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# Clinicians' Perspectives on the Developmental Repair Model

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# Clinicians' Perspectives on the Developmental Repair Model

by

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MSW Clinical Research Paper

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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 the findings of the study. This project is neither a Master's thesis nor a dissertation.

**Abstract**

This study gathered qualitative data on the Developmental Repair Model from clinicians working with it currently. The research question that guided this research was: What are clinicians' perspectives on the Developmental Repair Model (DRM). The research was gathered by collecting data through standardized, structured interviews with clinicians from an inner-city agency in the Midwest. Findings of this research include themes of unique ways clinicians made the DRM their own by: creating special visuals or techniques; ways clinicians modeled fixing mistakes or narrating their own emotions; how clinicians used the strengths perspective while working with families by understanding individual struggles; how clinicians received support through peer consultation; ways in which clinicians used their sense of self while working with children such as kneeling on the floor instead of standing over a child; how clinicians integrated the four domains of the DRM into their daily practice; and finally how clinicians perceive the DRM as a strengths-based model. This information adds to the growing discussion on children's mental health concerns and what evidence-based models are currently being used to address such concerns. Additionally, this research encourages the continuation of placing importance of the special needs of children with disrupted attachment.

**Acknowledgements**

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**Clinicians' Perspectives on the Developmental Repair Model**

Attachment disruption or insecure attachment formation in young children has become increasingly present and acknowledged in the therapeutic community. Thanks to theorists like John Bowlby, the significance of the attachment experience between infant and caregiver has been studied and applied to understanding both typical and atypical development in children (Brandell, 2010; Riggs, 2010). Frederick and Goddard (2008) believe that attachment theory can be useful in describing the adverse effects of disrupted attachment. By knowing how infant/caregiver attachment is formed and the benefits of a secure attachment, we can begin to understand what attachment disruption looks like and the consequences of an insecure attachment.

Attachment disruption can happen when children grow up in an environment that is not meeting their caregiving needs. Riggs (2010) developed a model in which "emotionally abusive parenting" consisting of "frightening or frightened behavior, rejection, or inconsistent behavior" leads to an infant attaching insecurely (p. 7). From there, infants develop into children who struggle with "emotional regulation," "negative internal working model development," and "maladaptive coping strategies" which can lead to "poor social functioning" (p. 7).

Parenting styles in which insecure attachments are formed can be neglectful or abusive. Every year there are over 740,000 children and youth are brought to hospitals around the country because of violence-related injuries, and there are over three million reports of child maltreatment made to local and state officials. Additionally, records for 2010 show that among victims of child maltreatment, 34 percent were younger than four years old (Center for Disease Control, 2012).

Abuse and neglect in the United States is a real problem that has real consequences for these children. The Center for Disease Control's (2012) 2010 report states that 81.2 percent of these victims were maltreated by their parent. The mental health community refers to this type of parental abuse as complex trauma (van der Kolk, 2005). Through the abuse inflicted by a caregiver, the young child's brain is not organized in a way that allows for the child to rely on the caregiver for support and safety and the child begins to adopt the abusive caregiver's mentality (van der Kolk, 2005).

Some mental health professionals are stepping in to administer treatments with these children, allowing them to repair disrupted attachment. Children with disrupted attachments present many different behaviors. For purposes of this paper, the researcher will focus on the external and aggressive behaviors. According to Gearity (2009), these children show aggression to both adults and peers. Additionally, they lack the capacity to follow social norms, and when these children become upset they "externalize pain, and protect themselves" (Gearity, 2009, p. 11). When children become upset they can become aggressive as way of showing their feelings. It is for these presenting behaviors that children get referred to mental health agencies that focus on attachment disruption and repair.

While many children suffer from disrupted attachments, they may not be severe enough in their symptomology to warrant a diagnosis of Reactive Attachment Disorder (RAD). Reactive attachment disorder is primarily seen in children who are victims of serious neglect but can also be seen in children victim to other kinds of abuse as well. These children have been subjected to persistent pathogenic care. Children who are

abused physically or sexually, live with alcoholic parents, drug addict parents, or parents who have mental illness are also at risk for developing RAD (Hornor, 2008).

According to the DSM-IV-R description of RAD, children are "markedly disturbed and [have] developmentally inappropriate social relatedness in most contexts, beginning before age 5 years" (American Psychiatric Association, 2000, p. 130). In the diagnosis of RAD the DSM-IV-R requires the clinician to assess quality of care present in one of three ways, "(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. frequent changes in foster care)" (American Psychiatric Association, 2000, p. 130).

Children who have histories of abuse often present real problem behaviors associated with attachment disruption. However, when behaviors are not as extreme as RAD behaviors described earlier, what treatment plan do clinicians follow? How do clinicians work with families that may be struggling with this child's behavior? The purpose of this paper is to address this issue. This research will gather qualitative data on clinicians' opinions on the Developmental Repair Model, a model created for repairing disrupted attachments. The Literature Review will outline how attachments are formed, what happens in a secure versus insecure attachment and the risk factors associated with insecure attachment. Additionally, the Literature Review will present information on available therapeutic techniques for attachment disruption and the effectiveness of these techniques.

## Literature Review

In order to study the efforts to improve attachment more fully one must have a solid working knowledge on the research and information already circulating within the therapeutic community on attachment.  Research has given social workers a solid foundation to work from in terms of identifying healthy attachment and what factors play into the development of a disrupted attachment style.  However, as will be shown through this literature review, there is still much need for the examination and development of evidence-based treatments.

First, the literature review will discuss attachment definitions, how attachment is formed and finally the repercussions of an insecure attachment. Then a review of current therapeutic treatments used for repairing attachment and working with children diagnosed with RAD, such as parent counseling, holding therapy, and Video-based Intervention to Promote Positive Parenting. Finally, the literature review will end with an overview of the Developmental Repair Model which will guide the rest of the research.

### Attachment

John Bowlby came to understand the infant/mother relationship in a way that was unheard of for his time. Bowlby argued there was a difference between dependence and attachment. According to Bowlby's research, all infants are dependent on their mother from birth but the process of attachment takes time (Bowlby, 1969).  Bowlby found that there is a "dynamic equilibrium between the mother-child pair," in which the mother responds to the infant's needs and the infant grows to attach to the mother (Bowlby, 1969, p. 236).

Attachment to a caregiver serves many purposes. For an infant the caregiver is the main protector and source of comfort (Main, 2000). Additionally, attachment provides infants with the opportunity to learn survival techniques and grow from the mother (Bowlby, 1969). Dan Siegel (1999) wrote that attachment fulfills the infant's desire to be in close interactions with a caregiver. Humans are born with the ability to recognize their birth mother's voice and actually show a preference for that voice (Taylor, 2002). However, while most of these reasons to attach serve a survival purpose, Bowlby argued that there was another developmental purpose infants attach (Bowlby, 1969).

Mary Main (1995) suggested that in addition to Bowlby's concept of the infant attaching to the "primary" attachment figure, there may be two or three other attachment figures in an infant's life as well. For example, the infant can be attached to both mother and father. Main also noted that these interactions do not have to be positive; an infant will in fact attach to a caregiver that is abusive (Main, 1995). According to Siegel (1999) the attachment relationship is essential for shaping and categorizing current experiences but also the growth and development of the brain. Through the attachment relationship and the caregiver/infant interactions, the attachment style is categorized into one of two types- secure or insecure (Siegel, 1999).

**Attachment Styles**

Attachment is a process that happens between an infant and the caregiver. Attachment development has been studied closely by various researchers but the most well-known and highly regarded study is the strange situation developed by Mary

Ainsworth.  Ainsworth and her colleagues set out to find "the attachment behaviors through which such a bond first becomes formed and that later serve to mediate the relationship" (Ainsworth, Blehar, Waters, Wall, 1978, p. 17).

The strange situation was developed to assess the quality of attachment through the response of the infant to the caregiver returning after leaving for a short period of time (Main, 2000). Ainsworth had the theory that separating the infant from the caregiver should trigger the attachment system (Siegel, 1999).

As described by Main (2000), Mary Ainsworth discovered what she and Bowlby had hypothesized all along- the relationship between the mother and infant impacted the attachment style. "Ainsworth found that the organization of attachment to the mother differed among infants in systematic accordance with the way the mother had responded to the infant's signals and communications through the first year of life" (Main, 2000, p. 1076). Main was able to discern a difference in the attention given to these babies by the mothers and the resulting characteristics of the babies. These types of attachment where organized into two categories: secure attachment and insecure attachment (avoidant and resistant) (Ainsworth et al., 1978).  Disorganized attachment was later developed to label children who were described as "unclassifiable" by Main and Solomon (1986).

**Secure Attachment.** Secure attachment is a style of attachment that develops when the environment has been predictable and consistent for children (Shaw & Páez, 2007).  These caregivers have consistently attended to the needs of their infant in a loving and stable way. Ainsworth et al. (1978) observed that these mothers were more "affectionate during bodily contact" than mothers of avoidantly or resistantly attached

babies (p.145). Securely attached infants have learned to use their caregiver as a secure

base (Goldberg, 1995). The child's motivation can be increased to confidently explore the

world around him or her (Shaw & Páez, 2007). Securely attached babies will become

distressed when the caregiver leaves the room and then will be comforted enough by the

return of the caregiver to go back to playing in the room (Main, 2000).

**Insecure Attachments**

  **Avoidant.** Avoidant attachment is the organization of attachment that occurs

when the caregiver is inattentive to the infant's needs. These children do not show

emotional distress when separated from the caregiver (Goldberg, 1995). Sroufe and

Fleeson (1986) describe the type of caregiving these infants experience as "less

responsive" (p. 60). Aisnworth et al. (1978) hypothesized that avoidant babies found

close bodily contact with their mothers to have a negative connotation due to caregiver's

rejecting type behavior towards the infant. Daniel Siegel (1999) explained further an

avoidantly attached infant's style of proximity seeking behavior,

> The view of such a child's internal working model of attachment is that the parent
>
> has never been useful at meeting his emotional needs and is not attuned to his
>
> state of mind; therefore, behaviorally, it serves no purpose to seek the parent upon
>
> return (p. 93).

These infants do not seek to be in close proximity to their caregiver because they have

learned that in order to survive with their caregiver they cannot be too needy.

  **Resistant/Ambivalent.** Infants that are attached in a resistant/ambivalent manner

have been raised in an environment where the caregiver is very inconsistent with care.

Ainsworth et al. (1978) observed that these mothers waited longer than mothers of non-resistant attached babies in attending to their infant's cries. These infants struggle being apart from their caregivers to explore their surroundings (Goldberg, 1995). In Ainsworth et al.'s (1978) research of the strange situation scenario, children who are ambivalently attached desired to be picked up and also did not want to be held, but also did not want to be put down.

        **Disorganized/Disoriented.** During the strange situation research Ainsworth et al. (1978) discovered infants that did not fit into the existing categories of attachment styles. Main and Solomon (1986) later reviewed these tapes and discovered that infants who were "unclassifiable" had similar disorganized behavior. The researchers created the Type D attachment category of disorganized/disoriented. They found that these infants would behave in ways such as "simultaneous display of contradictory behavior patterns" or "behavioral stilling" (Main & Solomon, 1986, p. 97). For example, some children would freeze upon their parent's return or run to the caregiver but then suddenly stop or push them away (Hesse & Main, 2000).

        According to Main and Hesse (1990) disorganized attachment is often the result of an infant being fearful of the caregiver (as cited in Hesse & Main, 2006). The term "fright without solution" is used to describe the situation in which the infant feels fear but instead of having a safe base to return, the attachment figure does not offer comfort and therefore does not help 'solve' the problem of fear (Hesse & Main, 2006). These infants cannot be comforted by the caregiver because the caregiver is the source of the fear (Siegel, 1999).

**Risks Associated with Insecure Attachment**

If an infant does not have the opportunity to securely attach to a caregiver there may be many negative consequences. Children who have been victims of neglect or abuse early on in life may develop poor coping skills, learning disabilities, poor functioning within a family or school system, and within peer groups (Taylor, 2002). As these children reach school age they need to have love, nurturing, and caregivers that engage with them in an intellectual way that aids in their cognitive development (Shaw & Páez, 2007). If these essential pieces of love, nurturing, safety, consistency, and engagement are lacking, children may not feel safe to explore their environments and participate in the world around them.

Generally, children with insecure attachments are at greater risk for psychiatric disorders such as anxiety or mood disorders (Hesse & Main, 2000; Siegel, 1999). Specifically children classified as having disorganized attachment styles may relate to the world in a more aggressive way. "Studies have found that these children may become hostile and aggressive with their peers. They tend to develop a controlling style of interaction that makes social relationships difficult" (Siegel, 1999, p. 109).

Dysregulation, a common word used in the mental health field to describe a behavioral and/or emotional state does not have one concise definition. Gearity (2009) describes "emotional reactivity" in which children "react to others emotions with aggressive acts that quickly become out of control" (p. 11). Riggs (2010) includes emotional dysregulation as part of her hypothesized model for "relationship adjustment, psychological aggression, and psychological victimization" in which she defines it as

"chronic fearful arousal" and "limited, negative affect" (p.7).  Behavioral dysregulation could be thought of as the behavioral representation of emotional dysregulation. Behavior dysregulation for purposes of this paper and research will be conceptually constructed as the inability to modulate aggressive behaviors.

The DSM-IV diagnosis of a specific attachment disorder is referred to as Reactive Attachment Disorder (RAD) and fits under disorganized attachment.  Children diagnosed with reactive attachment disorder frequently show problem behavior both in the home and at school. Simply stated, children diagnosed with RAD struggle with building strong, meaningful relationships (Shaw & Páez, 2007). Due to reactive attachment disorder's staple characteristic of the inability to form a secure attachment, this can impact children's relationships with any other member of their life. The anxiety of lacking meaningful relationships can present itself through many behaviors including rage.

Adoptive mothers of children with RAD have described their children presenting behaviors such as self-stimulation, hoarding food, lying, and defiance of authority (Wimmer, Vonk, & Reeves, 2009). Children diagnosed with RAD are also more likely to show aggressive behavior towards themselves and others (Zilberstein, 2006).  Many times these behaviors of aggression and control issues may turn into conduct problems as the child gets older (Zilberstein, 2006).  These findings support Shaw and Páez's (2007) report that children diagnosed with RAD are often disrespectful and likely to challenge authority figures.  It is important to note that while there is a correlation, researchers cannot say with certainty that the aggression is strictly a RAD symptom (Zilberstein, 2006).

**Attachment Repair**

There are not many widely recognized forms of attachment-based interventions. According to O'Connor and Zeanah (2003),

> A general conclusion from the large and steadily growing literature is that several particular interventions are moderately effective, but the mechanisms underlying the treatment response are as yet not clear, and very few studies compare attachment-based interventions with an intervention derived from an alternative theoretical perspective (p. 234).

Therapists working with clients and their families challenged by a disrupted attachment, struggle with finding an evidence-based treatment model. In this part of the literature review the researcher will outline various therapies used to address attachment problems.

Attachment therapy is based on the principles of attachment theory. The primary focus of this therapy is the relationship between the child and caregiver (Cornell & Hamrin, 2008). O'Connor and Zeanah (2003) have identified most interventions are focused around the "real-life interactions between parent and child" with specific focus on the sensitivity and responsiveness of the parent to the child's needs (p. 234). The ultimate goal of attachment-based therapy is to create a caregiver-child relationship in which the caregiver is the secure base and the child can consecutively utilize this safe base (O'Connor & Zeanah, 2003).

There are many forms of attachment-based techniques used in attachment therapy interventions. Zeanah, Berlin, and Boris (2011) identify Child-Parent Psychotherapy (CPP) developed by Fraiberg to be a supported attachment intervention. Through CPP the therapist guides the caregiver in exploring his or her childhood memories and how the

memories could potentially be influencing the current parenting style (Zeanah, Berlin, & Boris, 2011).  Their conclusion was supported by reviewing five randomized clinical trials of CPP and found that it did help parents respond more consistently and compassionately to their baby's needs (Zeanah, Berlin, & Boris, 2011).

Clausen, Ruff, von Wiederhold, and Heineman (2012) found that psychotherapy techniques can work with foster children with history of disrupted attachment.  This study looked at 20 different therapist-client dyads that had used relationship-based psychoanalytic play therapy during the sessions (Clausen, Ruff, von Wiederhold, & Heineman, 2012).  The researcher found that the relationship-based psychoanalytic play therapy with young foster care children significantly reduced various mental health symptoms (Clausen, Ruff, von Wiederhold, & Heineman, 2012).

Another intervention used for attachment disruption is holding therapy. This technique was built on the premise that physical touch is a necessary part of developing healthy attachment. Dozier (2003) pointed out that this type of therapy is commonly used with children who have been in the foster care system and adopted children.  During times of dysregulation, these children are physically held against their will to make some sort of connection to their new caregiver. Drisko and Zilberstein (2008) who studied holding therapy specifically with relation to RAD found that through this very confrontational, physical therapy that children can "release locked in emotions and memories" (p.478).

While Drisko and Zilberstein (2008) report success there is much controversy over holding therapies. Attachment therapists argue that in fact holding therapies do nothing for building the attachment between caregiver and child but rather do the

opposite (Dozier, 2003).   Instead, the argument is the child may experience increased severity of trauma from the act of being physically held against his or her will (Dozier, 2003).  Pignotti and Mercer (2006) argue there is clear risk for physical and psychological trauma when the adult grabs, pokes, or lies on top of the child during the therapy session. Additionally through this practice, children have actually died from holding therapy done inappropriately.

   **Treatments for RAD.** There are a variety of attachment-based treatments used for treating children diagnosed specifically with RAD.  Each treatment ultimately focuses on assisting the child in building a secure attachment with the caregiver in his or her life. Most treatments focus on the child and interactions with others in their environment (Drisko & Zilberstein, 2008).

   Parent counseling therapy focuses on helping caregivers of children diagnosed with RAD in order to create "good enough" environments in which the child can begin to establish a secure attachment (Drisko & Zilberstein, 2008, p.477).  Through this type of therapy parents are set up with multiple supports to tune into the behavior and recognize what the child is trying to convey when he or she presents with bad behavior. A variation of parent counseling is the in-home attachment intervention known as the Video-based Intervention to Promote Positive Parenting (VIPP).  VIPP is used over the course of four at-home sessions as a teaching tool to help parents of infants learn and establish a healthier attachment (Zeanah, Berlin, & Boris, 2011).  The video models the healthy interaction of mother and infant and promotes an idea of what a healthy attachment looks like. Additionally, some direct contact interventions that also include the caregiver

receiving individual treatment to help the caregiver become more aware of his or her child's needs (O' Connor & Zeanah, 2003).

**Developmental Repair Model**

The final treatment intervention discussed in the literature review will be the Developmental Repair: A Training Manual developed by Anne Gearity (2009).  This model will help frame the method section of this research project. The Developmental Repair Model (DRM) was created through research on healthy, normal development and what risks are present during this developmental time period (Gearity, 2009).  Instead of just quieting or silencing a child when he or she becomes dysregulated it is imperative to work with the child to learn ways of self-regulation (Gearity, 2009).

The DRM helps guide clinicians in working with very at-risk children ranging from ages three to eight that are presenting with aggressive and disruptive behavior as well as struggling to self-regulate (Gearity, 2009).  These at-risk children who may have been exposed to disrupted care, violence, family difficulties, or unexpected loss, as described by Gearity (2009), "confuse interactions with adults and peers, have emotional reactivity, distorted perceptions, and inadequate skills" (p.11, 12). Examples of this include expecting adults to be angry when provoked, expecting needs to be unmet by adults, using aggressive play, becoming hyperaware of danger, fixating on only bad memories, and lacking in effective problem solving skills (Gearity, 2009).

This model concentrates on helping to promote change in a child's internal thinking versus only using external consequences as a means to control.  The intervention emphasizes using clinicians as "regulating partners" for children to help them organize

their internal thinking and relating to the world (Gearity, 2009, p. 8). Self-regulation

consists of being in control of arousal and emotions and according to Gearity (2009),

"supports exploration self-awareness, organization, [and] self-control" (p.37). The model

goal is that as, "children become more internally organized and regulated, they can

relinquish aggressive behaviors for behaviors that are more self-protecting and

connecting to others" (Gearity, 2009, p.8).

Anne Gearity (2009) argues that when an adult joins at-risk children during times

of arousal he or she can then help to co-regulate with the child. This helps the child to

learn new ideas on how to self-regulate during times of distress (Gearity, 2009). In

normal arousal, the child is triggered by something that indicates danger which then

creates a heightened sense of awareness. This heightened awareness forces the brain and

body to become hyper-vigilant and to figure out how to handle this situation. In a typical,

healthy attachment, a caregiver would step in and help calm the child and then be able to

learn from the experience.

When the arousal stays heightened because there is no caregiver to offer comfort

or perhaps there is unreliable caregiver support, the child does not learn how to cope, and

his or her internal self-regulation patterns are never formed (Gearity, 2009). If this

becomes a pattern for children, they begin to interpret adult help in the calming processes

as scary and dangerous (Gearity, 2009). It is in this misconception of adult help being

scary where the clinician works to help create change. Clinicians work to help children

learn that adults can provide support during times of dysregulation and distress.

**The four domains- Relating.** There are four developmental domains presented in the model. The Relating domain requires that the clinician must 'join' with children that are in distress. Gearity (2009) describes the process of *Joining*,

> Joining is a mutually regulating experience. Children initially push adults away or pull adults into their dysregulating chaos. Staff can feel threatened, confused or even provoked to retaliate. Instead we must tolerate these dysregulating encounters as necessary to know about children's painful internal experiences. By staying interested, we can regain our regulatory balance, and bring them back with us. […] Joining involves both physical availability and mental attention (p. 45-46).

Gearity (2009) stresses adults must stay consistent and reliable in helping because children are expecting the adult to not help. Through this relational component, the clinician works to "interrupt children's isolation or faulty self-reliance" (p. 46). Through this process, "We establish a reliable pattern of concern and usefulness, and notice when they [children] can accept help" (p. 46).

**Thinking.** The second domain the researcher will discuss is the thinking domain. It is in this domain that the clinician assists the child in realizing thoughts that may be fueling the feelings he or she are having (Gearity, 2009).  It is also within this domain that the clinician works with the child on reflective thinking, which encourages children to pay attention to their own thoughts. Gearity uses the concept "shared awareness" to describe when the clinician explains what has happened and then "joins" with the child to process through what that experience felt like together (Gearity, 2009).

**Feeling.** The third domain is feeling. Gearity (2009) points out that children first develop and discover their feelings in relation to others.  The clinician helps the child to recognize emotions and orient him or herself to be appropriately aligned with their emotion. Gearity (2009) further explains this concept by giving the example of children often using anger to demonstrate many different emotions like fear, sadness, or being hurt.  Through the feeling domain, clinicians can help children to re-organize their thoughts and more accurately name emotions and experience these emotions safely (Gearity, 2009).

**Acting.** The final domain in the DRM is the acting domain. Gearity (2009) stresses in her model that imposing a consequence with these at-risk children does not help. Instead clinicians must work with them and repair behavior together.  Through the acting domain children are able to learn new ways of behaving and perceiving their world that enable them to "increase internal behavior control and improve social inclusion" (Gearity, 2009, p.44).

The DRM also describes how important it is to include families in the process of repair.  Gearity (2009) described two ways in which this intervention differs from others. First, the clinician must acknowledge the parent as the expert on the child, however, the clinician stays firm in his or her diagnostic judgments and uses clinical skill to help the parent better understand the child and his or her presenting behaviors. The clinician then asks the parent to think of ways the child can be successful outside of the home (Gearity, 2009).  By doing this, the intervention promotes the parent to engage with the child in a new way (Gearity, 2009).  It is in this new way of engaging with the child, which the model refers to as "experiments" that the parents are asked to be aware of how their child

is thinking and perceiving the world. The clinicians work in a partnership with the parents to help them relate better to their child (Gearity, 2009).

The DRM describes the importance of staff support through this process. The model acknowledges the difficulties of working with dysregulated children and offers advice to professional teams working with this population. Dr. Gearity stresses the importance of staff consultation and clinical supervision in which staff can get advice, discuss hard cases, and find their own emotional regulation. Staff consultation should be used to help staff to realign their own emotions by releasing tension, according to Gearity (2009), because staff members that are most aware of their emotional states are the most effective clinicians.

Finally, the Developmental Repair Model concludes with an outline of how this therapeutic intervention should look in a day treatment setting. Gearity (2009) encourages a classroom of about six or seven children with two adults. The two staff members each have different duties such as running the activities or attending to children's needs. Gearity (2009) says that the foremost challenge of day treatment is including all children into the social group setting. The focus of the clinician's role is to help children maintain self-regulation in order to be able to be active members of the group.

The schedule of the three-hour day treatment session consists of play, art projects, snack, large motor play, structured learning activities, and school work (Gearity, 2009, p 93, 94). However, while that is what the schedule says there is much more going on. Children are learning to cope with transitions which, on a deeper level, is learning to

work with loss and control, regulatory skills such as biofeedback interventions like body awareness exercises, and check-ins, which requires children to reflect on how they are feeling (Gearity, 2009, p. 93, 94).

The familiar 'time out' practice is also something the DRM has altered. Instead of the classic idea of a time out being the experience of having time out of the larger group, the DRM "replaces the time out with *time with children*" (Gearity, 2009, p. 96). It is at this time that the clinician joins with the child and helps to co-regulate with them. If there does come a time when the dysregulation has become too much for a child and calming down is not possible, then Gearity (2009) says child needs a break from that setting. Taking a break with a child means removing him or her from an area that has too much stimulation and joining them in a quiet space where the child can deescalate. In this process, the child is removed from the whole group but continues to be with a clinician. Now the clinician can focus on helping to co-regulate instead of what caused the dysregulation (Gearity, 2009).

The final element of the DRM is documentation. Gearity stresses the importance of documentation because it assists clinicians in picking up on patterns of behavior. There should be goals and objectives set for each child that track how the child is doing in day treatment.  Additionally, there should be discharge criteria and a graduation of the group should be a special and meaningful event (Gearity, 2009). Gearity (2009) also emphasized the importance of aftercare in maintaining contact with schools, for example, on the progress of children, however, due to financial reasons, aftercare is often forgotten.

**Conceptual Framework**

**Strengths perspective applied in child development**

The conceptual framework that guides this research project is the strengths and empowerment perspective lens which focuses on child development and working with families.  Children living within their family systems have to overcome various obstacles to achieve normal development. As social workers it is important that we emphasize the strengths of these children and families but do not forget or discredit the difficulties endured (Miley, O'Melia, & DuBois, 2011).  By working with families in this manner, social workers do not brush off the difficulties the family has endured but rather focus on the strengths that have helped them to survive. Through the strengths and empowerment lens, the questions that have guided this research study thus far will continue to resonate throughout the methods, results, and discussion sections focusing on the child development process and the strengths that at-risk families possess.

Empowerment of the child and family happens when a clinician is using the strengths perspective. Working with dysregulated children who come from chaotic homes is among the more intense and stressful jobs, so clinicians that are actively using the strengths perspective while working with families automatically have given that family hope. That same perspective will help continue to guide the lens of this paper by looking at the ways the DRM has helped to empower clinicians, children, and families by incorporating strengths into assessing areas of child development and treatment planning.

Incorporating strengths into assessment and treatments are not the only way in which clinicians can work within the strengths and empowerment perspective. Clinicians

need to have a strengths perspective because relying on personal attributes alone can

cause burnout and job stress.  Working with children and their families that have histories

of trauma, abuse, neglect, or chaotic life styles is very challenging. Research has been

dedicated to finding out what keeps workers working in this field. Zosky (2010) found

that among child welfare workers, there was no difference in emotional exhaustion,

depersonalization, and personal accomplishment between both workers who identified as

thinking dominant and those who identified as emotionally dominant.  What these results

suggest is that no matter what personality type you are, working with tough families is

difficult. That is why it is important while working with struggling families and children

to have a strengths perspective.

According to Saint-Jacques, Turcotte, and Pouliot (2009) more social workers are

using a strengths perspective while working with struggling families. This research

assumes that using a strengths perspective is imperative to ethical, evidence-based, and

effective treatment.  The introduction and literature review has demonstrated, there are

many children affected by attachment disruption and struggling to succeed in mainstream

society.  Therapy techniques are available, while research on the effectiveness of each is

limited. This research aims at providing insight into how the profession of social work is

integrating the Developmental Repair Model into practice.

**Research Question**

As shown by this literature review, there is a growing body of research assessing

the usefulness and validity of attachment-based interventions and techniques. Some of

these methods are well supported while some are highly controversial. However, one

conclusion can be drawn from this research-there is not a lot of evidence-based-practice

models for therapists to utilize when working with clients that have disrupted attachment and their families. The goal of this research is to add to the literature on the developmental repair model and how clinicians are integrating the model into practice. The question that will guide this research is *What are clinicians' perspectives on the Developmental Repair Model?*

## Methodology

It is important that as clinicians we are using an evidence-based practice that supports, encourages, and helps foster change in our clients. The aim of this qualitative research was to interview clinicians who are using the developmental repair model in their practice with children as to what their views on the model are. The research question that guided this research was: *What are clinicians' perspectives on the Developmental Repair Model?* The DRM has recently been established as a treatment intervention and this research aimed to gain insight on how clinicians are working with it, what they see as strengths, and what are challenges of the Developmental Repair Model.

The data for this qualitative research was gathered by doing standardized, structured interviews with clinicians at a Midwestern, intercity agency. This research is qualitative because of the nature of this material. Understanding the feelings, unique perspectives, and opinions of clinicians could only be obtained through a qualitative interview situation. Berg (2009) wrote that qualitative research captures the details of experience, and that is what this research hoped to do.

The advantages of gathering data through interviews were many. Because of the interview process, respondents were more likely to give fuller and more detailed

responses (Monette, Sullivan, & DeJong, 2011). Additionally, the researcher was able to

control extenuating factors such as making sure it was the correct clinician answering the

questions, all the questions were answered, and providing clarification if needed

(Monette, Sullivan, & DeJong, 2011).  The researcher was also able to ensure that

respondents were in fact clinicians working in the field with the DRM and that they

understood the questions being asked. Disadvantages of doing interviews for this research

were time related in that interviews do take more time to conduct and analyze.  For

purposes of this project, however, the researcher was able to interview all participants

interested.

**Sampling**

The sampling strategy that was used for this research was a non-probability

availability/convenience strategy. It would be impossible to create a random sampling

frame of only clinicians working with the DRM, therefore, the researcher used

convenience sampling to gather data from one agency known to be using this method of

treatment.

The advantage of using non-probability availability/convenience sampling was

that the researcher was able to identify clinicians that do utilize the DRM and specifically

ask those practiced clinicians about their perceptions of effectiveness. Limitations of this

sampling strategy were that all clinicians came from the same agency so the results are

not generalizable, and this data will not be representative of all clinicians working with

the DRM. Also, due to the practice evaluation purpose of this research, these clinicians

were also somewhat familiar with the researcher so there may have been a willingness or

unwillingness to express true feelings. However, it was clearly defined that the interview answers were very confidential and in no way affected the working relationship. Additionally, clinicians were allowed to skip questions if they wanted to as well.

The researcher first obtained permission from the agency to conduct the research (see Appendix A). Then the researcher emailed potential participants. In this email there was a cover letter with a description of the research project and purpose (see Appendix B). The clinicians were asked to email back with available times to conduct the interview if they were interested in participating. Once a time was set up, the researcher had the participant read and sign the Consent Form and then conducted an interview with each clinician (see Appendix C). Interviews lasted from as long as 20 minutes to a full hour. Data was collected through the interview on an audio recording device. After data collection the audio material was then transcribed and the audio material was destroyed. The respondents consisted of three clinicians that had a range of experience working with the DRM.

**Measurement**

The measurement plan for this research project included a survey comprised of 17 questions. This instrument was created using a strengths perspective and child development lens. The questions are as follows:

1) What is your clinical licensure? How long have you been licensed?

2) How long have you worked with the Developmental Repair Model?

3) How do you build a strong relationship with a child in day treatment?

4) How do you become a "regulating partner" and join with a child during times of dysregulation?

5) In what ways do you show consistency while working with the kids?

6) How do you help a child learn reflective thinking?

7) How do you help children discover and recognize their feelings?

8) The DRM describes repairing behavior together.  How does this look during your treatment sessions?

9) What are ways you work to include families in on the developmental repair process?

10) Are there obstacles to family engagement in the process? If yes, please explain.

11) Are there ways in which the staff is supported here? If yes, please explain.

12) Are there areas in which staff could be more supported? If yes, please explain.

13) The DRM describes explicitly how to work with children in a day treatment setting. Are there ways in which you make the DRM your own such as personal touches?

14) Are there any variations you think would be helpful for your peers to know about?

15) What do you think is the most effective piece of the DRM?

16) Do you think that this model is a strengths-based framework? If yes or no, please explain.

17) Would you make any changes to the DRM? If yes, please explain.

These questions are both reliable and valid. The questions have proven to be reliable due to the straightforward nature of the question and unambiguous meaning.  Reliability was also established through the review of the instrument by professionals and colleagues in the field.

This interview instrument is also a valid form of measurement. These questions have high content validity because they were derived from words used in the DRM manual and clinicians should have been familiar with the phrasing. Additionally, there is high face validity because these questions were directly assessing clinicians' views on various aspects of the DRM.  These questions are tied to the literature because they enhance the research demanding the need for finding an evidence-based treatment that works for children with disrupted attachments.

**Data Analysis**

The type of coding that was used for analyzing the transcription is analytic induction. Through this analysis process the researcher began by creating a coding scheme based on the theory discussed in the literature review and conceptual framework. The coding scheme that guided the analysis of this research was 1) how clinicians are using a variety of tactics to make the DRM their own, 2) how clinicians are modeling, 3) how clinicians are using the strengths perspective while working with families, 4) how clinicians are having the ability to discuss cases with other professionals, the staff feels supported and appreciated in their work, 5) how clinicians are using their sense of self, and 6) how clinicians are integrating all four domains into every day practice. While

these themes guided the coding from the beginning, the researcher was open to additional themes that may have been present during data analysis.

**Human Subject Protection**

Due to the nature of this research and the qualitative data gathering it is important to be aware of human subject protection. The researcher provided informed consent to all participants.  Additionally, all research findings were kept confidential allowing clinicians to feel comfortable expressing their true reactions and feelings about using the Developmental Repair Model.  It was also made very clear that there is no coercion into participating in this research study. The clinician's relationship with the researcher was not at all affected.

The risks and benefits of participating in this research were few. A potential risk of participation could have been clinicians feeling worried if negative opinions shared on the about the DRM are not kept confidential, however, this did not happen due to the level of protection of human participants taken in this study.  The researcher safeguarded all materials by keeping audio footage confidential and kept transcripts anonymous. After the audio tape was transcribed it was then destroyed.  Transcripts were destroyed after the final revisions of the paper were completed and they were no longer needed.

This research was meant to help clinicians by giving them feedback on how their colleges are working with the DRM.  Additionally, this research could help the agency discover areas in which the model is not being used completely or ways in which the clinicians are altering the model to better fit the specific needs of their clients.

**Limitations**

As discussed earlier there were several limitations to this research. First, the research was only being conducted within one agency; therefore results are only applicable to this agency. This excludes other clinicians who may also be working within the DRM framework. Additionally, while this may not have been a limitation, the researcher was familiar with the agency and the clinicians. This could have potentially created reluctance to share honest feelings about true opinions of working with the DRM.

**Biases**

In addition to conducting the literature review, the researcher has experience working with children from disrupted attachments. With the researcher's knowledge of the research showing the lack of evidence-based treatments available in combination with personal experience and seeing the need for a treatment model that works, a potential bias for this research was to be looking for positives in the DRM when perhaps the data is showing otherwise. Additionally, this researcher has great respect for the clinicians working in this tough field and it was imperative that the researcher stayed neutral and fair while coding the data. A way in which these biases were kept in-check was by using only quotes given from the participants and not paraphrasing any information. By doing this, the data is directly derived from the participants and is in no way a reflection of the researcher's opinions.

**Findings**

The data collected through the interview process provided themes and patterns within each individual clinician's work. In particular the coding schemes that guided the analysis of this research: 1) how clinicians are using a variety of tactics to make the DRM

their own, 2) how clinicians are modeling, 3) how clinicians are using the strengths perspective while working with families, 4) how clinicians are having the ability to discuss cases with other professionals, the staff feels supported and appreciated in their work, 5) how clinicians' are using the sense of self, and 6) how clinicians are integrating all four domains into every day practice proved to be evident in all three interviews. Additionally, another theme discovered was that clinicians believed the DRM to be a strengths-based model. Finally, there were sub themes found around psycho-education, narration, and consistency.

**Making the DRM their own**

All three clinicians discussed ways in which the DRM looked different from the original model during their sessions. Clinicians spoke of using their own personal experiences or the unique experiences of the children to tweak the DRM to best fit their style or the need in their rooms.  Clinicians molded the DRM to fit the academic level, emotional level, or special needs of the children and families engaged in day treatment services.

> *For example, there are certain phrasings that I don't really love and so I kind of tweak them to make, to phrase them a little bit differently to something I can see myself using on a daily basis.* –Interview B

> *...but I think that just with the different kids you kind of always have to be tweaking it, every time a new kid starts or a kid graduates I think that we're tweaking our model a little bit in our classroom.* –Interview B

*I would say I don't follow it explicitly. Just because I think that all of our kids*

*come in with, a little bit of different environmental factors, so different ways that*

*their families respond to them, different traumas that they have experienced and*

*just different experiences whether they have been in an academic learning before*

*or they have been in a, you know, any [kind] of structured setting before. –*
Interview A

**Modeling**

The theme of modeling was one seen woven throughout most of each interview.
Modeling came in many forms such as modeling how to make mistakes and remain
regulated or how to slow down and make decisions. Clinicians showed great
intentionality when discussing how they interacted with the children and how modeling
behavior or affect was another way of teaching these children repairing skills and coping
techniques.

*…one example I think of that we use a lot in the classroom is, 'kids make mistakes*

*and grownups make mistakes too' so sometimes for instance if I am like reading a*

*book, I'll forget to give kids their reward for coming to the table first and*

*someone will say something and I will say, 'oh yeah, whoops, I made a mistake*

*too, its ok' just to kind of reinforce that we do make mistakes…* -Interview B

Another clinician uses visuals to aid in modeling,

*…one thing that I have found to help is that I have a, sort of a 'think' sheet so it*

*says like what I did, how I was feeling, what I can do differently, and then what*

*happens when I do things the way I am supposed [to]…* - Interview C

**Using the strengths perspective with the family**

Clinicians offered insight and understanding in their discussion around family engagement. Clinicians were able to empathize with families under stress and would supplement their typical protocol with parents to better support the family. Additionally, they expressed how important it is to have family support and engagement for their clients and that it does make a difference for these children. A sub-theme found within this major theme was that clinicians often use tools such as psycho-education to help inform and empower families on mental health diagnosis and resources.

> *There is a lot of psycho-education that goes on. So it's like a three by three square and the kids are earning rewards every time they have listening ears, or ignore, or keep things little or whatever their specific goals happen to be and then we send that home to help encourage the parents to be doing these sort of things and be talking about it and so they are getting familiar with the lingo that we are using and the process so that they can start to change their behavior even little incrementally...* –Interview C

> *I think it's a lot about psycho-education and I think it depends on the child too of how to describe the experience and also the parents' experience of like what their childhood was like and how that affects the way that they parent.* –Interview A

> *...it [stress] is something that I feel like as a clinician it is really hard to fully understand until you sit down with the parent and have heard all the stress they are under between raising the kids, being a single parent, not having money available for Christmas presents or hats or mittens.* – Interview B

**Support through peer consultation**

Support through the use of peer and supervisor consultation was something that clinicians found to be very helpful and useful in their work. Clinicians found that being in close proximity to other mental health professionals offered support and the availability to share ideas and feedback. Additionally, peer support through staff development trainings was also found to be helpful.

> *…I would say [Agency] has such a great team model.  I really like that about it in that you are always surrounded by other people that you are working with. We sit in offices with other clinicians.  Our supervisor, I would say, [supervisor's name] is very involved [with] how things are going in our rooms.*  -Interview A

However, all clinicians did mention that there were additional ways in which they could be supported at the agency and that the further up the ladder you went, the less support in place for you.

> *I mean ideally I would say that it would be nice to have a little bit more time after day treatment to be able to process those hard interactions, that's the biggest barrier that I see to kind of all of our staff being on the same page and making sure that they know how to handle the same situation next time if it didn't go well.* –Interview A

> *… as you go up the ladder there is less and less support available. For example, in my position, I do have one supervisor, and then I have people who are kind of at the same level as me who are also good for support.  But it can be difficult I know, for staff to find support just with conflicting schedules…* –Interview B

**Clinicians' use of self**

Clinicians offered many examples of ways in which they use their sense of self in engagement with children. The times and places that each clinician focused on in ways they use their sense of self as a tool to connect with children varied for each. Clinicians discussed ways that they change their voice or the way they are standing or sitting to let a child know that they are a safe/non-threatening adult. Other ways clinicians use themselves as therapeutic tools were through mirroring children's emotions. Additionally, a sub-theme discovered here was how clinicians use narration and consistency in their use of self to engage with kids.

*I think that really just working day after day after day increasing their trust in adults and building that bond so they really understand that there is somebody who they can attach to, who they trust, and who is going to be there on a daily basis and [be] reliable with their messages to them is really important.* -Interview B

*Through mirroring a lot and working with them. … So just kind of naming what it is and talking them through it…* -Interview C

*I think one of the key things in joining with a child is making sure that you don't seem scary to them depending on what their experiences have been. Some of those ways is really getting on the level on the child, so getting down, kneeling, talking in a slow, calm voice, and just letting them know that you kind of understand and that you can help them is how you become that regulating partner for them.* -Interview A

**Integration of four domains**

The four domains- relating, thinking, feeling, and acting, were represented within each interview. The clinicians have found ways to incorporate each domain into their daily day treatment session through various activities, visuals, or ways they engage with the children. In this theme, the researcher collected examples given by how each domain looks in various clinicians' unique treatment sessions.

One clinician described how he or she relates to children by joining, described in the relating domain, with a child during times of dysregulation:

*I would say the first step with a kid once they start day treatment is joining with the child. So really making sure that they know that you are there for them. So that kind of involves working solely on the relationship before talking about the behaviors and working on their goals.* –Interview B

Another way in which one clinician would incorporate thinking into the decision-making process was through the 'thinking sheets' mentioned earlier:

*But I would say the biggest thing I think about reflective thinking is doing that processing after they come down from their dysregulation, so once you kind of get to that calm and then there is that area for new learning...* –Interview A

Additionally, one clinician spoke about how reflective processing is used to correlate both the feeling and acting domains with the thinking domain:

*I start with a new child in day treatment talking through just saying how I think they are feeling. For example, 'I wonder if you were mad that the other child stole*

*your toy and that's why you hit them.' So kind of doing the processing for them*

*almost and then once they have been in day treatment a while and have kind of*

*adapted to that and learned some skills then let them have a chance. So say, 'I*

*wonder what made you mad?' or 'I wonder what made you throw the toy?' and*

*have them be able to think about that reflectively.* -Interview B

**Strengths-based DRM**

One theme that was discovered after conducting the interview was that all

clinicians believed the DRM was founded in primarily a strengths-based perspective.

While most clinicians did recognize that the model did illuminate the obstacles for or

challenges of the child, it primarily focused on the strengths and long-term goals.

Additionally, all the interviewed clinicians felt very pleased with the model and would

not want to modify the model as it appears right now.

*I don't think that it is strictly strengths-based because I think it does focus a lot on*

*the kid's dysregulation but it's also on how to fix it, which I see as strengths-*

*based even if it's not pulling direct strengths out of the child. But it does, I think,*

*work off of a few [strengths] like when is the child doing well and noticing that.* –

Interview A

*I would say it is a strengths-based framework, I am kind of hesitating because I*

*feel like the whole concept of repairing something that's broken is what I feel like*

*would not be strengths based, BUT, I am going to still say yes it is strengths-*

*based because once you move passed like 'yup you are going to repair this'*

*you're going to focus on what are the positive things and how can we keep*

*working with the positive things and I think that the model does a good job of working proactively into the future versus going into the past.* -Interview B

*I do, I do think it is very much a strengths-based framework because you are talking about ... yes in some respects you're talking about the deficits and what the kid is missing but you're also talking about this is how we are, we can best support them and these are the ways we can do that.* – Interview C

The themes found in this research were very illuminating in how clinicians are using the DRM within their own practice. Clinicians were able to provide unique perspectives on ways they feel as though the model is working for them and how they are individualizing it for the special children they are working with. Clinicians identified ways in which they incorporate the four domains of the model into the work by narrating, modeling, mirroring, and using their sense of self to connect with kids in a nonthreatening, therapeutic manner.  Ultimately, these clinicians find the model to be a strengths-based framework; however, they could not avoid that fact that they must acknowledge the presenting problem initially and then begin to focus on the strengths of the child.

## Discussion

The findings from this qualitative study match up closely with the findings of the literature review. However, what this data adds to the literature is the specific and detailed examples of ways in which the DRM is working for these participants.  This research paper was intended to be exploratory and uncover data to explore the how the developmental repair model is being used in social work practice.  Established through

the clinicians' given examples of ways in which they utilize the model, there are many ways the model has proven effective in their day treatment rooms.

An exploratory piece of this research was to discover how clinicians are using the DRM differently in their practice. Clinicians offered many great examples of ways they have taken the DRM and tried to create personal and unique visuals or phrasings to best suit the special needs found in their day treatment room. Clinicians were able to tweak the model and use it as a guide for the interventions in place in their classrooms.

The DRM describes using modeling as a tool for implementing skills in all four domains. This research found that all participants identified ways in which they incorporated modeling in to their practice with these children. In the relating domain, modeling is used to help modulate emotions and establish a relationship pattern of care (Gearity, 2009). In the thinking and feeling domains, clinicians used personal examples of narrating their own feelings to children about when they made a mistake and how they are fixing it, connecting both the thinking piece and the feeling piece by organizing the experience of making a mistake and fixing it without losing control of feelings. Finally, in the in the acting domain, clinicians help model behaviors by verbalizing as well as providing visuals for children to reference.

Gearity (2009) as well as researchers such as O'Connor and Zeanah (2003) and Zeanah, Berlin, and Boris (2011) identified the importance of family engagement in the work with young children. All clinicians supported this as well within their answers. Clinicians gave examples of engaging parents by using techniques such as psycho-education and implementing classroom strategies in the home. Additionally, clinicians

identified working with parents to better understand the parent's own memory of childhood and what being a child was like for them.  As discussed in the literature review this idea of exploring parental experiences of childhood was supported by Zeanah, Berlin, and Boris (2011) in their assessment of Fraiberg's work with Child-Parent Psychotherapy.

Another complimentary theme found in both the conceptual framework and the collected data was the use of the strengths perspective while working with the families. Saint-Jacques, Turcotte, and Pouliot (2009) discovered that social workers are using the strengths perspective when working with families struggling with challenges.   Clinician B in particular identified how actually hearing the parents' story of oppression and the challenges they are facing can help the clinician to better empathize with and understand the family. This can then lead to helping the family engage more in the treatment because they feel more supported.

An area of slight discrepancy found between the literature review and the data was in the support through peer consultation theme. Anne Gearity (2009) wrote of how important it is for staff to be allowed the opportunity to discuss difficult clients with peers to regain their own emotional balance.  Clinician A felt appreciation for the team model, however, also felt that there is a limited time for group processing of difficult client interactions.  Clinician B also pointed out that due to busy schedules it is hard to have find support from peers.

Gearity (2009) wrote, "By staying interested, we can regain our regulatory balance, and bring them back with us. […] Joining involves both physical availability and

mental attention" (p.45-46). We can see that through the use of self shown by the clinicians they are engaging with these children in very therapeutic ways. Clinician B explained how just the consistency of being physically present there every day helps to build trust. Additionally, Clinician C explained that he or she uses their sense of self to mirror the emotions of children. Finally, another example given in which the clinician can use his or her sense of self is to make sure to not appear scary or seem like a threat to the child. These clinicians showed how they use their sense of self through being available every day and as Dr. Gearity (2009) wrote, providing mental attention to things such as how they can appear in a nonthreatening way or using their own expressions to mirror for a child, can be very therapeutic and regulating for a child.

Throughout much of the literature review studies have shown that successful components to attachment repair therapies include providing a secure base for children and relationship-building opportunities (O'Connor & Zeanah, 2003; Clausen, Ruff, von Wiederhold, & Heineman, 2012). Through Dr. Gearity's work in developing the DRM and the four domains, these clinicians are able to make sure that there is an opportunity for relationship-building and developmental repair to take place within their treatment rooms, "We demonstrate our intention to help them. Because early regulatory learning is based on relationship reliability, we start by offering a new helping relationship" (Gearity, 2009, p. 45). Clinician B described building the relationship up through the relating domain before beginning to work on behaviors and goals. Through the thinking domain, Clinician A was able to explain how 'thinking sheets' help the child to visualize the thought process and begin to internalize that new learning. These findings relate well

with the literature in that according to the information present, these clinicians are providing the necessary pieces of successful attachment repair.

An area of exploration for this research that was not connected to the literature review was to obtain clinicians' perspectives on if they believed the model was strengths-based.  Clinicians offered unique insight into their beliefs of the model. All clinicians identified that they did in fact believe it was a strengths-based model but only to a point. The model does recognize the 'problems' that the children are experiencing and it does require the clinician to focus on these problems. However, as pointed out by Clinician B, once the problems have been identified, the model encourages the work to move forward and focus on positives while not dwelling on the past.

These findings can be integrated into multiple avenues of social work practice principles.  First, these findings can be used as a tool to engage in advocacy work for children's mental health services. There is much to lose if we do not provide children with disrupted attachments and families with the opportunity to repair and grow from early disruptive experiences. This model provides advocates with a language that can allow for discussion on what children need in their relationships to be successful. Additionally, the literature review completed suggests that if these children are not reached early there may be detrimental effects experienced later on in life.

This model can be used as a teaching agent for other agencies or even within social work academia.  Through the concepts and domains outlined, clinicians working with young children can have a resource to reference when questions arise or a particular behavior is puzzling.  Finally, future implications for policy and social justice issues

would be to increase funding for mental health agencies working with children to provide

more children with access to these services.

## Conclusion

Children with special needs due to attachment disruption have become a topic of

great interest for clinicians working with young children.  From previous research

conducted we know that attachment disruption can be caused by multiple factors such as

exposure to traumatic events, abuse, or neglect to name a few. This can cause children to

externalize their emotions by presenting with aggressive behaviors.  Research has shown

that these children struggle academically and socially because they do not have the skills

to modulate emotions and receive support from their environments.

Anne Gearity (2009) developed a model to help repair the disconnect created

when a child is confused about the role of healthy relationships in his or her life. Through

the DRM, Gearity (2009) outlines four domains that clinicians work on to reach and

repair behaviors with children.  Participants in this study provided additional information

on ways in which they utilize the model and ways in which they use their own clinical

judgment to enhance and individualize their technique such as narrating, joining,

mirroring, modeling, and family engagement and they found that DRM was helping them

to better understand and come up with interventions for these children.

This qualitative research adds to the growing body of literature and research that

is examining how children learn to cope with and repair attachment disruption. This

research provides the therapeutic community with more evidence that the DRM is

working effectively for clinicians that are providing services to young children.  Future

research should continue to concentrate on generating evidence for this model and circulating information on how clinicians are using the model to help individual clients. Finally, future research should aim to continue the conversation on how clinicians can incorporate a strengths-based framework into their work with children and families.

Ultimately the children of today are the future. As a society we need to make sure that we are offering all children a chance to be successful and happy in life. At-risk children are already overcoming obstacles that many cannot relate to. Children that have experienced a disrupted attachment in childhood may need additional help to relate to the world around them. According to this research, clinicians who integrated the DRM into their practice found it to be an effective tool while working with children who have a disrupted attachment. The individual and unique perspectives offered by the participants add detail and depth to the model, providing other clinicians and the social work field with new insights and supplementary resources for their work with young children with disrupted attachment.

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**Appendix A.** Agency Consent Form

# Agency CONSENT FORM

Researcher: Please provide your agency with the information about your project and have your agency contact complete this form.

Agency:  Please read this form and ask any questions you may have before agreeing to allow this study to take place at your agency. Please keep a copy of this form for your records.

| **Project Name** | Clinicians' Perspectives on the Developmental Repair Model | **IRB Tracking Number** | |
|---|---|---|---|

| General Information Statement about the study: |
|---|
| The aim of this qualitative research is to interview clinicians about their use of the Developmental Repair Model in their practice with children.  They will be asked what their views on the effectiveness of the model are. The research question that will guide this research is: What are clinicians' perspectives on the Developmental Repair Model? |

| Your agency is invited to participate in this research. The agency was selected as a host for this study because: |
|---|
| This agency actively uses the Developmental Repair Model and employs social workers and other clinicians who use the Developmental Repair Model. |

| Study is being conducted by: | Lauren Kelly |
|---|---|
| Research Advisor (if applicable): | Kendra Garrett |
| Department Affiliation: | Masters of Social Work |

| **Background Information** |
|---|
| The purpose of the study is: |
| It is of vital importance that as clinicians we are using an evidence-based practice that supports, encourages, and helps foster change in our clients. The aim of this qualitative research is to interview clinicians using the developmental repair model in their practice with children as to what their views on the effectiveness of the model are. The research question that will guide this research is: What are clinicians' perspectives on the Developmental Repair Model? This model is a recently established treatment intervention and the goal of this research is to gain insight on how clinicians are working with it, what they see as being strengths, and what they see as challenges of the Developmental Repair Model. |

| **Procedures** |
|---|
| Study participants will be asked to do the following: |
| *State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation,* |

| *frequency of procedures, audio taping, etc.* |
|---|
| The study participants will be invited to participate in a one hour interview regarding the Developmental Repair Model.  Participants will respond if they are willing to an email from the researcher to set up a time for an interview. On the day of the interview, before the interview begins, the participant will be asked to sign an informed consent.  The interview will then begin and is expected to last approximately one hour.  The interview will be audio recorded and then transcribed.  After transcribing, the audio recording will be destroyed and the transcription will be kept anonymous. |

**Risks and Benefits of being in the study**

| The risks involved for subjects participating in the study are: |
|---|
| A potential risk of participation could be clinicians feel worried if negative opinions shared on the effectiveness of DRM are not kept confidential, however, this will not happen due to the level of protection of human participants taken in this study. |

| The direct benefits the agency will receive for allowing the study are: |
|---|
| I will be sharing a copy of this study with the agency.  This research could help the agency discover areas in which the model is not being used completely or ways in which the clinicians are altering the model to better fit the specific needs of their clients. |

**Compensation**

| Details of compensation (if and when disbursement will occur and conditions of compensation) include: |
|---|
| There will be no compensation. |

**Confidentiality**

| The records of this study will be kept confidential.  The types of records,  who will have access to records and when they will be destroyed  as a result of this study include: |
|---|
| Only the researcher will have access to the records.  The audio tape will be transcribed and then destroyed when no longer needed. The consent forms will be kept in a lock box. Additionally, the transcripts will be kept on a password secured computer. If any transcripts are printed, they will be anonymous and kept secure in the lock box as well. |

**Voluntary Nature**

| Allowing the study to be conducted at your agency is entirely voluntary. By agreeing to allow the study, you confirm that you understand the nature of the study and who the participants will be and their roles.  You understand the study methods and that the researcher will not proceed with the study until receiving approval from the UST Institutional Review Board.  If this study is intended to be published, you agree to that.  You understand the risks and benefits to your organization. |
|---|

| Should you decide to withdraw, data collected about you | will be used in the study |
|---|---|

| Contacts and Questions | |
|---|---|
| You may contact any of the resources listed below with questions or concerns about the study. | |
| Researcher name | Lauren Kelly |
| Researcher email | xxx@stthomas.edu |
| Researcher phone | xxx-xxx-xxxx |
| Research Advisor name | Kendra Garrett |
| Research Advisor email | xxx@stthomas.edu |
| Research Advisor phone | |
| UST IRB Office | xxx-xxx-xxxx |

**Statement of Consent**

I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.

| Signature of Agency Representative<br>☐ *Electronic signature* | | Date | |
|---|---|---|---|
| Print Name of Agency Representative | | | |

| Signature of Researcher<br>☒ *Electronic signature\** | | Date | |
|---|---|---|---|
| Print Name of Researcher | Lauren Kelly, 11/15/12 | | |

*Electronic signatures certify that::

The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.

**Appendix B.** Example of cover letter sent through e-mail to Clinicians.


Dear _____

    My name is Lauren Kelly and I am a Master of Social Work student in the University of St. Thomas/St. Catherine University program. Part of the graduation requirement for this program is to conduct a research project. I have decided to focus my work on clinicians' perspectives on the effectiveness of the Developmental Repair Model.

    Because you work so closely with this model I would like to interview you about how you are working with it and what you see as strengths and challenges of the Developmental Repair Model.  I anticipate that the interview will take approximately an hour. Please be assured that participation is completely voluntary and that I will absolutely protect confidentiality. Furthermore, [Agency] will not know who chooses to participate and does not.

    If you think you might be interested please respond to this email.

Thank you for your time,

Lauren Kelly

**Appendix C.** Consent Form.

# CONSENT FORM

Please read this form and ask any questions you may have before agreeing to participate in the study.
Please keep a copy of this form for your records.

| Project Name | Clinicians' Perspectives on the Developmental Repair Model | IRB Tracking Number | |
|---|---|---|---|
| | | | |

| General Information Statement about the study: |
|---|
| The aim of this qualitative research is to interview clinicians about their use of the Developmental Repair Model in their practice with children.  They will be asked what their views on the effectiveness of the model are. The research question that will guide this research is: What are clinicians' perspectives on the Developmental Repair Model? |

| You are invited to participate in this research. You were selected as a possible participant for this study because: |
|---|
| The agency you are employed at actively uses the Developmental Repair Model. |

| Study is being conducted by: | Lauren Kelly |
|---|---|
| Research Advisor (if applicable): | Kendra Garrett |
| Department Affiliation: | Masters of Social Work |

| **Background Information** The purpose of the study is: |
|---|
| It is of vital importance that as clinicians we are using an evidence-based practice that supports, encourages, and helps foster change in our clients. The aim of this qualitative research is to interview clinicians using the developmental repair model in their practice with children as to what their views on the effectiveness of the model are. The research question that will guide this research is: What are clinicians' perspectives on the Developmental Repair Model? This model is a recently established treatment intervention and this research aims to gain insight on how clinicians are working with it, what they see as being strengths, and what they see as challenges of the Developmental Repair Model. |

| **Procedures** If you agree to be in the study, you will be asked to do the following: *State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.* |
|---|
| You will participate in a one hour interview regarding the Developmental Repair Model.  The |

interview will include questions about how you are working with the model and what you see as strengths and challenges of the Developmental Repair Model.  The interview is expected to last approximately one hour.  The interview will be audio recorded and then transcribed.  After transcribing, the audio recording will be destroyed and the transcription will be kept anonymous.

**Risks and Benefits of being in the study**

The risks involved for participating in the study are:

A potential risk of participation is that you might feel worried if negative opinions shared on the effectiveness of Developmental Repair Model are not kept confidential, however, this will not happen due to the level of protection of human participants taken in this study.

The direct benefits you will receive from participating in the study are:

The only direct benefit of this study is the opportunity to reflect on the Developmental Repair Model.

**Compensation**

Details of compensation (if and when disbursement will occur and conditions of compensation) include:

*Note:* In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment and follow-up care as needed. Payment for any such treatment must be provided by you or your third party payer if any (such as health insurance, Medicare, etc.).

There will be no compensation.

**Confidentiality**

The records of this study will be kept confidential.  In any sort of report published, information will not be provided that will make it possible to identify you in any way.  The types of records, who will have access to records and when they will be destroyed  as a result of this study include:

Only the researcher, Lauren Kelly, will have access to the records.  The audio tape will be transcribed with no identifying information and then destroyed. The consent forms will be kept in a lock box. Additionally, the transcripts will be kept on a password secured computer. If any transcripts are printed, they will be anonymous and kept secure in the lock box as well.

**Voluntary Nature of the Study**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any cooperating agencies or institutions or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the date\time specified in the study.

You are also free to skip any questions that may be asked unless there is an exception(s) to this rule listed below with its rationale for the exception(s).

You may change your mind about participation up until one week after the interview has been

| completed at which point I would not use your data. […] Participation in this study is completely voluntary. | | |
|---|---|---|
| Should you decide to withdraw, data collected about you | | will NOT be used in the study |

**Contacts and Questions**

You may contact any of the resources listed below with questions or concerns about the study.

| | |
|---|---|
| Researcher name | Lauren Kelly |
| Researcher email | xxx@stthomas.edu |
| Researcher phone | xxx-xxx-xxxx |
| Research Advisor name | Kendra Garrett |
| Research Advisor email | xxx@stthomas.edu |
| Research Advisor phone | xxx-xxx-xxxx |
| UST IRB Office | xxx-xxx-xxxx |

**Statement of Consent**

I have read the above information. My questions have been answered to my satisfaction and I am at least 18 years old.  I consent to participate in the study. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent to participate in the study.

| Signature of Study Participant ☐ *Electronic signature* | | Date | |
|---|---|---|---|
| Print Name of Study Participant | | | |

| Signature of Parent or Guardian (if applicable) ☐ *Electronic Signature* | | Date | |
|---|---|---|---|
| Print Name of Parent or Guardian (if applicable) | NA | | |

| Signature of Researcher ☒ *Electronic signature\** | | Date | |
|---|---|---|---|
| Print Name of Researcher | Lauren Kelly, 11/15/12 | | |

\*Electronic signatures certify that::

The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.