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Therapist's Perceptions on Working with the Developmental Repair Model with Children
who come from Disruptive Attachment Styles

Submitted by Molly S. Murphy
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work
University of St. Thomas & St. Catherine University
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Abstract

The present study was designed to look at therapist's perceptions on working with the Developmental Repair Model developed by Dr. Anne Gearity (2005) with children who come from insecure or disruptive attachment styles. Nine clinicians from an agency in the Minneapolis area were interviewed for this qualitative study. Each research interview lasted approximately 30 minutes. All the questions focused on different areas of the Developmental Repair Model, and different aspects of working with the particular population. Findings suggest that clinicians must truly know oneself, be comfortable adapting and practicing the model and understand the importance of language, and how to use it with children. Furthermore, findings about the children suggest they need relationship consistency, chances to "fix it," new experiences, new learning opportunities, and co-regulation skills and eventually self-regulation skills. Implications of the study indicate the importance for relationship formation and connection, and the growing need for infant and children mental health services in our country.

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With love,

Molly Seidel Murphy

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Come from Disruptive Attachment Styles

Attachment problems start when a child does not experience reliable and consistent care. As a result of this inconsistent experience, the child either adapts to too little care or becomes confused and disorganized around the quality of care given. Another attachment problem is when a child is harmed or extremely punished and therefore may start believing that he/she is bad and others are unsafe and dangerous. Inconsistency of caregivers can also cause attachment problems for the child, because he/she may begin to detect a pattern of adults not being able to carry things out and being unpredictable in their responses to situations (Blaustein & Kinniburgh, 2010). Reactive attachment problems occur when a child is harmed or severely neglected, extremely punished and therefore may be unable to expect care, instead believing he/she is bad and others are unsafe and dangerous. The lack of secure attachment causes, "children grow into adulthood exhibiting difficulties in their abilities to self-soothe, self-organize, regulate affect, and engage in healthy relationships" (Bowlby, 1969; Corbin, 2007, pg.540).

Attachment problems affect our population in a variety of ways. Disorganized or negative reactive attachments in childhood have been associated with increased psychiatric symptoms in adulthood. Several studies have shown that a poor attachment quality is a strongly correlated factor with incarceration, often costing our country billions of dollars every year (Beech & Mitchell, 2004; Smallbone & Dadds, 1998). Attachment disorganization becomes evident in multiple developmental domains. Many

children with attachment problems are more likely to display behaviors that are confusing, hostile, and aggressive (Berry, Barrowclough, & Wearden, 2008). The child's thinking can become disorganized when his/her caregiver is confusing, inconsistent, or sending frightening messages (Tasca, Ritchie, & Balfour, 2011). Children with attachment problems have difficulty making sense of their past experiences, indicating a low understanding of how their minds work. A low understanding comes from confusion over how their caregiver's minds work so they remain confused about their own needs, perceptions and intentions. Children who experience attachment problems have difficulty managing their emotions, while their securely attached peers become better acquainted with emotions as they get older (Blaustien & Kinniburgh, 2010). Early attachment disorganization leads to difficulties in relating and trusting other adults and peers later in life.

It is estimated that healthy attachments exist between a caregiver and an infant in 65% of the population and unhealthy attachments occur in 35% of the population in the United States (Zeanah, Berlin & Boris, 2011). Studies claim that attachment remains relatively stable and consistent throughout one's life (Waters, et al., 2000). Studies have also shown that attachment can be malleable. Therefore, with new situations or experiences (e.g. effective psychotherapy or adverse adult trauma) an individual can fluctuate between healthy and unhealthy states throughout his/her life (Bakersman-Kranenburg & vanIjzendoorn, 2009; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000).

Therapies exist for treating attachment problems in children. All have slightly different means to the same end: showing a child it is possible to create and build healthy

interactions that can be different and more reliable than the original attachment patterns. Many therapists agree the relational approach to attachment problems has always been the most effective approach, because it is the child's expectations of care from adults that needs to be repaired for the child. In 2009 Anne Gearity, Ph. D. published the Developmental Repair Model to work specifically with children who have experienced disrupted attachment patterns and who are presenting with aggressive symptoms. The Developmental Repair Model relies heavily on the expertise of the therapist to build a rapport with the child, and begin to recognize emotions.

This study was designed to examine the perceptions of therapists who are utilizing the Developmental Repair Model to treat insecure and disorganized attachments in children.

Literature Review

The literature review will first look at previous research regarding definitions of attachment and lack of attachment. It will then go into depth about the different types of attachment patterns discovered by several prominent researchers in attachment theory. The researcher will also go over Bowlby's common phases of the development of attachment. Next, the researcher will look at the diagnosis of attachment disorder in the DSM IV. Finally, the researcher will examine a key treatment option for attachment issues, and delve into the relational model of Developmental Repair. The research used examines theories, patterns, styles, associations, and treatments found through an extensive research process using PsychINFO, Social Work Abstracts, and other research databases.

Definitions of Attachment

John Bowlby proposed attachment theory for developmental psychology in 1958. Bowlby defined attachment in young children as “a strong disposition to seek proximity to and contact with a specific figure and to do so in certain situations, [most] notably when frightened, tired or ill” (Bowlby, 1969/1982, p.371). From a relational perspective, attachment is defined “as the organization of behaviors in the young child that are designed to achieve physical proximity to a preferred attachment figure at times when a child seeks comfort, support, nurturance, or protection” (Zeanah, Berlin, & Boris, 2011, p. 819). Mary Ainsworth, the well-known developmental psychologist and, theorist, defines attachment as, “an affectional tie that one person forms to another specific person, binding them together in space, and enduring over time” (Zeanah, Berlin, & Boris, 2011, p. 819). A positive relationship with a caregiver brings consistency to a child’s life. Poor attachment to a caregiver can lead to an inability to form positive relationships, poor impulse control, and disruptive behaviors (Koponen & Kallad, 2009). According to Alan Schore (2000) attachment becomes a regulatory system where interactive experiences promote important adaptations on many different levels. Children and their caregivers come together to create psychological and biological regulation, which at first is shared (Schore, 2000).

Attachment insecurity can occur when children receive neglectful, and frightening care-giving; when children have scarce support from caregiver in managing the challenges of childhood; when in distress, they must rely on insufficient or ineffective coping skills. Two main consequences may begin to emerge from relying on insufficient and ineffective coping skills. First, the child is unable to develop advanced and effective

coping skills. Second, the child can become more aggressive or present with ADHD-like symptoms in the face of distress (Blaustein & Kinniburgh, 2010).

Beginning early in life, infants understand whether their needs are accepted and responded to by the attachment figure. The attachment figure becomes the center of an infant's life. Usually the particular choice of attachment figure is inferred by a child's tendency to go selectively to a particular caregiver (often the mother). The attachment figure should provide comfort, support, and protection in order for the child to feel secure (Zeanah & Fox, 2004). Through a healthy relationship with an attachment figure a child can learn about effective self-regulation, reflective functioning, emotions, and how to form stable relationships.

It is important for a child to feel validated in relationships. Validation instills personal confidence that a child is capable of making good things happen. In a difficult situation, a child with positive confidence is able to find someone who can help him/her find a healthy solution. A solid and healthy attachment with a primary caregiver appears to be associated with a high probability of healthy relationships with others (Maughan & Cichetti, 2002).

Co-regulation into self-regulation:

Regulation is the regaining and maintaining of equilibrium, despite the present stressor or stimulation. The process of regulation first starts for an infant as a shared, mutual experience, usually when the caregiver and child are both unsettled. Co-regulation is when a caregiver is able to provide appropriate stimulation for an infant's current mood or state with the ability to calm or sometimes repair disturbances for the infant (Maughan & Cichetti, 2002). Consistent and reliable caregivers are able to co-regulate with their

children in order to later promote positive self-regulation skills. Co-regulation shows the child he or she is not alone, and that someone is there to help. Co-regulation is responsive care, which generally leads toward a secure attachment with the caregiver(s). Also, a caregiver has the ability to instill self-assurance or reliance in their infant through co-regulation (Leahy, Tirch, & Napolitano, 2011).

The ability to self-regulate is established through effective co-regulation. Self-regulation is the ability to calm or bring one's current state back down to a normative level in order to perform basic tasks. Children who have difficulties with self regulation are often labeled "bad children" and struggle with emotion and behavior control; when they attend school or daycare, they are put into in school detention or are suspended due to their difficult behaviors. Children, who have not learned the capacity for self-regulation skills, often will find other ways to "calm down" their arousal states. These children rely on behaviors that eventually will physically exhaust them such as screaming, running, hitting, kicking, and or crying. These exhausting behaviors result in two unfortunate outcomes for the children: first they tend to scare away other children, and adults tend to reject or ignore them or respond in kind to their aggressive behaviors; secondly these behaviors exhaust their bodies to the point where they cannot function or learn (Leahy, Tirch, & Napolitano; Schore, 2003). These behaviors prevent children from learning new experiences that could be helpful.

Internal Working Models

Internal working models are mental representations and thoughts about attachment relationships based on repeated interactions with caregivers. Children who experience disruption or disorganization in their attachment have unreliable mental

representations that contribute to negative expectations of care or disorganized care experiences (Dykas & Cassidy, 2011). Subsequent environmental changes are much more difficult, because of the foundational insecurity. This confusion could cause anxiety and mental health suffering (Bretherton & Munholland, 2008; Dykas & Cassidy, 2011). Over time, secure internal working models become stable, this allows for individuals to experience stability that permeates throughout their different social worlds (Dykas & Cassidy, 2011). The majority of children are raised to be securely attached, therefore, their internal working models are generally stable.

Four Phases of Attachment Development According to Bowlby

1) Orientation and signals with limited discrimination of figure:

During this initial stage the infant does not exhibit a certain preference for attachment figure. Initially the infant is not necessarily attached to caregivers. The infant begins to slowly develop a bias for the caregiver who provides the most consistent, regular care. This stage usually lasts about 2 to 3 months.

2) Orientation and signal toward one of more discriminated figure(s):

In the second stage of attachment development the infant begins to differentiate between caregivers and other individuals. Familiarity with a caregiver leads to preference. The infant responds differently to caregivers, if more than one is present. The second stage can happen as early as 9 to 10 months. The caregiver now begins to play a central role with the child, by easing discomfort the infant may be experiencing.

3) Maintenance of proximity to a discriminated figure by means of locomotion as well as signals:

In the third stage of attachment development, motor behavior becomes more integrative in the infant's life, and he/she is more efficient; therefore, the infant's participation is more complex. Overall infant behavior becomes more organized on a goal-corrected basis. Strangers are commonly treated with caution at this stage. The foundations of a secure base are set and can be observed by age one in most children.

4) Formation of a goal-corrected partnership:

In Bowlby's final stage, the child begins to see the caregiver as an individual with his/her personal set of goals with plans to work toward them. Typically, this attachment phase begins around the third year of life. A partnership can develop in which the child will modify his/her behaviors and motives based on those of the attachment figure (Zeanah; Bowlby; Posada, 2008).

Secure Attachment

Children who demonstrate a secure attachment pattern will protest a caregiver leaving and be comforted upon his/her return. Secure attachment is built upon the sense that when an individual becomes distressed, he/she may approach a caregiver who will provide support (Bodner & Cohen-Fridel, 2010). Securely attached children are more likely to learn a multitude of words to describe their emotions in order to effectively communicate how they are feeling. They also have an ability to consider others' reactions, feelings and needs, and can better think through cause and effect (Tasca, Ritchie, & Balfour, 2011). In the presence of secure attachments, children are more likely to venture out and explore their immediate environment (Zeanah, Berlin, Boris, 2011). The behavior of securely attached children reflects the internal working models of their

parents as available, responsive, sensitive and exploratory (Ainsworth et al., 1978; Dykas & Cassidy, 2011).

Securely attached children are shown to be more cooperative and display more internal control with adults than insecure children (Londerville & Main, 1981; Matas, Arend, & Sroufe, 1979). Secure children are able to experience the caregiver as a safe haven and secure base. By deriving comfort from the caregiver whenever a frightening situation arises, the child is then able to go out and explore once he/she has been comforted (Dykas & Cassidy, 2011; Fonagy & Target, 1997). According to research done by Park et al. (2004) the child “derives self-esteem, in part, from family support” (pg. 1250). This research shows the importance of family support for the development of self.

The securely attached caregiver will appropriately, promptly, and consistently respond to the need of his/her child. Within the context of a secure attachment the caregiver is seen as a stable, consistent, almost ‘landmark’ type figure in which to base a child’s many explorations from (Ainsworth, 1978). A caregiver’s sensitivity “prompts the child to begin organizing self-experience according to clusters of responses which will eventually come to be verbally labeled as specific emotions” (Fonagy & Target, pg. 684, 1997). Based on the positive reaction of the sensitive caregiver, the child will learn that the expression of emotions can be useful in alerting people during periods of distress. Secure people can cope with upsetting information before it starts to overwhelm them, because of their experiences with supportive caregivers who have assisted them in gaining capacities for tolerating upsetting feelings (Dykas & Cassidy, 2011). Sensitivity and dependability are important characteristics for caregivers to possess. Bowlby was instrumental in developing a timeline for the development of attachment.

Insecure Types

According to research, children who demonstrate insecure attachment styles can have significant developmental and emotional difficulties later in life (Cole & Putnam, 1986). The lack of development of self-regulation skills among insecurely attached children can lead to an impaired sense of self. This research suggests significantly impaired self-regulation is an important process in determining the relationship between attachment and maladjustment (Schatz, Smith, Borokowski, Whitman & Keogh, 2008). Children who come from an insecure type of attachment are more likely to doubt self, and have less of an inability to trust in others. According to research done by Cole and Putnam (1986) children who lack development of self-regulation skills may demonstrate barriers in the development of self which include: (1) disturbances in the sense of self, ability to separate from self, [possibly due to dissociation], loss of own memories, and possible disturbances of body image; (2) poor affect and impulse control and possible aggression toward self or others; (3) constant insecurity whether in isolation or relationships.

Insecure-Ambivalent

Children who demonstrate an insecure-ambivalent attachment pattern protest the caregiver leaving and react immediately upon their return. Children who are ambivalently attached are often clingy, whiney, crying and will continue these behaviors for an unusual length of time. The child who is ambivalently attached takes a longer time to be soothed by a caregiver. Ambivalently attached children typically have difficulties in preschool, but they are more passive and needy. Children who are ambivalently attached tend to be more pessimistic, lower in self-efficacy, less resilient, and a lower ability to cope

(Cooper, Shaver, Collins, 1998). They are forced out of anxiety to maintain access to this agitated state that brings up painful memories related to the attachment caregiver (Tasca et al., 2011). Children who are ambivalently attached tend to view themselves internally as unpredictable, untrustworthy, and have difficulties with decision making. The effects may last into adulthood and can be expressed similarly to those in childhood.

More research has been done about what happens as an ambivalently attached person becomes an adult. Later in life an ambivalently attached adult can appear obsessive and jealous in close relationships (Connors, 2011). An adult who is ambivalently attached is in a relationship he/she may have intense worries about his/her partner's responsiveness and has a constant desire for closeness and safety (Bodner & Cohen, 2010). These inappropriate needs come from past experiences with unresponsive or unreliable attachment caregivers. Adults who are ambivalently attached clinging to partners in a hyper vigilant way in order to prevent abandonment (Rholes et al., 2011). The research also goes into other symptoms and how pervasive these can be for ambivalently attached children and adults.

Children and adults who are ambivalently attached tend to ruminate on negative past attachment experiences. The ruminating causes them to be significantly more vulnerable to depression and depressive symptoms (Rholes et al., 2011). A study done by Bekker and Croon (2010) found depression and anxiety are strongly related in adults who are ambivalently attached. According to Cooper et al. (1998) ambivalent individuals, "were the most poorly adjusted overall, reporting not only the highest symptom levels and the poorest self-concepts, but also the highest levels of problematic or risky

behaviors” (p.1392). Like most people with depression individuals who are ambivalently attached have a difficult time keeping others in mind.

Insecure-Avoidant

Children who form an avoidant attachment pattern with their caregiver lack emotional expressiveness, especially as infants (Bartholomew, 1990). Avoidant attached children “do not expect that expressing their affect and seeking proximity will result in positive outcomes. They have learned that vulnerability results in behaviors from attachment figures that provoke a worsening of emotional experience” (Tasca et al., pg. 250, 2011). Children and infants respond to separation from caregivers with minimal external displays of distress, while at the same time experiencing intense internal arousal (Fonagy & Target, 1997). Children who are avoidant may see their parents as consistently failing to provide a safe environment in times of distress, so the need to look inward for safety can be crucial. Children who are avoidantly attached tend to minimize feelings, and be emotionally dismissive.

Adults who were raised with avoidant attachment become vulnerable to utilizing a variety of negative behaviors to cope with emotions. These behaviors can include addictive behaviors, substance abuse, self-harm, and other activities that suit their strategy to cope in non-relational ways (Connors, 2011). In a study done by Berry et al. (2008) “attachment avoidance was positively correlated with paranoia” (pg. 1278). Also in this study, avoidant individuals typically tried to form negative therapeutic alliances, thus helping to perpetuate their negative view of others (Berry et al., 2008). Avoidant individuals have a “preference for interpersonal distance, discomfort with emotional closeness and with dependence on relationship partners, extreme self-reliance, and low

emotionality” (Bodner & Cohen-Fridel, pg. 1354, 2010). All of these personal qualities make the avoidant population very difficult to work with, especially as a clinician.

Disorganized

While insecure patterns of attachment may provide some degree of predictability in care, disorganized patterns of attachment leave children with no consistent expectations of the caregiver. Children who demonstrate a disorganized attachment pattern often lack in coping strategies, display inappropriate ways of interacting with peers, and physically freeze, rock, and become violent when interacting with others (Main & Soloman, 1990). Children with disorganized attachment have been shown to cause difficulty with regulation that becomes evident with others by age 5 (van de Kolk & Fisler, 1994). A typical example of a disorganized attachment relationship is between an abused child and the abusive parent. This abusive relationship has an effect on the cognitive and affective characteristics from a child’s primary relationships (van der Kolk, 2005). The infant has, “to manage extreme arousal at a time when infant capabilities are insufficient to ensure self-regulation” (Carlson, pg. 1108, 1998). Disorganized children have trouble relying on others to help them; however, they are often unable to regulate their emotional state autonomously (van de Kolk, 2005). Children with disorganized attachment possess the internal working model of their parents as a source of danger (Ainsworth et al., 1978; Dykas & Cassidy, 2011). Disorganized attachment leads the child to experience life as hopeless, and to believe that others are rejecting and uncaring (Park, Crocker, & Mickelson, 2004). When a child is raised with a disruptive and disorganized attachment style, the incapacity to regulate internal states affects both self-definition and one's attitude toward one’s environment.

The caregiver in a disorganized attachment pattern may demonstrate role confusion, maltreatment, and possess ineffective communication skills (Zeanah et al., 2011). The adult interactions serve as a “double bind” for children who come to experience their caregivers as a source of danger and comfort. Irrational, aggressive, angry, and chaotic parenting often leads to children imitating these same behaviors (Perry, 2006). The disorganized caregiver inconsistently provides protection, motivation, and then fear (Gubman, 2004). The caregiver is the child’s attachment figure and potential harbor for safety in a threatening world. However, that same caregiver can be abusive and a stressor who might unexpectedly threaten or hurt the child with psychological or physical violence (Van IJzendoorn & Bakersman-Kranenburg, 2003). The disorganized caregiver provides no consistent pattern of attachment on which the child can rely, therefore, the child panics and usually disengages from the caregiver.

Further research on the lasting effects of disorganized attachment reveals truly startling results. A study by Fearon and Belsky (2011) showed that the effects of disorganized attachment may increase over time, especially for boys who live in chaotic environments. Disorganized attachment may have a significant role in the development of later clinical problems associated with conduct and aggression (Fearon & Belsky, 2011). Children with disorganized attachments are more prone to develop dissociative disorders (Carlson, 1998). According to Carlson’s (1998) research about disorganized attachment was associated later in life with single parenthood and with maternal risk for parenting difficulties. Infants with high ratings of “disorganization were more likely... [to have experienced] a variety of forms of maltreatment in the first year of life” (Carlson, 1998, p. 1118). Infants who are later classified as having disorganized attachments are at an

increased risk of severe externalizing problems, dissociation, and post-traumatic stress disorder (PTSD).

Diagnosis/Reactive Attachment Disorder

Only one diagnosis exists in the DSM IV (APA, 2000) for attachment problems in children, and this is Reactive Attachment Disorder (RAD). Please see appendix B for the full Diagnostic criteria for 313.89 Reactive Attachment Disorder of Infancy or Early Childhood, which was taken from the DSM IV, (APA, 2000). There are two sub-types of RAD: Inhibited and Disinhibited type. Both types of RAD stem from pathogenic care, which is persistent disinterest for the child's essential emotional need for stimulation, affection, and comfort; continuous disinterest of the child's essential physical needs; and repeated shifts of primary attachment figures that prevent the formation of a stable caregiver (APA, 2000; Zeanah & Fox, 2004).

Reactive Attachment Disorder (RAD) is often seen in children from institutionalized forms of care, severe neglect of care, and seriously maltreated children (Zeanah & Fox, 2004). The diagnosis of RAD is not to be taken lightly, and should be made carefully by the clinician. Often children will be diagnosed with RAD when a diagnosis of Oppositional Defiant Disorder or Conduct Disorder would have been more appropriate (APA, 2000). Signs of RAD usually appear before the age of five. Treatment for children with RAD, "should mirror the stability, consistency, attunement, and reliability of an appropriate care giving environment" (Corbin, pg. 545, 2007). There needs to be stable and reliable treatment in order for children with attachment problems to begin to feel part of a relationship.

Prevention and a Treatment of Attachment Problems in At-Risk Families

Parent Child Interaction Therapy (PCIT) is a popular treatment for attachment problems that involves the caregiver who takes the lead role in therapy with the child. The focus of PCIT is the caregiver-child attachment which benefits both the parent and child's wellbeing (Harwood & Eyberg, 2006). Improvements were observed on all caregiver reports including child self-esteem, and measures of mother-child functioning (Eisenstadt, 1993). According to Eyberg and Robinson (1982), after PCIT, both caregivers and children rated lower anxiety and greater internal control. The caregiver-child relationship and individual benefits were researched three to six years after PCIT was administered. The results were positive and proven to maintain and even boost the relationship between the caregiver and the child (Hood & Eyberg, 2003). Both the caregiver and child are validated through engaging in learning more effective and positive ways to communicate with one another (Harwood & Eyberg, 2006). While PCIT can be effective with at-risk families, often caregivers resist intervention and are unable to recognize their children's needs. PCIT does require the caregiver to commit a considerable amount of time and motivation in order to be successful. Therefore, the dropout rate is high for this type of intervention therapy.

Another treatment for children with attachment problems is the Developmental Repair Model. This evidence informed treatment model is based on attachment and relational theory. The focus of the Developmental Repair Model is on changing the child and helping him/her become more organized and secure. This study examines the perceptions of therapists who use the Developmental Repair Model to treat insecure or disorganized attachments in children.

Conceptual Framework

Information for the Conceptual Framework section comes from:

Gearity, A.G. (2009). Retrieved from <http://www.washburn.org/pdf/WCCDevRepair-Grayscale-singlepages-smallerfile.pdf>

The Developmental Repair Model begins with helping at-risk children interrupt negative attachment patterns and use adults, who are part of the intervention, especially in moments of danger or internal distress. Negative and sometimes violent behaviors are seen as earlier learned reactions to chronic stress and disorganization. Aggressive behavior becomes the child's maladaptive way to approximate self-regulation and puts the danger outside of them. This is a child's best attempt to maintain self-regulation. Although aggressive behavior perpetuates chaos and internal dysregulation. The process of Developmental Repair uses repeated interactions that involve or provide reliable and consistent adult care as an antidote to earlier insufficient or disorganized care. This repetition allow children to experience and create a healthier relational pattern with adults, and re-activates the possibility of new learning that includes seeking out adults as a source of security. In order to understand the Developmental Repair Model, it is important to review the function of biological arousal and relational management of arousal in typical and atypical development.

The normal arousal curve

A child's internal arousal is normally regulated with consistent adult help. Over time, a child will learn new skills to tolerate and regulate these internal feelings of arousal. Also, a child will gain confidence in his/her ability to restore reasonable biological and psychological equilibrium. The ability to manage arousal begins with co-

regulation or shared regulation, when the caregiver provides needed regulatory help, and then gradually becomes self-regulation (Gearity, 2009).

Chronic arousal

Often children with too little compromised or disorganized care have a limited ability to regulate and manage painful arousal. Chronic arousal dysregulation can happen when a child lacks consistent adult attention and help. Although arousal is an expression of distress and panic, children can eventually learn to manage this painful state by shifting to more aggressive behaviors; they shift danger or confusion from inside to outside. Without solutions children flounder in their environments, eventually believing problems cannot be solved. Children begin to see minor distresses as something that cannot be fixed. The lack of adult soothing can cause children to feel a heightened state of arousal, which increases their feelings of fear. Highly at-risk children rarely find balance and are in a constant state of alert/fear.

The Developmental Repair Model focuses on four developmental domains: capacities to relate, think (awareness), feel (emotion regulation), and act (behavior regulating/effortful control). This conceptual framework appreciates the interactive nature of development and recognizes how a change in each domain impacts children's functioning and developmental adaptation. In this section, examples will be used to illustrate how these domains can be brought to real life therapeutic interventions.

Four Developmental Domains: Relating

The developmental repair model assumes all children operate in complex developmental interactions. The first involves relational expectations and strategies. At the start of the intervention, it is imperative to join with the child. The model defines

joining as, “being available to children, and becoming interested in their experiences and perceptions. We join children to re-activate the normative process of becoming regulated, which starts with the expectation that adults can and will help” (pg. 45). In order to provide reparative help, adults must be attuned to children’s distress, and provide relief in ways that approximate attachment reliability. It is the clinician’s responsibility to stay with the child, to show him/her what a regulatory partnership looks and feels like. Co-regulating represents what most normative children experience, and at-risk children need. Co-regulation increases a child’s self-regulatory balance in the face of distress.

Joining is most important for children when difficult situations emerge. Joining with them is crucial to establishing their self-regulation capabilities. Interrupting patterns of desire for isolation or self loathing is another key element of joining with a child. An essential piece to joining is the act of staying with the child’s experience, and for most adults this can be a hard thing to do. The main goal is, “We want them to need us, although dependence is not our end goal. Letting us in, accepting our regulating help, is our end goal. We become dependable to them...Shared regulatory experiences become pathways to repairing their self-regulatory capacities” (pg. 46). The continued process of successfully joining with a child is called hiring. In order to effectively utilize the Developmental Repair model it is essential the child hires you.

Here are some examples of joining language:

-I won't let you throw chairs, because when you throw chairs it scares you and can the hurt others.

-My job is to keep you safe even when you're big mad.

-When things get mean, remember I don't leave...that doesn't work.

-Vouching for one another as adults: *He/She knows how to help just like I do.*

Four Developmental Domains: Thinking

As written about in the Literature Review, one of the tenets of normative development is how the caregiver begins to recognize and interpret the child's mind. The adult helps the child by sharing their understanding, interpretations, and responses to their environment. This knowledge that comes from the caregiver's mind will also belong to the child. The understanding and sharing of the child's mind allows for emerging self and fosters the shared awareness with their caregiver. Without this help the at-risk child struggles to know their own feelings/ideas and the feelings/ideas of others. Effective social communication is rarely modeled or practiced with at-risk children.

Because at-risk children are no longer infants, to address arousal dysregulation and related emotional distress, clinicians must first help identify what is happening in their minds. Through the use of the Developmental Repair Model clinicians bring the experience of shared awareness by recognizing the child's perspective rather than immediately trying to change it. Adults suggest ideas and possibilities for how children might be feeling, and how they perceive experiences, especially interactions and the intention of others. Because of joining, clinicians are better able to read children's faces, body communication and behaviors to predict what may be happening inside them. Clinicians join children in reflecting on situations that could have several different outcomes or interpretations. Practicing these exchanges allows for cultivation of self-awareness. Once children are able to reflect on their own experiences as making sense, they can start to trust their minds and use thoughts and perceptions to organize their responses.

Recognizing negative self-talk with at-risk children is crucial. Interrupting children's negative perceptions and shifting the focus so they can see their own value and competence will help improve coping skills. These negative self-talk interpretations can be threatening both to others and to their own wellbeing. The child needs to learn that thoughts can be different from actions, and that it is possible to know intentions, beliefs, and assumptions that can mediate both feelings and actions.

Examples of Reflections/Shared Awareness:

-Use your words to tell me why you are so mad-sad. I will listen, and then we can figure out what to do. You can tell me instead of me having to guess.

-My guess is you wanted to say no to this book. You can tell me what book you want to read, rather than throwing it in my face or across the room. What good is the book going to do all the way over there anyway?

-This feels mixed up.

Four Developmental Domains: Feeling

Children initially discover feelings through interactions with their primary caregivers. Feelings are also learned through interactions with other people in one's environment, often mediated by the primary caregivers. When the caregivers' presence is reliable, children are able to trust emotions and feelings. When care is inconsistent, feelings become conflicted or confused. With the Developmental Repair Model, emotions are recovered with adult assistance. Children begin to allow adults to help them recognize and name feelings. This process requires a shared awareness; "they need to see our [adults] feelings as organized and reliable first. When feelings-with-someone becomes

safe and tolerable, children can start to see their own emotions as good and useful” (pg. 57). Naming emotions for children helps them stay calmer instead of aroused.

The Developmental Repair Model explains the importance of modulating emotions to keep from getting into “arousal storms.” It is important to show children how to adjust feelings or emotions to fit the context. Making some feelings such as anger or rage smaller in intensity as well as elevating more vulnerable emotions such as sadness or hurt is fundamental to this intervention. An at-risk child must learn that feelings have the ability to change over time. For an at-risk child, anger is usually a primary emotion. It is important that a child learns alternative feelings and emotions so he/she does not become stuck. Emotions cause children to move into action; therefore, the usual aggression needs to be replaced with something active. Increasing one’s capacity for regulation allows him/her to act purposefully, rather than reactively. Children learn how to best manage their own emotional energy. Some children may do this with physical activities, while others may be gifted at talking about their feelings and emotions.

Examples of naming emotions:

- When you are mad, you don't have to get mean.

- I see [Child's name] you are big mad right now, what could we do together to fix it?

Examples of how to use modulation:

-Using words like big or little in front of feeling words to gauge how much of a feeling the child is actually feeling.

-Utilizing your body and showing them how mad, sad, happy, worried you think the child is he/she can always correct you.

Four Developmental Domains: Acting

This domain encompasses the behavioral component to the treatment model. Development Repair, “does not ignore behaviors, but we are realistic that demanding behavioral changes activates power struggles and forces imposition of external controls” (pg. 61). Learning to be in control of their own bodies is essential for at-risk children in order to maintain and manage positive behaviors. It is important for at-risk children to learn, “behaviors that are effective, instead of defensive” (pg. 61). Adults help connect emotions to behaviors. Children become motivated to think about different options and feel what connecting with an adult is like.

Controlling personal behavior requires much effort. Effortful control “is a natural outcome of secure attachment, because children look to their parents for guidance about how to act and then try hard to maintain that connection” (pg. 62). Effortful control can happen once children have experienced consistent and reliable support and regulatory assistance to understand what is happening and how they are feeling. This begins as mutual regulation and, with support, develops into self-regulation. At-risk children need consistent adult attention to repair motivation in order to control personal behavior. Kindness is also very important, because they often expect adverse and conflicting interactions, especially with adults. Many at-risk children struggle with anxiety through acting out behaviors, wrapped around the fear they might not get what they need. It is imperative that adults let the child know the importance of being taken care of. Also, the child needs to know an adult can help fix situations that arise.

The following are common messages used by adults who are using the Developmental Repair Model:

-Here handing out food is a teacher's job; your job is to be a kid.

-Spilling that milk was an accident. I know you weren't being tricky. Let me clean it up and get you another one. You can eat the rest of your snack now.

-You don't have to snatch that toy here. You can just ask me with your words if you can take the toy home. My answer will be yes, but if you are sneaky, my answer will be no.

These messages give the child a choice. The feelings of helplessness or hopelessness subside, because the child feels power in being able to choose.

As the "intervention alliance is strengthened" (pg.63) the adult is able to frequently address behaviors, even when there is resistance from the child. The ability to collaborate and negotiate effectively with children is important, especially at this point in the intervention. Pre-living future experiences for at-risk children can help them deal with situations they cannot control. This allows them to practice first with a safe adult.

Sometimes it is important to distinguish behaviors that may be inappropriate in one setting, but are needed for survival in another. The challenge for adults is to honestly decipher those options for them. For example:

-You don't need to act tough here. Kids and grown-ups here don't like it when you swear. In your neighborhood you may need to act tough and swear, but remember here we are practicing for school and don't need to do those things for people to like us.

When a child feels more secure with his/her relationship reliability, and their own self-regulatory capabilities, they are more able to tolerate negative consequences when they misbehave. Treatment is most effective if home-life also becomes more secure. However, even if families continue their chaotic lifestyle children are still able to utilize the intervention in school and in their communities. One thing that must remain

consistent throughout treatment is the clinician's reliability and availability as the child's regulatory partner.

Different Ways the Developmental Repair Manual can be Implemented

The Developmental Repair Training Model was developed for a Minneapolis/St. Paul Children's Mental Health Agency to work with young children ages 3 to third grade in an intensive group day treatment setting. The Developmental Repair Model can be implemented in a day treatment child's family, school, daycare and individual therapy settings. Many of the children have experienced complex trauma and demonstrate aggressive and disruptive behaviors.

All children in the agency's treatment program have individual goals they are working on. The therapists use the Developmental Repair Model as their guide in providing intervention strategies for the children. One component of this intervention is providing breaks for children in a separate room, "break room" for children who may become over stimulated or dysregulated to the point of harming themselves or others. In the break room, an adult is always present with the child, focusing on helping them find internal regulation. Within this model, the purpose of break room time is to come back to the group setting feeling more regulated and ready to interact with peers.

Constructs embedded in the Developmental Repair Model have also been applied to working with older children, teens, and adults in both private practice and agency settings. Information for the Conceptual Framework section comes from:

Gearity, A.G. (2005). Retrieved from <http://www.washburn.org/pdf/WCCDevRepair-Grayscale-singlepages-smallerfile.pdf>

Methodology

Research Question

What are therapists' perceptions of the effectiveness of the Developmental Repair Model on children with insecure attachments?

Research Design

The purpose of the research was to explore therapists' perceptions of a particular therapeutic model. The study was qualitative and utilized the interview method to gather data. Qualitative method was the most effective way to gather relevant data that pertained to this therapeutic method (Berg, 2008). There were nine interviewees, all of whom had been educated in the fields of social work, psychology, or marriage and family therapy. The interviews lasted approximately 30 minutes and were recorded with a mini-recording device for transcription purposes. The interviewer also completed the transcription process and did not omit anything.

Instrument/Measurement

The instrument had been prepared and approved by research chair Dr. Kendra Garrett, and committee members Theresa Bozic LICSW, and Dr. Anne Gearity.

Instrument:

Questions:

In relation to the four domains of the Developmental Repair:

- > How do you help a child learn to rely on adult help?
- > How do you therapeutically join with a child?
- > How to you help a child learn more self-regulation?
- > How do you help a child learn to understand relational experiences?

> How do you help a child learn to take more charge of his/her actions?

Others

> How do you make the Developmental Repair Model your own?

> What would you change about the Developmental Repair Model?

> What elements of the Developmental Repair Model do you find most effective?

> What outcomes have you seen with the Developmental Repair Model?

The questions were created from completing a review of research literature and finding certain themes that seemed to stand out to the researcher (Berg, 2008; Monette, Sullivan, & DeJong, 2011). The questions were formatted intentionally and aimed to focus on the therapeutic relationship that was stressed in the literature. Reliability is the idea that an instrument will produce consistent results every time it is administered (Monette, Sullivan, & DeJong, 2011). Reliability checks were performed on the instrument by classmates to ensure that all questions are free of jargon and are comprehensible for the participants. Validity refers to how accurately an instrument measures the concepts being studied (Monette, Sullivan, & DeJong, 2011). There was an accurate representation of face validity because the researcher found the instrument questions to accurately represent and measure the overall research question.

Sampling Plan

In order to gather data about therapist's perceptions of the impact of using Developmental Repair as a treatment approach with at-risk young children who have attachment deficits, the researcher interviewed nine therapists at a Minneapolis/St. Paul agency who use the Developmental Repair Model in their daily practice. Each interviewee was selected by using the method of purposive sampling because he/she

needed to be working with the Developmental Repair technique in some way. Purposive sampling allowed “the investigators [to] use their judgment and prior knowledge to choose people for the sample who best serve the purposes of the study” (Monette, pg. 506, 2011).

Data Analysis

The research was analyzed with a qualitative strategy called the analytic induction method. Using the analytic induction method the researcher first conducts a more flexible coding process of the data and then has a set of key words and terms to look for (Monette, 2011). The researcher will conduct an analysis of the data, while also integrating theory. Therefore, the use of analytic induction method “is grounded to established theory and is also capable of developing theory” (Berg, 2008, p. 322). Once the codes were identified, common or similar codes were consolidated and named as themes. Each theme has direct quotes from the interviewees regarding their opinions and views. Every theme also has common sub themes, and those also have direct quotes from the interviewees.

Another important step was the partner reliability check. A research partner was chosen from the research course and provided with the anonymous interview transcripts. The research partner was asked to code the data and look for themes. Before the coding process began, the partner was informed of the research questions, the type of people being interviewed, an initial code list, and a list of the questions asked by the interviewer. The researcher then compared and analyzed the partner’s coding and themes with her own list.

Protection of Human Subjects

Prior to the interview, the interviewee was given a consent form. The consent form was provided in order to ensure the interviewee's protection, and discussed the specific steps taken to protect the interviewee from harm or wrongdoing. Issues such as interviewee confidentiality and being provided with non-threatening questions were considered. In addition, the interviewee had the right to choose whether or not to participate in the study and determined where the interview would take place. There were no risks or benefits for the participating subjects. The researcher gave the date of 5/1/12 to the participants for when the transcriptions and tape records were to be destroyed.

Limitations of Study

With every research study there are limitations. One limitation was the small number of respondents the researcher was able to reach for this study due to the factors of time and accessibility. Another limitation encountered was a lack of agencies that use the model; therefore, the researcher was unable to contact therapists from other agencies.

Personal Biases

The researcher's personal bias has to do with the Developmental Repair Model itself and the agency where the model is practiced. Last year the researcher interned at this agency and saw first-hand how effective the Developmental Repair Model can be with children. After interviews and gathering data about their opinions, the researcher stands firmly behind this model. The researcher believes it is a good practice model and should be adopted in more day treatment facilities. Also, as a developing clinician, the researcher tends to favor a more psychodynamic/relational approach toward therapy. The researcher believes our early experiences shape who we later become. This is not to say

that change is not possible, but how we function and organize ourselves exists within every one of us and has been present since early childhood. In order for change to take place, it is imperative to look at those early organizing structures and experiences.

So given the personal biases, the researcher took several measures to make sure her own opinions were kept out of the findings. First, the researcher asked a research partner to look over the data and find common themes. Second, the researcher was constantly checking in with self-regarding biases and whether or not she was letting them affect the research. Lastly, the focus of the findings section is the voice of the participants because the researcher wanted their voices and opinions to be heard.

Findings

The purpose of this research study was to expand general knowledge of the Developmental Repair Model, and to hear from clinicians who practice the model in their daily work. Many important themes were found within the rich data that was provided and sub themes also were identified under most themes. An overview of each of the following thirteen themes that emerged from the data will be presented: new experiences; relationship forming and joining; co-regulation; self-regulation; dysregulation; new learning; fixing it/repairing; setting limits/taking charge of actions; the clinician's knowing of oneself; limitations of the model and practicing the model; foursquare idea; importance of the language; and finally the special way these clinicians look at children.

New experiences:

Providing a disorganized or insecurely attached child with positive and supportive new experiences was a key concept that came out of this study. The respondents talked about the new experience being something unusual for the child and how important it is to have someone they trust be there with them to help them sort through what is happening to them. A respondent talked about how a new experience could be something as little as showing a child in the day treatment setting he or she can get basic needs met. For example, one of the respondents explained during snack time, the newer kids will sometimes become dysregulated if their milk spills or all their cookies fall on the floor. At home this means no more or a punishment. During their time in day treatment, children learn that accidents can happen and they can always get more. Here is evidence from the data about the importance of new experiences:

It becomes so important to name the new experience for the child, [in order to] help reorganize them around new ways of [looking and thinking] about things.

Offering children new experiences was an important aspect; the researcher found two other sub themes that are intrinsically tied to providing and understanding these new experiences. The first sub theme is naming the new experience for the child. Respondents described naming as describing, reminding or sometimes guessing what the child is thinking, feeling, or reacting to based on his/her behaviors. Here is one clinician's take on how they use naming in new experiences:

So what you can do is provide them with new experiences, and name that for them, 'Remember when you get upset I can help you' or 'Remember when you pulled out x's chair it hurt them and you felt really bad about it.

The other important sub theme of new experiences is the repeating/repetition of the experience itself and the messages within the experience. By repeating the new

experiences, the child begins to know you will be a dependable figure in their life and this often can take weeks or months to establish with children who are insecurely or disorganized attached to their caregivers at home. Eight out of the nine clinicians talked about the importance of repetition and how this must be shown to children over and over again. Here are examples of two clinicians talking specifically about the importance of repetition:

It is about repetition, these messages and experiences need to be repeated over and over again.

So by repeating things, following through on what we say we are going to do, and remembering things they ask for. Just consistency, reliability, and doing things repetitively so they know we can help.

Respondents said children with insecure attachments need these positive new experiences but they also need to know what is happening to them by having a secure caregiver name it for them. Also, due to the lack of care and assistance in earlier years, the child needs to experience the new experiences over and over again until they become something that is expected.

Relationship Forming and Joining:

According to the respondents, relationship forming is definitely something that needs to take place in order for effective work to be done with children. Frequently, children who come to a day treatment setting have been kicked out of several places before and have a difficult time trusting others. Two clinicians described how relationships typically look from a child's point of view:

By the time they get here, [day treatment] it's also their norm. [For example they think or say] "I'm a bad kid, this is what I do. Being regulated and having people like me is a foreign experience." For most kids being bad and getting in trouble is the abnormal. Our kids think, "I can't trust them, they are going to hurt me anyhow, so I am going to hurt them first."

They need to build trust in you and, if they have never trusted adults before, it can take awhile for them to know you mean what you say, you're not going to trick them, you are not going to leave them alone, and you're not going to walk away.

Another clinician discussed the importance of looking at the negative reactions a child might have, coming from past relationships the important role as a 'new person' one can play:

I think the most helpful part for me is you are kind of starting over. A lot of their reactions to us are their reacting based on prior experiences. So if we kind of start at a clean slate and start at the bottom of the ladder, or the bottom of the steps, we start to build through the relationship that whole trust part and as you are building up what you reactions are and how you view your relationship with them.

Transparency was another common sub theme within most of my interviewee's responses in relation to the importance of joining or relationship forming. Being someone who doesn't hide things and someone who can be very open and honest from the start is necessary with children who come from insecure attachments. Here is an example from one clinician:

We try to be transparent of what we are doing; using words more than you would normally with a kid. To say like, 'this is what I am doing' or 'I'm showing you I'm not being sneaky', 'I'm showing you or telling you we can try again'. And just being super transparent about your availability, your intentions and your support and being committed to doing it for days, months at a time until it starts to stick.

According to all of the people interviewed another key aspect to relationship forming and joining with children is the sub theme of showing up. Here is evidence of data collected about the importance of showing up:

The most important thing we do is we keep showing up every day. Most of our kids obviously do not rely on adult help or think that adults can help because adults are the ones who have harmed them in the past. So I believe something that is special would be, our way of showing up.

Showing up every day is the best way to join with them.

The final, most important sub theme for relationship forming and joining is the need for consistency and reliability. Children from insecure attachments do not know what to expect from adults and the interviewees spoke about how it is important to name what to expect. Here are some examples of that:

You can expect when I get mad, I'm not going to get mean. You can expect I'm going to approach you in a consistent and nurturing way.

This is what you can expect from me: When you act in a certain way here, you can expect I will respond in a certain way, these are the things I won't do. You can expect I will have real emotions too, I will be mad for real, I will be sad for real, I will be happy for real but when I am those things I can be those things with boundaries and appropriately I can do those things within that relationship.

Another big thing...when they are distressed and showing them that we are not going to be mean, we're not going to be abusive, we're not going to do those things they expect, rather we will do things they don't expect, in a more positive way of course.

Every single interviewee spoke about the importance of joining with a child and everyone seemed to do it in his/her own way. Humor was a big way the clinicians join with children. All the clinicians also spoke of relationship forming and joining as the first steps and until there is a relationship, no work or repair can really be done. Here are some interviewees speaking about the importance of joining:

The first way of joining that comes to my mind is humor; the child can understand the relationship isn't just about being serious. A relationship is fluid, and active...

Building trust and joining with the kid. When new kids start one of the main issues, we want them to trust us so they know we can help. So joining a lot of joining in play and in feelings.

So joining is going to be the key part to all of that [treatment], and this can be the first six months or first half of treatment getting them to realize you are consistent and reliable.

Co-Regulation:

Respondents emphasized the skill of learning how essential it is to co-regulate with another person before moving onto working on their own self-regulation work. Co-regulation was a key concept that all nine clinicians spoke about as something very important. When clinicians would talk about co-regulation there always was an end goal that children will be able to someday self-regulate. Here is an example of one clinician talking about that:

A huge emphasis is placed on using the relationship for regulation, that doesn't happen until you're hired. They know you are safe, know you are useful, know you are not going to get mad or scary at them for making mistakes, that is when they can use your relationship to calm themselves down. Eventually, over time they are able to do it on their own.

Another clinician discussed the importance of modeling for a child what self-regulation looks like. The clinician is also referencing the importance of establishing that relationship, which has to be there first in order for co-regulation work to begin:

If a kid has a big melt down then it is modeling and showing a kid first how it could look. We want a kid to be really tuned in to an adult. So what we are trying to do is co-regulate with the kids what I see in that, envision in that and do every day is the idea of modeling that regulation and once we have that relationship we can move towards self-regulation.

Here the respondents speak about the relationship being used to model and show how the children can expect something new and more positive from their experience of relating to one another and to the clinicians:

Helping them know sometimes things they expect, it's something different. Showing them actually even helping them in those moments, "why don't you come over here and play with me, and I will show you how to do it." So modeling for them this is how you can play together. This is how you can play together and it feels good, this is how you can share.

Another key aspect that respondents identified with co-regulation was utilizing the tools of body awareness, to help center and ground children who are all spun up and becoming dysregulated. According to respondents, the children at the agency's day treatment program often have a difficult time listening and tuning into their bodies. Here is evidence from the data about the importance of body awareness:

I think we are doing a lot more body awareness stuff, notice your heartbeat. To give kids more concrete things to hold onto. We use the word "regular" for our kid word for "regulated." Noticing and being their brain for them before they know what that feels like. Especially, initially, when everyone is all over the place, so something concrete, a heartbeat has worked really well.

Self-Regulation:

All of the participants spoke about the importance of self-regulation. The researcher found it particularly interesting that the clinicians would often reference their own self-regulation and the importance of maintaining it. Here are two quotes from clinicians referencing how they work with self-regulation:

Demonstrating self-regulation myself. Modeling it myself first, talking about it, and naming it.

[In response to a child's dysregulation] Sometimes frustrated...This is a safe place, I am a safe adult and it is hard to remember that stuff in the heat of the moment so for me it is really helpful to go back and read about their lives. The things they've been through I haven't even, will never come close to experiencing. So that is an encouraging reminder to forge ahead to work with self-regulation and understanding those feelings.

As treatment progresses, one respondent spoke about the importance of slowly turning the co-regulating relationship into one's own self-regulation:

Eventually, the hope is that the kid can do it on their own, first you interrupt the dysregulation and give them something else, and then you help them practice it, sometimes after awhile giving reminders kids are slowly able to do it on their own. Then they see that it feels good, and it gets a better response that's more positive and then they try and use it.

Dysregulation:

Every clinician talked about joining children in moments of dysregulation, and how powerful that can be. Joining is a powerful way of co-regulating and being there with someone. An important sub theme is staying with the child during moments of dysregulation and not leaving no matter how hard it gets. The goal, according to the clinicians, is to help the child out of a dysregulated state so he/she can return to where new learning can take place. However, working with dysregulation can be very difficult, and here is one clinician talking about what he/she does:

When kids are dysregulated, words are not super effective anymore. Their brains are not in charge; dysregulation is seen as a trauma reaction, emotional reaction. The best thing that we can do, and that we do is stay with kids. Taking deep breaths, exaggerated calming sounds, sensory interventions, icepacks, water, wet paper towels, lotions, rubbing on the walls, knocking on the door, anything you can do to stop the kid from spinning and get them back to the regular curve is kind of the first priority. Making sure a kid is safe, and making sure you stay with them.

One clinician commented that for some children dysregulation becomes something that is “comfortable” for them:

Sometimes we see a kid doing really well and all of a sudden we see him/her lose it. Sometimes it feels safer or more comfortable to lose it. Being that big mad feels safer than letting someone know what you are really worried about.

An important sub theme is not leaving a child who is dysregulating. Every clinician talked about the power of staying with children through moments of dysregulation and how it is essential to establishing and maintaining a relationship. Here are two quotes from clinicians about the sub theme of staying with a child:

A child who is often left to themselves, joining is an adaptive thing in so many different ways, the essence of what I am saying the partnering with in the moment of dysregulation, to be alongside, to be a presence of stability of that relationship, in order for children to tolerate their own internal stress, internal anxiety.

[What dysregulation looks like?] To me it looks like complete confusion. In certain kids it creates anxiety. It's how they know you will go away. That is the importance of not going away during times of dysregulation.

New learning:

New learning also became a key theme and something all clinicians spoke about as being important to their program and the Developmental Repair Model. The sub theme of naming again gets used here, because it becomes influential in a child's learning process. Some of the new learning that may take place was described by one clinician:

[Learning there are] different ways to be mad, sad, or worried and different ways to express it. It's not okay that someone hit you or teased you, but this is how we can do it different.

The clinician's role was also discussed at length. This is where the sub theme of naming became an important element of the new learning process. Here are two clinicians talking about the process of naming and how and or why it is done:

Naming is what we do when we narrate what the child is doing or experiencing. So take a behavior, like throwing a chair. Naming is the process of going under that. Like, "you got worried so you thought you needed to throw something" or "I surprised you, sorry I surprised you." Finding the feeling beneath the behavior.

Reading basically every interaction, emotion, every time they are dysregulated. Then process it with every time afterward, because that is where the new learning takes place.

Finally, a clinician spoke about why the new learning needs to take place:

So we are trying to get our kids back to the typical curve where new learning can take place. It's where they can use people to be calm, not just exhausting oneself to calm down. Learning how to calm their bodies, how to use adults, skills and techniques for calming down.

Fixing it/Repairing:

Another key theme that arose within the data was the importance of fixing or repairing relationships because of something that happened. The clinician needs to address the behavior of the child, however, over half the clinicians spoke about the negative and punitive nature of our school system's timeouts. Timeouts are not helpful because no new self-regulatory or socio-emotional learning is able to take place. Here is one clinician speaking about the nature of fixing and repairing:

Fixing and repairing it with them, instead of the punitive 'you hit that kid' or 'you threw that chair at me' now you are going to go sit in a timeout. Well now they sat in the timeout and still no learning has taken place about why their body and brain got so mad, or why they reacted the way they reacted, and how it could be repaired or done different. They have to be taught that, timeouts don't fix anything.

The same clinicians spoke about the need for a collaborative way to figure it out and repair the situation together. Here is evidence of the collaborative effort from the data:

[Collaborative effort is] about figuring out a way to do it different, figuring out a plan or a way to fix it together. As opposed to putting a kid in a different space, shutting the door until they calm down, avoiding, no new learning happens.

Setting limits/Charge of actions:

A theme all nine clinicians talked about was the process of setting limits and how to have children take charge of their own actions. Many of the clinicians talked about the importance of building awareness and empowering the children to let them know they have a choice. Often children from disorganized or insecurely attached homes feel they need to react to everything, leaving them feeling powerless to do anything. From the data, it became clear that children are either in charge of too much at home or in charge of too little. Here are three clinicians talking about the importance of empowerment and taking charge of personal actions:

All of our kids feel like they want to be in charge, but they still need to be the kid. So that's what they want most of all is grown-ups to be grown-ups. It becomes more of; like it's time to color you can choose whether you want markers or crayons. Not choose what you are doing next. So it's giving them the right kind of power because a lot of our kids being in charge of themselves and everyone around them are all they've ever known and that's too much.

Building awareness, helping the child developmentally where they are at, name their actions or what is going on, we also like to "fix it" here, giving chances, kids feel empowered because of that.

Our kids need so much empowerment. They are so used to reacting instead of taking charge of their actions.

Another key aspect to working with children is how a program handles or looks at behaviors and what those behaviors may mean. All the clinicians the researcher interviewed believed the day treatment children initially communicated primarily through their behaviors. Behaviors such as hitting, kicking, throwing, cussing, and wrecking things are learned behaviors. Children have learned to cope with stress, confusion, and frustration by demonstrating these behaviors. Here is one clinician talking about the way behavior is perceived and dealt with:

Behavior, the way we think of it here is a way of communicating some confusing internal experience, feeling or idea. Naming is us being those words for our kids; it's our attempt to be that for them.

The figure eight approach, where sometimes you are following their lead and other times they are following your lead, because you can't be overly controlling. It can make someone feel unsafe, especially kids who aren't safe they need to feel in control sometimes. So sometimes it is a reciprocal approach, pulling the clients rather than pushing the clients where you want them to go.

The clinician's knowing of oneself:

A theme that arose throughout six of the nine clinician's interviews was the concept of getting to know oneself and being aware of oneself. Also, other clinicians commented on how Developmental Repair has affected them as people and that it's okay

to be effected by the work that you do. Here are four examples of what the clinicians had to say about the awareness of self:

I think you need to be aware of your strengths and your weaknesses.

You have to be willing to give up some of your own [stuff], I'm a grown-up I don't do silly things like dance and sing, and you kind of have to give up on your own insecurities and be vulnerable with kids too and just play and be with them.

Developmental repair in my mind is a model of doing relationship. And I don't do relationship like [this person] does relationship or [this person] does relationship I don't do relationship like anyone else does relationship. I am unique.

Being honest with the kids and with yourself about your own feelings, like it's okay to get mad at the kids to use your honest emotions. I go back and read the model every once and awhile to make sure I am staying true to the work that we are doing. Also, taking time to just listen to other people's messages to get new ideas. Trusting in the work with the children, it takes some practice, using that loud voice for the first time, and just making sure it does not feel fake. Our job is to be the adult; their job is to be the kid, and having confidence in that.

Limitations of the model and practicing the model:

The limitations to the Developmental Repair Model and to practicing the model as a clinician also became an interesting theme that arose within the data. Clinicians talked a lot about the lack of being able to generalize the model across other settings. This could be due to the lack of availability of mental health knowledge, sensitivity and collaboration between agencies. Here are some reasons clinicians felt there were some limitations to practicing and implementing the model:

It's really challenging to explain it to others, particularly schools and parents. They usually think you are letting the kid get away with too much.

Maybe one of the biggest limitations is it's not done everywhere, so it's sort of in isolation. I happen to think it's a really great model, and we adapt to problems really well as they arise. But communicating that to other providers, families, and school stuff is difficult because of time and funding issues.

Makes it hard for kids to generalize it to other settings. Generally, it can be successful, but it is a struggle we talk about often as a team.

Another struggle talked about by three clinicians was the behavioral component, and not wanting to make it too much about the aggressive behaviors elicited by the children. Here is one clinician talking about that struggle:

...we always talk about with the model, because it is a relational model how you work in those necessary behavioral components without becoming super behavioral because I think the thing we like most about it is it's not just about point charts and reinforcement, because our kids are not there yet. To feel comfortable knowing there are times when more behavioral interventions are appropriate and how to get unstuck.

The first sub theme for limitations is populations. Several of the clinicians pointed out two populations which the Developmental Repair Model has not been successful. Children who are on the Autism or Fetal Alcohol Spectrum are the two disorders respondents mentioned as being difficult to work with in the day treatment classroom with other “typically” developing children due to either issues of memory, cognition, sensory issues, or relational abilities. Two clinicians talked about these populations:

We have found road blocks with specific groups of kids on the autism spectrum because our model is so relational.

...we have not had great success with FAS or Autism because [the model] doesn't apply the same way relationally.

Within the limitation theme, the challenge of family work is the final necessary sub theme. All of the clinicians in some way spoke about the difficulties in working with families. Many of the clinicians talked about the struggles the families are going through, and how hard it can be to manage the chaos in some families. Here are four clinicians that talk about the multitude of struggles in working with families:

We are constantly challenged by the family work and engaging families and finding the expectations that make sense for each family. Home can be really hard to engage sometimes.

The parents, like our kids have to be ready to say, let's really think about why my kid is that way. That can be really scary when you might be the person that has been the abuser or the victim in an abusive relationship. I believe there is a lot of guilt that parents feel, therefore, making it difficult for parents to share their stories.

Sometimes parents never got to be kids themselves so they don't know how a kid is supposed to act.

Four square idea:

Seven out of the nine clinicians talked about the four square idea as a useful therapeutic tool for working with children. The four quadrants are: think, relate, act and feel. These are all talked about at length in the Conceptual Framework, a previous section of this paper. Here are two respondents speaking about the importance of the four square model:

I like the four square: think, relate, act, and feel. When I am stuck with a kid, I immediately go to that strategy and think, where is this kid at? We are usually stuck in one of those four areas.

We use the four square idea to look and strategize about a kid. It is a really great way of looking at the whole kid and looking at what is under the behaviors...it's a continuous idea of understanding a kid.

Importance of language:

The Developmental Repair Model has its own way of talking and relating through the language used with children. As the clinicians spoke about their work, the importance of language became apparent. Clinicians talked about how important it is to name feelings, and to have a shared language in order to build relationships. Here are three clinicians talking about the importance of language:

[It is] we language, we're going to help you, we will do this together

[What's special about our program is] having a shared way of being with kids, and the simplicity of the language [we use] with the kids.

This language becomes something that can be applicable for adults as well. Many clinicians talked about utilizing it in their everyday lives outside of day treatment for solving issues with family and friends. Here are some other ways clinicians have used the language:

The whole 'name it and tame it' works for anybody. You name what's going on and you figure out a way to fix it. I think that is applicable for anything you do.

One thing that is really important to remember is to use the same language with parents as we use with the kids in the group. The parents benefit from learning this new language of togetherness.

A special way of looking at kids:

A key concept which grew out of this study was the interesting way the respondents look at children. Children were not talked negatively and the respondents seemed to really care about working with this difficult population. One clinician explained it this way:

All the staff here...actually like these kids and like working with them. We find out interesting things about them, and continue to notice those things.

Also, all the participants discussed how they notice children first, and understand their behaviors as serving a function for them. Here are two clinicians' comments:

I think our way of thinking about kids is really helpful. It doesn't have to be so behavioral. The behaviors these kids are demonstrating make perfect sense given what they've gone through. They have had to protect themselves in order to survive. It's easier to look tough and scary than to be scared and vulnerable.

When the person doesn't notice the behaviors, they notice the kid.

Another clinician spoke about how feelings and behaviors are tied together:

We say it all the time: our kids get scary when they are scared or frightening when they are frightened.

Discussion

This study used qualitative data to generate responses from nine clinicians working with children who come from disorganized or insecure attachments. The literature reviewed states the importance of a healthy secure attachment in relation to higher self-regulation, self-reliance and self-esteem. The attachment pattern between a caregiver and child can become a pivotal force in depicting the success or failure of a child's future in school, the community, and beyond. Overall, the findings from this research are compatible with what was found in the literature review. The researcher will go through each theme and compare it with the research found, and will also bring out several emerging themes from the research as well.

The value of providing new experiences was something that was very consistent with the literature. The need for repetition comes from basic biology and how our brains are wired (Schoore, 2003). Children who have never experienced consistency are not expecting it and will not expect it in the future. For some children to trust and rely on an adult may take a very long time. This was evident in both the literature reviewed and in findings from this research (Van IJzendoorn & Bakersman-Kranenburg, 2003).

The importance of forming relationships was consistent in the literature and research findings. It is evident that early relationships will go on to influence later interactions in the community, school, and work settings (Maughan & Cichetti, 2002). In the study the respondents placed a much higher emphasis on the need to be transparent and to keep showing up every day. While the literature mostly focused on validation in relationships. However the literature, as well as the respondents, state that a need for consistency and reliability are important factors to forming relationships (Blaustein & Kinniburgh, 2010).

The themes of co-regulation and self-regulation are intrinsically linked together. The importance of having a stable co-regulator was apparent in both this research study and the literature reviewed. One's capacity to self-regulate is based on one's history with his or her caregiver evident in the literature and research study (van der Kolk, 2005 ; Leahy, Tirch, & Napolitano, 2011).

Another important issue talked about in this research study was how body awareness has become a helpful and clear determinant for children to measure their own body's level of arousal. More research and education can be done on body awareness for young children with mental health issues because research shows it can be an important tool for practitioners and children (van der Kolk, 2005).

Dysregulation became an important theme in the research study. The study provided clinicians observations and the practical implications of working with children who demonstrate signs of dysregulation. The literature evaluated children who come from a disorganized attachment pattern and found they have serious problems relying on others and regulating their own emotional state (van de Kolk, 2005). In this research study a common pattern of children's dysregulated behavior was to be upset and disengage from relationships.

Another important theme is setting limits this can provide children with physical and emotional safety. Children from secure attachments are provided with age appropriate limits. These age appropriate limits and boundaries are necessary for successful and healthy relationships in the future (Fonagy & Target, 1997). The respondents talked about how it is important to expect positive behaviors from the

children. However, they seemed to have a realistic way of looking at children and their situations.

Another common theme that was evident in both the conceptual framework and this research study was the four square strategy. Many of the respondents found by assessing a child's thinking, acting, behaving, and feeling capacities to be very beneficial in evaluating a child's functioning (Gearity, 2009).

There were several emerging themes from this research and that would be interesting to study in the future. One emerging theme was the special way in which the respondents viewed children. The respondents spoke of their deep connection and respect for the children. A second emerging theme was the importance of repairing and fixing difficulties that arise within a relationship. The third theme to emerge was the particular language used when working with children in the day treatment program. The language is very specific and purposeful, requiring practice to understand and use it effectively.

The most important theme to emerge from the research was the strengths and limitations of the Developmental Repair Model. The feedback identified the following strengths and the importance of: relationship building; the day treatment setting; the consistency of treatment; the relational model; and the focus on feelings rather than behavior. The feedback identified the following limitations as: the difficulty in collaborating with other professional teams; the difficulties that arise when working with families; and the need for adaptations to the model in order to serve children with ASD and FAS.

Strengths and limitations of the study

One strength of this study is the significance it could have on the future of children's mental health. This study examined the unique perspectives of therapists who use the Developmental Repair Model when working with children that come from insecure or disorganized caregivers. The study included a variety of mental health disciplines, including social work, psychology, and marriage and family therapy. Each clinician offered his or her different perspective on the experiences of working with such an intense relational model. Currently, this day treatment center is the only place where the Developmental Repair Model has been implemented and is supervised from the creator of the model, Dr. Anne Gearity. The researcher was able to get nine out of eleven clinicians to participate in the study; therefore the sample size was strength of this study. Another strength is the possibility of raising awareness of the comprehensive mental health services being provided in the Minneapolis/St. Paul Area for children and their families.

Although the sample size for this particular study may be strength, a larger sample size would be beneficial in determining more conclusive findings. Another limitation would was the inability to speak to more people involved in the child's treatment process. These people would include the child's teachers, case managers, family members, and getting the child's perspective.

Conclusion

The findings of this study suggest several implications for social work practice. Social workers need to play an integral role in the importance of children's mental health. Social workers need to provide education to other mental health professionals regarding

the work of the Developmental Repair Model. This model is an effective treatment for addressing early childhood attachment issues. Effective services could be coordinated between home, school, and day treatment facilities with better education of this model. Finally, as social workers we have an obligation to be concerned about vulnerable children and what is happening to them in today's society.

Another important issue involves the field of Social Work education and the lack of focus on children's mental health concerns. The research indicates the younger we intervene in a child's life, the likelihood of the child being successful increases (van der Kolk, 2005). Early intervention programs are sprouting up all across the country and mental health professionals are beginning to recognize the importance of specialized training for children's mental health needs. It would benefit future social workers to have sufficient knowledge of the diagnostic criteria regarding emotional development for children ages birth to five years old.

Implications for policy and further research

As suggested by the literature review and the findings of this study there is a need for additional policy changes to children's mental health. The findings from this research suggest adequate funding for programs that demonstrate effectiveness such as the Developmental Repair Model. More funding for the Developmental Repair Model would provide adequate treatment in mental health facilities and multiple school settings.

Implications for further research include the importance of clinicians knowing themselves because working in difficult systems requires a good sense of self and self-regulation. Further research regarding the benefits of self-reflective practices would be interesting to study. More research is needed to examine the sub themes of family, school

collaboration, and populations the model struggles to reach. Researches regarding the different ways clinicians perceive children would be fascinating. The clinicians in this study had amazing stories to tell about the children and the connections they made with them. Many plans for future research should be made because the Developmental Repair Model is an inspiring and strengths-based therapeutic technique.

In summary, the Developmental Repair Model is a unique therapeutic method that works with children who come from disorganized and insecure attached homes. It is a calm and gentle approach to children who have experienced harmful relationships in their past. The model helps repair disrupted attachment patterns by providing healthy relational experiences to the child. The model tells children that they are valued and worthwhile versus naughty and bad. For the first time, children realize that adults are genuinely interested in their thoughts, feelings, and needs. The Developmental Repair Model needs to be further exposed to other community agencies in order for change to occur in our society.

**Appendix B Diagnostic Criteria for 313.89 Reactive Attachment Disorder from the
DSM-IV-TR (APA, 2000) of Infancy or Early Childhood**

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):

(1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)

(2) diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessively familiarity with relative strangers or lack of selectivity in choice of attachment figures)

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

(1) persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection

(2) persistent disregard of the child's basic physical needs

(3) repeated changes of primary caregiver that prevent formation of stable attachments (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specify type:

Inhibited Type: if Criterion A 1 predominates in the clinical presentation

Disinhibited Type: if Criterion A 2 predominates in the clinical presentation

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