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Chapter 2: Changing Attachment Patterns

Attachment security includes valuing relationships, and especially the qualities of sensitivity, trust, and repair. Secure attachments assist with developing an integrated awareness between emotions, their social and emotional meaning, and our internal physical states/signals like heart rate, dry mouth, visceral upset, relaxed belly, face flushing, pleasure, or desire to flee.

Many adults notice the ease and joy with which others connect, and decide they want that for themselves. They value relationships even if they did not have security in their early lives. As children they may have had a relationship with a grandparent, teacher, or neighbor who provides an alternative secure base model.

Some individuals will come into therapy looking for help in their parenting relationship. In the first session, they will mention someone who helped them to believe that there was a better way of connecting than the one they had with their parents. I encourage eliciting more information, while noting their wisdom in forming this relationship. This beginning reflection helps clients to believe in their potential to have healthy attachments.

Adult relationships that develop security

After formerly abused people have participated in therapy, developed loving marital relationships, or received nurturing support from an adult, they can show a change in their attachment style, as discussed in the last chapter.

L. Alan Sroufe has remarked at the positive changes in parent-child security that some of his moderate-risk, single mothers showed after developing supportive partner relationships (2002). Changes reflect increased emotional support and decreased daily life stress as someone helped to carry the load of the household.

When working with families, I enjoy thinking of ways that parents can co-regulate each other better as well as reduce stress. These changes are early wins in therapy that benefit families. For example, one parent saying to the other that they will take care of dinner and the children while the other parent has a weekly evening to spend with a friend. Or, for two weeks, at least ten times daily, one parent notices and speaks about the kind, positive things that the other parent does for the family. There are many ideas mentioned throughout Part II. At this point, I want to emphasize that attachments are patterns that are usually mutable with supportive co-regulating adults and decreased stress. Therapists are in ideal positions to help with suggestions in these areas.

Supportive therapeutic relationships as a basis for secure attachments

Individual therapy is a classic avenue to move attachments to secure patterns. As clients form attachments to their attuned and empathetic therapists, with therapists bonding in return, clients form abilities to connect and regulate (Siegel, D., 2015).

Therapeutic interventions have included a number of model research-based programs, some of which are briefly described here. For a more thorough discussion, I recommend Chapter 32, in *The Handbook of Attachment* (Berlin, L., Zeanah, C., Lieberman, A., 2016).

Child-Parent Psychotherapy (CPP) or Preschool Parent Psychotherapy (PPP)

This psychanalytic-informed, dyadic model's "principal goals are to help the parent (1) reconnect with the pain, fear, anger and helplessness evoked by frightening childhood experiences and (2) understand his or her current negative feelings toward his or her infant as a reenactment of unresolved conflicts about his or her own parents or other important childhood figures resulting from these frightening experiences. The therapist's empathic guidance is considered the essential ingredient for helping the parents explore their past, practice new parenting behaviors, and free their child from engulfment in the parents' conflicted childhood experiences" (Berlin, L., Zeanah, C., Lieberman, A., 2016, P. 741). A manual for CPP, titled "Don't Hit My Mommy!" explains the program for those interested in reading further (Lieberman, A., Ghosh Ippen, C., van Horn, P., 2015).

A number of research projects show CCP and PPP programs' effectiveness in changing parents' working models of attachment. These studies show decreases in children's behavior problems and increases in maternal empathy, maternal interaction and involvement, dyadic goal-directed partnerships, and lower avoidance (Berlin, L., Zeanah, C., Lieberman, A., 2016). CPP and PPP are effective interventions for children who have been exposed to trauma. Other study findings have shown a decrease in maternal trauma symptomology, an increase in language development in children, and positive effects on cortisol regulation in children (Berlin, L., Zeanah, C., Lieberman, A., 2016).

In describing the intervention, Berlin, Zeanah, and Lieberman describe:

> "The CPP therapist uses play and unstructured interactions as vehicles to promote a goal-corrected partnership, translate the motivations and feelings of the child and the parent toward each other, address trauma reminders, and reframe mutual negative attributions. When this therapeutic focus on the present is not sufficient to promote improvement, the CPP therapist guides the parent into an exploration of her or his childhood experiences that are being reenacted in relation to the child. CPP therapists also provide case management and connect the family to relevant community service when concrete problems of living interfere with the parent's ability to create a safe family environment" (Berlin, L,, Zeanah, C., Lieberman, A., 2016, p. 741).

The success of this intervention is the formation of a relationship between parents and their therapist, followed by the therapist introducing changes in the dyadic relationship. This program is a year-long manualized program with the noteworthy research outcomes. Interestingly, this is about the length of time that many private practice clients spend in therapy on parent-child attachment issues. I included the key tasks in the descriptive paragraph above, since many therapists will be undertaking these activities in their practices, even if they are not part of a CPP or PPP program. They may perform more casework tasks than they would do with other types of families, as occurs in the CPP cases. The therapists are encouraged to develop a trusting relationship with the parent first, followed later by changes in the parent-child relationship (Berlin, L, Zeanah, C., Lieberman, A., 2016).

Circle of Security (COS)

Circle of Security assists at-risk mothers with a developmentally appropriate understanding of their infants' and children's needs. This program uses video tapes of infants and toddlers, helping parents to identify infant's cues and "miscues." It provides information on attachment and autonomy through instruction and clear graphic illustrations. The facilitators help parents to develop sensitivity to children and infants, realizing how much infants and toddlers want their

mother's love and attention. They also work on children's exploration and mastery, helping parents to appreciate their roles as a secure base. A 20-week, group-based version of the program lasts 75-minutes per session. The program shows effectiveness in increasing security of attachment and decreasing the rate of disorganized attachment, even though it does not directly treat children with their parents (Berlin, L, Zeanah, C., Lieberman, A., 2016); Hoffman, K. T., Marvin, R.S., Cooper, G., Powell, B., 2006).

Attachment and Biobehavioral Catch-up (ABC)

ABC supports sensitive parenting of infants and young children in foster care. Knowing that the infants and children often give contradictory or muted cues, the program helps foster parents to understand the needs of abused infants and children and to continue to react in a nurturing and contingent manner. The intervention is a 10-week program for foster parents. The parents in the intervention complete an attachment diary. The infants showed a remarkable rate of movement into secure attachments if their foster parents also had secure attachment states of mind. (Dozier, M., Lindhiem, O., Lewis, E., et al., 2009).

A research project using the ABC model followed 115 children with a history of CPS involvement in infancy. All children were living with a biological parent who was a voluntary participant in the program. Assignment to ABC or control was random. All infants were under two years of age. The goals were three-fold: increasing nurturing during times of distress, decrease frightening parental behavior, increase synchronous interactions. Session 1-2 focused on nurturance, 3-4 on "following the lead," 5-6 on reducing intrusive and frightening behavior, and 7-10 on parents' histories of care and how that influenced their care. The program gave live coaching. They describe a major success factor as being" in-the-moment feedback, with moment-to-moment alterations in parent-child interaction" (Bernard, K., Hostinar, C., Dozier, M., 2015, p. 115). The parents had opportunities to practice new parenting approaches in real-time with their children. Therapists introduced the changes and supported parents as they made those changes.

The control intervention was DEF or Developmental Education for Families, a home-visitation program focusing on parent education about children's motor, cognitive, and language development. They followed up in preschool, when children were between 46 and 67 months. They found that the children in the ABC group showed "a movement toward typical cortisol production, with higher morning levels and a steep decline across the day, whereas children in the control condition exhibited blunted morning levels and flattened diurnal cortisol slopes that are typical in pediatric samples experiencing neglect and more generally in groups experiencing ongoing stress. The results suggest that the intervention was successful in having persistent, long-term effects on the functioning of the HPA stress system. This may have beneficial implications for preventing child psychological and physical health problems, given previous reports linking cortisol disruption to those deleterious child outcomes" (Bernard, K., Hostinar, C., Dozier, M., 2015, pp 114).

Yet another study using ABC is showing better receptive language in children who received the ABC intervention vs. control. They note the responsiveness of parents as the critical factor in the improved language development of children (Bernard, K., Lee, A. Dozier, M., 2017).

I have included these model research programs because they help us to focus on what seems to work best when improving attachment outcomes in children. ABC gives parents many opportunities to practice interactions with their children, with support. The work with ABC, COS, and CPP all emphasize parents' developing theory of mind for their children or infants.

Parents are given someone who cares for them as they care for their children in the ABC and CPP models. CPP and PPP include the practicalities of help for parents with stressors, decreasing the stress and increasing attachment capacity. Those are bright lines that link programs.

Attachment patterns improved through reduced stress and increased support

Other notable programs specifically target attachment security in traumatized or highly stressed children. Among them are Attachment Regulation Competency (ARC) with researchers Margaret Blaustein, Kristine Kinniburgh, and Joseph Spinazzola, and Multidimensional Treatment Foster Care (MDTFC) with Phillip Fisher and collaborating researchers (Kinniburgh, K., Blaustein, M, Spinazzola, J., 2005), (Fisher, P., Gunnar, M., Dozier, M., Bruce, J., Pears, K. 2008). Both of these programs have a goal of improving attachment security in the vulnerable population of foster children. The program includes psychosocial competencies and behavioral contingencies. ARC descriptions includes both attachment and trauma approaches, with a strong emphasis on children's agency and mastery.

I have included MDTFC's program as an example of using direct, psychosocial support along with extra help for foster parents and their use of behavioral contingencies. MDTFC has been extremely effective in improving hormonal (cortisol) levels in children, preparing for school success, and reducing foster care disruptions sharply (Tinienko, J., Fisher, P., Bruce. J., Pears, K, 2010).

When I am working with the highest risk children, I look at the supports of MDTFC, attempting to replicate many of these through existing community programs and my own efforts. Their model includes:

1. 12 hours of specialize instruction for foster parents that includes sensitivity to children, discipline, home structure,
2. 24-hour phone access for foster parents,
3. weekly parenting group meetings,
4. daily telephone contact,
5. weekly skills group for Pre-K children for school readiness
6. transition help to a permanent home that is prepared to use the structure and sensitivity that parents have provided, and skills that children have learned,
7. treatment with a child therapist whose focus was to improve functioning and prosocial skills preschool/daycare and home settings (Tinienko, J., Fisher, P., Bruce, J., Pears, K., 2010).

This model has had success with older children, as well, using treatment foster care as an alternative to residential placement (Fisher, P., Gilliam, K., 2012).

In the MDTFC model, foster parents' cortisol levels were measured. They were strongly correlated to children's externalizing behavior, as seems only logical. After caseworkers provided support for foster parents, they measured cortisol levels again, which dropped. Interestingly, externalizing behaviors in children dropped, as well, even though the parent support did not include children (Fisher, P., Stoolmiller, M, 2008).

The two programs, ARC and MDTFC, are instructive in the use of two factors. First is including adults as co-regulating helpers for parents, and the second is targeting psychosocial factors to increase competency and decrease stress. In describing their theoretical framework:

> "ARC is a Strengths-based model, which emphasizes the importance of building or re-building safe relational systems. In the context of that safe system, the model focuses on skill-building, stabilizing internal distress and enhancing regulatory capacity in order to

> provide children with generalisable skills which enhance resilient outcome. In many ways, the model of ARC mirrors the healthy development that takes place within the normative secure attachment system, in which the safe relationship provides the foundation for healthy outcomes (Blaustein, M., Kinniburgh, K., 2007, p. 49).

These projects use cognitive behavior approaches in tandem with relationship approaches out of the psychodynamic tradition. Readers will note these as co-existing in the case approaches in Part II. I have found value in them both, with benefits for my clients as I use them in a strategic manner. This chapter described some important research-based interventions from both psychoanalytic and cognitive behavior therapy, along with the salient features of these approaches. As clients are moving into extreme hyperarousal or hypoarousal, it can be beneficial to shift away from cognitive behavioral approaches to other therapeutic processes. Being able to move between cognitive and psychodynamic approaches helps therapists to move with their clients' needs. We will discuss the when and how to shift in the upcoming chapters.

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