

6-9-2016

A Chance for Change: Treating Disorganized Attachment With The Attachment Healing Center Model of Treatment

Michele Coleman

Follow this and additional works at: http://digitalrepository.unm.edu/educ_ifce_etds

Recommended Citation

Coleman, Michele. "A Chance for Change: Treating Disorganized Attachment With The Attachment Healing Center Model of Treatment." (2016). http://digitalrepository.unm.edu/educ_ifce_etds/13

This Dissertation is brought to you for free and open access by the College of Education ETDs at UNM Digital Repository. It has been accepted for inclusion in Individual, Family, and Community Education ETDs by an authorized administrator of UNM Digital Repository. For more information, please contact kevco@unm.edu.

Michele H. Coleman

Candidate

Individual, Family and Community Education

Department

This dissertation is approved, and it is acceptable in quality and form for publication:

Approved by the Dissertation Committee:

Dr. Kristopher Michael Goodrich , Chairperson

Dr. Bruce Alan Noll

Dr. Sharon Warner

Dr. Thomas Anthony Chavez

**A CHANCE FOR CHANGE: TREATING DISORGANIZED
ATTACHMENT WITH THE ATTACHMENT HEALING
CENTER
MODEL OF TREATMENT**

BY

MICHELE H. COLEMAN

B.A., Psychology, Wesleyan University, 1976
M.S., Human Development, Virginia Polytechnic Institute and State
University, 2000

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy

Counselor Education

The University of New Mexico
Albuquerque, New Mexico

May 2016

DEDICATION

To my family, thank you for your love and commitment to my success in this life. Thank you Mom, my Great Aunt Harryette, for loving me and raising me as your precious baby, and instilling in me a love for learning. Thank you Great Aunt Louise, Great Aunt Kitty, Great, Great Uncle George for your loving presence and guidance. Thank you cousin Arthur Thomas for encouraging me to follow my dream. Thank you to my stepdad, Herman Walker, for demonstrating what it means to live a Christ-like life. To my brother Roland Selby who is always in my corner whether I am laughing or crying. Thank you for always being there for me. To my daughters Kathryn James, Kimber Sharp and Kelsi Sharp who provided me the experience of what it is like to be loved as Mom. Thank you for your love and patience with me as I worked tirelessly to bring about change in the lives of children and families. I am so appreciative of everyone at the Attachment Healing Center who supported me in this endeavor, especially Michelle Schilling and Taylor Janis. Without your belief and commitment to the work we do in the community, this study never could have gotten off the ground. Thank you so much for your support. And I am forever grateful to my life partner, Terry Morris for your undying love and support despite the late hours and endless work commitments.

It is because of all the love that has been poured into me that I am who I am in the world today. Thank you for believing in me.

ACKNOWLEDGMENTS

I have been so blessed to have Dr. Kristopher Michael Goodrich chair my committee as you challenged me to be my best. Thank you for being there when I was stranded and in need of guidance and support. When you joined the team the bar was raised. As a result, I rose to the occasion and the result is an outstanding study dedicated to making a difference in the lives of children and families.

I am fortunate to have met Dr. Bruce Noll in my minor of Organizational Learning and Instructional Technology. I now know how to teach and reach the adult population like teachers, parents and counselors. Thank you for calling me higher and never accepting anything less than my best. There are things I could hear from you that I might have fought had others tried to share.

My writing has improved by leaps and bounds since my first English class with Dr. Sharon Warner. I love the way you challenge us all to examine and consider how our writing will impact our audience. You created such safety and support in your classes that was no way I could emerge from any of your classes without my writing being exemplary. Thank you not only for the instructor you are but for the humble, loving servant you are to all of your students. I have been gifted with your presence in my life.

Dr. Thomas Chavez I am grateful for your willingness to pinch hit at the last moment. Without you, this dissertation would not have been possible. Thank you for saying yes and for bringing your wisdom about family functioning and qualitative research to the table.

The completion of this entire PhD process never could have been accomplished without the undying support of my agency angels Rebecca Sue Hurst and Jane McCoy. Thank you for your commitment to me and the work we bring to the world.

**A CHANCE FOR CHANGE: TREATING DISORGANIZED ATTACHMENT WITH
THE ATTACHMENT HEALING CENTER MODEL OF TREATMENT**

BY

Michele H. Coleman

B.A., Psychology, Wesleyan University, 1976
M.S., Human Development, Virginia Polytechnic Institute and State University, 2000
PhD., Counselor Education, University of New Mexico, 2016

ABSTRACT

In this study I investigated the psycho-educational component of the Healing in Resonance model of treatment as implemented at the Attachment Healing Center for working with children who have been identified as having disorganized attachment. Multi-case methodology was used with five families representing five parents and five children.

Grounded theory was used to analyze the journals, interviews and focus group discourse of the participants. There were also some quantitative tools used to diagnose the children and to quantify their behavioral changes. The grounded theory analysis revealed the importance of the child's caregivers taking ownership for how they show up in relationship to their child. In this relationship the parent must address the child's underlying need and not their behavior.

While the therapeutic component of the model of treatment was not studied, the parents reported that the relationship they had with their therapist was critical to their ability to implement interventions and perspectives they were learning in the groups. As the parents saw the interventions modeled by the clinician working with the family, the parents were able to see the changes they needed to implement in the relationship with their child. As the child's behavior began to shift in response to the parents' change the parents expressed a sense of hopefulness and gratitude. The change came about more quickly than the parents

anticipated as most of the parents had previously implemented a behavioral modification approach to helping their child change and this relationship approach brought about change more quickly than the parents thought possible. As the child's behaviors began to change the parents were grateful for the changes and stated that the family moved from chaos to calm or from conflict to cooperation. From the research findings the critical training components that most impacted the parents and supported their bringing about change in their parenting style were discussed. Additionally, I also provided suggestions for further research.

Keywords: *attachment, emotional regulation, attunement, disorganized attachment, adoption, foster care, multi-case study, grounded theory, reactive attachment disorder*

Preface

I was raised by my great-aunt whose relationship with alcohol was less than ideal. Despite her challenges, throughout my life I knew I was loved. Next to alcohol, I was the most important thing in her life. By today's standards I think they would say we were homeless for the first nine years of my life. We stayed on more people's spare beds, or couches, and empty basements than I can remember. But despite all of these moves, my Great-Aunt, who I refer to as my mom, was always there with me.

For summers, one of my mom's older sisters would give her a break and I would stay with this great-aunt and her five children. This relationship started when I was just a couple of months old. My mom wanted to go to a party, so she drove the three hours to her sister's house and asked if they could watch the baby. I was so cute, so of course her sister said yes. Three months later, my mom returned to get me.

During this chaotic upbringing, my mother was not always in a state to ensure my safety. From the age of six to nine, I was sexually abused by her main boyfriend. At times, she would call on him to "babysit" me so she could go out. One time she walked in on him and she was outraged. It only took him an hour to weasel his way back into her good graces. However, the next time she arranged for him to "babysit" me, I insisted on having a friend stay with me. It was a good thing too, because he brought a friend. It did not matter because with a friend I could fight my way to safety, and that is exactly what my girlfriend and I did.

It was about this time that my mom had a nervous breakdown. One night she started seeing men flying around the bedroom. As she and I shared a bed, this meant the men were flying around me too. She kept swatting at them and yelling at them and bouncing on the bed

like they were under the bed trying to get at her. After several hours of being tormented in this way, she got me dressed and we went outside to wait for her boyfriend to come and rescue her. At three am in the morning on 14th Street in Washington, D.C., my mom and I waited to be rescued. This just happened to be the same street where ladies of the night await their dates. Needless to say there were many curious looks coming our way. After standing on this street corner for two hours without her boyfriend arriving to rescue us, she decided to chance going back into the apartment. By this time, it was almost time to start getting dressed for school. When I arrived home from school that day, I waited for Mom to come home from work, but she never did. I don't know if it really took this long, but in my young child's brain it seems to me I was left for four days before my mom's youngest sister and her oldest daughter arrived at the apartment to take me to a stranger's house. Being a latchkey child and accustomed to taking care of myself both before and after school, being alone this long was not a survival issue for me. When my relatives arrived, they told me my mom was in the hospital. She had had a nervous breakdown. I did not know what that meant, and I went in to a state of numbness.

In this numb, bewildered state I was taken to a couple's house. I had never seen this couple in my entire life. Later that year I was to learn that my mom's youngest sister was actually my grandmother and her oldest daughter was my birth mother. The couple I was taken to were friends of my birth mother. They had agreed to take me in until my mom who was raising me, who I refer to as my real Mom, was out of the hospital and stable enough to resume her role as a parent. The adults were doing a lot of talking. It seemed like the words were just floating over my head. Eventually, the loving couple asked me a question in a real gentle tone and all I could do was look at them. I could not make sense of what they had

asked me, and I certainly could not make my voice work in a way that would convey how I was actually feeling. I just sat there and stared at them. Somehow, they understood and came over and helped me get settled into their home. I stayed in this home for a year with this loving couple and their daughter.

Despite all of my moves, this was the first time I was away from my great-aunt/mother. I was not even allowed to talk to her on the phone. I missed her terribly. In today's terms this placement would have been referred to as foster care. I lovingly refer to it as informal foster care. This was my first experience with an out-of-

home placement. For me this experience was extremely positive because in this couple's home I learned what it meant to live a stable family life. Their daughter was a monster to me, but they seemed to take to me, loved on me, and treated me as family. It brings tears of love to my eyes now as I write about them. The blueprint for how to do family was laid down in my brain during the year I lived with this loving couple.

My Mom did indeed get herself together and after a year I returned to her care. That year we moved to another state so my Mom could have support in her parenting duties. We moved to New York to live with another one of her older sisters. We lasted less than a year in the one bedroom apartment shared with my great-aunt and her husband. From here we moved to a great-great uncle's home in upstate New York. It was this year that I put my foot down about moving from school to school. All through my elementary years, I went to a minimum of two schools a year. Most years I attended three schools in one academic school year. So despite being an hour and a half away from my school, I commuted from upstate New York by subway to Greenwich Village in order to stay in the same school.

It was in my great-great uncle's home that I was told my Mom who was raising me, was not my birth mother. My world fell apart. I did not know who I was. I did not know where I belonged. I felt like my whole life had been a lie. I literally came apart. Despite this internal turmoil, when my uncle discovered that my great-aunt/mother was an alcoholic, he devised a plan to get me away from her. He said she had a disease that made her an unfit mother. While that might be true, she was the one who was always there for me. I loved her. I knew she loved me.

One night when my mother returned from the graveyard shift at her job, she was locked out of the house. As she banged on the door and woke the family up, my uncle answered by throwing her clothes out to her and yelling that she was not welcomed back in his home. I was at the top of the stairs screaming for my mother, begging my uncle to let her in. She was my Mom and I loved her. I did not want to experience another year of life without her. He demanded I return to my room. Distraught, I did as I was told. My great-great uncle worked with other family members to take my great-aunt/mother to court to get me away from her. During the year I lived with my great-great uncle and his wife, he reparented me and taught me how to live a refined life. My uncle loved me immensely and he poured that love into preparing me to be a gracious, intelligent, and cultured young woman.

The day we arrived in court, the judge took me and my mother into his chambers and asked me who I wanted to live with. I looked him in the eye and told him I only knew one Mom and I wanted to live with her. This would never happen today, but the judge looked at my great-aunt/mother and instructed her to get married and establish a stable environment for me. She had one year to do as he was asking. He returned to the courtroom and announced his decision that I was to live with my grandmother, my mother's baby sister, for one year

while my mother stabilized her life. The judge was clear I was not to live with my birth mother, although she could have contact with me. He was emphatic that I was to be cared for by my grandmother. The gavel then hit the block.

I am now sixty-two years old and to this day, that year I lived with my grandmother was the worst year of my life. This was the year I experienced kinship care. It seemed to me that my grandmother blamed me for everything that was wrong with her life. It was all my fault that I was born. Her middle daughter who was a few months younger than me, tortured me by telling her friends of my abusive past. Again, it felt like it was all my fault that these experiences happened to me. Somehow, I was damaged material. I was not good enough for my aunt's friends to play with. They would point fingers, giggle and whisper things about me. It was this year that I became a loner. I did not need people. My Mom sent me letters and in one of these letters she included a picture of herself with the man she intended to marry. I kept that photo under my mattress and looked at it for comfort whenever life became unbearable. I spoke to my mother twice during this year. On the day of my mother's wedding I returned to her loving arms, and met the most gentle soul I call my stepfather.

One day when I was about fourteen, in her frustration, my mother picked up a belt or whatever was handy and proceeded to beat me as she had done so many times before in her attempt to discipline me. This time, however, I was different. In the past, I did not know any better, and assumed as a child I had to let my mother beat me. After several years living in other people's homes though, I now had an understanding of a different way of disciplining a child. I put my hand on my mother's hand that held the weapon and I stopped it in midair. She looked at me with wide eyes and no words. I told her, "No, you will not hit me anymore." I released her hand and walked away. Beating me had never had the impact my

mother thought it would. My behaviors never changed. I thought I was a stupid child who had to be beat for the same things over and over again. It was not until I was an adult that I discovered the brain does not change from a focus on the negative.

From the experiences of the first fourteen years of my life, I have an intimate understanding of what it means to be raised in a less than ideal home. I know what foster and kinship care can be like. I know what it is like to be sexually and physically abused. I know what it is like to be homeless and to go without food. I know that these experiences do not define who I am and I also know that surviving these experiences has significantly contributed to the depth of understanding that I bring to my work. I am not saying every child's experience was like my experience, but I have a framework from which to understand another person's unique experience. I know not to judge the child for what the adults did to him. I know the child was not responsible for the conditions under which she was raised. I know the child developed some behaviors, attitudes and perspectives that helped him or her survive their environment. I also know those behaviors can be changed when the child is placed in a different environment. My early childhood experiences inform my commitment to working with this population – children in the foster care and adoption system. I even work with birth children to help the families bring about the necessary changes to be reunited with their children. I know how much it means to the child to stay with their family. My experiences inform my commitment and dedication to developing a model of treatment that will release the child from unhealthy, dysfunctional, coping behaviors so he or she can relearn what it means to live in a family. It is from this perspective that I undertook this research to study the model of treatment that has helped hundreds of children just like myself learn how to allow adult caregivers to take care of them. Researching the effectiveness of this

model of treatment and concretizing the model's components might impact the lives of many as we can then teach the model to others so children just like myself can benefit from the love of a family. This is my goal.

Table of Contents

Preface	viii
Chapter 1	1
Introduction to the Study	1
Background.....	1
Theoretical Underpinnings for the Study.....	5
Statement of the Problem.....	15
Purpose of the Study.....	16
Literature Review	19
Significance of the Study	19
Diagnosing Attachment Disorder.....	19
Treatment approaches for disorganized attachment.....	20
Attachment system.....	22
Parent child relationship	24
Emotional regulation.....	26
Attuned communication.....	26
Research Assumptions.....	29
Methodology	31
Chapter 3	31
Participant characteristics	33
Participant Selection.....	35
Procedures	36
Data Collection	37
Instruments	38
Research design	40
Treatment intervention.....	41
Attachment Healing Center Model of Treatment	43
Researcher’s Position	46
Trustworthiness	47
Chapter 4	49
Results	49
Data Analysis.....	50
Sharon	57
Parent journaling through the group process	59
Child Assessments	62
Family Assessment following Parent Group	63
Factors Contributing to Change in the Family.....	67
Stephen	69
Parent journaling through the group process	70
Child Assessments	76
Family Assessment Following Parent Group	78
Factors Contributing to Change in the Family.....	78
Cheryl	80
Parent journaling through the group process	82
Child Assessments	86
Family assessment following parent group.....	88
Factors Contributing to Change in the Family.....	92
Gloria	93
Parent journaling through the group process	94

Child Assessments	103
Family Assessment Following Parent Group	104
Factors Contributing to Change in the Family	109
Gregory	111
Parent journaling through the group process	111
Child and Family Assessments	119
Factors Contributing to Change in the Family	119
Analysis	121
Research questions addressed	121
Sample Case Progression – Track II	126
Emerging Themes – Track III	136
Emerging Theory Around The Work	140
Emerging Theory Related to the Group and the Material	141
Chapter 5	143
Discussion	143
Study Limitations	145
Recommendations for Further Research	146
Clinical Implications	147
References	151
Appendix A	158
Definition of Terms	158
Appendix B	160
Methodology	160
Appendix C	161
Coding Grid	161
Appendix D	162
RAD Questionnaire	162
Please tick the statement that best describes your child	162
Appendix E	164
Family Observation Rating Scale	164
Appendix F	169
Parent Group Weekly Content and Activities	169
Appendix G	170
Journal Questions	170
Appendix H	171
Focus Group Questions	171
Appendix I	172
Consent to Participate in Research	172
Appendix J	178
Consent form prior to adding Focus Group Consent	178
Appendix K	184
Prescreen Questions	184
Appendix L	185
Research Script	185

Chapter 1

Introduction to the Study

Background

Children who have been abused and/or neglected since birth continue to challenge our foster care, adoption, and mental health communities. Such children are labeled as “special needs” (Festinger, 2002). Whether the child with special needs is born in the United States, or born internationally and raised in the United States, treating the behaviors such a child brings has not proven to be a simple endeavor (Festinger, 2002). Parenting a child whose brain did not receive the foundational experiences necessary for normal healthy development requires more than what most parents bring to the relationship (Siegel & Hartzell, 2004). Through my various roles over the past fifteen years with Child Protective Services, I have learned that foster and adoptive parents are not told of these challenges. Sometimes families are not told because the social workers themselves do not know what the child has been exposed to and sometimes families are not told most because little is known about what it takes to successfully help a child who was abused or neglected in his or her early childhood development.

According to the US Department of Health and Human Services (2012), the mean age of a child entering foster care is five years old. Fortunately for over 463,000 children in the US foster care system, there are homes and families available (National Foster Care Coalition, 2012). While foster care is designed to be a temporary system, on average a child is in the system for approximately two years with an average of three moves (National Foster Care Coalition, 2012). This means that a child for one reason or another is not able to stay with one family for that entire two years. Something happens in the first family unit that

causes the child to leave the family before being adopted which is referred to as a disruption. Sometimes the child is moved to another family. Sometimes the child leaves the pre-adoptive home and is placed in a residential setting like a group home, hospital, day treatment, or residential facility. Rather than having a family in which to connect, children placed in facilities have “staff” to rely on to meet their needs. With each move there is a change in routine, or a change in schools. There is a chance they are moved away from brothers and sisters, and have to start over in figuring out how to live within a family so they do not experience yet another disruption (Hardy, 2007).

According to the National Foster Care Coalition (2012), foster care affects all ages of children. In 2008, of children in the foster care system 35 % were under 6 years of age; 27% were ages 6 to 12; and 38% were between 13 and 21 years of age. The Coalition reported that the numbers of children in foster care waiting for adoption or reunification has decreased over the past 10 years, while the number of children aging out of the system, meaning the child turned 18 or 21 without being permanently connected to a family support system, has increased. Children who age out of the system are at higher risk for unemployment, health issues, homelessness, and incarceration (Heimpel, 2009).

If children are in foster care for an average of two years and they represent all age groups, the question seems to be, how does a child age out of the system? This is a good question for which there is very little data. Through my experience with Virginia and New Mexico Children Youth and Family Departments I ran across numerous stories of children who entered the system at a young age, but could not be maintained in a family setting and had to be sent to a facility to get the needed help before they are placed once again in a family. In theory, this out-of-home placement should have provided the necessary treatment

for the child to learn how to function successfully in a family. Unfortunately, all too often this is not the case. Based on these experiences I have coined the phrase, “the revolving door of treatment.”

Department of Health and Human Services estimated that anywhere from 10-25% of the children who are in the process of being adopted, end up not being adopted (Festinger, 2002). This refers to the child’s behavior becoming so severe the potential adoptive parents no longer feel they can adequately parent that child so the family returns the child to the foster care system. If the family makes this decision after the adoption has been legally finalized, some Child Protective Systems say the adoption was dissolved. Unfortunately, there are no good statistics on the number of children who are returned to a state’s custody since after adoption the family may change the child’s name. In many states, returning an adopted child is a criminal charge against the parents and they are no longer able to foster or adopt in the state. Festinger (2002) reported that dissolutions occur because families who adopt special needs children lack information about where to find services, and when families are able to find services the cost is prohibitive.

Coleman (2000) looked at the foster care system and evaluated one aspect of the breakdown in the parent child relationship: the behaviors an abused child brings into their new family. This research study picked up where that thesis left off and, in addition to addressing such behaviors, explored the issue of treatment. What can be done to help our children who are distressed learn how to live and function normally in a family?

This study aimed to benefit children who were adopted from domestic and international sources. Regardless of where the child was adopted from, any child removed from their birth family experiences challenges that prove problematic for the adoptive family.

Many of these parents are challenged by the behaviors their children present. Parents of international adoptees often have the means to place their children in residential facilities that will keep the child for extended periods of time. However, the result is the same; the child can turn 18 and enter the world without connections to a family or support system. The question this study asked was: what can be done to help the child who is difficult to parent? Can something be done to help stabilize the child's extreme behaviors so that they can learn to function in a family?

The Attachment Healing Center (AHC) opened in 2006 with a model of treatment rooted in neuroscience concepts and designed to address the needs of a child and family where the child has been identified as having disorganized attachment and some have the diagnosis of Reactive Attachment Disorder (RAD), (APA, 2000). Children with disorganized attachment or with the diagnosis of RAD do not trust their adult caregivers, based on the neglectful or abusive parenting they received as an infant through age two. A child with an attachment disorder can be aggressive, defiant, charming, and manipulative.

Based on the therapeutic approach of working with these children and their caregivers, the Attachment AHC has steadily grown over the past ten years with an increase in referrals, and in increase in the number of agencies doing the referring. With each successive year there is an increase in the number of children who discharge from treatment no longer qualifying for a diagnosis of reactive attachment disorder. It is precisely because of the Agency's success rate that AHC continues to grow serving more than twelve regions of the state of New Mexico. This study aimed to research the effectiveness of this model of treating disorganized attachment.

Theoretical Underpinnings for the Study

John Bowlby (1988) provided the foundation for attachment theory with his groundbreaking work outlined in his book *Secure Base*. The theoretical perspective for this study was a combination of the latest attachment neuroscience concepts as taught by Allan Schore (2003), and Dan Siegel (2004, 2007, 2012). This author decided to take the neuroscience findings of Siegel and Schore and add them to Bowlby for the resultant model of treatment being tested in this study. These concepts are explored in depth in the next section.

The Global Association for Interpersonal Neurobiology Studies (GAINS) is comprised of scientists, researchers and practitioners dedicated to informing the public about critical neuroscience concepts that impact our daily life. Siegel (personal communication, 20t05) has stated that he hopes those involved in GAINS will take the neuroscience information and find ways to apply it to bring about significant change and betterment for the populations the members serve in the community. Many populations served by the mental health community are represented in the GAINS organization.

This author took seriously Siegel's call to action to apply his information to the population served. The concepts learned through various associations like GAINS, along with educational training from the University of New Mexico, Virginia Polytechnic Institute, and Portland State University have been used to develop a model of mental health treatment for children deemed resistant to treatment. As a result of the research shared by these scientists and others, there is now access to learning how one human brain connects to another and how the human brain learns to bring about change in behavioral functioning. Childre and Martin of the HeartMath Institute, Dr. Allan Schore, Dr. Dan Siegel, Diana

Fosha, Lynne McTaggart, and others have documented how to bring about change in the behavior of a child whose early childhood experiences included abuse and neglect. This study built on the foundation laid by these pioneers.

Attachment. Neuroscience is the study of how the brain works. There are neural fibers in the human brain that come together in networks and these networks correspond to behaviors. (Doidge, 2007). In order to change behavior, it is important to change the connections within these neural networks. Neuroscience informs us that there are two components necessary to changing the wiring of the brain. The first is that experience changes the structure of the brain and secondly, the brain changes in relation to another brain (Siegal, 2007). Neuroplasticity is the fact that the brain is always changing (Doidge, 2007). From the time we are born until we die, our brains are changing based on the experiences we have. For children, the critical “other” brain is the adult caregiver’s brain. When the adult caregiver is unable to meet the child’s physical and emotional needs, the child turns elsewhere to get their needs met. Children whose needs are not met as infants, learn to depend only on themselves to meet any needs that arise, whether physical or emotional (Keck & Kupecky, 2009).

The most important emotional need to be met in childhood is that of attachment. According to John Bowlby (1988), one’s initial attachment occurs within the first two years of life. During this critical time period, the infant learns to look to the caregiver to meet his or her physical needs, provide safety and protection as well as emotional comfort and regulation.

The nature of the attachment relationship is determined by how responsive the adult caregiver is to the infant. When the infant’s physical and emotional needs are met on a

consistent basis, the infant learns to trust that someone outside of himself will meet his needs. Consequently, as the infant grows into adulthood, he communicates his needs clearly to others, with the expectation that those needs will be consistently met. A child who has needs consistently met is said to be Securely Attached. If in the early years, a child does not learn to trust others, but rather learns to depend on adults as an older child or as an adult, then this type of person's attachment style is referred to as Earned Secure (Siegel, 2007).

At the other end of the continuum is Disorganized Attachment. When an infant does not have her needs consistently met, or she cries to communicate there is a need, and that need is met with a negative response from the caregiver, the child learns not to communicate needs to another human being. In these situations, infants learn to repress any physical or emotional need and instead work to manipulate the environment in order to get the adults to take care of her without allowing the adults to come in close (Siegel, 2007).

If many needs go unmet, the child's brain shuts down to the pain signal associated with the need (Keck & Kupecky, 2009). This can be compared to an individual who has been hungry for a very long time because they could not take a break to eat a meal. After awhile, the hunger pain goes away, yet the individual has not eaten. The hunger pain goes away because the brain cannot stand to be in pain or agitation for long, and so it stops processing the pain signal coming from the stomach. *The pain goes away, but the need is not met.* This is experienced by the infant as if she met her own need (Keck & Kupecky, 2009).

Consequently, these children become attached to themselves. They learn that to communicate a need to another means certain death. For death is what it feels like to the child when she cannot get fed when hungry, clothed when cold, or held when lonely (Coleman, 2000). The

diagnosis for children with disorganized attachment is Reactive Attachment Disorder (RAD) (APA, 2000).

In between secure and disorganized attachment is Anxious Attachment. This is the child who cannot anticipate when his needs will be met because his needs are met so inconsistently (Siegel, 2012). A child's attachment style becomes important when an adult is looking at how to connect with the child in order to help. A parent might want to connect in order to be that other brain that helps the child re-wire their neural networks. As a result of the child being held in positive regard by a caring other, the child's brain pathway is primed for changing (Siegel, 2012). As the child opens up emotionally to another, he is able to release the behaviors that have been used to communicate his feelings (Fosha, 2000). The result is the child experiences a change in his behavior.

Emotional regulation. A child's attachment style determines how she will handle the regulation of her emotions (Schoore, 2003). Emotional regulation is a component of Attachment. Attachment provides safety and security to the infant as well as emotional regulation. Emotional regulation is defined as being able to calm the infant when she becomes distressed. An infant becomes emotionally dysregulated when she has a need and becomes distressed as she communicates that need to the world (Schoore, 2003). From a brain perspective, the child goes to a negative place, feeling that she will not be okay. When the positive, nurturing caregiver comes to soothe the infant and determines what the need is and meets that need, the child slowly begins to calm down and emotionally ends up in a calm, peaceful state of being. Once she is calm, we say the child is emotionally regulated.

Based on Schoore's (2003) research initial emotional regulation takes place in the interactions between the infant and the caregiver. Schoore calls this co-regulation. Co-

regulation develops during the first two years of life. As the infant's brain learns all of the necessary functions to exist on his own, he also learns how to calm or regulate himself based on how the caregiver's brain calms and regulates the infant's immature brain. It is important that a child learn there is a positive place that can be reached after something bad or distressful happens. If the child's brain cannot find this place, what happens is the child may fall into a negative or a shame place and end up staying there. Becoming dysregulated and not knowing how to become calm is demonstrated when a child who has disorganized attachment is told "No." The child's emotional system becomes so overloaded he begins to tantrum in an effort to throw off the anxiety and extreme discomfort he is experiencing (Schoore, 2003).

Emotional regulation is key in the attachment relationship. Emotional regulation is critical in any relationship, not just the primary attachment relationship. If as children we learned that others care about what we think and feel, we will be more inclined to share our thoughts and feelings to their natural resolution (Fosha, 2007).

There is an emotional release and healing that takes place when a positive, caring other can stay connected in communication through the expression of difficult emotions (Siegel & Hartzell, 2004). An individual can have a difficult emotional experience and be able to release the energy from that experience by sharing the emotional component of the experience with a caring other. This is neuroscience at work. The pain and stress of the negative emotional experience is transformed. In a secure attachment, the damage caused by the stress the client experienced can be corrected by exposure to a caring and responsive other (Baylis, 2006; Siegel, 2012;).

Siegel (2007) and Baylis (2006) discussed the relationship between therapist and client. In a secure attachment between therapist and client, a corrective experience is accomplished by the establishment of an attuned/connected relationship in which the emotional state of the therapist is used to calm the emotional state of the client (Siegel, 2007). As the client learns how to down regulate her dysfunctional coping mechanism through her interaction with a caring and regulated other, she eventually learns how to do this on her own without the other having to be present during stressful times. When the two can link up their emotional or affective states of being, there is a chemical reaction within the brain. This chemical reaction causes new neural connections to be formed based on the experience between the two who are securely attached. Additionally, one is open to learning and growing by being “held” by the caring other providing a positive environment with positive feedback and minimizing negative feedback (Schoore, 2003; Siegal, 2012).

These affective positive states are achieved through mutually coordinated communication. According to Allan Schoore, the purpose of an attachment relationship is to regulate affective states (2003). One way in which this is achieved is through the production of oxytocin that is released in the body in response to positive experiences. These experiences in a therapeutic and parenting relationship are times when the interactional pattern is one in which the parent is attentive, caring, and aligns with the child in such a way that the child experiences emotional relief and is able to be calmed and soothed as a result of being heard, validated, and felt. When one experiences this chemical in response to positive experiences, the effect is that the individual wants to repeat the experience because it feels so good. As a consequence of providing positive feedback in a caring manner, the child has an increased desire to continue to learn and grow in order to be rewarded.

Changes in brain patterns or neuronal connections occur because there is activation of certain neural networks, and there is incentive for the neurons to change their wiring pattern. That incentive can be in the form of a positive chemical reaction that feels good to the body or it can be in the form of a positive outcome for change in behavior. Either of these will cause the neurons to be motivated to fire together in similar circumstances (Cozolino, 2002). Thus it is critical for a parent to punctuate when a child has achieved some level of functioning or desired outcome so that the likelihood of that behavior occurring is increased.

There are more neural networks from the emotional part of the brain or the limbic system than there are from the cognitive part of the brain (Fishbane, 2007). As a result, we seem to be wired to experience life through our emotions. Unfortunately in our upbringing, our emotional life is what gets stunted. We are taught not to feel or to blunt our feelings so as not to be overwhelmed or not to be abandoned and left all alone with our emotions (Fosha, 2002). Consequently, by the time we become adults, we have learned some fairly sophisticated ways of numbing our feelings in our interactions with others. This behavior keeps us from experiencing an authentic and satisfying life. It becomes the parent's job to help the child experience these emotions in a caring, supportive, nurturing relationship. As a result of being that caring other, the parent assists the child in bringing about desired and lasting change in their behavior, by changing the child's brain. In making this connection between therapist and client Baylis stated, "As therapists lend themselves to their clients, the attachment or bond that develops is reflected through improvements in outcome associated with neurological change" (Baylis, 2006).

This is a daunting task for a parent and equally daunting for the therapist who is responsible for helping the parent through training, consulting and overseeing how the parent

implements the interventions provided. In the therapeutic relationship, the child is impacted by the relationship the therapist has with the parent. If the parent is to be regulated and supportive of the child's process, then the therapist likewise needs to be regulated and supportive of the parent's growth process as well. The therapist who strives to be that supportive other to the parent must have unconditional regard for the parent and must take care to develop their own capacity to connect with another.

Through the therapist's ability to connect with the parent, any distress, agitation or issue needing to be worked through can be done within the relationship. The caregiver who helps children work through their trauma and attachment issues needs to release the energy from that intensive work in a supportive and nurturing relationship. They need a therapist who can be mindful of their own state of being in order to be attuned or connected to the parent's state of being. When the communication between the parent and therapist or parent and child is mutually coordinated with a give and take flow we say there is attuned communication taking place.

In this attuned relationship, the parent is able to release the energy associated with the therapeutic experience or experiences they had with their children. The parent is down regulated and thus able to resume their caregiving work from a regulated, attuned, positive place of being.

Right brain communication. There are two hemispheres to the human brain (Schoore, 2003). Allan Schoore's (2003) team of neuroscientists study how one hemisphere communicates with another hemisphere. The left hemisphere is considered to be in charge of linguistic expression along with analytical and problem solving skills. The left hemisphere is also believed to be focused on the past and the future and sees the individual as being

separate and apart from all else. In the author's experience it seems as if children who have suffered early childhood abuse and neglect have a strongly developed left-brain that is responsible for their ability to survive in an adverse environment.

By contrast, the right hemisphere is believed to be the creative and intuitive hemisphere (Taylor, 2008). The right hemisphere is focused on the present moment and sees the individual as an integral part of the whole universe. The right brain experiences no separation. In the infant/caregiver dyad, Schore (2003), stated the right brain of the adult caregiver is communicating with the infant's right brain. The infant's brain is learning how to perform all kinds of physiological functions from this communication during those critical first two years of life. One of the most critical functions being learned is how to get calm when distressed.

This too is a component of one's attachment style. A child's distress can be cured when there are high levels of empathy, unconditional regard, and acceptance by a positive, caring adult (Bowlby, 1988; Siegel, 2004). As such, it becomes critical for the caregiver to place significant emphasis on developing an emotionally attuned, nurturing and supportive relationship with the child such that she feels heard and felt.

Resonance. To achieve resonance in the parent child dyad, a connection must be made between the caregiver and child. Heart Math (Childre, 2000) described the electromagnetic frequency that one's heart puts out as a signal that broadcasts to everyone. When the frequency of two hearts is in alignment, it is said there is resonance between those two individuals. The frequency alliance that is created between individuals enhances the likelihood that there will be emotional resonance. Emotional resonance occurs when the right

brains of two individuals are synchronized as a result of their electromagnetic frequency being coherent.

Through emotional resonance, there is significant nonverbal, communication between the two individual's right brains (Schore, 2003; Siegel 2012). While Schore's, (2003) neuroscience team can verify that there are about 40,000 pieces of information shared from one right brain hemisphere to another, the team is still researching how this sharing of information occurs. To date, they are aware of five modes of nonverbal communication, through 1) eye contact, 2) facial expression, 3) tone of voice, 4) closeness or proximity and 5) body language, one has the ability to communicate his or her internal state to another.

Coherence. When the brain and heart are in alignment or their brain and heart waves have a similar pattern, it is said the individual is in a state of coherence (Childre, 2000). When individuals are coherent, their systems operate at optimal efficiency (Childre, 2000). Based on McCraty's (2003) research it is now understood that the heart is responsible for emotional processing. The heart acts as an information processor enabling us to learn and remember. This function operates without input from the neocortex (McCraty, 2003, p.3) This correlates to Schore's (2003) work of right hemisphere brain functioning, stating that it is the heart that is responsible for our emotional processing. McCraty has maintained that the heart influences, "...higher brain centers involved in perception and emotional processing" (p. 3)

Positive emotions along with feelings of appreciation have been correlated with physiological states of coherence (McCraty, 2003). Such a state of coherence has also been shown to improve cognitive functioning and mental clarity as well as an increased sense of

well-being and emotional stability (McCraty, 2003, p.5). When two coherent systems are entrained, or their wave patterns are synchronized, they are said to be in resonance.

Statement of the Problem

Is it possible to teach a parent and child how to achieve coherence within themselves and then facilitate resonance or heart to heart connection between the two? If our brain changes in relation to another brain, can we change the brain of a child whose early childhood experiences taught them the world was a hostile place in which they were responsible for their survival, to a brain that knows there are others who care about them and will look after their physical and emotional needs? “Once a new pattern is established, the brain strives to maintain a match with the new program, thus increasing the probability of maintaining coherence and reducing stress, even during challenging situations” (McCraty, 2003, p. 5).

In the current approach to treating children with attachment issues, the child is responsible when their behaviors do not get better. Could it instead be that the treatment approaches used to assist families in bringing about behavioral change are the problem and not the child? What if, as neuroscientists tell us, the need to connect or attach to a loving caring other remains with us throughout the lifespan? If approached from a neuroscience perspective is it possible that parents could be taught how to reach and connect to these behaviorally challenged children whose early childhood experiences taught them that adults were not to be trusted?

The problem is if we don't reach our children who are merely victims of stressful lives, these children face incredible obstacles to becoming healthy, functioning, contributing members of society. In my work with this population of children, I am amazed at how

brilliant they are and what an insightful perspective they bring to life when they are given a chance to emerge as connected individuals able to heal and grow. This perspective is in contrast to the child showing up in life with behaviors designed for protection from the next perceived threat to their survival. The past sixteen years of serving this population of children and their caregivers has taught me these children do indeed change and are not resistant to treatment when the treatment approaches them and their families from a perspective of changing their environment. If the mental health approach to serving this population of child does not change, thousands of children annually age out of the foster care system not connected to a family structure only to face high odds of experiencing unemployment, incarceration, homelessness, and ill-health (Heimpel, 2009).

Purpose of the Study

If the connection between parent and child is important then studying this connection and exploring what can be done to enhance the connection is important as well. The Attachment Healing Center (AHC) model of treatment teaches parents how to create an environment in which the child is able to heal, grow and trust the adults to take care of them. In evaluating a treatment modality for Reactive Attachment Disorder, Becker-Weidman (2008) stated that it is the affective attuned communication that makes a difference in treating children who do not trust.

At AHC we believe we increase a parent's ability to become attuned to their child. We also work with the child to teach them how to allow themselves to feel vulnerable in this type of relationship that they have not experienced before. The purpose of this research is to study what specifically the AHC model of treatment does to enhance the attuned

communication between parent and child. The model of treatment is called, Healing in Resonance.

Through studies conducted at HeartMath Institute (2000) it has been demonstrated that when one person is motivated to connect to another, being coherent within one's self increases the likelihood of being in resonance or connecting physiologically with another. Allan Schore (2003) has researched the importance of right brain development in infants and informs us that the most important connection to be made during infancy is the connection of the adult caregivers right brain with the infant's right brain. Through this right brain to right brain connection, a child learns emotional regulation and has the experience of being seen, felt and heard by a caring other (Siegel, 2012).

A child emerging from a home where they were abused or neglected learned that in order to survive they had to learn how to manipulate, charm, and control the adult caregivers in order to get their needs met. This is done without letting the adults stay in close too long so that the child does not end up being hurt again. In order to function in a family, a child must learn how to trust that adults will meet their needs without inflicting harm. As a child learns to trust they discover that adults can meet their needs and that it can feel good to have an adult be responsible for taking care of them. By allowing the adult caregivers to really care for them, the child has an opportunity to move out of survival mode into growth mode (Lipton, 2008). In growth mode a child has an opportunity to get connected to a family, learn how to get along with their peers and can possibly excel in school.

We believe there is a way to teach such a child how to trust and it is the purpose of this study to research our model of treatment to determine its effectiveness in working with this population. After researching the Attachment Healing Center model our aim is to then

teach others, parents, teachers, and counselors, how to work with children and their caregivers to bring about a different life experience for children who had less than an ideal beginning to life.

Literature Review

Significance of the Study

This study was undertaken to address the need for an effective treatment for children identified as displaying behaviors and emotional issues associated with the diagnosis of Reactive Attachment Disorder (RAD). These behaviors are severe and the need for treatment is dire (Festinger, 2002; Hardy, 2007). Heimpel (2009) states that the plight of children who age out of the foster care system without being connected to a family or caring adult are at risk for unemployment, serious health issues, incarceration, and homelessness. Is it possible these children emerge from the system alone because we do not know how to meet the needs of this population?

Festinger (2002) discussed the need for post adoption services to help families and children. To date, services are few and have limited effectiveness (Hardy, 2007). If it were possible to determine how to repair the damage done by the abuse and neglect a child receives as an infant, perhaps we would stand a chance of reversing the behaviors a child diagnosed with reactive attachment disorder displays. Golden (2011) outlined the following characteristics as possible behaviors displayed by children with attachment difficulties: Failure to relate to others in socially and age appropriate ways; Contradictory responses; Indiscriminate sociability; Resist comforting. The purpose of this research was to study what specifically the Attachment Healing Center model of treatment, Healing in Resonance, does to enhance the connection between parent and child that helps the child learn to trust adults.

Diagnosing Attachment Disorder

According to the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association, 2000) pathological care provided by the caregiver contributes to the child's poor

social behavior in relation to others. The DSM is also clear that every child experiencing abuse or neglect in the first five years of life does not necessarily end up with reactive attachment disorder (RAD).

Diagnosing a child with reactive attachment disorder is challenging. There are some assessment tools, however there is a debate about how effective these tools are in diagnosing the disorder (Puckering, 2011). Some clinicians are reluctant to give a child the diagnosis because of the stigma associated with the disorder. There is the belief the child will not get better because the disorder is resistant to treatment (Sherpis, Doggett, Hoda, Blanchard, Rendro-Michel, Holdiness & Schlagheck, 2003). No one wants to be responsible for pinning a terminal label on a child (S. Marin, personal communication, April 2007).

In order to meet the requirements of the diagnosis, these behaviors must be present prior to age five. There are two types of reactive attachment disorder, inhibited type where the child is more withdrawn and disinhibited type, where the child is more aggressive. According to the DSM-IV-TR (APA, 2000) this disorder is associated with “grossly pathological care” (p. 127) provided by the caregiver. The three criteria for pathological care are: 1) persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection; 2) persistent disregard for the child’s basic physical needs; 3) repeated changes of primary caregiver that prevent formation of stable attachments.

Treatment approaches for disorganized attachment

The third criteria for RAD, repeated changes of primary caregiver that prevent formation of stable attachments, can present a challenge when evaluating the living conditions of children in foster care. Who is to say what contributes to a child moving from one foster home to another. Could it be the child’s inability to function effectively in a family setting

that contributes to their being removed from one family to another? Is it possible that the child does not settle into one family because the family setting itself feels unsafe to the child? Perhaps it is not the moves that contributes to the child having an attachment disorder, but rather what precipitates the moves. After several moves where parents declare that the child's need exceeds their abilities, a child is often placed in an out-of-home facility like a hospital or residential treatment center.

Children with attachment issues are routinely admitted to inpatient facilities because their behaviors can become so severe it is near to impossible to keep them safe in a family setting (S. Marin, personal communication, March 2011). Current treatment approaches seem to focus on the behaviors the child exhibits or on the parenting skills of the provider. One such program is the Mellow Parenting Programme (Puckering, 2011). This approach was proven effective in improving the parent/child relationship where the child still resides with the birth family and the children were at risk due to marital difficulties, domestic violence, and social disadvantages. Parents in the population served had mental health issues identified and the children had behavioral difficulties. This treatment program ran for one full day a week for 14 weeks. There was a group for the mothers, videotaping of the interactions between mother and child and shared mealtimes. Based on the success of the program with young children and their parents, the Mellow program was modified to work with school-aged children identified as having attachment difficulties.

While this approach proved highly effective with the original population studied, the results were not as favorable with school-aged children diagnosed with RAD. Some of the children in the pilot study did not live with their biological families and were of a different age than normally treated with this approach, although other demographics seemed to match.

The researchers felt the fact that some of the children were in foster care and not with their biological families possibly contributed to the parents not being as invested in examining their own issues as a component of treatment for the foster child. The parent seeing their role as significant in the treatment of the child identified as having an attachment issue seemed to be a key factor. While the parents' emotional health improved, there was no significant improvement of the children's behavioral presentation (Puckering et al., 2011)

Hardy (2007) reported on a case study from a residential facility where staff members were split as to the approach they felt would be best for an eight year old child identified as having attachment issues. Some staff felt the child needed structure, while others felt the approach should be more nurturing. Regardless of which approach was used, the child resisted all attempts at helping him bring about a change in his aggressive behaviors. By the end of the case study, even the staff members who were initially in favor of approaching the resident with a nurturing demeanor had been reduced to having no patience with the child and resenting the fact that the young boy resisted all attempts at connection. This suggests that treatment should focus on the nature of the relationship between the child and the adult caregiver and not solely on the child's behavior.

The approaches raised above appear to address the child's behaviors or the parent's mental health presentation. The connection between the child and caregiver has not been addressed. It is my belief that this is where treatment should be focused.

Attachment system

The attachment system between caregiver and child is an infant's key to survival when all goes right (Connors, 2011). An infant's attachment system provides safety and protection, allows the infant to get their needs met and when developed appropriately,

enables emotional regulation. In monitoring the state of the environment to determine if it is safe or threatening, Connors stated the infant's attachment system is probably always operating and is doing so out of awareness. "The infant or child actively organizes information concerning the attachment figure's availability and regulates his or her behavior accordingly in order to optimize security" (Connors, 2011, p. 351). A child with secure attachment uses the adult figure to maintain emotional regulation. A child reared without an adult caregiver to depend on, develops strategies for relying on themselves to ensure safety and to achieve some level of emotional stability (Main, 1995).

There are two attachment styles that come from a child receiving pathological care, insecure attachment and disorganized attachment. According to Main (1995) an infant who has received dismissive care minimizes a display of emotion in order to maintain an attachment with their caregiver. Such an infant is said to have an insecure attachment style. This infant will stay close to the adult in an effort to find ways to conditionally meet their emotional needs. An infant whose mother has been self-absorbed and is only responsive periodically learns to maximize their display of emotional need in order to garnish some of the caregiver's attention. Disorganized attachment is said to result when the infant has not developed a strategy for managing overwhelming affect and has not found an effective way to get their needs met (Siegel, 2007).

One's attachment style initially developed in infancy, determines how an individual handles relationships (Siegel, 2012). Connors stated it is from an infant developed attachment style that one learns about the self in relation to others. This is the initial blueprint from which the developing infant determines how to show up in peer relations, in relationships with other adults, and with authority figures, such as teachers.

Parent child relationship

In talking about an infant's original development, Peirce (2009) quoted Joseph Chilton Pearce (1992) when discussing the fact that it is through the heart that the embryo communicates with the mother. After birth, it is this connection between mother and child through their hearts' communication that remains vital. Quoting Pearce, Penney Peirce (2009) stated, "When the mother's subtle sphere overlaps the infant's, a major communication takes place. This subtle communication might be below the level of awareness for the mother, but is the only level of awareness fully active in the infant." Peirce concludes, "So, the heart-to-heart skill of *feeling into* – child to mother and mother to child – is our original method of growth and survival" (pp. 54-55).

The cell biologist Bruce Lipton, in *Biology of Belief* (2005), stated that it is the environment that communicates to the cell. In a safe environment the cell is able to grow. In a hostile environment, the cell must do whatever is necessary in order to ensure its survival. In essence, a cell is either in growth or in survival mode, but it cannot be in both modes at the same time. The cell determines how to behave – to grow or to survive, based on the environmental cues. The pathological care an infant received communicates an unsafe environment and the infant has to adapt their behaviors to ensure their survival; this is a critical concept. The behaviors associated with children identified as reactive or as disorganized attachment are behaviors designed to ensure the infant's survival. And given the number of children with these behaviors whether or not they have received the diagnosis, it seems as if the cellular system was quite successful in surviving a hostile environment.

According to Lipton (2008) when that infant grows those behaviors that ensured his initial survival are now the behaviors that are inhibiting the child from experiencing a safe

environment. For example, in the original home due to the caregiver's inability to meet the child's physical need for food, a child might steal or hoard food on a regular basis and hide it in his room until it rots. This child now needs different behaviors to support them in entering growth mode. This child now must learn that their hunger needs can be regularly met by the adult caregivers. The child also needs to learn that it is safe to have an adult in close proximity. For many of our children having an adult in close brings fear because of early childhood experiences with adults inducing pain when in close proximity. The child must have the experience of safety in his environment with adult caregivers. When a child can have an experience of safety at the hands of an adult caregiver, he has a chance of entering growth mode in which he can learn new behaviors. As a result of leaving survival and entering growth mode, the child would have a new paradigm for how to effectively do relationships with others without having to protect himself in the process.

Based on the pathological care the infant has received, the decision is made that the environment is hostile. As Connors (2011) has suggested, the infant is constantly scanning her environment. Pearce (2009) stated it is through the heart that the child receives the information about the state of the environment. When an infant has a shocking experience, and not having your needs met or receiving pain as a result of expressing a need is indeed a shock to an infant, a vigilant part of that infant is switched on to ensure this experience does not happen again. Unfortunately in an attempt to protect the organism, for older children, that system of protection that was switched on is alerted any time an adult or another person comes close and begins engaging in similar behaviors that activated that initial alarm to bring about safety ensuring behaviors. Instead of those behaviors keeping the child safe as they grow, those behaviors are actually pushing away the adult caregiver and the safe environment

the child needs cannot be attained. Pearce said to heal this cycle, the key is to return to the original shocking experience and reprogram that automatic response.

Schore (2003) informed us that the attachment system is a lifespan system. It comes online in the third trimester in utero and is active until the day we die. Since this system is operating below the level of awareness, reprogramming or repairing an automatic attachment response seems to have to occur at this level as well.

Emotional regulation

The dynamic described among right brain communication, coherence, resonance and attuned communication is emotional regulation. As outlined earlier, the infant learns many physiological functions through the heart to heart or right brain to right brain connection with the mother. This connection and resultant communication starts in utero and continues after the baby's birth. Emotional regulation is a critical component of attachment. Emotional regulation speaks to the concept of how a baby learns to get calm when distressed (Schore, 2003).

Attuned communication

The HeartMath Institute (Childre & Martin, 2000) has done extensive research into the resonant connection that is made between individuals, what Schore (2003) called attuned communication. When a person is coherent, meaning their heart and brain waves have a similar pattern, the electromagnetic field produced by the heart can be measured up to ten feet away (Buhner, 2006; Childre & Martin, 2000). According to Buhner (2006) we communicate information about ourselves as an organism through our electromagnetic field (EM). EM passes from the heart of one individual to the heart of another, it then travels to the brain where the information contained within the field is decoded. Perhaps this is the field

Pearce (2002) spoke of when he stated that there is subtle communication between the infant and the caregiver. McCraty (2003) stated that this energetic system of communication is present in adults as well, and operates below the level of awareness.

McCraty (2003) took a closer look at the energetic system of communication and provided further insight into the role of the heart. As a person's emotions change, so does their heart rate variability. According to McCraty, emotions are actually the result of the brain and heart working together. Positive emotions produce increased physiological coherence, meaning the heart and brain are working together. McCraty stated that such states contribute to an increase in emotional stability and well-being, or what we would call emotional regulation. Through the expression of positive emotions, like appreciation, an individual can experience a prolonged state of coherence. With continued practice achieving a coherent state, the brain learns this new pattern and aims to maintain it even during stressful situations. This is exactly what the infant brain needs in order to stay open to new possibilities when encountering an adult. Without a state of coherence our hypothetical child is depending on what was learned in infancy. In infancy adults meant pain and the need to be in survival mode to ensure protection. Instead of retreating to a place of fear, if we can help the child achieve a state of coherence in the face of an adult caregiver, perhaps we have a chance of healing the initial shock that resulted in the behaviors that are now seen as dysfunctional in a family setting.

When an adult caregiver can get coherent within themselves they are more likely to help the child achieve coherence as well. When the parent and child are in coherence within themselves and connected to one another we say they are attuned. Attunement here refers to the adult being coherent, or their heart and brain waves in alignment and as a result of the

adult being calm, regulated and coherent they are able to energetically connect with the child. When the adult in this state of coherence connects with the child it helps the child's brain and heart become coherent and between the adult and child there is a give and receive of energetic information and connection which can be observed through their give and take of verbal and non-verbal communication.

Through measures of heart-rate variability, attunement between clinician and client have been measured (Robinson, Herman, & Kaplan, 1982). These times of attunement were directly connected to times when the clinician was experiencing high levels of empathy for the client. Attunement has also been measured in a firewalking ritual (Konvalinka et al., 2011). Based on measures of heart-rate variability, the study found that empathy only enhanced synchrony and attunement when the observer was related to the firewalker. The authors noted that while attunement had been measured in family members, it had never been measured in a natural setting. There also seems to be a gap in the literature concerning measuring attunement between caregiver and child.

Trust vs. Mistrust

Erikson talks about eight stages of human development. The first stage which occurs in infancy and is believed to run from birth to about 18 months of age. During this stage of development a child learns to look to the adult caregiver to meet their daily physical and emotional needs. If a child does not learn to trust the adults during this time, can they learn it at a later date?

Repairing Attachment

McCarty (2003), as well as Gudzer, Bond, Rabiau, Zelkowitz, and Rohar (2011), stressed the importance of all those involved in treatment being motivated to bring about

change. Escudero, Friedlander, Varela, and Abascal (2008) called this a “shared sense of purpose” (p. 203) and stated that the therapist and family sharing a sense of purpose is a significant contributing factor to bringing about a change in family dynamics. McCraty (personal communication, December 10, 2011) stated it is also necessary for a caregiver and child to share a sense of purpose in order for there to be a resonant connection established which can then be measured through heart-rate variability.

Research Assumptions

This study was undertaken as the first test of the Healing in Resonance treatment modality as practiced at the Attachment Healing Center. This research was the first step in asking if a resonant connection can be made between a child who experienced abuse, neglect or other trauma in the first few years of life and an adult caregiver who is taught the neuroscience of attachment. Once a child has learned mistrust in Erikson’s first stage of development is it possible to teach them to trust? Traditional therapeutic approaches tend to miss the mark in bringing about lasting change with a child who does not trust adults due to traumatic experiences from the first few years of life. The second question is does this treatment approach help to bring about a lasting change in a child’s behavior? While this study did not look at the in-home or in-office therapeutic component, it asked this question of one aspect of the treatment approach. Did the psycho-educational parent group contribute to bringing about lasting change in the parent-child relationship?

The first assumption is that there was heart-to-heart communication going on below our level of awareness (McCraty, 2003). The next assumption is that this communication began in infancy (Pearce, 2002) when the child was receiving pathological care which communicated that there were elements of the relationship between child and adult that were

unsafe. An unsafe environment would trigger in the child an urgency to protect themselves in order to survive (Lipton, 2005). The research question then was, can we consciously learn another way to enter that state of attunement or connection and provide the child with a different experience so that the original wounding and shock to the system can be healed through the parent-child connection, where the wounding first occurred, even if the original wounding did not occur with the current adult guardian? Is repair between parent and child possible so that the child can learn to release her defenses and begin to trust adult caregivers to meet her needs and have control over her? In other words, can the child learn trust of care and trust of control after the trust versus mistrust stage of development has passed? This study aimed to determine if indeed a state of resonance can be reached in a parent/child dyad where all involved are motivated to bring about a change, through the use of positive emotions like appreciation and empathy. Once achieved can that state of resonance then be measured in a natural setting through heart-rate variability? If such a state between caregiver and child can be reached, and this state can be measured, the next step is to determine if sustaining such a state has an impact on the behaviors of the child in relation to others. We did not directly measure heart-rate variability in this study, however we qualitatively measured if the parent's experience of the parent-child relationship changed and if the child's behaviors changed as a result of the parent's experienced change in the dyad.

Methodology

Chapter 3

This research aimed to investigate the parent group training aspect of the Healing in Resonance model of treatment as practiced at the Attachment Healing Center (AHC) where children identified as having disorganized attachment are treated. When a child has had severe abuse or neglect as a part of their upbringing prior to the age of five and they present with opposition, defiance, aggression, and resistance to adult care they can be diagnosed with Reactive Attachment Disorder (RAD). Not all children with disorganized attachment receive such a diagnosis.

Helen Minnis (2006) describes the internal process of what happens to a child who has misattuned communication as discordant intersubjectivity. Minnis described intersubjectivity as, "...the process whereby an infant's brain development is 'supported by the intuitive responses of parents and other human companions'" (p. 339). Coupling the concept of intersubjectivity with the RAD diagnosis, children who have suffered what the DSM-IV (APA, 2000) refers to as "grossly pathogenic care," Minnis says these children "...have not experienced subtle distortions of essentially normal relationships, but major distortions, inconsistencies or even the absence of healthy relationships" (p.338). What these children learned instead is that the caregiver they need for comfort and survival is also someone to fear. There is a confusion experienced within the child that results in a disorganized attachment style. Children who fear their caregivers tend to show up either shut down and not allowing the parents to care for them (referred to as inhibited) or children are extremely physically and verbally abusive as a means of preventing the parents from caring for them (referred to as disinhibited).

Parenting children who fear their caregivers yet need them to meet daily physical, emotional and developmental survival needs is extremely challenging. The Healing in Resonance model of treatment used at AHC aims to teach parents how to connect with a child that is terrified of connecting with adult caregivers. Training the parents in a group was recommended by numerous AHC therapists who struggled to get parents' attention while conducting therapy in home environments that tended to be very chaotic due to the behaviors exhibited by the child or children.

During the parent group training the parents are taught the neuroscience concepts that help parents understand their child's brain. The training also provides a new perspective on how to do parent child relationships in an effort to help the child heal. From here the parents are taught how to be the agent of change who through implementation of the neuroscience-informed interventions bring about a different experience for their child in relationship with the parent. The disorder developed in relationship with the primary caregiver, and so this study assumed its remedy was found in relationship with a positive, caring, nurturing caregiver who could bring about corrective experiences for the child.

Through these corrective experiences the child is able to have attuned, concordant communication and thus learns that connecting with his caregiver has a rewarding and pleasing quality. The child then seeks these positive interpersonal experiences on a regular and more consistent basis. As the child learns a new way of interacting with adult caregivers his brain is changed as evidenced by his change in behavior. The Healing in Resonance approach to treatment does not aim to manage behaviors, but rather to change the child's brain. The result is that the child's brain is changed along with their perspective on the nature of being in relationship with adult caregivers.

Participant characteristics

The population studied was parents of children between the ages of three and eighteen years of age who through clinical interviews by current and former clinicians were identified as having disorganized attachment. Each of these children was living with an adult caregiver, defined as either a birth or adoptive parent. Four of the parents identified as White U.S. citizens with a college degree. One participant identified as mixed race, identifying as White, Mexican and Irish. This participant had a junior college degree. The participants were all English-as-their-first-language speakers and they all had an annual household income greater than \$50,000. Only one parent indicated any prior experience working with children identified as having attachment or trauma issues. This parent has fostered over 100 children and home-schools special needs children.

The exclusion criteria for participant selection was: adult caregiver not over 18 years of age; adult caregiver's child's age was younger than 3 or older than 17; adult caregiver was not the legal guardian; the family was seeking mental health counseling through another agency; the family previously received treatment through the Attachment Healing Center; none of the adult caregivers were willing to travel to the four weeks of group; none of the adult caregivers were willing to attend all four weeks of the psycho-educational group; the adult caregiver was not able to speak and write in English; the adult caregiver was not willing to journal about their experience of implementing what was taught in group into their parenting style with the child identified as having disorganized attachment; adult caregiver was not willing to be interviewed about implementing the material discussed in group; the adult caregiver was not willing to be observed parenting their child; and there were comorbid disorders in the parent or child that excluded them from this study.

The participants received in-home family counseling and in-home without-client counseling. There was a four-week psycho-educational group for the caregivers while the children attended a four-week emotion-focused group. The participants were all willing to travel to the Las Cruces office for the entire four weeks of the parent group training.

Efforts were taken to ensure that participants were of varying socioeconomic levels and representative of various ethnic and racial backgrounds by recruiting from the current list of families enrolled in treatment at AHC. Children and families are referred to the agency through the New Mexico Children Youth and Family Department in Las Cruces, as well as from the local hospital and residential and treatment foster care facilities. However, while the children were of Hispanic, White or African-American backgrounds, the parents were all White. The children also came from varying socioeconomic environments prior to their current living situation.

The resultant participants were recruited from three different parent groups. These five parents are the ones who were able to follow through with the research requirements. During the first parent group of volunteer parents, the researcher explained the study and obtained the potential participants' informed consent. Children of the parents who volunteered were informed of the study and their informed consent was also obtained. Of the eight parents over three groups who signed the informed consent in the first group only five parents completed all of the study requirements. While the invitation to participate in the research was extended to about 45 parents only five of those parents were able to commit and complete all of the research requirements.

Participant Selection

Stake (1993) spoke to multi-case study as an opportunity to study a phenomenon across different environments. Parents attending the AHC psycho-educational parent groups were asked to participate in the study looking at the impact of the group on the treatment of their child and family.

The study included the adult caregivers attending four two-hour psycho-educational groups that informed the caregivers of the neuroscience concepts used in the development of the model that was being researched. While the adults attended a psycho-educational group, the children attended a peer group aimed at helping the children get in touch with their feelings that are not being appropriately expressed.

This study aimed to determine the effectiveness of the parent group in supporting the AHC model in treating children identified as having disorganized attachment styles. Disorganized attachment styles develop in infancy. Due to the pathological care the child received they learned how to survive a family setting by pulling adults in close to get basic needs met and then pushing the adults away before the caregiver had a chance to inflict pain on the child. Many treatments for this attachment style have been attempted, but for various reasons, they do not seem to be able to help a child learn how to feel safe in a family environment. Each year, about 25% of the 463,000 children who are in foster care age out of the system without being connected to a family support system (Hardy, 2007). Determining the effectiveness of this treatment approach aimed to help the caregiver of a child with disorganized attachment learn how to teach their child to trust the parents. Once the child learns to trust they have a chance of being raised in a family setting instead of a residential

setting. Such a treatment would set this child up to be connected to a family support system after the child turns eighteen and enters the world as a young adult.

Not every child we see and treat meets the criteria to be diagnosed with RAD, however, they may still have disorganized attachment. Some of these children are referred to AHC with the diagnosis of Reactive Attachment Disorder (RAD) and some do not have that diagnosis when referred, yet have all of the symptoms. Four of the five children whose parents were in the study were diagnosed with RAD. The fifth child had severe RAD symptoms but did not have the diagnosis when referred.

Procedures

Once the adult participants signed an agreement to be part of the study, they were given questions to answer after each week of attendance at the psycho-educational group. Every child over the age of seven was also given a child assent giving permission to be observed during a family therapy session once the parent had completed four weeks of journaling. The parents journaled about their experience applying the concepts covered in group. The parents also were asked to journal about how their relationship with their child was or was not changing as a result of implementing the information learned in the parenting group. A copy of the journal questions can be found in Appendix G.

The participants were each given four envelopes in which they could seal each week's journal and present it to the research assistant at the start of the following week's group. The researcher collected all of the journals and transported them in a locked box to Albuquerque for data analysis. Once the parents completed their journals, the researcher observed a family therapy session.

A family session was observed to determine the quality of the relationship between the child and the adult caregiver. A Family Therapist Rating Scale (Piercy, Laird & Mohammed, 1983) was used to capture the attachment behaviors and relationship style between child and parent. Following the observations, the researcher interviewed the parents. One family had discharged from treatment by the time the observation was scheduled, so an interview was conducted in the family home where the relationship between child and one of the parents could be observed.

Conducted as a focus group, the findings of the research were presented by the researcher and research assistant to all of the parents who took part in the study. While the intent of the focus group was to present the findings, the participants took the opportunity to connect with one another and shared how they were able to sustain the success they achieved using the AHC approach to treatment. A study code was assigned to each adult participant so the findings are anonymous. The findings are posted on the agency's website.

Data Collection

Journals from all adult participants were collected and placed in a locking box for transport to the agency headquarters in Albuquerque, NM. The initial diagnostic assessment was used to determine if one of the children in the home had disorganized attachment or presented with symptoms of trauma or attachment disorder. All of the children whose parents agreed to be in the study were either diagnosed with RAD or had RAD symptoms. A summary of the clinical assessment was included in the study, but the assessments themselves were not included.

Once the journals were collected, the researcher conducted an observation of the child and parent in a regularly scheduled therapy session. Following the observation, the researcher

interviewed the parent to address any questions raised as a result of reading the journals. The interview and observation were conducted as a part of ensuring that the meaning being constructed through the data gathering was consistent with the meaning the research participants assigned to the data (Stake, 1995).

The study findings were presented to the research participants in a focus group. Prior to the focus group, each participant had an opportunity to read and edit the vignette that was created based on their journals, interview and observation. Fassinger (2005) states the importance of allowing the research participants an opportunity to verify the accuracy of the data collected and to clarify the data they have provided. There were a set of focus group questions created prior to the group, however, once the group was underway the questions evolved. The final list of questions can be found in Appendix H.

Instruments

It was not necessary for the children in the study to be diagnosed with RAD, but it was necessary for them to present with a disorganized attachment style of relating to their caregiver. In order to determine that every child in the study either had reactive attachment disorder (RAD), or had disorganized attachment without the diagnosis, a complete diagnostic clinical interview assessment was administered by the Branch Clinical Director who was also the research assistant. This clinical assessment took place during the initial meeting with the child and parent to determine if the family was appropriate for the study. To assess the child for the diagnosis of reactive attachment disorder the DSM-IV-TR was used to determine if all of the criteria were met, along with the Minnis 17-item questionnaire for reactive attachment disorder (Minnis, Rabe-Hesketh, & Wolkind, 2002). The Minnis RAD questionnaire was completed at the start of treatment during the assessment, prior to the and during the focus

group to determine if there was a change in behaviors as a result of parents attending the parent group training. All of the families received in-home or in-office family counseling in addition to the group training. Any resultant changes in the child's behaviors cannot be solely attributed to the parents' attendance in group.

There are two subtypes of the reactive attachment disorder, inhibited type and disinhibited type (APA 2000). In the inhibited type the child fails to respond to social interactions in age appropriate ways and in the disinhibited type the child demonstrates indiscriminate charm with all adults. In the cluster analysis of the Minnis questionnaire, two of the three groups in their instrument test corresponded with the two subtypes of the disorder. The questionnaire scores were significantly associated with many of the symptoms associated with the disorder, for example, conduct problems and problems with peer relations (Minnis, et al., 2010).

The RAD questionnaire (Minnis, 2002) was developed for use with children between the ages of 18 months and 17 years of age. The RAD questionnaire is a 17-item assessment that has good internal consistency with a Cronbach's alpha of 0.70. The items are broken down into clusters associated with Attachment Disorder – Disinhibited type (AD-D) and Attachment Disorder – Inhibited type (AD-I). The AD-D cluster has a Cronbach's alpha of 0.66 and the AD-I cluster 0.70. The inter-rater reliability was 0.81. The intra-class correlation of the test-retest study was 0.78. The Minnis questionnaire can be found in Appendix D.

Based on the initial assessment of the child, the Minnis RAD questionnaire was completed to determine the level of severity the child presented with at the start of treatment. The RAD questionnaire was also used at the end of the Parent Group which was before the interviews to determine the level of change in behaviors exhibited by the child. To capture

the child and parent relationship characteristics observed during the family session, A Family Therapist Rating Scale (Piercy, Laird & Mohammed, 1983) was used to identify the interpersonal behaviors the parent was engaging in to express concordant communication with their child. Given this is the experience the child needed to have corrected, this was the behavior the researcher sought to observe. The rating scale was used during the observation of the regularly scheduled therapy session. While this scale is not a validated instrument for observing parent child interactions, it is a good scale for observing the interpersonal relationship skills needed to create emotional safety in a relationship as one interacts with a child in an effort to rewire their brain around how to do intimate relationships. This scale was used as a means of concretizing the behaviors being observed between parent and child where the behaviors surrounding the mutually coordinated communication is critical to capture. A copy of this instrument can be found in Appendix E. For this study the scale was renamed Family Observation Rating Scale.

Research design

Stake (1995) indicated that qualitative research is used when the researcher wants to find out about the processes of a phenomenon. If the AHC approach to treatment, Healing in Resonance, was effective, and the training the parents received as a part of treatment contributed to that effectiveness, what was it about the parenting training that was making a difference? Stake also stressed the importance of the role of the investigator. It is important for me as the researcher to be aware of the perspectives I bring to the study and to capture how I am impacted by the data gathering process.

Yin (1993) stressed the importance of identifying what descriptors are important and will be included versus what descriptors will be excluded. For this study to compare the

effectiveness of this treatment approach against any other approach, it was important to know if the participants have tried other treatment modalities before coming to AHC. Additionally, the age of the child and whether or not they were a birth or adoptive child was a descriptor that was included. The behaviors the child presented at the start of treatment compared to the behaviors witnessed during the study were important to compare. If there were differences, it was important to ask what if anything contributed to those differences. In particular, it was important to gather the adult participant's experience with the group as a contributor to the child's behavioral change. Once these questions were answered, the data gathered was used to generalize to a theory of what if anything, contributed to the parent and child's change in relationship, (Yin, 1993).

Treatment intervention

The AHC model of treatment, Healing in Resonance, consists of in-home and in-office outpatient treatment for children with severe behaviors. When the behaviors are not as oppositional or defiant towards the adult caregivers, the child and family can be seen in the office. From a family systems perspective (Minuchin, 1998) it is best not to put the parent in the middle when trying to address disturbing behaviors. When children with severe issues come into the office they tend to be more anxious. As a result, they don't demonstrate the behaviors the parents typically experience when the child is at home. A child presents differently at home when they feel more comfortable in his or her surroundings. For this reason the model of treatment indicates that a child with severe acting out behaviors be seen in the home, so that the therapist can witness these behaviors and address them directly instead of stating to the child that the parents told the therapist about the disturbing behaviors.

A child's behavioral severity is judged by how verbally and physically aggressive the child is in preventing the adult caregiver from meeting the child's needs and having control of the child's life. Severity is also judged based on the child's lack of emotional regulation. When a child gets anxious or aggressive and does not have a means for calming himself without doing damage to himself or another, this is categorized as severe. When the behaviors are mild or moderate, the child and family can be seen in the office. As the child begins to stabilize and behaviors begin to normalize, treatment is transferred to the office. Transferring the location of treatment from the home to the office is also another way of indicating hope to the family that healing is possible.

In addition to seeing the child and family either in the home or office, the clinical team has asked for assistance in having the parents attend a psycho-educational group with other parents so that without the distraction of the children, the parents can learn and ask questions about the neuroscience that drives the AHC approach to treatment. This study addresses the effectiveness of the parent group as a contributor to the AHC model of treatment, Healing in Resonance.

Following the guidelines of neuroscience on healing attachment wounding in addition to following structural family systems approaches to treating children, the treatment approach comes through the adult caregiver(s). Realizing the caregiver's unhealed childhood wounding would be triggered as a result of parenting a child with trauma and attachment issues, the treatment focus included the mental wellbeing of the caregiver as well as the child. Once the caregiver was able to remain grounded and not reactive, the three requirements of neuroplasticity could be implemented. The three requirements were 1) there had to be a mature, in charge, calm, regulated adult the child could get into relationship with,

2) the child needed to have corrective experiences within that positive relationship and, 3) both sides had to be motivated to change.

Attachment Healing Center Model of Treatment

The model being studied was developed as the result of training and a master's degree in Marriage and Family Therapy Systems, coupled with a five-year certification program in Dr. Dan Siegel's Interpersonal Neurobiology studies. The concepts learned around brain development, attachment, trauma and the importance of attuned affective expression have all contributed to the development of this model of treatment, Healing in Resonance.

The model's first foundational concept is that the child's brain changes in relation to a positive, caring other through corrective experiences (Siegel, 2012) where both the child and caregiver are motivated to change (Escudero, 2008). When an adult caregiver aims to provide a corrective experience to the child in their home it is essential that they remember the child's brain can change, but only when the caregiver is that positive, caring other. This means, regardless of how the child is behaving, the caregiver must respond from a nurturing stance. This speaks to the second foundational concept: an individual can change when the environment is safe enough to allow them to shift from a stance of survival into a stance of growth and change (Lipton, 2008).

The third foundational concept is that emotional regulation, a component of attachment, is learned and healed through a nurturing, relationship in which there is attuned, concordant communication. A child learns to get calm by being pulled in close to a regulated, nurturing adult caregiver. When the caregiver can stay regulated they can co-regulate the distressed child. Through co-regulation, and attuned affective communication, the child becomes regulated as well (Schoore, 2003). As the child repeats corrective experiences in

response to their distress signal, the child learns to trust another. A child's distress signal can look like defiance, aggression, lying, charm, manipulation, and resistance. As the adult responds calmly to the child's behaviors, the child learns how to get calm in the middle of a dysregulating experience. As these experiences are repeated, the child learns to trust another.

This ties into the fourth foundational concept, which is that the child's disobedience, defiance and opposition are an expression of the child not trusting the adults to meet their need. It is important for the caregiver to remember these four foundational concepts in responding to their child's need, regardless of how the child is communicating the need.

The fifth foundational concept comes from two family systems theorists, Murray Bowen (Gilbert, 2006) and Salvatore Minuchin (1998). The parents are in charge (Gilbert, 2006), so it is through the parents that the clinicians work to bring about change in the child's behavior. The majority of the interventions are tools the parents use in day-to-day parenting activities. The five foundational concepts are all implemented according to a modified version of Minuchin's Structural Family Therapy. There are five steps in our process 1) joining with the parents, 2) creating an enactment or marking one that occurs naturally, 3) restructuring by helping the parents view the interaction from a healing perspective and implement an intervention that will shift the interactional pattern, 4) reframing the behavior and providing positive feedback whenever the child shifts in relation to the caregiver regardless of how minimal that shift may be, and 5) closure with homework to provide practice for the new skills acquired during the session. The model was implemented in two therapeutic sessions within each family visit. The first segment was a family session without the client to join and guide the parents and the second was a family session with the child to help the family bring about change in the moment.

There was an overarching principle that drove the work in the family system. Both the child and the parent had to be motivated to bring about change in their own behavior (Escudero, Friendlander, Varela & Abascal, 2008). No change would come about if both sides of the equation were not motivated to change.

Clinical training. In preparing to deliver the four-week parent group centered in neuroscience, one of the research assistants was trained to facilitate the groups. Additionally, the clinicians who provided therapy for these families were also trained in the AHC model of treatment, even though for this study there was no focus on the therapy. The student investigator was not connected to training the parents. The student investigator did, however, conduct the family observation session, interviews and focus group.

Each training session lasted two hours with two to four hours of preparation prior to the training. The research assistant's preparation took the form of reading original works and sometimes writing a response to the reading. Training for the research assistant/facilitator and clinicians included modules on: attachment theory according to Bowlby (1988); attachment from a neuroscience perspective according to Schore (2003); attachment from a brain perspective by Siegel (2012); attachment from a heart perspective by HeartMath (Childre & Martin, 2000); resonance and relationships according to McCraty (2003); energy of relationships according to McTaggart (2007) and Peirce (2009); nature or nurture according to Lipton (2008); self-care; power of relationships (Luquet, 1996); Structural Family Therapy (Minuchin, 1974); Bowen family therapy (Gilbert, 1996, 1992); and power of emotions (Fosha, 2000).

The researcher/facilitator demonstrated mastery of the information by leading discussions, creating activities for teaching the information to others and role playing

applications of the theoretical perspectives in challenging scenarios. Additionally, the facilitator/research assistant and clinicians were able to discuss the principles underlying every intervention that could possibly be used with a family in treatment.

Parenting training. Five parents received eight hours of training on the basics of attachment, neuroscience, and heart-brain connection. During this training, the impact of various interventions were discussed in conjunction with how to implement these interventions with one's child. The modules covered in the parenting training included: week one – attachment and the cycle of trust; week two – triune brain, mirror neurons, four defenses; week three – right brain communication, emotion focus, schemas; week four – self-care. Training for the parents took place weekly for approximately two hours each week over a four-week period. Appendix F contains a chart outlining the parent group content, interventions and activities.

Researcher's Position

Stake (2006) encouraged the researcher to share their biases and perspectives in evaluating cases studied. With that in mind, the reader should know that I am the main researcher and owner of the Attachment Healing Center. I also developed treatment modality and materials being studied. As the main researcher, however, I did not facilitate the parent groups, but rather trained another clinician in the model of treatment being studied and this research assistant conducted the parent groups. Additionally, other than the observations of the family therapy sessions, as the main researcher I did not conduct or supervise any of the therapy delivered to the research participants.

Additionally, I am currently raising an adoptive son diagnosed with Reactive Attachment Disorder. My son was adopted two years ago. He was 11 years old when we

adopted him. At that time he could not read on a first-grade level. Over the past two years, in addition to the academic challenges, there have been severe behavioral challenges, with severe defiance and physical as well as verbal aggression towards us, his adoptive parents.

After two years of intense work, my son can now read on a fifth-grade level, and instead of sitting in the back of his class being the clown, he sits in the front of the class engaged with the academic material. While there have been significant academic gains, the behavioral gains have been slower to materialize.

As I read through the participants' journals it was as if the parents were pulling in close and reminding me of all the tools and interventions that helped them bring about change in their own homes with their children. These reminders helped me stay grounded and, instead of reacting to my son's aggressive and violent outbursts, I was able to get curious about what need was underneath these behaviors. Throughout the process of coding and analyzing the participants' journals, interviews and family session observations, I felt supported to implement what was being studied in a day-to-day, moment-by-moment basis. As a result, my son's behavioral challenges are finally shifting on a major level, rather than in small increments. Seeing this change in my own family, I have been impacted with the importance of offering parent support groups following the first round of Parent Trainings. The ongoing support from parents who have been through the process is invaluable in helping a parent stay the course with a behaviorally challenged child who does not trust his adult caregivers to meet the ongoing day-to-day needs or to have control over him.

Trustworthiness

Maxwell (2005) discussed respondent validation as the "single most important way of ruling out the possibility of misinterpreting the meaning of what participants say and do and

the perspective they have on what is going on, as well as being an important way of identifying your own biases and misunderstandings of what you observed” (p. 111). In providing the research participants an opportunity to verify the findings each participant was allowed to review and edit the vignette created from their journals, interview and family session.

Additionally, a focus group was held where the findings were discussed. The response to the focus group was overwhelmingly positive. In addition to verifying the trustworthiness of the themes and emerging theories presented, the research participants highlighted the importance of the work coming through the parents. They said when they took the focus off their child and put on themselves and the schemas and wounding they as parents needed to heal, this made all the difference.

Chapter 4

Results

Five parents of five children were asked to journal about their experience in a four week parent psychoeducational group. Following the journaling, the parents were interviewed in order to have an opportunity to expand on their writings. There were four assessments completed on the children including the observation of the family's functioning. Only the RAD Questionnaire was used as a pre and post assessment. The results of the RAD Questionnaire along with the Family Observation Rating Scale are presented as a part of each individual case study, as a means of validating any change the parents expressed occurred within their family. The results of the pre and post RAD questionnaire assessments given to the children are presented in Appendix D following the blank RAD Questionnaire form.

The name of each participant presented here is a pseudonym. Appendix B contains a chart of the activities the participants engaged in as a part of this study. Appendix F contains a list of the topics covered in each week's psychoeducational class including interventions discussed along with activities presented.

The factors addressed during the case study were: What behaviors did the children exhibit that triggered the parents? How did the parents respond to those behaviors before, during and after the training? If the parents changed as a result of the training, did the child's behavior change as well? If change occurred, what if anything from the training contributed to that change? These questions are addressed in each case review.

Stake (2006) cautioned against comparing the cases to one another, but rather to look at each case to determine what that case had to contribute to the phenomenon being studied. With this in mind, each parent's experience is presented individually. While each case is

presented individually, there are emerging themes across cases. These themes will be highlighted in a consolidated cross-case synthesis of what information emerged from each individual case. The cross-case synthesis is not meant to be a generalization of the study's findings across cases.

Data Analysis

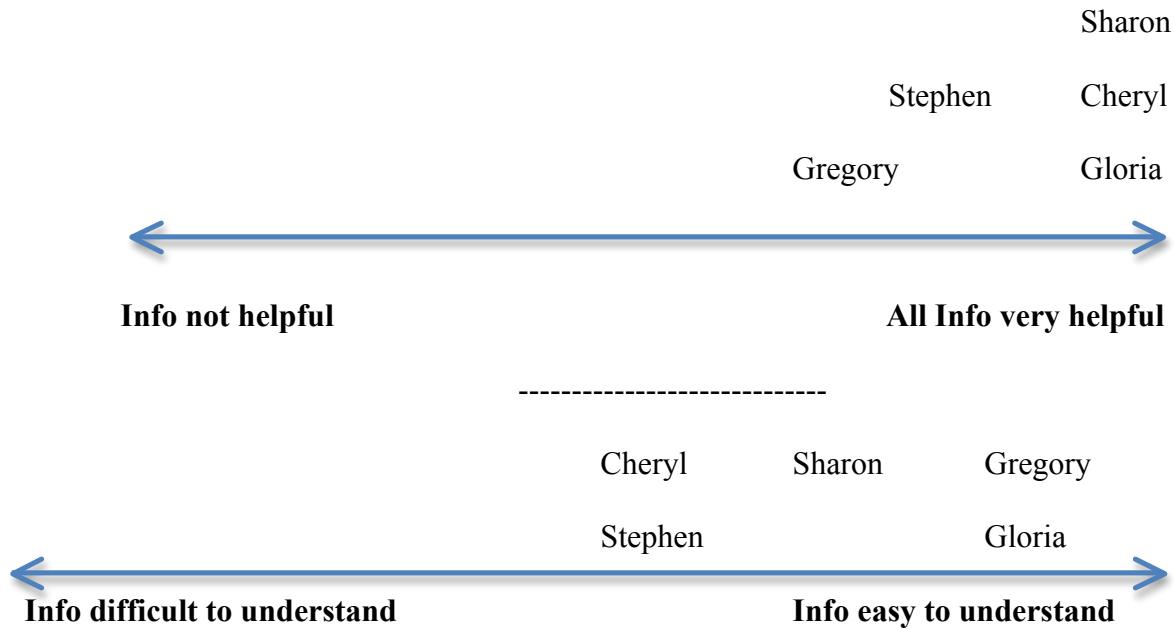
Coding. A grounded theory approach was used to analyze the data collected through journals, interviews and observations. The first step in allowing a theory to emerge from the data was open coding. The student investigator created a chart according to the Miles and Huberman (1994) column format for tracking each participants' answer to the journal questions. Each question was laid out in a grid and the participant's answer to that question was written in the column assigned to that question. One of the questions is presented in Appendix C for an example of how the grid was used.

Meanings were assigned to each participants' answers. These meanings were then grouped together into categories that included all of the concepts. Once this was done for the journals, the transcribed data from the interviews was added to the grid and compared to see if additional coding concepts not already included in the categories emerged. The categories were modified to ensure all new data coding were represented in the categories.

Once the categories were completed from the interview and journal data, the third step in the process was axial coding. During this process the relationships between the categories were examined. There was a constant comparison to see if several categories could be combined into key categories. For instance, the following statements were combined for one statement that reflected there was a change in parenting style: Parent and child getting closer; better communication between parent and child; relationships continue to improve;

less raising of voice; improved relationships with my children; all 3 children shifting; children able to stay regulated in the unknown. These statements were combined into a category of “improved relationships with my children.” This category was combined with the category that addressed the change the parents were bringing about in how they were interacting with their children. Those statements were: adult emotions calmed before engaging child; connected positively to each other’s emotions; I stay calm, in control of my words and actions; less reactive; working to stay grounded; awareness helps; logic and anger don’t help bring about change; not engaging in power struggles now; I have more patience; staying regulated when my child blows up I don’t have a strong reaction; take ownership for our beliefs that drive our parenting; challenge parents to think through their own belief system; take time to calm self first before engaging the child; now aware of anxiety triggers; I used to get overwhelmed with feeling everyone looked to me to fix things; breathing and slowing things down, helps. These statements were combined into the category of “focus on parent’s emotional state first”. The category of “focus on parents first” was combined with the category of “improved relationships with my children” to get “the parent child relationship improves when the parents focus on themselves first.”

There was a constant comparison with four different types of comparisons implemented. First categories and related sub categories were compared. Next these categories were compared to new data as it was transcribed and added to the grid. The third step was to identify and expand the properties of the categories and place them along a continuum. The last comparison step was to place each participant’s study classification along the continuum to capture the variations in their experiences. Below is a figure of the categories “information was helpful” and “information was easy to understand.”



This comparison process of evaluating categories and their relationship stopped when the resultant categories seemed to satisfactorily capture the participants' experiences. As the coding from the interviews was added to the journal coding and there was no new information that did not already fit in an identified category, it was clear there was no additional data emerging.

The final stage in the grounded theory approach of allowing a theory to emerge from the data was conducted through selective coding. All of the categories that emerged from the data were reviewed to see if there was a core or central category that integrated all of the other categories into a core story that speaks to the relationship among all of the categories (Fassinger, 2005). One of the research assistants mirrored the coding process to validate the researcher's categories that were being captured from the data were consistent with the emerging themes they saw in the journals and interviews.

The emerging theory was constantly compared to the data to validate that the theory was grounded in the participants' experiences. The emerging theory was also compared to

the current literature on attachment disorder to enrich the understanding and offer an explanation of what had occurred during the change process (Fassinger, 2005). The result was an identified theory that had a set of well-developed categories with statements that spoke to the relationship among the categories.

This emergent theory is being used to contribute knowledge to the field of counseling. The goal was to determine what if anything can be done to help children who experienced early childhood trauma in their primary relationship with their caregivers learn to move from mistrust to trust of adult caregivers. This therapeutic work was being undertaken in an effort to bring about lasting change in the child's behavior and ability to do relationships in a family setting.

The data from the journals and interviews spoke to the emerging theory of what contributed to change in the parent's relationship interaction pattern with their child. The RAD questionnaires and observation data were used to confirm that change had indeed come about in the parent-child relationship.

The questionnaire used in the first study group was slightly different than the questionnaire used in the last study group. Two questions were added as a result of modifying the research from including a focus on the therapy to not including a focus on the therapy. Those two questions were, "Describe your relationship with your child before the training" and "Describe your current relationship with your child."

The results of the RAD Questionnaire and the diagnostic assessments were used in creating the vignettes for each parent. Within each vignette the behaviors observed through the use of the Family Observation Rating Scale were addressed. A cross-case synthesis was

developed based on this emergent theory outlining the relationship among the categories and themes.

In presenting findings, Stake recommends three analysis tracks in which the assertions being made in each case can be reviewed. Track I focuses on each case, thereby preserving situationality. Track I analysis is presented below as vignettes for each participant. The researcher with assistance from the data auditor, pulled together a skeleton story based on the journals and interviews. The researcher then built on the skeleton including additional information from the journals, interviews, observations, assessments, and focus group. At the beginning of each vignette is the result of the clinical diagnostic assessment of the child at intake, prior to the parent taking the training, and a diagnostic assessment just prior to the researcher's observation of the family session. Additionally, at the end of each vignette, the results of the diagnostic assessment tools are presented.

According to Stake, Track II will merge similar findings across cases. According to Stake (2006) "Remember, Case Findings merge to some extent across Cases, some of them around a framework of proposed multicase Themes" (p. 50). This cross case analysis is not a generalization but rather a synthesis of what each participant stated that was similar to other participants. Track II is presented as a Sample Case Progression. Stake's last track is Track III where the emerging themes from all of the participants is presented.

Theoretical sampling. Theoretical sampling took place during the focus group with the research participants for clarification and elaboration on their earlier journals and interviews. The process of open, axial, and selective coding started over with the data from the focus group to ensure the final emergent theory and categories were still accurate in expressing the participants' experiences. The focus group data validated the emergent theory

and related categories. Through the process of the focus group one of the emergent themes and an intervention were highlighted as being essential in being able to bring about lasting change in a family's interactional pattern.

The research participants were adamant that the focus on the child and their behavior does not work. It actually keeps the family stuck. Instead, while it may seem counterintuitive what the parent is to do is focus on their personal healing. The parent is to take the focus off the child and put it on themselves. The parent looks at themselves to see what wounding is being triggered by the child's behavior and then heal that in themselves first.

When the parent heals their personal wounding the result is the parent shows up differently in relation to their child and through the day-to-day interactions with the calm, regulated parent, the child changes their experience of the interpersonal relationship between parent and child. One of the research participants, Gloria put it this way, "It takes more than just going through the motions and doing it [the model] you have to become it."

Memo writing and auditing. The student investigator kept a journal throughout the data analysis process recording developing ideas, assumptions, insights, feelings and connections to personal experiences with the material being studied. As the theory was emerging the constructive process was recorded through memo and journal writing.

The data auditor who supported the student investigator in analyzing the data also journaled about his experiences with the data from the journals and transcriptions from the interviews and focus group. The communication between the data auditor and the student investigator are also a part of the data used in coding and analyzing the data to reach an emergent theory with associated themes.

The data auditor supported the student investigator in the auditing process. As the student investigator worked on the coding process of allowing the theory to emerge, the data auditor supported the process of categorizing, theorizing and theme development by reading the journals and interviews to ensure the coding was consistent with what they saw emerging from the data. The researcher and data auditor stayed in constant communication sharing back and forth the emerging categories and themes they each felt the data was reflecting. The student investigator's advisor provided oversight on the unfolding process to ensure the process adhered to acceptable procedures.

This next section is Track I from Stake (2006) where each participant is presented as a vignette.

Sharon

Sharon had a six year-old birth daughter, Olivia. Olivia was just four years old with a younger sister who was one year old when Sharon divorced their father. During the study both girls lived with Sharon and visited their father on the weekends. Sharon had joint custody of Olivia and her sister.

Prior to coming to the parent training, Sharon described her relationship with Olivia as difficult and riddled with arguments and yelling on a daily basis. According to Sharon, "It was strained. I feel we both had anxiety because every day was a fight to do everyday things." Olivia would get triggered when plans changed or when she felt out-of-control in the decision-making process. Sharon reported becoming triggered when she couldn't find a solution to a problem, or when Olivia said hurtful things, such as, "You don't love me," or "I want to stay with my Dad and not you!"

Sharon stated, "I acted more like a dictator with a 'my way or the highway' approach. It never worked and now I know why after learning the model." "My threshold for the tantrums has recently been very low. When I am tired and emotionally low, it would trigger me my daughter was continually negative and obstinate. I'm trying to communicate with my daughter before things escalate to let her know that I need time to sort my feelings." Sharon said she did not know what to do to help Olivia or to improve their relationship. Sharon felt she and Olivia were not a team but seemed instead to be constantly battling each other. "I didn't feel like we were a team. It was her against me and vice versa." By week four, Sharon

was looking back and seeing how far the two of them had come, “I am far less stressed at home, whereas before my stress was home.”

At the time of the initial assessment, Sharon stated that Olivia was running the house. Whenever she did not get her way, Olivia would throw a big tantrum and run outside to the backyard where she knew she was not allowed to go because of safety concerns. Sharon could tell her daughter was not letting her be in charge. At the start of the Parent Group, Sharon expressed hopelessness over having no control of her child and family life. “I feel hopeless and not in control of the situation.”

According to Sharon, it seemed as if her daughter was in need of someone to be in charge. When the therapist came into her home and started interacting with the family, Sharon stated that it seemed as if the therapist went into full crisis intervention therapy mode. During the family observation, Sharon reflected that in the beginning of therapy it seemed as if her daughter wanted someone to be in charge, so the therapist took over and modeled for Sharon how to be the adult in charge. Sharon reported that she was grateful for this, because it showed her what she needed to do to restore safety and parental authority in her home.

In her journal Sharon wrote that she was surprised Olivia responded so well to the therapist taking charge. When a person struggles to say what their real need is, but rather the need shows up in the behavior, we say the child or adult is miscuing. Even though Olivia was continually miscuing, the therapist could tell Olivia was ready for change. Through this therapeutic process, Sharon was very supportive and open. According to the therapist, both Mom and daughter seemed highly motivated to bring about change in their relationship.

The therapist stated that she felt resourced, like her well was full when she left the house. This is a sign of resonance. When the parent is motivated and working hard with the

therapist to bring about change, it can be seen that both the client and the therapist are coherent. When two individuals are coherent together HeartMath (Childre and Martin, 2000) states that this is a condition for resonance. In resonance the two coherent beings energize one another as the connection is experienced as more than one plus one equals two. The therapist stated that she felt this was going to be one of the "miracle families."

Sharon and Olivia started therapy with the Branch Clinical Director. Typically, the Director, who is also a therapist starts with a family and then brings a new therapist on to train them. As the new therapist learns the model of treatment and is clinically up to implementing the model with the family, the Director will remove herself from the case, checking in on the family monthly to do live supervision, ensuring the quality of care the family receives is appropriate. As Sharon and Olivia were transferred to another therapist, they continued to make progress in therapy.

Parent journaling through the group process

In the Parent Group, Sharon said she felt like she was learning valuable new skills. For example, she learned to not internalize what her daughter said. She learned that when Olivia gets upset, she as the Mom and adult in charge needs to maintain her composure and stay at her baseline, making an effort to lower her own emotions before she engaged her child. "Our communication has improved quite a bit." "I learned that when she is upset I need to maintain my composure and stay at my baseline." Sharon learned about miscues and how to see that behind bad behavior was a need.

Sharon said she also learned about how to be in control without being a dictator. "I make the decisions for our family but I let her choose between 2 options when possible. I have talked to her about plans changing and explained that it can be good at times." This kept

Sharon in control, but it also gave Olivia a sense of control and a feeling of being respected. Sharon also learned how to maintain her authority, by not becoming activated as easily as she had in the past. “I feel as though I have less anxiety during these situations and neither of us get as escalated as usual.” In the focus group Sharon reported that watching the therapist model how to get calm and approach her daughter and seeing her daughter respond differently to the therapist than she did to Mom, opened Sharon’s eyes to how to interact differently with her child. “My child stopped her normal behavior and became curious about what the therapist was doing. My daughter responded.”

Additionally, Sharon said she learned new communication skills in the Parenting Group. She talked with Olivia about how plans change and explained that it can be good at times. “When I feel that she is going to escalate I try to calm myself and we talk it out.” During this conversation, Sharon would let her daughter know that Mom needed time to sort out her feelings. Sharon learned that it was okay at times to communicate how she was feeling to Olivia. “It helped learning that it is okay to let your child know what you’re feeling and take time for yourself to ground.”

In week four’s journal, Sharon reported she learned about meditation, grounding, self-care and the importance of taking time every day for herself. “I will dedicate time for myself. I can’t pour from an empty cup and I need to be able to give my kids my all, so doing things for myself is imperative.” Furthermore, as Sharon began to understand how her behaviors were connected to her daughter’s trauma, she became interested in doing her personal healing work. “I plan on looking into some of my own trauma and try to identify some of my own triggers.”

Over the course of the Parenting Group and after, Sharon reported seeing signs of change in herself: She was less stressed and as a result, could approach situations with a more peaceful mentality. Sharon was much less stressed at home in particular. “I am far less stressed at home, whereas before my stress was home.” She was better able to stay calm when she felt her daughter was going to escalate. As a result of the training, Sharon stated she was better able to be firm but loving.

Sharon reported seeing many signs of change in Olivia as well. Instead of acting out, Olivia was verbalizing more about her feelings. Sharon also felt that her daughter was talking more in general. “It seems so much more open. She tells me her feelings instead of screaming or acting out and she talks a lot more in general.” By week four Sharon noticed, Olivia “has started to understand how to compromise and she has also learned when an issue is non-negotiable. She is learning boundaries.”

When conflicts did arise, Sharon felt less anxious, better able to remain calm, and as a result, both mother and daughter were able to have more times when they could talk things out. “We talk so much more and we are more connected to each other’s emotions. We are both working towards the same goal.” Before the Parent Group, Sharon said their relationship felt like a battle between opposing sides, now they are working towards the same goal.

During the Focus Group, Sharon shared that after the Parent Group she took the focus off herself and her healing work and began focusing on changing her daughter’s behavior. As a result, Sharon and her daughter got stuck in their interactional pattern and Olivia’s behaviors began to revert to where they were when the family started with AHC. During the focus group process, one of the other parents, Gloria, poured out her story and begged Sharon

to trust the process. Gloria told Sharon that once she, "...released the fear that drives the train..." the child's behaviors go away and the mother daughter relationship improves.

Child Assessments

At intake, prior to any interventions, Olivia scored a 41 on the RAD Questionnaire. The majority of her points (28) were scored in Cluster 3, which indicates she is definitely suffering from an attachment disorder exhibiting behaviors associated with both disinhibited type and inhibited type.

Olivia was extremely demanding of her mother's time and attention and could not be soothed. Mom tried to address Olivia's needs, but Olivia would not allow her mother to soothe her, take care of her or direct her actions. During the family session, Olivia stated that she worried about her mom's emotional state. Based on this statement it seemed as if Olivia saw her mother as fragile. The therapist asked probing questions around Olivia's behavior of trying to keep her emotional expression hidden from her Mom.

Through the therapist's questioning Olivia revealed that she held that view of her mom based on things her father had told her. Olivia did not feel she could approach her mother and ask certain questions for clarification or to understand better, so she kept what her father shared to herself. During the observation of the family session. Olivia started to cry as she shared with her mother some of the things her father had told her that made her keep her distance from her mother.

Sharon handled the disclosures extremely well. Sharon had journaled that she was learning to stay more calm and regulated in her interactions with her daughter, and this is what the researcher observed Sharon doing. As Olivia hunched over, crying, Sharon moved her body in close to Olivia and gently pulled Olivia into her lap. Despite Olivia's struggling

and not wanting to tell her mother her feelings, it became evident that Mom's strong, yet nurturing stance communicated to Olivia that it was safe to share all of her feelings with her mother. As Sharon pulled her daughter in close and took many breaths to stay grounded, Olivia began to open up and eventually they both cried as Sharon held her daughter on her lap and in her arms.

Sharon and her daughter had been receiving services for seven months at the time of the post assessment during which Olivia scored a 17 on the RAD questionnaire. The areas of the most significant improvements were: Is demanding or attention seeking; Tends to be afraid of new things or situations; Is difficult to comfort when fearful/scared; Can be aggressive towards him/herself e.g., using bad language about him/herself, head banging, cutting, etc.; If you approach him/her, he/she often runs away or refuses to be approached; Has few friends; Acts younger than his/her age; Very 'clingy'/ wants to be with you all the time; If you approach him/her, you never know whether he/she will be friendly or unfriendly.

Olivia scored a 14 on the RAD Questionnaire completed during the Focus Group. Such a score indicates continued progress in the parent child relationship, however, Sharon could still see there was work she had to do in bringing about a healing in their relationship.

Family Assessment following Parent Group

Many positive interactions were observed during the family session. When one way of connecting with her daughter did not work, the researcher observed Sharon shifting her approach. She got down on the floor next to Olivia. Sharon first started asking Olivia what was wrong, and then when she saw her daughter begin to withdraw, she shifted and said, "I was so frustrated. I should have stopped and asked if we were safe. If we can talk about it, it

will help us.” With this shift in tone and perspective, Olivia moved in close to her mom and with her head in her mom’s lap began sharing some of her scary feelings.

The focus of therapy in the home had been for Olivia to be able to tell her mother she was mad about the divorce. In this family session, Olivia moved in close to her feelings and found the support and comfort to tell her mother in words how she felt about what her father recently told her around her mother and father no longer being married.

Mom established appropriate boundaries with Olivia and maintained being the adult in charge. This was witnessed when Sharon redirected her daughter to leave her cousins and stop playing to come and join the family session. Sharon used her tone of voice. Mom’s posture, along with her tone of voice communicated to Olivia that Mom expected her to follow her directions and consequently Olivia left her play and without an argument moved into the family session.

To communicate empathy and sensitivity to her daughter’s feelings, Sharon spoke at a comfortable pace and moved in close using her right-brain communication tools. At one point Sharon said, “I love you a whole lot. I just want you and your sister to be happy.” In response, Olivia opened up and shared what her Dad had told her during her last visit that had disturbed her. Until this family session, Olivia had been reluctant to tell Mom anything shared by her Dad. However, during this session Olivia opened up. Confirming her child’s experience, Sharon responded with, “Thank you for sharing those tough feelings around the divorce.”

Throughout the observation of the family session, Sharon consistently spoke at a comfortable pace and was clear and concise in her communication with her daughter. As Olivia began to struggle with wanting to tell her mother of her painful feelings, she dropped

her head and began to withdraw. Mom moved in close and got down on her daughter's level. She then used her right brain communication skills to maintain being a safe adult in charge open to connecting emotionally with Olivia.

Instead of being pulled into Olivia's miscue of shutting down and not engaging verbally or physically, Mom identified that her daughter needed some additional emotional support. Just talking was not helping Olivia share what she was afraid of saying. Recognizing that her daughter was not shifting and seemed to be focused on wanting to take care of mom's emotional state, Sharon physically moved in closer to determine what was in the way of her daughter sharing all of her emotions, and asked, "Can I hold you? Will it help if I hold you?" This demonstrated Sharon's attunement to her daughter's need over the behavior that was presenting as a miscue. As a result, with this request to be pulled in close, Olivia allowed her mother to put her onto her lap.

Once she was pulled in closer, Olivia began to share. As she shared, she looked up to see how Mom was doing emotionally with what was being said. Sharon was crying and it seemed to impact Olivia's ability to stay open to continue sharing. Olivia started to shut down and stopped sharing. Sharon maintained being the adult in charge by not letting her daughter's emotional disconnect drive mom's behavior. Instead Sharon remained grounded with some silent breaths and then co-regulated her daughter and added, "Mommy is crying because she loves you so much. I'm crying now because I wish I could do something every day to make it better." By this statement, Sharon demonstrated her ability to focus on the solution over the problem. This statement also communicated that mom was okay even though she was crying. Through this statement Sharon removed an obstacle that was in the way of Olivia connecting emotionally with her mother. Olivia believed her mother was

crying for these reasons and seemed to understand it was okay to continue sharing even though tears were involved in the conversation.

As Olivia continued sharing, Sharon worked to discover what additional things were needed to motivate her daughter to bring about change. “Cause Mommy doesn’t always have the right answers, but I’m trying. I want you to always know you are safe. Anything Mommy can do to make you feel safe, I want you to tell me.” Sharon used her own discomfort to appropriately elicit and give voice to Olivia’s emotional pain. “Mommy can sense the feelings you have.” This allowed Olivia to go deeper in sharing her emotions about how it makes her feel when her father shares painful things about her mother.

In hearing her daughter’s sharing, Sharon worked to discover what she could do to motivate the two of them to bring about lasting change. “So what’s our plan? ‘Cause you know Mommy has to have a plan. Do you think returning to Mommy minutes would be helpful? How can we do that?” The family session ended on a high note with hopefulness of the two being able to continue the progress made in this particular session. In getting to this point, the additional relationship skills that were maximally effective and observed included: Shifts approach when one way of connecting is not working; Helps the child maintain the position of the child in the family dynamic; Assumes the role of calm, regulated parent in charge when the child wants to take control; Connects with the child before correcting them; Uses relationship as key as a means of determining what the child can and cannot do; Responds when the child initiates communication; Parent pays attention to their own discomfort and uses it appropriately in relation to their child; Uses own affect to elicit affect in child; Keeps the interaction in the here and now; Facilitates child using her words to ask

for their needs and wants; Helps the child see they have a choice in how they respond;
Consistently marks miscues with curiosity.

Factors Contributing to Change in the Family

The combination of training with other parents along with in-home therapy seemed to be a critical factor in helping Sharon bring about change in her family. From in-home therapy, Sharon realized she could be the adult in charge without being a dominating parent. When Sharon witnessed the therapist being the adult in-charge in a loving and gentle way, and then saw how her daughter responded to having a safe in charge adult, Sharon realized this was one aspect of taking back control of her home and family life.

John Bowlby (1988) the original author of attachment theory, theorized that a child needs a secure base to connect with in order to work through any distress. The adult caregiver is to be that secure base. When the adult caregiver can be the calm mature brain in charge, this provides a sense of security for the child. Sharon was willing to learn how to be the safe, calm adult in charge in order to bring about change in the relationship with her daughter.

According to the therapist, both Sharon and Olivia were motivated to change. Escudero (2008) indicated that in order to bring about change in a relationship it is essential that both sides be motivated to change. Having Sharon and Olivia interested in doing their part to bring about a change in their mother-daughter relationship was a critical component to their following through on therapeutic interventions recommended by their therapist.

From the parent group, Sharon learned she had to be emotionally calm when Olivia began to dysregulate. She also learned not to take anything personally that Olivia said to hurt her feelings. Sharon remained the adult in charge by not allowing herself to become activated

by how her daughter behaved. Sharon also learned the value of looking beneath the behavior to see what need the behavior was pointing to that needed to be addressed.

As Sharon took responsibility for how she was showing up in her relationship with her daughter, her daughter's behavior began to change. Sharon became focused on self-care and in addition to meditating and grounding, she started individual therapy to address her own wounding. As Sharon took her self-care seriously, she had more patience for her daughter.

Stephen

Stephen is married to Cheryl. They have raised four birth children into adulthood. They then adopted five special needs children, three of which have symptoms of trauma and disorganized attachment, but only two have the diagnosis of reactive attachment disorder. These two are siblings and were adopted at the ages of three and four, after experiencing severe neglect and extreme sexual abuse in their birth family.

The siblings have been in this adoptive home for 11 years. In their adoptive home, the children have lied, stolen from stores, experienced enuresis, been aggressive with younger siblings and peers at school, hoarded food or overate, and presented with poor hygiene. The couple had the children in therapy for 11 years with no change in their behavior. The couple was desperate and willing to try anything when they found the Attachment Healing Center. According to Stephen's journal they did not really think this treatment approach would make a difference, but they thought, "What do we have to lose? Let's give them a try."

Stephen and Cheryl had received treatment from AHC prior to taking their first parent group, however, the therapist that served the family did not use the Healing in Resonance model of treatment. Having had therapy at AHC previously is an exclusion criteria. Stephen and Cheryl were allowed into the research because the treatment they received was not characteristic of the AHC therapeutic approach and hence it was felt they had not truly experienced treatment characteristic of the Attachment Healing Center.

Stephen and his wife Cheryl took the Parent Group twice before. This was their third time through the material. Both Stephen and his wife Cheryl participated in the research. Their vignettes will be presented separately as their journals and observations of their family sessions were conducted separately.

Parent journaling through the group process

After the first week of parent group, Stephen reported in his journal that he was feeling very frustrated in his relationship with his children. The children would often act defiantly, saying, “No,” refusing to do what was asked of them, sticking out their tongue, throwing things or making a rude comment. Sometimes they would even angrily say, “I hate you.” He felt that he previously didn’t know how to address his children. “A lot of frustration – just not knowing how to address the defiance without starting a major altercation.”

After the second Parent Group, Stephen wrote that he was trying to keep calm and grounded, even when his children were completely out of control. In the past, when his children would act defiantly, it triggered him. He wrote in his journal it felt like his, “heart was tightening up.” But now he was keeping calm and getting down to their level to talk to them.

According to his journal, in class Stephen continued to learn the importance of keeping himself grounded. He also learned about the importance of being right brained. “If my brain is full of words I know I am being left-brained. If I am thinking in images then I am being right-brained.” Stephen wrote that he appreciated learning about being right brained and wanted to learn more.

Schore (2003) researches the role of right brain communication and functioning in interpersonal relationships. While Schore’s work influences the model of treatment, the parents are introduced to this concept of left versus right brain functioning in a manner that makes the information interesting and easy to understand.

During the Parent Group, parents were introduced to the two hemispheres of the brain by watching the TED talk by Dr. Jill Bolte Taylor. Dr. Taylor is a neuroanatomist who had a

stroke and from the inside is able to tell the story of how she experienced her two hemispheres working independently. Based on this video the facilitator has the parents list what characteristics are in the left versus the right hemisphere. The lists are created on the board so the parents have a visual of how distinctly these two hemispheres influence our behavior.

The left brain is detailed oriented with a focus on the past and the future. It is also more judgmental and analytical, and works as a serial processor able to handle only seven pieces of information per second. The right brain by comparison is more big picture oriented. While the left brain is a verbal brain with a focus on words, the right brain is a visual brain with a focus on pictures and patterns. The right brain is also aware of its connection to all, and is sensory based, processes emotions, and lives in the now moment. If compared to a computer, the right brain operates like a parallel processor, able to handle multiple pieces of information at one time. Given that the right brain can process multiple pieces of input at once, it can handle eleven million bits of information per second (Schoore, 2003).

As parents when we operate from our right brains we are not letting our past experiences as children cloud our judgment, but rather are able to be open and receptive to the current non-verbal information coming from our child. Since the right brain is all about connection, it is the brain that works to find a solution by putting all the pieces together as a puzzle. One of the parents, Cheryl, actually experiences learning the model of puzzle pieces that finally fit together. Here Stephen is reflecting on how he shows up differently when he parents from his right brain that cares about emotions and connections. “That right brain communication is more effective than trying to reason or be ‘bigger’ than the child.”

Stephen felt that what he was learning was making sense, and he could see the changes at home. “It seems to be making a lot of sense.” He stated that he felt there was more unity in his family. He also felt there was more of a sense of peace. “More of a sense of peace with them. Conflicts take some time to get resolved, but they do get resolved and not just ‘stuffed inside’ to keep simmering.”

After the third Parent Group, Stephen wrote in his journal that he was feeling more peaceful. At the same time, he also noticed that he sometimes felt impatient inside. “More peaceful, but sometimes I feel impatient inside, that I am wasting my time and things are not changing as fast as I would like.” “I am trying to keep calm and grounded, even with my children completely out of control.”

He wrote that he learned in class that right-brain communication is more effective. “That right brain communication is more effective than trying to reason or be ‘bigger’ than the child.” He also learned about marking. “About positive marking – that the correct type of praise can really affect the child’s behavior.” Stephen reported that the material seemed clearer this time through the class.

Marking is one of the interventions in the Healing in Resonance model of treatment. Rather than pointing out what our children do wrong and giving them a lecture over it, we instruct the parents to simply note that it happened. We call it marking. It is a one sentence observation. We find with our children if we don’t mark when they do something, going forward they have no memory of doing it at all. After we mark the incident, when the child asks for something, we connect with them around their courage in asking for their needs and wants.

As parents, we base whether or not they get what they are asking for on how they have been doing in relationship with us. If we asked them to do something and they did not, we mark it, and when they want to play with their friends, we connect their not listening to us and doing as we asked as to their desire to be in a relationship where the other's requests are not honored. The result is, they don't get to play with their friends, but it is based on how they are treating the parents. Conversely, if the child is doing well, this too is marked and connected to whether or not they get what they ask for because they are doing as their parents have asked. This intervention helps the child learn to focus on their relationship with the parents.

At home, Stephen stated he felt the relationships with his children were definitely not perfect but had improved. There was less unproductive arguing going on. "Definitely not perfect, but the relationship is improved with less arguing and getting nowhere." He planned this week at home to focus on looking for schemas in the children's brains and for what was underneath the acting out.

After the fourth Parent Group, Stephen wrote he noticed he was feeling much closer to his children and did not seem to get upset as easily as he used to. "Get on his level and somewhat close to him and get curious- ask a curious question – particularly about his feelings at the time, and looking for what is underneath his actions."

Week four is when the parents are taught the importance of focusing on themselves and paying attention to their self-care regimen. "The importance of self-care, that it is essential in helping keep ourselves calm and in control of our actions and the words we speak." After the group on self-care Stephen began to see his role as the change agent in his son's life. "That staying 'grounded' that is remaining relatively calm and in particular control

our actions and tone of voice is very important for it maintains positive personal relationships.”

Another intervention taught in the model is to scan for and highlight the positive behaviors our children engage in. It can be a challenge for parents to notice the positive because it is sandwiched in between so much negative. However, as Stephen stepped into being the change agent in his son’s life he began to see the value of scanning for and highlighting the positive. “About positive marking – that the correct types of praise can really affect the child’s behavior.” “I am implementing the positive marking more.”

As a result, Stephen reported that he noticed his tension was greatly reduced and that it seemed to be reduced in his children, too. “The tension is greatly reduced in me and it also seems to be greatly reduced in him as well. His tone of voice softens in particular.” He felt that a big influence in these changes was what he had learned in the previous class about looking for what is actually underneath the actions versus what was coming out on the surface in his son’s behaviors. “Looking for schemas in the children’s behaviors. Looking for what is underneath the acting out.”

Through the progression of the parent group, we can see how Stephen’s relationship with his son evolved as we look at his answers to the question, *Describe your current relationship with your child*. After week two Stephen wrote, “More unity – even though they still don’t obey instantly. More of a sense of peace with them. Conflicts take some time to get resolved, but they do get resolved and not just ‘stuffed inside’ to keep simmering.” Following week three Stephen wrote, “Definitely not perfect, but the relationship is improved with less arguing and getting nowhere.” Concluding with week four where Stephen is seeing a definite connection to a change in their ability to talk through things and how he is beginning to feel

towards his son. “Conflicts that are slightly less frequent, but after a 5 to 10 minute ‘grounded’ discussion seems to be at least partially resolved and leave a peaceful feeling between us.”

Stephen wrote that in class he learned about the importance of self-care. “The importance of self-care, that it is essential in helping keep ourselves calm and in control of our actions and the words we speak.” He also understood that staying grounded was very important for maintaining positive personal relationships. “That staying ‘grounded,’ that is remaining relatively calm and particularly control my actions and tone of voice, is very important for maintaining positive personal relationships.” Overall, Stephen’s reflection on the group was, “The material seems to be straightforward and clear particular when I go back and review it.”

During the interview, conducted a few months following the end of the Parent Group, Stephen reported that things at home were much improved. “Less stress, less tension, less conflict. Less bad things.” In his journal Stephen talked about scanning for calm in his home. In the interview he was asked to explain what that meant. “I see my kids reading books, and they are not pulling them away from each other. I see them ask each other nicely for the things they want. Our birth kids did that but they did not have the trauma our adoptive kids had. I don’t usually separate the two.”

Stephen stated that he felt shocked to see this change in behavior, which was from the oldest child to the youngest. In his interview Stephen stated, “When I’m scanning for calm, I see a calmness over the home. I’m shocked to see this change in behavior. It is from the oldest to the youngest. Food, it used to be you touch it, you die. Now my daughter said, you can have my dessert. I was like, who is this child?”

Stephen reported that his most important realization from the Parent Group was things that come up on the surface are not the real issues. Most other therapeutic approaches try to treat the surface behaviors without investigating what is driving the behavior. “Mostly, the things that come up on the surface are not the real issue. Most other therapies try to treat that. We have to stop and see what the real issues are. Here we go underneath to see what the child is really expressing. When my son says, “I hate you, he doesn’t really hate me, he is expressing something else.”

Child Assessments

Hogan is the oldest of the children adopted by Stephen and his wife Cheryl. Hogan was neglected and physically abused by his birth family, leading to adoption by his current family at age four. His abuse also included severe sexual abuse. Hogan, now 16, was having issues with physical aggression towards his siblings and verbal aggression towards all family members. He struggled with enuresis, binge eating and hygiene issues, refusing to wash when in the shower. Mom reported concerns about sexual inappropriateness. He was hit or miss on taking medications, completing chores, and demonstrated explosive behaviors. He was at risk for out-of-home placement or Treatment Foster Care, meeting criteria for the latter at the time of intake. At that time, he was also diagnosed with Reactive Attachment Disorder and Post Traumatic Stress Disorder.

Hogan scored an 18 on the RAD Questionnaire. Hogan’s highest scores are in Clusters 1 indicating his behaviors are associated with children who have disinhibited type of attachment disorder (AD-D) and grouped with children who might be classified as having an anxious or immature attachment style. In the post assessment conducted prior to the family

observation, the one area Hogan had significantly improved in was “Can be aggressive towards him/herself e.g., using bad language about him/herself, head banging, cutting, etc.”

According to Stephen in the interview, Hogan seems to have a conscience now as he shares difficult feelings with his father. As his son’s relationship improved with Stephen and his wife, their son’s emotional safety seemed to improve. This was evident by the difficult conversations their son initiated about his past trauma. As Stephen and his wife continued to communicate emotional safety through their own emotional regulation in relation to their son, they reported feeling closer to their son because he began to let them into his life.

Now that Stephen has attended the Parent Group three times, he reported that he now sees that his first therapist assigned to him from the agency did not use the model of treatment and was not doing their deep and meaningful personal work. As a result, Stephen’s family was in chaos for a bit. However, after being assigned a different therapist, who was doing her personal work and was familiar with the healing in resonance model of treatment, Stephen reported that he began to see some major shifts in his children in a very short while.

After three months, both parents reported fewer enuresis incidents, less lying, less over eating, and a reduction in aggression. Stephen and his wife reported that the sibling group and their youngest child were able to come to their parents when they were emotionally distressed and allowed Stephen and his wife to co-regulate them and to take care of their needs.

During the Focus Group, Stephen scored Hogan a 12 on the RAD Questionnaire, while his wife scored Hogan a 13. This score demonstrated the gains Hogan made during the therapeutic process were still in place and there was even more progress in Hogan’s ability to

allow his parents to meet his needs and have control of his affairs. Hogan was learning to interact appropriately with his parents.

Family Assessment Following Parent Group

Stephen was observed in family session with his oldest adopted son, Hogan. During this session Stephen was observed using short, specific and clear communication while speaking at a comfortable and relaxed pace. After his son discussed an event that happened at home, Stephen confirmed his child's experience of that event. His son continued to stay engaged with his dad while he spoke to the therapist and his father about his week and his challenges.

When his son expressed nervousness around sharing, Stephen responded appropriately to his son's emotional distress. Stephen used his own affect to connect with his son's affect and anchored the emotional mirroring in a positive scan for something his son was doing well at home. This strong emotionally connected support seemed to provide Stephen's son with the courage to share his inner thoughts and feelings during the session. While his son shared and struggled, Stephen consistently focused on the solution over the problem, consistently marking the miscue with curiosity. Stephen and his son stayed oriented towards one another even when the topic being discussed was difficult for the two of them.

Factors Contributing to Change in the Family

Stephen's main contributor to change in his family seemed to start with Stephen's sense of calm within. As Stephen learned to shift from his logical left brain to his right brain that was more focused on emotional regulation and connection, Stephen began to see a calm spread over his family and in his home. Schore (2003) researched right-brain communication and taught the importance of the mature brain getting calm and regulated *before* engaging the

dysregulated child's brain. Stephen seemed to experience the change in his children's behaviors by focusing on calming himself first. Maintaining this calm in his home when interacting with his children took Stephen a few weeks to master. However, he points to this critical factor as being the turning point in the relationships he had with his children and that they had with one another.

Keck and Kupecky (2009), discussed attending to the need underneath a child's behavior in order to determine what is driving the behavior. Stephen learned to remain curious about what need was underneath his children's behavior. As Stephen remained curious about the need and did not allow the behavior to anger him or dysregulate him, Stephen found that he could facilitate what he called "grounded" conversations that helped to restore peace in the family. Once his child or children had an opportunity to talk about what was bothering them, the need for the behavior to express seemed to disappear.

As Stephen created emotional safety for his children to discuss what was bothering them, he noticed more peace throughout his home. His children began getting along more cooperatively not just with their parents, but also with one another. In order to maintain his calm and curious attitude, Stephen learned the importance of self-care and endeavored to continue his focus on taking care of himself because he saw the impact it had on his family's functioning.

Cheryl

Cheryl is married to Stephen. They have raised four adult children of their own and have adopted five special needs children. As a couple, this is their third time going through the Parent Group. In some ways, Cheryl said she was skeptical of the material, feeling that she had tried these things and they didn't work if the child refused to cooperate. Cheryl also wished she had been taught how to intervene with her children before their behaviors escalated.

For the research we are looking at Cheryl's relationship with her daughter Elizabeth and youngest son Noah. Elizabeth was severely abused and neglected for the first few years of life. This included severe sexual abuse. By the time she was three years old she had been removed from her birth family and was adopted by her current family.

Now 14, almost 15, Elizabeth was reported by Mom to regularly lie, cheat and steal. She had stolen at least four times from WalMart. She was highly aggressive with her younger siblings, as well as with her peers in school. She ate and hoarded food compulsively. She also had terrible personal hygiene and regular enuresis, after which she would not clean herself. Additionally, according to Mom, Elizabeth regularly hid her medications and refused to do any chores around the house.

During the interview, this is what Cheryl shared around starting treatment with AHC. "When the family started with AHC in June, I thought my daughter was going to go to RTC, [residential treatment center] and I knew she would not come back. Six places in state and 6 out of state rejected her because they said she would burn out their staff. The process was burning me out as we were getting nowhere with it, and I told my husband I could not keep up with the process. This was my Hail Mary pass. Even when you said we have had people in

the past who were going to go residential but didn't. I thought, 'You have not met my daughter.' I felt double minded at that point as I was trying to say goodbye to my daughter in my heart. By August, I knew she would not be going to go away." At the time of assessment with AHC, Elizabeth was diagnosed with Reactive Attachment Disorder and Post Traumatic Stress Disorder and met criteria for treatment foster care intake.

Noah was removed from the home of his biological parents when he was eight months old. He was then placed with relatives for six months before also being removed from that home as a result of abuse. At the age of two, he was placed in regular foster care, at which time he stopped saying words. Cheryl wrote, "Noah was placed in two 'forever homes' but disrupted in each. The State had to do a BIP (Best Interest Placement) with us. The State told us the only place left was to institutionalize [Noah]." After being adopted by Cheryl and Stephen and being placed in speech therapy Noah started speaking again. At three years of age, Noah was adopted by Stephen and Cheryl. According to Cheryl, "With the birth home as his first home, and his adoption home as his last home, Noah has lived with seven families.

Now eight years old, Noah struggles with defiance and imposing on sibling boundaries. Cheryl reported that Noah became impulsive and hyperactive when asked to complete any task and thus had trouble following through. His anxiety levels were high, and he couldn't stand it when family members raised their voice. Noah also had significant anxiety about sleeping alone in his room and struggled with both enuresis and encopresis. Previously diagnosed with ADHD at intake, Noah was also diagnosed with Fetal Alcohol Syndrome.

In week two when asked to reflect on what her relationship was like with her children prior to the Parent Group Cheryl wrote, “Broken, hurting individual. We both wanted to relate but didn’t know (all of the children actually) how to do it without triggering each other.” In reflecting on the past relationship in week three Cheryl wrote, “**CHAOS** – it seemed they thrived in the craziness.” By week four she was able to talk about the lack of emotional connection, “I tried to put out emotional fires that flared up but never able to put out the coals.”

Parent journaling through the group process

At the start of the parent group when asked to write about how she handled her children’s acting out behaviors, Cheryl wrote, “I get frustrated with myself because I don’t seem to get through to them on a lot of levels – logic is not processed well.” As a result of not seeming to get through to her children Cheryl’s body responded with, “Tension, headaches, tiredness, despair, worry.” Cheryl wrote that it seemed as if everyone was expecting her to “fix” things.

This was Cheryl’s third time going through the Parent Group, however, after the first Parent Group in this cycle, Cheryl wrote, “Most of it we already had with CYFD, but it gives me hope again.” Cheryl wrote about one important takeaway after the first class, “I need to change, not just the kids.” Another important fact Cheryl reported on was, “I don’t make as many mess-ups as I thought.” As she wrote about how she was relating to the information Cheryl said, “I use some of this material already so I know I am doing something right.”

After week two of the Parent Group, Cheryl wrote in her journal that she felt she was becoming more regulated, more relaxed and was not on high alert all the time. “I am more regulated and therefore my children are more regulated. We are able to praise the children

after pushing pause and see it go in.” She compared their former behavior to how they were currently showing up. “When my child would disrupt by stealing, cheating, etc., I had a hard time pulling her in because ‘here we are again’. But now I am finding it easier to push pause.” Cheryl journaled on the things that were helping her bring about these changes. “Breathing, getting grounded and then seeing the miscue, pausing it, going under it and curious questioning.” In her body she noted, “More relaxed not on high alert and hypervigilant all the time.” In the focus group Cheryl shared that it was seeing the small changes in her children as a result of using the treatment approach that helped her stay focused on continuing to implement the interventions she was being taught. “When you could start seeing changes, it makes all the difference.”

More and more, Cheryl was understanding that her children’s behavior was not the issue. “Learning that we all miscue but we have actions now that by following the model we can parent by going under the miscue rather than chasing the behavior.”

Cheryl wrote that the more she heard the information in the classes, the more she understood how each piece fit together to complete the model. “I am understanding how the model works together and not just bits and pieces.” As she applied what she was learning she reflected on how the family used to do relationships, “Broken, hurting individuals. We both wanted to relate by didn’t know (all of the children actually) how to do it without triggering each other.” As compared to how they related now, “A family learning to work together mending broken hearts and emotions.” During the focus group Cheryl added, “Learning that I as the parent benefit staying on bridge even when the child pushes me off helps me to get back on bridge and try again. It becomes about being in relationship rather than ‘teaching the child a lesson about pushing me off bridge.’ By working at getting back on bridge and

encouraging my child to join me helps them to see that healing can happen with past broken hearts and emotions.”

While the information was useful, it seemed like a lot. “It is a lot to take in and I feel we need more time.” As she invested taking the four-week class three times, Cheryl could see what she was gaining. “The more I hear the info the more I understand how each piece fits together to complete the model. I learn more each time I take the class.”

After the second class Cheryl started noticing changes in family functioning, “A family learning to work together mending broken hearts & emotions.” By the time of the third Parent Class, Cheryl wrote that she noticed the new approaches she was learning were having an impact at home. “Calm is beginning – we are able to shift them down faster & even their speech is not as hurried.”

At the same time, Cheryl reported that as the family was more regulated, the children’s trauma was beginning to surface. “One is bringing up lots of trauma and wants to rid himself of it. One is spinning in her trauma and disrupting. One is getting so much better – co-regulating with my husband and I.”

In her journal, Cheryl wrote she continued to resonate with the teachings about getting under the behaviors and seeing what was coming up for her children. “I am worn out but in a good way – like I’m running a marathon because it is good work.” When asked what she was learning that was supporting the changes in her family, Cheryl said, “That if we are chasing behaviors we are not getting to the trauma we are parenting the miscues rather than dealing with what is coming up for him and us. Behaviors are very loud and distracting!”

Cheryl reflected in her journal that after the first parenting class she was a little skeptical about the material being presented in the group. Here for the third time though, she

had a different experience, “**IT WORKS!** I am finally being given tools that I understand to connect with my child.”

As classes continued Cheryl gained insight and felt now that it was never too late. “Slow progress is still progress. The brain can heal.” After week three Cheryl journaled about her insight around what helped bring about this healing process, “I have to be grounded and regulated *before* I try to help co-regulate my RAD kids.”

After the fourth Parent Group, Cheryl wrote about her increased awareness about her own emotional state, “I am starting to feel my anxiety going up. I am able to stay or return to calmness faster using the relaxation techniques shown us.” Cheryl was breathing consciously, “Breathing, slowing things down.” Cheryl reported feeling calmer internally. “I am calmer and therefore our children are calmer and are moving into an emotionally healthier state.”

Cheryl journaled about one important self-care message she received, “I was given permission to take care of myself. I have never heard that info before it has always been taking care of our special needs children.” And the impact of putting herself first was not lost on Cheryl, “If I don’t take care of myself I can’t take care of others.” “I deserve to do the best for myself and I am still a good mother.”

Looking back on the class, Cheryl wrote, “It has been wonderful getting to know others that share our journey.” Cheryl also wrote about how she felt she was really now learning firsthand why the model worked. In contrast to the chaos Cheryl said she felt in her home when the group began, she now felt she was enjoying her children, “I tried to put out emotional fires that flared up but never able to put out the coals.” When writing about the

relationship with her children after the fourth class, Cheryl wrote, “I enjoy them – I delight in them.”

Cheryl said she was in awe at the speed with which change occurred. “The speed at which this change happened, I am in awe. We were in therapy for 11 years. We said the same things for 11 years, but she gets it now. It goes in. And my other two boys as well.” Before it seemed as if nothing could help Elizabeth shift her behaviors. Now, after working with AHC, Elizabeth’s behaviors were less defiant. It seemed as if the things Cheryl had been trying to teach her daughter for the past eleven years, were finally going in. Not only were Elizabeth’s behaviors shifting, but Hogan and Noah were allowing their parents to take care of and have control of them as well.

As an example, Cheryl told how they were recently visiting friends in Los Alamos, and Noah ran out of medication. “My youngest, this last week, we were in Taos, and we ran out of medication for him for two days. Usually if he misses it one day he has to write a letter to his teacher apologizing because he is off the wall. Here we are away from home, in this little tiny car, in the two days there was only one time when he struggled, and it was fidgeting. We helped him ground and he did an incredible job. I am amazed! We had an appointment in Albuquerque to get him diagnosed with ADHD, so he could get a higher medication. He got diagnosed with it, but now I am not sure that is the issue. This would be emotional regulation.”

Child Assessments

Noah scored a 30 on the Minnis RAD Questionnaire. The majority of his high scores are in Cluster 1 with mostly Factor 2 behavioral symptoms like Acts younger than his age.

The behaviors Noah exhibited are associated with disinhibited type attachment disorder (AD-D) and/or anxious/immature attachment style. (Minnis, 2006).

In the post assessment Noah showed improvement in the following areas: Tends to be afraid of new things or situations; Acts younger than his/her age; Is often unhappy, tearful or distrustful; Can be aggressive towards him/herself e.g., using bad language about him/herself, head banging, cutting etc.; Has few friends; Is too friendly with strangers; Often gives you cuddles; Often starts a conversation; Is demanding or attention seeking; If you approach him/her, he/she often cuddles you.

Prior to the Focus Group, Cheryl scored Noah a 17 on the RAD Questionnaire, indicating that he was continuing to make significant progress in his ability to trust his parents. During the Focus Group, Cheryl shared that Noah is now connected to Dad with a string around Stephen's belt loop so Noah always feels physically connected to and protected by his father. Additionally, when Noah goes to the store with a family member he is placed in the shopping cart to keep him from becoming overly anxious and running away. When Cheryl asked if he knew why he was in the cart, she reported Noah saying, "Yeah, it's to keep me safe!" Cheryl said this made her feel relieved that Noah sees being in the cart as a good thing.

Elizabeth scored a 31 on the pre assessment Minnis RAD Questionnaire. The majority of her behavioral symptoms lie in Cluster 1 and 3 indicating that she exhibits characteristics associated with both disinhibited (AD-D) and inhibited attachment disorder (AD-I). Some of her behaviors are also associated with an anxious/immature attachment style. Elizabeth showed improvement in her behavioral expression with the most significant changes in the following areas: Tends to be afraid of new things or situations; Is often

unhappy, tearful or distressed; Has few friends; Is too friendly with strangers; Very 'clingy'/wants to be with you all the time; Is difficult to comfort when fearful or scared; Is demanding or attention seeking; If you approach him/her, you never know whether he/she will be friendly or unfriendly.

According to the pre and post RAD Questionnaires, Elizabeth made progress in acting more like her age. She now has a few friends, whereas she struggled making friends during the initial assessment. Elizabeth started out being indiscriminately charming with strangers, and now is better at waiting until she gets to know the person before befriending them. Her attention-seeking behaviors are improving. She used to be clingy and difficult to soothe when distressed, however, now she allows her mother and her father to comfort her on occasion.

In the scoring completed before the Focus Group, Cheryl scored Elizabeth a 20 on the RAD Questionnaire. This score indicated that Elizabeth is continuing to interact more appropriately with her parents allowing them to care for and have control of her affairs. Prior to the focus group Cheryl shared that Elizabeth has now allowed Noah to join the mother/daughter early morning time together. "I never expected her to get to a place of being able to share my time. She even gets on the floor with Noah and completes a puzzle with him before she comes and sits by me for her one-on-one time."

Family assessment following parent group

For the post parent group family therapy observation Cheryl was observed with her daughter Elizabeth. Cheryl was observed using short, specific and clear communication with her daughter. Starting the session Cheryl scanned for the positive and made it big by focusing on what was different in their morning routine. Mom started with, "This morning we had a

breakthrough on something we have worked on for 11 years. Today she made some really big steps and used words to express her deep feelings.” The therapist asked what was different about this morning. Cheryl responded with, “We have been very busy lately, where I could see this situation where she was not present emotionally. Today I saw it at our coffee time. I get her up an hour before the other children. I would not have been able to connect with my mother in this way, however, my daughter looks forward to our time.”

Cheryl discussed the taking of a family photo and how during the setup Elizabeth moved away from everyone. Cheryl said, “She will come if she is invited, but not if she is not invited.” This family photo experience tied in with a writing assignment their therapist had assigned. The therapist asked Elizabeth to write about what she recalled concerning her birth mother. Cheryl asked what had been written. Elizabeth responded with, “She didn’t feed me. So I know she didn’t love me.” As Elizabeth began sharing her memories of her birth home, Cheryl was observed moving in close seemingly to provide emotional support. Cheryl used right-brain communication to convey empathy and sensitivity to Elizabeth’s feelings. Cheryl confirmed Elizabeth’s experience of her early childhood experience and added a compassionate piece about Elizabeth’s birth mother doing the best she could. As Elizabeth went on to talk about her writing concerning her birth mother, Cheryl stated that she saw a light go on in Elizabeth’s eyes that she had never seen before. “When she shared her experience with her birth mother made her feel like she was not wanted, I saw a light go on in her eyes. I have never seen this before.”

Cheryl continued her sharing, “I would say it was like watching you be born. Watching you come alive as we talked about it.” Elizabeth’s response was to make a bid for her mother’s closeness as she said, “I feel affectionate.” Cheryl then motioned for Elizabeth

to come into her mother's arms as Elizabeth began to go deeper into her emotional expression.

Cheryl was observed creating safe emotional space for Elizabeth to continue sharing the painful memories of her mother and what messages this less than ideal care embedded in Elizabeth about her worth and place in a family. Throughout the observation of this dynamic the researcher saw Cheryl use curiosity to gather information about Elizabeth's perception of her early childhood memories. Elizabeth continued to share painful memories, "My brother used to go to the neighbor's to get food." Cheryl continued to praise Elizabeth for her courage in sharing these difficult memories and for being open to discuss the meaning Elizabeth gave these experiences.

Cheryl moved at Elizabeth's pace, allowing the child to set the tone for the discussion. Elizabeth expressed not feeling like she had a place in the family. As Cheryl validated Elizabeth's internal experience of being in a family, Elizabeth's posture noticeably relaxed and she began to breathe deeper, as she moved in even closer to her mother. Cheryl demonstrated an ability to be attuned to her daughter by moving in closer. Cheryl placed her arm around her daughter and by doing so seemed to engender hope and communicate safety. Cheryl then engaged Elizabeth and encouraged her to share her perspective. It is unclear whether or not this conversation had taken place in previous family sessions. However, Elizabeth continued sharing about her memories of her birth family. While Cheryl felt Elizabeth was too young to have any real memories of what transpired, she nonetheless communicated that Elizabeth's feelings and memories from her birth family were of real importance.

From there Cheryl began talking about how she and Elizabeth got up early this morning before anyone else in the house, so they could spend their one-on-one time together. Elizabeth shared how connecting with mom in this way made her feel wanted. With this sharing, it seemed as if Cheryl was connecting with her daughter in a deep and meaningful way. Cheryl seemed to sense this was a special moment, and so she asked her daughter, what made her take food? Elizabeth stated that she had a big hole and she was trying to fill it with food. Whenever she did not feel wanted, she would eat large quantities of food to satisfy that feeling. Elizabeth shared when she saw Mom giving the other children in the home affection and attention, it made Elizabeth feel worse. It was during these times that she had the cravings to eat. Cheryl used curiosity to gather additional information about this behavior, and because Cheryl was doing a great job of using her right brain to communicate emotional safety and regulation, Elizabeth was able to talk in depth about her eating to fill the hole.

Cheryl encouraged Elizabeth to focus on a solution over the problem. Cheryl also helped Elizabeth see she had a choice in how she responded when the other children in the home received affection and attention. Cheryl did a great job of not going over all the historical times of when Elizabeth hoarded food, but rather stayed in the here and now in her communication around the situation. Cheryl facilitated Elizabeth using her words to ask for her needs and wants to solve the problem going forward.

In addition to these behaviors, during the family session, Cheryl was also observed: Responding when Elizabeth initiated communication; Asking Elizabeth for her current feelings; Scanning for and highlighting the positive; Concentrating on meeting the need

instead of the miscue; Identifying obstacles that tended to get in the way of her connecting with Elizabeth; Empathizing with Elizabeth; Asking for current feelings.

Factors Contributing to Change in the Family

Cheryl's journals and interviews seemed to point to three main factors that helped Cheryl bring about change in her family's functioning. The first of these was Cheryl's ability to focus on her emotional state and when she felt herself becoming anxious or overwhelmed by one of her children's behaviors, she would breathe and get grounded. Siegel and Hartzell (2004) highlighted the importance of the parent taking care of themselves and doing their personal work in order to enhance their parenting. Cheryl did just that. She paid attention to her emotional state in the moment, and if she needed to breathe or get grounded she took the time to do so. Additionally, she went a step farther and focused on taking care of herself on a regular basis which seemed to increase her patience and resilience with her children.

The third critical factor Cheryl wrote and spoke about that changed her family's dynamic was her ability to look beyond her children's behaviors to the need that was expressing. In order to see beyond their behaviors and to reframe those behaviors as trauma expressing, Cheryl once again connected it to her being able to stay emotionally regulated so she could co-regulate her child and provide them the space and emotional safety to talk about what was really bothering them.

Gloria

Gloria's first-born child is Sophia. When Gloria attended the group and started therapy, Sophia was sixteen years old. Sophia is from Gloria's first marriage in which there was a lot of domestic violence. Sophia witnessed this ongoing domestic violence between her parents from the time she was a baby. This domestic violence was at times severe. For example, on one occasion, Sophia's father held a gun to her head and her mother's head and threatened to kill them.

When Sophia was seven her mother left her father, eventually remarrying and having two boys with her new husband, Gregory. Gregory was also a part of the research, and his story will be told next. Now sixteen, Sophia lived with her Mom, stepfather and two half-brothers.

Prior to the Parent Group, and the start of treatment, the relationship between Gloria and Sophia was strained. Sophia's relationship with Gregory, her stepfather, and brothers was distant. Gregory did not understand Sophia's difficult behaviors and was critical of her. Furthermore, Gloria was wounded from her first marriage and had a tough time trusting anyone else to parent Sophia. She did not want Sophia to get hurt again, so Gloria built up walls to prevent Gregory from parenting Sophia. This further increased the emotional distance between Sophia and her family. During the Focus Group, Gloria shared, "I was so full of fear before we started with you that I was not connected to anyone in my family."

At the time of intake, Gloria shared in the clinical interview that Sophia's behaviors were out of control. Gloria reported that a month earlier Sophia had been charged with possession of marijuana. Gloria also reported that Sophia was impulsive, forgetful, and disrespectful in the home. According to Gloria, Sophia did not take responsibility for her

behaviors, and frequently lied and manipulated. She refused to do chores, threatened to run away, was explosive, verbally aggressive, and had tantrums on a daily basis that consisted of yelling, slamming doors and throwing things.

Additionally during the clinical interview, Sophia seemed to have significant difficulty sustaining relationships with her peers and maintaining personal hygiene, such as wearing the same clothes for up to four days at a time. Gloria said Sophia ate sporadically, hoarding food in her room and eating throughout the night. Sophia had a history of using alcohol and marijuana. Gloria said she was unsure of exactly how much Sophia was using. Gloria also reported that Sophia had severe depressive symptoms and bouts of insomnia.

The emotion Gloria said she felt most around Sophia was anxiety. Sophia seemed to escalate out of control when plans changed suddenly or when she heard the word, “No.” Gloria said she did not know how to get Sophia to behave in a safe and secure way and Gloria would get scared and start panicking. Gloria also admitted that she felt she was not in control and was not able to have an impact on her family's health.

Gloria said there was no sense of unity or of being a team with her family members. Gloria had a feeling of not being able to keep it together and of being overwhelmed with raw emotion. Gloria perceived that Sophia felt unloved and feared that her needs would not be met. For her part, Gloria admitted to feeling exhausted and emotionally depleted.

Parent journaling through the group process

Early on in the Parenting Group, Gloria journaled, “My emotions are very high. Probably the emotion I feel the most is anxiety. I react a great deal from anxiety with her.” In answer to the question, ‘What are some triggers’, Gloria wrote, “Her escalating out of control

when plans changed unexpectedly or the word ‘No’. I couldn’t get her to behave in a safe and secure way and I would get scared and start panicking.”

Gloria found that she was better able to manage her emotions and communications than she used to be. In response to the question, how was she handling those triggers now, Gloria wrote, “Managing my emotions and communication. When I am not scared or panicked I can set boundaries and we can talk through plan interruptions. Co-regulation helps tremendously. Not being afraid of setting safety boundaries and Nos.” In her body Gloria noticed, “I still get pretty worried but I feel a sense of hope in my heart (chest/stomach). I think it could lead to a more relaxed posture.”

In response to what she learned in the first class Gloria wrote, “Having more mindfulness about brain function and the importance of connection, need meeting, and trust. Also bringing down my own stress by breathing, Heart Math, grounding techniques. Good Stuff!”

After the first week, the thing that impacted Gloria the most was, “Understanding where my child is as far as what is going on in her brain, in her emotionally. What she is trying and has been trying to communicate for years. Understanding is bringing me more compassion and grace.” The amount of information shared seemed to be just right for Gloria. “I reread my packet when I got home. It is really what I needed. Exactly what I need. It was just enough to not be overwhelming but enough to where I really had a lot to chew on.” “I really appreciate the handouts to read and I have taken a million notes. It’s great!”

At the end of the first week Gloria’s insight was, “That I may not have parented well before but by golly it is not too late to have a good trusting, connected relationship with my daughter.” By the second week of the Parent Group, Gloria wrote, “This week I am definitely

feeling more calm, compassionate and in control. My anxiety has lessened and I don't feel as negatively reactionary.”

In her home life, Gloria journaled that she noticed there was less tension and that she was connecting more with her husband. “1. Connecting more with my spouse. Less extreme emotion from our daughter has helped in getting on the same page. 2. Keep calm and carry on is our new motto. Lol. Marking behaviors is actually really helping.” Overall, the tone in the family was changing, “I am less tense. There is less tension in our home. We are working together and everyone's stress is less.”

In class, Gloria wrote that she continued to increase her knowledge and it was this information that has helped to support the behavioral changes experienced in her family. “Parents being a secure base. Experiences shape brain structure. Children with attachment issues need help re-organizing their brains. Wow. It is only done in relationships – positive ones. Self-regulating techniques. Mirror neurons.” When asked to journal about what aspects of this week's class impacted her the most Gloria wrote, “I really loved learning about the triune brain, reptilian, mammalian and cerebral cortex. The function of these areas alone and together.”

When asked what was her take away from this week's class, Gloria wrote, “Things do go much better when everyone is grounded and peaceful. My epiphany was that when I am stressed my personality changes into one who is more left brained. (I took an extensive personality test a few years back with my job.) When I'm stressed I get more logical and serious and organized. My daughter cannot stand this and it's a trigger for her. I start saying and explaining everything and she goes wild. I'm going to make it a point and use mirror neurons 'feel her' and stay on course.” When asked how she is connecting to the information

Gloria wrote, “I find it really easy to apply this information to intervene. My husband always applies it differently and it is great to learn this together and apply it to our family and ourselves.”

After the third Parent Group, Gloria wrote that she was noticing a difference in how she was reacting to her daughter. “It is absolutely noticeably different. Better. Before, even three weeks ago, it was very reactive, negative and stressful.” In the past some of the triggers for things to go wrong were, “Me feeling exhausted and emotionally depleted, and then my daughter feeling unloved and fearing her needs won’t be met. She getting loud and me shutting down more.” After three weeks, Gloria handles these triggers differently now. “Nipping my emotions at the bud. I am so much more aware of mine and my daughter’s emotional levels. I’m checking in more with her.” At home she is noticing, “Less anxiety. I had so much anxiety it affected everything. Calm home, and loving. Better connecting in my marriage.”

About class, Gloria wrote that she was finding it really easy to connect with the concepts and ideas that were being presented and that they were opening up a world for her that was both new and lovely. Gloria was learning about emotions, fears and schemas, and while this material was new to her, she wrote that it just made so much sense. Gloria was fascinated to learn how our deep beliefs and perspectives can alter reality. Gloria said this information spurred her to begin exploring her own schemas.

Gloria wrote that as she applied this new information it helped support the changes they were experiencing in the home. “We talked about emotions, fears, and schemas. Much sense. Paying attention to my emotions helps me stay above, able to see, able to make changes, able to stay in the right frame of mind, prefrontal cortex, right brain, making new

connections.” What impacted her the most from this week was, “Learning about schemas. That deep beliefs or perspectives can alter reality. WOW! It is really quite fascinating. I’m exploring my own schemas.”

Her take away from this week’s class was, “Hope. My hope grows weekly. Understanding my emotional state and my family’s emotional state is what I am going to explore. I have tools to help me. I am grateful.” Gloria connected with the information. “It is really easy to connect with the concepts and ideas in the lessons. It’s easy to read, easy to understand and apply practically. It’s a whole new world but lovely!”

With the Parent Group and weekly therapy sessions, Gloria reported feeling that she had all the tools she needed to make positive changes. Gloria’s hope for a harmonious family life was growing weekly, and she felt that her entire family was motivated. “I look forward to reading and re-reading all the materials we received in class. The weekly therapy sessions are amazingly helpful too. We have all that we need to make positive changes.” During the Focus Group, Gloria shared that seeing the therapist model what she was learning in class, “Showed me how to implement the tools. I remember thinking, ‘Oh, okay! That’s how you do it.’ When [therapist] came into our home and modeled the treatment approach I was worried about how my daughter would react. I wasn’t sure how she would respond and what I would do. But it didn’t make my child defensive and that surprised me.”

At the time of the final Parent Group, Gloria noticed the following changes in her emotional reaction to Sophia. “I am noticing anxiety and a little bit of panic when I see my daughter interact with friends, boyfriend and her Dad’s family. I’m working on sitting with it, rating it, breathing to stay level headed and ultimately accomplish healing and connection.” As a result of having tools to use, Gloria noticed the following changes in her

body. “More love. More connection. Less anxious in my stomach and muscles. My husband told me the other day that I’m more coherent, happy and present.” Gloria reported feeling that about half the time now she was able to recognize what was happening in her conflicts with Sophia. “About ½ the time I am able to recognize what is really going on and use some tools like 1) getting grounded 2) physical touch with emotional openness 3) figure out what the real need is.”

In class, Gloria said she enjoyed the continued look at schemas. “I really loved learning about schemas. Very interesting. I’ve been working on that little bit and I think it’s definitely helped! Self care. This class was really life changing. (coupled, of course, with the weekly therapy. It was a one two punch.)” In writing about what impacted her the most about this week’s class, Gloria wrote, “I appreciated the couples’ dialogue. [The facilitator] helped us with it a little more in a home therapy session. It helped me and my daughter resolve some resentment. I need to keep practicing.” In the Focus Group, Gloria stressed, “It was really important that [therapist] pointed out that some of the areas we were struggling in were about us doing our personal work. The therapist helped us uncover our schemas that needed to be healed.”

As the Parent Group wrapped up, Gloria wrote, “I am so thankful for this model, for [the facilitator] for all of the help and resources and information. We’ve been on a six year journey of trying to find help and answers. We have struck gold! Plus all of the material is easy to understand yet extremely effective.”

In the post Parent Group interview, six months later, both Gloria and Sophia felt that there had been huge changes in their lives. Gloria said, “We are doing so much better. I have, I am more maternal with her. She has responded to that. She likes to come in close. It’s better.

It definitely is better. I see sometimes when I get fearful or she stays away longer and then it becomes harder for us to reconnect. Yes. I just saw [Sophia] in a different way. In a tender way. The understanding helped me see her in a maternal way. To just connect with her and understand where she is coming from and. I think I had a lot of blinders towards her. I couldn't see her. I started seeing her for the first time and she was 16/17 years old. This is you, your personality. I just saw her for the first time. In a genuine, without blinders, just pure.”

When reflecting on the changes the family sustained six months after discharge Sophia said, “At first me and my Mom had trouble connecting because it was too much at times. She would, now she can say I really hate when you do that. Now it's like okay. It definitely deescalated the negative emotions. Now we can have more trust in the process and have a difference of opinion and say I hear you, you hear me.”

When asked about the current level of stress in the home, Gloria said, “I think it's so much less! It is stressful because we have a busy life with a lot of moving parts. It is not emotionally stressful. I really find myself able to kind of emotionally breathing well.” Sophia shared her perspective, “And we can work together better. Before if it was stressful, we were butting heads. Now we can communicate better. I can watch the boys. It is just easier to mesh. We communicate better, which definitely takes the stress level down.”

They both agreed that they were meshing better as a family and had a feeling of all being in it together. “I think that I just brought in a lot of parenting baggage into our marriage. This is my second marriage, [Sophia's] dad it was a very abusive relationship. She witnessed a lot of abuse. Then when I got the courage and we decided this is not working and I left the relationship, I got into another relationship and he was very critical of [Sophia].

When I got married I did not want my husband to parent her, and I did not want him to hurt her. Going through this process at attachment healing helped us to heal. We are doing this. We are doing this. We are going to find out how to parent her and find out who she is. It helped me to lose some of that mistrust, and my guards and my walls, and she don't cross this line. Healing with her helped us mesh as a family.”

Gloria acknowledged that she had been very critical of Sophia and was suppressing her daughter's creative, whimsical side, which in turn caused Sophia to feel rejected. Seeing this allowed Gloria the space to heal it, to love herself and to let go of her fear and hurt.

According to Gloria, a big piece of this change was that she felt her negative emotional reactions were slower and quieter and that she was able to see and reflect better. Gloria was also doing a better job with self-care and had been able to receive more support from her husband.

Looking back on the parenting group, Gloria reported feeling that the information she received was vast and powerful. When asked if they were still using the information eight months after discharging from treatment, Gloria said, “I think the information in group was so vast. It was incredible. Some things it just sticks and you do it, and some of the ones you need to go back and read. I think us just realizing that. I think it was schemas and some of those voices to play a part in our life and we believe them. The landscape of our minds. If you believe something even if it is not true, it is true in how you live your life. This is important to make sure we are really believing and saying the right things. And really removing the blinders that surround needs. The basics. We are in this together. We are going to figure this out together. That was the biggest thing. We are going to trust each other, and we are going to heal together and learn to trust each other. I guess deep inside, our life is

beyond repair. I thought it was too late. Just feeling that grief. It was like no, that is not true and sort of that WOW! No, we were handed this gift. We are in this until the last breath together. That was a real gift to us. It's not broken beyond."

In the interview, Gloria and Sophia were asked what it was like at home now. Gloria said, "I think that it's more family. More we are in this together. My distrust and not wanting to bring my husband into parenting [Sophia], it did draw lines. And [Sophia] did not feel like a part of the family at all. It was really hard for her. Now. She will come home and the boys are with her and it's just this. We are all family. It was not even something I had with her growing up. I was a big hot mess, so this is a new feeling." Sophia had this to say about family life now, "I feel the same way. I am so thankful for my boys and for my Mom. I am thankful I get to be a part of this family."

During the interview Gloria was asked how long it took to bring about change in the family. "It was immediate. Every time [the therapist and facilitator] would bring something to us, or point something out to us, we would go over the packet together sometimes. She would say, 'Do you remember' if we had a problem. We would be like, 'No, let's talk about it.' Every time she would do that, me and my husband would talk about it and we take off with it. We were being handed these how tos. It was oh, this is how it works. It really was so fast. We were surprised at how fast it was."

In a follow-up clinical assessment, two months later, eight months after the end of the Parent Group, Sophia had turned her academic struggles into straight A's and one B. She showed minimal to no depressive symptoms and only minor anxiety symptoms. According to Gloria, Sophia's tantrums had decreased from daily to less than once a week. Gloria reported being able to downshift in less than five minutes.

The therapist working with the family reported, looking back, that over the course of the Parent Group the family displayed significant improvement in relationships, communication, emotional regulation and connectedness.

Child Assessments

Sophia scored a 23 on the Minnis RAD Questionnaire. Sophia's scores were not predominantly in any one cluster. Her behaviors were spread out. Given this, it does not seem as if Sophia demonstrated significant behaviors associated with either type of attachment disorder. She did experience major stress in her relationships at home and at school that interfered with healthy family functioning. According to the pre and post answers on the questionnaire Sophia had major shifts in the following areas, indicated by her scores moving from "Exactly like my child" over two positions to "A bit like my child": Tends to be afraid of new things or situations; Is often unhappy, tearful or distressed; Has few friends; Is difficult to comfort when fearful/scared; Is demanding or attention seeking; If you approach him/her you never know whether he/she will be friendly or unfriendly.

In the following category Sophia moved from "Like my child" to "Not at all like my child": If you approach him/her, he/she often runs away or refuses to be approached.

Following the Focus Group, Gloria and Gregory scored Sophia a 14 on the RAD Questionnaire. The only question they scored her "Exactly like my child" was, "When you have been parted for a short time, he/she seems happy to see you." Of all the categories to be exactly like their child, this is definitely a positive attribute for Sophia to display with her parents. A majority of the answers they chose were, "Not at all like my child."

Family Assessment Following Parent Group

Gloria's family discharged from therapy approximately seven months after they started treatment at the Attachment Healing Center. Given that a family session could not be observed, since the family had successfully discharged, Gloria invited the researcher to come to their home to conduct the interview. Both Gloria and Sophia were present for the interview. Gregory was stuck at work and had to reschedule his interview for a separate time.

The most impressive aspect of the observation of family functioning was the fact that Sophia's two little brothers looked up to her and she seemed to be an integral middle person between mom and her brothers. Sophia arrived home from school and immediately engaged mom about something to eat. Gloria used a sense of humor when Sophia looked in the refrigerator and commented that there was nothing to eat. Gloria reflected on the commercial that highlights the difference of what a teen sees when they look in the refrigerator versus what a parent sees. In response to her daughter's demands, Gloria demonstrated warmth, a sense of humor and concentrated on meeting the need instead of engaging the miscue.

Through the use of right-brain communication, Gloria encouraged Sophia to find her own solution. As an observer this made a lot of sense, and the way Gloria went about sidestepping a power struggle was nothing short of magical. Through her tone of voice, moving in close to her daughter, then moving away after setting Sophia up for success by offering suggestions, Gloria communicated confidence in her teen to be able to resolve the after-school snack issue.

One of Sophia's brothers asked her for assistance and, very appropriately Sophia took care of the immediate safety issue and then directed him to Gloria, as the adult in charge. As Gloria went to address her son's request, Sophia had important information to share

concerning his request, and without being asked, Sophia shared with Gloria. Gloria saw this as a positive and thanked Sophia for her support and based on the additional information, Gloria made her decision and implemented actions based on all the information available. During the Focus Group, Gloria shared, “We have the companion star for Sophia’s graduation from treatment at home. He took scotch tape and plastered on the wall in our bedroom. The star is low on the wall at his level so he can see it whenever he comes into our room.” The researcher highlighted that the star is possibly important to their young son because it symbolizes that he got a big sister as a result of the work she did at AHC.

Sophia joined the discussion and throughout the interview, she and Gloria took turns answering questions. Gloria seemed comfortable enough sharing her personal issues that were in the way of her parenting Sophia appropriately prior to attending the Parent Group and having in-home therapy.

In her journal Gloria had written that she struggled setting boundaries and saying No, to Sophia. The researcher asked what fear Gloria had to release in order to shift her perspective around setting boundaries. “Yes! Yes! It was more than a fear. I think it was hurt. It was a real wound I had in my heart with my Mom.” “It became, I just saw the cycle really closely. I am getting emotional. I was very critical and didn’t want, I was suppressing her creativity. She is very creative, whimsical. It was just this fear, it hurt inside of me. It was critical and I wanted to fix the creative part of her and she felt rejected by me. So we just had this dance. [Tears.] Me, just seeing it, allowed God to come and heal it. It allowed me to pull her in close and allowed me to love myself and heal all that hurt and fear.”

Sophia was highly respectful and did not comment on anything her mom said that seemed like sensitive personal information. Based on this mature attitude, it seemed as if both Sophia and Gloria contributed to the emotional safety in the relationship.

The researcher asked how Gloria's body was responding to Sophia now that the family had discharged from treatment. "We are doing so much better. I have. I am more maternal with her. She has responded to that. She likes to come in close. Its better. It definitely is better. I see sometimes when I get fearful or she stays away longer and then it becomes harder for us to reconnect."

The researcher asked Gloria to share more about the connection between compassion and understanding. Gloria said, "Yes. I just saw [Sophia] in a different way. In a tender way. The understanding helped me see her in a maternal way. To just connect with her and understand where she is coming from and. I think I had a lot of blinders towards her. I couldn't see her. I started seeing her for the first time and she was 16/17 years old. This is you, your personality. I just saw her for the first time. In a genuine, without blinders, just pure.

Treatment ended eight months ago, and the researcher was curious about how Gloria's negative reaction to her daughter was doing now. Gloria shared, "It is quieter. It is slower and quieter and I'm able to just see and reflect and see. Myself and whatever I'm feeling negative over and not be so outward with it." Sophia commented, "At first me and my Mom had trouble connecting because it was too much at times. She would .. now she can say I really hate when you do that. Now it's like okay. It definitely deescalated the negative emotions. Now they can have more trust in the process and have a difference of opinion and say I hear you, you hear me."

The researcher asked what their relationship was like now. Gloria responded first, “I think it’s so much less! It is stressful because we have a busy life with a lot of moving parts. It is not emotionally stressful. I really find myself able to kind of emotionally breathing well.” Sophia agreed, “And we can work together better. Before if it was stressful, we were butting heads. Now we can communicate better. I can watch the boys. It is just easier to mesh. We communicate better, which definitely takes the stress level down.”

Gloria stayed attuned to her daughter and when Sophia initiated communication, Gloria responded. There seemed to be an ease of back-and-forth sharing of the painful truth the family had endured together. As they were reflecting on the healing experienced in this family, Gloria asked Sophia if it was impacting her relationship with her bio dad. Sophia responded, “My dad’s an interesting one. Sometimes he’s like on his grumpy days and you have to leave him over there. When he is having good days, it helps.” Sophia continued with an experience that let her know her bio dad was seeing a change in how she was showing up. “I remember one day, I think I was just going to school and my dad sent me a text, ‘think you are a good kid and I love you.’ My dad does not do good with showing his emotions.”

During the Focus Group, Gloria shared, “She is amazing. She still spends time with her father’s family but she doesn’t take them in. She has like this resilience to not let their crazy impact her. When she comes back home, she is the same sweet child we worked so hard to help her be. I am just amazed she is not impacted by them anymore.” “And now she is a straight A student. She is getting back to being the type of student she was in elementary school. The other day she asked me how long she has to be in school if she wants to become a neurologist. I told her about 12 years after college depending. She said, okay. I want to be a brain doctor. I thought oh my! Most kids in high school are counting the days until they are

done with school and here my child was looking forward to being school forever! I guess we did something right.”

During the family observation, still speaking respectfully of her father, Sophia was able to compare life in her home now with how life was previously. During Sophia’s deep and meaningful sharing of her feelings, Gloria confirmed Sophia’s experience of a specific event and of life in her birth home more generally. Gloria spoke at a comfortable pace and conveyed empathy and sensitivity to Sophia’s feelings.

Both Gloria and Sophia talked about how things had greatly improved in their home and in their relationship since mom started the Parent Group and the family had in-home therapy. As the two shared about the impact of group and in-home therapy, the researcher asked them if doing in-home therapy helped the group experience. Gloria responded, “Absolutely enhanced. There was no way it detracted in any way. I think the two go hand in hand. Unless you do multiple rounds of the parenting group. Because there is a lot of information. The great things was the way [facilitator] really knew the material. She recognized when we were having a problem, so we knew the information, but we needed someone to help plug it in. To show this is how we do it. I think she knew the model so well and knew the information so well, she could easily remind us. And then we could really run from there.”

Gloria was able to identify the obstacles that had previously gotten in the way of she and Gregory connecting emotionally with Sophia. Both Gloria and Gregory did their work to remove those obstacles. As a result, the family cohesion was actually palpable during the interview in their home. The researcher asked where Gloria she was in the process of recognizing the impact her personal issues have on the relationship with her daughter. Gloria

said, “Yes, this whole experience was giant flashlight on issues. The sky’s the limit. I think that as we continue to go there is a lot of realization. This last month or so, one thing I’ve really been thinking about and getting, something I’m able to receive grace and what that is, and what that means in my life. That’s another thing I’ve really realized in my life. I’ve been so critical because I had not received grace for myself. I think that is the way life is, you just go on learning about yourself and it helps the next relationship. The sky’s the limit. So you just keep going.”

Gloria was able to identify the obstacles that had previously gotten in the way of how she and Gregory connecting emotionally with their daughter Sophia. Observing the ease at which Gloria and Sophia shared their growth experience in front of one another, and noticing how emotionally connected Sophia seemed to be with her brothers and they with her, the researcher observed family cohesion during this interview process. The genuine way in which each of the family members present for the interview interacted and emotionally connected with one another made the family cohesion actually palpable during the interview in their home.

Factors Contributing to Change in the Family

Gloria’s shift in her awareness around her emotional expression seemed to be the turning point for her ability to bring about change in her relationship with Sophia. Diana Fosha (2000) wrote that our defenses kick in when we don’t recognize our body’s early warning signals that we are having an emotional reaction. As Gloria was able to recognize the early signs that her emotional wounding was being triggered by her daughter, Gloria took personal responsibility for those emotions and interrupted her former pattern of projecting her emotional pain onto Sophia.

As Gloria's family relationships began to shift and heal, Gloria saw the importance of self-care and doing her personal work. As she worked on understanding the schemas that were activated in response to Sophia's behaviors, Gloria was able to change those schemas or perspectives. Bruce Lipton in *Biology of Beliefs* (2008) stated that subroutines run below our level of awareness, but those subroutines dictate how we experience reality. Here those subroutines are being referred to as schemas. In Gloria's ability to own her perspectives, she was able to rewire her perspectives and change how she responded to Sophia.

Gloria admitted to being very critical of Sophia and this in turn made Sophia feel rejected. In the interview, Gloria shared that this is how she felt with her mother. Her mother did not honor her creative side and without paying attention to it, Gloria recreated the dynamic she grew up with in the relationship with her mother. As Gloria owned her own wounding, she then felt empowered to change that interaction. Once Gloria focused on shifting this interaction pattern, Sophia began feeling seen and accepted by her mother and the result was that she could relax and be herself with all of her family members.

One final contributing factor is that Gloria began to allow her husband to have a relationship with Sophia. As Gloria gained insight into how she was standing between Sophia and Gregory, staying in the middle of Sophia and Gregory's father-daughter relationship, she realized she was projecting negativity onto their relationship. Based on a past experience a schema had been created that Gloria was enacting in an effort to keep her daughter safe. Gloria took ownership for this schema also and allowed it to shift as she brought the schema forward for healing.

Gregory

Gregory is married to Gloria. Sophia is Gregory's 16 year old stepdaughter. In addition to Sophia, Gregory and Gloria have two young sons. Sophia's behaviors prior to treatment at AHC seemed to be out of control. In the interview, Gregory reflected on his relationship with Sophia. "Our relationship was difficult. I know some of it was typical teenage type rebellion. She's very, by nature, for whatever reason a closed person. She wouldn't let us into her life. She had been in trouble with the law. We were just closed from her life. It was affecting everyone."

He went on to describe how the family relationships were impacting Sophia's life outside of the family. "...there were a lot of power struggles, where [Sophia] wouldn't follow the rules. Just couldn't connect with her. She was hanging out with these people who were negative influences. Her self-esteem was terrible. Where she felt she didn't deserve good friends, or she didn't. One of the common themes in our relationship was that she felt we loved our two sons more than we loved her. She felt left out, like she was not as important."

Parent journaling through the group process

In his journal, Gregory wrote about his experience with behavior modification approaches to assist he and Gloria in raising and helping Sophia. "Behavior modification by and large hasn't worked; we're desperate for new ideas/tools; also [facilitator/therapist] has emphasized safety in our home, and has given us language/perspectives/tools for dealing with unsafe situations. This has been so helpful."

As the Parent Group began, Gregory wrote about his emotional reaction to Sophia. "I'm still struggling to react as I always have. The tools I believe are useful, but they are not yet habits for me." When Sophia was disrespectful, blaming or dismissive, Gregory would be

triggered. This is what he wrote about how he currently handled those triggers, “I’m aware that it is not helpful to ‘power up’ in these moments, but I still am struggling [with] marking.” As Gregory wrote in his journal and reflected on the experience, he could feel that he was getting angry.

In the first class, Gregory stated that he was particularly impressed by, “Respond to the miscue as if it’s the need; this is HUGE!” His take away from the first class was, “Try not to take the miscue personally, and respond to that place of hurt/need.”

In the Comments section, Gregory wrote that their class facilitator was, “...doing a great job.” He also had a significant comment about one of the readings for class. “Regarding ‘The Cosmic Journey’ as a person who believes in a more God centered version of creation, I have a few comments. I’m not offended at all by being presented with these evolutionary ideas. That being said, I don’t see how referring to our brains in animalistic terms enhances or adds to, or increases the understanding of the brain or the model. Leaving out the ‘evolution’ of the brain would be more welcoming to people who believe in a God centered creation, but would still be highly insightful as to how the brain works. Just my opinion ;-)”

After the second week of the Parent Class, Gregory reported, “Still trying to get in the habit of marking vs reacting.” The impact of learning this approach as a couple was reflected in his writing. “My wife is helping me; my instincts are still to respond negatively.”

In class, Gregory said he learned about right brain and left brain. “Left brain is more logic and organization, this is my natural inclination anyway as recognizing that helps me be more aware that I need to work on shifting to right brain.” In his writing, as Gregory worked on shifting to his right brain he found he was showing up with more emotional presence. “Realizing that I don’t have to always respond with reason, but try to be more emotionally

available.” As he saw the impact of the right brain Gregory wrote that he wanted to know more. “How to practically shift to right brain especially since emotion is harder for me to tap into.” His take away from the second week’s class was, “Being in the moment, and trying not to solve the problem logically.” In response to what material is he connecting to most Gregory wrote, “I like learning about the research and how the brain works; it helps to understand behavior.”

After the third Parent Group, Gregory wrote he was noticing some changes. “More patience; aware of my triggers.” Whereas in the past he would respond logically, he was reacting differently to what used to trigger him, “I’m seeing that there is an underlying need that isn’t being met, and I’m trying to identify what it is.” As a result of responding differently, Gregory noticed, “More calmness, more patience.” He attributed this change in his responses in part due to the explanation in the week-two class about schemas. “Really appreciated how [facilitator] explained the schemas, and how the underlying belief systems drive these responses.

Gregory wrote about what impacted him the most, “The schemas and trying to figure out what lies my daughter is believing; getting the practical tool that says, ‘I know it’s hard to believe, but...’” Gregory found it so helpful to have a concrete explanation for what was happening in his family. “It’s so helpful to put words to what is taking place inside of myself and my family, from a scientific perspective; it helps bring understanding in order to deal with the challenges.” Gregory’s take away from week three’s class was, “Looking deeper at my daughter’s belief system and how childhood trauma has reinforced them.”

After the fourth Parent Group, Gregory reported in his journal, “I have more patience; also she is more regulated now, as we’ve had fewer blow ups (that’s nice!).” In the past, “I

would get angry, and argue logically and factually.” However, as he took in the information taught in class he started to show up differently in his relationship with his daughter. “I realize that left brain doesn’t really work when she is dysregulated; I’m not engaging in power struggles nearly as often.”

As the interaction between Gregory and his daughter began to shift to a more positive relationship, Gregory began to focus on the personal work he had to do. “Emotional conflict creates a lot of anxiety for me; anger in others makes me afraid; now I’m trying to look beyond the emotion and figure out the need.” He wrote about what he learned in class that helped support this change, “I see how cortisol influences my ability to process; by staying regulated, the ‘fireworks’ don’t create a strong reaction in me.”

According to Gregory’s journal, he really appreciated the in-class discussion of self-care. He was also greatly impressed to learn that, “80% of reality is inside the brain. This is HUGE! WOW; this reality affects not only families, but communities, cities, governments, and nations.” Gregory reflected that in particular he was impressed by learning about the science of the model and how or why we respond to life the way we do.

Gregory’s journal reflected that the main things he took away after the fourth class was the importance of spending time caring for himself and to really contemplate why he behaves or does certain things. Gregory wondered, “To spend time caring for myself, and to really contemplate “why” I believe or do certain things, (am I believing a lie that is preventing me from being who God created me to be?)”

The two ideas that seemed to impact Gregory the most by the fourth group were the importance of self-care and taking personal responsibility for one’s perceptions. “Reflecting on the fact that “perception is reality” and how that influences every area of our life; I think

more examples of what this looks like would drive the point home more, and challenge parents to think through their own belief systems.”

Looking back on the Parent Group as a whole, Gregory wrote that he felt the group in combination with the therapy sessions had been life changing for his family. He expressed feeling very thankful. “This training and counseling has been life changing for us; we are so thankful; we really appreciate [facilitator/therapist].” During the Focus Group, when asked about his experience of seeing the therapist model the treatment approach in his home Gregory said, “Learning the tools and then see it modeled and know how to implement it differently. This really helped. I think this is the reason things moved so quickly in our home.”

In the interview, Gregory reported that following the Parenting Group, he and his family continued to work with a therapist to apply the skills learned in the Group. After seven months, they all decided so much progress had been made that they could stop therapy. Gregory said, “[Sophia] had really stabilized. Our relationship with her was much improved. She was more open. [Gloria] and I, our relationship seemed stronger. It felt like we had done everything we needed to do. [Therapist] was still getting help, and it seemed like in terms of [Sophia] there wasn’t much more we could do for this season any way.”

Reflecting back on this progress eight months after finishing therapy, Gregory commented in the interview, “We are not marking that much. Part of that is [Sophia’s] improvement. She’s not giving us as many things to mark. She has really matured a lot in the last year. She’s taking her school seriously. She had her best report card, this last nine weeks. Straight As and one B. There are just fewer things that are problems. She’s becoming more helpful with her brothers where she had been disengaged with them. She’s taking more time

just loving them. Pouring her love into them. That is something that was not happening. Even helping around the house more. She can still grow in that area. She is helping more than she ever would. Those were the kinds of things she used to not do. 'Can you help with the kids? With the house? What about these friends you are hanging out with' Those things have improved so there is not much to address. She is driving and a part of me in the back of my mind is a little worried. Who is she really hanging out with? The fact that she is getting good grades means she has to be making some good decisions."

For his part, Gregory stated that he felt the stress levels in the home and in every relationship within the family had come down. In the interview Gregory said, "Definitely stress has come down. We can see it in every relationship. With [Gloria] she is less anxious she feels much better about the direction that [Sophia] is going. There is not nearly as much fighting. There used to be major intense heated conversations. Where she would end up storming out, slamming the door and riding away on her skateboard. Those just aren't happening."

When asked about what tools he had used to help communicate emotional safety to Sophia, in the interview Gregory said, "[The therapist] really helped us when it came to trying to pull [Sophia] in. Physically be near her. She taught us how to point out the truth. That was something [Sophia] literally believed lies. Even if the truth was in front of her face, wherever her schemas were, she couldn't even see the truth. The therapist even witnessed it one day. [Gloria] had said something in a rude way, in a negative comment, and it hurt [Sophia]. Right on the spot [Gloria] said, 'I'm sorry, I should not have said that.' Not 30 seconds later, [Sophia] said, 'See, my mom can't even apologize.' All of her schemas, her belief system, the truth couldn't get in. [The therapist] taught us how to note if something,

even just to mark good things that happened. ‘Hey [Sophia] did you not notice I really did address your concerns today? Do you see I really did help you with your problem today?’ To counter those perspectives we don’t love you. Those were really helpful. I think just understanding, it was the biggest one of the biggest things I learned that helped me learn when [the therapist] taught us in the parenting class. 80% of reality is what we believe. This just gave me a better understanding of where [Sophia] was coming from. That statistic can be applied to everything, every area, every person. That is so Huge! So it helped me have more grace for [Sophia]. To realize that in different circumstances, her belief system was all wrong about herself, us, her school, whatever it was. She was believing the wrong thing. So we have to help her see the truth in a loving way.”

This increase in grace towards Sophia was just one of many manifestations of change that Gregory reported noticing in himself. “I think I still need to improve. To some degree yes. I think I’m a lot less confrontational or less quick to react in a negative way. Because I understand where she’s coming from and some of the lies that she believes. In that regard I’ve improved.” He said he felt more space internally to tolerate difficult emotions in himself and in the home. When asked about his triggers, Gregory said, “I feel tense, like a tightening. Part of it is my own journey of learning to live with women. They are more emotional and I am learning to let that be okay. Emotions for me were always very scary. That is one of my issues. Especially anger emotions were scary for me. Even frustration or sadness, that is probably all the right brain stuff. I don’t know how to operate in that area. Those situations automatically create my stress or anxiety or whatever to elevate.”

Gregory was learning that it was OK for his wife and Sophia to express more emotion than he did. “Disrespect still bothers me, but I try to be more patient. Usually it comes up

when [Sophia] is disrespecting her mom. My reaction is to defend or protect [Gloria]. I try to let them work it out before I get involved....They are more emotional and I am learning to let that be okay.” In the interview Gregory expressed seeing growth in his wife, Gloria as well.

Still, Gregory felt he wanted to continue to work on what he learned in the Parent Group and in therapy. He wanted to be able to show up calmer and less reactive. When asked how he was doing shifting his schemas Gregory said, “Good question. I still struggle with the same ones. Schemas. I think it’s been helpful, one of them is believing I’m not good enough. I’m always coming up short. At least one thing that is helpful, that uncovering those schemas, so that [Gloria] and I can identify them in each other. Hey I see it looks like you are going into that schema. At least that helps we are able to help each other. It’s still there, but at least not that we are working together that is positive. If so, in what ways?”

In addition to the changes Gregory saw in himself, he also noticed the stress level in the house was coming down. “Definitely stress has come down. She can see it in every relationship. With [Gloria] she is less anxious she feels much better about the direction that [Sophia] is going. There is not nearly as much fighting. There used to be major intense heated conversations. Where she would end up storming out, slamming the door and riding away on her skateboard. Those just aren’t happening.”

In his week four journal, Gregory reported how the group and counseling impacted his family. “The training and counseling has been life changing for us; we are so thankful; we really appreciate [facilitator/therapist]. He felt a lot of appreciation for the group and for what he learned in it. “The parenting class was really great. Thank you for what you did. That point about belief. I wish everyone could know that. “What you are believing is driving your life!”

Child and Family Assessments

Gregory's stepdaughter Sophia's assessments are reflected here as a repeat of what was reflected in Gloria's write up.

Sophia scored a 23 on the Minnis RAD Questionnaire. Sophia's scores were not predominantly in any one cluster. Her behaviors were spread out. Given this, it does not seem as if Sophia demonstrated significant behaviors associated with either type of attachment disorder. She did experience major stress in her relationships at home and at school that interfered with healthy family functioning. According to the pre and post answers on the questionnaire Sophia had major shifts in the following areas, indicated by her scores moving from "Exactly like my child" over two positions to "A bit like my child": Tends to be afraid of new things or situations; Is often unhappy, tearful or distressed; Has few friends; Is difficult to comfort when fearful/scared; Is demanding or attention seeking; If you approach him/her you never know whether he/she will be friendly or unfriendly.

In the following category Sophia moved from "Like my child" to "Not at all like my child": If you approach him/her, he/she often runs away or refuses to be approached.

Following the Focus Group, Gloria and Gregory scored Sophia a 14 on the RAD Questionnaire. The only question they scored her "Exactly like my child" was, "When you have been parted for a short time, he/she seems happy to see you." Of all the categories to be exactly like their child, this is definitely a positive attribute for Sophia to display with her parents. A majority of the answers they chose were, "Not at all like my child."

Factors Contributing to Change in the Family

The factors that seemed to help Gregory shift in his relationship with Sophia, were his ability to own how strong emotions impact him. Once Gregory gained insight around his own

internal processing of negative emotions he was able to get grounded and then to shift his focus to how he could improve his interaction with his stepdaughter. Gregory spoke about the impact of learning left-brain versus right-brain functioning. He realized that a lot of his behaviors were left-brain driven and were based on schemas he picked up from his family of origin. Murray Bowen (Gilbert, 1992) theorized that a person's level of differentiation does not change after they leave their family of origin. It seems as if Gregory's way of dealing with emotions had been with him since he was a young boy. Now in relationship with Sophia he was being challenged to change that conditioned response.

As Gregory gained insight into the schemas that were driving his behavior, he was then able to get curious about the schemas driving his stepdaughter's behaviors. As Gregory focused on what need was underneath Sophia's behaviors, he was less reactive to how she showed up in relation to her family members. It seems as if Gregory's ownership for how he was showing up in relation to his stepdaughter enabled him to create more emotional safety between them. This increase in emotional safety then enabled Sophia to interact more positively with Gregory and also with her younger brothers.

Analysis

Research questions addressed

There were six questions being addressed by this study. The first question addresses whether or not the research participants have tried other treatment modalities. Of the five participants representing five children, four of the participants had tried other treatment modalities. The treatment modality most prevalent in their community and the one usually recommended for children was a behavior modification approach.

The second question is a follow-up to the first, asking how this treatment approach compares to the other treatment modality the parents have tried. Three parents in particular wrote about how many years they had been in treatment elsewhere. In week one of his journal Gregory wrote, “Behavior modification by and large hasn’t worked; we’re desperate for new ideas/tools.”

In her week four journal Gloria wrote about the journey to find help. “I am so thankful for this model, for [our therapist], for all of the help and resources and information. We have been on a six-year journey of trying to find help and answers. We have struck gold! Plus all the material is easy to understand yet extremely effective.” In week one, Stephen wrote, “We have tried behavioral modification for 11 years and were dealing with the same problems. Ten months of using this model we see, feel and hear healing for our entire family.” In the Focus Group his wife Cheryl said, “It’s treatment that heals. It’s not forever.”

According to the participants in this study, it does not seem to matter if the child is birth, step or adoptive. All of the parents reported experiencing a significant change in their

child's behavior as a result of the information they learned in group. Each parent wrote and spoke about the impact of having group coupled with in-home therapy.

Without exception, each parent reported severe behavioral challenges in their child prior to treatment at the Attachment Healing Center. All of the children seemed to struggle with trust of control in particular, and the parent's inability to redirect their child was a huge trigger for the parent. As parents we cannot keep our children safe and we cannot meet their needs if they do not let us parent them.

The research participants experienced this inability to care for their children as despair. After trying treatment elsewhere for years with no change, the parents began to feel hopeless believing that no one could help them. Even Cheryl was skeptical when she started treatment at AHC. In her interview she said, "When the family started with AHC, I thought my daughter was going to go to RTC, and I knew she would not come back. Six places in state and six out of state rejected her because they said she would burn out their staff. The process was burning me out as we were getting nowhere with it, and I told my husband I could not keep up with the process. This was my Hail Mary Pass. Even when you said we have had people in the past who were going to go residential but didn't, I thought, 'You have not met my daughter.' I felt double minded at that point as I was trying to say goodbye to my daughter in my heart. By August, I knew she was not going away."

There was a similarity in how the parents attempted to address these behavioral issues. Gregory labeled it as "powering up." This is when parents feel they need to yell and be more intense than their child. In her interview, this is how Cheryl referred to her parenting stance prior to training, "I used to think the more seriously the behavior showed up, the

stronger I had to be, so they would realize what they had done. But now, I know I can stay calm because the model is going to do the work instead of me.”

In her week three journal, Gloria wrote about how she used to show up in these terms, “Before, even three weeks ago, it was very reactive, negative, and stressful.” It seemed as if the parents felt they were bringing everything they had to effect change, but nothing they did worked. Their child seemed to get worse before their very eyes.

This desperation may also be a factor in how well the parents responded to the information. As Escudero (2008) stated, change only comes about when both sides are motivated to change. Having tried other modalities with no change in their child’s behavior may have primed the parents to give this treatment approach their all in the hopes that finally they had found something that would make a difference in their family’s functioning.

Without exception, each of the children realized significant behavior changes. There were no trust-of-care or trust-of-control issues witnessed during the observation of the family sessions. Trust-of-care is when the child knows the adult caregiver will take care of their needs like food, shelter, clothing and so the child does not take charge of these things. Trust-of-control is when the child trust the adult to be in charge of them so when the adult says no, or redirects the child, the child knows the adult will keep them safe so they do as asked or directed.

All of the severe behaviors are only known from the diagnostic clinical assessments by the therapist and the parents’ reports. During the session between Sharon and Olivia, there were remnants of Olivia not trusting her mother. However, what kept Olivia from escalating and becoming violent towards her mother in an effort to keep her feelings buried away, was how Sharon responded. When Olivia began to shutdown verbally and to move in on herself

physically, Sharon moved in close. Not only did Sharon move in close physically, but also her words became softer and more soothing. It was obvious that Sharon had shifted to her right brain which was more emotionally regulated.

Schore (2003) stated that it is the mature regulated brain that helps the immature brain to regulate. This is exactly what was witnessed as Sharon entered regulated mom mode. As Sharon moved in close, Olivia, resisting at first, slowly began to allow her mother to meet her emotional need. As Olivia allowed her mother to soothe her, Olivia began to share openly and freely about emotions she had been holding onto for years. In this one pivotal moment, Sharon provided such emotional safety that Olivia could not resist sharing and unloading all she had been carrying.

In addressing what contributed to the differences observed and experienced in the children's behaviors there is a sample cross case analysis presented below. This sample is a compilation of the five cases studied. The overarching theme seems to be the focus on the parents changing, not on the child's behaviors. As a result of focusing on the parents bringing about change, the child's behaviors changed in response to the parent's change.

In addressing if the group experience contributed to change, each of the participants had something positive to say. Gregory said, "Something beyond our wildest dreams. A gift of repair and connection for our entire family." Stephen said, "Brings deep meaningful and lasting change to all relationships."

In week three, Cheryl wrote, "IT WORKS! I am finally being given tools that I understand to connect with my child." In her journal Gloria wrote, "It is easy to connect with the concepts and ideas in the lessons. It's easy to read, easy to understand and apply practically. It's a whole new world but lovely." In week four Sharon wrote, "I feel as though

all of the information can be used daily in our interaction, therefore it's easy to try each day to do better." As his last statement in week four, Gregory wrote, "This training and counseling has been life changing for us; we are so thankful; we really appreciate [our therapist]." In week four of his journal Stephen wrote, "The material seems to be straightforward and clear particularly when I go back and review it."

In the Focus Group, the participants shared the things they thought contributed to the groups being so successful. Each of them attended different groups as a part of the research, however, the experiences seemed to be similar across groups. Gregory said, "Having food each week was good." Gloria said, "You don't feel alone. We're all working together." Cheryl said, "In the home everything is coming at you. Bombs are going off in the middle of therapy. You can't really focus on the material there."

Cheryl and Gregory were the only ones to journal about the other participants in the group. In her week four journal Cheryl said, "It has been wonderful getting to know others that share our journey." In week one Gregory said, "mainly just some of the other parents trying to take over the session." At this point it is unclear whether it was the group process or the information that had the most significant impact. This question was asked during the focus group and the response from Gloria was, "In group you don't feel alone. We're all working together You also avoid the, 'Your kid is perfect' stuff." All the parents joined in here as they hate it when their child's charm and manipulation gets over on other adults. These adults can be family members, teachers, counselors, child care workers or teachers at church.

Sample Case Progression – Track II

In accordance with Stake's (2006) presentation of findings, track II merges similar findings across cases. This next section will review the five cases and will address the similar findings in those cases as they pertain to the research questions.

Week 1. Prior to finding the Attachment Healing Center, parents seemed to feel hopeless as they had tried other treatment modalities with limited results. It did not matter if the child was a birth child or an adoptive child. The child's age also did not seem to matter as the parents in the research had children ranging from ages 7 to 16.

The behaviors the research parents were dealing with at intake ranged from tantrums at being told no, or having plans change at the last minute or being redirected from something they wanted to do. Tantrums showed up as verbal or physical aggression. The children would not allow their adult caregivers to meet their needs. As an example some of the children stole food in the middle of the night and hide it in their bedrooms. They might lie about simple things when the truth to the contrary was obvious. The children tended to struggle in school partly because they had no emotional regulation and could not sit still and focus to complete their assignments. The children in the research also tended to struggle with taking directions from their teachers, who were seen as authority figures. Peer relationships were a challenge as well as their peers tended to not want to play or interact with them.

Parents have tried putting their children in time out, along with taking things and privileges away from them. None of these things worked so the parents began to try to be bigger than the child by yelling or getting more intense with their directives. The yelling or getting bigger and more intense than the child didn't make a difference either and instead only served to make the parents feel bad. The parents's anxiety continued to go up as they

anticipated an argument any time they had to redirect their child, say no, or change plans. By the time the parents found AHC they were feeling hopeless, like nothing would ever help and family life would never get better. They all spoke to feeling a sense of dread when their child was about to come home from school or they were about to see their child after being away for the day.

Most of the children in the study exhibited behavioral symptoms associated with disorganized attachment. Fahlberg (1990) categorized these behaviors as trust-of-care and trust-of-control. In healthy development trust-of-care comes online between birth and two years of age. This is when an infant learns to trust the adult caregiver to feed them, change them and take care of their daily needs. The infant learns to ask for their needs and wants by crying, and the adult responds to their emotional distress first. Such a response teaches the child emotional regulation. After calming the child, the parent then meets the need. The child learns the adult can be depended on to meet those daily needs so the child will let the adult take care of those needs as they arise.

Trust-of-control comes online between the ages of two to four. During this time, the child has some mobility and is learning independence. Trust-of-control is exhibited when the adult says no, or redirects the child from an activity the child wants to engage in, and the child listens to the adult caregiver and does as asked without incident. The toddler at this point has learned the adult is safe and can be trusted so the toddler does as asked. According to Siegel (2012) when a child has a traumatic experience during the last trimester in utero or the first two years of life when the attachment system is being formed, the child's trust/mistrust development is impaired. According to Siegel, it is traumatic for a child to be raised without a secure attachment figure. Bowlby (1988) describes a secure attachment

figure as someone who is consistently present to meet the child's physical and emotional needs. Siegel states that the adult caregiver must be emotionally calm and grounded in order to attune to the child in a way that the child feels seen and heard. Siegel says this attuned communication must occur at least 65% of the time in order for the infant to develop a secure attachment to their caregiver.

According to the DSM IV-TR (2000), children who have experienced abuse or neglect during the first two years of life are at risk for disorganized attachment, meaning they do not trust their adult caregivers to meet their needs. When a child has been hurt by an adult caregiver during their early childhood experiences, they generalize to all adults, assuming others will hurt them as well. According to the research participants, parenting such a child can be challenging.

Week 2. All but one of the families had been engaged in years of therapy with no positive change in their child's behavior. As a result of seeking help but not finding any relief the parents became discouraged, and felt hopeless. Each family found their way to AHC differently, however because they were feeling so discouraged they each were willing to try anything in the hope of finding a treatment approach that would work. They each started treatment a bit skeptical but were willing to try anything out of desperation. At intake during the clinical assessment, each parent was told about and invited to attend the upcoming four week parent training group.

Reflecting on the information from the first week, it seemed each of the parents made the conscious decision to implement what they learned about the Cycle of Trust and understood the mechanics behind how their child learned to trust or mistrust them. For each of the parents, the change in family dynamics at home began after the first week of Parent

Group. Each family coupled the group training with in-home therapy. Without exception they each felt this combination was vital to their success in bringing about change in the family's dynamics. One intervention the parents implemented was to get curious about what their child's behavior was trying to communicate to the parents about the child's need. In meeting that need the parents understood that they were the agent of change and had to respond to their child's miscues instead of reacting as they had always done in the past.

Looking at their child's behaviors as miscues, rather than defiance, significantly shifted how the parents viewed their children. Up until the parent group, the parents thought their child was doing these things intentionally to hurt the parents. Cheryl's statement about miscues and the parents seems to capture how the other parents felt as well, "Don't take the behavior personally. Miscues are not personal."

At the end of the first week for homework the parents were assigned reading on the three brains in one, the triune brain (Pearce, 1993). The facilitator connected this science to the science of mirror neurons and the parents learned that when their child is in survival brain, it can trigger the parent to go to survival brain as well. And vice versa. So when the parent was yelling at their child to do something or to stop doing something, the parent was actually sending their child into survival mode. This was just the opposite of what the parent wanted to do. At the end of the first week it seemed as if the parents learned that all of their parenting skills were working against the relationship they were hoping to experience with their child.

Up until this point in the group process, each of the children in the study had experienced their parents as not being emotionally available even though it was for different reasons. Some of the children came from severe physical abuse or neglect. Some of the

children were with their birth parent, but that parent had been emotionally compromised and the child experienced this emotional absence as not having their needs met. Through their early childhood experiences each of the children came to view the parents as adults who would not meet the children's needs. When the child developed to the trust of control stage, they did not trust their parents to be in control of them for fear that they would not be safe if the adult was in charge.

The children would start to get scared and anxious about what would happen next if the parent was telling them no or was redirecting their behaviors. In order to shift their child's experience of them, the parents had to consciously think about being in their connected brain, or their mammalian brain in order to provide connection and the experience of intersubjectivity differently for their child. A child normally learns intersubjectivity as an infant through the interactions they have with their parents intuitive responses to their plea for attention. One parent put it this way, "Children with attachment issues need help re-organizing their brains. WOW! It is only done in relationships – positive ones. Self-regulating techniques. Mirror Neurons." When speaking about his stepdaughter, Gregory said, "I'm going to make it a point and use mirror neurons to 'feel her' and stay on course." This is an expression of the parent working to repair the child's experience of intersubjectivity. Gregory is talking about responding to his stepdaughter's bid for attention and need to be met by 'feeling her' so he can respond appropriately. This was a corrective experience for both of them.

Learning that our children's behaviors are not directed at us, but rather are an expression of how they are feeling inside based on earlier childhood experiences, seemed to help parents release the fight and the need to be in survival brain. The information around the

triune brain (Pearce, 1993) and mirror neurons (Rizzolatti, 2008) helped empower the parents to see when their child went to defense due to a fear that they would be hurt again by an adult caregiver. The parent's motor cortex where the mirror neuron system resides recreates a sense of not being safe, based on the child going to defense in response to the parent interacting with them. The parent reacted to the child's defenses. Once the parent understands the dynamic that is playing out in their home, they felt empowered to bring about a change in how they responded to their child's reactivity. As the parent began to show up differently in relation to their child, the child had a corrective experience in the parent-child relationship, and it seems as if the child's brain changed in relation to this corrective experience (Siegel, 2012). Based on the child's behavior changing for good we make the assumption that the child's brain changed as well. The child began to experience appropriate intersubjectivity in relation to their parent. Given that this is how the child learned their relationship style initially, it is only in relationship with a positive, caring other that the child can have an experience of emotional safety which sets them up to heal their original relationship style (Schoore, 2003). As Cheryl put it, "Our children heal through us."

Week 3. By the third week the parents started to experience real change at home. At the focus group each of them expressed how amazed they were in the speed at which the relationship with their child began to change. They each spoke about getting along with fewer fights, meltdowns and aggression when faced with the previous triggers. Sharon put it this way, "I am far less stressed at home, whereas before, my stress **was home.**" (Researcher added bolding to highlight the participant's emphasis.) Sharon's statement seems to capture how the parents felt about the impact of their former parenting style on the feeling tone of

their family. By the third week the parents had practiced the tools enough to begin seeing the change not just in themselves but in the responses of their family members as well.

This week in class the discussion centered around emotional regulation, which is another component of the attachment system. The facilitator said that when the adult caregiver gets calm, this is how the child learns to get calm. It is not the adult trying to kick into parent overdrive that will bring about change in the child's behavior. As a matter of fact, focusing on the behaviors is actually a setup for failure. According to the parents, this seemed counter intuitive. They each spoke about responding positively to the information as shared, Gregory said, "It helped to have the combination of the parent groups and in-home therapy sessions" When speaking of the material presented Gloria said, "Well-rounded spirit, soul and body." Cheryl said, "Not just one thing –parent group, individuals, practical tools given."

When speaking of what was helping bring about change in the home so quickly, Gloria shared, "Value of being in the home is that we see the miscues easier." The combination of group training and in-home therapy seemed to be one key to the families' success in bringing about change in their child's reactivity and resultant behaviors. As the parents became the model of treatment Cheryl shared, "When my child starts to escalate, it's my cue to get calm." Gregory summed it up with, "Things do go much better when everyone is grounded and peaceful. Grounding enhances connection."

In addition to getting calm as their child engaged in dysfunctional behaviors, the parents were able to become curious about what might be driving their child's out-of-control behaviors. It would be nice if the children could just tell their parents in words what was disturbing them, but their early childhood experiences had taught them that adults cannot be

trusted. As a result, the children were communicating the only way they felt safe enough to do so. To get underneath their children's behaviors, the parents had to engage their right brain and get curious about the underlying need. Stephen said, "Don't focus on miscues. See miscues as warning signs of deeper hurts and emotions." Cheryl's perspective was shared like this, "...if we are chasing behaviors, we are not getting to the trauma; we are parenting the miscues." And yet Stephen said this is what helped them, "Looking for what is actually there underneath the actions versus what is coming out on the surface."

Schore (2003) conducted extensive research on the development of right-brain communication and the impact on changing the brain. Schore also published extensively on the ability of one calm, regulated adult to communicate that state to another. Schore stated that it is the mature, regulated brain that will drive the emotional tone of the interaction. In this instance, we want the parent to be the one with the mature, regulated brain.

Week 4. Given that this model is driven by a family systems perspective, it focuses on the parent being the adult in charge (Gilbert, 1992). The focus is not on the child's behaviors. In the Focus Group, Cheryl put it this way, "It incorporates everyone." This was very different than the experience the parents had with other treatment approaches. This was very different for all of the parents, given what they had been taught about how to parent and what they were being taught in other treatment modalities.

During this last week, the facilitator stressed the importance of self-care. Here the parents were being given permission to attend to their needs. The parents were being asked to stay calm and non-reactive when their children yelled at them and were defiant and oppositional. To continue showing up emotionally regulated in order to bring about change in the parent child relationship the parents were being instructed to ensure they were resourced

first. The parents were being taught to be the agent of change in their families. No longer was the focus going to be on the child and their behaviors. Now, the focus had to be on the parents. During the Focus Group, Gloria shared her journey with Sharon instructing her to take her focus off her child's behaviors and instead focus on healing her own wounding. Gloria said, once Sharon addressed her own needs and shifted how she showed up in relationship with her daughter, her daughter's behaviors with everyone would change.

Seeing all of the changes that were being experienced in their home, the parents were willing to shift their focus to make sure they were taking care of themselves so they could be the parents their children needed and deserved. Cheryl put it this way, "Good parenting can begin at any time. It's not too late." Gloria started to stress over what she had done leading up to this moment, however in the end she said, "...I may not have parented well before but by golly it is not too late to have a good, trusting, connected relationship with my daughter." Hearing others own the mistakes they had made in parenting their children helped Sharon not go to shame over the mistakes she had made. It was not too late, as the other parents were communicating based on the change in their children's behavior.

The parents were finding the more they practiced the tools they learned in group, the easier it became to connect with their children. The children were being less defiant and more loving with their parents. This shift in interaction pattern, encouraged the parents to spend more positive time with their children. One of the interventions that the parents reported in the Focus Group was different but highly effective was scanning for the positive and making it big. Gloria shared that this was the one thing the therapist did with their family that was transformational and unexpected, "The thing that really surprised me is how [therapist]

would come into our home and focus on what we were doing right. This was such a different experience for me.”

The one drawback highlighted by Sharon, was that as a single parent she did not have a partner she could tag when she was feeling emotionally depleted. According to Sharon, friends and family have no idea of how challenging it was to raise her daughter alone.

One of the family systems founders, Virginia Satir (1988) wrote on the importance of the parents taking care of themselves so that they are resourced enough to attend to the physical and emotional challenges their children bring forth. A part of self-care is doing our personal work, because the parent’s wounding can be activated through the mirror neuron system when the child’s wounding is being expressed. In his book, *Biology of Belief*, Lipton (2008) sheds light on a hidden subroutine that runs in the background of our interactions. Lipton stated that our embedded beliefs drive our experience of reality. To this we add Charlotte Shelton (2011) who informed us that 80% of our experience of reality is internal and based on the past. Any new experiences are seen through a filter based on our history. The result is we are constantly running past experiences. Rick Hanson (2013) saw such a mechanism as being a skill developed over time to ensure our survival. If something bad happened to us in the past, we continually scan to make sure we avoid such a situation in the future.

Diana Fosha (2000) spoke to the importance of doing our emotional work so that we allow others to see our pain and in turn we can be there to help another heal through their pain. When we hold onto those experiences that have wounded us, Fosha says we have a compromised view of ourselves and consequently have a distorted view of the other. The place for a parent to intervene is to heal the compromised view they have of themselves, so

they can begin to see the truth of who their child is underneath the expression of their pain and wounding.

Siegel (2012) shared that change occurs only with another brain. If we are to change our schemas, or embedded beliefs and perspectives, we need to be in an emotionally safe relationship (Schoore, 2003). Sometimes this healing relationship is with a counselor when there is no partner available within the family system, or no support system available. Sharon spoke to the model's dependence on another brain as a drawback because she was a single parent whose partner lived in another state. "I feel extremely depleted, which is why I mention having ideas for single mothers. I realize that the model, when it comes to getting relief is based on a two parent home." Since the scientists tell us the way to heal one's attachment style is to be in an emotionally safe relationship (Siegel, 2012) one consideration to address this issue would be to have ongoing support groups. Belonging to a support group is definitely a self-care activity.

Emerging Themes – Track III

In accordance with Stake's (2006) recommendation for presenting findings on multiple case research, Track III is where the case findings are presented as factors or themes. Both the researcher and the data auditor coded the journals and interviews for themes. Following is a list of themes that emerged from the data. The data gathered from the participants' responses to the research questions, were used to generalize to a theory of what, if anything from the Parent Group may have contributed to the parent and child's change in relationship (Yin, 1993). One of the central themes in each of these vignettes is the fact that all of the parents took ownership for how they were showing up and shifted their parenting

approach. The focus was not on getting the child to change, but rather working on how the parent could change in their interactions with their child.

Another overarching theme was that each parent felt like they had been looking for a model such as this one, only they did not know where to find it. They were in agreement that a focus on their child's behaviors had not brought about any lasting results and contributed to a feeling of hopelessness.

Four of the five parents had different terms for their perspective of trying to dominate their child or children in an effort to get the child to change. As a result of trying to be "bigger" than the child, and not having this approach work, the parents became discouraged and hopeless. The overarching theme seems to be when the parent is willing to do their personal work and step forward as the agent of change the child exhibits lasting behavioral changes. These are themes that emerged in support of the parent being the adult in charge: hopefulness; behavior modification does not work; parent must be the change agent; parents who attend the parent group are fed by the material; they started out with anxious parenting; the relationship they have with their therapist is essential; including weekly therapy on top of the parent group is critical; all familiar relationships improve; behavior is not the issue, address the need not the behavior.

Taking a closer look at these themes we see that as the parents started to see a change in their child relatively quickly, they became more hopeful. Most of the parents had sought help through counselors that used a behavior modification approach. The parents reported that this treatment approach stayed on the surface and did not bring about any change in their child's behavior. Being in treatment for awhile with no change in behavior is what led the parents to feel hopeless.

The parents are critical in bringing about any change in their child's behavior. As a result, the parents felt empowered. As a part of being the change agent the parents reported it was important that they stayed grounded and emotionally regulated. Through continued consistent practice being the calm, patience adult in charge, the parents reported seeing a change in their child's behavior. A contributing factor to all of this change was the gratitude the parents felt for receiving help that made a difference. Additionally, one intervention that seemed to go a long way was the parents scanning for the positive behaviors their child engaged in and making a big deal out of it. The parents highlighted that it was not only important for them to show gratitude to their child for the positive behaviors the child engaged in but it also felt great when the therapist scanned for the parent's positive and made that big as well.

In working hard to change the perspective the parent had around their child's behavior it was essential that the parent engaged in quality self-care. Appropriate self-care might have been a nutritional diet, drinking plenty of water, exercising and talking to a close friend, whatever it was, the parents said it was essential to practice good self-care. The parents said they must be resourced and feel supported before they can show up as the calm, regulated adult in charge with their child.

A key self-care element was the parent doing their personal work. As the parent identified what kept them from being the calm, positive other, they gained increased self-awareness. Sometimes this self-awareness took the form of the parent signing up for their individual work so they had an opportunity to heal their childhood wounds.

The parents said they felt fed by the information, as all of it was helpful. The fact that the model of treatment was based on the latest research in science and this research was broken

down into easily understood information the parents were able to gain a better understanding of what was going on inside their brain as well as what was happening in their child's brain. This knowledge helped the parent shift from an anxious parenting style fraught with hopelessness, despair and frustration to a parenting style full of hope.

In bringing about such a significant change in their parenting style and thus in the relationship they had with their child, it was vital that the relationship the parent had with the therapist was a positive, nurturing one. The client therapist relationship was significant as weekly therapy enhanced the information learned in the group. All family relationships improved, as everyone healed and experienced an enhanced connection with one another. Most of the parents reported that not only did family relationships improve, but so did their work relationships, friendships and other relationships shift as well, as the parent shifted. The parents marveled at the fact that they came to understand the behavior was not the issue, and it was most important that they addressed the need and not the behavior if they wished to see a change in their child's behavior. The parents said they took their attention off the behavior and instead placed it on what was driving the behavior.

As a result of these factors the parents experienced moving from an anxious state to a calm one. The family relationships moved from a stance of conflict to one of cooperation. The family tone moved from chaos to order. The parents moved from feeling isolated from one another to feeling connected to each other. There was a powerful emotional connection that developed among all family members. As each parent was motivated, it inspired the child to be motivated especially as the child began to feel emotionally connected to their parent. Through this strengthened emotional connection, the child was able to overcome their

behavioral challenges and moved through to the point of learning how to do family relations successfully. As a result, home life became enjoyable.

These themes were synthesized into the following emerging theories and resultant relationships.

Emerging Theory Around The Work

The approach is a relationship-based model of treatment working with children who have had traumatic early childhood experiences that impacted the child's ability to trust adult caregivers. When the adult caregiver was willing to be the agent of change the child's intersubjectivity was healed through corrective experiences that occurred naturally within the parent-child relationship. This healing was accomplished by the following. The adult was willing to look at their own perspectives that reduced their ability to be positive, nurturing, calm and grounded. The parent was willing to see the behavior as a need instead of the child willfully acting out. The parent was willing to be the calm, in-charge, nurturing adult regardless of how the child was behaving. Often times getting grounded, or using right-brain communication helped with remaining the calm in-charge adult. The adult was willing to change their interactional pattern with the child first, before the child changed. The parent was willing to heal their childhood wounding that informed their reactivity towards the child and blocked the parent's ability to respond positively to the child instead. The parent was willing to focus on self-care so they were resourced and able to be the calm, adult in charge when the child began to behave in aggressive ways in an effort to meet their own needs. The parent-child relationship healed as a result of the parent implementing the tools taught. Focusing on the child's behavior did not work; the parent owned their personal healing work first and then the child shifted in relation to the healthy parent. Through all of these

interactions, the child's sense of intersubjectivity appeared to heal. The most important intervention was focusing on the positive, in the parent by the clinician as well as in the child by the parent.

Emerging Theory Related to the Group and the Material

When parents were taught the neuroscience of their child's behavioral problems as it relates to intersubjectivity, parents were inspired to embrace the work in learning and applying the material to bring about change in their family dynamic. The information provided an understanding of the parenting task ahead and inspired hopefulness followed by giving parents a new way to see their child. This hopefulness was followed by gratitude once the parent implemented what was learned in class and they saw a shift in the child's behavior and the overall family dynamic.

The information provided an understanding of what was happening from a scientific perspective and this helped the parent be the change agent. Parents expressed needing more time to practice the material with one another through examples and role plays. The parents stated that they learned from one another in a group setting.

In the group setting, they all agreed the behavioral modification approaches did not work with their children. The most impactful material presented in the parenting group was: Left-brain vs right-brain functioning where the focus is on emotional regulation and not behaviors; the power of schemas in contributing to both the parent's and the child's realities; the importance of the parent being regulated before they intervene with their child; the importance of the parent's self-care; understanding the child's behavior as miscues instead of willful acting out.

There were two limitations identified and one suggestion. One limitation was that the treatment approach required a second brain. When there was only one parent in the home, there was no support for that parent in which they could be co-regulated to help them be the calm, in charge, nurturing adult. The question becomes, how can we provide support for single parents? The second limitation was that in the study while the children were of diverse cultural and economic backgrounds, the parents were not.

There was a suggestion made by the parents that the homework provided be personalized. The parents wanted to be given assignments at the end of each class that helped them personally integrate the material learned from that week's class into their home life.

Another theme that surfaced during the focus group was the intervention of scanning for the positive as a critical tool. Scanning for the positive and making it big was significant in helping the parents bring about change in their parent child relationship. Once the parents began to implement a positive focus on their child's behavior, coupled with keeping the focus on their own healing work, the parents began to witness changes in their children's behaviors. As a result of seeing even a slight change, the parents went from being hopeless to hopeful. By the end of treatment, the parents were overwhelmingly grateful for the impact the model of treatment, Healing in Resonance, had on every member of their family.

Chapter 5

Discussion

This qualitative investigation of whether or not the parent group training aspect of the AHC model of treatment was effective in helping parents bring about changes in their child's behaviors associated with reactive attachment disorder lead to support that the training is effective, especially when coupled with therapy. Three conditions highlighted as important for bringing about change in the child's behavior were 1) that the treatment approach must come through the parent; 2) the parent must be willing to heal their attachment wounding before change in the child will be evident; and 3) in order to bring about change in the child's behavior, which was highlighted by the parents, scanning for the positive and "making it big" is essential in helping the child bring about change in their experience of intersubjectivity.

Pace and Zavattini (2011) conducted a brief longitudinal study on children adopted after the age of 12 months who presented with insecure attachment styles, meaning they did not trust adults to care for them. The study determined that when the adoptive mother had a secure attachment each of the late-adopted children enhanced their attachment style in relationship to the securely attached mother. Those children adopted by insecurely attached mothers did not enhance their attachment styles at all. The securely attached mothers valued attachment interactions and reinforced positive interactions with their child.

The Pace and Zavattini study highlighted the importance of reinforcing positive interactions between parent and child and the importance of focusing on the positive was also a finding in this study. When the parents have their interactions positively highlighted by the therapist and the parents highlight the child's positive interactions with them, this was seen as one of the most impactful interventions. Additionally, the Pace and Zavattini study

indicated the connection to the mother's attachment style was critical to the child's healing. This finding supports the finding in the current study of Healing in Resonance as the parents highlighted the importance of them healing their attachment wounds as a critical factor in helping to bring about change in their child's attachment style.

The focus of the Pace and Zavattini study was on the Internal Working Models of attachment (IWMs) between the parent and child. "The IWMs are initially relationship specific but then they generalize and are the mechanisms through which early experience influences later development, regulating affective, social and cognitive functions in adults" (Pace and Zavattini, 2010, p. 82). These day-to-day positive interactional experiences seemed to bring about lasting change in the child's behavior. In the study around the Healing in Resonance treatment approach, it was through these naturally occurring experiences between parent and child that the parent was able to provide corrective experiences for their child's healing of their attachment wounding.

The Mellow Parenting Programme (Puckering, 2011) is a full day, 14- week parent psychoeducational and support group. The original program included a children's group as well. The Mellow Parenting Programme was initially designed for birth mothers whose children experienced a compromised early childhood due to the challenges the mother faced. With this population the program had medium progress in bringing about a change in the behavior of younger children, but no effect in bringing about change in the older children. When the program introduced foster parents there was no change in the child's behavioral functioning. The researchers felt the program's success was due to the birth parent taking ownership for how they had previously interacted with their child and the parent's desire to bring about change in the relationship. The foster parents demonstrated no such buy-in.

This study around Healing in Resonance, provided a change in the parent child interaction even when the parent was not a birth parent. The parents in this current study had buy-in into the treatment of their child and took personal responsibility for the way in which they interacted with their child in order to effect change.

The current study was also able to support the parents in bringing about change through a four week, eight hour training program as opposed to 14 weeks. There were only mothers enrolled in the Mellow Programme, and this current study was applied to both mothers and fathers with equally effective results.

Twardosz and Lutzker (2009) commenting on the work of Bruce Perry, discussed findings that the brain of a child who has experienced neglect or abuse is most profoundly changed by experiences that occur naturally in relationship. This finding aligns with the work as practiced at AHC coming through the parents. It is in relationship with their adult caregiver that the child's brain was healed as evidenced by the child's sustained behavioral changes in the day-to-day interactions.

Study Limitations

The small size of the study presents a limitation. Additionally, while the children came from diverse socioeconomic backgrounds and represented several cultures, including Hispanic, African-American and White, all of the parents who completed the study requirements were White with at least some college experience and had an annual income greater than \$50,000. It is unclear at this point how the treatment approach would transfer to working with parents of various socioeconomic and diverse cultural backgrounds.

Sources of potential bias. The student investigator is also the developer of the model of treatment being studied. This personal bias could have presented a threat to credibility and

trustworthiness. Additionally, while the researcher did not facilitate the parent groups, the researcher was also an adoptive parent of a child with disorganized attachment.

To mitigate these biases, the researcher kept a journal to document the internal process of being impacted by the material while also applying the material in her home life. Additionally, there were two clinicians familiar with the treatment approach also working on the study. One of the clinicians who no longer works within this treatment approach, provided ongoing data auditing to ensure what was being reflected in the write-up of the study was an accurate portrayal of what the participants were communicating. The other clinician facilitated the four-week group class and supervised the in-home therapy of the research participants.

Recommendations for Further Research

Additional qualitative research with a diverse population of parents is indicated to see how the model of treatment transfers across cultures and socioeconomic differences. All of the participants reported the importance of the training group in conjunction with in-home therapy. Given the connection between the psycho-educational group and family therapy a qualitative study investigating the components of both aspects of treatment and how they support one another seems that it would add to the knowledge of how this treatment approach can help children with disorganized attachment. This would provide knowledge into what is contributing to change in the parent/child relationship.

Some of the studies reviewed addressed using fMRIs to determine the brain pattern of children with disorganized attachment versus those with secure or anxious attachment styles. A quantitative study using fMRI scans to capture the impact on the brain of interventions aimed specifically at healing a child's experience of intersubjectivity in relation to their

primary caregiver would be highly beneficial. It is believed that this treatment approach does not manage behaviors, but rather changes the brain and as a result, behaviors change. It seems critical to investigate this aspect of the treatment approach to quantify if the brain really is changing and if so in what ways.

fMRIs would describe the changes in the brain that occurred as a result of the healing power of the parent-child relationship. The process of behavioral changes was facilitated by the relational aspects of the interventions taught to the parents. Being able to describe the brain changes would support this incredible relational work.

Another quantitative study to follow up on these findings is to measure the heart-rate variability of the attunement between a parent and child. Measuring the attunement or lack thereof between the caregiver and child prior to implementing this treatment approach and then measuring attunement during predetermined intervals of treatment like weekly or monthly, would provide a significant indicator of changes in attunement and empathy as measures of connection between parent and child.

Clinical Implications

Given that the parents felt the group was an essential component to their learning and understanding the neuroscience concepts that were driving the treatment approach, it seems as if parent trainings would be an easy way to educate and support foster and adoptive parents seeking to make a difference in the life of a child. There are many children nationwide who are returned to State custody because the parents feel ill equipped to change the child's aggressive behaviors (Festinger, 2002).

Children identified as having an attachment disorder have a reputation for not getting better. This could be the result of what Pace and Zavattini (2010) refer to as a stable Internal

Working Model of attachment (IWM). The IWMs are revised when there is a significant change in the child's caregiving environment. The AHC model of treatment, Neuroscience of Attachment: Healing in Resonance, aims to do just that, by helping the caregiver focus on providing positive, naturally-occurring experiences in the parent-child relationship in the family's home environment. With the large number of children entering the foster care and adoption system and struggling to learn how to function in a family, it seems as if this treatment approach could have an impact by helping children learn to trust their adult caregivers, so that they can learn how to function in a family system. When a child can learn to be a part of a family system, they will not age out of foster care with no connection to family, but rather will be an integral part of a family unit that can support them as they mature into adulthood.

While Healing in Resonance, supported the parents in bringing about significant changes in their child's behavior, there were some revisions the parents stated they would like to see in upcoming parent groups. In her interview, Cheryl was very specific about her recommendations for implementation of the model of treatment. She said, "A) I would slow it down. There is so much information. This is our third time. The first two times I came out thinking people were speaking another language. There was so much information. B) I would have case studies, parents could take home and study. It is hard to take it from the group when you are in the midst of upheaval to see that is trust of care. I understand what is being taught now, but it took me three times. C) Role plays are too extreme, but vignettes to take home would be good. D) Start every single week with a breathing exercise. For us to experience the calming, would be important. It's like labor: if you've never experienced labor, it is hard to explain."

During the focus group the other parents added the following to what they would like to see in future group offerings: Personalized homework at the end of each week so the parents could implement the interventions to address their specific issues to provide, "...more practical implementation of the model through homework;" Have the group be six weeks long instead of four weeks to allow for more role plays and practical application exercises in class; Offer ongoing support groups as the group process helps the parents stay on track and provides the relief and validation a parent needs; Offer a support group for single parents; Write a book where the parents can refer to the treatment interventions in times of desperate need.

This study looked at the psycho-educational parent group training for caregiver's of children identified as having disorganized attachment. Children with disorganized attachment do not trust their caregivers to meet their needs or to have control over them. As a result, such children struggle to learn how to successfully function in a family setting. Many of these children age out of the foster care system not attached and not belonging to a family system. As a result, researchers have reported that such a child is at higher risk for unemployment, health issues, homelessness and incarceration (Heimpel, 2009).

This study contributes to the body of knowledge around what might be needed to help such a child learn that despite trauma and attachment wounding in his or her early childhood experiences, there is hope for a different way of interacting within a family system. It is hoped that there will be additional research building on these findings to support further development of a treatment approach that helps our most disenfranchised children learn that they too can experience belonging within a safe and emotionally connected environment. As a parent, this is my wish for all children.

References

- American Psychiatric Association, (2000). *Diagnostic and Statistical Manual of Mental Disorders (2000). DSM-IV-TR Fourth Edition*. Arlington, VA: American Psychiatric Association.
- Barkley, R. A., (1997). *Defiant children: A clinician's manual for assessment and parent training* (2nd ed., Vol 264). New York: Guilford.
- Baylis, P. (2006). The Neurobiology of affective interventions: A cross-theoretical model. *Clinical Social Work Journal, Vol 34, No. 1, Spring*, 61-81.
- Becker-Weidman, A. (2008). Treatment for Children with Reactive Attachment Disorder: Dyadic Developmental Psychotherapy. *Child and Adolescent Mental Health*. Vol 13:1, pp. 52-59.
- Bowlby, J. (1988). *A Secure Base: Parent-Child Attachment and Healthy Human Development*. London, England: Routledge.
- Buhner, S. H., (2006). Aithesis and the heart as an organ of perception. *Canadian Journal of Herbalism*. 27 (1), 21-26.
- Childre, D., Martin, H. (2000). *The HeartMath Solution: The Institute of HeartMath's Revolutionary Program for Engaging the Power of the Heart's Intelligence*. New York, NY: Penguin Group.
- Coleman, M. *A Chance for Change: The Role of Trust in Foster Care*. Falls Church: Virginia Polytechnic Institute and State University, 2000. Master's Thesis.
- Connors, M. (2011). Attachment theory: A "secure base" for psychotherapy integration. *Journal of Psychotherapy Integration*, 21 (3), 348-362.

Cozolino, L. J. (2002). *The neuroscience of psychotherapy : Building and rebuilding the human brain* (Norton series on interpersonal neurobiology; Norton series on interpersonal neurobiology). New York: Norton.

Department of Health and Human Services http://www.childwelfare.gov/pubs/s_disrup.cfm
[accessed 3.13.12](#)

Doidge, N. (2007). *The Brain that Changes Itself: Stories of Personal Triumph from the frontiers of Brain Science*. London, England: Penguin Books.

Escudero, V., Friedlander, M. L., Varela, N., Abascal, A. (2008, May). Observing the therapeutic alliance in family therapy: associations with participants' perceptions and therapeutic outcomes. *Journal of Family Therapy*, 30 (2), 194-214.

Fahlberg, V., Colburn, R., Forest Heights Lodge (1990). *Residential Treatment: A Tapestry of many therapies*. Indianapolis, IN: Perspectives Press.

Festinger, T. (2002). Bureau of Consular Affairs, Department of State, accessed 3.3.12
http://adoption.state.gov/about_us/statistics.php

Festinger, T. (2002). After Adoption: Dissolution or Permanence? *Child Welfare*, May/June 2002, Vol. 81 Issue 3, p515, 19p.

Fishbane MD. (2007). Wired to connect: neuroscience, relationships, and therapy. *Family Process*, 46(3), 395-412.

Fosha, D., (2000). *Transforming power of affect: A model of accelerated change*.
New York: Perseus Books Group.

Gilbert, R., (1992). *Extraordinary Relationships: A new way of thinking about human interactions*. Chronimed Publishing.

- Golden, J. A., (2011, Spring). Introduction to a special issue on the assessment of children with reactive attachment disorder and the treatment of children with attachment difficulties or a history of maltreatment and/or foster care. *Behavioral Development Bulletin*, 15, 1-3.
- Gudzer, J., Bond, S., Rabiau, M., Zelkowitz, P., Roahar, S. (2011, August). The Relationship between alliance, attachment and outcome in a child multi-modal treatment population: Pilot study. *Journal of the Canadian Academy of Child & Adolescent Psychiatry*, 20 (3), 196-202.
- Hanson, R. (2013). *Hardwiring Happiness: the new brain science of contentment, calm and confidence*. New York: Harmony Books.
- Hardy, L. (2007). Attachment Theory and Reactive Attachment Disorder: Theoretical Perspectives and Treatment Implications. *Journal of Child and Adolescent Psychiatric Nursing*. Vol 20:1, pp 27-39.
- Heimpel, D. (2009). *Children of the System*. *Newsweek*, March 9.
- Keck, G. & Kupecky, R. (2009). *Parenting the Hurt Child: Helping Adoptive Families heal and grow*. Colorado Springs: NavPress.
- Konvalinka, I., Xygalatas, D., Bulbulia, J., Schjodt, U., Jegindo, EM., Wallot, S., Van Orden, G., Roepstorff, A., (May 17, 2011). *Proceedings of the National Academy of Sciences of the United States of America*. 108 (20), 8514-8519.
- Lipton, B. (2008). *Biology of Belief: Unleashing the power of consciousness, matter and miracles*. New York: Hay House.
- Luquet, W., (1996). *Short-term couples therapy: The Imago model in action*. Bristol, PA: Brunner/Mazel.

- Main, M. (1995). Recent studies in attachment: Overview, with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment Theory: Social, developmental, and clinical perspectives* (pp. 407-474). Hillsdale, NJ: Analytic Press.
- Maxwell, J. (2005). *Qualitative Research Design: An Interactive Approach*. Second edition. *Applied Social Research Methods Series*, 42. Thousand Oaks, CA: Sage Publications.
- McCraty, R. (2003). *The Energetic Heart: Bioelectromagnetic interactions within and between people*. Boulder Creek: Colorado, HeartMath Institute.
- McTaggart, L. (2007). *The Intention Experiment: Using your thoughts to change your life and your world*. New York: Free Press.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks: Sage Publications.
- Minnis, H., Rabe-Hesketh, S., & Wolkind, S. (2002). Development of a brief, clinically relevant, scale for measuring attachment disorders. *International Journal Of Methods In Psychiatric Research*, 11(2), 90-98. doi:10.1002/mpr.127
- Minuchin, S. (1998). *Family Healing: Strategies for Hope and Understanding*. New York: The Free Press.
- Minuchin, S., Fishman, H.C., (1981). *Family Therapy Techniques*. Cambridge, MA: Harvard University Press.
- National Foster Care Coalition. (2012, March). *Foster Care Facts*. Retrieved from <http://www.nationalfostercare.org/facts/fostercare.php>.
- Pace CS, & Zavattini GC. (2011). 'Adoption and attachment theory' the attachment models of adoptive mothers and the revision of attachment patterns of their late-

- adopted children. *Child: Care, Health And Development*, 37(1), 82-8.
doi:10.1111/j.1365-2214.2010.01135.x
- Pearce, J.C., (1993). *Evolution's end: Claiming the potential of our intelligence*. New York: Harper.
- Pearce, J.C., (2002). *The Biology of Transcendence: A blueprint for the human spirit*. Rochester, VT: Inner Traditions.
- Peirce, P. (2009). *Frequency: The power of personal vibration*. Hillsboro, Oregon: Beyond Words.
- Piercy, F. P., Laird, R. A., & Mohammed, Z. (1983). A Family Therapist Rating Scale*. *Journal Of Marital And Family Therapy*, 9(1), 49-59. doi:10.1111/j.1752-0606.1983.tb01483.x
- Puckering, C., Connolly, B., Werner, C., Toms-Whittle, L., Thompson, L., Lennox, J., Minnis, H. (2011, January). *Clinical Child Psychology & Psychiatry*, 16(1), 73-87.
- Puckering C, Connolly B, Werner C, Toms-Whittle L, Thompson L, Lennox J, & Minnis H. (2011). Rebuilding relationships: a pilot study of the effectiveness of the Mellow Parenting Programme for children with Reactive Attachment Disorder. *Clinical Child Psychology And Psychiatry*, 16(1), 73-87. doi:10.1177/1359104510365195
- Reynolds, C., and Kamphaus, R., (2004). *The Clinician's Guide to Behavior Assessment System for Children*. 2nd Edition. New York: Guilford Press.
- Rizzolatti, G. (2008). *Mirrors in the brain: how our minds share actions and emotions*. Oxford, NY: Oxford University Press.
- Satir, V. (1988). *The new peoplemaking*. Palo Alto, CA: Science and Behavior Books.

- Schore, A. (2003). *Affect dysregulation and disorders of the self*. New York, NY: WW Norton & Co.
- Schore, A. (2003). *Affect regulation and the repair of the self*. New York, NY: WW Norton & Co.
- Shelton, C. (1999). *Quantum Leaps: 7 skills for workplace re-creation*. Boston, MA: Butterworth-Heinemann.
- Shields, A., Cicchetti, D., (2007). Cognitive and emotional control and perspective taking and their relations to empathy in 5 year old children. *The Journal of Genetic Psychology*, 163 (3), 301-322.
- Siegel, D. (2012). *The Developing Mind, Second Edition: How relationships and the brain interact to shape who we are*. New York, NY: Guilford Press.
- Siegel, D. & Hartzell, M. (2004). *Parenting from the Inside Out*. New York, NY: Penguin Group.
- Siegel, D. (2007). *The Mindful Brain: Reflection and attunement in the cultivation of well-being*. New York, NY: WW Norton & Co.
- Stake, R. E. (2006). *Multiple Case Study Analysis*. New York, NY: Guilford Press.
- Stake, R. E. (1995). *The Art of Case Study Research*. Thousand Oaks, CA: SAGE Publications.
- Taylor, J. (2008). *My Stroke of Insight: A Brain Scientist's Personal Journey*. New York: Penguin Group.
- Twardosz, S., & Lutzker, J. R. (2010). Child maltreatment and the developing brain: A review of neuroscience perspectives. *Aggression And Violent Behavior*, 15(1), 59-68.
doi:10.1016/j.avb.2009.08.003

Woltering, S., Lishak, V., Elliott, B., Ferraro, L., & Granic, I. (2015). Dyadic Attunement and Physiological Synchrony During Mother-Child Interactions: An Exploratory Study in Children With and Without Externalizing Behavior Problems. *Journal Of Psychopathology And Behavioral Assessment*, 37(4), 624-633. doi:10.1007/s10862-015-9480-3.

Yin, R. K. (1993). *Applications of Case Study Research*. Newbury Park, CA: SAGE Publications.

Appendix A

Definition of Terms

Adoption disruption. Before a child is legally adopted by the parent or parents, the family decides not to complete the legal adoption process (Festinger, 2002).

Adoption dissolution. After the legal adoption process has been completed, and the family decides they no longer wish to or are unable to continue parenting the child they adopted (Festinger, 2002).

Anxious attachment. An attachment style where a child's needs were met inconsistently and consequently does not know when to trust that others can be depended on to meet their needs (Siegel, 2012).

Attachment. The connection between two people that creates safety for one to ask the other for what is needed and wanted (Bowlby, 1988).

Attunement. In a relationship between two people this is the level of connectedness, joint attention, and reciprocity that occurs within the dyad. (Woltering, Lishak, Elliott, Ferraro & Granic, 2015)

Coherence. When the brain and heart are in alignment or their brain and heart waves have a similar pattern it is said the individual is in a state of coherence. Such a state can bring about calm, centeredness, and optimal efficiency making one able to perform at their peak (Childre & Martin, 2000).

Disorganized attachment. An attachment style where the child has learned to meet their own needs instead of being able to trust others to do so (Siegel, 2012).

Earned secure. If in the early years, a child does not learn to trust others, but rather learns to depend on adults as an older child or as an adult, we say the child or person is Earned Secure (Siegel, 2012).

Emotional regulation. Being able to be calmed when upset. The natural rhythm of having ups and downs and being able to move seamlessly between the two (Schoore, 2003).

Emotional resonance. Emotional resonance occurs when the right brains of two individuals are synchronized as a result of their electromagnetic frequency being coherent (Schoore, 2003).

Foster Care. The placement of children with families outside of their birth home for the purpose of being temporarily parented (Hardy, 2007).

Intersubjectivity. “Refers to the shared, reciprocal experience between the parent and child whereby the experience of each is having an impact on the experience of the other” (Becker-Weidman, 2008).

Resonance. When the frequency of two hearts is in alignment, it is said there is resonance between those two individuals. The frequency alliance that is created between individuals enhances the likelihood that there will be emotional resonance (McCarty, 2003).

Secure attachment. A child who has his needs consistently met is said to be Securely Attached (Siegel, 2012).

Appendix B

Methodology

Step 1
Pre-Clinical Assessment: Conducted with parent and child – Interview; administer RAD questionnaire Diagnosis assigned as part of the clinical assessment
Step 2
Research assistant facilitates four weeks of psychoeducational groups Parents attend four weeks of psychoeducational groups
Step 3
Parent journals each week about their experience of the material in their home
Step 4
Researcher reads journals and develops questions for parent interviews Researcher reads journals and writes about how her reaction to the participants' sharing Data auditor reads journals and writes about his reactions to the information shared
Step 5
Post clinical assessment completed Administer RAD Questionnaire
Step 6
Researcher conducts interviews with the parent participant
Step 7
Researcher observes a family session during a regularly scheduled therapy session with the exception of one family where the family had favorably discharged by the time the interview was scheduled. The researcher visited the family home to observe how one of the parent's interacted with the child. Family Rating Scale used to document behaviors observed (Family Therapist Rating Scale)
Step 8
One on one meeting with each parent participant to have them review their vignettes
Step 9
Focus group conducted with all parent participants to review emerging themes and address additional questions to clarify those emerging themes

Appendix C
Coding Grid

6. What aspects of this week’s training impacted you the most?

	Gregory	Gloria	Cheryl	Stephen	Sharon
WEEK 1	Respond to the miscue as if it’s the need; this is HUGE!	Understanding where my child is at as/or as what is going on in her brain, in her emotionally. What she is trying and has been trying to communicate for years understanding is bring me more compassion and grace.	I need to change, not just the kids.	Our children heal through us. This is not hopeless & our children can heal! The circle of attachment.	Understanding more about the miscues and how to identify them.
WEEK 2	Realizing that I don’t always have to respond with reasons, but try to be more emotionally available.	I really loved learning about the triune brain reptilian, mammalian and cerebral cortex. The function of these areas alone and together.	Implementing the model more consistently	Keeping right brained. If my brain is full of words I know I am being left brained. If I am thinking in images then I am being right brained.	Learning how the brain can repair itself and feeling that there is hope that my daughter can heal.
WEEK 3	The schemas and trying to figure out what lies my daughter is believing; getting the practical tool that says, “I know its hard to believe but...”	Learning about schemas. That deep beliefs or perspectives can alter reality. WOW! It is really quite fascinating! I’m exploring my own schemas.	It’s never too late, slow progress is still progress. The brain can heal!	About positive marking – that the correct types of praise can really affect the child’s behavior.	Learning that you can’t and won’t always be perfect, as a parent, but the more you use the model the more it becomes second nature.
WEEK 4	“80% of reality is inside the brain” this is HUGE! WOW; this reality affects not only families, but communities, cities, governments, and nations.	I appreciated the couple’s dialogs. Michelle helped us with it a little more in a home therapy session. It helped me and my daughter resolve some resentment. I need to keep practicing.	If I don’t take care of myself I can’t take care of others.	The importance of self-care, that it is essential I helping keep ourselves calm and in control of our actions and the words we speak.	I found the self-help aspects helpful especially the idea of setting aside 20 min a day for myself.

Appendix D

RAD Questionnaire.

Please tick the statement that best describes your child.

	Exactly like my child	Like my child	A bit like my child	Not at all like my child	For Office Use Only
Tends to be afraid of new things or situations					1
Acts younger than his/her age					2
Is often unhappy, tearful or distressed					3
Is apathetic/'can't be bothered'					4
Can be aggressive towards him/herself e.g. using bad language about him/herself, head banging, cutting etc.					5
Has few friends					6
Has no conscience					7
Is too friendly with strangers					8
Often gives you cuddles					9
Often starts a conversation					10
Very 'clingy'/wants to be with you all the time					11
Is difficult to comfort when fearful/scared					12
Is demanding or attention seeking					13
If you approach him/her, he/she often cuddles you					14
If you approach him/her, he/she often runs away or refuses to be approached					15
If you approach him/her, you never know whether he/she will be friendly or unfriendly					16
When you have been parted for a short time, he/she seems happy to see you					17
Scoring	3	2	1	0	

Assessment Results: RAD Questionnaire

Parent	Child	Pre	Post	Most improved
Sharon	Oliva	41	17	Demanding; afraid of new situations; difficult to comfort when scared; aggressive towards self; refuses to be approached; has few friends; acts younger than her age; clingy; never know if she will be friendly or unfriendly when approached.
Stephen	Hogan	18	12	Can be aggressive toward self
Cheryl	Elizabeth	31	20	Tends to be afraid of new things or situations; is often unhappy; has few friends; too friendly with strangers; too clingy; difficult to comfort when fearful/scared; demanding or attention seeking; when approached don't know if she will be friendly or unfriendly.
	Noah	30	17	Tends to be afraid of new things or situations; acts younger than his age; if often unhappy; can be aggressive towards himself; has few friends; too friendly with strangers; often gives you cuddles; often starts a conversation; is demanding or attention seeking; if you approach him he often cuddles you.
Gloria and Gregory	Sophia	23	14	Tends to be afraid of new things or situations; is often unhappy; has few friends; difficult to comfort when fearful/scared; is demanding or attention seeking; when approached you don't know if she will be friendly or unfriendly; if you approach her she runs away or refuses to be approached.

Appendix E

Family Observation Rating Scale

Directions: Rate the relative effectiveness with which the adult caregiver engages in the behaviors listed below. These behaviors should be evaluated according to the training provided in the AHC model of treatment. On the Comment lines at the end of each section, include the positive behaviors that will be used to highlight the behaviors observed.

Not present (0); Ineffective (1); Neutral (2); Minimally Effective (3); Effective (4); Very Effective (5); Maximally Effective (6)

0 1 2 3 4 5 6

Structuring Behaviors

- | | | | | | | | | | |
|-----|-------|-------|-------|-------|-------|-------|-------|---|---|
| 1. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Helps the child define their needs. |
| 2. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Stops chaotic interchanges. |
| 3. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Shifts approach when one way of connecting is not working. |
| 4. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Uses short, specific and clear communications. |
| 5. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Asks open-ended questions. |
| 6. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Avoids offering solutions or advice prematurely. |
| 7. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Lays down ground rules for the adult child interaction. |
| 8. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Confirms area of pain or struggle |
| 9. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Scans for the positive, or strengths and makes it big |
| 10. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Uses right brain communication to redirect the child |
| 13. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Accepts and attempts to understand the child's perspective. |
| 14. | _____ | _____ | _____ | _____ | _____ | _____ | _____ | : | Establishes appropriate boundaries with the child and maintains being the adult in charge |

Comment: _____

Relational Behaviors

1. _____ : Engenders hope.
Communicates safety
2. _____ : Maintains being the adult in charge to communicate emotional safety.
3. _____ : Engages the child and encourages them to share their perspective
4. _____ : Parent appropriately communicates their feelings in relation to the child's behavior.
5. _____ : Demonstrates an ability to be attuned to the child.
6. _____ : Demonstrates warmth.
7. _____ : "Communicates" the attitude that the child's problem or question is of real importance.
8. _____ : Use of right brain communication conveys empathy and sensitivity to the child's feelings.
9. _____ : Speaks at a comfortable pace.
10. _____ : Empathizes with the child
11. _____ : Confirms child's experience of an event.
12. _____ : Concentrates on the interaction with the child, consistently communicating trust of care and control as the adult in charge.
13. _____ : Demonstrates a good sense of humor.
14. _____ : Caregiver/parent can identify obstacles that get in the way of connecting emotionally with their child.
15. _____ : Parent moves in close to regulate their child
16. _____ : Parent moves in close to regulate their child.
17. _____ : Uses right brain communication to provide emotional regulation

Comment: _____

Process Behaviors

- 1. _____ : Checks out pronouns to see who did what to whom.
- 2. _____ : Focuses on process over story.
- 2. _____ : Works to determine what need the miscue is pointing to
- 3. _____ : Concentrates on meeting the need instead of engaging the miscue.
- 4. _____ : Attempts to improve child's self-esteem
- 5. _____ : Relabels child's behaviors in alignment with AHC model, i.e., miscues not behavior.
- 6. _____ : Helps the child maintain their position as a child in the family dynamic
- 9. _____ : Identifies when the boundaries between parent and child have been blurred and highlights this for their child
- 10. _____ : Assumes the role of parent in charge when the child wants to take control.
- 11. _____ : Uses right brain communication when reestablishing authority
- 12. _____ : Connects with the child before correcting them.
- 12. _____ : Moves in close to regulate parent and assist them with co-regulating a dysregulated child.

Comment: _____

Experiential Behaviors

1. _____ : Uses relationship is key as a means of determining what the child can and cannot do.
2. _____ : Encourages the child to find their own solutions.
3. _____ : Responds when the child initiates communication.
4. _____ : Asks for current feelings.
5. _____ : Redirects the child when the focus becomes about the other as a means of blame.
6. _____ : Scans for and highlights the positive.
7. _____ : Uses role playing or enactments.
8. _____ : Pays attention to his/her own discomfort and uses it appropriately in relation to the child.
9. _____ : Uses own affect to elicit affect in child.
10. _____ : Keeps the interaction in the here and now.
11. _____ : Focuses on solution over problem.
12. _____ : Uses curiosity to gather information about the child's perception of a situation
13. _____ : Facilitates child using his or her words to ask for their needs and wants.
14. _____ : Works to discover what will motivate the child to bring about change.
15. _____ : Helps the child see they have a choice in how they respond.
16. _____ : Consistently marks miscues with curiosity.
17. _____ : Helps the child take responsibility for their actions.

Comment: _____

Family Observation Rating Scale Profile

Study #: _____

Researcher: _____

Comments:

		Structuring	Relationship	Process	Experiential
6	60 55				
5	50 45				
4	40 35				
3	30 25				
2	20 15				
1	10 5				

Note: A profile of a parent's behavior may be constructed in two ways. In one approach, raw scores, the total points within each category, may be added and placed on the profile. However, it may at times be helpful to use the mean ratings of only those behaviors actually observed within each category. The above profile has been constructed to accommodate either method.

Appendix F

Parent Group Weekly Content and Activities

	Week 1	Week 2	Week 3	Week 4
Content	Attachment Neuroscience Cycle of Trust	Triune Brain Four Defenses Mirror Neurons	Right brain communication Emotion focus Schemas	Importance of Self-Care
Interventions	Understanding the parent's attachment style; Importance of parent healing their wounding	Becoming aware of when the adult is parenting from the survival brain from the mammalian brain for connection	Rewiring schemas Tools for shifting from left hemisphere communication to right hemisphere communication	Relationship is Key
Activity	Behaviors associated with a child who trusts adults vs. a child who has learned mistrust	Freeze-Frame: shifting from survival brain to the mammalian or neocortex in order to create emotional safety and encourage connection in the parent-child dyad	Watch TED talk, A Stroke of Insight by Dr. Jill Bolte Taylor. Parents identify what is associated with the left hemisphere processing vs. right hemisphere processing	Couple's Dialog (IMAGO)

Appendix G

Journal Questions

1. What if anything are you noticing about your emotional reactions to your child?
2. What were some previous triggers?
3. How are you responding to those triggers now?
4. What are you noticing in your body as a result of those responses?
5. What did you learn in class that supported or did not support this change?
6. What aspects of this week's training impacted you the most?
7. What aspects of this week's training impacted you the least?
8. What do you wish you could have learned more about?
9. What are you taking away from this week's class?
10. In what ways are you connecting to the material discussed in class?
11. In what ways are you not connecting to the material discussed in class?
12. Describe your relationship with your child before the training.
13. Describe your current relationship with your child.
14. Additional comments:

Appendix H

Focus Group Questions

- How does this model of treatment compare to other models of treatment you have used to address your child's behavioral issues? Have you tried other treatment models?
- What enabled you to learn all you learned from the parent group?
- How did you learn? What allowed you to learn?
- What prompted the changes in your household?
- How would you describe the process of change?
 - What characteristics of the group facilitation inspired you to implement the material you were learning in group?
- The counselor did some treatment modeling:
 - What was your experience of seeing the treatment modeled?
 - Did you know your therapist was modeling the treatment approach?
 - What was your process as a parent observing?
- What was your experience participating in the group?
- Did the group contribute to your change process? (What aspects of the group facilitation inspired you to want to change?)
- Can you separate out what aspect of change the group contributed to versus in-home or in-office counseling? If so, what aspects do you attribute to the group?
- How have your thoughts about your child changed since you attended the group?

Appendix I

The University of New Mexico

Consent to Participate in Research

January 2016

Introduction

You are being asked to participate in a research study that is being done by Michele Coleman, who is the Principal Investigator and student, from the Department of Individual, Family, and Community Education at the University of New Mexico, under the direction of Kristopher Goodrich, PhD., Faculty Advisor. This research is studying the parent group training component of the Attachment Healing Center's model of treatment, Healing in Resonance.

You are being asked to participate in this study because we want to determine what if any impact the training has on parenting a child with disorganized attachment. We will invite up to 15 families to participate with the hope that 5 people will take part in this study. This is a multiple site project in that we will recruit from Albuquerque, and Las Cruces, New Mexico. All research activities will take place in the State of New Mexico.

Attachment Healing Center, a division of Inner Guidance, LC is funding this study. There is no outside funding for this study.

This form will explain the research study, and will also explain the possible risks as well as the possible benefits to you. We encourage you to talk with your family and friends before you decide to take part in this research study. If you have any questions, please ask one of the study investigators.

What will happen if I decide to participate?

If you agree to participate, the following things will happen:

- Attend four two-hour psycho-educational groups for adult caregivers of children with disorganized attachment
- You will be asked to journal weekly after each of the four parenting groups.
- The groups will inform the caregivers of the neuroscience concepts used in this treatment approach of parenting children with attachment issues.
- Following turning in your weekly journals, there will be one interview and one observation of you parenting implementing some of the tools taught in training.
- Should you decide to drop out of the study, this will not impact your ability to continue obtaining mental health treatment from the Attachment Healing Center.
- Your weekly journals will be given a study number that will link your personal information with the journal. The link between the study number and your personal information will remain intact until after the data analysis has been

completed and the document linking you and your study number will be destroyed.

- Your journals will be placed in a locked box for transport by the Student Investigator to the Faculty Advisor, Dr. Kristopher Goodrich, at the University of New Mexico.
- The data gathered from your journals will be entered into a computer database, encrypted and password protected. Following the data gathering and analysis, the data will be stored on a flash drive along with your consent form and will be locked in a file cabinet and maintained by the Principal Student Investigator, Michele Coleman.
- Hard copy notes of the observation and interview will also be stored in a lock box for transportation to Dr. Goodrich. Notes from the observation and interview will remain in Dr. Goodrich's possession.
- You will be invited to attend a where you will have an opportunity to review and edit the vignettes created from your participation along with an opportunity to comment on the research findings. The focus group will be audiotaped.
- Michele Coleman and Dr. Goodrich will have access to your study information. Data will be stored for six years and then will be destroyed.

How long will I be in this study?

There are three aspects to the study; 1) attendance at weekly parenting training for four weeks, 2) weekly journaling for four weeks, 3) observation and interview at the end of the parent training. The following is the time we anticipate each activity will take:

- Parenting group – 8 hours
- Journaling – 4 hours
- Interview and observation – 1 hour
- Focus group, including vignette review – 2 hours

What are the risks of being in this study?

There are risks of stress, emotional distress, inconvenience and possible loss of privacy and confidentiality associated with participating in a research study.

Additional risks of being in this study include becoming uncomfortable when confronted about personal issues that may be contributing to your child's dysfunctional coping behaviors. Distress can be typical in the counseling change process, and change can be helpful. The licensed and trained clinicians know how to address and support this stress and can help alleviate the stress. Should you become agitated and require additional individual therapy, a clinician from our agency can be assigned to you. Information from your individual session will not become a part of the study. You may also call Agora Hotline at 1.866.HELP1NM (1.866.435.7166) In Albuquerque, 277.3013.

With the audiotaping of the focus group, there is a risk of a breach in confidentiality. To address this potential risk pseudonyms will be used and focus group recordings will be

transcribed and destroyed after transcription to guard participant confidentiality. You can decline participation in the focus group with no harm or consequences.

It is also important that you know that there are legal limits with regard to confidentiality. In certain situations the research investigators, who are also counselors, may be required to reveal information obtained during the groups or from your journals to other persons or agencies without your permission. These situations include, but are not limited to;

- where there is a threat of bodily harm to yourself
- where there is a threat of bodily harm to another person
- where there is evidence of any type of child abuse
- where there is evidence of any type of elder abuse or abuse of other dependent adults who are not able to protect their rights.

For more information about risks, ask the study investigators.

What are the benefits to being in this study?

There may or may not be a benefit to you from participating in this study. As a participant in this study you may receive a small benefit from the insight obtained through the journaling process or as a result of the interview.

Additionally, families participating in the research are guaranteed a therapist to support applying the concepts learned in group.

What other choices do I have if I do not want to be in this study?

Participation in this research is voluntary. You may still attend the four-week psychotherapy group and you can obtain mental health services from our agency if you do not wish to participate in this study. However, there may be a wait for a clinician at the time you are seeking services. If you choose to withdraw, no penalties will occur.

How will my information be kept confidential?

Information obtained as part of this study will be assigned a study number. Information without the participant's name will be entered into a computer database, encrypted and password protected. Data will be stored on a flash drive and along with consent forms will be locked in a file cabinet and maintained by the Principal Investigator Michele Coleman. The link between your personal information and the study record number will be destroyed after the data analysis is completed. Michele Coleman and her Faculty Advisor, Dr. Kristopher Goodrich, will have access to your study information. Data will be stored for six years and then will be destroyed.

We will take measures to protect the security of all your personal information, but we cannot guarantee confidentiality of all study data.

Information contained in your study record is used by the principal investigator and her faculty advisor and other study investigators. The University of New Mexico Institutional

Review Board (IRB) that oversees human subject research and/or other entities may be permitted to access your records. There may be times when we are required by law to share your information. Your name will not be used in any published reports about this study. A copy of this consent form will not be kept in your medical record, but will be kept in your study record.

Finally, you should understand that the investigator and her research team are not prevented from taking steps, including reporting to authorities, to prevent serious harm of yourself or others.

What are the costs of taking part in this study?

There is no cost to you to be in this study.

Will I be paid for taking part in this study?

Once you have submitted your journal entries for your experience implementing what was shared in each of the four weeks of group, you will be compensated with a \$25 Amazon gift card to thank you for your participation in this study.

Compensation is considered taxable income. Amounts of \$600 or more will be reported by UNM to the Internal Revenue Service (IRS).

How will I know if you learn something new that may change my mind about participating?

You will be informed of any significant new findings that become available during the course of the study, such as changes in the risks or benefits resulting from participating in the research or new alternatives to participation that might change your mind about participating.

Can I stop being in the study once I begin?

Your participation in this study is completely voluntary. You have the right to choose not to participate or to withdraw your participation at any point in this study without affecting your future mental health care or other services to which you are entitled. Up until the completion of the data analysis you also have the right to request that your data no longer be included. After the data analysis has been completed however, we will no longer be able to determine which data are connected to you.

Whom can I call with questions or complaints about this study?

If you have any questions, concerns or complaints at any time about the research study, please contact the Faculty Advisor, Dr. Kristopher Goodrich at (505) 277-7222, or kgoodric@unm.edu. Dr. Goodrich has no affiliation with the Attachment Healing Center.

If you need to contact someone after business hours or on weekends, please call (505) 270-1297 and ask for Michele Coleman or call (505) 321-1827, which is the Center's emergency phone number.

If you would like to speak with someone other than the research team, you may call the UNM Office of the IRB at (505) 277-2644.

Whom can I call with questions about my rights as a research participant?

If you have questions regarding your rights as a research participant, you may call the UNM Office of the IRB (OIRB) at (505) 277-2644. The IRB is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human participants. For more information, you may also access the OIRB website at <http://irb.unm.edu>.

CONSENT AND AUTHORIZATION

You are making a decision whether to participate in this study. Your signature below indicates that you read the information provided. By signing this consent form, you are not waiving any of your legal rights as a research participant.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this consent form, I agree to participate in this study. A copy of this consent form will be provided to you.

I agree to have my participation in the focus group audiotaped.

Name of Adult Subject (print)

Signature of Adult Subject

Date

INVESTIGATOR SIGNATURE

I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

Name of Investigator/ Study Team Member (print)

Signature of Investigator/ Study Team Member

Date

Appendix J

Consent form prior to adding Focus Group Consent

The University of New Mexico Consent to Participate in Research April 2015

Introduction

You are being asked to participate in a research study that is being done by Michele Coleman, who is the Principal Investigator and student, from the Department of Individual, Family, and Community Education at the University of New Mexico, under the direction of Kristopher Goodrich, PhD., Faculty Advisor. This research is studying the parent group training component of the Attachment Healing Center's model of treatment, Healing in Resonance.

You are being asked to participate in this study because we want to determine what if any impact the training has on parenting a child with disorganized attachment. We will invite up to 15 families to participate with the hope that 5 people will take part in this study. This is a multiple site project in that we will recruit from Albuquerque, and Las Cruces, New Mexico. All research activities will take place in the State of New Mexico.

Attachment Healing Center, a division of Inner Guidance, LC is funding this study. There is no outside funding for this study.

This form will explain the research study, and will also explain the possible risks as well as the possible benefits to you. We encourage you to talk with your family and friends before you decide to take part in this research study. If you have any questions, please ask one of the study investigators.

What will happen if I decide to participate?

If you agree to participate, the following things will happen:

- Attend four two-hour psycho-educational groups for adult caregivers of children with disorganized attachment
- You will be asked to journal weekly after each of the four parenting groups.
- The groups will inform the caregivers of the neuroscience concepts used in this treatment approach of parenting children with attachment issues.
- Following turning in your weekly journals, there will be one interview and one observation of you parenting implementing some of the tools taught in training.
- Should you decide to drop out of the study, this will not impact your ability to continue obtaining mental health treatment from the Attachment Healing Center.
- Your weekly journals will be given a study number that will link your personal information with the journal. The link between the study number and your personal information will remain intact until after the data analysis has been

completed and the document linking you and your study number will be destroyed.

- Your journals will be placed in a locked box for transport by the Student Investigator to the Faculty Advisor, Dr. Kristopher Goodrich, at the University of New Mexico.
- The data gathered from your journals will be entered into a computer database, encrypted and password protected. Following the data gathering and analysis, the data will be stored on a flash drive along with your consent form and will be locked in a file cabinet and maintained by the Principal Student Investigator, Michele Coleman.
- Hard copy notes of the observation and interview will also be stored in a lock box for transportation to Dr. Goodrich. Notes from the observation and interview will remain in Dr. Goodrich's possession.
- Michele Coleman and Dr. Goodrich will have access to your study information. Data will be stored for six years and then will be destroyed.

How long will I be in this study?

There are three aspects to the study; 1) attendance at weekly parenting training for four weeks, 2) weekly journaling for four weeks, 3) observation and interview at the end of the parent training. The following is the time we anticipate each activity will take:

- Parenting group – 8 hours
- Journaling – 4 hours
- Interview and observation – 1 hour

What are the risks or side effects of being in this study?

There are risks of stress, emotional distress, inconvenience and possible loss of privacy and confidentiality associated with participating in a research study.

Additional risks of being in this study include becoming uncomfortable when confronted about personal issues that may be contributing to your child's dysfunctional coping behaviors. Distress can be typical in the counseling change process, and change can be helpful. The licensed and trained clinicians know how to address and support this stress and can help alleviate the stress. Should you become agitated and require additional individual therapy, a clinician from our agency can be assigned to you. Information from your individual session will not become a part of the study. You may also call Agora Hotline at 1.866.HELP1NM (1.866.435.7166) In Albuquerque, 277.3013.

It is also important that you know that there are legal limits with regard to confidentiality. In certain situations the research investigators, who are also counselors, may be required to reveal information obtained during the groups or from your journals to other persons or agencies without your permission. These situations include, but are not limited to;

- where there is a threat of bodily harm to yourself
- where there is a threat of bodily harm to another person
- where there is evidence of any type of child abuse

- where there is evidence of any type of elder abuse or abuse of other dependent adults who are not able to protect their rights.

For more information about risks, ask the study investigators.

What are the benefits to being in this study?

There may or may not be a benefit to you from participating in this study. As a participant in this study you may receive a small benefit from the insight obtained through the journaling process or as a result of the interview.

Additionally, families participating in the research are guaranteed a therapist to support applying the concepts learned in group.

What other choices do I have if I do not want to be in this study?

Participation in this research is voluntary. You may still attend the four-week psychotherapy group and you can obtain mental health services from our agency if you do not wish to participate in this study. However, there may be a wait for a clinician at the time you are seeking services. If you choose to withdraw, no penalties will occur.

How will my information be kept confidential?

Information obtained as part of this study will be assigned a study number. Information without the participant's name will be entered into a computer database, encrypted and password protected. Data will be stored on a flash drive and along with consent forms will be locked in a file cabinet and maintained by the Principal Investigator Michele Coleman. The link between your personal information and the study record number will be destroyed after the data analysis is completed. Michele Coleman and her Faculty Advisor, Dr. Kristopher Goodrich, will have access to your study information. Data will be stored for six years and then will be destroyed.

We will take measures to protect the security of all your personal information, but we cannot guarantee confidentiality of all study data.

Information contained in your study record is used by the principal investigator and her faculty advisor and other study investigators. The University of New Mexico Institutional Review Board (IRB) that oversees human subject research and/or other entities may be permitted to access your records. There may be times when we are required by law to share your information. Your name will not be used in any published reports about this study. A copy of this consent form will not be kept in your medical record, but will be kept in your study record.

Finally, you should understand that the investigator and her research team are not prevented from taking steps, including reporting to authorities, to prevent serious harm of yourself or others.

What are the costs of taking part in this study?

There is no cost to you to be in this study.

Will I be paid for taking part in this study?

Once you have submitted your journal entries for your experience implementing what was shared in each of the four weeks of group, you will be compensated with a \$25 Amazon gift card to thank you for your participation in this study.

Compensation is considered taxable income. Amounts of \$600 or more will be reported by UNM to the Internal Revenue Service (IRS).

How will I know if you learn something new that may change my mind about participating?

You will be informed of any significant new findings that become available during the course of the study, such as changes in the risks or benefits resulting from participating in the research or new alternatives to participation that might change your mind about participating.

Can I stop being in the study once I begin?

Your participation in this study is completely voluntary. You have the right to choose not to participate or to withdraw your participation at any point in this study without affecting your future mental health care or other services to which you are entitled. Up until the completion of the data analysis you also have the right to request that your data no longer be included. After the data analysis has been completed however, we will no longer be able to determine which data are connected to you.

Whom can I call with questions or complaints about this study?

If you have any questions, concerns or complaints at any time about the research study, please contact the Faculty Advisor, Dr. Kristopher Goodrich at (505) 277-7222, or kgoodric@unm.edu. Dr. Goodrich has no affiliation with the Attachment Healing Center.

If you need to contact someone after business hours or on weekends, please call (505) 270-1297 and ask for Michele Coleman or call (505) 321-1827, which is the Center's emergency phone number.

If you would like to speak with someone other than the research team, you may call the UNM Office of the IRB at (505) 277-2644.

Whom can I call with questions about my rights as a research participant?

If you have questions regarding your rights as a research participant, you may call the UNM Office of the IRB (OIRB) at (505) 277-2644. The IRB is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human participants. For more information, you may also access the OIRB website at <http://irb.unm.edu>.

CONSENT AND AUTHORIZATION

You are making a decision whether to participate in this study. Your signature below indicates that you read the information provided. By signing this consent form, you are not waiving any of your legal rights as a research participant.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this consent form, I agree to participate in this study. A copy of this consent form will be provided to you.

Name of Adult Subject (print)

Signature of Adult Subject

Date

Signature of Legal Adult Guardian

Date

CHILD ENROLLMENT

Name of Child Subject (print)

Age of Child*

*Ages 7-11 read and sign a separate "Assent to Participate in Research" form.

INVESTIGATOR SIGNATURE

I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

Name of Investigator/ Study Team Member (print)

Signature of Investigator/ Study Team Member

Date

Appendix K

Prescreen Questions

Once a parent states an interest in participating in the research, there will be a call made to Pre-Screen them into the research. The following questions will be asked:

- Is your child between the ages of 3 and 17?
- Are you seeking mental health counseling through another agency?
- Have you been clients of the Attachment Healing Center in the past?
- Do you have legal custody of your child?
- Is there one adult willing to be a part of the Parenting Group?
- Do you have transportation for travel to the Parenting Group once a week for four weeks?
- Are you proficient in and able to write in English?
- Are you willing to journal weekly for four weeks about your experience with the material discussed in parenting group?
- Are you willing to be interviewed following your journaling?
- Following the journaling are you willing to be observed parenting your child?

Does your child display any of the following behaviors?

- Inability to be comforted by an adult caregiver
- Poor peer relations
- Displays indiscriminate charm with people they do not know
- Displays approach/avoidance behaviors with adult caregiver
- Lies when telling the truth seems simpler to the adult
- Engages in “crazy lying” meaning they will lie even when the obvious evidence points to the fact they are lying
- Steals or hoards food
- Night time enuresis
- Is a finicky eater
- Does not allow the adult caregiver to redirect them without a fight
- Cannot accept “no” as an answer
- Hurts animals
- Sets fires
- There was pathological care in the child’s first two years of life
- The mother suffered depression and was emotionally unavailable for an extended period of time during the first two years of life
- The mother was under extreme stress during pregnancy
- Mother was under extreme stress during the child’s first two years of life
- Primary caregiver was hospitalized for an extended period of time preventing daily contact with child and child had multiple caregivers during this time, during the first two years of life

Appendix L

Research Script

Assistant will say:

[In addition to greeting the client and hearing the reason for their call, if the caller is a new client, the assistant can inform the caller that there is research ongoing and ask if the caller is interested.] Are you interested in volunteering for research evaluating the Attachment Healing Center's four-week Parent Group Training? Know that you can still obtain services even if you do not wish to be a part of the research. Shall I read you the requirements? [If the caller says no, then the all will proceed normally to obtain client information and start the intake process.] If you are still interested after hearing what is involved, I will inform one of the research team members and they will call you to inform you of the research requirements and to complete a pre-screening .

A Researcher team member will describe the research as such before doing a pre-screen:

Attend four two-hour psycho-educational groups for adult caregivers

- Journal about your experience utilizing the tools discussed in the group.
- This means there will be four weeks of journaling. You will be given envelopes in which you can seal the first three weeks of journal entries and give them directly to the researchers who are conducting the training and they will place your journal entries into a locked box. The fourth week you will deliver your journal in a sealed envelope directly to the office and place it in a locked box.
- Be available for one interview with the researcher following your journaling
- Be open to having your parenting observed one time by the researcher, following the journaling.

All components of the above are required to participate in this study. Participation in this study is voluntary. If you choose to withdraw, no penalties will occur. If you choose to participate to the end, you will receive an Amazon gift card valued at \$25.