrawal or love, or shame.

- **Treatment Logistics:**
  - A comprehensive initial assessment must be conducted that touches on the seven domains that may be affected by Complex Trauma. This treatment program serves to develop a detailed treatment plan.
  - Treatment usually involves 1 session per week of 2 hours divided up as follows:
  - The initial several sessions are just with the caregivers to assist them in "discovering" the important elements of attachment-facilitating parenting and in reviewing the text, *Attachment Parenting*, edited by Arthur Becker-Weidman, PhD.
  - Once the caregivers are ready, then each 2-hour session begins with the therapist meeting with the parents, followed by the conjoint session with the child and caregivers, followed by time with the caregivers to "debrief" about the session.
- **Treatment Components:** Treatment must be provided in a consistent manner to develop and maintain a therapeutic alliance. The components include:
  - Therapist use of self: (***DDP*** involves the intersubjective sharing of self and therapist attunement with the client)
  - Focus on connections before compliance
  - PACE (Playful, Acceptance, Curious, Empathy) and PLACE (Playfulness, Love, Acceptance, Curiosity, and Empathy)
  - Intersubjective sharing of experience
  - Reflective capacity
  - Affective/Reflective dialogue
  - Commitment
  - Insightfulness
  - Development of a coherent autobiographical narrative
  - Co-regulation of affect
  - Co-creation of new therapeutic meanings
  - Follow-lead-follow
  - Interactive repair
  - Nonverbal-verbal dialogue
- **Treatment Phases:** There should be differential use of the components in the five phases of treatment:
  - Creating the Alliance
  - Maintaining the Alliance
  - Exploration
  - Integration
  - Healing
- **Treatment Tools & Resources:**
  - Role-plays
  - Use of media to engage family in collaborative and enjoyable activities to decrease tensions and improve affective connections

Child/Adolescent Services

Dyadic Developmental Psychotherapy (DDP) directly provides services to children/adolescents and addresses the following:

- Trauma-related symptoms such as flashbacks, temper tantrums, difficulty trusting adults, disorganized attachment patterns, impaired affect regulation, impaired behavioral regulation, impaired peer-relationships, developmental delays in socialization, daily living skills, and communication

Parent/Caregiver Services

Dyadic Developmental Psychotherapy (DDP) directly provides services to parents/caregivers and addresses the following:

- Difficulty attuning with their child, "buttons" triggered in parent by child's behavior, past trauma that interferes with implementing attachment-facilitating parenting skills

Recommended Parameters

Recommended Intensity:

After comprehensive initial assessment is conducted, the therapy is a weekly 2-hour session.

Recommended Duration:

Approximately 1 month for per year of child's age; for adolescents, approximately ten to fifteen months.

Delivery Settings

This program is typically conducted in a(n):

- Adoptive Home
- Foster/Kinship Care
- Outpatient Clinic
- Residential Care Facility

Homework

Dyadic Developmental Psychotherapy (DDP) includes a homework component:

The skills developed in session are asked to be practiced during the week. Drawings may be taken home and redone with the family. Parents may be asked to track certain behaviors and their response and to keep a journal. Children and caregivers may be asked to jointly prepare a time line of the child's history.

Languages

Dyadic Developmental Psychotherapy (DDP) has materials available in a language other than English:

Finnish

For information on which materials are available in this language, please check on the program's website or contact the program representative (contact information is listed at the bottom of this page).

Resources Needed to Run Program

The typical resources for implementing the program are:

- Typical therapy office
- Videotaping equipment
- Texts for families (*Attachment Parenting*, edited by Arthur Becker-Weidman, PhD and/or *Creating Capacity for Attachment*, edited by Arthur Becker-Weidman, PhD)

Minimum Provider Qualifications

- Be a licensed mental health practitioner with authority to practice in their jurisdiction
- Certification in Dyadic Developmental Psychotherapy as an Attachment-Focused Therapist/Family Therapist by the Attachment-Focused Treatment Institute

Education and Training Resources

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contacts:

- **Arthur Becker-Weidman, PhD**
  Center for Family Development & Attachment-Focused Treatment Institute
  AWeidman@Concentric.net
  phone: (716) 810-0790
- **Daniel A. Hughes**
  www.ddpnetwork.org
  dhughes202@gmail.com
  phone: (717) 673-6119

Training is obtained:

Through The Attachment-Focused Treatment Institute:

The Attachment-Focused Treatment Institute (http://www.attachment-focusedtreatmentinstitute.com) certifies practitioners of ***Dyadic Developmental Psychotherapy*** and Attachment-Focused Treatment. This is a University-based certification program, a part of the Graduate Counseling program of the Academy of Human Development. Practitioners required to show competency in the differential use of the components of treatment (14 specific components) in different phases of treatment (five phases). Training is available on site, at the host's location, and via the internet using Cisco webEx.

Through The Dyadic Developmental Psychotherapy Institute (DDPI):

The Dyadic Developmental Psychotherapy Institute (DDPI) offers face to face certificated ***Dyadic Developmental Psychotherapy*** Training Programs, as well as supervision leading to a DDPI Practitioner Certificate.

Education and Training Resources, including events and trainings, practitioners, consultants and trainers for professionals and parents, can be found on this website: www.ddpnetwork.org

Number of days/hours:

48 to 60 hours, depending on trainee's goals.

The number days/hours for the DDP Level 1 and Level 2 (which are the prerequisites for Practitioner Certification) are 4 days and 28 hours each. The website may be consulted for other DDPI sponsored activities: www.ddpnetwork.org - resources - latest news, resource library and newsletters (UK, US/CA).

Relevant Published, Peer-Reviewed Research

This program is rated a "**3 - Promising Research Evidence**" on the Scientific Rating Scale based on the published, peer-reviewed research available. The practice must have at least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) establishing the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. Please see the Scientific Rating Scale for more information.

References

Becker-Weidman, A. (2010). *Dyadic Developmental Psychotherapy: Essential practices & methods.* Lanham, MD: Jason Aronson.

Becker-Weidman, A. (2011). *The Dyadic Developmental Psychotherapy casebook.* Lanham, MD: Jason Aronson.

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Parent-Child Interaction Therapy (PCIT)

Scientific Rating:

1

Well-Supported by Research Evidence

Child Welfare System Relevance Level:

Medium

About This Program

The information in this program outline is provided by the program representative and edited by the CEBC staff. ***Parent-Child Interaction Therapy (PCIT)*** has been rated by the CEBC in the areas of: Disruptive Behavior Treatment (Child & Adolescent) and Parent Training Programs.

Target Population: Children ages 2.0 - 7.0 years old with behavior and parent-child relationship problems; may be conducted with parents, foster parents, or other caretakers
For children/adolescents ages: 2 – 7
For parents/caregivers of children ages: 2 – 7

Brief Description

Parent-Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. ***PCIT*** is time-unlimited; families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behavior as within normal limits on a standardized measure of child behavior. Therefore treatment length varies but averages about 14 weeks, with hour-long weekly sessions.

Program Goals:

The goals of the Child-Directed Interaction part of ***Parent-Child Interaction Therapy (PCIT)*** are:

- Build close relationships between parents and their children using positive attention strategies
- Help children feel safe and calm by fostering warmth and security between parents and their children
- Increase children's organizational and play skills
- Decrease children's frustration and anger
- Educate parent about ways to teach child without frustration for parent and child
- Enhance children's self-esteem
- Improve children's social skills such as sharing and cooperation
- Teach parents how to communicate with young children who have limited attention spans

The goals of Parent-Directed Interaction part of ***Parent-Child Interaction Therapy (PCIT)***are:

- Teach parent specific discipline techniques that help children to listen to instructions and follow directions
- Decrease problematic child behaviors by teaching parents to be consistent and predictable
- Help parents develop confidence in managing their children's behaviors at home and in public

Essential Components

The essential components of ***Parent-Child Interaction Therapy (PCIT)*** include:

- Child Directed Interaction (CDI):
  - Parent-child dyads attend treatment sessions together and the parent learns to follow the child's lead in play.
  - The parent is taught how to decrease the negative aspects of their relationship with their child and to develop positive communication.
  - The parent is taught and coached to use CDI skills. These skills help the parents give positive attention to the child following positive (e.g. non-negative) behavior and ignore negative behavior.
  - By learning CDI skills, the parent is taught:
    - To give labeled praise following positive child behavior.
    - To reflect or paraphrase the child's appropriate talk.
    - To use behavioral descriptions to describe the child's positive behavior.
    - To avoid using commands, questions, or criticism because these verbalizations are intrusive and often give attention to negative behavior.
  - The parent is observed and coached through a one-way mirror at each treatment session.
  - After the first session, at least half of each session is spent coaching the parent in CDI skills utilizing a 'bug in the ear'. a wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears.
  - The parent's CDI skills are observed and recorded during the first five minutes of each session to assess progress and to guide skills learned through coaching during session.
  - Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in positive interactions and the achievement of skill mastery.
  - The parent is provided with homework between sessions to enhance skills learned in the session.
  - Dyads do not proceed to the Parent Directed Interaction (PDI) until the parent demonstrates mastery of the CDI.
- Parent Directed Interaction (PDI):
  - Parent-child dyads attend treatment sessions together and the parent learns skills to lead the child's behavior effectively.
  - The parent is taught how to direct the child's behavior when it is important that the child obey their instruction.
  - The parent is observed and coached through a one-way mirror at each treatment session.
  - After the first session, at least half of each session is spent coaching the parent in PDI utilizing a 'bug in the ear,' a wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears.
  - Parent's PDI skills are observed and recorded during the first five minutes of each session to assess progress and guide the coaching of the session.
  - The parent learns to incorporate the effective instructions and commands (e.g. commands that are direct, specific, positively stated, polite, given one at a time, given only when essential, and accompanied by a reason that either immediately precedes the command or accompanies the praise for compliance) learned during the CDI component.
  - The parent learns to follow through on direct commands by giving labeled praise after every time the child obeys and beginning a time-out procedure after every time the child disobeys.
  - The parent learns a time-out procedure to use in the event that the child disobeys a direct command. The parent begins by issuing a warning, which will lead to the time-out chair, and then to the time-out room if the child continues disobeying.
  - The parent is coached to use the PDI algorithm, which gives the child an opportunity to obey and stop the time-out procedure at each step.
  - Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in their PDI skills.

- Once the parent demonstrates mastery of the procedures, she/he is given homework that gradually increases the intensity of the situations as the child learns to obey.
- Treatment does not end until the parent meets pre-set mastery criteria for both phases of treatment and the child's behavior is within normal limits on a parent-report measure of disruptive behavior at home.

- ***PCIT*** can be delivered in a group format as well. When done so, small groups of 3 or 4 families in 90-minute sessions are recommended. This will allow adequate time for individual coaching of each parent-child dyad while other parents observe, code, and provide feedback in each session. For additional information, please check the ***PCIT***website homepage at www.pcit.org and select "PCIT Integrity Checklists and Materials."

Child/Adolescent Services

Parent-Child Interaction Therapy (PCIT) directly provides services to children/adolescents and addresses the following:

- Noncompliance, aggression, rule breaking, disruptive behavior, dysfunctional attachment with parent, internalizing symptoms

Parent/Caregiver Services

Parent-Child Interaction Therapy (PCIT) directly provides services to parents/caregivers and addresses the following:

- Ineffective parenting styles (e.g., permissive parenting, authoritarian parenting, and overly harsh parenting)

Recommended Parameters

Recommended Intensity:
One or two 1-hour sessions per week with the therapist

Recommended Duration:
The average number of sessions is 14, but varies from 10 to 20 sessions. Treatment continues until the parent masters the interaction skills to pre-set criteria and the child's behavior has improved to within normal limits.

Delivery Settings

This program is typically conducted in a(n):

- Community Agency
- Outpatient Clinic

Homework

Parent-Child Interaction Therapy (PCIT) includes a homework component:
During the first phase of treatment, homework consists of a daily 5-minute parent-child play interaction (called child-directed interaction, or CDI) in which the parent practices the relationship enhancement skills.

Languages

Parent-Child Interaction Therapy (PCIT) has materials available in a language other than English:
Spanish
For information on which materials are available in this language, please check on the program's website or contact the program representative (contact information is listed at the bottom of this page).

Resources Needed to Run Program

The typical resources for implementing the program are:

- Two connected rooms with a one-way mirror on the adjoining wall (one room for client, other room for coach) or another method for the therapist to unobtrusively observe the parent.
- A wireless communications set consisting of a head set with microphone and an ear receiver (i.e., "bug in the ear")
- A VCR and television monitor to tape record sessions for supervision, training, and research purposes

Minimum Provider Qualifications

A firm understanding of behavioral principles and adequate prior training in cognitive-behavior therapy, child behavior therapy, and therapy process skills (e.g., facilitative listening) is required. For training in this treatment protocol outside an established graduate clinical training program, the equivalent of a master's degree and licensure as a mental health provider is required.

It is recommended that the 40 hours of intensive skills training be followed by completion of two supervised cases prior to independent practice. For within program supervisors, it is recommended that they complete a minimum of 4 prior cases and complete a within program trainer training.

Education and Training Resources

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contact:

- PCIT International
  www.pcit.org/certified-trainers
  pcit.international@gmail.com

Training is obtained:
On-site and off-site

Number of days/hours:
5 days for a total of 40 hours; follow-up consultation through the completion of two cases

Implementation Information

Since ***Parent-Child Interaction Therapy (PCIT)*** is rated a 1, 2, or 3 on the CEBC Scientific Rating Scale, information was requested from the program representative on available pre-implementation assessments, implementation tools, and/or fidelity measures.

Show Implementation information...

Relevant Published, Peer-Reviewed Research

This program is rated a "**1 - Well-Supported by Research Evidence**" on the Scientific Rating Scale based on the published, peer-reviewed research available. The program must have at least two rigorous randomized controlled trials with one showing a sustained effect of at least 1 year. The article(s) below that reports outcomes from an RCT showing a sustained effect of at least 1 year has an asterisk (*) at the beginning of its entry. Please see the Scientific Rating Scale for more information.

Child Welfare Outcomes: Safety and Child/Family Well-Being

Show relevant research...

References

Chaffin, M., Funderburk, B., Bard, D., Valle, L.A., & Gurwitch, R. (2011). A combined motivation and Parent-Child Interaction Therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology, 79,* 84-95.

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Hood, K. K., & Eyberg, S. M. (2003). Outcomes of parent-child interaction therapy: Mothers' reports on maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology, 32*, 419-429.

Contact Information

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Theraplay

Scientific Rating:

3

Promising Research Evidence

Child Welfare System Relevance Level:

Medium

About This Program

Target Population: Children ages 0-18 who exhibit behavioral problems and their caregiver (biological, adoptive, or foster)

For children/adolescents ages: 0 – 18

For parents/caregivers of children ages: 0 – 18

Brief Description

Theraplay is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun, physical, personal, and interactive and replicate the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behavior, overactive-aggressive behavior, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behavior and interpersonal problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, ***Theraplay*** has been used for many years with foster and adoptive families.

Program Goals:

The goals of ***Theraplay*** are:

- Increase child's sense of felt safety/security
- Increase child's capacity to regulate affect
- Increase child's sense of positive body image
- Ensure that caregiver is able to set clear expectations and limits
- Ensure that caregiver's leadership is balanced with warmth and support
- Increase caregiver's capacity to view the child empathically
- Increase caregiver's capacity for reflective function
- Increase parent and child's experience of shared joy
- Increase parent's ability to help child with stressful events

Essential Components

The essential components of ***Theraplay*** include:

- Session structure:
  - First session: Information-gathering interview with the parents.

- Second and third sessions: Observation sessions using the *Marschak Interaction Method (MIM)*, in which the child and one parent perform a series of interactive tasks together
  - The *MIM* is a structured technique for observing the relationship between two individuals. It consists of a series of simple tasks designed to elicit a range of behaviors in the four ***Theraplay*** dimensions: Structure (key concepts: Safety, Organization, Regulation); Engagement (key concepts: connection, attunement, acceptance, expands positive affect); Nurture (key concepts: regulation, secure base, worthiness); Challenge (key concepts: competence, confidence, supports exploration). The interactions are videotaped and later analyzed by the therapist(s) in preparation for a fourth session with the parents.
- Fourth session: Planning session where the therapist(s) and parents discuss their observations of the interaction and together agree on a plan for treatment
- Fifth through 20th session: Direct ***Theraplay*** with the family

- Treatment components:
  - Interactive and relationship-based and utilizes innate capacities for social interaction (rhythm, affective resonance and synchrony, and mirror neuron functions)
  - Provides a direct, here and now experience and utilizes now moments, non-congruence, and multiple foci of change
  - Guided by the adult and utilizes concepts of holding environment, authoritative parenting, and resilience building
  - Responsive, attuned, empathic, and reflective and utilizes contingency, primary intersubjectivity, attunement to vitality and categorical affects, empathy, mindfulness, and reflective function
  - Geared to the pre-verbal, social, right brain level of development and utilizes concepts of experience-dependent brain development, primacy of right brain development in early life, and co-regulation of physical and emotional internal states
  - Multisensory and utilizes touch and appropriate stimulation of body senses for social development, attachment, regulation of physiological development, stress reduction, and positive body image
  - Playful, but does not employ a lot of toys or props and utilizes affective synchrony and amplification of interest and joy to connect with the child
  - Involves parents n the treatment and strives to give parents a more positive, empathic view of their child, to have them become competent co-therapists, to teach them about appropriate developmental expectations, and to consult about behavior management
- Typically provided as family therapy but has a group version available with a recommended group size of 4-10

Child/Adolescent Services

Theraplay directly provides services to children/adolescents and addresses the following:

- Withdrawn, depressed, fearful, shy, acting out, angry, non-compliant, Oppositional Defiant Disorder, relationship and attachment problems, Reactive Attachment Disorder, posttraumatic stress disorder (PTSD), complex relational trauma, Developmental Trauma Disorder, regulatory problems, ADHD, autism spectrum disorders, and developmental delays

Parent/Caregiver Services

Theraplay directly provides services to parents/caregivers and addresses the following:

- Has a behavioral/relationship problem with their child, was not well-parented, and needs to experience how being taken care of feels

Recommended Parameters

Recommended Intensity:

Families typically receive 30-45 minute weekly sessions (shorter for younger children)

Recommended Duration:

Approximately a year and a half (weekly for 18-24 weeks then four follow-up sessions)

Delivery Settings

This program is typically conducted in a(n):

- Adoptive Home
- Community Agency
- Foster/Kinship Care
- Hospital
- Outpatient Clinic
- Residential Care Facility
- School

Homework

Theraplay includes a homework component:

Parents use the play activities at home with their child, starting with activities that have been enjoyed during therapy.

Languages

Theraplay has materials available in languages other than English:

Finnish, German, Japanese, Korean, Spanish, Swedish

For information on which materials are available in these languages, please check on the program's website or contact the program representative (contact information is listed at the bottom of this page).

Resources Needed to Run Program

The typical resources for implementing the program are:

Ideally, an agency would have a treatment room of approximately 150 square feet (12 x 12) or larger , with a small couch or love seat, a cabinet with doors for supplies, and two 3 feet by 8 feet gym mats. Optimally there would be very few other games/toys/furniture in order to reduce distraction. Optimally there would be an adjacent observation room with a one-way mirror to see the session. This requires some type of audio system (baby monitors are fine). Furthermore, a camcorder for recording the sessions and a computer or other mode to play back the videos is necessary. Videotaping would only be done with client's consent. It is possible but not optimal to practice the model without videotaping.

Minimum Provider Qualifications

One must have a Master's or doctoral level degree in a mental health field that prepares one to provide clinical services to families and children, and one must be fully licensed to provide these services independently to complete the introductory and intermediate trainings and become a certified therapist. Individuals may earn associates status and work under competent clinical supervision, if they have not fulfilled the education level

required to be a certified therapist. Supervisors and trainers must be licensed therapists for at least two years prior to entering the supervisor/trainer practicum.

It is recommended that all participants in the introductory level training have a masters or doctoral degree as above, but students will be admitted as well.

Education and Training Resources

There is a manual that describes how to implement this program, and there istraining available for this program.

Training Contact: Catherine Tucker (contact info. below)

Training is obtained:

The training is offered three times yearly in Chicago and on-site upon request, including open registration training at host venues.

Number of days/hours:

The Introductory ***Theraplay*** & *MIM* training is 26 contact hours over four days. Intermediate training is 19 contact hours over three days. The supervision practicum to become certified includes an additional 40 supervised hours.

Implementation Information

Since ***Theraplay*** is rated on the Scientific Rating Scale, information was requested from the program representative on available pre-implementation assessments, implementation tools, and/or fidelity measures.

Show Implementation information...

Relevant Published, Peer-Reviewed Research

This program is rated a "**3 - Promising Research Evidence**" on the Scientific Rating Scale based on the published, peer-reviewed research available. The practice must have at least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) establishing the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. Please see the Scientific Rating Scale for more information.

References

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Booth, P. B. (2000). Forming an attachment with an adopted toddler using the Theraplay approach. In: *The Signal. Newsletter of the World Association for Infant Mental Health, July-Sept, 8*(3).

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Contact Information

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Trust-Based Relational Intervention (TBRI) – Caregiver Training

The information in this program outline is provided by the program representative and edited by the CEBC staff. This program has been rated by the CEBC in the following Topic Areas:

Parent Training Programs that Address Behavior Problems in Children and Adolescents

Scientific Rating	Child Welfare Relevance
3 — Promising Research Evidence	**High**

About This Program

Target Population: Parents (e.g., birth parents, foster parents, kinship parents, adoptive parents, etc.) and caregivers of children who come from 'hard places,' such as maltreatment, abuse, neglect, multiple home placements, and violence

For parents/caregivers of children ages: 0 – 17

Brief Description

TBRI Caregiver Training is a group in-person parent training program. TBRI is a holistic approach that is multidisciplinary, flexible, and attachment-centered. It is a trauma-informed intervention that is specifically designed for parents and caregivers of children who come from 'hard places,' such as maltreatment, abuse, neglect, multiple home placements, and violence, but is an approach that can be used by parents and caregivers with all children. TBRI consists of three sets of harmonious principles: Connecting, Empowering, and Correcting. These principles can be used in homes (e.g., birth homes, foster homes, kinship homes, adoptive homes, etc.), schools, orphanages, residential treatment centers, and other environments. They are designed to be used by parents and caregivers with children and youth of all ages and risk levels. TBRI is based upon how optimal development *should* have occurred. By helping caregivers understand what should have happened in early development (including prenatal development), TBRI principles can be used by parents and caregivers to help guide children and youth back to their natural developmental trajectory.

Program Goals:

The goals of ***Trust-Based Relational Intervention (TBRI) – Caregiver Training*** are:

- Help caregivers create an environment of physical, social, and psychological safety
- Help caregivers recognize and meet children's physiological needs (e.g., hydration)
- Help caregivers structure experiences to enhance emotional and behavioral self-regulation
- Enhance caregivers' mindful awareness and mindful caregiving
- Build and strengthen secure attachments between caregivers and children
- Build and strengthen resilience in caregivers and children
- Help caregivers master the use of proactive strategies for behavioral change
- Help caregivers master the IDEAL Response (Immediate, Direct, Efficient, Active, Leveled at behavior, not child)
- Help caregivers master Levels of Response (Playful, Structured, Calming, Protective)

Essential Components

The essential components of ***Trust-Based Relational Intervention (TBRI) - Caregiver Training*** include:

- TBRI® Connecting Principles
  - Connecting Principles help children build trust and meaningful relationships. These include:
    - Engagement Strategies, which connect with children nonverbally, such as with eye contact, behavior matching, and playful engagement.
    - Mindfulness Strategies, which involve parents and caregivers being aware of what they bring to interactions with their children, such as being conscious of their own relationship histories.
- TBRI® Empowering Principles
  - Empowering Principles help children learn important skills like self-regulation. There are two types of Empowering strategies:
    - Physiological Strategies, which focus on the internal physical needs of the child. These include things like hydration, blood sugar, and sensory needs.
    - Ecological Strategies, which focus on the child's external environment and guide children toward learning self-regulation skills. Ecological Strategies include things like transitions, scaffolding (guided support appropriate to a child's level that facilitates learning), and daily rituals.
- TBRI® Correcting Principles
  - Correcting Principles help children learn behavioral and social competence so that they can better navigate the social world they live in. Correcting Principles include:
    - Proactive Strategies, which are designed to teach social skills to children during calm times.
    - Responsive Strategies, which provide caregivers with tools for responding to challenging behavior from children.
- During a ***TBRI Caregiver Training*** session, TBRI principles and strategies are implemented with participants. Water, snacks, and nutritious food are provided for the parents/caregivers, physical activity occurs at regular intervals (i.e., physiological strategies), and there are structured transitions and a predictable schedule (i.e., ecological strategies). Relationships with participants are purposefully developed through discussions, activities, breaks, and lunches (i.e., engagement and mindfulness strategies). These intentional practices allow for participants to experience a parallel process between the training and the TBRI Principles and Strategies.
- For a ***TBRI Caregiver Training*** session, the number of participants trained is dependent upon the number of TBRI Educators conducting the training. A team training approach with 2 or more training facilitators is recommended for all groups.
- The minimum number of trainees recommended is 10, the quality of discussions and activities begin to decline with fewer participants. The maximum number is dependent upon the number of trainers and the space. Typically, the recommended maximum is 50 participants; 25-40 participants is an ideal size for discussions and activities.
- Following the ***TBRI Caregiver Training*** sessions, participants are provided with implementation support through having access to TBRI Educators for questions, problem solving, and coaching. Some agencies who host the ***TBRI Caregiver Training*** sessions also provide regular support groups and continuing education classes after the training, but this is not part of the TBRI training and is therefore optional.

Parent/Caregiver Services

Trust-Based Relational Intervention (TBRI) – Caregiver Training directly provides services to parents/caregivers and addresses the following:

- Caregivers' lack of mindfulness, and associated deficits (e.g., inability to remain calm and recognize children's needs)
- Caregivers' lack of awareness about their own caregiving history, and its impact on their own ability to provide care
- Caregivers who have children that experience the following:

- Inability to give and/or receive nurturing care
- Hyper-vigilance and lack of felt safety
- Inability to regulate their own emotions and/or behavior
- Problem behavior, including both internalizing and externalizing behaviors
- Sensory related deficits, including, for example, hypersensitivity and/or hypo-sensitivity to touch
- Poor social skills (e.g., doesn't know how to appropriately ask for their needs)

Services Involve Family/Support Structures:

This program involves the family or other support systems in the individual's treatment: TBRI involves all individuals involved in providing care for children including biological parents, adoptive parents, foster parents, caseworkers, teachers, coaches, therapists, counselors, social workers, child advocates, and direct care staff. Caregivers not attending the training sessions and other people who provide care for the child are strongly encouraged to attend a ***TBRI Caregiver Training*** session (or watch a DVD from The Healing Families series or read The Connected Child book) in order to use the same voice with the child.

Recommended Parameters

Recommended Intensity: 6-hour training sessions
Recommended Duration: Four days

Delivery Settings

This program is typically conducted in a(n):

- Community Agency
- Outpatient Clinic
- Residential Care Facility
- School

Homework

This program does not include a homework component.

Languages

Trust-Based Relational Intervention (TBRI) – Caregiver Training does not have materials available in a language other than English.

Resources Needed to Run Program

The typical resources for implementing the program are:
Computer, projector, and Internet access

Minimum Provider Qualifications

Trainers must be TBRI Educators in order to train others in the intervention. There is no minimum educational requirement to attend the trainings to be a TBRI Educator.

Education and Training Resources

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contact: Vicki Lindsey **child@tcu.edu** **phone: (817) 257-7415**
TBRI Educator training is obtained through the TCU Institute of Child Development.

Number of days/hours:
TBRI Educators must complete the TBRI Practitioner Training, as well as the TBRI Educator Training in order to gain access to the TBRI Educator training materials and train parents/caregivers.

- TBRI Practitioner Training is intended for professionals working with caregivers and children (note: these practitioners do not train parents on TBRI, they learn the TBRI principles to help them work with the children and families they see in their practice). It includes 2 phases:
  - Phase 1: Online pre-training includes an interpersonal interview, reading assignments, watching DVDs, and answering comprehension and application questions. Each module takes approximately 3-4 hours to complete (total 15 – 20 hours).
    - TBRI® Overview
    - Connecting Principles
    - Empowering Principles
    - Correcting Principles
    - Putting It All Together
  - Phase 2: On-site training includes lectures, activities, video scoring, role-plays, case studies, and skills checks (40 hours)
  - After completing both phases successfully, participants are considered TBRI Practitioners, but to lead TBRI Caregiver Training, TBRI Practitioners must also complete TBRI Educator training.
- TBRI Educator training consists of 5 online units designed to deepen understanding of TBRI, enhance training skills, and allow participants to become familiar with all training materials. Each unit takes approximately 3-4 hours to complete (total 15 – 20 hours). After successful completion, participants are considered TBRI Educators.

  TBRI Educators have access to TBRI Educator training materials and are authorized to train clients (e.g., caregivers, biological parents, foster parents, kinship caregivers, biological caregivers) and individuals within their organizations who can then use the TBRI principles in their practices.

  Total = Approximately 80 hours

Implementation Information

Since ***Trust-Based Relational Intervention (TBRI) – Caregiver Training*** is rated on the Scientific Rating Scale, information was requested from the program representative on available pre-implementation assessments, implementation tools, and/or fidelity measures.

Show Implementation information...

Relevant Published, Peer-Reviewed Research

This program is rated a "**3 - Promising Research Evidence**" on the Scientific Rating Scale based on the published, peer-reviewed research available. The practice must have at least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) establishing the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. Please see the Scientific Rating Scale for more information.

Purvis, K.B., Razuri, E. B., Howard, A.R., Call, C., DeLuna, J., Hall, J.S., & Cross, D. R. (2015). Decrease in behavioral problems and trauma symptoms among at-risk adopted children following trauma-informed parent training intervention. *Journal of Child & Adolescent Trauma, 8*(3), 201-210. doi:10.1007/s40653-015-0055-y

Type of Study: Randomized pretest-posttest design with a control group
Number of Participants: 96

Population: Age — Children: 5-12 years; Adults: 41-43 years

- **Race/Ethnicity —** Children: 37.5% White/Caucasian, 30.2% Black/African American, 5.2% Hispanic/Latino, 21.9% Asian, 2.1% Native American, and 3.1% Other; Adults: 97.9% White/Caucasian, 2.1% Hispanic/Latino
- **Gender —** Children: 62.5% Male and 37.5% Female; Adults: 93.8% Female, 6.38% Male
- **Status —** Participants were adopted children with histories of early maltreatment and neglect and their parents.

Location/Institution: Texas Christian University

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
The current study evaluated the effectiveness of ***Trust-Based Relational Intervention (TBRI) – Caregiver Training*** in reducing behavioral problems and trauma symptoms in at-risk adopted children. Participants were randomly assigned to either ***TBRI Caregiver Training*** or a control group. Reported here are results for the 48 participants in the ***TBRI Caregiver Training*** group and 48 participants in a matched sample control group who had complete data through the final round of data collection. Measures utilized include the *Strengths and Difficulties Questionnaire (SDQ)* and *Trauma Symptoms Checklist for Young Children (TSCYC)*. Results indicated that children of parents in the ***TBRI Caregiver Training*** group demonstrated significant decreases in behavioral problems and trauma symptoms after intervention. Scores for children in the control group did not change. Limitations include lack of full randomization, use of small sample size, reliance on self-reported measures, and lack of follow-up.

Length of postintervention follow-up: None.

References

Purvis, K. B., Cross, D. R., & Pennings, J. S. (2009). Trust-Based Relational Intervention: Interactive principles for adopted children with special social-emotional needs. *Journal of Humanistic Counseling, Education, and Development, 48,* 3-22.

Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-Based Relational Intervention (TBRI): A systematic approach to complex developmental trauma. *Child & Youth Services, 34*(4), 1-28.

Purvis, K. B., Parris, S. R., & Cross, D. R. (2011). Trust-Based Relational Intervention: Principles and practices. In E. A. Rosman, C. E. Johnson, & N.M. Callahan (Eds.), *Adoption Factbook V* (pp. 485-489). Alexandria, VA: National Council for Adoption.

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