

Practice Models to Address Complex Attachment Challenges

1. Introduction

1.1 Introduction

Welcome back to the National Adoption Competency Mental Health Training for Mental Health Professionals. This lesson is: Practice Models for Working with Parents and their Children to Address Complex Attachment Challenges.

In this lesson, we will explore evidence-based attachment therapies and practice models that therapists can use with families.

1.2 Section 1: Lesson Objectives

At the end of this lesson, you will be able to:

- Integrate into clinical practice strategies and therapeutic tools for helping families understand and honor their children's previous attachments and unique story
- Integrate into clinical practice strategies and therapeutic tools for helping families:
 - Address attachment challenges
 - Create a healing environment that facilitates attachment
 - Employ therapeutic parenting strategies that enhance children's safety and attachment
- Identify clinical practices associated with attachment that are not effective and could even be potentially harmful

1.3 Attachment Therapy

The harm that has come to children in the context of early adverse relationships needs to be healed in nurturing, caregiving relationships. Traditional parenting and discipline techniques are often not sufficient to achieve this. Attachment therapy is a diverse field that includes a range of treatments, some with an empirical base, focused on promoting secure attachments in children and youth.

However, beginning in the late 1980s, an approach to treating Reactive Attachment Disorder was developed that utilized forced holding and coercive techniques to induce rage in children, with the goal of getting them to vent and break down their resistance to accepting adult control and nurturance. These include "rebirthing" therapy, "compression holding" therapy, and parenting advice involving forced excessive intake of fluids.

These controversial coercive attachment therapies have been rejected by most professionals as unsafe and unethical and have been repudiated by professional associations such as the American Psychological Association and the American Professional Society on the Abuse of Children.

It is essential that we differentiate responsible attachment therapies from the ones that have raised legitimate concerns to help parents find sound, ethical, and effective treatment for children with attachment challenges.

1.4 Attachment Therapy Models

We will explore a range of evidence-based and evidence-informed practice models that can be used to strengthen attachment between children and their parents or guardians. The attachment interventions with the highest rating of scientific evidence are for toddlers or very young children. Attachment and Biobehavioral Catch-up (ABC) and Parent-Child Interaction Therapy (PCIT) are described in the resource, *Additional Attachment Therapies*. Also included in this handout are Child-Parent Psychotherapy, Circle of Security, and Filial Therapy.

Throughout this module, we will utilize content from four specific models that can be used with children and youth of all ages who have experienced complex trauma. These models have promising research evidence and include:

- Attachment, Regulation, and Competency (ARC)
- Trust-Based Relational Intervention (TBRI)
- Dyadic Developmental Psychotherapy (DDP) and
- Theraplay

There is more detailed coverage of some of these models in future modules, particularly the module on therapeutic parenting.

1.5 Goals of Attachment Therapies

All attachment therapies have similar goals. Click the images to hear the goals for caregivers and their children.

Goals for caregivers include:

- Increased attunement to their child's feelings and behaviors
- Increased awareness of their child's emotions and perceptions underlying behaviors
- Increased empathy and empathic response to their child
- Increased capacity to engage their child and meet their needs
- Increased positive interactions with their child and communicating delight in and appreciation of them
- Resolution of past relational traumas that are interfering with parenting capacity

Goals for children include:

- Improved ability to accept appropriate physical and emotional closeness with their parent
- Improved capacity to express own feelings and needs
- Improved self-esteem
- Enhanced felt safety
- Enhanced security and trust in attachment relationship
- Increased ability to self-regulate in stressful situations

2. Attachment, Regulation, and Competency (ARC)

2.1 Attachment, Regulation, and Competency (ARC)

Let's start with the Attachment, Regulation, and Competency (ARC) intervention framework, developed by Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW.

2.2 Components and Goals of ARC

The ARC framework is a flexible, components-based intervention developed for children and adolescents who experienced complex trauma and their caregivers. We will do a brief overview of ARC in this lesson and revisit aspects of the work in the modules on trauma and therapeutic parenting.

First, please review the resource, *The ARC Framework*, which outlines the core targets in this framework depicted in the graphic. This is a refinement of the original framework that was developed in 2004. ARC was recognized by the National Child Traumatic Stress Network as a promising practice, and their fact sheet on ARC is in the Resources.

Foundational strategies are relevant to all of the intervention components and include engagement, psychoeducation, and routines and rituals. Likewise, the overarching goal of trauma experience integration is addressed throughout the treatment process.

The three domains of Attachment, Regulation, and Competency are the central, core targets of this intervention. Click each domain to hear the highlights of each.

Attachment

- Supporting parents or guardians in managing their own emotional and physiological responses
- Enhancing attunement in the caregiver-child relationship
- Building effective trauma informed responses to child and youth behavior

Regulation

- Supporting children and youth in developing awareness and knowledge of their feelings, thoughts, and behaviors
- Helping children and youth develop increased capacity to tolerate and manage emotional and physiological experiences
- Enhancing tolerance for, and strengthening skills in, building relationships

Competency

- Building comfort and safety in relationships
- Strengthening executive functions, such as making choices and problem solving
- Identifying and exploring aspects of self and identity
- Building a coherent, positive sense of self, which integrates the past and present

2.3 Strengthening Attunement Video

A key building block of the ARC model is attunement in the attachment process. Let's learn more about this concept from Dr. Margaret Blaustein.

[Video Transcript]

INTERVIEWER: So when discussing attunement, you discussed the importance of a caregiver being able to read a child's cues, but that a secondary goal is really helping children to also be able to read their caregivers cues. Can you talk a little bit more about that dynamic?

DR. MARGARET BLAUSTEIN: Sure, so let me say first what attunement is, okay, and attunement is really about being able to read. I think of it as sort of that message underneath the behavior. And to me, a great example of this is with a pet who can't talk to you, right, where you learn to figure out by their body language what they're communicating. Or someone who you just know so well that they don't have to talk to you. You know by the way they walk in the door, right, whether they're upset, whether they've had a good day or a hard day.

And all of that is how we learn over time someone's language, and that language goes far beyond words. And when attunement works really well, it's very much a foundation for intimate relationship in every way that intimate relationship occurs. And the challenge is sometimes there are misattunements.

Now, in every relationship there's misattunements. There's moments when we miss the mark, right, where we misread something in someone else. But when we have a situation in which a child or adolescent has experienced a lot of relational danger in their lives or betrayals or losses or abandonment, all of the ways that relationships don't go well, over time, as a way to protect themselves, they start looking for those cues that that might happen again.

And that means that the child maybe, again, searching for signs that you're angry or searching for signs that you're not interested in them or that you don't care about them or whatever else, and that's protective if they can pick it up early and take care of themselves. But sometimes they misread it. They expect to see it and then they see it.

So something as simple as an adult saying, "Hold on a second," right. A child says, "I need to talk to you." The adult says, "Hold on a second." What the child has just read, at times in that, is, "I don't care about you. I'm not interested in what you have to say."

So on the one hand, we have the adult, who's trying to accurately read the child's communications. We have a child who is, hopefully, trying to read the adult's communications. But if you end up with a mismatch, where the child is reacting to what they think they're seeing and responding to it, can make it harder for the adult to understand what's happening.

And then you add sometimes we have adults who've also been hurt in a relationship or who are protecting themselves in some way or who've built up in a negative pattern maybe with this particular child, and so they're vigilant now to signs that something's going to not go well in that relationship.

And so we have this real clash happening in the relationship. And a lot of times, when you break it down what you find is that both sides are actually wanting the same thing, which is the relationship to go well, but they're so--in some ways their brain is doing such a good job of taking care of them that it actually prevents them from having what they want.

So, one of our challenges in doing this work is helping people kind of bring that guard down a little bit and learn to read each other's language in a way that might be a little bit more accurate.

[End of Video]

Video obtained from: <https://www.youtube.com/watch?v=eFwNWi9F6tA>.

2.4 ARC Activity Reflection

Alvin and George, adoptive parents of Kenny, age 7, are working with an ARC therapist on the mis-attunement that is happening between them and their son during a recent interaction. Kenny was in his room talking on the phone with his older brother, who lives in a group home. When George walks by, he sees Kenny kicking the bed and hears swearing. George warned Kenny that he will lose privileges if his behavior continues, but Kenny just asks to be left alone.

As the therapist, what might you suggest for how to address this missed opportunity for attunement? List three ideas here.

2.5 ARC Activity Response

Here are some ideas:

- When in therapy with Alvin, George, and Kenny together, the therapist can support Alvin and George by asking Kenny what he is feeling today using a feelings chart. Then, she can support Kenny by asking Alvin and George how they are feeling.
- At home, parents can play a modification of charades, acting out different emotions, with Kenny guessing the emotion. Then, change roles, with Kenny acting out emotions for his parents to guess.
- Have family meetings at the end of the day to share what happened in each person's life, with a focus on reflective listening to Kenny, not problem solving.
- Have a communication or message board in a central location in the home where family members note how they are feeling today.

2.6 Considerations for Foster and Adoptive Parents Video

Let's return again to Dr. Blaustein and listen to her thoughts on the special considerations for foster and adoptive parents for building an attuned relationship.

[Video Transcript]

DR. BLAUSTEIN: There are certainly different challenges in fostering or ultimately adopting a child, because you're starting from a different place in getting to know someone and the child has a life that predates the life they had with you, right. And the family, the foster/ adoptive parents, have a life that predates the child, and that can have a lot of strengths and maybe holding different experiences so that you have different resources to build on. The child brings some resources. The family or caregivers bring some resources. But it also has its own particular challenges.

And I think one of the biggest challenges that I've seen is, in some ways, a lack of acknowledgment of those differences that caregivers may bring their expectations about who a child is going to be. Most caregivers who go into fostering or looking to adopt a child go in with the best of intentions. They want to open their hearts and to love a child, and sometimes the assumption is just loving this child is going to be enough. And kids come with a lot of history and a lot of experiences that make that hard, including a lot of negative relationship experiences.

And so, there's often a mourning process that caregivers have to go through. And then there's really a getting to know this child. So there's the expectation, right, of who the child is going to be. We all kind of have that when we go into a relationship. We have this picture of who we think the other person is going to be. And then to really build a relationship, we have to get to know the actual person.

And so, one of the things I hold to be really important is there being this real getting-to-know-you process on both sides of the caregiver's getting to know who this child is. So, it's not just the child learning the rules and the expectations and the traditions of the home. But it's the parents learning what's important to this child? What traditions are they used to? What rules are they used to? How do they understand relationship?

It may be that in our family we have an expectation that we do a lot of hugging or we're very physical in our affection; and for this child that feels really threatening. And so, if this child doesn't hug me, I worry that they're not affectionate. But it may be that she shows being affectionate in a different way, and I have to learn how to figure that out, how to read that.

So there's this real mutual process of learning to read each other's language and knowing that it doesn't always look like you might expect it to.

[End of Video]

Video obtained from: <https://www.youtube.com/watch?v=eFwNWi9F6tA>

2.7 ARC Video Reflection

List three considerations for adoptive and guardianship parenting that you identified from watching this video clip.

2.8 ARC Video Response

Important considerations include the reciprocity of the following issues, as well as the impact on both the child and family.

- A recognition that parents or guardians and the child are starting from a different place, each having had a life predating this relationship.
- Awareness of expectations going into this new relationship, with possible mourning, that some expectations will not, and cannot, be met.
- The family and child both coming to know each other's background, values, and traditions.

For all of these issues, it is important for the therapist to work with the family to support communicative openness and the expression of feelings between the child and family.

3. Trust-Based Relational Intervention

3.1 Trust-Based Relational Intervention

Now let's turn to Trust-Based Relational Intervention (TBRI), developed by Drs. Karyn Purvis and David Cross at Texas Christian University.

3.2 Overview of TBRI

TBRI is intended to help parents, caregivers, and others working with children and adolescents from hard places (children at-risk for attachment problems) to focus on the whole child and promote connection with the child. At-risk child populations include a range of situations:

- Difficult pregnancy or birth
- Early hospitalization
- Abuse or neglect
- Other trauma

Please review the resource, *An Overview of Trust-Based Relational Intervention*, which outlines the strategies included under three groups of guiding principles:

- Empowering Principles to address physical and safety needs
- Connecting Principles for attachment needs, and
- Correcting Principles to disarm fear-based behaviors and teach desirable behaviors

We will revisit these strategies in later modules.

3.3 Family Experience with TBRI Video

Let's watch the following video of a family's experience with TBRI.

[Video Transcript]

TCU INSTITUTE OF CHILD DEVELOPMENT: EST 2005 A TBRI® PORTRAIT THE CHRISTENSEN FAMILY: TBRI® HOME PROGRAM 2007 CLEMMONS, NC.

LEE CHRISTENSEN: My name is Lee Christensen, and we adopted our daughter Chloe from China in 2004.

[Chloe crying]

ROD CHRISTENSEN: Chloe, sit in the chair, please.

LEE CHRISTENSEN: Chloe had tantrums all day, every day. They were destructive. She could pick up a chair and throw it.

[Three adults sitting around a coffee table with a girl and a boy reading]

DR. KARYN PURVIS: No lying. Good.

LEE CHRISTENSEN: And because of all the attention that Chloe was getting in trying to deal with her tantrums, we had another child that we didn't know was suffering too. And I think it was at that time that we knew that we needed to get help from someone.

ROD CHRISTENSEN: I'm Rod Christensen. We got help from Dr. Purvis. Our family was extremely chaotic. We walked on egg shells trying to avoid meltdowns. It was a constant battle to maintain peace in our home.

[Chloe standing on a slide on a playground]

CHLOE: I didn't get a shot of doing that.

LEE CHRISTENSEN: But I said we might, if we have time, come back later, but we've got to--

ROD CHRISTENSEN: Chloe has power and was very strong in her desire to control situations, as even a small child. I tell people all the time, "Chloe would flip over a table." I'll be honest and tell you that when we were invited to Texas to meet Dr. Purvis, I thought, "This can't be real," but was at the point that I would have done anything. So, I stuffed my concerns, and we got on the plane and I was amazed at what I found.

[Chloe talking to a woman]

DR. PURVIS: Look how precious is that girl. This is a beautiful child.

CHLOE: It's me.

DR. PURVIS: It's Chloe.

LEE CHRISTENSEN: Dr. Purvis met us in my aunt's home, and in a matter of, I think it was probably just one day, gave us this whole program.

[Chloe crying]

DR. PURVIS: What did you do wrong, Chloe?

LEE CHRISTENSEN: Can you tell me?

CHLOE: I don't know.

LEE CHRISTENSEN: You don't know?

I didn't know how I was going to make it work. I didn't understand that she was always saying things about being attuned to our child, and I kept thinking, "What if I'm never attuned? What does that mean?" What kids really want is family time. They just want to be with you.

ROD CHRISTENSEN: In a nutshell, Dr. Purvis took our very chaotic, messed-up life and helped us get back toward order.

[Rob, Lee and Ben sitting on the floor]

LEE CHRISTENSEN: The amazing Chloe. Woo!

ROD CHRISTENSEN: The program works because it understands the root cause. It wasn't a misbehavior issue. It was the result of coming from tough places. Having a glimpse into the science that's behind all of this definitely helps me understand it. Maybe that's the way I think about things.

LEE CHRISTENSEN: I had more compassion because I understood it more. We were clueless going into an adoption, and I think the guilt I feel is that I didn't do research. But I didn't know to do research on something I didn't know about.

I can't imagine what the last 11 years would have been like had we not had the help from her that we got. I can't imagine what it would have been like for our marriage. I can't imagine what it would have been like for our son. And I can't imagine what it would have been like for Chloe.

I see other families that don't want to listen, and I see when they hug their child or kiss their child and I see the child wipe it off, and I remember Chloe doing that.

And I just wouldn't want her to be 12 years old still wiping off my kisses. [Chloe, Lee, Rod and Ben playing a game around the kitchen table]

ROD CHRISTENSEN: We laugh a lot. That's sort of where this house is. We laugh because we can, because we're not wrestling with issues. Ben has benefited from the program in that he was impacted by the situation in our home. And I can't really imagine what he would have been at 13 had we not had help from Dr. Purvis.

BEN CHRISTENSEN: My name is Ben Christensen. I'm 13 years old and I'm in the 8th grade. It was just--it was difficult. Sometimes I just had a hard time just at home and stuff with the tantrums and stuff, and I wouldn't know what to do. So, I would just kind of have to go off to the side, and a lot of times I just missed out on stuff.

ROD CHRISTENSEN: But because of the program, we were able to be a family and be nuclear and grow together.

BEN CHRISTENSEN: I think we know how, when anybody gets upset, how to cope with it, just at our age now even, it taught us that. And also it just helped out with her when she was smaller.

CHLOE CHRISTENSEN: I'm Chloe Christensen and I'm in 7th grade and I'm 12 years old. I do know I did throw a few temper tantrums a lot when I was little, but I don't think I throw that many now. Usually I just like to play sports a lot. I'm kind of athletic, so sports is usually the thing I do the most. I actually like school a lot. I like getting up in the--well, I don't like getting up in the morning, but once I'm up and everything, I like going to school. Oh yeah, I like life. Life is good.

LEE CHRISTENSEN: Chloe now, at 12 years old, has the biggest personality ever. She is her own person. She's not a follower.

ROD CHRISTENSEN: Chloe's a well-adjusted girl. She's an amazing daughter. She's an athlete.

CHLOE CHRISTENSEN: Well, I want to kind of go into like the Olympics maybe one day and try that, just kind of see what would happen. Just kind of try it.

LEE CHRISTENSEN: She's a great student. She's a great friend. She has compassion. I'm proud of her empathy. I am. I'm a proud dad.

[End of Video]

Video obtained from: <https://www.youtube.com/watch?v=t4CK7b-a2H0&t=6s>.

3.4 Considerations with TBRI

As the Christensens state in the video, TBRI helped them to gain more compassion in understanding their daughter's early experiences, become attuned to her needs, and build skills to manage her behavior and teach her self-regulation.

While TBRI can be used with many children, this approach should be modified if used with children for whom direct eye contact is discouraged or considered disrespectful. Use of direct eye contact as proposed in this model may appear coercive and uncomfortable for these children.

For more information about this, check out the TBRI podcast episode linked in the Resources tab.

3.5 TBRI for Teens

While TBRI is primarily used as a parent training curriculum both in-person and online, it can also be delivered in a therapeutic camp setting. In recent years, it has been adapted for very vulnerable teens in a camp setting. Let's listen to a short introduction to its application for teens:

For additional information about TBRI, and resources for parents, click on the link in the Resources tab.

[Video Transcript]

DR. KARYN PURVIS: I want to talk about one of the choices for life that I hope you'll all make and that's the choice of respect.

MODERATOR: Perhaps the most important lesson you want teenagers to learn is that they can always express their needs as long as it's done with respect.

DR. PURVIS: Let me ask you this question, are there some feelings that are good and some feelings that are bad? Somebody raise a quiet hand and tell me: Are some feelings good and some feelings bad?

THOMAS: Yes.

DR. PURVIS: You think some are good. Which ones are the bad ones, buddy?

THOMAS: Ones that don't make you feel good.

DR. PURVIS: Okay, so there's feelings that don't feel good at all, right?

MODERATOR: Because teens from hard places can often be out of touch with their emotions, we start with the basics.

DR. PURVIS: Basic feelings are happy, sad, angry, afraid, right?

MODERATOR: Here, Dr. Purvis uses a feelings chart, which you might find helpful, too.

DR. PURVIS: You can say, "I feel angry about that. I feel sad about that. I wished I didn't have to do that." Those are all honest, right? So we call those good words. You want to raise a question, yes?

THOMAS: What do you consider bad words?

DR. PURVIS: Bad words would be, "You're stupid. I hate you. That's dumb. That sucks." Words that are not descriptive are not good words. "That sucks" doesn't tell the adult what you need. Good words are feeling, honest words that are said with respect. Yes?

TIARA: Like whenever you ask or command people to do something for you, "Do this for me," and then a good word, "Can you do this for me?"

DR. PURVIS: Good words. Good words.

MODERATOR: Tiara, who's participating more, not only receives praise from Dr. Purvis, she gets a knuckle bump from Moe. Instead of forcing participation, we offer choices to encourage it.

ADULT MALE: Do something about this.

MALE TEENAGER: I'm getting tired of you always judging my closet.

DR. PURVIS: We have this notion that we have to make the rules, and they have to stick with our rules, and yet what we demonstrated was in everything that we did, "You can participate or not participate," and usually they would choose to participate.

So somebody want to demonstrate what you practiced just now?

[Kids acting out skits in a group.]

MODERATOR: Moe and his buddy Noel are quick to volunteer.

MOE: Noel, it's time to get ready for bed.

NOEL: That's stupid. I don't feel like going to sleep.

MOE: Hang on now. I'm going to try that again. [CROSSTALK] Let's try it again. Noel, it's time to go to bed.

NOEL: Can I have a compromise please, like ten minutes?

MOE: What do you want to do?

NOEL: Ten minutes, and then I'll go to sleep.

MOE: All right, you'll have everything done in 10 minutes?

NOEL: Yes.

MOE: Be ready and lights out?

NOEL: Yes.

MOE: Okay, you have a deal. [APPLAUSE]

[End of Video]

4. Collaborative Problem-Solving

4.1 Collaborative Problem-Solving

Let's turn now to Collaborative Problem-Solving.

4.2 CPS Overview

Collaborative Problem-Solving (CPS) was developed by Dr. Ross Greene, founding Director of Lives in the Balance, and Dr. Stuart Ablon, as a trauma-informed model of care with the goal of helping youth and caregivers resolve differences in expectations rather than trying to modify children's behavior through application of rewards and punishments. This is based on the premise that challenging behavior occurs when the expectations being placed on a child exceed the child's capacity to respond adaptively, and that some children are lacking the skills to handle certain demands and expectations.

The CPS approach was first described in his book, *The Explosive Child*, and has demonstrated effectiveness with children and adolescents ages 3 to 21 with a wide range of social, emotional, and behavioral challenges.

The model focuses on identifying the skills the child needs help learning and the expectations they need help meeting, referred to as unsolved problems.

4.3 Dr. Stuart Ablon

Take a moment and watch this video clip from the co-founder of CPS, Dr. Stuart Ablon as he discusses the CPS approach.

[Video Transcript]

DR. STUART ABLON: So collaborative problem-solving is a way of understanding why kids, and for that matter anybody, behaves in a challenging way and then what to do about it. Collaborative problem-solving really just follows all of the research in the neurosciences for about a half a century now that has shown beyond the shadow of a doubt that when youth exhibit chronic challenging behaviors, it's not that they lack the will to behave well, but rather they lack the skills to behave well--that they struggle with skills related to things like problem-solving, flexibility, frustration-tolerance. It's almost like they have a learning disability in those areas.

And so collaborative problem-solving is a very structured way of helping people understand what the problem's all about in the first place, and honing in on exactly which skills these kids struggle with, and then providing a very clear, replicable process that can be used in any setting to help kids develop those skills as they problem-solve collaboratively with the adults around them. And the process itself also helps to build the kind of relationship necessary to not only solve problems, but to practice these skills naturalistically together with the kids.

What is common sense about collaborative problem-solving is the awareness that, well, if it's a lack of skill, not will, getting in these kids way then traditional disciplinary strategies that just try to motivate kids aren't going to work. We need to do something else. So everything about this model is indeed common sense, but it flies in the face of conventional wisdom. Collaborative problem-solving has a basic philosophy behind it, and the philosophy is kids do well if they can. Not kids do well if they want to. Kids do well if they can. Which suggests if a kid could do well he would do well.

And if he's not doing well something's got to be standing in his way. And when you look at kids, for instance, in correctional facilities, they have had no end of pain in their young lives. If all it took was motivation for these kids to behave better, they had more motivation than anybody in the world. And so, once you realize that it's not a lack of will, it's a lack of skill, it's pretty easy to get your head around the need to do something else.

[End of Video]

4.4 CPS Model

The CPS model is recognized as an empirically supported, evidence-based treatment by the California Evidence-Based Clearinghouse for Child Welfare (CEBC). For more information, see the link in the Resources tab.

5. Conclusion

5.1 Wrapping Up

In this lesson, you learned about three practice models developed for children and youth having experienced complex trauma. These interventions teach therapeutic parenting principles to address the range of developmental outcomes impacted by complex trauma, and we will examine specific skills and strategies from these models in a later module.

5.2 Your Journal

Please click on the journal page to write down your reflections on this lesson.

5.3 Journal Reflection

Reflecting on this lesson, what are your key takeaways and how might you apply these in your practice?

5.4 Journal Response

Click the "Print Results" button to print and save your answers.

5.5 Conclusion

Congratulations! You have completed Practice Models to Address Complex Attachment Challenges. In the next lesson, we will look at additional interventions to address complex attachment challenges.