Attachment and Development Trauma

Assessment and Intervention

Independent Social Work Matters Ltd.

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About this Course

Attachment theory is essential for understanding how human beings function in relationships and how people develop social and psychological difficulties. It is also fundamental for understanding what constitutes psychological wellbeing.

Course aim.

This two course aims to provide an introduction to contemporary attachment theory with a focus on enabling participants to use this knowledge to inform assessments and formulate more effective plans for children

Learning outcomes.

By the end of the course participants will have been given the opportunity to:

1. Understand the importance of attachment theory in assessing the needs of infants and children and why and how the quality of attachment may impact on a child's development
2. Consider advances in neuroscience and how these have deepened our understanding of the way that the brains of infants and children develop
3. Understand how attachment patterns develop and ways in which we may recognise these
4. Have an overview of the Dynamic Maturational Model of Attachment and Adaptation (DMM);
5. Understand how the developmental pathways lead to the various insecure strategies (The 'ABC' model of attachment); The characteristics associated with the A, B and C strategies;
6. Understand how the behaviour of children and adults can be best understood when we focus on the function of the behaviour rather than the surface appearance of the behaviour;
7. Understand how attachment theory strongly signals the importance of relationship-based practice as being a key feature of successful assessment and intervention
8. Consider a range of tools that may be used to assess the pattern of attachment for individual children and their parents and carers
9. Identify how an understanding of the attachment experiences of children and adults can inform assessments and assist in developing effective plans.

Programme: Day 1

9.30am Introductions and learning outcomes

Danger & Emotional Regulation

11.00am ***Break***

11.30am Applying the learning to practice

Baby Cues and Mentalisation

1.00pm. ***Lunch***

1.45pm Still Face Experiment

Observing accurately to reframe understanding

Reframing language with an attachment perspective

3.00pm ***Break***

3.15pm Developing an attachment informed intervention plan

4.30pm Close

Programme: Day 2

9.30am Reflection on learning from Day 1

Patterns of Attachment and Information Processing

The A, B, C Model of Attachment

11.00am ***Break***

11.15am The Neurobiology of Attachment

Trauma

12.45pm. ***Lunch***

1.30pm What's my strategy and why does it matter?

Self-awareness and its importance to relationship based practice

3.00pm ***Break***

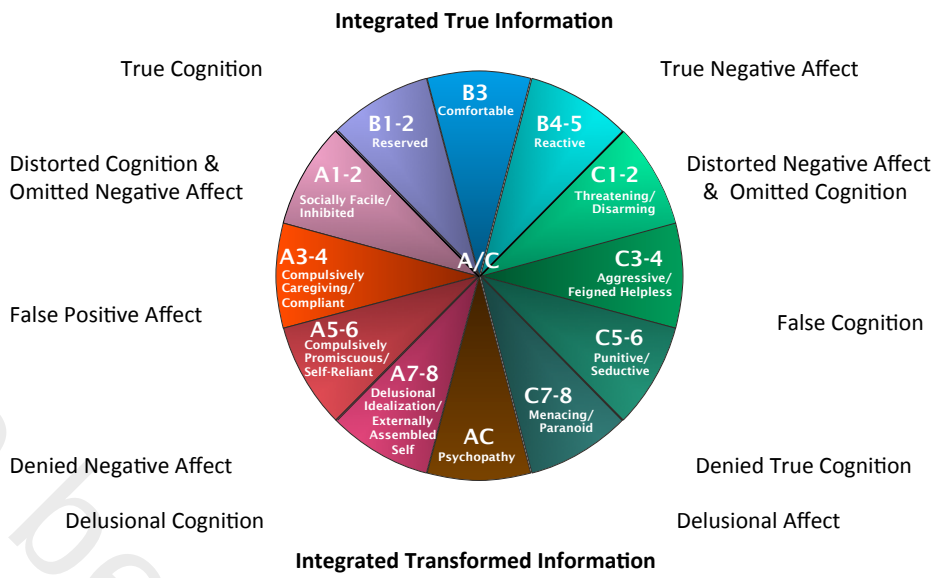
3.15pm Case Study: Life river exercise

Developing an intervention plan using an attachment based perspective

Embedding the learning

Course review and evaluation

4.30pm Close



Dynamic-Maturational Model Self-Protective Strategies

Patricia M.Crittenden, Ph.D.

The descriptions below accompany and elaborate the circular model of self-protective strategies.

Type B strategies integrate cognitive and affective information in a balanced and flexible manner.

B3: The Type B strategy involves a balanced integration of temporal prediction with affect. Individuals using the Type B strategy show all kinds of behaviour, but are alike in being able to adapt to a wide variety of situations in ways that are self-protective, partner-protective, and progeny-protective. As often as possible, they cause others no harm. They communicate directly, negotiate differences and find mutually beneficial compromises. They distort information very little, especially not to themselves. They display a wider range of individual variation than people using other strategies-who must constrain their functioning to employ their strategy. This strategy functions in infancy. By adulthood, two sorts of Type B strategies can be differentiated. Naïve B's simply had the good fortune to grow up safe and secure. Mature B's, on the other hand, 1) have reached neurological maturity (in the mid-30's), 2) function in life's major roles, e.g., child, spouse, parent, and 3) carry out an on-going process of psychological integration across relationships, roles and contexts. Where naïve B's tend to be simplistic, mature B's grapple with life's complexities.

B1-2: Individuals assigned to B1-2 are a bit more inhibited with regard to negative affect than B3s, but are inherently balanced.

B4-5: Individuals assigned to a B4-5 exaggerate negative affect a bit, being sentimental (B4) or irritated (B5), but are inherently balanced.

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Type A strategies emphasise cognitive contingencies while inhibiting display and awareness of feelings.

A1-2: The A1-2 strategy uses cognitive prediction in the context of very little real threat. Attachment figures are idealised by over-looking their negative qualities (A1) or the self is put down a bit (A2). Most A1-2s are predictable, responsible people who are just a bit cool and business like. Type A strategies all rely on inhibition of feelings and set danger at a psychological distance from the self. This strategy is first used in infancy.

A3: Individuals using the A3 strategy (compulsive caregiving, cf., Bowlby, 1973) rely on predictable contingencies, inhibit negative affect and protect themselves by protecting their attachment figure. In childhood, they try to cheer up or care for sad, withdrawn and vulnerable attachment figures. In adulthood, they often find employment where they rescue or care for others, especially those who appear weak and needy. The precursors of A3 and A4 can be seen in infancy (using the DMM method for the Strange Situation) but the strategy only functions fully in the preschool years and thereafter.

A4: Compulsively compliant individuals (Crittenden & DiLalla, 1988) try to prevent danger, inhibit negative affect and protect themselves by doing what attachment figures want them to do, especially angry and threatening figures. They tend to be excessively vigilant, quick to anticipate and meet others' wishes, and generally agitated and anxious. The anxiety, however, is ignored and downplayed by the individual and often appears as somatic symptoms that are brushed aside as being unimportant.

A5: A5 individuals use a compulsively promiscuous strategy (Crittenden, 1995) to avoid genuine intimacy while maintaining human contact and, in some cases satisfying sexual desires. They show false positive affect, including sexual desire, to little known people, and protect themselves from rejection by engaging with many people superficially and not getting deeply involved with anyone. This strategy develops in adolescence when past intimate relationships have been treacherous and strangers appear to offer the only hope of closeness and sexual satisfaction. It may be displayed in a socially promiscuous manner (that doesn't involve sexuality) or, in more serious cases, a sexual promiscuity.

A6: Individuals using a compulsive self-reliant strategy (Bowlby, 1980) do not trust others to be predictable in their demands, find themselves inadequate in meeting the demands or both. They inhibit negative affect and protect themselves by relying on no one other than themselves. This protects the self from others, but at the cost of lost assistance and comfort. Usually this strategy develops in adolescence after individuals have discovered that they cannot regulate the behaviour of important, but dangerous or non-protective caregivers. They withdraw from close relationships as soon as they are old enough to care for themselves. There is a social form of the strategy in which individuals function adaptively in

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social and work contexts, but are distant when intimacy is expected, and an isolated form in which individuals cannot manage any interpersonal relationship and withdraw as much as possible from others.

A7: Delusionally idealising individuals (Crittenden, 2000) have had repeated experience with severe danger that they cannot predict or control, display brittle false positive affect and protect themselves by imagining that their powerless or hostile attachment figures will protect them. This is a very desperate strategy of believing falsely in safety when no efforts are likely to reduce the danger (cf., the "hostage syndrome"). Paradoxically, the appearance is rather generally pleasing, giving little hint of the fear and trauma that lie behind the nice exterior until circumstances produce a break in functioning. This pattern only develops in adulthood.

A8: Individuals using an A8 strategy (externally assembled self, Crittenden, 2000) do as others require, have few genuine feelings of their own, and try to protect themselves by absolute reliance on others, usually professionals who replace their absent or endangering attachment figures. Both A7 and A8 are associated with pervasive and sadistic early abuse and neglect.

Type C strategies emphasise feeling states in contexts where contingencies are complex of information is ambiguous or incomplete.

C 1-2: The C 1-2 (threatening-disarming) strategy involves both relying on ones own feelings to guide behaviour and also using somewhat exaggerated and changing displaying negative affect to influence other people's behaviour. Specifically, the strategy consists of splitting, exaggerating, and alternating the display of mixed negative feelings to attract attention and manipulate the feelings and responses of others. The alternation is between presentation of a strong, angry invulnerable self who blames others for the problem (C1, 3, 5, 7) with the appearance of a fearful, weak, and vulnerable self who entices others to give succorance (C2, 4, 6, 8). C1-2 is a very normal strategy found in people with low risk for mental health problems and a great zest for life. Infants display the C1-2 strategy.

C3-4: The C3-4 (aggressive-feigned helpless) strategy involves alternating aggression with apparent helplessness to cause others to comply out of fear of attack or assist out of fear that one cannot care for oneself. Individuals using a C3 (aggressive) strategy emphasise their anger in order to demand caregivers' compliance. Those using the C4 (feigned helpless) strategy give signals of incompetence and submission. The angry presentation elicits compliance and guilt in others, whereas vulnerability elicits rescue. The precursors of this strategy can be seen in infancy (using the DMM method for the Strange Situation), but the strategy only functions fully in the preschool years and thereafter.

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C5-6: The C5-6 strategy (punitively obsessed with revenge and/or seductively obsessed with rescue) is a more extreme form of C3-4 that involves active deception to carry out the revenge or elicit rescue. Individuals using this strategy distort information substantially, particularly in blaming others for their predicament and heightening their own negative affect; the outcome is a more enduring and less resolvable struggle. Those using a C5 (punitive) strategy are colder, more distant and self-controlled, and deceptive than people using C3. They appear invulnerable and dismiss other people's perspectives while forcing others to attend to them while misleading others regarding their inner feeling of helplessness and desire for comfort. Individuals using the C6 (seductive) strategy give the appearance of needing rescue from dangerous circumstances that are, in fact, self induces. C6 individuals mislead others regarding their anger. This alternating pattern is often seen in bully-victim pairs, within gangs, and in violent couples where the hidden half of the pattern is usually forgotten or forgiven-until the presentation reverses. This strategy develops during the school years, but does not fully function fully until adolescence.

C7-8: C7-8 (menacing-paranoid) is the most extreme of the Type C strategies and involves a willingness to attack anyone combined with fear of everyone. Type C strategies all involve distrust of consequences and an excessive reliance on ones own feelings. At the extreme, this pattern becomes delusional with delusions of infinite revenge over ubiquitous enemies (a menacing strategy, C7) or the reverse, paranoia regarding the enemies (C8). These two strategies do not become organised before early adulthood.

Type A/C strategies alternate or blend Type A and Type C strategies.

A/C: A/C strategies combine any sub-patterns. In practice, most A/C's consist of the more distorted patters, i.e., A3-4 or higher and C3-4 or higher. Individuals using these strategies display either very sudden shifts in behaviour (A/C) or, in the case of the blended strategies (AC), they show very subtle mixing of distortion and deception. The extreme of the blended form is psychopathy.

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Nb. Remember that there will be many explanations for behaviour….your job is to hypothesise about what the behaviours *might* mean and link it to your understanding of the child's developmental history…

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SIGNS OF DEVELOPMENTAL TRAUMA AT HOME & SCHOOL

When children experience early loss, separation, abuse or neglect their brain development is affected in significant ways. They often experience what is known as Developmental Trauma, which means their development has gone off track and they cannot behave, feel, relate and learn like other children their age. Developmental Trauma can be repaired with a holistic, 'bottom up' approach; with safe and sensitive relationships with adults being central.

SIGNS OF SENSORY PROBLEMS AT HOME

- Strong dislike for certain foods & textures
- Strong dislike for touching or overly tactile
- Sucking, biting, chewing to self-sooth
- Avoidance of routines such as tooth brushing
- Jumpy, restless and alert, even when safe
- Difficulty knowing when they are hot/cold; hungry/full or when they need the toilet

SIGNS OF SENSORY PROBLEMS AT SCHOOL

- Difficulty with concentration & attention
- Overwhelmed by noisy busy classrooms
- Difficulty throwing and catching a ball
- Difficulty with co-ordination and balance
- Poor handwriting and pencil grip
- Shutting down/zoning out frequently throughout the day

SIGNS OF ATTACHMENT INSECURITY AT HOME

- Avoidance of emotional intimacy or emotionally over-spilling
- Feeling 'hard to reach', emotions are bottled up and the child is hard to read
- The parent/carer feels exhausted with the unrelenting demands, crises and emotional needs of the child.
- Boundary setting can trigger a big reaction or non-compliance in child
- Episodes of distress or anger last much longer than expected
- Separations trigger anxiety or anger in the child
- The child is controlling of his/her parents and siblings

SIGNS OF ATTACHMENT INSECURITY AT SCHOOL

- Difficulties processing new information
- Under performance or over-dependence on academic perfection
- Difficulties planning, organising and completing tasks
- Struggles with transitions, loss and change
- Big reactions or zoning out for reasons not obvious to others
- Difficulties in friendships
- Find it hard to ask for help or the child is always needing help
- Over compliance or disruptive behaviour in class

SIGNS OF EMOTIONAL DYSREGULATION AT HOME

- Prolonged meltdowns over small things
- Lots of arguments as the child cannot see things from their parents' perspective
- Very limited empathy for others
- Frequent child to parent violence
- Tearfulness and clingy behaviours at separation
- Bedtime routine is prolonged and painful
- In teens – self harming, drug use, promiscuity

SIGNS OF EMOTIONAL DYSREGULATION AT SCHOOL

- Outbursts of anger or distress at small events such as a change in activity
- Immaturity in friendships – jealousy, possessiveness, struggles to share
- Too emotional to take on board new learning
- Tearfulness and anxiety at drop off
- Over-dependence on adults
- Rule breaking
- Aggression, running off and hiding

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Nb. Remember that many of us in the room will have an ACE score of 4 or more. Exposure to danger isn't equivalent to trauma. If young people had safe and supportive parents then they are likely to have had the resources to overcome the challenges of the adverse experience (resilience & learning to safeguard themselves in the future). If not then this is what produces toxic stress….

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Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

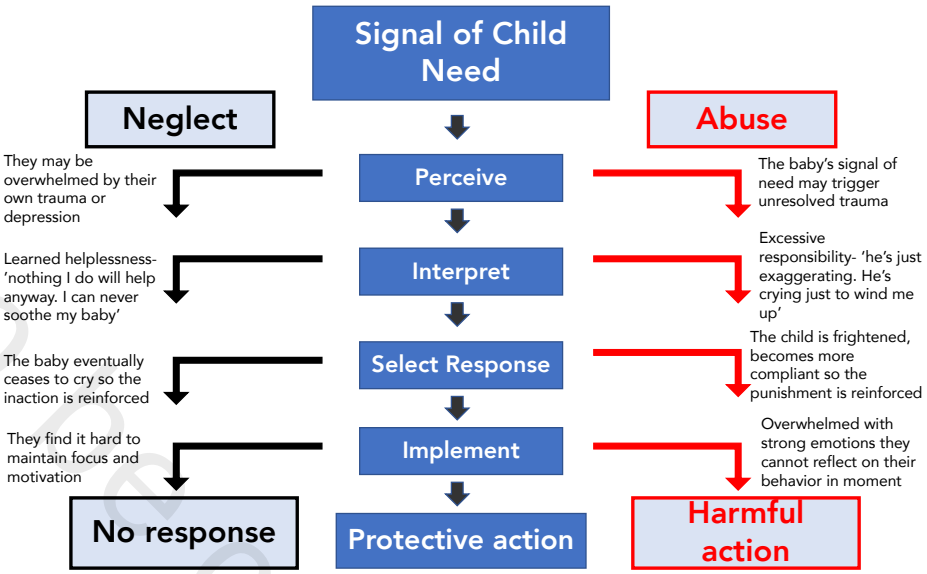
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Information Processing: Neglect & Abuse



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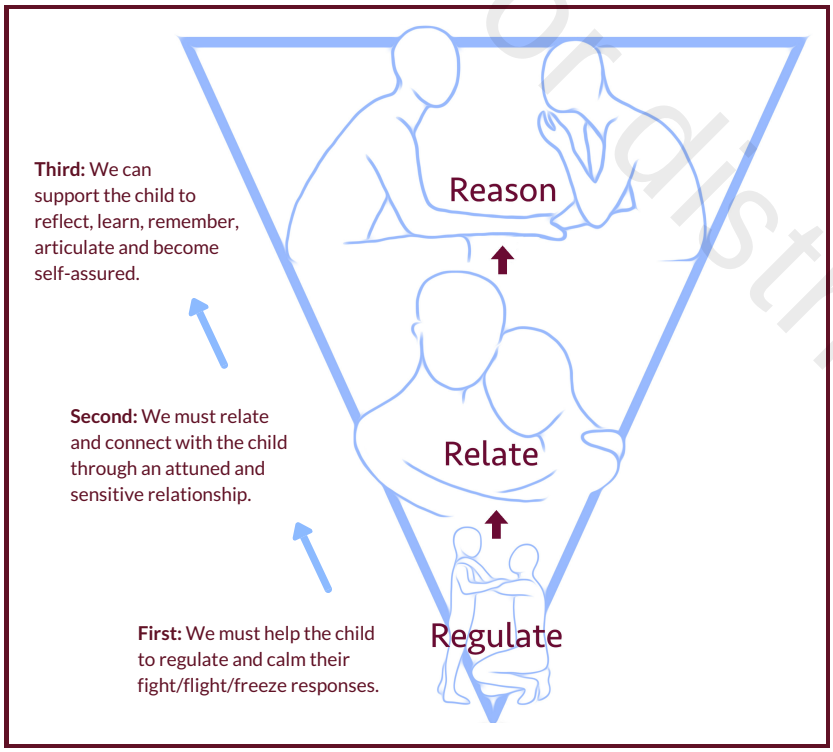
The Three R's: Reaching The Learning Brain

Dr Bruce Perry, a pioneering neuroscientist in the field of trauma, has shown us that to help a vulnerable child to learn, think and reflect, we need to intervene in a simple sequence.



Heading straight for the 'reasoning' part of the brain with an expectation of learning, will not work so well if the child is dysregulated and disconnected from others.

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Child Communication Cues Here is a complete list of engagement and disengagement cues both potent and subtle. It is interesting to note that the number of disengaging cues far exceed the number of engaging cues we in our behavioural repertoire.

Engagement Cues		***Disengagement Cues***	
Potent	**Subtle**	**Potent**	**Subtle**
Babbling Facing Gaze Feeding sounds Giggling Mutual gaze Mutual smiling Reaching toward caregiver Smiling Smooth cyclic movements Talking Turning head to caregiver	Brow raising Eyes wide and bright Facial brightening Feeding posture Hands open, fingers slightly flexed Head raisin Hunger posture Immobility	Back arching Choking Coughing Crawling away Cry face Crying Fussing Halt hand Lateral head shake Maximal lateral gaze aversion Overhand beating movement of arms Pale/red skin Pulling away Pushing away Saying "no" Spitting Spitting up Tray pounding Vomiting Walking away Whining Withdraw from alert to sleep state	Arms straightened along sides Cling posture Diffuse body movement Dull-looking face/eyes Eye blink Eyes clinched Facial grimace Fast breathing Finger extension Frown, brow lowering Gaze aversion Hand-behind-head Hand-to-back-of-neckHand-to-ear Hand-to-eye Hand-to-mouth Hand-to-stomach Head lowering Hiccups Hunger posture Immobility Increase in sucking noise Increased feet movement Increased sucking movements Join hands Leg kicking Legs straightened with tension Lip compression Lip grimace Looking away Pout Pucker face Rapid wrist rotation Self clasp Shoulder "shrug" Sobering Tongue show Turning head Ugh face Whimpers Wing Palm Wrinkles forehead Yawn

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Getting to know one another

Getting to know your new baby takes time and by watching their signals and cues you can begin to work out what it is they like and don't like and what they need.

What are baby cues?

Baby's reactions may look random but every movement maybe a cue or communication. For example, squirming or pulling away may be a sign that he doesn't like having his face wiped. He may be still, quiet and watch intently if something interests him.

Babies can't think like older children, but they do experience strong feelings and bodily sensations. They are very sensitive to their environment, the people around them, the sounds, smells and emotions in the room. Just think about the urgency in a newborn baby's hunger cry! It can feel as if his world is falling apart. As baby gets older he will feel safer because he knows his needs will be met and then he will be able to wait for a short time.

Taking some time to just to watch and wonder

The key to understanding baby's language is taking the time to watch. In the busy rush of everyday life, it is easy to miss baby's subtle cues.

Every now and again take a little time to just watch your baby's behaviour and wonder what is going on for him? What might he be feeling behind the behaviour that you can see? Babies are learning all the time and love hearing your voice, so wonder out loud! Sharing your thoughts out loud by saying things like "*I am just wondering if you are hungry or you need an extra cuddle?*" will convey the feeling to baby that you are trying to work it out.

Use the sleep wake / states to give you confidence

Knowing what sleep or wake state your baby is in will really help you puzzle out what he needs. You will notice he can only do things when he is in the 'right' state so, for example, he won't want to feed when he is in the drowsy state, and he won't want to play when he is crying. He will only want to smile and coo when he is in the quiet alert state.

Born ready to connect

We are all born to relate to one another and right from birth baby will be able to recognise your voice and he will enjoy fleetingly looking at your face and, after a few weeks, he will gaze for longer. Parents and babies can't be connected all the time though! That would be overwhelming for baby and exhausting for you. Baby will connect for a short time - then need to look away. Give him time to engage again when he is ready. Being connected is not all about face-to-face interaction though. Touch and movement are important and being held close helps baby feel safe.

Getting the pace right

Every baby is different and each day baby will have his own pattern and will move through the sleep wake states many times. Watching baby's cues and signals will help you to get the pace right so you can meet his needs more easily. This does take time though – it doesn't all happen straightaway and some babies do cry a lot at first.

Getting the interaction right for your baby at different times of the day.

Start by thinking what sleep/wake state your baby is in. Then take another few seconds and ask yourself the following questions:

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Is this interaction too much for my baby at this time?

Babies naturally move from having fun to finding it all too much. Watch for signs:

- Baby may look away for a time. Hold him so he can look away when he wants. Give him time to look away – he will either come back to look again or may move into a different sleep/wake state.
- Don't be disappointed if he looks away - it is the way babies manage their emotional arousal.
- When it is all too much babies sometimes sneeze, yawn, hiccup, bring up a little milk, their skin tone pales or deepens because they need to change state.
- Some babies get overwhelmed quickly so slow the pace, watch and wait for baby's cues before responding

Is this interaction too little for my baby at this time?

Some babies may make fewer demands and may need more attention and take time to engage in play:

- Watch you baby carefully and notice what special things he likes.
- Give lots of cuddles and notice if he has a favourite cuddling position?
- Talk to him slowly and warmly and make eye contact and watch, wait and notice his responses.
- Don't rush him, give him your warmth and attention while he discovers things himself.
- Try singing along with music or learn some nursery rhymes and watch his reactions.
- At first he will enjoy just being close to you and having time to watch your face.
- When he is a few months old he will enjoy sitting on your knee and looking at a baby picture book with you.
- Watch his responses and wonder what he might be feeling.
- Think how you are feeling. It's harder to engage in fun interactions if you are feeling low. Don't try to battle through on your own. Tell your health visitor who will make sure you get some support.

Is this interaction just right for my baby at this time?

Only a small part of interaction is face to face (see quiet alert state). Babies feel safe by being against your body, feeling your warmth and hearing your heartbeat and gentle voice. When baby is in the quiet alert state:

- Find a comfortable position for you both and give him time and enough space to gaze at your face. The distance from your face to your lap is usually perfect!
- Wait until baby looks interested then speak slowly and warmly.
- Take a very short turn and watch and wait for baby's response –at first he will watch and after a few weeks baby will vocalise back.
- Baby will become skilled at conversational turn taking - learning a very important skill about how we take turns in conversation – so give him lots of time.
- Don't feel disappointed when baby needs to look away – it is one way he can manage his emotional arousal. Give time for baby to look again when they are ready. Talk to your health visitor about interactions with your baby.

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Observing Interaction Handout

Watch the interaction carefully

1. What sleep/wake state was the baby in?
2. Was this interaction too much, too little or just right for this baby at this time?
3. How would you describe the baby's experience? If you were the baby how would you feel?
4. Did the adult give space and time to encourage the baby's initiative?
5. Was there eye contact between them? Too much, too little or just right?
6. Did the baby become overwhelmed? Was he able to look away and come back in his own time (rupture and repair)?
7. How was the adult able to help the baby regulate his emotions?
8. How did the baby respond to the touch? Notice if the parent kissed the baby and how the baby responded.
9. What voice tones were used by adult and baby? Was there reciprocity (turn taking)?
10. What was the baby's posture and muscle tone like?
11. Were the mother and baby well positioned for play?
12. What do you imagine the mother might be feeling?
13. Check your observation against the attunement principles. How many apply?
14. Can you pick one authentic attuned moment that you can build upon?

Being attentive	• Looking interested • Turning towards • Friendly intonation and posture • Giving time and space for other • Wondering about what they are doing, thinking or feeling
Encouraging initiatives	• Waiting • Listening actively • Showing emotional warmth through intonation • Naming positively what you see, hear, think or feel • Naming what you are doing, hearing, thinking or feeling • Looking for initiatives
Receiving initiatives	• Showing you have heard, noticed the other's initiative • Receiving initiative with friendly body language • Returning eye-contact, smiling, nodding in response • Receiving what the other is saying or doing with words • Repeating / using the other's words or phrases

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WHAT TO LOOK FOR IN ASSESSING ATTACHMENT

Birth to one year

Does the child ….?

appear alert?

respond to humans?

show interest in the human face?

track with his/her eyes?

vocalise frequently?

exhibit expected motor development?

enjoy close physical contact?

exhibit discomfort?

appear to be easily comforted?

exhibit normal or excessive fussiness?

appear outgoing or is passive and withdrawn?

have good muscle tone?

Does the parent(s) ….?

respond to the infant's vocalisations?

change voice tone when talking to the infant or about the infant?

show interest in face-to-face contact with the infant?

exhibit interest in and encourage age appropriate development?

respond to the child's indications of discomfort?

show the ability to comfort the child?

enjoy physical contact with the child?

initiate positive interactions with the child?

identify positive or negative qualities in the child that remind the parent of another family member?

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WHAT TO LOOK FOR IN ASSESSING ATTACHMENT

One to five years

Does the child ….?

explore the environment in a normal way?

respond to parent(s)?

keep occupied in a positive way?

seem relaxed and happy?

have the ability to express emotions?

react to pain and pleasure?

engage in age-appropriate activity?

use speech appropriately?

express frustration?

respond to parental limit setting?

exhibit observable fears?

react positively to physical closeness?

respond appropriately to separation from parent?

respond appropriately to parent's return

exhibit body rigidity or relaxation?

Does the parent(s) ….?

use appropriate disciplinary measures?

show interest in child's development?

respond to child's overtures?

encourage physical closeness with the child?

comfort the child in a positive way?

initiate positive interactions with the child?

accept expressions of autonomy?

see the child as 'taking after' someone? is this positive or negative?

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WHAT TO LOOK FOR IN ASSESSING ATTACHMENT

Primary School Children

Does the child ….?

behave in a way which reflects a liking for him or herself?

appear proud of achievements?

share?

perform well academically?

always test limits?

try new tasks?

react realistically to making a mistake?

Does the child show, fear, anger or acceptance?

have the ability to express emotions?

establish eye contact?

exhibit confidence in own abilities or does he or she frequently say 'I don't know'?

appear to be developing a conscience?

move in a relaxed way or is there body rigidity?

feel comfortable speaking to adults?

smile easily?

react to parent(s) being physically close?

have positive interactions with siblings and/or peers?

appear comfortable with his or her sexual identification?

Does the parent(s) ….?

show interest in child's school performance?

accept expression of negative feelings?

respond to child's overtures?

give support to the child in terms of developing healthy peer relationships?

handle problems between siblings equitably?

initiate affectionate overtures

use appropriate disciplinary measures??

assign age appropriate responsibilities to the child?

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WHAT TO LOOK FOR IN ASSESSING ATTACHMENT

Adolescence

Does the child ….?	*Does the parent(s) ….?*
aware of his or her strong points?	set appropriate limits?
aware of his or her weak points?	encourage appropriate autonomy?
developing interests outside the home?	trust the adolescent?
comfortable with his or her sexuality?	Trust the adolescent?
engage in positive peer interactions?	show interest in and acceptance of adolescent's friends?
perform satisfactorily in school?	display interest in adolescent's school performance?
exhibit signs of conscience development?	exhibit interest in adolescent's outside activities?
free from severe problems with the law?	have reasonable expectations of chores and/or responsibilities adolescents should assume?
accept and/or reject parents' value system	stand by the adolescent if he or she gets into trouble?
keep occupied in appropriate ways?	show affection?
comfortable with reasonable limits or is he or she constantly involved in control issues?	think the child will 'turn out' ok?

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Name it to Tame it

When children, young people or adults we work with have tantrums or behave in ways that are difficult, our first response is often to try to stop the behaviour. With "name it to tame it", we try to first of all understand what feelings are underneath the behaviour. By just describing the feelings people usually feel calmer and listened to, and their behaviour changes. So instead of just responding to the behaviour, you respond to the feeling underneath the behaviour. Use this table to think about different ways of responding:

	Child, Young person or Parent says or does…	Worker responding to just behaviour	Worker responding to the feeling underneath the behaviour
Name it to Tame it			

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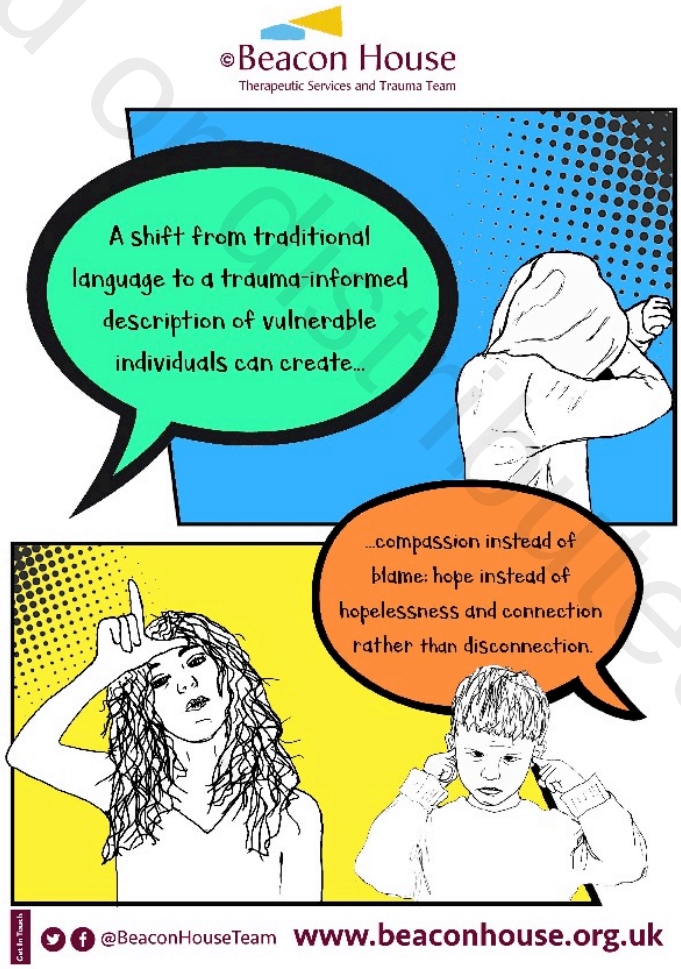

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The Neurobiology of Attachment

Our brains are made up of three interconnecting brains, each with some particular functions:

1. Core reptilian brain
2. Lower mammalian brain
3. Higher human brain, all connected by a massive network of nerves, but each with its own special functions

The reptilian brain is the most ancient part of the brain, largely unchanged by evolution and shared with all other vertebrates. The reptilian brain activates instinctive behaviour related to survival and controls essential bodily functions required for sustaining life, including: hunger, digestion/elimination, breathing, circulation, temperature, movement, posture and balance, territorial instincts, fight of flight

The mammalian brain also known as the emotional brain, the lower brain or the limbic system has almost the same chemical systems and structure as in other mammals such as chimps. It triggers strong emotions that need to be managed well by the rational brain. It also helps to control primitive fight or flight impulses. This part of the brain activates: rage, fear, separation distress, caring and nurturing, social bonding, playfulness, explorative urge, lust in adults

The rational brain, also known as the frontal lobes of the neo cortex. Amounts to 85% of the total brain mass and envelopes the ancient mammalian and reptilian parts. It is on the frontal lobes of a child's brain that emotionally responsive parenting has a dramatically positive impact. Its functions and capacities include: creativity and imagination, problem solving, reasoning and reflection, self-awareness, kindness, empathy and concern. This part of the brain has led to the greatest achievements of humans but when cut off from the mammalian brain's social emotion systems, it is also responsible for appalling cruelties.

The adolescent brain:

- Brain continues to develop through adolescence into the twenties and thirties
- One of the brain regions that develops most in adolescence is the pre-frontal cortex
- Limbic system (information processing and reward processing.) is hyper sensitive to risk taking in adolescence. Pre-frontal cortex not yet developed enough to mediate the desire to take risks. Driven to become independent from parents and impress their friends
- Reframing opportunity: Adolescence is an excellent opportunity for education and social development vs. problem to be survived

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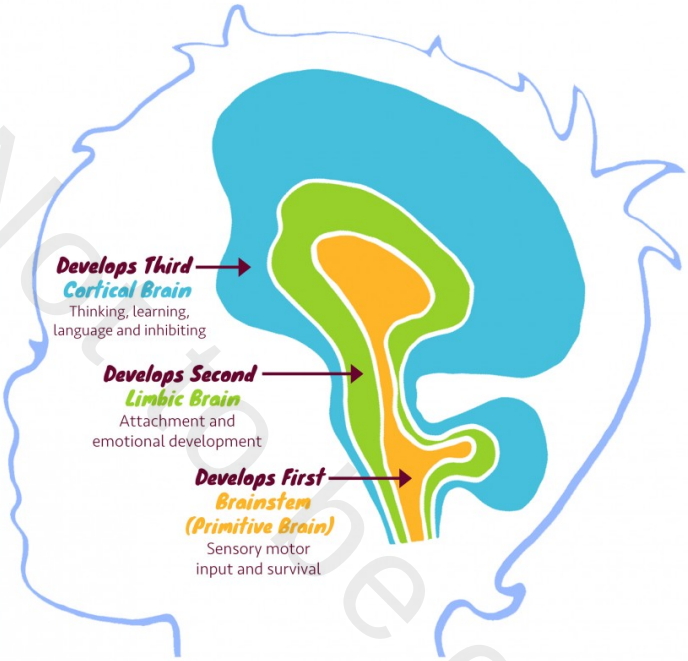

Children's brains develop from the bottom up.

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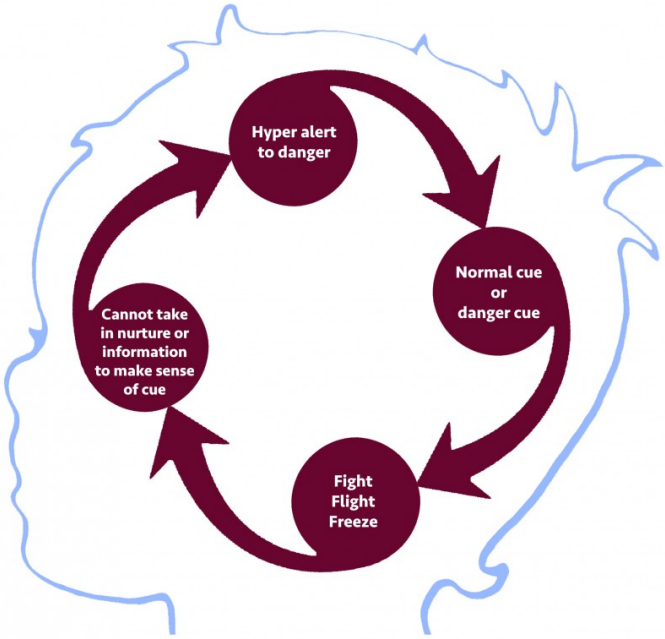
Survival Loop



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School

The Neuro Sequential Model of Therapy

Building from the bottom up

Integration

THIRD FOUNDATION

Working with the cortical brain to:
- Develop the child's sense of identity
- Make sense of the child's life story
- Strengthen reciprocal relationships

Interventions:
- Family therapy
- Therapeutic Life Story Work
- Creative Arts Therapy
- Psychotherapy - EMDR, MBT
- DDP
- Drama therapy

SECOND FOUNDATION

Working with the limbic brain to:
- Build the bonds of attachment
- Support parents to co-regulate and mentalize
- Process traumatic memories
- Enable the parent/carer to regulate their own emotions

Interventions:
- DDP
- Theraplay
- Therapeutic parenting
- Parent-child Psychotherapy
- Video Interaction Guidance
- EMDR, drama & movement therapy

FIRST FOUNDATION

Working with the primitive brain to:
- Regulate the child's fight/flight freeze/submit survival systems.
- Develop co-regulation between the child & adult
- Disarm child's survival response in school
- Enable the parent/carer to regulate their own emotions

Interventions:
- Sensory Attachment Intervention
- Stabilise the school environment
- Systemic intervention with school and home
- Therapeutic parenting
- EMDR, drama & movement therapy

Child's Development

Therapy

Wider Network

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Parents / Carers

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Developmental Trauma

Brain Area:
Brainstem (Primitive Brain)

Developmental Trauma:
1. Somatic/Sensory

Examples:
- Sensory processing difficulties
- High or low arousal (fight/flight/freeze/submit)
- Impulsivity and pervasive anxiety
- Impaired sleep patterns
- Poor muscle tone and co-ordination
- Taste and texture preferences
- Heart rate difficulties
- Abnormal breathing
- Unexplained medical symptoms
- Body flashbacks to states of fear

Moves up to

Brain Area:
Limbic Brain

Developmental Trauma:
2. Attachment
3. Emotional regulation
4. Behavioural regulation

Examples:

Attachment
- Clinging
- Oppositional
- Rejecting
- Distrustful
- Overly compliant
- Loss of expectancy of protection by others
- Loss of trust in social agencies

Emotional Regulation
- Heightened emotions: anger, rage, fear, sadness, excitement, joy
- Deadened emotions: numbness, emptiness, low mood

Behavioural Regulation
- Re-creating traumatic situations
- Self-harming
- Aggression
- Running
- Hiding

Moves up to

Brain Area
Cortical Brain

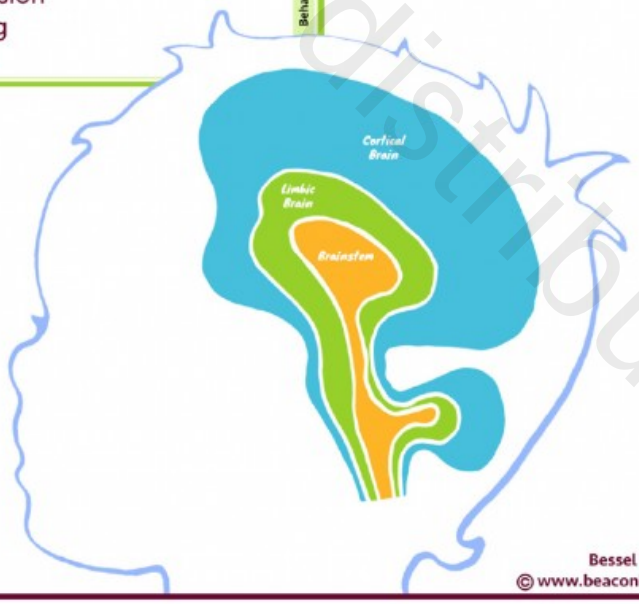
Developmental Trauma
5. Self esteem
6. Dissociation
7. Cognitive problems

Examples

Cognitive problems
- Information processing impairments
- Executive dysfunction (problems in planning, organising and executing)
- Inadequate problem solving
- Remembering and recalling information

Dissociation
- Identity confusion
- Flashbacks
- Disorientation
- Memory lapses

Self esteem
- Self hate
- Self blame
- Self loathing
- Self doubt
- Worthlessness
- Helplessness



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An Introduction to the ABC patterns of Attachment

Secure: Parents are interested in and alert to infant's state of mind-are anxious to understand their child and to be understood by them ➔child develops an internal model of the self as loveable and psychologically intelligible➔child will mentally represent others as potentially interested available and responsive at times of need➔at times of stress the child will have a positive view of others as a resource

Insecure A: Parents feel anxious and irritated when the child makes emotional demands and will distance themselves when child signals distress. Rather than attempt to understand the child-will impose their view of what a "good child" is➔child adapts to rejecting caregiver by downplaying (over-regulating) negative emotions-children get most attention when hey behave in the way the parent wants them to behave (Compulsive A)➔Intimacy will be avoided➔when stressed will feel anxious-has not learnt how to elicit sensitive care and protection

Insecure C: Under involved carers-more interested in whether child loves them than in the child's needs-slow to respond to distress➔child increases displays of distress to overcome caregiver's insensitivity-feels angry that parental care cannot be taken for granted-seems to be no relationship between their behaviour and whether the carer will respond (coercive)➔child can become distressed at being left alone, poor concentration, moody. Tries to control other people's unpredictability through coercive behaviour ➔others give up, confirming fear that others let you down

Disorganised (in ABC+D model) A/C or A+ & C+ in DMM: When carer is source of fear-highly organised strategy to deal with it➔if parents are rejecting and physically abusive➔compulsively compliant or if parents needy/unable to look after themselves➔compulsive caregiving. If parents abusive and neglectful ➔child seeks to be in control rather than be controlled➔bossy aggressive, violent self abusive

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Four aspects of the 'A' strategy

Functions of the strategy for the person	**Cognitions or pre-conscious mental 'rules'** (normative to endangering)	**Behaviours** (normative to endangering)	**The 'story' that accompanies the 'A' strategy** (normative to endangering)
Over-regulate/control own negative emotions and **deactivate** attachment behaviours in order to…..	Be good.	Superficial/socially facile/ people-pleasing	I didn't need comfort-everything was fine
increase attachment figure's acceptance, proximity and responsiveness, via…	Follow the rules	Inhibited/ withdrawn	My childhood was perfect, but don't ask me for examples
	I'm responsible	Compulsive care-giving	There was a problem in my childhood but my parents were not to blame
compliance, care-taking or self-sufficiency Plus: Use self-representations that self is **strong** and **invulnerable,** and **defensively exclude** internal world (feelings and emotions) in order to…	Don't ask, don't challenge, don't feel. (Feelings are dangerous)	Compulsive compliance	I solved the problems because I looked after my parents or by being such a good boy/girl
	You can't hurt me/I don't need comfort/This is just business/Just sex	Compulsive social or sexual promiscuity (can lead to emotionally callous behaviour)	There were problems and my parents were lousy, but I left home and decided I could go it alone
avoid negative emotions that create discomfort	I don't need other people/Do as I say and don't cause me to feel uncomfortable emotions	Compulsive self-reliance (can lead to bullying/ controlling behaviour to minimise and avoid negative feelings)	There were serious problems, but I protected myself by anticipating every danger (because no-one else was there to protect me)

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Four aspects of the 'C' strategy

Functions of the strategy for the person	**Cognitions or pre-conscious mental 'rules'** (normative to endangering)	**Behaviours** (normative to endangering)	**The 'story' that accompanies the 'C' strategy** (normative to endangering)
Hyper-activates attachment behaviour via…..	Feelings rule, and I am angry!	Threatening	I cannot predict other people's behaviour or control my own
exaggerating 'poor me' feelings (cry, whine etc.) or anger in order to…	It's not my fault. Things happen to me	Dismissing/sulking/ clingy/coy	Let me tell you everything I can think of. It's too complicated, so I cannot draw conclusions about responsibility
increase attachment figure's predictability, and **availability**	Pay attention to me or else I will….	Aggressive/ coercive	There was a problem and my parents are to blame
whilst feeling **resentful** at attachment figure's unpredictability	Look after me or I will be hurt by….	Feigned helpless	I am angry/helpless because I am still waiting for them to fix it
Plus:	How dare you….	Punitive/defiant/ oppositional	Other people can't help me, or they hurt me and must be punished (including you)
Anxious that attachment figure will withdraw, but **resists comfort and so…** remains in **under-regulated, emotionally aroused** state and… **cognitively** disconnects: no link between attachment figure, words and actions	Don't hurt me….	Seductive/bullied	Here is a pseudo-problem that I want you to struggle with (not the real problem) and that can never be solved, but I need people attentive to me. I will seduce or tantalise or scare you into not giving up on me

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Treatment implications for clients using an 'A' strategy:

Client's stance

- A core dilemma underpinning the A strategy is fear of emotional intimacy versus fear of isolation.
- More concerned with *what happened* than *how they felt about it.*
- Core concept: 'My thinking will keep me safe and help me survive.'
- Over-arching strategy: an exterior presentation that inhibits negative affect.

Worker's stance

- Central therapeutic challenge: to hear and work with the *fearful* (desiring comfort and protection), *sad or angry person* beneath the outwardly positive, neutral or distancing exterior.
- Build trust to overcome suspicion.
- Beware of trying to find a quick fix. Be prepared to stay in 'for the long haul'.
- Honour the client's story whilst eliciting more balanced stories, including painful or difficult emotions.

Approaches that might help

- Encourage 'I' statements.
- Don't 'attack' their idealised attachment figure – this will usually cause the client to defend them.
- Give 'permission' to the client to reveal their 'shadow' emotions and impulses, without fear of reprisal.
- Unpick the client's assumptions, errors, omissions, distortions and self-deceptions (ie. related to thinking and feeling).
- Help client to express true affect, e.g. fear, anger, sadness or need for comfort.
- Help client to use active or projective methods (e.g. objects, drawing) to externalise issues like shame, guilt and remorse. The 'A' strategy often carries with it a burden of shame, and it may help the client if they are able to 'place' the shame outside of themselves, and perhaps 'give it back' to whom it belongs.
- Encourage client to show him or herself self-compassion.
- Help client to accurately distribute responsibility for events in their past and present.
- Help client to develop intimacy skills, especially skills such as asking for care or comfort, and expressing feelings.
- Help client to develop the skills of mentalisation, self-reflection and emotional self-awareness.
- Teaching problem-solving skills.
- Help client to develop skills of reciprocity in relationships (the goal-directed partnership).
- Help client to identify strengths and build self-esteem.
- Help client to appraise themselves from their own perspective, not that of others.

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Treatment implications for clients using an 'C' strategy:

Client's stance

- A core dilemma underpinning the 'C' strategy is fear of abandonment versus fear of losing autonomy.
- Less concerned with *what happened* than *how they felt about it.*
- Core concept: 'My feelings will keep me safe and help me survive.'
- Over-arching strategy: To exaggerate the display of genuinely felt fear or sadness and alternate it with the display of anger (with varying degrees of one presentation being dominant) in order to involve the other person (eg. their attachment figure) in an ongoing, unsolvable, everlasting struggle.

Worker's stance

- Central therapeutic challenge: when the outward presentation is *fear and desire for comfort*, to hear and address the underlying *anger*. When the outward presentation is *anger*, to hear and address the *underlying fear, vulnerability and desire for comfort.*
- In both cases, to also help the person to organise their thinking about people and relationships and how they think and behave when they feel stressed or threatened in relationships.
- Build trust to overcome suspicion.
- Beware of trying to find a quick fix.
- Honour the client's story whilst helping client to arrive at a more coherent story from uncontained emotion and unstructured narrative. Help client to include a balance of true cognition and affect.
- Avoid colluding with stories that blame others and / or characterise their attachment figures as 'all good' or 'all bad'. This will reinforce the 'C' strategy.

Approaches that might help

- Create structures and clear boundaries.
- Unpick the client's assumptions, omissions, errors, distortions and self-deceptions (ie. related to thinking and feeling).
- Help client to separate their own feelings from those of other people.
- Help client to develop accurate perspective-taking and a view of other people that balances different perspectives.
- Help client to identify exceptions, eg. when their attachment figure behaved differently.
- Help client to make accurate links between their feelings and the events they describe
- Help client to accurately distribute responsibility for events in their past and present.
- Help client to develop intimacy skills work, especially skills such as asking for care or comfort, and talking about feelings.
- Help client to develop the skills of mentalisation, self-reflection and emotional self-regulation.
- Encourage client to show him or herself self-compassion.
- Help client to develop problem solving skills.

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10 Ways to Help Parents to Protect their Children

Patricia M. Crittenden, Ph.D.

1. **Assess parents' danger:** Consider dangers to parents before trying to change parents. (Drugs, abandonment by their parents, couple violence, poverty, our threat to remove their child). Reduce the danger.
2. **Assess parents' needs & readiness to change:** Evaluate parents' needs and readiness to learn. No matter what the child needs, professionals must begin with what the parents need and are ready to learn. Everyone is ready to change something; begin there. (You can't teach division to someone that can't add!)
3. **Understand each parent's perspective empathetically:** Professionals need to set aside their own perspective and the child's perspective (temporarily) to step fully into each parent's perspective. This is the basis for empathy.
4. **Communicate this to each parent & correct your misunderstandings:** Articulate your appreciation of their experience to the parent and accept their corrections. To work with professionals, the parent must recognize themselves in our description of them.
5. **Integrate:** ONLY THEN can the professional consider the multiple perspectives: parent, child, and professional. Parents must do this all the time. We can too.
6. **Identify the gap:** Usually there is a gap between what the parent needs and is ready to learn and what the child needs from the parent.
7. **<u>This gap is where innovative services are needed</u>** This is what specialized training and experience are meant to accomplish. Think outside the box. Off the menu. Demonstrate creative problem solving. After all, that is what we want parents to do with their children! Let's show parents how to:
   a. Be empathic
   b. Be flexible
   c. Be creative
   d. Be exploratory as we seek an individualized plan for each family and person
   e. Attend to multiple perspectives at once
   f. Use feedback from our initial efforts to change and improve our approach
   g. Articulate this process to parents.
8. **Keep safety in mind:** Parent and child safety is crucial. So is our own. Professionals need to balance their own, parents' and child safety. If we are not explicit about this, we might not protect anyone.
9. **Prioritise!** Don't get caught up on trivial problems. Keep the BIG PICTURE in mind. Winning skirmishes (clean rooms, compliance with professionals etc.) can cost the child the battle. Be empathic!
10. **Apply the Golden Rule:** Let's treat parents the way we want them to treat their children. Let's describe that process, with humility for what we don't know and didn't accomplish. The Golden Rule can't be improved.

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Framework for using your understanding to think about family problems:

1. Construct a genogram noting the attachment history of young person and key family members if known. Go back at least two generations and note intergenerational patterns of strength and risk.
2. What have been the dangers? What are the current dangers? Does this understanding of their developmental history help you understand any difficulties the young person or parents/carers are currently experiencing?
3. What don't you know?
4. How strategy do you think the young person and/or key family members might be using and what is its self-protective function?
5. What do you need to do next?
6. Using your knowledge from the last 2 days, develop a plan that will increase the child's security and comfort.
7. Think about whether the intervention needs to be more cognitively or affectively oriented.
8. Make sure you consider the potential value that you and your involvement will have….
9. How might the parents/carers be assisted to increase their availability to be a secure base for the child?
10. What support do you need to work with the family in this way?

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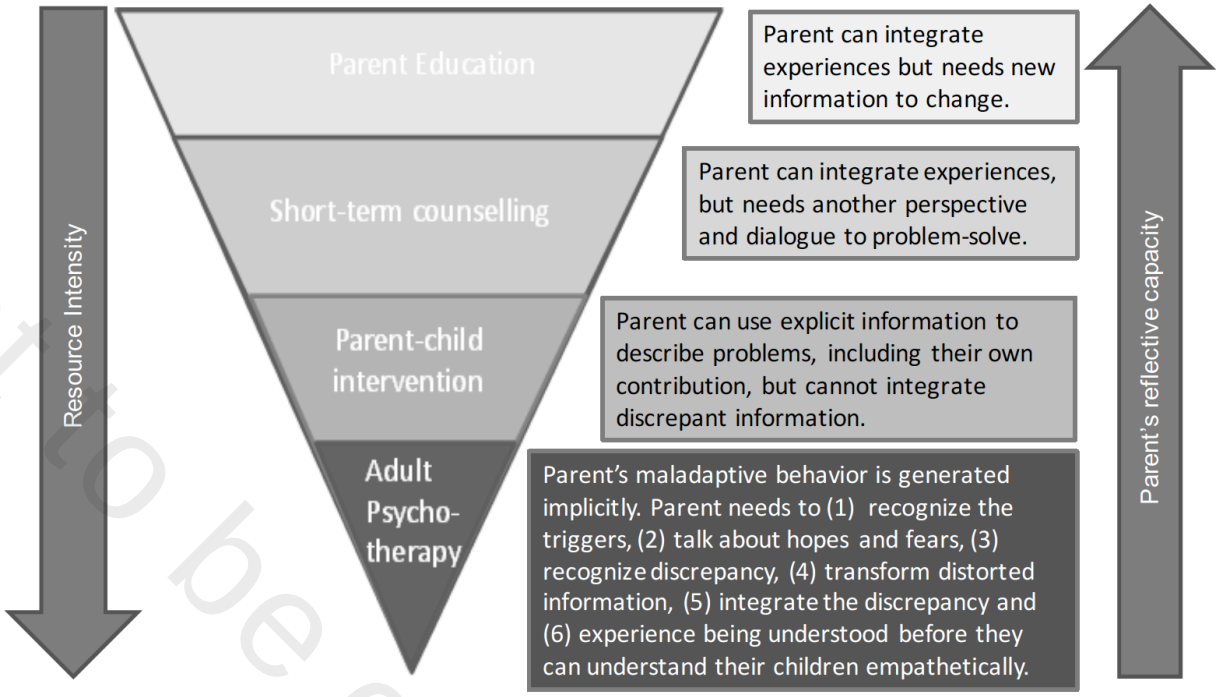

Gradient of Interventions

Patricia M. Crittenden,Ph.D.

Parent education
Parent can integrate, but needs new information.

Short-term counselling
Parent can integrate and has information, but needs another perspective and dialogue around the perspective

Parent-child intervention
Parent can use explicit information to describe problems, including their own contribution, but cannot integrate discrepant information.

Adult psychotherapy (personal, not parenting)
Parent's behavior is generated implicitly, i.e., not consciously, and is maladaptive, sometimes dangerously so.

Parent needs understanding of implicit 'triggers', verbalization, recognition of discrepancy, integration, plus the experience of being understood empathically before they can understand others (for example, their children) empathically.

Parent is not yet ready for parenting interventions.

Crittenden, P. M. (2005). Preventive and therapeutic intervention in high-risk dyads: The contribution of attachment theory and research. IKK-Nachrichten. (English is on www.patcrittenden.com.)

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Levels of Family Functioning

Patricia M. Crittenden, Ph.D.

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I. Independent and Adequate

Families in this category are able to meet the needs of their children by combining their own skills, help from friends and relatives, and services which they seek and use. Such families, like all families, face problems and crises. It is their competence at resolving these problems which makes them adequate.

II. Vulnerable to Crisis

Families in this category need temporary, i.e., six months to a year, help resolving unusual problems; otherwise the family functions independently and adequately. Examples of common precipitating crises include birth of a handicapped child, divorce, loss of employment, death of a family member, entry of a handicapped child into school, and sexual abuse in day care of a child. Because each of these crises could result in chronic problems, it is the nature of the family's response, not the nature of the crisis, which results in the vulnerable classification.

III. Restorable

Families in this category are multi-problem families who need several types of training in specific skills or therapy around specific issues. Following intervention, it is expected that the family will function independently and adequately. The period of intervention can be expected to last 1-4 years and require active case management to organize the sequence of service delivery and to integrate the services.

IV. Supportable

There are no rehabilitative services that can be expected to enable these families to become independent and adequate. With specific on-going services, the family can meet the basic physical, intellectual, emotional, and economic needs of their children. Services, and management of those services, will be needed until all the children are grown. Examples of supportable families include those with a mentally retarded mother, a depressed mother, or a parent who abuses alcohol or drugs chronically.

V. Inadequate

There are no services sufficient to enable these families to meet the basic needs of their children, now or in the future. Permanent removal of the children should be sought.

Crittenden, P.M. (1992). The social ecology of treatment: Case study of a service system for maltreated children. American Journal of Orthopsychiatry, 62, 22-34.

Levels of Parental Reasoning

Patricia M. Crittenden, Ph.D.
Family Relations Institute
Miami, FL USA

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Abdication

Level 0: Parent doesn't know why they do what they do or is incoherent.

Level 0.5: Parent defers to others or echoes their views.

Egoistic reasoning

Level 1: Parent makes decisions based on self-interest (self-state).

Level 1.5: Parent tries to behave the way they would have wanted if they were the child.

Conformist reasoning

Level 2: Parent's decisions are based on normative standards.

Level 2.5: Parent modifies normative standards on the basis of some characteristic of the child (e.g., age, sex).

Individualistic reasoning

Level 3: Parent selects their own behavior in response to unique aspects of the child.

Level 3.5: Parent's reasoning includes more than one level, but is not fully individualized to child, self, and present circumstances.

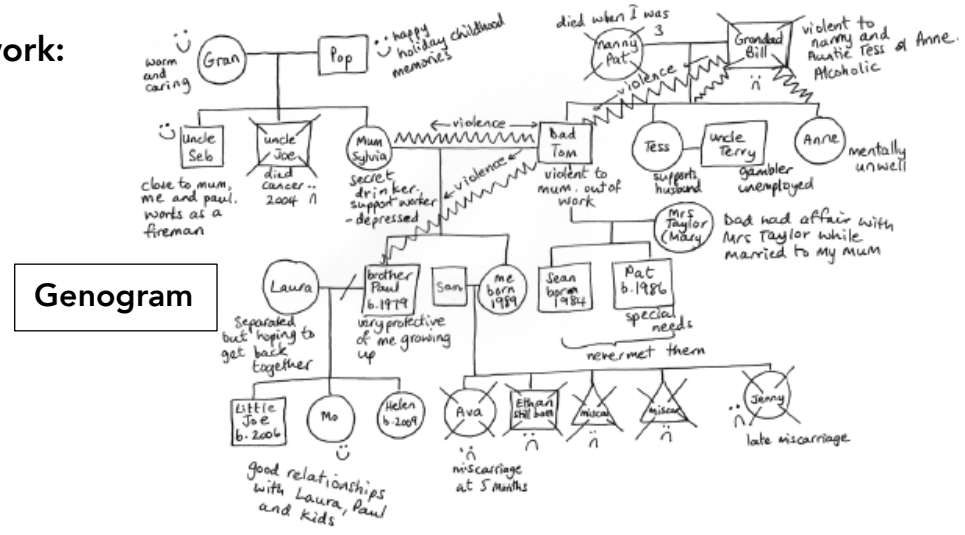
Integrative reasoning

Level 4: Parent's reasoning is based on the integration of information from lower levels, including the unique characteristics of the child, the self, the immediate situation, and long-term experience and consequences.

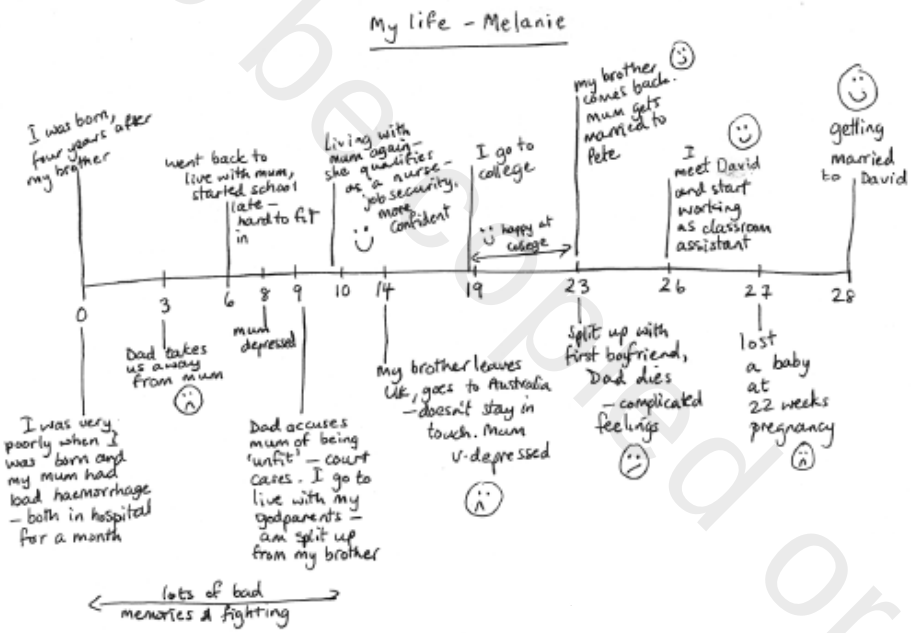
Modified from: Crittenden, P. M., Lang, C., Claussen, A.H., & Partridge, M. F. (2000). Relations among mothers' procedural, semantic, and episodic internal representational models of parenting. In P. M. Crittenden and A. H. Claussen (Eds). The organization of attachment relationships: Maturation, culture, and context (pp. 214-233). New York:Cambridge University Press.

Some ideas for direct work:

Genogram



Timeline



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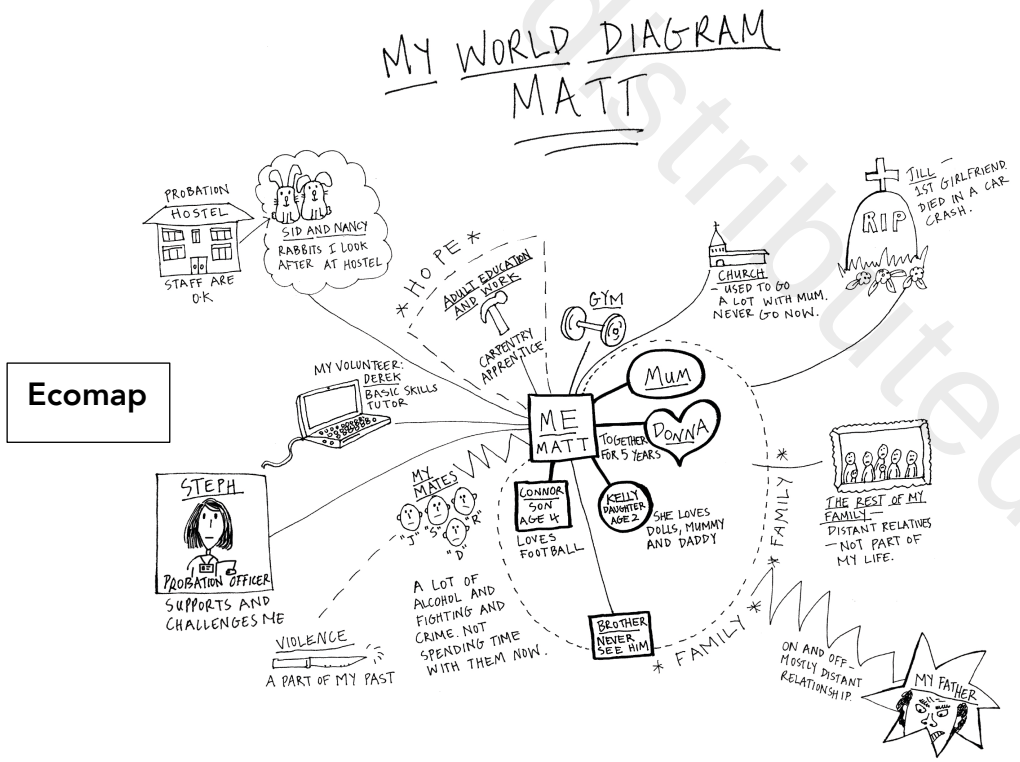

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Feeling cards

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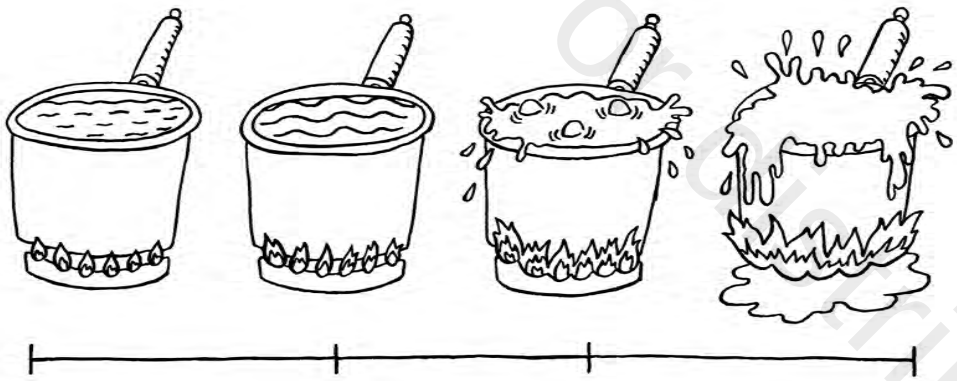
Worksheet 8.9

Pot of bubbling feelings

The Pot of Bubbling Feelings



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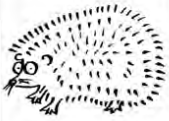
Worksheet 10.1

When I feel unsafe

Feeling Unsafe/Putting Up Defences

When I am feeling "unsafe" and need to protect myself I ...

Surround myself with barbed wire	Go into attack mode like a hungry shark	Go into my own protective bubble	Put on my bulletproof vest	Retreat into my tortoise shell
Make myself small/invisible	Hide away in the fog	Freeze on the spot	Whizz around like a dart	Paint on a smile like a clown
Put up my spikes like a hedgehog 	Zoom away like a speeding car	Push people away like an opposing magnet	Think in black and white	What else?

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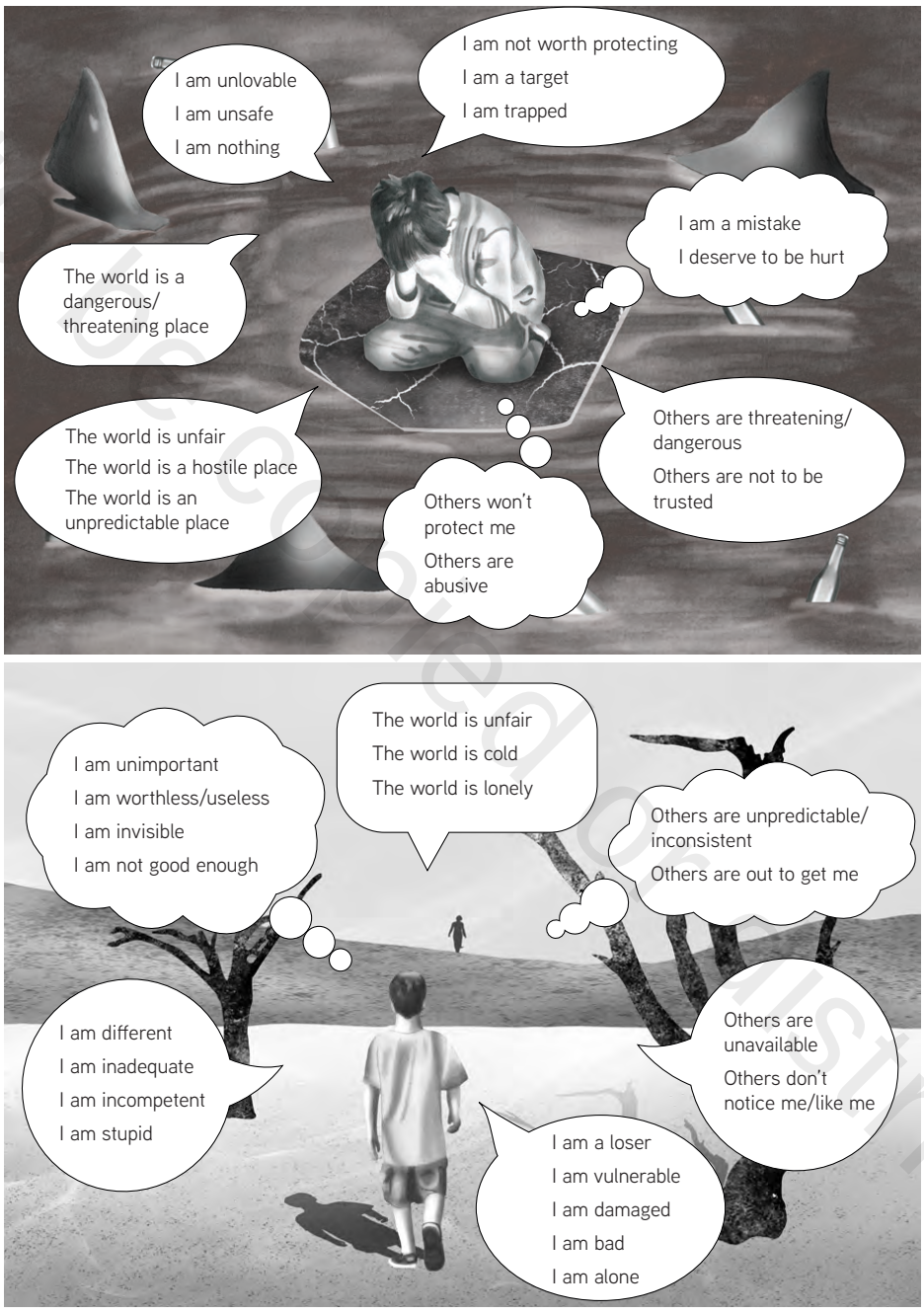
Worksheet 5.1

Common core beliefs worksheet



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On line resources:

- International Association for the Study of Attachment www.iasa-dmm.org
- Dr. Patricia Crittenden's website: www.patcrittenden.com (includes course information):
- Dan Siegel's website: www.drdansiegel.com
- Useful article about the neuroscience of psychotherapy: http://psychservices.psychiatryonline.org/cgi/content/full/54/10/1419

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LEARNING LOG AND ACTION PLAN

The purpose of this log is to capture the learning at the end of a course and record any actions you may wish to take before the business of everyday life takes over. You may wish to use this document in supervision or as part of your record of continual professional development.

My personal learning goals attending this course were....

1.

2.

3.

Key areas of learning for me on this course were....

1.

2.

3.

Aspects of the course that particularly challenged me were:

Areas I wish to explore further are?

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One thing that I will take away from the training that I will do differently and will make a positive difference to service users is....
Other improvements that I want to make to my work By when?
What will tell me or others that I have been successful in improving my practice?
Who/ what will assist me in making improvements?

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