

Spring 2017

# A mixed methods study of a psychoeducational attachment-based intervention for families experiencing separation and loss

Kelly C. Atwood  
*James Madison University*

Follow this and additional works at: <https://commons.lib.jmu.edu/diss201019>



Part of the [Clinical Psychology Commons](#)

---

## Recommended Citation

Atwood, Kelly C., "A mixed methods study of a psychoeducational attachment-based intervention for families experiencing separation and loss" (2017). *Dissertations*. 136.

<https://commons.lib.jmu.edu/diss201019/136>

This Dissertation is brought to you for free and open access by the The Graduate School at JMU Scholarly Commons. It has been accepted for inclusion in Dissertations by an authorized administrator of JMU Scholarly Commons. For more information, please contact [dc\\_admin@jmu.edu](mailto:dc_admin@jmu.edu).

A Mixed Methods Study of a Psychoeducational Attachment-Based Intervention for

Families Experiencing Separation and Loss

Kelly Atwood

A dissertation submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Doctor of Psychology

Combined-Integrated Program in Clinical and School Psychology

May 2017

---

FACULTY COMMITTEE:

Committee Chair: Anne Stewart

Committee Members:

William Whelan

Craig Shealy

Cara Meixner

## Acknowledgements

It is with sincere gratitude that I would like to first acknowledge Dr. Anne Stewart, my academic adviser and dissertation committee chair. Anne, thank you for your guidance and encouragement. When I began the CI Doctoral Program, you told me it would be challenging and you told me there would be support. Both were true. You were a safe haven during those challenging times, you encouraged me to explore, and reminded me to play and enjoy the process.

Thank you to my dissertation committee. Dr. Bill Whelan, thank you for your generosity of spirit. You graciously shared your knowledge, resources, and time with me. Thank you for welcoming me to join in the facilitation of your Attachment Security Course and allowing me to study your course. Dr. Craig Shealy, thank you for your insight and perspective. You have a wonderful ability to see the forest for the trees and have moved me along throughout the dissertation process, helping me stay grounded in my values. Dr. Cara Meixner, I am in awe of your passion and dedication to teaching and research. Your assistance in developing a rigorous and sound methodology was central to the success of this project.

This process would not have been possible without the assistance of Somer George and Ariel Marrero. Thank you for your time and energy in helping to code qualitative data. Your willingness to be part of this project, your hard work, and your collaboration were instrumental in completing a study that allowed for participant voices to be heard.

I have been fortunate to travel this road with my CI cohort and the CI faculty, a strong, intelligent, and caring group of people. It has been a joy and an honor to be a part of the CI Program and to know and work with each of you.

Finally, I would like to thank my parents, Bill and Jan Atwood, and my husband, Matt Wade, for supporting me. You encouraged me, celebrated my successes, and comforted me when I felt uncertain. Thank you for your unconditional love and your patience. I love you!

## Preface

"We cannot separate the health of the individual from the health of the family, the community, and the world." -Patch Adams

Icimani (ee - chee - mah - nee) is the Lakota Sioux word for journey. A reflection of worldview, thoughts, and emotions, this Lakota Sioux word offers a way to frame my own development. My growth can be viewed as a journey influenced by culture, relationships, and resilience. The most impactful icimani of my life began when my parents and I left our family, friends, and familiar surroundings in Southwestern Michigan to live on the Rosebud Sioux Indian Reservation. Over the course of 11 years, we lived on four Native American Reservations in North Dakota, South Dakota, and New Mexico. My father was a dentist and Active Duty Officer in the Indian Public Health Service. My mother was a teacher and worked in the public schools and Head Start program. During this journey, I was influenced by beliefs associated with American, Native American, and military culture. The opportunity to learn with and from children and adults, from other cultures, to witness the power of place, and to embrace, and sometimes fight against, change has led me to value relationships, strive to acknowledge the relevant context, and search for adaptive ways forward on my icimani.

The values of culture, relationship and resilience, fostered in my youth, have continued to ground me as an adult as I navigate change and challenge. When I consider each phase of my life, there has been a caring relationship that centered me and provided encouragement and safety to engage with my environment and approach uncertainty and new demands. My parents provided this security in my youth, and as I have continued on my educational and professional journey, I have been fortunate to know advisors and

mentors who have generously shared their wisdom, and who support and delight in my growth. In this relational context, dimensions of resilience grew. I learned to reach out for help, offer assistance, regulate my emotions, make meaning, and cope adaptively.

Influenced by my journey, my identity as a clinical psychologist is one in which relationship provides the base for meaningful work, both with clients and with other professionals. It is an identity that approaches change and integrates new information. As I continue on my *icimani*, I hope to create and be involved in systems of care that honor the importance of relationship and personal reflection. As an active contributor in responsible, attuned systems of care, I plan to deepen my understanding of vulnerable individuals and families as they navigate change and challenge. As demonstrated in the literature and my own life, healthy interactions and responsive care correspond with increased emotional security, more satisfying interpersonal connections, and an enhanced ability to explore, bounce back, persist, and create adaptive ways forward.

## Table of Contents

Acknowledgements.....	ii
Preface .....	iv
List of Tables .....	viii
List of Figures .....	ix
Abstract.....	x
I. Introduction.....	1
II. Review of the Literature .....	5
Adoptive and Foster Families .....	5
Attachment Security Model and the Foster/Adoptive Population .....	5
Evidence-based Interventions Grounded in attachment theory.....	8
Attachment and Biobehavioral Catch-up.....	8
Theraplay .....	10
Child-Parent Relationship Therapy.....	11
Military-Connected Families .....	13
Veteran Parents and Traumatic Brain Injury, Posttraumatic Stress Disorder, and Substance Use Disorder .....	17
Attachment Theory .....	25
Purpose of Current Study .....	29
Research Questions .....	30
Qualitative Research Question.....	30
Quantitative Research Question.....	30
Special Topics in Parenting: A Guide for Therapists Using an Attachment Security Framework.....	31
III. Methods.....	32
Participants.....	32
Design .....	33
Procedures for Data Collection .....	34
Instruments.....	35
Qualitative Semi-structured Interview .....	35
Parenting Stress Index-4-Short Form.....	36
Child Behavior Checklist .....	37
Analysis.....	40
Qualitative Data .....	40
Quantitative Data .....	41
Integration of Qualitative and Quantitative Data.....	42

IV.	Results.....	43
	Qualitative Data .....	43
	Quantitative Data .....	51
	Parenting Stress Index .....	51
	Child Behavior Checklist .....	53
V.	Discussion .....	61
	Limitations of the Current Study .....	65
	Recommendations for Future Research .....	66
VI.	Appendices.....	69
	Appendix A: Consent to Participate in Research.....	69
	Appendix B: Registration Form.....	71
	Appendix C: Parenting Stress Index-4-SF.....	72
	Appendix D: Child Behavioral Checklist for Ages 6-8.....	73
	Appendix E: Child Behavioral Checklist for Ages 1 ½-5 .....	74
	Appendix F: Semi-structured Qualitative Questionnaire.....	75
	Appendix G: Special Topics in Parenting: A Guide for Therapists Using An Attachment Security Framework .....	78
VII.	References.....	104



## **List of Tables**

Table 1. Major Themes and Sub-themes. ....	44
Table 2. Side-by-side Table of Results .....	58

## List of Figures

Figure 1. Graphic Representations of Design .....	34
---	----

## **Abstract**

This mixed methods study examined foster and adoptive parents' experience of an attachment-based psychoeducational parent education course. A semi-structured qualitative interview explored parent perceptions of the course content and the impact of the course on parental stress levels, parent-child interactions, and child behavior in a sample of parent participants, after parents completed the 8-week Attachment Security Course. Prior to and following completion of the course parents completed quantitative measures of parenting stress, parent-child interaction, and child behavior. Due to the small sample size, the quantitative results were not interpretable in aggregate form. Emphasis was placed on the qualitative data to gather information about participants' experience. As the research process progressed a secondary product emerged, a special topics in parenting guide for therapists working from an Attachment Security intervention framework. The results of this study, combined with the literature and clinical experience of providing an Attachment Security course for Veteran parents were used to generate the guide.

## **Chapter I**

### **Introduction**

Each year hundreds of thousands of children and families involved in the United States child welfare system experience separation and loss. The Children's Bureau, an office of the Administration for Children and Families under the U.S. Department of Health and Human Services, works with State and local agencies to administer programs which aim to prevent child abuse and neglect, provide education and support resources to families, and provide safe homes for children who are unable to return home. Families typically become involved with the child welfare system due to suspected child maltreatment, including sexual, physical, or emotional abuse, and/or physical or emotional neglect (Child Welfare Information Gateway, 2013).

The Children's Bureau publishes the Adoption and Foster Care Analysis and Reporting System (AFCARS) data for each fiscal year. Preliminary estimates for the 2014 fiscal year indicate that 415,129 U.S. children were in the foster care system; 264,746 U.S. children entered the foster care system; 238,230 U.S. children exited the foster care system; 60,898 U.S. children, whose parental rights were terminated, were waiting to be adopted; 107,918 U.S. children were waiting to be adopted; and 50,644 U.S. children were adopted with public child welfare involvement (Children's Bureau, 2015). With such a large number of children and families experiencing separation and loss, many interventions intended to offer education and support to these families have been developed and studied.

Military families are another specific family population that frequently experiences separation and loss due to deployment and frequent moves. Historically, it

was not a necessity for the military to consider significant family support services, as the majority of service people were single men, however; as the system changed to an all-volunteer force, service member demographics changed. According to the Department of Defense (2013), which heads the United States military, there are approximately 2.5 million Active Duty and ready reserve military personnel, 42.7% of whom have families. Additionally, there are currently an estimated 21 million veterans of the United States military (Department of Veterans Affairs, 2014). In the National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses (Westat, 2010) it was reported that 75% of Veterans are married and 90% of the Veteran population has been married. Eighty-six percent of Active Duty spouses reported minor children or dependent older children, while 29.5% of Veteran spouses and 6.5% of surviving spouses reported minor children or dependent older children (Westat, 2010). As the demographics of the United States military have changed from a majority of single men to men and women, many of whom have families, there has been a call for available services and resources to adjust based on current military population needs. This includes implementing programs to serve military-connected families, who experience such challenges as frequent moves, separations, loss, and other military-related stressors.

Within the discipline of psychology, there are several theories particularly well positioned to address the unique challenges faced by both foster and adoptive families and the military-connected family population. First, the central focus of this paper, attachment theory, provides knowledge surrounding particular issues of separation and loss within the context of relationship. This is a complement to family systems theory in

terms of understanding the impact of the unique challenges related to separation and loss, often experienced by military families and foster and adoptive families, in the context of relationship.

Second, family systems theory allows for the families to be considered in the broader context in which they live. It allows the family to be viewed as a unit in which all members are connected. This means that life experiences, changes, and events that impact one member of the family system will impact all members of the system. This frame has important implications when considering the value of providing support to the entire family unit.

Research on interventions targeting the foster and adoptive family population has been extensive, however; despite acknowledgement by organizations including the Department of Defense, the Department of Veterans Affairs, Veterans, Active Duty Service Members, and other organizations that serve Veterans and service members, that there need to be increased services and resources for military-connected families, there continues to be a lack of evidenced-based interventions specific to the military-connected family population.

This study examined the impact of an 8-week attachment-based course for foster and adoptive parents on parental stress, child behavior, and parent-child interaction to inform future iterations of the course. The results are applicable to foster and adoptive families reaching out for support in their parenting endeavors, as well as other families who experience separation and loss, including military-connected families. The psychoeducational course is based in the Attachment Security model, grounded in

attachment theory, and has been used with many foster and adoptive families, however; this particular course has not previously been systematically evaluated.

The project is a mixed methods, convergent parallel design, with emphasis on the qualitative portion of the data and participant voices. Quantitative data was gathered using reliable and valid measures to provide additional information on the constructs of parent stress and child behavior. The data were collected concurrently. The intention was for data to be mixed during the interpretation phase after separate analysis, however; due to the small number of complete data sets for participants, the quantitative data is not interpretable in aggregate form.

The qualitative component of this study was used to identify and describe participants' experiences of the Attachment Security Course as it relates to course objectives, parent stress, child behavior, the parent-child relationship, and the participants' own unique experiences and insights. Prior to the course, quantitative data was collected on parent stress levels and child behavior. Instruments used included the Parenting Stress Index-4-Short Form (PSI-4-SF) and the Child Behavior Checklist (CBCL). After the final course session, parents completed a qualitative semi-structured interview as well as another PSI-4-SF and CBCL.

As the research project progressed a secondary purpose emerged, namely to develop a special topics in parenting guide for therapists working from an Attachment Security intervention framework. The results of this study, combined with the literature and clinical experience providing an Attachment Security course for Veteran parents were used to generate the guide.

## **Chapter II**

### **Review of the Literature**

#### **Adoptive and Foster Families**

According to the Child Welfare Information Gateway (2014), a service of the Children's Bureau, the Administration for Children and Families, and the U.S. Department of Health and Human Services, there were approximately 415,129 children in foster care in 2014. Twenty-nine percent of those children were placed with a relative and 46% were in nonrelative homes. For approximately 55% of the children in foster care, there was a goal of family reunification, and 51% of the children discharged from foster care in 2014 were reunited with their parents or primary caregiver. Families involved in the child welfare system experience disruptions and separations in the parent-child (or primary caregiver-child) relationship when developmentally, the child is reliant on the parent or primary caregiver to help them regulate and make sense of emotions, cognition, behavior, and physiology (Hertsgaard, Gunnar, Erickson, & Nachmias, 1995; Hofer, 1994, 2006).

#### **Attachment Security Model and the Foster/Adoptive Population**

In their chapter, *The Ongoing Crises of Disruptions and Dissolution in Foster Care and Adoption: Play and Filial Therapy to Repair Attachment Relationships*, Stewart and Whelan (2015) describe the hallmarks of typical, non-traumatic childhood development, as well as the hallmarks of separation and loss in childhood development. They also discuss implications for evidenced-based, theoretically grounded approaches to intervention with children, particularly children involved in the welfare system, who have experienced separation and loss.



In the context of typical, non-traumatic childhood development, children's needs for co-regulation of emotions can be met through playful interactions, soothing, and partnership behavior within a safe caregiving relationship. Children demonstrate secure attachment to their caregiver when they are able to be soothed by their caregiver and feel confidence in their caregiver to protect them and assist them in managing emotions and distress. Children involved in the child welfare system, however, experience separation from one or more caregivers, experience loss in regard to important relationships, and often worry about the physical and/or emotional wellbeing of their family members. Such separations frequently disrupt the opportunity for children to develop confidence in their caregiver's reliability to offer protection, comfort, and assistance in emotional regulation. Thus, many children involved in the child welfare system struggle with emotional regulation and have difficulty trusting and allowing caregivers and others help them to make sense of their thoughts, emotions, and behaviors (Stewart & Whelan, 2015).

Due to increased stress, lack of psychological, emotional or physical safety, lack of predictability, and/or a chaotic home environment many children who have been involved in the child welfare system display patterns of anxiety, over-arousal, emotional inhibition, or emotional dysregulation. Foster and adoptive parents may describe their children as having difficulty listening, paying attention, following directions, learning from mistakes, being honest, being respectful, sharing their feelings, and repairing ruptures in relationships. Early experiences of loss in relationships can directly impact core needs to feel valued, known, and loved. Even when an attachment relationship has a negative or unhealthy valence, worries about being rejected or unwanted may be

triggered when there is a separation or loss in that relationship (Stewart and Whelan, 2015).

Therapists with knowledge and clinical skills related to childhood development, the impact of trauma, and attachment theory, are well positioned to work with children, parents, and the parent-child dyad to address needs related to separation and loss. Healing requires attunement to the child's internal experiences and behavior in the following areas of attachment and functioning: need for protection, sensitive and reflective caregiving, co-regulation of experience, partnership behavior, support, and ability to repair rupture in relationship. When therapists and caregivers are accurately attuned to a child, they are increasingly reliable in their emotional responses to the child, and better able to assist the child in regulating their emotions, thoughts, and behaviors (Stewart & Whelan, 2015).

For positive therapeutic outcomes with children and families involved in the child welfare system, therapists should consider the following tenants of the therapeutic intervention: 1) therapeutic alliance with the child and family 2) knowledge of attachment theory 3) knowledge of the impact of trauma and trauma intervention 4) consultation with systems of care, particularly the school and child welfare agencies 5) knowledge of parent-child and family systems interventions 6) knowledge of child welfare policies, programs, and resources 7) knowledge of assessment measures that correspond with case conceptualization to determine the efficacy of the intervention and 8) recognition of cultural variables (Stewart & Whelan, 2015).

Children involved in the child welfare system experience disruption and separation from caregivers during developmentally sensitive time periods. The impact on

child development was reviewed and applicability of the Attachment Security model as an intervention was introduced. Next, evidence-based interventions grounded in attachment theory are reviewed.

### **Evidence-based Interventions Grounded in Attachment Theory**

A number of parenting interventions were reviewed, both commercially available and research project programs. Interventions grounded in attachment theory were identified for inclusion by demonstrating a focus on enhancing the parent-child relationship to address separation and loss, fidelity to attachment theory, and efficacy with the foster and adoptive population. Attachment and Biobehavioral Catch-up, Theraplay, and Child Parent Relationship Therapy were selected for further description due to their identification as evidence-based programs (SAMHSA, 2016).

**Attachment and Biobehavioral Catch-up.** Dozier, Zeanah, and Bernard (2013) reviewed an evidence-based intervention, designed for foster parents with foster children ages 0 to 5, that addresses the relational dimensions of synchrony, nurturance, stability of care, and commitment. The Attachment and Biobehavioral Catch-up (ABC) intervention is a 10 session, manualized program designed for implementation in the home of either foster parents or birth parents.

The focus is on the parents' behavior, and the authors note that synchronous and nurturing skills are targeted. Parents are asked to practice following their child's lead during various video-recorded activities and are given feedback as they review the videos. Additionally, the "coaches" provide feedback in session as parents demonstrate synchronous behavior or other behavior. Nurturance is addressed as parents view sample videos of families where the child's behavior does not elicit the type of nurturing care

desired. Psychoeducation is provided around the idea that children need their parents even when they do not clearly express this need. Following this intervention, parents are again provided feedback in their own sessions regarding their own nurturing behavior. Randomized control trials of this intervention with foster and birth parents referred by the child welfare system have demonstrated enhanced parental synchronous behavior and child attachment (Dozier, Zeanah, & Bernard, 2013).

Dozier, Zeanah, and Bernard (2013) identify four relational dimensions that allow for children to experience co-regulation of emotion, cognition, behavior, and physiology by a caregiver and experience optimal development. These dimensions include synchrony, nurturance, stability of care, and commitment. The authors define synchrony as “parents who follow the child’s lead in interactions” (Dozier, Zeanah, & Bernard, 2013, p. 166). By being in the child welfare system, children experience disruption in care, thus impacting optimal development. The authors suggest intervention is necessary for these children at the parent and systems levels to provide opportunities for children in the welfare system to receive synchronous and nurturing care, increase caregiver commitments, and decrease disruption in the parent-child relationship (Dozier, Zeanah, & Bernard, 2013).

The ABC program provides a theoretically grounded intensive intervention that directly addresses issues related to separation and loss frequently experienced by foster and adoptive families and targets important relational dimensions. Though relatively brief, the intervention is an intensive one, with various formatting for sessions including psychoeducation, coaching, and video-recorded sessions taking place in the families’ homes. While these methods are evidenced-based (SAMHSA, 2016) and theoretically

grounded, interventions that offer increased flexibility, while maintaining fidelity to the treatment régime, are needed. For example, there may be barriers related to confidentiality, liability, or third party payers and working in the families' home or videotaping sessions.

Two additional evidence-based interventions grounded in attachment theory and aimed at enhancing the parent-child relationship include Theraplay (Booth & Jernberg, 2010) and Child-Parent Relationship Therapy ( Bratton, Landreth, Kellam, & Blackard, 2006).

**Theraplay.** Ann Jernberg developed Theraplay (The Theraplay Institute, 2013), an attachment-based intervention, appropriate for parents with children ages 0-18, focused on the relational dimensions of structure, engagement, nurture, and challenge, aimed at strengthening an attuned parent-child connection. By providing opportunities for interactional play, in which the parent acts as a safe base, the child experiences security and organization. Enhancing the attachment bond leads to increased self-esteem, trust in others, and positive engagement. Family therapy is completed in approximately 20 sessions, with parents observing their child's treatment with an Interpreting Therapist in a separate room for first half of the therapy. The Interpreting Therapist discusses strategies, interactions, hopes, and concerns with the parents. In the second half of treatment, parents continue to spend part of the session observing and spend part of the session with the therapist in the Theraplay room. In the Theraplay room the parents become co-therapists and are coached as they interact with their child. The family then returns quarterly during the first year after therapy for "check-ups" and once a year thereafter (Jernberg, 1984). A study with children in long-term foster care in Finland

showed improvements for children across scales on the Child Behavior Checklist (CBCL) following Theraplay treatment. Following two intensive 4 day interventions with Theraplay, the children who had experienced abuse, neglect, and/or loss, showed a decrease of symptoms on the CBCL immediately post-intervention and then again after 6 months (Makela & Vierikko, 2004). Theraplay is considered an evidence-based intervention program and is listed on the Substance Abuse and National Health Service Administration's (SAMHSA, 2016) website for National Registry of Evidenced-based Programs and Practices (NREPP).

In sum, Theraplay is an evidence-based, theoretically grounded intervention focused on enhancing parent-child relationship through an experiential process. Though there is a manual to consult, the intervention is flexible in terms of application and location of services. This particular intervention requires that both children and parents participate, which could pose some difficulty in settings such as a Veteran's Affairs Medical Center, which provides direct service primarily to service member and spouse.

**Child-Parent Relationship Therapy.** Child-Parent Relational Therapy (CPRT), developed by Garry Landreth, PhD and Sue Bratton, PhD, is a therapeutic model based in filial therapy, child-centered play therapy, and attachment theory, which is intended for parents with children ages 3 to 8 years of age (Bratton, Opiola, & Dafoe, 2015). The parent-child relationship is identified as the mechanism for change and as an essential component for healthy child development. In the model, parents are trained in child-centered play therapy in a group setting, consisting of 6-8 parents. A total of 10 sessions are held, once a week for 2 hours. Parent goals are to develop the ability to respond to their children in an attuned, accepting, understanding, and empathic manner, to enjoy

their child and parenting, to gain confidence, and to better understand child development. Child goals include experiencing security in their relationship with their parent(s), expressing thoughts and emotion, and gaining an ability to better regulate their emotions and behaviors. Finally, a goal for the dyad is to have more satisfying parent-child interaction. Therapists are trained in CPRT and receive supervision prior to implementing this model of treatment. Therapists also receive a protocol and materials, though emphasis is placed on utilizing the protocol with clinical judgment based on client presentation, as opposed to rigidly adhering to the protocol. To date, 36 studies, with a total of 1,100 participants, have been completed examining CPRT's effects, 19 of which have an experimental design. Overall results demonstrate CPRT's effectiveness in reducing parental stress, improving parental empathy and decreasing negative child behaviors. These effects have been demonstrated with a number of populations and concerns including, children living in domestic violence shelters, children in the foster care system, children who have been adopted, children whose parent(s) have been incarcerated, children with chronic illness, children with learning difficulties, pervasive developmental disorders, speech problems, adjustment difficulties, children who have been sexually abused, and children who demonstrate various internalized and externalized behavioral concerns (Bratton, Opiola, & Dafoe, 2015).

CPRT is also theoretically grounded and boasts a strong evidence base. It is listed on the SAMHSA (2016) website for National Registry of Evidenced-based Programs and Practices (NREPP). Though there is a manual to guide therapy, it is not one that requires rigid adherence and allows for adaptation based on family presentation/need and the clinical judgment of the therapist. The intervention takes place in the clinic setting and

focuses on parent training. This particular intervention requires the therapist to have specific training in the intervention prior to implementation, which may make the intervention less accessible for some therapists.

A number of interventions have been developed and researched in an effort to provide effective education and support to foster and adoptive families. Interventions such as the ABC program, Theraplay, and CPRT are evidence-based, grounded in theory, and focus on enhancing the parent-child relationship in order to directly address the themes of separation and loss. The interventions vary in terms of flexibility, preferred location for services, and required family members present. The research on attachment-based family interventions completed to date can inform the development of interventions for other family populations, such as military-connected families, that frequently experiences stressors related to separation and loss.

### **Military-Connected Families**

“Military service is a reciprocal partnership between the Department of Defense, service members and their families.” -The Department of Defense

Historically, it was not a necessity for the military to consider significant family support services, as the majority of service people were single men, however; as the system changed to an all-volunteer force, service member demographics changed. According to the Department of Defense (2013), which heads the United States military, there are approximately 2.5 million Active Duty and ready reserve military personnel, 42.7% of whom have families. Additionally, there are currently an estimated 21 million Veterans of the United States military (Department of Veterans Affairs, 2014). In the National Survey of Veterans, Active Duty Service Members, Demobilized National



Guard and Reserve Members, Family Members, and Surviving Spouses (Westat, 2010) it was reported that 75% of Veterans are married and 90% of the Veteran population has been married. Eighty-six percent of Active Duty spouses reported minor children or dependent older children, while 29.5% of Veteran spouses and 6.5% of surviving spouses reported minor children or dependent older children (Westat, 2010). Though the statistics show many Active Duty Service Members and Veterans have families (Department of Defense, 2013; Westat, 2010), adaptation to support services following the changing demographics has been a relatively slow process (Albano, 1994).

Military-connected families are likely to face unique stressors during their service including separation and reunion, mobility, and dramatic lifestyle changes. Multiple separations, moves, and significant changes in the lives of military-connected families are frequently cited as impacting the wellbeing of children and family (Drummet, Coleman & Cable, 2003; Segal & Segal, 2006; Johnson et al., 2007). Despite the large number of military personal who have families and the understanding of unique stressors posed to the military families, there is a paucity of research involving intervention specific to military families (Drummet et al., 2003; Johnson et al., 2007; Riggs & Riggs, 2011).

While there is a lack of research related to intervention specific to military families, there is a body of research that has focused on the impact of military related stressors on the family unit, which can inform future and continued research related to intervention specific to military families. For example, one study examined military family functioning related to deployment, and children's responses to separation from a parent during Operation Desert Storm. Three hundred eighty-three children and the non-deployed parent participated in the study. Children and parents completed self-report

measures, and were divided into two comparison groups: families who had a parent deployed during Operation Desert Storm and families who had a parent at the military base during Operation Desert Storm (Jensen et al., 1996).

Results of this study indicated that children who experienced parental deployment demonstrated higher levels of child depression than children who did not experience parental deployment. No differences were found in anxiety levels or children's behavior problems as reported by their parents. Moreover, like their children, parents with deployed spouses also reported higher levels of depressive symptoms. These families reported a higher level of stressors during the year, compared with families of non-deployed personnel (Jensen et al., 1996).

The results of this study show that the functioning of the child and the non-deployed parent are closely linked. Results indicated that children of a deployed parent who have a higher level of symptoms also have a non-deployed parent with a higher level of symptoms and increased levels of family stress (Jensen et al., 1996). Consequently, the results of this study support the idea that it may be most effective to address the difficulties during deployment through systemic family interventions.

Finkel, Kelley and Ashby (2003) conducted another study focusing on the family unit. They examined the relationship between maternal factors, family factors, family mobility and mothers' and children's reports of child psychological wellbeing in military-connected families. A total of 86 mother-child dyads participated, with the majority from families in which the father was the Active Duty Service Member. Most participants were Caucasian, 30-40 years old, and had a college degree. Mothers filled out a series of questionnaires related to family cohesiveness, adaptability, marital satisfaction, maternal

depression, and stress, as well as child(ren)'s sadness, anxiety, with drawn behavior, aggression, and non-compliance. Children filled out a series of questionnaires related to loneliness, social avoidance, distress, fear of negative social evaluation, peer relationships, perceptions of self-worth, and attitudes toward their mothers. A series of multiple regression analyses were conducted.

While the sample lacked diversity, results were consistent with those of previous research. Researchers found that the longer a child lived in one location, the better their peer relationships were. They also found positive mother-child relationships were correlated with lower rates of loneliness, social isolation, and lower rates of fear of negative evaluation from others. Subsequently, mothers' depressive symptoms were found to be predictive of children's sadness, anxiety, and withdrawal. Children's feelings toward their mothers also were found to be predictive of mothers' reports of children's aggressive and non-compliant behaviors (Finkel et al., 2003). Together with previous research, this study highlights the reciprocal nature of interactions within family systems as well as the correlation between positive parent-child relationship and psychosocial wellbeing. Additional contributions could be made to the literature by including the entire family unit in such studies, to further the understanding of the impact of mobility on the family system as a whole. Future research would also benefit from inclusion of a theoretical frame, such as attachment theory, which conceptually addresses the impact of stressors. Studies that identify challenges military-connected families face can help inform intervention support.

## **Veteran Parents and Traumatic Brain Injury, Posttraumatic Stress Disorder, and Substance Use Disorders**

In addition to separation and loss military-connected families may experience due to death, deployment, or re-locations, military service members are at an increased risk for additional factors that can contribute to an experience of separation or loss, such as traumatic brain injury (TBI), Posttraumatic Stress Disorder (PTSD), and substance use disorders (SUDs).

TBI is often referred to as the signature injury of the Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) conflicts (Okie, 2005). Between 2000 and 2015, approximately 357,048 medical diagnoses of TBI were made in the military (Defense and Veterans Brain Injury Center, 2017). Though research has identified traumatic brain injury as impacting the family in psychological, cognitive, and behavioral domains, researchers (Pessar, Coad, Linn, & Willer, 1993) note that there has not been a significant amount of data collected on the impact of traumatic brain injury on parent and child behavior. A study was conducted to examine the effects of brain injury on children's behavior. Results from reports of uninjured parents showed 22/24 families identified increased acting out behavior, emotional, and relational problems in their child following the parent's brain injury. Twenty-three of twenty-four uninjured parents reported a negative change in the injured parent's parental behavior, identified as increased negative behavior, reduced positive behavior, and failure to fulfill the parental role. Ten of twenty-four uninjured parents reported relationship problems related to the child's withdraw from the injured parent (Pessar, Coad, Linn, & Willer, 1993).

Additional research has found that parents with TBI engage in less encouragement of developmental tasks, less nurturing, and demonstrate lower levels of activity with their children, as well as less adherence to rules. Uninjured spouses reported decreased feelings of love and acceptance toward their children. Parents with TBI and their children also reported higher levels of depression than comparison groups (Ulysal, Hibbard, Robillard, Pappadopulos, & Jaffe, 1998). Though more research needs to be done, the research to date indicates parental TBI is associated with decreased positive parental involvement with children, representing a relational loss.

In addition to the need for more research regarding the impact of TBI on parenting, Sherman et al. (2015) make a case for the necessity of further research regarding parent-child communication about parental PTSD. They note fifteen million adults in the United States will experience PTSD and have at least one child. Sixty-three percent of OEF/OIF veterans who have PTSD report children living in their home. They cite past research that identified a link between parental PTSD and behavioral and/or emotional difficulties in children. Moreover, parents with PTSD have reported more difficulties with parent-child interactions and lower rates of parenting satisfaction, than parents who do not have PTSD. Veterans with diagnoses of PTSD have reported low rates of expressiveness and cohesiveness in their families. Correlations between parental PTSD and poorer parent-child communication, problem solving and affective involvement have also been identified (Sherman, Larson, Straits-Troster, Erbes & Tasse, 2015).

Since difficulties with communication have been associated with PTSD, it may be particularly difficult for parents who have PTSD to discuss issues surrounding PTSD

with their children. Thus researchers examined a number of variables from the perspective of the Veteran with PTSD. They found many Veteran parents had some motivation to discuss PTSD with their children, however; many Veteran parents also cited detractors from communication related to avoidance symptoms of PTSD, shame, potential child distress, and potential damage to the parent-child relationship (Sherman, Larson, Straits-Troster, Erbes, & Tassej, 2015). Parents should not be pushed or forced to disclose such symptoms, and any disclosure needs to be done in a developmentally sensitive manner for the child. As noted in the literature, PTSD often presents a challenge to parent-child communication and emotional attunement, and an experience of separation or loss can result for both child and parent.

There is a strong association between PTSD and SUDs across civilian, Veteran, Active Duty, Guard and Reserve populations. Over 20% of Veterans with PTSD also have a diagnosis of SUD, and approximately 33% of Veterans treated for an SUD also have PTSD. Approximately 10% of Veterans of the conflicts in Iraq and Afghanistan have a problem with alcohol or other drug use. The Department of Defense conducted a Survey of Health Related Behaviors among Active Duty Military Personnel in 2008 and found that overall the military population showed less illicit drug use than the civilian population (2.3 percent of military personnel used in the month before data was collected), more prescription drug use than the civilian population (11% of service members reported misusing prescription drugs in 2008), and more alcohol use than the civilian population (20% of service members, and 27% of combat exposed service members endorsed binge drinking every week in the month data was collected). Data collected between 2004 and 2006 showed 1 in 4 Veterans aged 18-25 years old met

criteria for a SUD within a year of data collection. That is double the rate of SUD in Veterans aged 25-54 (National Institute on Drug Abuse, 2013), and accounts for a significant number of Veterans in an age bracket likely to have young children.

The National Institute on Drug Abuse (2003) identified the effects of substance abuse on parenting. Specific impact varied somewhat by drug type, and common possible effects included neglecting parental responsibilities, parental emotional dysregulation, inattention to children's basic needs, exposure of the child to unsafe situations, lack of supervision, and inability to provide structure. Such common possible effects threaten children's need for protection, support, sensitive caregiving, co-regulation of experience, and partnership behavior.

With all the potential stressors facing military families, the American Psychological Association (APA) established the Task Force on Military Deployment Services for Youth, Families and Service Members in 2006 in response to the need for intervention support. The Task Force was assigned the responsibility of identifying mental health needs of military-connected families and constructing a plan to address those needs. The Task Force examined current literature as well as surveys conducted by military-connected family organizations. The Task Force identified the lack of rigorous research conducted specifically on the mental health and the wellbeing of service members and families during periods of major military operations as a major limitation in their report. They also found that installation-level military medical treatment facilities and the military medical centers and clinics depend on designated psychologists or independent local providers to establish and employ programs supporting service members with deployment related issues. Thus, the content and consistency of programs

varied across sites based on availability of professionals, their experience, and command support for mental health programs. The Task Force reported that while psychologists are modifying evidence-based treatment programs for usefulness with military service members, there continues to be a lack of empirical evidence to support use of such treatment programs with service members and their families addressing deployment issues. Additionally, the empirically supported programs that are established are primarily for service members as opposed to family members or the family unit, who may also require or benefit from services (Johnson et al., 2007).

Despite the lack of rigorous research available on interventions specific to military-connected families, there are a number of literature reviews that highlight and summarize the current available literature, needs identified in the literature, and future directions research may take. Paley, Lester, and Mogil (2013) compiled one such article that uses a family systems and social ecological lens to contextualize military families' experience of deployment(s) at an individual, dyadic, and family level. Specifically, the authors examine how deployment impacts the service member and each of the family members (e.g., parenting, couples, co-parenting), the impact of deployment on life transitions (such as the cycle of deployment and family life cycle), moderating factors in the military families' deployment-related experiences (e.g., age of child, gender of child, length of deployment, family constellations, family members understanding of deployment, social support, embeddedness in military community, historical and sociocultural context) and areas that require further research (e.g., need for process oriented research, longitudinal research, special populations, prevention and intervention research). The authors assert that in order to provide responsive and effective care, it is



imperative that mental health clinicians and researchers understand the challenges and experiences of military-connected families. In addition to the authors' systemic theoretical frame, of particular interest to the current study, the authors conclude that there is a need for prevention and intervention research for the military-connected family population. They note, family members play a significant role in helping or hindering a service member's wellbeing. They state, it is necessary for the systems of care to provide preventative care to promote resilience in military-connected families (Paley et al., 2013). While the importance of the family system is highlighted in this review, it does not comment on or identify a conceptual grounding in theory that addresses issues specifically related to separation and loss.

Specific interventions and programs have been designed and implemented in response to military-connected family needs. Operation Building Resilience and Valuing Empowered (BRAVE) Families (OBF) was implemented by the Child and Adolescent Psychiatry Services at Walter Reed National Military Medical Center (WRNMMC). The initiative was developed as a preventative intervention that is collaborative and educational in nature. When service members are seen at the hospital opportunities are presented for their families to participate. The family members may complete the Parent Guided Assessment Instrument (PGA-I) to determine needs, and family, individual, therapeutic art, and play-based interventions may be offered (Smith, Chun, Michael, & Schneider, 2013).

OBF provides a flexible, needs based intervention in a manner that is collaborative. The pre-clinical nature of the program reduces concerns related to stigma and provides approachable support and information. At this time, research has not been

conducted to evaluate the efficacy of the program. Additionally, theoretical grounding for the interventions, such as attachment theory is not provided, nor are details of interventions. More information regarding the conceptual frame or theoretical grounding as well as the specific interventions utilized would be helpful in better understanding the utility of the intervention. There is an ongoing need for the development of interventions that are flexible enough to serve military-connected family needs across settings and specific enough to provide some continuity of care. Accessibility to providers should also be considered.

One recent research study related to a specific military-connected family intervention provided a longitudinal examination of the program, Families OverComing Under Stress (FOCUS). The program was developed based on family systems theory and the corresponding developmental and intervention research. FOCUS, a free, 8-session, individual family program identifies itself as a preventative intervention, intended to increase resilience in military-connected families who have experienced parental military service during wartime. Specific aspects of interventions included in FOCUS are an assessment of family resilience, psychoeducation, and development of a shared family narrative, as well as resilience skill building (Lester et al., 2016).

The study was implemented by the US Navy's Bureau of Medicine and Surgery in 15 US and international locations between July 2008 and December 2013. The sample included 2,615 active-duty military families. Adults and children over the age of 6 completed standardized assessments at the intake, upon completing FOCUS, and then again 1 month and 6 months post completion. Measures were used to assess parental psychological health, child psychological health, and prosocial behavior, family

functioning, parent posttraumatic stress, anxiety in children, and children's coping skills. Lester et al. (2016) built on previous findings, which indicated that FOCUS reduced parent and child psychological health risk symptoms, improved family adjustment, and fulfilled the expectations of the participants, to determine whether or not the improvements were consistent over time for all family members. Using previously collected data, researchers aimed to inform services and make improvements in available services. Patterns of change in child and parent psychological wellbeing were evaluated over time. Improved family adjustment and increased levels of resilience in parents and children were maintained (Lester et al., 2016).

The authors make a significant contribution to the literature by beginning to bridge the existing gap between the call for increased services specific to military families and the lack of research on such interventions. Lester et al. (2016) acknowledge the timeline of their study was based on public health need and indicated that the optimal design may have been a randomized control trial, which there was not time to implement. While a randomized control trial would provide valuable information, a mixed methods design would provide a more congruent link to the study's apparent advocacy paradigm. Including the voices of the participants by adding a qualitative component to such studies would aid in understanding the nuances and complexities of military-families' experiences of particular interventions. Additionally, the FOCUS program lacks grounding in a conceptual frame specifically addressing issues related to separation and loss.

Though the above-mentioned studies and literature cite the importance of working with the military-connected family unit, attachment theory is not cited. The Attachment

Security model compliments a family systems conceptualization by highlighting the influence of relationship or connection between family members. The Attachment Security model in particular, offers insight into the impact separation and loss, concerns central to the military population, can have on families.

Military demographics have changed, and a population that once consisted of a majority young single men now includes roughly 43% of service members who have families (Department of Veterans Affairs, 2014). Military family members face unique stressors related to military service, such as separation and loss related to deployments, multiple moves and significant life changes (Drummet, Coleman & Cable, 2003; Segal & Segal, 2006; Johnson et al., 2007). There is a limited body of research that examines the impact of such stressors on the family unit, and there is an extremely limited amount of research related to the efficacy of intervention programs specifically for the military-connected family population (Johnson et al., 2007; Paley, Lester, & Mogil, 2013). There are a number of literature reviews that summarize the current research that may inform intervention programs and identify the need for the study of specific interventions.

### **Attachment Theory**

Connections are made in the literature between the relevance of attachment theory and both adoptive and foster families as well as the military-connected family population. As defined by theorist John Bowlby, “Attachment behavior is any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world” (1988, p. 26-27). Attachment theory posits that an infant’s instinctual responses integrate into attachment behavior during the first year of life (Bowlby, 1958), and that the infant’s connection

with the primary caregiver is essential in the development of cognitive, affective, social-emotional, neurological, and behavioral functioning (Bowlby, 1988). Attachment theory directly addresses issues surrounding needs being met and relational patterns surrounding separation and loss: separation and loss being specific challenges faced by adoptive and foster families and often military-connected families, particularly those families who have experienced a deployment.

The relationship between attachment theory, child welfare, and military family systems can be traced back to the early phases in the development of attachment theory. Some of the first recorded observations of parent-child separation were in the 1940's during World War II in the Hampstead Nurseries. Anna Freud and Dorothy Burlingham observed children aged 0 to 4 years old, who had been separated from their parents and cared for in a wartime nursery (Bowlby, 1982). Freud and Burlingham's work culminated in their 1944 book, *Infants without Families*. Through their observations around the power of emotional attention, Freud and Burlingham concluded that 1) it is preferable to raise children in families as opposed to orphanages, which served as powerful evidence to drive the practice of adoption, and 2) attachment is essential to healthy development (1944).

Research has demonstrated insecure patterns of attachment present a vulnerability to maladaptive responses, which are increasingly likely to occur during periods of elevated stress (Kobak, Cassidy, Lyons-Ruth, & Ziv, 2006). For example, an insecure attachment pattern present in the parent who remains at home during a deployment with children is correlated with less than ideal parenting strategies, which impacts the children's attachment patterns (De Wolff & van IJzendoorn, 1997). Several studies have

indicated that emotional distress of partners at home during deployment is positively correlated with insecure attachment styles and family disruption during separation (Cafferty, Davis, Medway, O'Hearn, & Chappell, 1994; Medway et al., 1995).

According to Cafferty et al. (1994), a secure pattern of attachment can support adaptive responses during reintegration. Additionally, common psychological concerns experienced by Veterans, such as depression and trauma symptoms are associated with marital problems, parental dissatisfaction, parenting disagreements and lower levels of family functioning (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Hendrix, Erdmann, & Briggs, 1998; Kessler, 2000).

A wealth of studies have examined the relationship between secure attachment patterns and positive child development (Sroufe & Siegel, 2011; Sroufe, England, Carlson, & Collins, 2005; Van Ijzendoorn & Bakermans-Kranenburg, 2009). Mary Ainsworth, a developmental psychologist famous for her work in early emotional attachment, identified parent/caregiver attunement as the essential component in the development of secure attachment (Ainsworth, et al, 1978). Additional studies have found reflective functioning to be strongly associated with secure attachment and positive developmental outcomes (Fonagy & Target, 1997; Bick & Dozier, 2008). Reflective functioning involves the parent's/caregiver's ability to see the child in the context of development, and family systems, in addition to demonstrating awareness and regulatory skills related to one's own emotions. Co-regulation, or mutual regulation, of the child's experience, including the child's thinking, emotion, and behavior has also been identified as an important component of positive developmental outcomes (Tronick, 2007). Co-regulation requires parents/caregivers to integrate attunement and reflection to provide a

response that is likely to meet the child's relationship needs.

These three components are integrated into the Attachment Security intervention approach. This intervention involves observing child interactions to better understand internal experience and relationship needs (Whelan & Stewart, 2015). Just as Whelan and Stewart (2015) discuss in their description of intervention by a play therapist utilizing the Attachment Security frame, in the Attachment Security Course foster care and adoptive parents are taught to observe children in parent-child interactions via video clips, in terms of proximity and contact seeking, interaction maintenance, body orientation, tone of voice, content of speech, affect, eye gaze, and body language. From the video observations, and in reference to a developmental framework, parents/caregivers develop the ability to distinguish accurate signals from inaccurate signals, also known as miscues or noise, and make inferences about the child's feelings, thoughts, and needs based on the interaction.

Attachment-based interventions are also a good fit for use with the military-connected family population, as well as other families experiencing separation and loss, because they are grounded in decades of empirical research and theory. The approach of using video observations to build the child-parent relationship by helping parents understand children's reactions to separations and reunions has already been suggested for use with military-connected families (Paris, DeVoe, Ross, & Acker, 2010). It has been suggested that relationship-based interventions are appropriate for military families who have experienced parental trauma symptoms, disrupted attachments, or both (Paris et al., 2010).

The current study is the first step in a proposed line of research toward building on the literature that identifies changing military demographics: Approximately 43% of service members now have families (Department of Veterans Affairs, 2014) and a need to develop interventions for the military family unit (Johnson et al., 2007; Paley, Lester, & Mogil, 2013). A limited body of previous research has shown military family members face unique stressors related to military service, such as separation and loss related to deployments, multiple moves and significant life changes (Drummet, Coleman & Cable, 2003; Segal & Segal, 2006; Johnson et al., 2007). Consequently, there is also a paucity of research related to the efficacy of intervention programs specifically for the military family population (Johnson et al., 2007; Paley et. al., 2013).

### **Purpose of the Current Study**

The purpose of this dissertation research project is to study foster and adoptive families' experience of an 8-week attachment-based parent psychoeducational course and the utility of the Attachment Security framework as it maps onto course objectives, parenting stress, child behavior, and parent-child interaction, in addition to parents' own unique experiences. Analysis of results are used to inform future iterations of the course for foster and adoptive families, as well as other families experiencing separation and loss, particularly the military-connected family population.

The psychoeducational course is based in the Attachment Security framework and has been provided to foster care and adoptive parents for 3 years. The project used qualitative interviews, and quantitative measures, examined through the lenses of attachment theory and a family systems approach in an effort to promote the wellbeing of families who experience stressors related to separation and loss. The project evaluated



the intervention in an effort to inform support services available for foster and adoptive family populations as well as other family populations experiencing separation and loss, such as the military-connected family unit.

### **Research Questions**

This study used a mixed-method approach, with emphasis on the qualitative data, to examine foster and adoptive families' experience of the Attachment Security course as it maps onto course objectives, perceived levels of parental stress, child behavior, parent-child interaction quality, information learned related to course objectives, as well as parents' own unique experiences.

The main questions for this study are:

**Qualitative Research Question.** Qualitative data are used to develop a deeper understanding of the ways in which the Attachment Security Course was relevant, or not, to parent concerns and goals related to parenting stress, child behavior, and parent-child relationship. Additionally, the qualitative data provides insight into parents' unique experience of the course and helps identify which components of the course were most helpful. How was the Attachment Security Course relevant, or not, to overall parent experience as well as parent concerns and goals related to parenting stress, child behavior, and parent-child relationship?

### **Quantitative Research Questions.**

**Question 1.** How is parent-child interaction quality, as measured by the Parenting Stress Index (PSI-4-SF), impacted following the 8-week attachment-based psychoeducational course?

**Question 2.** How are levels of parenting stress impacted following the 8-week

attachment-based psychoeducational parent course? This will be determined through scores on the Parenting Stress Index.

*Question 3.* How will ratings of problematic child behavior be impacted as measured by Child Behavior Checklist (CBCL)?

### **Special Topics in Parenting: A Guide for Therapists Using an Attachment Security Framework**

An unanticipated outcome of the study was the creation of the **Special Topics in Parenting: A Guide for Therapists Using an Attachment Security Framework**. The **Special Topics in Parenting: A Guide for Therapists Using an Attachment Security Framework**, describes special parenting topics from an attachment theory perspective and provides a model for therapists to consider when exploring sensitive parenting issues with clients. The guide is based on results of the current study, literature related to sensitive topics in parenting, as well as clinical experience conducting an Attachment Security course with Veteran parents (Appendix G).

## **Chapter III**

### **Methods**

This mixed methods study is situated in the advocacy-transformation paradigm, as it is the position of this researcher that further research and implementation of programs developed to serve families experiencing separation and loss, need to be explored and developed. The current study examined foster and adoptive families' experience of an 8-week attachment-based psychoeducational course, particularly in relationship to parenting stress, child stress, and parent-child interaction.

Qualitative data were used to develop a deeper understanding of the ways in which the Attachment Security Course was relevant, or not, to parent concerns and goals related to parenting stress, child behavior, and parent-child relationship. Additionally, the qualitative data expanded on what specifically parents learned from the course and helped identify which components of the course were most helpful.

The quantitative research questions were as follows:

Question 1. How is parent-child interaction quality, as measured by the PSI-4-SF, impacted following the attachment-based psychoeducational course?

Question 2. How are levels of parenting stress impacted following the 8-week attachment-based psychoeducational parent course? This will be determined through scores on the Parenting Stress Index.

Question 3. How will ratings of problematic child behavior be impacted as measured by Child Behavior Checklist (CBCL)?

### **Participants**

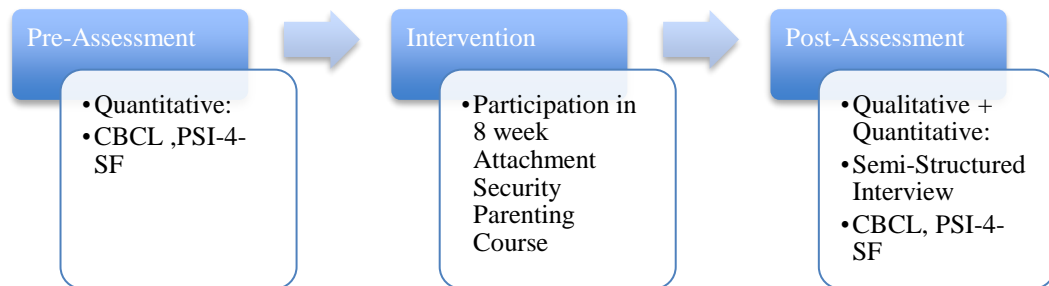
Participants in this study were adoptive and foster families in a mid-Atlantic

region with a child (or children) between the ages of 3 and 18 living in the home, who were referred to the Attachment Security Course by the local Department of Social Services. All parents participating in the course were offered the opportunity to participate in this research study as well. A total of 4 of 6 parents elected to participate in the study, representing participation from 2 family units. All participants were Caucasian and both couples were heterosexual (male/female). Participants 1 and 2 were a couple in their 40's who focused on their relationship with their 15 year old foster son, whom they were in the process of adopting. Participants 3 and 4 were a couple in their 50's, who focused on their relationship with their 3 year old foster son.

### **Design**

The current study is an intervention mixed methods study (refer to Figure 1), a type of nested design in which qualitative and quantitative data are collected concurrently, analyzed separately, and then merged (Creswell & Plano-Clark, 2011). The qualitative strand of the study included a post-intervention semi-structured interview to learn more about participants' unique experiences of the course. The quantitative strands of the study were administered both pre and post-intervention and included data derived from self-report questionnaires including the Parenting Stress Index (PSI-4-SF) and the Child Behavior Checklist (CBCL). Both qualitative and quantitative data were collected with the intention of converging the two forms of data to bring greater insight than would be obtained by either type of data separately. Qualitative strands of data are weighted more heavily, and due to the small sample size, the quantitative data were analyzed descriptively, versus the initial intent to utilize inferential statistics (i.e., Wilcoxon).

Figure 1

*Graphic Representation of Design***Procedures for Data Collection**

Prior to the study, permission from the Institutional Review Board (IRB) at James Madison University was granted to conduct the research project. Participants for this research (n=4) came from a private mental health clinic in Virginia. Participants were made aware of the study via announcement at the clinic. Interested parents were provided with more information and given the opportunity to ask further questions about the project.

Prior to the intervention, the parent(s) were asked to complete an informed consent document, followed by self-report measures. They began by completing the Parenting Stress Index (PSI-4-SF) and Child Behavioral Checklist. The PSI-4-SF identifies parent level of stress and locates the source of the stress in the Parent and/or Child Domain. The Child Behavioral Checklist is a parent's rating of child social-emotional-behavioral functioning.

Following the administration of the pre- assessment measures, the parent/primary caretakers (dyad) participated in the 8-week attachment-based, psychoeducational course, developed for adoptive and foster care parents. The Attachment Security Course focused

on identifying children's attachment patterns, areas of resilience, and difficult emotional and behavioral habits related to stress and changes. The focus then turned to ways of shaping children's behavior, emotions, and building cooperation and satisfying parent-child interactions.

Participants viewed videotapes of various child interaction patterns (typical development as well as children under stress). Parents were given opportunities to practice identifying children's emotional signals, making sense of confusing behaviors, and helping children cope more effectively with stressors. The course materials are informed by research in child development, neuroscience, and the experience of families. Parents received evidenced-based information about making sense of children's confusing and difficult behaviors, identifying children's strengths, as well as emotional needs, and additional ways to improve children's behavior and mood.

Upon completion of the course, parents/primary caregivers completed a post assessment, including a semi-structured interview as well as a follow-up CBCL and PSI-4-SF.

## **Instruments**

**Qualitative Semi-Structured Interview.** A semi-structured phenomenological follow up interview (see Appendix F) was conducted after the final course session to provide an opportunity for participants' voices to be heard. The brief semi-structured phenomenological interview focused on participants' experience of the course, particularly in relationship to parenting stress, child stress, and parent-child interaction quality. The interview was grounded in Rubin and Rubin's (2012) Responsive Interviewing Model, which places emphasis on the participants' experiences and

worldview. As such, questions were designed to be open-ended, allowing participants to share their thoughts without the restriction of close-ended or leading questions. The influence of the interviewer's personality, beliefs, and style are considered as they impact the exchange between interviewer and interviewee. In addition to the awareness of the interviewer's stimulus value, the interviewer avoided imposing her views on the interviewees by using active listening skills and asking follow-up questions relevant to the information shared by the interviewee. Attention was also given to the ethical implications for the relationship in which personal information was exchanged (Rubin & Rubin, 2012).

**Parenting Stress Index-4-Short Form (PSI-4-SF).** The Parenting Stress Index-4-Short Form (PSI-4-SF) is a measure of overall level of parental stress, as well as child and parent characteristics that may serve as source of stress within the family. It focuses on the parent, the child, and parent-child interactions. The PSI-4-SF contains 36 items, consisting of statements on a 5-point Likert-type scale with response options ranging from "strongly agree" to "strongly disagree." A total score and three subscales are generated including Parental Distress (PD), Parent-Child Dysfunctional Interaction (PCDI), and Difficult Child (DC). Factor analytic studies related to the full-length PSI determined the three subscales were the best way to capture information related to the parent-child system in short form. There is also a measure of test taking behavior, the Defensive Responding score. The Total Stress score identifies personal parental distress, distress related to the parent-child interaction, and stresses resulting from child behavior. The PD score determines distress related to personal factors such as concerns regarding parenting competence, stresses associated with the restrictions on other life roles, conflict

with the other parent, lack of social support, and depression. The P-CDI score describes the extent to which the parent perceives that the child is a negative aspect of his/her life and does not meet his or her expectations. The DC score focuses on child behavior related to temperament or learned behaviors. The normative range for scores is within the 16<sup>th</sup> to 84<sup>th</sup> percentiles. Scores in the 85<sup>th</sup>- 89<sup>th</sup> percentile range are described as high, and scores in the 90<sup>th</sup> percentile or higher are considered clinically significant. The Defensive Responding score is considered low if the raw score is 10 or lower.

The PSI-4-SF has been shown to have good internal consistency with coefficient alpha reliability ranging from .88 to .95 for the subscales. Test-retest reliability for the original PSI-SF has demonstrated a correlation coefficient at .84 for the Total Stress scale, .85 for the Parental Distress scale, .68 for the Parent Child Dysfunctional Interaction, .78 for the Difficult Child scale. As it the measure is derived from the original PSI, it is assumed to have similar validity to the full-length PSI. The correlation between the Total Stress scale on the PSI and the Total Stress scale on the PSI-4-SF was .98 (Abidin, 2012).

**Child Behavior Checklist (CBCL).** The Child Behavior Checklist (CBCL) is a measure of a child or adolescent's emotional, social, and behavioral problems, which is completed by parents. The CBCL for ages 6-18 combines a 113-item behavior problems-checklist with a seven-part social competency checklist, with items focused on the child or adolescent's behavior within the past 6 months.

The CBCL school-age form items are divided by: three Competence Scales (Activities, Social, School); a Total Competence Scale score; eight Syndrome Scales (Aggressive Behavior, Attention Problems, Delinquent Behavior, Social Problems,



Somatic Complaints, Thought Problems, Anxious/Depressed, and Withdrawn); an Internalizing Problem Scale score; an Externalizing Problem Scale score; and a Total Problem Scale score.

Scores are identified as falling into a normal, borderline, or clinical range. Competence scores with a T score of less than 31, falling below the 2<sup>nd</sup> percentile define the clinical range. The borderline range is identified as a T score of 31-35, falling between the 2<sup>nd</sup> and 7<sup>th</sup> percentiles. The normal range is defined as a T score greater than 35, above the 7<sup>th</sup> percentile. The Total Competence Scores, obtained by summing raw Competence Scores, have a less conservative cut point. These scores fall in the clinical range if T is less than 37 (below the 10<sup>th</sup> percentile), the borderline range when T falls between 37 and 40 (in the 10<sup>th</sup> to 16<sup>th</sup> percentiles), and the normal range when T is greater than 40 (above the 16<sup>th</sup> percentile). Scores on the Syndrome Scales are in the clinical range when they fall above the 97<sup>th</sup> percentile ( $T \geq 70$ ), and are in the borderline clinical range when they fall between the 97<sup>th</sup> and 93<sup>rd</sup> percentile ( $70 > T > 64$ ). Scores are in the normal range when they fall below the 93<sup>rd</sup> percentile ( $T \leq 64$ ). For the Internal, External, and Total scores, T scores above 63 (above the 90<sup>th</sup> percentile) are in the clinical range; T scores between 60 and 63 (84<sup>th</sup> to 90<sup>th</sup> percentile) fall in the borderline range; and T scores below 60 (below the 84<sup>th</sup> percentile) fall in the normal range.

For the CBCL ages 6-18, reliability was also very high, with most test-retest rs falling between .80 and .90. The rs for Total Competence and Total Problems fell between .91 and .95. Additionally, all items discriminated significantly ( $p < .01$ ) between demographically matched referred and nonreferred children (Achenbach & Rescorla, 2000).

The CBCL for ages 1 ½-5 consists of a 100-item behavior problems checklist, as well as a descriptive response section. Checklist items on both versions use a three-option response scale (0/1/2) for each problem with 0 indicating not true for their child, 1 indicating somewhat or sometimes true, and 2 indicating very true or often true. Items are focused on the child's behavior within the past 2 months.

The Syndrome Scales are comprised of clusters of behavior that represent particular types of problems, such as the Sleep Problems Scale. Scores are identified as falling into a normal, borderline, or clinical range. Scores in the clinical range fall above the 97<sup>th</sup> percentile, scores in the borderline clinical range fall between the 97<sup>th</sup> and 93<sup>rd</sup> percentile and scores in the normal range fall below the 93<sup>rd</sup> percentile. Some Syndrome Scales are more broadly categorized into Internalizing and Externalizing categories. The Total Problems score sums the Internalizing and Externalizing Scales, the Sleep Problems Scale, as well as other problems that are not on any of the Syndrome Scales. Scores for the Internalizing, Externalizing, and Total Problems Scales, that fall above the 90<sup>th</sup> percentile are in the clinical range, scores between the 90<sup>th</sup> and 83<sup>rd</sup> percentile are in the borderline clinical range, and scores below the 83<sup>rd</sup> percentile are in the normal range.

The DSM-5-Oriented scales relate the identified behavioral and emotional problems to DSM categories. These do not correspond exactly to the DSM disorder criteria, however. Scores on the DSM-5-Oriented scales fall in the clinical range when they are over the 97<sup>th</sup> percentile, in the borderline clinical range when they are between the 97<sup>th</sup> and 93<sup>rd</sup> percentile, and in the normal range when they fall below the 93<sup>rd</sup> percentile.

For the CBCL for ages 1 ½- 5, reliability was high on most scales, with most test-retest rs falling between .80 and .90. The Total Problems r was .90. There are also high concurrent correlation between indices and related instruments such as the Conners' Parent Rating Scale and the Quay Problem Behavior Checklist. Content and criterion validity of the problem scales is supported by significant discrimination between referred and nonreferred children.

### **Analysis of Data**

**Qualitative Data.** The semi-structured interviews were recorded, transcribed verbatim, and uploaded to a Word file. A three person coding team, including this researcher, was established. Memos made during the coding process by individual coders were documented. Data were analyzed in aggregate form in accordance to Charmaz's (2006) procedures for inductive coding. The transcripts were analyzed using a thematic content analysis with consensus coding approach (Creswell & Plano Clark, 2011).

As this researcher has studied the literature on stressors typical of adoptive and foster families and has provided therapeutic intervention to adoptive and foster families in the past, she has some bias. Additionally, this researcher had to consider how other personal and professional experiences may influence her worldview and thus interactions with participants as well as the data.

A research team was assembled for the coding process in order to increase trustworthiness (i.e., qualitative rigor) through confirmability processes. The team-based qualitative inquiry included inductive procedures, with a focus on staying close to the participants' language during the initial coding process. A categorical coding system was developed during focused coding to identify themes in the participants' narrative

statements. Next, axial coding allowed for the delineation of subcategories and the organization of the codes. In the final phase of coding, theoretical integration, a skeleton was constructed (Charmaz, 2006).

Two members of the coding team read initial transcripts together to code for emergent themes. At this preliminary phase, the goal was to assign codes to the participants' descriptions of their experiences of the 8-week course. The two team members coded each transcript line-by-line with opportunities for coders to discuss whether a statement warranted the application of a particular code and why. Codes were refined as a result of these discussions. One member of the team served as the code keeper and one as a note taker, to document the team's process (Fonteyn, Vettese, Lancaster, & Bauer-Wu, 2006). After the second participant interview transcript was complete, the two team members began coding independently. The two team members then met to determine consensus on the codes.

This researcher, the third team member, collapsed codes with overlapping meanings and determined that the codebook was complete when all relevant content in the transcripts was condensed to a parsimonious set of codes (Fonteyn, Vettese, Lancaster, & Bauer-Wu, 2006).

**Quantitative Data.** Quantitative data were not analyzed in aggregate form due to the small sample size. Instead individual participant results are reported by descriptive statistics (e.g., frequency) to provide additional information regarding each participant's unique experience of the course in the domains of parenting stress, parent-child interaction, and child behavior.

**Integration of Qualitative and Quantitative Data.** Qualitative and quantitative data were compared and synthesized using a table (see Table 2). The side-by-side table is not used to indicate equal weighting of the data, rather as a visual aid to examine possible convergence, divergence, contradictions, or relationships of two sources of data (Creswell & Plano Clark, 2011).

## **Chapter IV**

### **Results**

This chapter presents the results of the semi-structured interview, a table of the major qualitative themes and sub-themes, as well as illustrations of themes from participant interviews. A description of quantitative data from self-report questionnaires is provided in addition to a side-by-side table integrating qualitative and quantitative results.

There were a total of six participants in the Attachment Security course; four foster/adoptive parents, representing two family units, completed the study. Each family unit focused on their relationship with and the behaviors of one child. Participants 1 and 2 focused on a 3-year old male child, and participants 3 and 4 described a 15-year old male child.

#### **Qualitative Data**

Each participant engaged in a semi-structured, phenomenological qualitative interview (see Appendix F). Emphasis was on participants' voices being heard in relationship to their experiences of the course, and the impact of the course on parent stress, parent-child interaction, and child behavior. Themes from the qualitative data were coded in an emergent manner without apriori hypotheses. Interestingly, and likely due to the interview structure and content, the coding team found that the participant responses mapped well within categories related to parent stress, parent-child interaction, and child behavior, as well as parent experience of the course. This way of grouping qualitative results aligns well with the quantitative data. Major themes, subthemes, and their definitions are presented in Table 1.

Table 1

*Major Themes and Sub-Themes*

Major Themes	Sub-themes	Definition
Parent Experience	<ul style="list-style-type: none"> <li>• Learning</li> </ul>	Participant reports of acquisition of knowledge or skills.
	<ul style="list-style-type: none"> <li>• Instructor</li> </ul>	Participant relationship with course instructor.
	<ul style="list-style-type: none"> <li>• Supportive</li> </ul>	Participant experience of encouragement or emotional help.
	<ul style="list-style-type: none"> <li>• Age Range</li> </ul>	Participant perception of target age-range for course.
	<ul style="list-style-type: none"> <li>• Convenient</li> </ul>	Fitting well within participant needs.
Parent Stress		Tension or worry experienced by parents.
Parent-Child Interaction	<ul style="list-style-type: none"> <li>• Impact of relationship</li> </ul>	The value and effect of the parent-child relationship.
	<ul style="list-style-type: none"> <li>• Help Child</li> </ul>	Parent offering of assistance to child.
	<ul style="list-style-type: none"> <li>• Little Moments</li> </ul>	Day-to-day examples of parent nurturance in the parent-child relationship.
Child Behavior	<ul style="list-style-type: none"> <li>• Behavioral Concerns</li> </ul>	Parental worry regarding observable child actions.
	<ul style="list-style-type: none"> <li>• Positive Behaviors</li> </ul>	Desired observable child actions.

Several sub-themes were reported by all of the participants. All of the parent responses included the sub-themes “learning”, “instructor”, “help child”, and “concerning behavior”. Other sub-themes were reported by three or fewer participants. The representative quotes from each of the four participants below illustrate the impact of the Attachment Security Course on parent experience, parent stress, parent-child interaction, and child behavior. First, sub-themes of parent experience are reviewed.

**Learning.** Related to the major theme parent experience, all parents reported the sub-theme of, “learning”. Below are excerpts from the participant interviews.

We walked out almost every Wednesday, we walked out going, ‘Okay, that’s why he’s doing what he’s doing. We’re going to give it another week.’

We were able to take home those little pearls of wisdom. Um, I think it helps us not only now but it will help us as he continues to grow and mature.

I do believe it had a more significant impact in understanding why he’s behaving the way he is and how he got to this point. It explains why he sees us the way he does and why he sees his biological family the way he does. It’s getting back to the explanatory elements of it.

**Instructor.** Related to the major theme parent experience, all parents reported the sub-theme of “instructor”. Below are excerpts from the participant interviews.



The course instructor just has to be one of the most patient-centered...you can just tell he lives and breathes this. He's just a very genuine person, authentic person, incredibly patient, incredibly passionate.

...Like um just explaining clips, you know some of the clips that were there. You know other parents would ask questions and he would give wow, unbelievable answers, like really good to where you would think 'Wow, that's good to know.'

**Age Range.** Related to the major theme parent experience, three parents reported the sub-theme of "age range". Below are excerpts from the participant interviews.

The course seemed to be more designed for people with younger kids, 10 and below, maybe even younger than that. Less so for teenagers who are already established, just farther along in their development or lack thereof.

Hmmm. To me it was more for older, like when he gets older, the course, to where I'll know some technique to really help him once he is older. Like most of the parents in here, when we were in here, they had teenagers. One lady had an 11-year-old. X was the youngest. We had the youngest.

**Supportive.** Related to the major theme parent experience, two parents reported the sub-theme "supportive". Below are excerpts from the participant interviews.

It would fill up our compassion reservoir every week when it was depleted when we walked in. It would be filled back up, at least part of the way.

I think it's given us some confidence in, 'hey, you know, we're doing things okay'. And I think it's given us some guidance, should we elect to foster children that may be older than X, teenagers, that sort of thing.

**Convenient.** Related to the major theme parent experience, one parent reported the sub-theme "convenient". Below is an excerpt from the participant interview.

I mean, we were, we were very excited about this course offering.

It was um, convenient for, for our schedule.

Next, participant descriptions of parent stress are identified.

**Parent Stress.** The major theme parent stress did not include sub-themes and two participants provided descriptions of parent stress. Below are excerpts from the participant interviews.

Fear of rejection is a big thing for me.

And so I think the struggle with X and us trying to figure out, okay, how do we continue to parent this kid when he doesn't...it's gone beyond for him normal teenager, 'I don't want to be parented'. He doesn't want anything to do with us,

because all the extra, all the other stuff, and mom over here, bio mom over here not wanting us to parent either. How do we manage this for long-term?

The following descriptions of sub-themes fall under the major theme of parent-child interactions.

**Help the Child.** Related to the major theme parent-child interactions, all parents reported the sub-theme of “help the child”. Below are excerpts from the participant interviews.

We wanted to um to be able to find some tools that we could you know reach into that tool box and be able to help him better cope with certain situations and to be able to um to develop more emotional.

I feel better about being able to help him, manage him to get through these meltdowns that he has. I feel better equipped.

**Impact of Relationship.** Related to the major theme parent-child interaction, three parents reported the sub-theme of “impact of relationship”. Below are excerpts from the participant interviews.

The adults in their life, even from the very beginning, the degree they make eye contact, the tone of their voice, how much time they spend with them, just how they hold them, even how they interact with them, the child reacts to it, shows

signs of reacting to and building on almost immediately and that will set them on a course that, as time goes on, becomes more and more established for good or ill. Often, with the response of the parents who aren't up for the challenge, it's going to be for ill.

I think it's the very important thing of even though he wants to disengage with us, we can't disengage with him.

**Little Moments.** Related to the major theme parent-child interaction, three parents reported the sub-theme of "little moments". Below are excerpts from the participant interviews.

Just do a little shoulder squeeze. I try to do little things like that. Nothing over the top that's going to threaten him, but they can feel weird, but just to let him know that we're still with him and we're not giving up on him.

Just holding him. Letting him know how much I love him, which I did before, but it really encouraged me that I was doing the right thing.

Finally, parent responses related to the major theme of child behavior are reviewed.

**Behavioral Concerns.** Related to the major theme child behavior, all parents reported the sub-theme of "behavioral concerns". Below are excerpts from the participant interviews.

A couple of months ago we were up at my sister-in-law's house and X turned around and thought that my wife had left. She was just in the other room and he couldn't see her and he got very upset. It was almost like he felt as though we were leaving him again at that relative placement.

...he didn't want anything to do with us. He announced that he didn't like us anymore, or he never liked us. Let me take that back. He never liked us and didn't want anything to do with us. He was done with us.

**Positive Behaviors.** Related to the major theme child behavior, three parents reported the sub-theme of "positive behaviors". Below are excerpts from the participant interviews.

I think it made us appreciative of that despite the fact that we have no relationship with our kid right now, it made us appreciative of some of the things, his positive traits that we know from our previous 2 years with him in which we did have a relationship, he's a good kid...I think it made us appreciate the strong points because some of the other parents are having much and in some ways more severe problems with their foster kids.

Like when the little toddler, they were at the playground, have you seen these clips? Okay, and remember the little fellow kept running away and coming back.

Yes. That was probably one of my- X does that all the time. I know he is making sure that I am there.

When examining qualitative data it is important to note that each participant engaged in an approximately 50 minute semi-structured interview, however; depth and breadth of content did vary by participant. While some participants had more coded responses than others, efforts were made to utilize data from each participant in the results chapter. Next, a description of quantitative data is provided.

### **Quantitative Data**

**Parenting Stress Index.** Participant 1, a female, appeared to respond in a valid manner on both administration one (Defensive Responding = 12) and administration two (Defensive Responding = 11). She endorsed scores falling within the normal range across all domains on both administrations of the PSI-4-SF measure.

Participant 2, a male, earned a low score on the second administration of the PSI-4-SF Defensive Responding Scale (raw score = 10). This score may indicate a combination of the participant attempting to present a positive impression of himself and/or a degree of competency in managing responsibilities and relationships with others. Participant 2 also reported a P-CDI score falling in the 94<sup>th</sup> percentile, the clinically significant range, on administration one and two. High scores on the P-CDI may indicate that the parent-child bond is threatened or was not developed. Other scores fell in the normal range. Participant 2 identified clinically relevant concerns only in the Parent-Child Dysfunctional Interaction domain.

Participant 3, a male, endorsed low Defensive Responding scores on both administration one (raw score = 7) and administration two (raw score = 9). Additionally, scores on the PD scale were low on both the first (PD = 6<sup>th</sup> percentile; T= 36) and second (PD = 10<sup>th</sup> percentile; T= 41) administrations of the PSI-4-SF. This is likely a combination of the participant trying to portray himself in a positive light and/or reflective of a competent individual, who handles parenting responsibilities well. Other scores fell in a normal range. The Total Stress score fell in the 22<sup>nd</sup> percentile (T = 41) on administration one and increased to the 46<sup>th</sup> percentile (T = 47) on administration two. The P-CDI score fell in the 24<sup>th</sup> percentile (T = 41) on administration one and increased to the 36<sup>th</sup> percentile (T = 44) on administration two. The DC score increased from the 58<sup>th</sup> percentile (T = 50) on trial one to the 82<sup>nd</sup> percentile (T= 61) on trial two. Although scores did not fall in a clinical range on either administration, participant 3's scores demonstrated somewhat of an increase across scales.

Participant 4, a female, endorsed a low score at both the first (raw score = 6) and second (raw score = 8) administrations on Defensive Responding Scales. Additionally, scores on the PD scale were low on both the first (PD = 8<sup>th</sup> percentile; T= 37) and second (PD = 10<sup>th</sup> percentile; T= 38) administrations of the PSI-4-SF, as was the P-CDI score on the first administration (P-CDI = 14<sup>th</sup> percentile; T = 39). Again, this is likely a combination of the participant trying to portray herself in a positive light and/or reflective of a competent individual who handles parenting responsibilities well. The DC score increased from the 76<sup>th</sup> percentile (T = 57) on the first administration to the 98<sup>th</sup> percentile (T =72) on the second administration. A score falling in the 98<sup>th</sup> percentile is considered clinically significant and indicates difficulty managing the child's behavior.

Other scores fell in the normal range including Total Stress which increased from the 30<sup>th</sup> percentile on administration one (T = 44) to the 74<sup>th</sup> percentile on administration two (T = 56) and the P-CDI score (P-CDI = 80<sup>th</sup> percentile; T= 58) on the second administration. Aside from the PD scores, participant 4 also demonstrated an increase in scores across scales.

Overall, it was expected that parent stress and child behavior concerns would maintain or decrease following the course and that reassessment after 6 months or more would reflect a decrease in parent stress and child behavior concerns, as parents would have more time to integrate concepts from the course into their daily lives. It was not anticipated that parent stress and child behavioral concerns would increase, however; there may be additional extenuating circumstances of which we are unaware for the individual family unit, and there were not enough participants to make generalizations regarding patterns across participants.

Three of the four participants earned one or more low scores on the Defensive Responding Scale. As indicated above, it may be that parents were both trying to portray themselves in a positive manner and are competent people who are able to handle the responsibilities of parenting well. It is also notable that foster and adoptive parents are a population that navigates parenting with others involved in the process, which may create a heightened sense of vulnerability to evaluation or judgment by others in relation to parenting.

**Child Behavior Checklist (CBCL).** Participants 1 and 2 completed the Child Behavioral Checklist (CBCL) School-age form for ages 6-18. Participant 1 reported that her child participates in one sport and that he has interests in one hobby. The child



belongs to no social organizations, teams, or clubs. Participant 1 reported that her child had three jobs or chores at the first administration and two jobs or chores at the second administration. Her child has no close friends and sees friends less than once a week outside of regular school hours. She rated her child's school performance as above average in language arts, social studies, math, and science, and average in foreign language at administration one of the CBCL. On administration two of the CBCL, Participant 1 rated her child's performance as above average in math and science, and average in language arts and social studies. Participant 1 endorsed a Total Competence score was in the clinical range on both administrations one ( $T=36$ ) and two ( $T=27$ ). Scores on the Social Scales were both in the clinical range (below the 2nd percentile), and the child's score on the School Scale was in the borderline clinical range (below the 7th percentile) on the second administration.

On the CBCL Problem Scales, the Total score fell in the clinically significant range ( $T=64$ ) on the first administration and in the borderline clinical range ( $T=61$ ) on the second administration. The Internalizing scores on administration one ( $T=72$ ) and administration two ( $T=70$ ) were both in the clinical range for boys aged 6-18. The score on the Withdrawn/Depressed Syndrome was in the clinical range above the 98th percentile. Somatic Complaints Syndrome Scale was in the clinical range on administration two. The Anxious/Depressed Syndrome Scale was in the borderline clinical range on administration two (above the 93<sup>rd</sup> percentile). Other scales were in the normal range (below the 93<sup>rd</sup> percentile). These results indicate that his foster mother reported more problems than are typically reported by parents of boys aged 6-18, particularly withdrawn or depressed behavior problems.

Participant 2 filled out only competence information on administration one and only Syndrome Scale information on administration two. It is unclear why the participant completed only one, and different portions of the CBCL at each administration. On administration one, Participant 2 reported that his child participates in no sports and that he has interests in two hobbies. He stated that his child belongs to no social organizations, teams, or clubs. Participant 2 reported that his child had no jobs or chores and has no close friends. He rated his child's school performance as above average in language arts, social studies, math, and science. Participant 2 endorsed a Total Competence score in the clinical range ( $T = 25$ ). The score on both the Social Scale and the Activities Scale were in the clinical range (below the 2nd percentile).

On the second administration, Participant 2 completed the CBCL Problem scales, and endorsed a Total score, which fell in the clinically significant range ( $T = 64$ ). The Internalizing score ( $T=70$ ) was also in the clinical range for boys aged 6-18. His score on the Withdrawn/Depressed Syndrome was in the clinical range, above the 98th percentile. Other scales were in the normal range. These results indicate that his foster father reported more problems than are typically reported by parents of boys aged 6-18, particularly withdrawn or depressed behavior problems.

Participants 3 and 4 completed the Child Behavioral Checklist (CBCL) for age's 1 ½ -5. On the empirically based scales, Participant 3's report of Total Problems fell in the normal range (below the 83<sup>rd</sup> percentile) on both administrations one ( $T= 41$ ) and two ( $T = 45$ ). The Sleep Problems Scale fell in the clinical range (above the 97<sup>th</sup> percentile) on both administrations one and two), and the Emotionally Reactive Scale was in the

borderline clinical range (above the 93<sup>rd</sup> percentile and below the 97<sup>th</sup> percentile) on administration one. Other scales were in the normal range (below the 93<sup>rd</sup> percentile).

The DSM-5-Oriented Scales score on Anxiety Problems fell within the borderline clinical range (between the 97<sup>th</sup> and 93<sup>rd</sup> percentile) on the second administration. Other scales were all scored within the normal range (below the 93<sup>rd</sup> percentile). These results indicate that overall the child's foster father reported no more problems than are typically reported by parents of boys aged 1 ½ - 5.

On the empirically based scales, Participant 4's report on the Total Problems score fell in the normal range (below the 83<sup>rd</sup> percentile) on both administrations one (T= 51) and two (T = 56). Internal Scales were elevated to a clinical level (above the 90<sup>th</sup> percentile) on both administration one (T= 71) and administration two (T= 73). The External Scale fell in the borderline clinical range (between the 90<sup>th</sup> and 83<sup>rd</sup> percentiles) on administration one (T= 60) and in the clinical range on administration two (T= 66). The Emotionally Reactive, and Sleep Problems Scales were in the clinical range (above the 97<sup>th</sup> percentile) on administration one and two. The Anxious/Depressed Scale fell in the borderline clinical range (above the 93<sup>rd</sup> percentile) on administration one and in the clinical range (above the 97<sup>th</sup> percentile) on administration two. The Withdrawn Scale fell in the clinical range (above the 97<sup>th</sup> percentile) in administration one. The Aggressive Behavior Scale fell in the borderline clinical range (between the 97<sup>th</sup> and 93<sup>rd</sup> percentiles) on administration two. Other scales were in the normal range.

The DSM-5-Oriented Scale scores on Depressive Problems and Autism Spectrum Problems fell within the clinical range (over the 97<sup>th</sup> percentile) on both administrations. Depressive Problems fell within the borderline clinical range (between the 97<sup>th</sup> and 93<sup>rd</sup>

percentiles) on administration one and in the clinical range (over the 97<sup>th</sup> percentile) on administration two. Oppositional Defiant Problems fell within the clinical range (over the 97<sup>th</sup> percentile) on administration two. Other scores fell within the normal range. These results indicate that overall the child's foster mother reported more problems than are typically reported by parents of boys aged 1 ½ - 5.

Table 2 integrates the qualitative and quantitative data described above. Major themes and sub-themes from participant interviews are compared to administrations one and two of the PSI-4-SF Total Stress scores and the CBCL Total Problems scores.

Table 2: Side-by-Side Table of Results

Participant Number	Quantitative Administration 1	Quantitative Administration 2	Qualitative
	PSI-4-SF Total Stress; CBCL Total Problems	PSI-4-SF Total Stress; CBCL Total Problems	Major themes and sub-themes
Participant 1:	T=51; 62%; Normal T=64, Clinical	T=52; 64%; Normal T= 64; Clinical	Parent experience: Learning, Instructor, Age Range, Supportive  Parent Stress  Parent-Child Interaction: Help Child, Little Moments, Impact of Relationship  Child Behavior: Behavioral Concerns
Participant 2:	T=59; 76%; Normal Unavailable	T=54; 68%; Normal T=64; Clinical	Parent experience: Learning, Instructor, Age Range  Parent Stress  Parent-Child Interaction: Help Child, Little Moments, Impact of Relationship  Child Behavior: Behavioral Concerns, positive behaviors
Participant 3:	T=41; 22%; Normal T=41; below 83%; Normal	T=47; 46%; Normal T=45; below 83%; Normal	Parent experience: Learning, Instructor, convenient, Supportive  Parent-Child Interaction: Help Child, Impact of Relationship  Child Behavior: Behavioral Concerns, positive behaviors
Participant 4:	T=44; 30%; Normal T=51; below 83%; Normal	T=56; 74%; Normal T=56; below 83%; Normal	Parent experience: Learning, Instructor, Age Range  Parent-Child Interaction: Help Child, Little Moments  Child Behavior: Behavioral Concerns, positive behaviors

Of note in Table 2, participants 1 and 2 reported a Total Problems score in the clinical range on the CBCL, and had coded responses within the major theme “parent stress”, whereas participants 3 and 4 did not have scores falling in the clinical range and did not have coded responses within the major theme of “parent stress”. The major theme “parent stress” may have a positive correlation with the Total Problems score on the CBCL.

All participants had Total Stress scores falling in the normal range on the PSI, including participants who endorsed a CBCL Total Problems score in the clinical range. Although the PSI includes the Difficult Child subscale, two additional subscales load onto the Total Stress score, and the CBCL offers a greater depth regarding child behavior concerns. The CBCL appears to provide valuable additional information related to child behavior. In terms of qualitative data, each participant endorsed child “behavioral concerns”, however; participant 1, who had a CBCL Total Stress score in the clinical range on both administrations one and two, was the only participant who did not report “positive behaviors”. “Positive behaviors” may have a negative correlation with the CBCL Total Stress score.

Participant 1 provided the most qualitative data. Consistent with this openness to sharing experience, participant 1 was the only participant whose score on the PSI Defensive Responding scale indicated no validity concerns regarding response style on the PSI.

The integration of qualitative and quantitative data suggests that the information collected is complementary and the quantitative and qualitative data gathered are consistent in attachment-related constructs assessed. The quantitative instruments appear

to align well with the research questions. With a larger sample size, the research design appears to be a viable one to assess parent-child interaction, parent stress, child behavior, and parents' overall experience of the Attachment Security Course.

This chapter provided a description of both qualitative and quantitative data, including sample quotes from participant interviews. Qualitative and quantitative data are also summarized and integrated for descriptive comparison. The next chapter will focus on summarizing the results as they relate to previous research and implications for future iterations of the Attachment Security Course and future research.

## **Chapter V**

### **Discussion**

The purpose of the current study was to examine foster and adoptive parents' experience of the Attachment Security Course and the utility of the framework in relationship to parenting stress, child behavior, and parent-child interaction, as well as parents' unique experiences of the course. This chapter will link the results of the current study to the previous literature, provide explanation of the significance of findings, and offer recommendations for both future iterations of the Attachment Security Course and future research.

While there are a number of attachment-based interventions established for foster and adoptive families, the Attachment Security Course is unique in that it is theoretically grounded and allows for flexibility while maintaining fidelity to the treatment model. The intervention is feasible to provide in a variety of clinical settings, as there are not requirements for availability of taping equipment, two-way mirrors, or particular supplies, other than a TV or computer on which to display video clips to parents. The intervention avoids some of the potential confidentiality, third party payer, and/or liability concerns that may come with home-based interventions. Additionally, the intervention is accessible to clinicians, as they are able to utilize the model, without completing any additional training requirements. The course is for the parent unit, which also may be beneficial in settings such as the VA, which provide services to the Veteran or the Veteran and their spouse, but not to anyone under 18 years of age.

Although the Attachment Security Course has been utilized with foster and adoptive parents for the past three years and is grounded in theory, the course has not



been formally evaluated. In this study, a format for program evaluation has been laid out, and qualitative data regarding participant experience has been collected to inform future research and iterations of the course.

As identified in the literature, the ABC program, Theraplay, and CPRT are established, evidence-based interventions geared toward foster and adoptive families, which focus on strengthening the parent-child relationship to address issues around separation and loss. Each of these interventions is grounded in attachment theory. The qualitative codes or themes gleaned from the Attachment Security Course participant interviews in this study map onto many of the goals and intervention strategies from these three programs. This provides initial evidence that the Attachment Security Course is affecting goals, which are consistent with other evidenced-based interventions grounded in attachment theory.

In the ABC program the focus is on parent behavior and their development of synchronous and nurturing skills. Though there is variation in semantics, the sub-thematic codes, “little moments”, defined as day-to-day examples of parent nurturance in the parent-child relationship, and “importance of relationship”, defined as the value and effect of the parent-child relationship, seem to map onto these skills. Like the Attachment Security Course, the ABC program provides sample videos of parent-child dyads where the child’s behavior does not elicit the nurturing care they need. Psychoeducation emphasizes the idea that children need their parents even when they do not clearly express that need, a concept referred to as “miscues” within the Attachment Security model. The following excerpt from the Attachment Security participant interview, illustrates the concept in relationship to addressing “meltdowns”.

I'll just look and make sure that he is okay. That he is not going to hurt himself.

And I'll go on and I'll sing a song or sometimes I'll just count and say, 'I love a X and a X loves me.' 'I don't love you!' And I'll say, 'Well, I still love you.'

Theraplay highlights relational dimensions of structure, engagement, nurture, and challenge with the goal of enhancing the parent-child relationship. The dimensions of engagement and nurture parallel the Attachment Security Course "Inner Needs," or emotional needs, while the dimensions of structure and challenge parallel the Attachment Security Course "Outer Needs", or needs related to exploration, engagement in tasks, and partnership behavior. These dimensions are also related to the previously mentioned sub-thematic codes of "little moments" and "impact of relationship", as well as the sub-thematic code, "help child", which is defined as the parent offering assistance to child.

The goals of CPRT are set in the domains of parent, child, and dyad, similar categorically to the major thematic codes found in participant interviews of the Attachment Security Course, which included parent stress, child behavior, and parent-child interaction. In CPRT, parent goals include developing the ability to demonstrate understanding, empathy, and acceptance to their child and to enjoy their child, gain confidence, and gain a better understanding of child development. Empathy and acceptance relate to the sub-themes already discussed. Goals related to understanding and confidence are similar to the sub-thematic codes of "learning" and "supportive", identified in the Attachment Security participant interviews. "Learning" is defined as

participant reports of acquisition of knowledge or skills and “supportive” is identified as participant experience of encouragement or emotional help.

Moreover, CPRT child goals are identified as gaining security in their relationship with the parent, expressing thoughts and emotions, and developing the ability to better regulate their emotions. The sub-thematic code of “help child”, defined as parent offering of assistance to child, reflects a similar concept as evidenced by Attachment Security participant interview content, such as the quote below.

So we really wanted to learn more to be able to help him with um his emotions.

The CPRT parent-child dyad goal is to have a more satisfying parent-child interaction, which is directly linked to the Attachment Security sub-thematic code, “importance of relationship”, or the value and effect of the parent-child relationship, as well as positive child behavior, or desired observable child actions. Qualitative data in this study provides initial evidence to suggest that the Attachment Security Course is likely to positively impact parent stress, parent-child interaction, and child behavior as the qualitative data from this study is in sync with goals and interventions from evidence-based programs grounded in attachment theory. Additional research may utilize a similar design to this study, and would benefit from a larger sample size to allow for analysis of quantitative data, in addition to building a more representative sample.

In the context of attachment theory, one additional sub-theme stood out in particular. “Instructor”, which is defined as participant relationship with course instructor, was coded in the narratives of all four participants. The participant emphasis

on relationship with course instructor parallels the content message of the Attachment Security Course, which highlights the importance of relationship and connection with a person well able to navigate the world, or in this case, specifically well able to navigate parent-child relationships. A body of therapeutic research has demonstrated the importance of the therapeutic relationship as a common factor in success in psychotherapy (Rosenzweig, 1936; Bowlby, 1980; Barlow, 2004; & Wampold, 2015). The qualitative results of this study further support the relevance of relationship and imply that an instructor who is able to act as a “safe haven” can engender a positive and safe space for learning to take place. This appears to be a fundamental aspect of the course, based on this sample of participant narratives. Based on current data, the central tenants of attachment theory, and previous research related to common factors, this is likely an aspect of the intervention that will demonstrate significance in future research.

### **Limitations**

The current study was most notably limited by the small sample size ( $n = 4$ ). As the current study is a mixed methods design relevant qualitative information is still gleaned regarding participants’ experience of the Attachment Security course, however; quantitative data were not interpretable in an aggregate form, as the sample size was too small to be used as a representation of the foster/adoptive family population from which to make generalizations.

The children of participants in the current study differed significantly in age (3 and 15 years of age). A larger study, including data from multiple cohorts, would likely allow for further comparison between similar age ranges and developmental periods.

This type of information could further inform the utility and efficacy of the course across various phases of childhood development.

It is recommended that future research plan for more extensive time for follow up, for example, collecting qualitative and quantitative data at 6-months following the intervention. Additional information including a second qualitative interview, as well as a third administration of the PSI and CBCL would provide insight into the effects of implementation and integration of information gained through the Attachment Security course. Changes in child behavior related to parents' practice of new ways of engaging their child following the course would be more likely to be evident.

Perhaps both a strength and limitation of the Attachment Security Course is its flexibility. As noted previously, its flexibility allows for accessibility to both clinicians and families. The course is not standardized, which allows for clinical judgment and adaptation based on family needs. The lack of standardization also must be taken into account when researching the course and caution should be used in making generalizations. For example, an error could be made if it was concluded that effects were due to the Attachment Security intervention, without accounting for other possible influences. An error could also be made if the course was inadequately administered. Replication across providers with a flexible model is a challenge.

### **Recommendations**

Cohorts for the Attachment Security Course are typically small in size, 8-10 participants. This is an appropriate size for the course and small mixed methods studies including qualitative interviews and use of a nonparametric test statistic, such as the Wilcoxon Signed Rank test, to examine quantitative results could provide further

contribution. This would provide helpful information regarding participants' experience of the course. Additionally, future studies may benefit from including multiple cohorts of the Attachment Security Course in the research project to decrease variability and allow for additional comparisons to be made, such as comparisons across developmental periods of the parents' children. With an average of 8-10 course participants, there is a small margin for study dropout before quantitative data analysis becomes compromised. Examining multiple cohorts offers an opportunity to meaningfully interpret both qualitative and quantitative data.

In order to maintain treatment fidelity in intervention research, it will be important for future studies to ensure the intervention stays true to the theory in which it is grounded, attachment theory. Frequency and length of contact (i.e. 2 hour sessions, once a week, for 8 weeks) should be consistent. Use of the same videos for demonstration of interaction patterns and children's behavior would provide further consistency. Development of a guide for the entire course, such as the CPRT manual, which provides relevant information for therapists, while allowing for some flexibility in application may be useful. A special topics guide may be found in Appendix G. The rubric presented in this guide may also be beneficial in assisting clinicians with maintaining the Attachment Security framework as it applies to a variety of examples. Finally, adding an assessment component to the course may help providers gauge the impact they are having on participants.

As additional data is collected for the foster and adoptive family population, the population for which the Attachment Security Course was originally developed, it would be beneficial to examine those results and use them to inform future research regarding

other family populations who experience separation and loss. Such populations may include the military-connected family population, those who have had a parent in prison, and the immigrant population to name a few.

## Appendix A

### Consent to Participate in Research

#### Identification of Investigators & Purpose of Project

You are being invited to participate in a project conducted by Kelly Atwood, Ed.S. and Anne Stewart, Ph.D. from James Madison University. The purpose of this dissertation research project is to study families' experiences of an 8-week attachment-based parent psychoeducational course. The project is being completed as part of Kelly Atwood's doctoral dissertation.

#### Project Procedures

Should you decide to participate in this project, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. You will be asked to complete pre and post intervention measures including questionnaires about your child's emotions and behaviors and your level of stress related to parenting. You will also be asked to participate in an interview at the end of the course regarding your experience of the course and the impact it has had on your perceptions of your child and parenting.

The intervention will involve parent attendance to an 8-week, attachment-based psychoeducational course.

#### Time Required

Participation in this project will require approximately 15 minutes of your time during the 8-week course and 1 hour of your time after the completion of the 8-week course. Each week over an 8-week period, you will attend the 2-hour course.

#### Risks

*The investigator does not perceive more than minimal risks from your involvement in this project, (that is, no risks beyond the risks associated with everyday life). Some questions asked may make parents feel uncomfortable, and this could be considered a risk of involvement.*

#### Benefits

Potential benefits from participation in this project include identification of ideas that promote positive family coping when faced with stressors such as separation or major life changes. As a whole, the research will provide data to inform evidenced-based intervention specific to both adoptive and foster families and the military-connected family population.

#### Confidentiality

The project's results will be presented in a doctoral dissertation research paper. The results of this project will be coded in such a way that your identity will not be attached to the final form of this project. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All



data will be stored in a secure location accessible only to the researcher. Upon completion of the project, the data will continue to be used for research and training purposes with your consent. Final aggregate results will be made available to participants upon request.

There are some limits to confidentiality, including the disclosure of abuse or injury to a child. If this information is shared, the researcher will be required by law to report this abuse to the appropriate authorities.

### **Participation & Withdrawal**

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

### **Questions about the Project**

If you have questions or concerns during the time of your participation in this project, or after its completion or you would like to receive a copy of the final aggregate results of this project, please contact:

Kelly Atwood, Ed.S.  
Department of Graduate Psychology  
James Madison University  
[atwoodkc@jmu.edu](mailto:atwoodkc@jmu.edu)

Anne Stewart, Ph.D.  
Department of Graduate Psychology  
James Madison University  
Telephone: (540) 568-6601  
[stewaral@jmu.edu](mailto:stewaral@jmu.edu)

### **Questions about Your Rights as a Research Subject**

David Cockley, Ph.D.  
Chair, Institutional Review Board  
James Madison University  
(540) 568-2834  
[cocklede@jmu.edu](mailto:cocklede@jmu.edu)

### **Giving of Consent**

I have read this consent form and I understand what is being requested of me as a participant in this project. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

\_\_\_\_\_  
Name of Participant (Printed)

\_\_\_\_\_  
Name of Participant (Signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Researcher (Signed)

\_\_\_\_\_  
Date

**Appendix B**

Participant # \_\_\_\_\_

**Registration Form**

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

DSS Agency & Social Worker: \_\_\_\_\_

First Name and Ages of Children: \_\_\_\_\_

## Appendix C

### Parenting Stress Index-4-SF

#### Sample Items:

Since having a child, I am almost never able to do things that I like to do.

- SA strongly agree
- A agree
- NS not sure
- D disagree
- SD strongly disagree

When I do things for my child, I get the feeling that my efforts are not appreciated very much.

- SA strongly agree
- A agree
- NS not sure
- D disagree
- SD strongly disagree

I feel that I am: (Choose a response from the choices below.)

1. a very good parent
2. a better-than-average parent
3. an average parent
4. a person who has some trouble parenting
5. not very good at being a parent

## Appendix D

### Child Behavior Checklist for Ages 6-8

#### Sample Items:

1. Please list your child's favorite hobbies, activities, and games, other than sports.

- None
- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

Compared to others of the same age, about how much time does he/she spend in each?

- Less than average
- Average
- More than average
- Don't know

Compared to others of the same age, how well does he/she do each one?

- Below average
- Average
- Above average
- Don't know

2. Acts too young for his/her age
  - 0 = Not true (as far as you know)
  - 1 = Somewhat or Sometimes True
  - 2 = Very True or Often True
  
3. Cries a lot
  - 0 = Not true (as far as you know)
  - 1 = Somewhat or Sometimes True
  - 2 = Very True or Often True
  
4. Headaches
  - 0 = Not true (as far as you know)
  - 1 = Somewhat or Sometimes True
  - 2 = Very True or Often True

## Appendix E

### Child Behavior Checklist for Ages 1 ½ -5

#### Sample Items

1. Looks unhappy without good reason  
0 = Not true (as far as you know)  
1 = Somewhat or sometimes true  
2 = Very true or often true
  
2. Can't sit still, restless, or hyperactive  
0 = Not true (as far as you know)  
1 = Somewhat or sometimes true  
2 = Very true or often true
  
3. Gets in many fights  
0 = Not true (as far as you know)  
1 = Somewhat or sometimes true  
2 = Very true or often true

## Appendix F

### Semi-Structured Qualitative Questionnaire.

Participant #: \_\_\_\_\_

Age of child referencing: \_\_\_\_\_

Thank you for your time. My name is Kelly Atwood and I am a 4<sup>th</sup> year doctoral student in the Combined Integrated Clinical and School Psychology Program at James Madison University. Dr. Whelan is a member of my dissertation committee – the faculty who help guide my research project, and Anne Stewart is my advisor. Prior to going back to school, I worked with children and families as a counselor. Many of the families were involved in the foster care system. My interest in working with foster and adoptive families and in attachment-based programs – basically programs that focus on healthy parent-child relationships, continues. For my dissertation, I am interested in learning more about your experience of the Attachment-Security Course. I think our conversation may take between approximately an hour.

I'd like to ask you a number of questions today, and this will be informal. Your responses will be anonymous – your comments will be associated with a participant number, not your name. The responses of all participants will be reviewed together to identify themes and to learn more about participant experience of the Attachment Security course. This will help us learn what is important to keep in the class and what you believe could be changed or improved to be more helpful

When the work is complete I can send you a summary of the findings, if you wish.

The Attachment Security course covered topics such as typical childhood development, ways of understanding children's behavior and misbehavior, how children express emotions, how they sometimes inhibit feelings and needs, and automatically miscue their needs (i.e., noisy versus accurate signals). The course highlighted the importance of small moments in shaping and child's experience in ways that can change their automatic feelings and behavior. It also highlighted ideas about children's inside needs and outside needs, and two aspects of a caregiving relationship with a child: emotion partnership and performance partnership.

Please keep these topics in mind as I ask you several questions regarding your experience of the course.

Any questions?

How did you learn about the AS course?

What influenced you to decide to take the class?

What other factors might have been influencing you to take the course or influencing you not to take the course?

Think back to just before you started taking this course.

What was going on in your life?

What worries and concerns about your relationship with your child did you have when you first came to the course?

Any particular event?

Any particular behavior?

Aspects of your relationship with your child?

What were your hopes or goals for the course?

Please choose 3 words that describe your experience in the course.

You described the class as XXX. Please think of an experience that help me understand

The course discusses performance partnership or outside needs and inside needs or emotional partnership. How has this this information impacted the way you interact with your child?

Did the course impact the way you view your role as a parent?

How does your child express their needs? Is it ever difficult to understand what their needs are? If so, could you provide an example. What information has the course offered that could be helpful in addressing your child's needs?

I would also like to ask you about your experience of specific components of the class:

Think back to the course....

Videos:

What did you find helpful or unhelpful about the use of videos?

Were there any video clips you found particularly helpful or useful? Any of the clips not useful?

Group Discussion:

What did you find useful or helpful about the group discussions in class?

Lecture:

How did the lecture impact you?

What did you find useful or helpful about the mini-lectures in class?

Attachment Security Graphics:

What did you find useful or helpful about the graphics?

Earlier in our conversation you said \_\_\_\_\_ was a concern.

We are interested in hearing your ideas about the impact you believe the course had.

What's different now as a result of the course?

Could you provide a descriptive example of an event or situation you've had that helps me understand how things go differently now?

If you had a friend who was considering taking the course, what would you want to tell them about the course?

What have we not covered that was an important part of your experience of the course?



## Appendix G

Special Topics in Parenting:

A Guide for Therapists Using an Attachment Security Framework

## Table of Contents

Introduction .....	80
___ Attachment Security Framework .....	81
___ Adverse Childhood Experiences .....	82
___ Background Information for Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) Service Members and Veterans .....	83
Special Topics .....	85
___ Responding to Parent’s Questions with an Attachment Informed Perspective .....	87
___ Spoiling .....	89
___ Corporal Punishment .....	91
___ Developmental Expectations .....	93
___ Reciprocal Nature of Parent-Child Relationship .....	96
___ Mental Health Concerns of Parents .....	98
References .....	99

Special Topics in Parenting:  
A Guide for Therapists Using an Attachment Security Framework

Parenting interventions with an attachment informed perspective, such as Theraplay (Booth & Jernberg, 2010) and Child Parent Relationship Therapy (Bratton, Landreth, Kellam, & Blackard, 2006) have been used with the foster and adoptive population. Using a group format, a psychoeducational course based in the Attachment Security model and addressing issues related to separation and loss, has been conducted with foster and adoptive parents. It is argued that the information is also salient for other family populations who experience separation and loss, including military-connected parents (Active Duty military, National Guard, Reserve and Veterans) and parents with their own trauma history.

This guide begins by providing a brief summary of the Attachment Security framework for understanding children's capacity for emotional and behavioral regulation. An overview of research findings from the Adverse Childhood Experiences studies is provided to illustrate the long term and pervasive impact of chronic stress and trauma on children's psychological and physical wellbeing. Contextual information regarding unique experiences and challenges faced by Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Service Member and Veteran parents, as well as parents who have their own trauma history. Finally, special topics in parenting are discussed. The topics were identified through interviews with foster and adoptive parents participating in a study examining participants' experience of the Attachment Security Course, clinical experience conducting an Attachment Security

class with Veterans, as well as literature identifying key variables in parent-child relationships that can impact child wellbeing into adulthood.

### **The Attachment Security Framework**

The Attachment Security Framework is grounded in attachment theory and thus focuses on the importance of the parent-child relationship. Attachment behavior is any form of behavior that results in a person attaining or maintain proximity to some other clearly identified individual who is better able to cope with the world (Bowlby, 1988). Attachment theory posits that humans have an extended developmental period, during which parents provide their vulnerable children, who are not yet physically, cognitively or socially mature, with protection, guidance, and nurturing.

The Attachment Security model highlights the fact that children develop within the context of relationships. Children rely on their parents to act as a safe haven, to have both their inner and outer needs met. Inner needs refer to the parent's attention to the child's emotional needs including assisting the child in regulating emotion, behavior, and thinking. The parent offers emotional protection and soothing. Outer needs refer to the parent's support and guidance as the child explores, learns, and engages in tasks. Over time, such interactions provide the foundation for the child's development of self-control, emotion regulation, competencies, and resilience.

According to attachment theory, early parent-child interactions shape internal working models of self and other, (a cognitive framework for understanding self, others, and the world) which inform future relational patterns. The literature on attachment theory has demonstrated that the parent-child relationship can impact how adults parent their own children, creating intergenerational patterns in relationship (Bowlby, 1951;

Sroufe, 2005; Steele, Steele, & Fonagy, 1996). Among other internal working models, people develop internal working models of the self as a parent based on their own experience of their parents, their perceived sense of self, and expectations of self and child. These working models also impact stress experienced in the parenting role (Steele et al., 2016).

### **Adverse Childhood Experiences**

The Adverse Childhood Experiences (ACE) Study demonstrated that exposure to ACEs in the first 18 years of life is associated with adverse health outcomes in adulthood, some of which could impact parenting. Such adverse health outcomes include depression (Chapman et al., 2004), suicidality (Dube et al., 2001), risk of illicit drug use and HIV sexual risk behavior (Dube et al., 2003; Meade, Kershaw, Hansen, & Sikkema, 2009), alcohol abuse (Dube, Anda, Felitti, Edwards, & Croft, 2002), heart disease, skeletal fractures, cancer, diabetes, and overall poorer health (Felitti et al., 1998). Results of the ACE study indicated associations between the total number of ACE exposures and prevalence of these health concerns across the life span. Of particular relevance to therapists facilitating the parenting course, high levels of ACEs are also associated with difficulty making sense of early childhood experiences that have implications for parenting. Research examining ACES and attachment in adults provides additional context regarding some parenting difficulties. Murphy et al. (2014) found that mothers who reported four or more ACEs, on a 10-category Adverse Childhood Experiences Questionnaire, endorsed more unresolved loss or trauma and demonstrated highly disparate states of mind (“cannot classify”) in response to the Adult Attachment Interview (AAI; Main, Goldwyn, & Hesse, 2003; Main, Hesse, & Goldwyn, 2008), a measure of

adult attachment patterns. Interviews classified as “cannot classify” are associated with failure in reality testing, dissociation, absorption, rapid shifts in emotional stance, numbing or passivity, and parent-infant relationships characterized by fear and disorganization (Lyons-Ruth & Jacobvitz, 2008; Steele et al., 1996; van IJzendoorn, 1995). Parents’ attachment patterns impact their working models (i.e. cognitive frameworks) of their children and their role as parents, particularly regarding domains of attunement and responsiveness (Haft & Slade, 1989; Slade, 2005; van IJzendoorn, 1995). Ammerman et al., (2013) found that childhood trauma had a significant positive association with parenting stress. Though childhood maltreatment was associated with parents’ lack of confidence, Bailey et al. (2012) found no association between maltreatment and overall parenting stress. Steele et al. (2016) found maternal exposure to ACEs during childhood is significantly associated with parental stress, after controlling for poverty and at-risk clinical sample. Thus, when the impact of poverty and clinical status are accounted for, exposure to ACES continued to influence mothers’ reports of parental stress.

As clinicians are aware of exposure to ACES, they may gain insight into the meaning ACEs have for the parent and offer both trauma-informed and attachment-based interventions to best meet the parent-child relationship needs.

### **Background Information for Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) Service Members and Veterans**

Attachment-informed parenting interventions may have particular relevance for the OEF/OIF/OND Service Members, many of whom have families. OEF/OIF/OND Service Members are part of the longest military operation in history. Two million

soldiers have been deployed, often for extended deployments and/or more than one deployment (Pickett et al., 2015). With more frequent and longer deployments, soldiers have less time at home with family. This is notable as service member demographics now include more women and more parents of young children than previous cohorts (Institute of Medicine, 2013). In 2012, 43.6% of military personnel including DoD Active Duty and Selected Reserve population had children, and the total number of military children was estimated to be 1,946,456 (Department of Defense, 2013). Of children in military families, 37.5% were under 5 years old, 30.4% were between 6 to 11 years old, and 24.9% were between 12 to 18 years old (Department of Defense, 2013). As a family population likely to experience separation and loss, the growing military family population is one that is likely to benefit from attachment informed parenting information and intervention.

### **Special Topics in Parenting**

Topics such as spoiling, the use of corporal punishment, understanding of childhood development, the reciprocal nature of the parent-child relationship, and mental health concerns of parents were identified through interviews with foster and adoptive parents who participated in the Attachment Security Course and through clinical experience in providing an Attachment Security course to military Veteran parents. Additionally, the literature supports the importance of such topics in relationship to mental and physical health (Shonkoff, Boyce, & McEwen, 2009). In line with the Adverse Childhood Events Study (ACES), literature has found childhood adversity and problematic family contexts impact children's wellbeing long-term (Chapman et al., 2004; Felitti, Anda, & Nordenberg, 1998).

As described by Turner et al., (2012), the Centers for Disease Control and Prevention created the Safe, Stable Nurturing Relationships or SSNR heuristic to organize three important variables in relation to the family context and children's wellbeing. Safety is identified as the "extent to which children are free from fear and harm within their social and physical environment"; stability is identified as "consistency and predictability in the child's environment"; and nurturing is identified as "availability, sensitivity, and warmth in responding to children's needs" (Turner et al., 2012, p. 210). In response to a call from the Centers for Disease Control and Prevention to study "safe, stable, and nurturing relationships between children and caregivers" Turner et al., (2012) sought to examine the relationships between childhood family experiences and contexts such as maltreatment, abuse, parenting behaviors, (including the use of corporal punishment), parent dysfunction (including parent psychological disorder and substance



or alcohol abuse), family stressors and instability, which represent domains across SSNRs. Additionally, they sought to examine the relationship between such SSNRs and childhood trauma symptoms. They found unsafe, unstable, and non-nurturing variables in the family context had negative and cumulative impact on childhood wellbeing. Their findings indicate that emotional abuse, inconsistent, and hostile parenting had particularly strong influence on prevalence of childhood trauma symptoms (Turner et al., 2012). Special topics such as spoiling, corporal punishment, developmental expectations, the reciprocal nature of the parent-child relationship, and the mental health concerns of parents are relevant to the SSNR model, and Turner et al.'s (2012) findings further implicate the importance of addressing such topics through programs and interventions which promote positive parent-child relationships.

### **Responding to Parent's Questions using an Attachment-Informed Perspective**

When conducting the interventions using an attachment-based perspective with parents, questions and concerns are welcomed to help the caregivers deepen their understanding. Questions about the following topics have often emerged indicating that facilitators and parents may benefit from further guidance about the topic. It is helpful to be aware of these general topics and have ideas about how to address these issues, whether in parent consultation or in psychoeducational courses. When guiding parents through examples of how to understand parent-child interaction, therapists may refer to the following rubric, which provides a frame for navigating situations from an attachment informed perspective:

See	<p>Notice the child’s behavior. Attend to the following elements of the child’s behavior:</p> <ul style="list-style-type: none"> <li>• Body Orientation</li> <li>• Proximity/ Contact</li> <li>• Tone of Voice</li> <li>• Content of Speech</li> <li>• Affect</li> <li>• Body Language</li> <li>• Eye Gaze</li> <li>• Behavior in the context of development and situation</li> </ul>
Read	<p>Determine if the child’s needs are inner needs (Need for an emotional “safe haven”) or outer needs (Need for a “secure base” from which to explore). Ask yourself:</p> <ul style="list-style-type: none"> <li>• What might my child need from me, as a person better able to navigate the world? (Is this an inner or outer need)</li> </ul> <p>Then consider:</p> <ul style="list-style-type: none"> <li>• Is my child directly communicating their needs?</li> <li>• Is my child miscuing, or behaving in a way that would elicit a response inconsistent with their need for connection?</li> </ul>
Reflect	<p>Notice your own reaction. Ask yourself:</p> <ul style="list-style-type: none"> <li>• What thoughts and feeling am I feeling right now?</li> <li>• How does my child’s behavior impact my response?</li> </ul>
Respond	<p><b>If Inner Needs</b> Attend to Inner needs or emotional needs of protection and acceptance:</p> <ul style="list-style-type: none"> <li>• Soothe</li> <li>• Listen</li> <li>• Reflect thoughts/feelings</li> <li>• Validate thoughts and feelings as appropriate</li> </ul> <p><b>If Outer Needs</b> Attend to outer needs of support, coaching and partnership:</p> <ul style="list-style-type: none"> <li>• Exploration</li> <li>• Learning</li> <li>• Problem-solving</li> <li>• Following rules</li> <li>• Discipline</li> <li>• Teaching</li> </ul> <p style="text-align: right;">Atwood</p>

## **Spoiling**

When the Attachment Security framework is presented to parents, concerns related to spoiling, or being too lenient or indulgent with a child, may be expressed. The Attachment Security framework highlights children’s “inner needs” or emotional needs, and teaches parents that children’s misbehavior may be interpreted as a need for connection to the parent, who is better able to cope with the world and assist them in navigating stressors. Typically when concerns about spoiling arise, parents have misinterpreted the idea that attending to the child’s “inner needs” or emotional needs is incompatible with providing appropriate consequences for misbehavior. This is not the case and parents may be reassured that seeking connection with the child, does not equate to indulgence or rewarding misbehavior. Examples may be offered for the parent to consider.

*After school, Jane rushes in the door, pushes her backpack to the corner, and loudly announces, “I’m going to play outside.” Her mother says, “Jane, I know you have homework. When you complete your homework then you can go outside. Why don’t you sit down at the table and get your books out. I will bring you a snack.” Jane raises her voice and says, “You are being unfair!” Jane goes to her room and slams the door. Jane’s mother is irritated and confused by Jane’s outburst. She takes some deep breaths and few minutes to consider what about this situation is distressing for Jane. She also asks herself what Jane might need from her. Jane’s mother goes Jane’s room, sits near Jane and calmly says, “I see your frustration. You really don’t want to do your homework tonight. You would rather play outside.” As Jane’s mother gazes at Jane, she notices Jane unfold her arms and look up a bit. Jane says, “Yeah. I am frustrated. I found out today that I got a ‘D’ on my last spelling test. There’s no point in doing this stupid homework, if I’m just going to get bad grades anyway!” Jane’s mother says, “You wanted a higher grade and you put time into studying for that spelling test. What are you thinking about your upcoming test?” Jane’s voice softens a bit and she says, “Yeah. We have to do test corrections when we get bad grades, and it’s embarrassing because all the other kids know who has to do test corrections. I’m worried I’ll get a bad grade again and feel embarrassed.” Jane’s mother*

*continues to ask Jane open-ended questions and validate Jane's thoughts and feelings. When Jane's mother notices that Jane has calmed down, she suggests, "How about we take a look at your spelling words together tonight? I can show you some strategies for remembering that worked for me when I was your age.*

The example illustrates the parent attending to the child's inner needs by validating the child's feelings. Jane's refusal to do her homework, raising her voice to her mother, and slamming her bedroom door was not appropriate behavior. Jane's mother did not excuse or condone her behavior. However, by validating Jane's feelings and attending to her emotional needs, she assisted Jane in moving to a calmer state. When Jane was calm, Jane's mother was able to assist her with adaptive problem solving. Jane's mother engaged in partnership behavior when she assisted Jane in navigating a challenging task/situation.

## **Corporal Punishment**

In addition to concerns related to being too lenient with a child, beliefs about the use of corporal punishment may be expressed. Clinicians will need to keep in mind duties related to mandated reporting, should disclosure of child abuse occur. If abuse is disclosed, necessitating a report to Child Protective Services (CPS), the clinician may consider modeling attuned partnership behavior; collaboratively making the report together with the parent in manner that attends to the parent's inner and outer needs by offering emotional support and assisting the parent in navigating the situation with CPS. This act would provide an experiential example of balancing connection and accountability for behavior.

If the parent is calm and particularly open and engaged, the facilitator may choose to assist the parent in exploring alternative options to corporal punishment, which allow for connection and appropriate consequences or natural consequences, outcomes that happen as a result of behavior that are not planned or controlled (Pryor & Tollerud, 1999). The facilitator may offer examples such as the example below. The literature demonstrates punishment is an ineffective strategy for behavior management (<https://www.apa.org/research/action/speaking-of-psychology/disciplining-children.aspx>). Education regarding the literature on punishment may be approached if the clinician judges that the parent would benefit from and is open to such information, however; this may also put the parent in a defensive position and create a power struggle. As psychoeducation reflects an outer need, clinicians may consider whether the parent they are working with has had their inner needs met and is calm, open, and engaged prior to proceeding to such tasks.

*Isaiah came home from school with a scowl on his face. He walked past his father, ignored his greeting and headed straight to his bedroom without speaking. His father realized his son was distressed and went back to his room. Isaiah was curled up on his bed and did not look up. His father said, "Son, you looked upset when you came home. It's not like you to go straight to your room without saying anything." Isaiah was silent. His father inquired, "Did something happen at school?" Isaiah silently handed his father a note from his teacher, which described an argument he was in with another student. His father said, "Oh, I can see it was a really tough day. You had an argument with one of your classmates and on top of that, got in trouble with your teacher. Those are both pretty upsetting things, and those kinds of things happen- even to adults sometimes." Isaiah shifted and turned his gaze toward his father. "When I have a difficult day at work, I often need some time to calm down and relax at home. You look comfortable here in your bed." Isaiah said, "I am. I want to be alone." His father said, "Sure. I understand. Here's a cool glass of water. You relax for a bit, and I'll be back in to check on you after awhile." Isaiah's father sat in the living room reading for a few minutes and went back to check on Isaiah just as he said he would. He said, "How are you doing, Isaiah?" Isaiah sat up and began to share parts of his story in a sad voice. His father listened, and paid particular attention to Isaiah's thoughts and feelings.*

*Later that evening, after dinner, when Isaiah appeared calm, his father said, "When these things happen, you always have an opportunity to choose how you will respond. How about you and I sit down together and work on a letter of apology to your teacher and your classmate?"*

Again, this example illustrates the parent attending to the child's inner needs by listening to and validating the child's feelings. The parent also supports the child's outer needs and engages in partnership behavior, assisting the child with an adaptive way forward.

## **Developmental Expectations**

It is important for therapists and parents to consider children's behavior in the context of development. An awareness of typical development in terms of emotional, social, and cognitive functioning can help us better understand children's behaviors and provide a reference point for parental expectations.

The average human brain is not fully developed until a person is in their mid-twenties. The extended period of development in humans allows for complexity in emotional, social, and cognitive functioning. People are afforded the luxury of an extended developmental period due to the presence of parent/caregiver relationships. Parents and caregivers are wiser, stronger and better able to navigate the challenges of the world, and their nurturance, guidance, and protection provide safety to the child during the vulnerability of development.

It should be noted that although "typical" development can be used as an approximate guide, each child is unique based on their own genetics and set of experiences. Some variation should not be cause for alarm.

Therapists may wish to utilize charts, such as the following chart adapted from the Centers for Disease Control and Prevention (2017), to engage parents in discussion of their child's development.



Age	Social/Emotional Tasks	Thinking/Learning Tasks
Infants (0-1)	<ul style="list-style-type: none"> <li>• Develop love and trust with parents and others</li> </ul>	<ul style="list-style-type: none"> <li>• Language development</li> </ul>
Toddler (1-2)	<ul style="list-style-type: none"> <li>• Show greater independence</li> <li>• Demonstrate defiant behavior</li> </ul>	<ul style="list-style-type: none"> <li>• Form simple phrases</li> <li>• Follow simple directions</li> </ul>
Toddler (2-3)	<ul style="list-style-type: none"> <li>• Express a wide range of emotions</li> <li>• Imitate actions of adults or peers</li> </ul>	<ul style="list-style-type: none"> <li>• Follow 2 or 3 step directions</li> <li>• Sort objects by color or shape</li> </ul>
Preschool (3-5)	<ul style="list-style-type: none"> <li>• Play with other children</li> </ul>	<ul style="list-style-type: none"> <li>• Dress themselves</li> <li>• Recall a story</li> </ul>
Childhood (6-8)	<ul style="list-style-type: none"> <li>• Friendship and peer acceptance become more important</li> <li>• More independent from family</li> </ul>	<ul style="list-style-type: none"> <li>• Think about the future</li> <li>• Become better at describing thoughts and feelings</li> <li>• Demonstrate more concern for others</li> </ul>
Middle Childhood (9-11)	<ul style="list-style-type: none"> <li>• Develop closer peer relationships</li> <li>• Peer pressure</li> <li>• Puberty approaches</li> </ul>	<ul style="list-style-type: none"> <li>• Increased attention span</li> <li>• See other's perspectives more clearly</li> <li>• Experience increased academic challenges</li> </ul>
Young Teen (12-14)	<ul style="list-style-type: none"> <li>• Increased attention to peer groups</li> <li>• Increased moodiness</li> <li>• Increased attention to self-image</li> </ul>	<ul style="list-style-type: none"> <li>• Develop more complex thought processes</li> <li>• Stronger sense of right and wrong</li> <li>• Better able to express emotion through talking</li> </ul>
Teenager (15-17)	<ul style="list-style-type: none"> <li>• Increasingly independent from parents</li> <li>• Increased capacity for deeper relationships</li> </ul>	<ul style="list-style-type: none"> <li>• Develop work habits</li> <li>• Plan for the future</li> <li>• Are better able to provide reasons for their choices</li> </ul>

#### Several Examples:

- It is unlikely a 5-year old child would have the ability to verbally describe his/her thoughts and feelings to their parent and may express emotion through acting out, withdrawing, expressing physiological complaints (like a stomach ache), or experiencing difficulty with concentration.

- A toddler would likely need simple directions such as, “Please bring your shoes”, as opposed to more complex directions requiring more cognitive ability, “After you finish brushing your teeth, please bring your shoes, shoes, and coat downstairs.”
- A teenager is likely to spend more time with friends and may demonstrate some defiant behavior toward parents as the teenager strives for more independence.

## Reciprocal Nature of Parent-Child Relationship

Parent-child relationships are bi-directional, and there is a mutual interchange related to each party's behavior. In other words, what the child does will impact the parent and what the parent does will impact the child. The following example demonstrates this concept within the context of separation and loss.

*Mrs. Gonzalez and her 8-year old son Mike missed each other and looked forward to her return home from deployment. Mrs. Gonzalez returned home from Afghanistan 6 months ago now. Mrs. Gonzalez reported that she had some difficulty transitioning back to civilian life and has continued feeling “numb” and distant from her son and husband since she returned. She is currently engaged in treatment for symptoms of Post-traumatic Stress Disorder. She endorsed symptoms of avoidance as being particularly bothersome. She avoids crowds, public spaces, particularly noisy areas, and some TV shows and movies. Mrs. Gonzalez also reported distress about several situations at home and is worried that Mike's performance at school has steadily declined. She believes he has taken less initiative in completing tasks like his homework, which is unlike him, and stated that he often complains of stomachaches, though his doctor has found nothing physically wrong. Mrs. Gonzalez' husband stated that he feels like things have changed a lot for everyone since the family reunited and noted that it was not the happily ever after reunion they had hoped.*

When considering the reciprocal nature of the parent-child relationship, it is clear that Mrs. Gonzalez' deployment impacted Mike (and the family unit as a whole) and Mike's behavior impacts his family unit. Mike perceives and experiences changes in his mother's behavior and affect, in particular, his mother reported feeling distant and “numb”, which is indicative of a loss of connection emphasized in the attachment frame. Mike has responded to the loss of connection with behaviors indicative of distress in children, such as physiological complaints and behavioral changes. Mike's changes in behavior are distressing to his mother who would like to see him do well and may inadvertently further exacerbate her symptoms of PTSD. Attachment security

interventions could interrupt this pattern and would provide a frame to enhance the Gonzalez' understanding of Mike's behavior as well as provide ideas for improving the parent-child connection in a way that that attends to both Mike's inner and outer needs.

## **Mental Health Concerns of Parents**

The scope of the Attachment Security parenting course is not intended to address crises situations or specific issues related parental mental health. Families who are currently in crisis should utilize other resources to first address the crisis situation. Parents who are dealing with their own mental health concerns, including symptoms of Posttraumatic Stress Disorder, a Substance Abuse disorder, or sequelae of traumatic brain injury should have outside resources for coping with those concerns. If these are acute mental health concerns those should be attended to first. If parents have chronic mental health concerns those concerns may be dealt with simultaneously, in another setting by an appropriate provider.

It is helpful to have resource contact information easily accessible. The following are a list of resources to identify in your area:

- Crisis phone numbers
  - 911
  - Suicide Hotline
  - Local Emergency Department Information
  - Police
- Contact information for at least 3 local therapists who work with adults on a variety of issues
- Contact information for 3, if possible, local psychiatrists
- Department of Social Services Contact Information
- Homeless Shelter
- Women's Shelter
- Local food banks

## References

- Ammerman, R. T., Shenk, C.E., Teeters, A.R., Noll, J.G., Putnam, F.W., & van Ginkel, J.B. (2013). Multiple mediation of trauma and parenting stress in mothers in home visiting. *Infant Mental Health Journal, 34*, 234-241.  
<http://dx.doi.org/10.1002.imhj.21383>
- Bailey, H. N., DeOliveira, C. A., Wolfe, V. V., Evans, E. M., & Hartwick, C. (2012). The impact of childhood maltreatment history on parenting: A comparison of maltreatment types and assessment methods. *Child Abuse & Neglect, 36*, 236-246.  
<http://dx.doi.org/10.1016/j.chiabu.2011.11.005>
- Booth, P. B., & Jernberg, A. M. (2010). *Theraplay: Helping parents and children build better relationships through attachment based play* (3<sup>rd</sup> ed.). San Francisco, CA: Jossey-Bass.
- Bowlby, J. (1951). Maternal care and mental health. *Bulletin of the World Health Organization, 3*, 355-533.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Bratton, S. C., Landreth, G. L., Kellam, T., Blackard, S. R. (2006). *Child parent relationship therapy treatment manual*. New York, NY: Routledge.
- Centers for Disease Control & Prevention. (2009). Preventing child maltreatment through the promotion of safe, stable, and nurturing relationships between children and caregivers. Atlanta, GA: Author.
- Centers for Disease Control and Prevention (2017). Child development. Retrieved from <https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/infants.html>

- Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective disorders*, *82*, 217-225.  
<http://dx.doi.org/10.1016/j.jad.2003.12.013>
- Creswell, J. W. & Plano-Clark, V. L. (2011). *Designing and conducting mixed methods research* (2<sup>nd</sup> ed.). London: SAGE Publications, Inc.
- Department of Defense. (2013). *2012 Demographics: Profile of the military community*. Office of the Deputy Under Secretary of Defense (Military Community and Family Policy).
- Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: Findings from the Adverse Childhood Experiences Study. *JAMA: Journal of the American Medical Association*, *286*, 3089-3096. <http://dx.doi.org/10.1001/jama.286.24.3089>
- Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J., & Croft, J. B. (2002). Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive Behaviors*, *27*, 713–725. [http://dx.doi.org/10.1016/S0306-4603\(01\)00204-0](http://dx.doi.org/10.1016/S0306-4603(01)00204-0)
- Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics*, *111*, 564–572.  
<http://dx.doi.org/10.1542/peds.111.3.564>

- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., .. Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*, 245–258.
- Haft, W. L., & Slade, A. (1989). Affect attunement and maternal attachment: A pilot study. *Infant Mental Health Journal*, *10*, 157– 172.  
[http://dx.doi.org/10.1002/1097-0355\(198923\)10:3157::AIDIMHJ22801003043.0.CO;2-3](http://dx.doi.org/10.1002/1097-0355(198923)10:3157::AIDIMHJ22801003043.0.CO;2-3)
- Institute of Medicine (2013). Returning home from Iraq and Afghanistan: Assessment of readjustment needs of Veterans, service members, and their families. The National Academy of Sciences. Retrieved from <http://www.iom.edu/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.
- Lyons-Ruth, K., & Jacobvitz, D. (2008). Attachment disorganization: Genetic factors parenting contexts, and developmental transformations. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed., pp. 666–697). New York, NY: Guilford Press.
- Main, M., Goldwyn, R., & Hesse, E. (2003). *Adult Attachment Classification System (Version 7.2)*. Unpublished manuscript, University of California, Berkeley, California.
- Main, M., Hesse, E., & Goldwyn, R. (2008). Studying differences in language use in



- recounting attachment history. In H. Steele & M. Steele (Eds.), *Clinical applications of the Adult Attachment Interview* (pp. 31–68). New York, NY: Guilford Press.
- Meade, C. S., Kershaw, T. S., Hansen, N. B., & Sikkema, K. J. (2009). Long-term correlates of childhood abuse among adults with severe mental illness: Adult victimization, substance abuse, and HIV sexual risk behavior. *AIDS and Behavior, 13*, 207–216. <http://dx.doi.org/10.1007/s10461-007-9326-4>
- Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., . . . Steele, H. (2014). Adverse Childhood Experiences (ACEs) questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships. *Child Abuse & Neglect, 38*, 224–233.
- Pickett, T., Rothman, D., Crawford, E. F., Brancu, M., Fairbank, J. A., & Kudler, H. S. (2015). Mental health among military personnel and Veterans. *North Carolina Medical Journal, 76*(5), 299-306.
- Pryor, D. B. & Tollerud, T. R. (1999). Applications of Adlerian principles in school settings. *Professional School Counseling, 2*(4), 299-304.
- Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *JAMA, 301*, 2252–2259.
- Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development, 7*, 269–281. <http://dx.doi.org/10.1080/1461673050024590>
- Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study

- from birth to adulthood. *Attachment & Human Development*, 7, 349–367.  
<http://dx.doi.org/10.1080/14616730500365928>
- Steele, H., Steele, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers, fathers, and their infants. *Child Development*, 67, 541–555. <http://dx.doi.org/10.2307/1131831>
- Steele, H., Bate, J., Steele, M., Dube, S. R., Danskin, K., Knafo, H., Nikitiades, A., Bonuck, K., Meissner, P., & Murphey, A. (2016). Adverse childhood experiences, poverty, and parenting stress. *Canadian Journal of Behavioral Science*, 41(1), 32–38.
- Turner, H. A., Finkelhor, D., Ormrod, R., Hamby, S., Leeb, R. T., Mercy, J. A., & Holt, M. (2012). Family context, victimization, and child trauma symptoms: Variations in safe, stable, and nurturing relationships during early and middle childhood. *American Journal of Orthopsychiatry*, 82(2), 209-219.  
<http://dx.doi.10.1111/j.1939-0025.2012.01147.x>
- van IJzendoorn, M. H. (1995). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological Bulletin*, 117, 387–403.  
<http://dx.doi.org/10.1037/0033-2909.117.3.387>

## References

- Abidin, R. R. (2012). Parenting Stress Index-Manual (4th. ed.) Lutz, FLPAR.
- Ainsworth, M. D., Blehar, M, Waters, E, & Wall, S. (1978). Patterns of attachment: A psychological study of the strange situation. Hillsdale, NJ: Lawrence Erlbaum.
- Albano, S. (1994). Military recognition of family concerns: Revolutionary war to 1993. *Armed Forces and Society*, 20, 283-302.
- Barlow, D. H. (2004). Psychological treatments. *American Psychologist*, 59, 869-878.
- Bick, J., & Dozier, M. (2013). The effectiveness of an attachment-based intervention in promoting foster mother's sensitivity toward foster infants. *Infant Mental Health*, 34(2), 95-103.
- Booth, P. B., & Jernberg, A. M. (2010). *Theraplay: Helping parents and children build better relationships through attachment based play* (3<sup>rd</sup> ed.). San Francisco, CA: Jossey-Bass.
- Bowlby, J. (1951). Maternal care and mental health. *World Health Organization Monograph*.
- Bowlby, J. (1969). *Attachment and loss, Vol. 1: Attachment*. New York: Basic Books.
- Bowlby, J. (1973). *Attachment and loss, Vol. 2: Separation*. New York: Basic Books.
- Bowlby, J. (1980). *Attachment and loss, Vol. 3: Loss, sadness and depression*. New York: Basic Books.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Bratton, S. C., Landreth, G. L., Kellam, T., & Blackard, S. R. (2006). *Child parent relationship therapy treatment manual*. New York, NY: Routledge.

- Bratton, S., Opiola, K., & Dafoe, E. (2015). Child parent relationship therapy: A10-session filial therapy model. In D Crenshaw & A. Stewart (Eds.), *Play therapy: A comprehensive guide to theory and practice* (129-140). New York, NY: Guilford.
- Burlingham, D., & Freud, A. (1944). *Infants without families*.  
Oxford, England: Allen & Unwin.
- Cafferty, T. P., Davis, K. E., Medway, F. J., O'Hearn, R. E., & Chappell, K. D. (1994). Reunion dynamics among couples separated during Operation Desert Storm: An attachment theory analysis. In K. Bartholomew, & D. Perlman (Eds), *Attachment processes in adulthood. Advances in personal relationships, Vol. 5.*, (pp. 309-330). London, England: Jessica Kingsley Publishers.
- Calhoun L. G. & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R. G., Tedeschi, C. L., Park, & L. G., Calhoun. (Eds.), *Posttraumatic Growth: Positive changes in the aftermath of crisis* (pp.215-238). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.
- The California Evidence-Based Clearinghouse for Child Welfare. (2016). *Theraplay*. Retrieved from <http://www.cebc4cw.org/program/theraplay/detailed>
- Cassidy, J., Woodhouse, S. S., Sherman, L. J., Stupica, B., & Lejuez, C. W. (2011). Enhancing infant : An examination of treatment efficacy and differential susceptibility. *Developmental Psychopathology*, 23(1), 131-48.
- Cassidy, J., Ziv, Y., Stupica, B., Sherman, L. J., Butler, H., Karfgin, A., Cooper, G., Hoffman, K. T., & Powell, B. (2010). Enhancing in infants of women in a jail-diversion program. *Attachment and Human Development*, 12(4), 333-353.

- Charmaz, K. (2006). Coding in grounded theory practice. In *Constructing grounded theory: A practical guide through qualitative analysis* (pages of chapter). Thousand Oaks, CA: SAGE Publications.
- Child Welfare Information Gateway (2013). *How the Child Welfare System Works*. Retrieved from <https://www.childwelfare.gov/pubpdfs/cpswork.pdf>
- Child Welfare Information Gateway. (2016). [Foster care statistics 2014.] *Numbers and Trends*. Retrieved from <https://www.childwelfare.gov/pubs/factsheets/foster/>
- Children's Bureau. (2015). *The Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2014 data*. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf>
- Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J.L. (2004). Posttraumatic stress disorder and current relationship functioning among World War II ex-prisoners of war. *Journal of Family Psychology, 18*(1), 36-45.
- Creswell, J.W. & Plano-Clark, V.L. (2011). *Designing and conducting mixed methods research* (2<sup>nd</sup> ed.). London: SAGE Publications, Inc.
- Department of Defense (2013). Report of the department of defense task force on mental health.
- Defense and Veterans Brain Injury Center. (2017). DoD TBI Worldwide Numbers since 2000. Retrieved from <http://dvbic.dcoe.mil/dod-worldwide-numbers-tbi>.
- De Wolff, M., & van IJzendoorn, M.H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. *Child Development, 68*(4), 571-591.
- Dozier, M., Zeanah, C. H., & Bernard, K. (2013). Infants and toddlers in foster care.

- Child Development Perspectives*, 7, 166–171. doi:10.1111/cdep.12033
- Drummet, A.R., Coleman, M., & Cable, S. (2003). Military families under stress: Implications for family life education. *Family Relations*, 52(3), 279-287.
- Finkel, L. B., Kelley, M. L., & Ashby, J. (2003) Geographic mobility, family, and maternal variables as related to the psychosocial adjustment of military children. *Military Medicine*, 168, 1012-1019.
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, 9, 679-700.
- Fonteyn, M. E., Vettese, M., Lancaster, D. R., & Bauer-Wu, S. (2006). Developing a codebook to guide content analysis of expressive writing transcripts. *Applied Nursing Research*, 21, 165–168.
- Gewirtz, A. H., Polusny, M. A., DeGarmo, D. S., Khaylis, A., & Erbes, C. R. (2010). Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq: Associations with parenting behaviors and couple adjustment. *Journal of Consulting Clinical Psychology*, 78(5), 599–610. doi:10.1037/a0020571
- Gewirtz, A. H., Erbes, C. R., Polusny, M. A., Forgatch, M. S., & DeGarmo, D. S. (2011). Helping military families through the deployment process: Strategies to support parenting. *Professional Psychology: Research and Practice*, 42(1), 56-62.
- Hendrix, C.C., Erdmann, M.A., & Briggs, K. (1998). Impact of Vietnam veterans' arousal and avoidance on spouses' perceptions of family life. *American Journal of Family Therapy*, 26(2), 115-128.
- Hertsgaard, L., Gunnar, M., Erickson, M. F., & Nachmias, M. (1995). Adrenocortical

- responses to the strange situation in infants with disorganized/disoriented attachment relationships. *Child Development*, 66, 1100–1106. doi:10.1111/j.1467-8624.1995.tb00925.x
- Hofer, M. A. (1994). Hidden regulators in attachment, separation, and loss. *Monographs of the Society for Research in Child Development*, 59, 192–207.
- Hofer, M. A. (2006). Psychobiological roots of early attachment. *Current Directions in Psychological Science*, 15, 84–88.
- Jensen, P. S., Martin, D., & Watanabe, H. (1996). Children's response to parental separation during Operation Desert Storm [Electronic Version]. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 433-441.
- Jernberg, A. (1984). Theraplay: Child therapy for attachment fostering. *Psychotherapy*, 21(1), 39-47.
- Jernberg, A. M., & Booth, P. B. (1999). Theraplay: Helping parents and children build better relationships through attachment-based play. San Francisco: Jossey-Bass Publishers.
- Johnson, S. J., Sherman, M. D., Hoffman, J. S., James, L. C., Johnson, P. L., Lochman, J. E., Magee, T. N., Riggs, D., Daniel, J. H., Palomares, R. S., Nicoles-Howarth, B., & Stepney, B. (2007). *The psychological needs of U.S. military service members and their families: A preliminary report*. Retrieved from <https://www.apa.org/about/policy/military-deployment-services.pdf>
- Kelley, M. L., Hock, E., Bonney, J., Jarvis, M., Smith, K., & Gaffney, M. (2001). Navy mothers experiencing and not experiencing deployment: Reasons for staying in or leaving the military. *Military Psychology*, 13(1), 55-71.

- Kessler, R. C. (2000). Posttraumatic stress disorder: the burden to the individual and to society. *Journal of Clinical Psychiatry, 61*.
- Kobak, R., Cassidy, J., Lyons-Ruth, K., & Ziv, Y. (2006). Attachment, stress, and psychopathology: A developmental pathways model. In D. Cicchetti, D.J., Cohen, (Eds.), *Developmental Psychopathology, Vol 1: Theory and method (2nd ed.)*, (pp. 333-369). Hoboken, NJ: John Wiley & Sons Inc.
- Lester, P., Liang, L., Milburn, N., Mogil, C., Woodward, K., Nash, W., Aralis, H., Sinclair, M., Semaan, A., Klosinski, L., Beardslee, W., & Saltzman, W. (2016). Evaluation of a family-centered preventative intervention for military families: Parent and child longitudinal outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry, 55*(1), 14-24.
- Makela, J., & Vierikko, I. (2004). From heart to heart: Interactive therapy for children in care. Report on the Theraplay project in SOS children's villages in Finland 2001-2004. *The SOS children's villages in Finland*.
- McKay, J. M., Pickens, J., & Stewart, A.L. (1996). Inventoried and observed stress in parent-child interactions. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues, 15*(3), 223-234.
- Medway, F. J., Davis, K. E., Cafferty, T. P., Chappell, K. D., & O'Hearn, R. E. (1995). Family disruption and adult attachment correlates of spouse and child reactions to separation and reunion due to Operation Desert Storm. *Journal of Social and Clinical Psychology, 14*(2), 97-118.
- National Institute on Drug Abuse (2003). The effects of substance of abuse on behavior and parenting Retrieved from



- <https://www.ncsacw.samhsa.gov/files/TrainingPackage/MOD2/EffectsofSubstanceAbuse.pdf>
- National Institute on Drug Abuse (2013). Substance abuse in the military. Retrieved from <https://www.drugabuse.gov/publications/drugfacts/substance-abuse-in-military>
- Nichols, M. P. (2013). Family therapy: *Concepts and methods* (10<sup>th</sup> ed.). Upper Saddle River, NJ: Pearson Education, Inc.
- Office of the Deputy under the Secretary of Defense (2011). *2011 Demographics profile of the military community*. Retrieved from [http://download.militaryonesource.mil/12038/MOS/Reports/2011\\_Demographics\\_Report.pdf](http://download.militaryonesource.mil/12038/MOS/Reports/2011_Demographics_Report.pdf)
- Okie, S. (2005). Traumatic brain injury in the war zone. *New England Journal of Medicine*, 352(20), 2043-2047.
- Paris, R., DeVoe, E. R., Ross, A. M., & Acker, M.L. (2010). When a parent goes to war: Effects of parental deployment on very young children and implications for intervention. *American Journal of Orthopsychiatry*, 80(4), 610-618.
- Pessar, L. F., Coad, M. L., Linn, R. T., & Willer, B. S. (1993). The effects of parental traumatic brain injury on the behavior of parents and children. *Brain Injury*, 7(3), 231-240.
- Pincus, S. H., House, R., Christenson, J., & Adler, L. E. (2006). *The emotional cycle of deployment: A military family perspective*. Retrieved from <http://hooah4health.com/deployment/familymatters/emotionalcycle.htm>.
- Reynolds, C. R., & Kamphaus, R. W. (2015). Behavior assessment system for children (3rd ed.). Circle Pines, MN: American Guidance Service

- Riggs, S. A., & Riggs, D.S. (2011). Risk and resilience in military families experiencing deployment: The role of the family attachment network. *Journal of Family Psychology, 25*(5), 675-687.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: "At last the Dodo said, 'Everybody has won and all must have prizes'". *American Journal of Orthopsychiatry, 6*, 412-415.
- Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data* (3<sup>rd</sup> Ed.). Thousand Oaks, CA: SAGE Publications.
- Substance Abuse and Mental Health Service Administration. (2016). *National Registry of Evidence-based Programs and Practices: Attachment and Biobehavioral Catch-up (ABC)*. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=68>
- Substance Abuse and Mental Health Service Administration. (2016). *National Registry of Evidence-based Programs and Practices: Child Parent Relationship Therapy*. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=196>
- Substance Abuse and Mental Health Service Administration. (2016). *National Registry of Evidence-based Programs and Practices: Theraplay*. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=156#hide4>
- Segal, M.W., & Segal, D.R. (2006). Implications for military families of changes in the armed forces of the United States. In G. Caforio (Ed.). *Handbook of the Sociology of the Military*. (pp. 225-233). Springer Science.
- Shore, P., Murphy, P., Lai, W. P., & Weingardt, K.R. (2013). Parenting for Service Members and Veterans (Version 1.0). [Web-based self-help course]. Retrieved

- from <http://www.VeteranTraining.va.gov/parenting/> United States Department of Veterans Affairs. (2014). *Veteran population*. Retrieved from [http://www.va.gov/vetdata/Veteran\\_Population.asp](http://www.va.gov/vetdata/Veteran_Population.asp)
- Smith, R. C, Chun, R. S., Michael, R. L., & Schneider, B. J. (2013). Operation BRAVE families: A preventative approach to lessening the impact of war on military families through preclinical engagement. *Military Medicine*, 178, 174-179.
- Sroufe, L. A., Egeland, B., Carlson, E., & Collins, W. A. (2005). Placing early attachment experiences in developmental context. In K. E. Grossmann, K. Grossmann, & E. Waters (Eds.), *The power of longitudinal attachment research: From infancy and childhood to adulthood*. (pp. 48-70) New York, NY: Guilford Publications.
- Sroufe, A., & Siegel, D. J. (2011). The verdict is in: The case for attachment theory. *Psychotherapy Networker*.
- Stewart, A. L., & Whelan, W. (2015). Disruption and dissolution in adoption and foster care. In N. Boyd-Webb, *Play therapy with children in crisis, 4th edition*. New York, NY: Guilford Press.
- The Theraplay Institute. (2013). *Theraplay Treatment Outcome Research*. Retrieved from <http://www.theraplay.org/index.php/theraplay-research>
- Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children*. New York, NY: W.W. Norton & Company.
- Ulysal, S., Hibbard, M. R., Robillard, D., Pappadopoulos, E., & Jaffe, M. (1998). The effect of parental traumatic brain injury on parenting and child behavior. *Journal of Head Trauma Rehabilitation*, 13(6), 57-71.

- van IJzendoorn M. H., & Bakermans-Kranenburg. M.J. (2009). Attachment security and disorganization in maltreating families and orphanages. In *Encyclopedia on Early Childhood Development*. Retrieved from [http://www.enfant-encyclopedie.com/Pages/PDF/van\\_IJzendoorn-Bakermans-KranenburgANGxp-Attachment.pdf](http://www.enfant-encyclopedie.com/Pages/PDF/van_IJzendoorn-Bakermans-KranenburgANGxp-Attachment.pdf)
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270-277.
- Westat. (2010). *National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses*. Retrieved from <http://www.va.gov/vetdata/docs/SurveysAndStudies/NVSSurveyFinalWeightedReport.pdf>
- Whelan, W., & Stewart, A. L. (2015). Attachment Security as a framework for play therapy. In D. Crenshaw, & A.L. Stewart (Eds.). *Play therapy: A comprehensive guide to theory and practice, (114-128)*. New York, New York: Guilford Press.