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Exploring Clinicians' Use of Evidence-Based Interventions that Treat Attachment Problems between Children, Five Years of Age and Under, and their Primary Caregivers

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2014

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Exploring Clinicians' Use of Evidence-Based Interventions that Treat Attachment Problems between Children, Five Year of age and under, and their Primary Caregivers

ABSTRACT

This exploratory quantitative study was an attempt to address the dearth of research regarding the use of attachment-focused evidence-based treatments (AF EBT) in the clinical setting. Thirty-eight Master's level or higher licensed mental health clinicians who work with children that are five years old and under, as well as with their primary caregivers, were surveyed via an anonymous web based questionnaire. The survey explored clinicians' level of awareness, training, use, adaptation, and perceived effectiveness regarding four AF EBTs, as well as potential barriers that may have impeded their use. The AF EBTs were Child-Parent Psychotherapy (CPP), Attachment and Biobehavioral Catch-UP (ABC), Video-feedback Intervention to promote Positive Parenting (VIPP), and Circle of Security (COS).

The findings showed that most participants were unfamiliar with the AF EBTs, despite being familiar with attachment theory and favorable toward evidence-based treatments (EBT). Even fewer participants used the AF EBTs. However, those that did, unanimously felt they were effective, with the exception of the ABC intervention. Most respondents adapted the AF EBTs. Without exception, being unaware of the existence of an AF EBT was by far the most commonly cited barrier that impeded its use. The other three most commonly cited barriers were: lack of agency support; difficulty accessing trainings; and not having a need for a new EBT. Implications and future recommendations are discussed.

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Most of all, I give thanks to my four year old daughter, who is my greatest source of joy and inspiration, and the one who has taught me most about attachment, development and life. I am blessed to have her in my life, and being her father is a gift, privilege and honor I cherish.

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CHAPTER I

Introduction

There is an abundance of research that has demonstrated how attachment plays a central role in human development and is critical to mental health (Ainsworth, 1969; Ainsworth, 1979; Allen, 2001; Davies, 2011; Karen, 1994; Lyons-Ruth, Easterbrooks, & Cibelli, 1997; Main, Hesse, & Kaplan, 2005; Shilkret & Shilkret, 2011; Sroufe, 2005). However, until recently, there had been a scarcity of research focusing on interventions that treat attachment problems (Bakersman-Kranenburg, van Ijzendoorn, & Juffer, 2003; Cook, Little, & Akin-Little, 2007; Cornell & Hamrin, 2008). Furthermore, some studies indicated that many of these interventions were not very effective (Bakermans-Kranenburg, Van Ijzendoorn, & Juffer, 2005; Bernard et al., 2012).

Given the important role attachment had been shown to play in regards to mental health, there was a clear need for more effective interventions that focused on treating attachment problems. Thankfully, in the past decade there has been a rapid increase in the development and research of attachment- focused interventions, especially in regards to interventions that are evidence- based and proven to be efficacious (Bernard et al., 2012; Dozier et al., 2006; Groeneveld, Vermeer, van IJzendoorn, & Linting, 2011; Herschell, Calzada, Eyberg, & McNeil, 2002; Hoffman, Marvin, Cooper, & Powell, 2006; Kalinauskiene et al., 2009; Lieberman, Ippen, & Van Horn, 2006; Oppenheim & Goldsmith, 2007; Zeanah, Berlin, & Boris, 2011).

Despite this progress, there is a dearth of research regarding the use of attachment-focused evidence-based treatments (AF EBT) in the clinical setting. Studies have shown that

there are often significant issues that can affect the successful implementation and widespread use of evidence-based treatments (EBT) in the clinical setting, thus leading to significant gaps between the research and clinical settings (Allen, Gharagozloo & Johnson, 2012; Karlin & Cross, 2014; Mitchell, 2011). EBTs need to expand beyond the research setting for them to be of actual use to clients,

Though it is likely that similar gaps between the research and clinical settings exist when it comes to AF EBTs, research regarding this matter is so scarce that one cannot conclusively make such a determination. Thus, there is a need for studies to ascertain if and how AF EBTs are used in the clinical setting. Given the tremendous scarcity of research in this area, this quantitative and exploratory study seeks to expand the very limited knowledge base regarding the use of AF EBTs in the clinical setting, and identify some of the factors that may impede their implementation from the research setting to the clinical setting.

Research has demonstrated that there are often many issues that can affect the demonstrated efficacy of an intervention when it is applied in the clinical setting (e.g. fidelity, supervision, follow-up training, etc.) (Garland et al., 2010; Mitchell, 2011; Schwalbe & Gearing, 2012). There are also many factors that can facilitate or impede the application of evidence-based treatments in the clinical setting, such as whether or not follow-up training and supervision is provided (Beidas, Edmunds, Marcus, & Kendall, 2012; Self-Brown, Whitaker, Berliner, & Kolko, 2012); how easily implementation support can be accessed (Mitchell, 2011; Schoenwald & H., 2001); organizational culture (Aarons & Sawitzky, 2006; Mitchell, 2011; Schoenwald & H., 2001); the amount of agency commitment and support that is provided (Mitchell, 2011; Schoenwald & H., 2001); clinicians' and administrators' attitudes toward EBTs (Aarons & Sawitzky, 2006; Mitchell, 2011; Schoenwald & H., 2001); the

attitudes of EBT developers and trainers toward clinicians and administrators (Kazdin, 2008); the design of the actual intervention (e.g. is it multifaceted and flexible enough to be easily adapted and used with the clinical population) (Kazdin, 2008); etc.

The proposed study involved surveying clinicians, via a web based anonymous quantitative questionnaire, regarding their use of AF EBTs to treat children, aged five years and under, and their primary caregivers. The purpose of the study was to expand currently limited research regarding the use of such interventions in the clinical setting, and identify some of the potential barriers that may contribute to a gap between research regarding these interventions and their application in the clinical setting. The research questions for this study were: 1) What are clinicians' level of awareness, training, use, fidelity versus adaptations, and perceived effectiveness of four AF EBTs in existence at this time and 2) What are some of the factors that may impede their implementation in the clinical setting? For the purpose of this study, a clinician is defined as any licensed mental health professional with a Masters level of education or higher, who works with children under five years of age and their primary caregivers.

AF EBTs are of particular relevance to social workers, relational aspects are central to both attachment theory and the practice of social work. Social workers are thus particularly well suited to apply AF EBTs effectively with their clients. Social workers, as well as any other mental health clinicians, strive to find interventions that will effectively help their clients. Given all of the above, there is a clear need for this study, as little is known about the actual use of AF EBTs in the clinical setting. We do not know how many clinicians are actually making use of AF EBTs. We do not know which factors may be impeding or

facilitating their dissemination and implementation. We do not know if they are as effective in the clinical setting as in the research setting.

Given the demonstrated importance of attachment to human development and mental health, and the fact that efficacious interventions that treat attachment problems now exist (i.e. AF EBTs), it is of great importance to take steps toward improving our understanding of how these interventions are being used in the clinical setting. This is ,especially the case, given that research has shown how fraught with problems EBTs can be in regards to their transition from the research to the clinical setting. If there are interventions in existence that may benefit our clients, we need to do everything we can to help ensure that these are indeed used effectively to treat them.

While the results of this study cannot be generalized due to limitations in sampling, the findings can add and further the very limited research regarding the use of AF EBTs in the clinical setting. The findings of this study may help justify and facilitate further research in this area. It may eventually lead to greater and more effective efforts being made toward dissemination, implementation and possibly adaptation of AF EBTs. This study may thus be a small but important step toward the ultimate goal of ensuring that AF EBTs reach as many clients as possible in the clinical population at large, and that they are used effectively in the clinical setting, so that clients may actually benefit from them.

CHAPTER II

Literature Review

The purpose of the study is to expand the currently limited research regarding the use of attachment-focused evidence-based treatments (AF EBT) that target children under five years of age and their primary caregivers, in the clinical setting; and to identify some of the potential barriers that may contribute to a gap between research and clinical settings.

Therefore, this chapter begins with a review of research that explains what attachment is; why it is so important; and the consequences that can occur when there are problems in the attachment system. The role of attachment in regards to development, and the broad details of the first five years of a child's development are then reviewed, because attachment plays such a critical role in human development (Davies, 2011). The importance of effective interventions that treat attachment problems is then highlighted, and followed by definitions of evidence-based treatment (EBT). This is followed by a review of the research that pertains to the four AF EBTs that are the focus of this study. The chapter concludes with a review of articles that focus on the gap between EBT research and their application in the clinical setting; the problems that often impede their implementation; and a presentation of the few studies that indicate the dearth of research regarding the dissemination and implementation of AF EBTs in the clinical setting.

Attachment Theory

Defined broadly and simply, *attachment* is the enduring affective bond that one individual develops toward another specific individual (Ainsworth, 1969; Ainsworth & Bell, 1970). As it will become clear in what is to follow, attachment is not a temporary, situational and variable phenomenon; and rather, it tends to be patterned, fixed and entrenched (Ainsworth,

1969; Davies, 2011; Shilkret & Shilkret, 2011; Weinfield, Sroufe, Egeland, & Carlson, 2008). Many attachment theorists believe that because human beings are so frail and dependent for so many years, they are biologically predisposed to attach or bond to at least one primary caregiver soon after birth (Allen, 2001; Bowlby, 1982; Cassidy, 2008; Davies, 2011). These theorists argue that infants develop such a bond as a means to ensure that they will be safe and that their needs will be met (Bowlby, 1988; Karen, 1994; Shilkret & Shilkret, 2011).

Assessing attachment: the Strange Situation and Adult Attachment Interview. Because of their emphasis on attachment's primary purpose being that of protection from danger, these theorists believe that attachment behavior is most easily observed when a child perceives danger and seeks their primary caregiver as a means of protection (Bowlby, 1982; Cassidy, 2008; Davies, 2011; Karen, 1994). This behavior is most easily observed typically between 12 and 18 months of age (Ainsworth & Bell, 1970; Ainsworth, 1979; Shilkret & Shilkret, 2011). Mary Ainsworth (1970, 1974, 1979a, 1979b) designed a procedure, called the Strange Situation, that can be used to provoke attachment behavior in order to observe, assess, and categorize a child's attachment pattern. The Strange Situation has been adapted to assess attachment categories at later years (Main et al., 2005; Sroufe, Egeland, Carlson, & Collins, 2005). Mary Main (1985, 1990, 2000, 2005) developed an assessment tool, called the Adult Attachment Interview (AAI), to help determine adults' attachment patterns. It is often considered the equivalent of the Strange Situation for adults. It is considered the gold standard for assessing adult attachment, like the Strange Situation is for children.

Types of attachment patterns. Ainsworth created a system that categorizes attachment into two broad types of attachment patterns: secure and insecure (Ainsworth, Bell & Stayton, 1972; Ainsworth, 1979; Ainsworth, 1974; Blehar et al., 1977; Bowlby, 1982; Davies, 2011;

Karen, 1994; Shilkret & Shilkret, 2011). Insecure attachment is also sometimes referred to as anxious attachment. Furthermore, Ainsworth's system divided insecure attachment into two subtypes of attachment patterns: Insecure/Ambivalent attachment and Insecure/Avoidant attachment (Ainsworth et al., 1972; Ainsworth, 1979; Bowlby, 1982; Davies, 2011; Karen, 1994; Shilkret & Shilkret, 2011). Mary Main later discovered that certain children's attachment patterns were disorganized, or became disorganized when under stress (Main & Hesse, 1990). Mary Main's AAI categorizes adult attachment patterns in a way that mirrors those for children: Secure-autonomous (Secure); Anxious/Dimissing (Insecure/Avoidant); Anxious/Preoccupied (Insecure/Ambivalent); and Unresolved Disorganized (Disorganized).

Secure attachment. *Secure attachment* is perhaps best conceived as the fixed affective bond between a child and his/her primary caregiver that is characterized by the child's internalized sense that the caregiver is a safe, protective, responsive and secure base from which he/she can safely explore his/her environment, and return to when the child perceives a threat (Ainsworth & Bell, 1970; Ainsworth, 1979; Bowlby, 1982; Bowlby, 1988; Karen, 1994; Shilkret & Shilkret, 2011). A child needs a caregiver that is attuned and responsive to its needs to develop a secure attachment (Ainsworth & Bell, 1970; Bowlby, 1982; Shilkret & Shilkret, 2011; Sroufe, 2005). By experiencing consistent and repeated responsiveness and security, the child develops positive representations, expectations, beliefs and organized views regarding his primary caregiver, himself and the world (Davies, 2011; Main, Kaplan, & Cassidy, 1985; Sroufe, 2005). Thus, the child develops an organized way of interacting with his/her primary caregiver, others and the world, and these translate into organized, observable behaviors that are categorized as secure attachment.

Ainsworth (1970, 1974, 1979, 1979b) noted that during the Strange Situation, securely

attached children are generally observed to engage in calm and exploratory behavior when in the presence of their primary caregiver. They, in effect, use their primary caregiver as a secure base from which to explore. These children will likely experience some level of distress when they perceive a potential threat, such as the presence of a stranger, and return to their primary caregiver for protection and reassurance (secure base). Once these children have re-established a sense of security, they will resume exploratory behavior. Ainsworth further details that if secure children are completely separated and unable to see their primary caregiver, they will likely experience even greater distress. However, when reunited with their primary caregiver, they can be reassured and comforted with relative ease; return to a calm and secure state; and are then usually able to resume exploratory behavior.

As securely attached children mature, their reliance on physical proximity to their primary caregiver decreases and gradually changes into a reliance on internal representations of the caregiver, and an internal and generalized sense of security (Ainsworth, 1979; Bowlby, 1973; Davies, 2011). A return to physical proximity to the caregiver nevertheless ebbs and flows as a child's internal resources become taxed, such as when tired, sick or hungry, and/or when faced with a greater threat or stressor.

Secure attachment is strongly correlated with resilience, as well as positive characteristics and outcomes throughout one's life (Bowlby, 1988; Karen, 1994; Lyons-Ruth, Easterbrooks, & Cibelli, 1997; Main, Hesse, & Kaplan, 2005; Sroufe, 2005; Zeanah, Berlin, & Boris, 2011). Sroufe (2005) and Davies (2011) state that securely attached children are better able to learn and develop, because they have a secure base from which they can explore. Their energy is more focused on exploration, rather than on desperately trying to establish a sense of security, as is the case with insecure children. According to these authors, securely attached

children thus tend to develop confidence, positive self-esteem, self-reliance, and independence. They develop an increasing ability to self-regulate. They are better able to adapt to changes and new environments. They have greater social skills and are better able to handle the complexities and challenges of relationships.

Insecure attachments. If there are persistent problems in attunement and responsiveness on the part of the primary caregiver, *insecure attachments* may form (Karen, 1994; Main et al., 2005; Shilkret & Shilkret, 2011; Zeanah et al., 2011). Insecure attachment, and much more so, disorganized attachment have been strongly correlated with negative outcomes for children, adolescents and even adults (Bernard et al., 2012; Carlson, 1998; Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010; Lyons-Ruth et al., 1997; Main, Hesse, & Kaplan, 2005; Sroufe, 2005). Given that the actions and attitudes of the primary caregiver have a significant impact on the child's attachment pattern, when working with children it is also important to work with parents to address issues that affect the attachment system and to provide effective interventions that promote secure attachment (Svanberg, 1998).

Insecure/Ambivalent attachment. Inconsistent primary caregivers may cause their children to develop an insecure (or anxious)/ambivalent (or resistant) attachment to them (Ainsworth, 1974; Davies, 2011; Shilkret & Shilkret, 2011; Sroufe, 2005). Such primary caregivers tend to respond inconsistently to their children's needs, responding only some of the time, in an untimely manner, or only after their children's expression of need has intensified and gone on for a prolonged amount of time; and their responses are sometimes not attuned or sufficient enough to help answer their children's needs or help soothe them (Ainsworth, 1979; Davies, 2011; Shilkret & Shilkret, 2011). These children tend to respond with ambivalence to

their primary caregivers when in need or distress (i.e. they seek proximity to the caregiver, but will also be angry with them); they are often very difficult to soothe; and they tend to be anxious and clingy (Ainsworth, 1979; Ainsworth, 1974; Davies, 2011; Shilkret & Shilkret, 2011). Because these children do not feel they have a secure base from which to explore from, and instead feel anxious, they tend to invest much of their energy and attention in trying to cling to their primary caregiver(s); and when they are not available, they tend to cling to any other caregiver, which ultimately interferes with exploratory behavior, and thus their learning (Ainsworth, 1979; Ainsworth, 1974; Davies, 2011; Sroufe, 2005) .

Sroufe (2005), details many ongoing and long term negative outcomes for children who form insecure/ambivalent attachments: developmental delays; difficulties with self-regulation; difficult and antagonistic relationship with their caregivers; lower self-reliance and increased dependency later in childhood; lower self-confidence and self-esteem; lower resiliency; greater difficulty coping with stress; difficulty adjusting and adapting to new or unpredictable environments; greater difficulty with socialization and relationships; poor problem solving skills; greater learning difficulties; greater passivity; increased helplessness; greater propensity for frustration; significantly greater likelihood of suffering from anxiety disorders later in life, and greater risk of depression.

Insecure/Avoidant attachment. Unresponsive caregivers may cause their children to develop an insecure/avoidant attachment to them (Ainsworth, 1979; Davies, 2011; Shilkret & Shilkret, 2011; Sroufe, 2005). These primary caregivers are likely to be dismissive of their children's needs, and ignore their attempts to get reassurance and physical closeness (Ainsworth, 1978; Davies, 2011; Sroufe, 2005). They may reject, punish or chastise their children for expressing needs or distress (Ainsworth, 1978; Davies, 2011; Sroufe, 2005). These caregivers

tend to have negative feelings toward caregiving, which they are likely to perform in a cursory and disengaged manner (Davies, 2011; Sroufe, 2005). They have a propensity to be irritable (Sroufe, 2005) and uncomfortable with close contact (Ainsworth, 1979). They tend to be psychologically unavailable, and thus are likely to avoid emotional engagement, feelings (Main, 2000; Main et al., 2005; Sroufe, 2005), as well as discussions of past experiences and those related to attachment (Main, 2000; Main et al., 2005).

It is important to understand the context in which this occurs. These primary caregivers likely developed an insecure/avoidant pattern of attachment as children; likely as a result of having been subjected to their parents' psychological unavailability, dismissive attitude, and avoidance (Davies, 2011; Main et al., 2005). Their dependency, as well as their attempts to seek physical proximity when distressed, was shunned. As a result, they became increasingly dependent themselves (the process of how this occurs will be detailed shortly) (Davies, 2011; Sroufe, 2005). Now that they are adults and primary caregivers, they now have their own struggles with dependency, and thus feel taxed when demands are placed on them by their children (Davies, 2011). It is in this context of overwhelm, and of having to draw from an empty well, that dismissing, discouraging and chastising the demands of their children becomes compelling and occurs. It in this context that caregiving becomes an endless aversive experience. It is in this context that these primary caregivers can often experience their children's needs and distress as a personal attack (Davies, 2011).

Mary Main and her colleagues (2005), in reporting the results of their longitudinal study, found that children with a pattern of Insecure/Avoidant attachment are likely to remain Insecure/Avoidant as adults, and likely to apply this template to most of their relationships. It should be noted that Mary Main labeled the adult equivalent of Insecure/Avoidant attachment as

Anxious/Dismissive attachment, because she observed these adults as being dismissive of their own experience, needs, distress, and attachment relationships; as well as being dismissive in all of those ways toward their children when they become primary caregivers (Main, 2000). These adults consistently downplay the value of attachment and important relationships; have trouble focusing on and recalling their own history; are often contradictory in what they report and how they view their relationships; tend to idealize their parents; tend to see themselves as strong individuals; and usually report that they are fine and that everything is fine in their life (Main, 2000).

The behaviors and attitudes of Anxious/Dismissive primary caregivers are perhaps best understood as defensive mechanisms these individuals had to develop as infants and children, in order to survive and deal with the constant dismissal of their needs and distress, as well as their attempts to seek a secure base being constantly rebuffed. Avoidance and being dismissive, toward themselves and others, is thus conceived as an adaptive response to such adverse circumstances, because it actually helps individuals maximize their contact with their primary caregiver (Ainsworth, 1979; Davies, 2011). Specifically, if a primary caregiver rejects, punishes, and feels negatively toward need, distress, and physical proximity, then a child is best able to maintain proximity, attachment and positive contact with that primary caregiver by suppressing their needs and expression of affect (Davies, 2011). In other words, Anxious/Dismissive primary caregivers are likely to be more tolerant, less rejecting, and less dismissive of their children, if their children present as being needless and free of negative affect. From the standpoint of the infant/child, it is better to get morsels of lesser quality than nothing at all. In addition, by avoiding their primary caregivers, and by dismissing/suppressing their own needs and feelings, these infants/children are better able to defend against the pain, anxiety and anger associated

with rejection, punishment and needs being denied constantly (Ainsworth, 1979; Davies, 2011; Main, 2000). As will be detailed shortly, as they grow older, these defensive mechanisms are likely to become entrenched and generalized to all relationships. The negative reactions of other caregivers, teachers, peers, intimate partners, etc., then only further reinforce their beliefs, defensive mechanisms, and attachment pattern. By the time they are adults and become primary caregivers, they are likely to continue to operate according to these beliefs, and to use the same defensive mechanisms and attachment pattern with their intimate partners and children.

In order to better understand Insecure/Avoidant attachment, it is important to describe the behavior and issues that these children face. During the Strange Situation procedure, Insecure/Avoidant children show little distress; have flat affect; do not seek proximity to their primary caregivers when under stress; focus on their environment, and actively avoid their caregivers (Ainsworth, 1979; Davies, 2011; Main, Hesse, & Kaplan, 2005). Though they show little distress, biobehavioral studies, measuring cortisol and heart rate levels of children with different forms of attachment during various stages of the Strange Situation, have found that their anxiety level is high, which further evidences the suppression of behavior and feelings mentioned previously (Main et al., 2005; Spangler & Grossmann, 1993). These children do not explore their environment with curiosity nor form a secure base, as secure children do; rather they use the environment in service of their defensive mechanisms, that is, as a means to distract themselves from anxiety, narrow their field of attention, and avoid their primary caregivers (Main et al., 2005). These children also behave differently when at home alone with their primary caregivers; they display anxiety and anger toward their caregivers when separations occur (Ainsworth, 1979). This again helps further support the notion of suppression of need, rather than being needless.

As these children's experiences are repeated countless times, and they grow older, their defensive reactions of avoidance, suppression of need and affect become more entrenched, generalized and inflexible (Davies, 2011; Main et al., 2005; Sroufe, 2005). These children tend to be more aggressive, non-compliant, and have more negative interactions with primary caregivers, teachers, and peers; and consequently, they are disciplined more often, which further reinforces their attachment style (Ainsworth, 1979; Davies, 2011; Sroufe, 2005).

Sroufe (2005) details rather unfavorable findings for insecure/avoidant children from his longitudinal study. These children tend to isolate. They have great difficulty handling social interactions, and struggle with all relationships, particularly with intimate relationships. They have difficulty being sensitive and empathic toward others. They struggle with asking for help, seeking comfort and reassurance, and accepting directives and suggestions. Sroufe (2005) continues by specifying that, though these children may have seemed strikingly independent as infants, they become increasingly dependent as they grow older. Their confidence, self-esteem and resiliency all greatly suffer. Teachers tend to be more intolerant, more controlling and have more negative interactions with them. Sroufe (2005) further explains that all of these factors affect their ability to explore their environment, develop and learn. In addition, Insecure/Avoidant children are also more vulnerable to stress and struggle to deal with it effectively. The chances of significant problems and/or psychopathology increase the more there are risk factors, and the less there are protective factors (Davies, 2011). Despite all of this, Sroufe (2005) points out that Insecure/Avoidant children are only at slightly higher risk than securely attached individuals. However, when psychopathology occurs, Insecure/Avoidant children tend to suffer from conduct disorders, and at times depression due to alienation and hopelessness. It should also be noted that many of these children had been incorrectly described

as having externalizing problems, because they were incorrectly classified prior to the discovery of disorganized attachment (Lyons-Ruth et al., 1997). Since then, Insecure/Avoidant attachment have been found to be more prone to having internalizing problems, which makes sense if one tends to suppress their needs and feelings; has difficulty accepting asking and accepting help; and does not acknowledge their vulnerabilities (Lyons-Ruth et al., 1997).

Disorganized attachment. Primary caregivers who routinely provoke fear in their children may cause their children's attachment to become disorganized (Carlson, 1998; Davies, 2011; Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010; Hesse & Main, 2006; Karen, 1994; Lyons-Ruth, Easterbrooks, & Cibelli, 1997; Main & Hesse, 1990; Main et al., 2005). There are several common reasons why these caregivers can elicit fear in their children: maltreatment; fearful expressions/responses of the caregiver related to the caregiver's own trauma history; and severe unresponsiveness, including unresponsive facial expressions (such as when the caregiver is severely depressed) (Carlson, 1998; Hesse & Main, 2006; Main et al., 2005). These are often associated with primary caregivers' own childhood history of maltreatment, unresolved trauma, severe depression, disrupted attachments, and/or possible dissociative disorders (Carlson, 1998; Fearon et al., 2010; Hesse & Main, 2006; Lyons-Ruth et al., 1997; Main et al., 2005). Though less commonly cited, domestic violence and marital discord are also likely very important contributors to provoking fear in children related to critical attachment figures, thus leading to disorganization of the attachment system (Lieberman, 2004; Lieberman, 2007; Owen & Cox, 1997; Zeanah et al., 1999).

Many researchers concur regarding what they believe occurs when infants and children's attachments become disorganized, which is detailed in what follows (Carlson, 1998; Fearon et al., 2010; Hesse & Main, 2006; Lyons-Ruth et al., 1997; Main et al., 2005). Infants and children

become disorganized because two contradictory and incompatible responses, that are fundamental to attachment, are elicited in these children when their primary caregivers are the cause of their fear. First, their primary caregivers' actions cause them fear. This fear then triggers these children to seek protection through their primary caregivers; which is the phenomenon of returning to the "secure" base that is a central element to attachment theory. However, the very person from whom they are seeking help is actually also the person who also makes them fearful. What is fundamentally incompatible is that the primary caregiver, whom is supposed to be the secure base, is in fact the dangerous situation. These infants and children cannot figure out how to resolve the paradoxical contradictory impulses that are elicited in them. Thus, as soon as they start moving toward their primary caregiver, the impulse to run away from danger (i.e. their primary caregivers) takes over. Conversely, as they start to run away from danger, the impulse to run toward their primary caregivers takes over. They thus become stuck in a catch-22, as these competing impulses go back and forth, overriding one another as they vie for emergence over one another (Carlson, 1998; Fearon et al., 2010; Hesse & Main, 2006; Lyons-Ruth et al., 1997; Main et al., 2005).

This internal conflict is actually visible in these infants and children's behavior (Carlson, 1998; Davies, 2011; Main & Hesse, 1990; Main et al., 2005). In fact, it is the presence of these behavior patterns, which will be described immediately following, that are an essential part of assessing and making the determination that an infant's or child's attachment is disorganized during the Strange Situation (Main et al., 2005). Infants and children with disorganized attachment will often display sequential or simultaneous contradictory behaviors that may be incomplete, misguided or appear to be aimless or like stereotypies. They are likely to present as confused, fearful, apprehensive and disorganized. They are likely to freeze or present as dazed.

However, as detailed above, these behaviors, which may seem aimless or random, actually make sense when placed in context and explained from the perspective of a child (Lieberman, 2007). Consider the following behaviors in the context of a child who is desperate to be picked up, protected and reassured by his/her caregiver; a caregiver who also frightens them because the caregiver is currently and has repeatedly had previous expressions of fear as a result of experiencing PTSD flashbacks due to their prior unresolved trauma. The child is frozen in place; showing expressions of fear; sobbing; hoping from one foot to other (walking in place, as in wanting to move toward the caregiver, but also being afraid of the caregiver); extending arms upward (as in wanting to be picked up); yelling and screeching; hyperventilating; begging to be picked up, and then kicking and punching, demanding to be put down, and pushing away as the caregiver actually responds to their demand to pick them up.

Because these infants and children are stuck in a catch-22 of both trying to flee and seek help from the same primary caregiver, they are unable to seek relief when they experience fear (Carlson, 1998; Lyons-Ruth, Bronfman, & Parsons, 1999; Main & Hesse, 1990; Main et al., 2005). Thus they escalate and become stuck in a highly activated state of distress. Such experiences are devastating and extremely detrimental to infants and young children, because they are dependent on their primary caregivers to regulate their affect, and their neurological system is fragile and undeveloped (Carlson, 1998; Davies, 2011; Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Over time, as these experiences are repeated, without any escape or other solution for regulating their affect, nor for calming their distress and deactivating their overwhelmed neurological system, infants and children likely come to depend on dissociation for coping with such inescapable high activation of distress (Carlson, 1998; Perry et al., 1995). Infants and children with disorganized attachment are often observed as freezing, stilling,

becoming dazed or in a trance, and other signs of dissociation (Carlson, 1998; Fearon et al., 2010; Main et al., 2005). There is concern that, because infancy and toddlerhood are particularly critical times for brain development, and that there is mounting evidence that brain development is use and experience dependent (i.e. experiences, as well as timing and amount of use, all influence brain development or the lack thereof), experiencing repeated and prolonged fear and trauma at such a young age may shape the brain to be prone to dissociation later in life, and also lead to poorly developed capacities for self-regulation throughout one's life (Carlson, 1998; Davies, 2011; Perry et al., 1995).

As children with disorganized attachment grow older, they are likely to experience great difficulty with self-regulation, which in turn impairs their ability to control emotions, deal with frustration, control impulses, and likely leads to problems with aggression and externalizing problems (Davies, 2011; Fearon et al., 2010; Lyons-Ruth, Alpern, & Repacholi, 1993; Lyons-Ruth et al., 1997; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006; Main et al., 2005; Sroufe, 2005). As infants and toddlers with disorganized attachment grow into childhood, they often become controlling as a means of trying to deal with having been so out of control in their young life thus far (Lyons-Ruth et al., 1997; Lyons-Ruth & Jacobvitz, 2008; Main et al., 2005). They are observed as often being controlling of their parents and peers, either through caregiving or punishment (Lyons-Ruth et al., 1997; Lyons-Ruth & Jacobvitz, 2008; Main et al., 2005). Controlling behavior at this age has becomes so prevalent for children who were previously determined to have disorganized attachment, that the attachment qualifier is changed from Disorganized Attachment, to being named D-controlling during latency (Main et al., 2005).

Davies (2011) and Lyons-Ruth and her colleagues (1997, 2008) help make more sense of these behavioral manifestations, by placing them into the context and perspective of the

disorganized child. As infants and toddlers, these now controlling children were likely severely neglected, abused, or seriously frightened and traumatized by their primary caregivers. Furthermore, whenever they were in a highly activated state of distress, they didn't receive protection, reassurance, and the consequent soothing and deactivation of their neurological system. As these experiences were repeated over and over again, they did not experience state and affect regulation, because infants and toddlers are dependent on their primary caregivers to regulate their affect and bodies. As a result they failed to develop the ability to self-regulate. Thus they have great difficulty coping with frustration, anger, rage, excitement, disappointment, and other strong emotions. They have poor ability to control their impulses. They are more likely to succumb to these emotions and become aggressive. They are also more prone to feeling aggression, because it is a common response to fear, which these children often experience. In addition, these children repeatedly feel out of control and powerless, both in regards to the external and internal environments. They come to increasingly make use of controlling behaviors as a means to compensate for their inability to self-regulate, and as a means cope with feeling so powerless and out of control.

Davies (2011), Lyons-Ruth and her colleagues (1997, 2008), and Sroufe (2005) add that these children's aggressive and controlling behaviors toward their peers further compound their problems. Such behaviors create relationship problems, and alienate them from their peers. Teachers become very controlling toward these children. All of this creates more frustration, anger and leads to more aggression. This further impairs their ability to self-regulate, to socialize, and to experience competency. Competency is also likely to be already impaired, because much of their energy and attention had to be focused on monitoring the home/parental/peer environment and reacting to and/or controlling it. Thus these children had

little time, resource and energy left to focus on exploring and learning their environment. Davies (2011), Lyons-Ruth and her colleagues (1997, 2008), and Sroufe (2005) further explain that these children also likely have difficulty trusting adults, like their own primary caregivers and teachers, because their primary caregivers were not trustworthy, in that they scared their children. As a result, it becomes hard for them to listen, learn, seek help, and respond to these adults. All of this further impairs their ability to develop. The authors indeed report that these children are more likely to have mental lags, problems with learning, problems with socialization, and other issues with development. They point out that these symptoms place these children at a disadvantage with their peers. These children are thus likely to have negative self-perceptions and low self-esteem. This in turn is likely to lead to more aggression and controlling behaviors with peers, to compensate for their deficits, negative self-perceptions, and difficulties with establishing and keeping relationships. Indeed, studies have found that these children are much more likely to have problems with aggression and externalizing behaviors (Davies, 2011; Fearon et al., 2010; Lyons-Ruth et al., 1997; Lyons-Ruth & Jacobvitz, 2008).

Disorganization of attachment is deeply concerning because it is has been strongly linked to dissociation, dissociative disorders, aggression, externalizing problems, severe psychopathology, severe depression and other serious concerns, such difficulties in learning, affect regulation, poor social skills, and other developmental delays and deficits (Allen, 2001; Cassidy & Shaver, 2008; Davies, 2011; Lyons-Ruth et al., 1993; Lyons-Ruth et al., 1997; Main et al., 2005; Sroufe et al., 2005). Because of its strong links to problems later in childhood, adolescence, adulthood, and strong correlation to adult disorganized attachment, parenting impairments, and primary caregiver maltreatment of their children, disorganization of attachment is rapidly garnering the majority of attention, research and treatment protocols in the field of

attachment.

Internal Working Models. Once an attachment pattern forms, it serves as the basic template, or Internal Working Model (IWM), upon which understanding of the self and others are based on (Bowlby, 1988; Fonagy, Steele, Moran, & Steele, 1993; Karen, 1994; Main & Hesse, 1990; Shilkret & Shilkret, 2011). IWMs then guide how one forms and manages relationships, as well as how one generally functions in the world. Examples of IWMs are whether one feels worthy of care and attention; whether one believes others can be trusted; whether one feels the world is a safe and responsive place; whether they feel they have agency and power to affect their lives; etc. (Davies, 2011)

Thus, attachment is not a temporary state that changes each time and according to circumstance, but rather a set way of relating to the primary caregiver and later, to other relationships. While one's attachment style may be modified with tremendous effort and help over time, it tends to be very resistant to change (Fonagy et al., 1993). Attachment theory has a tremendous amount of empirical research supporting most of its claims and crosses cultural and gender boundaries. Attachment theory has been critiqued for its lack of testing of other possible variables (e.g. temperament, peer influences, etc.) that could influence attachment beside a primary caregiver; over-representation of white middle class American families in its study populations; lack of research in other cultures; and lack of researchers from different cultures. However, since the mid 1970's, and especially in the last decade, these issues are being increasingly addressed in the attachment research community (Behrens, Hesse, & Main, 2007; Bretherton, 2010; Candelaria, Teti, & Black, 2011; Carlson, 1998; Cassidy & Shaver, 2008; David & Lyons-Ruth, 2005; Diener, Nievar, & Wright, 2003; Kalinauskiene et al., 2009; Karen, 1994; Lyons-Ruth, Connell, Grunebaum, & Botein, 1990; Lyons-Ruth et al., 1993; Lyons-Ruth

& Easterbrooks, 2006; Sroufe et al., 2005; Sroufe, 2005).

Child Development during the First Five Years of Life

Much of the information presented in this section is drawn from Davies' (2011) text, *Child Development: A Practitioner's Guide*. Unless otherwise noted, the information presented in this section is cited from this authoritative text on human development from an attachment perspective. Davies (2011) explains that an individual's first attachment experiences do not occur in a vacuum or static context. Rather, attachment develops in the context of the most profound and critically important relationship(s) in one's life, and during the most important and formative period of one's life. That is, attachment first forms between a newborn child and its primary caregiver(s), and in the context of the child's first years of development. During this time, the child is completely dependent on its primary caregivers for its survival and development (Allen, 2001; Davies, 2011).

Attachment theory was partly developed out of observations that children failed to thrive and develop, and often died, when primary caregivers were absent. It was in part from these observations that John Bowlby, the father of attachment theory, realized that the provision of physical care and meeting basic physical needs by any caregiver was not sufficient to sustain human life, and that something more was needed (Bowlby, 1951; Karen, 1994; Spitz & Wolf, 1947; Spitz, 1945). He hypothesized that what was missing was the affective investment (i.e. attachment) that the infant/child has in a select few individuals (i.e. the child's primary caregivers), and that this acts as the spark that ignites and fuels the will to live, and the drive and motivation to explore and develop. Davies (2011) adds that it is through repeated interactions between the infant/child and his/her primary caregiver(s), where the caregiver is attuned and responsive, that the infant/child experiences this affective investment: the profound and critical

sense that he/she is worthy of his/her parents' time, attention and care. Recall that attunement and responsiveness are what lead to the development of secure attachment, and that secure attachment results in an infant/child using their primary caregivers as secure base from which to explore. Exploration is an inherent and critical part of a child's development.

The role of attachment in supporting development. Davies (2011) describes the profound and complex interplay between attachment and development. He details how the outcomes of development are heavily dependent on the attunement and responsiveness of primary caregivers toward their child. A child's development is incredibly complex; and attunement and responsiveness is much easier said than done. In order to properly support a child's development, one must develop intimate knowledge of that child; the kind of knowledge that can only be acquired through intensive, prolonged, involved, attentive, interested and invested exposure to that child. Each child is a collection of innumerable idiosyncrasies. Davies (2011) stresses how infant/children's development is dependent on a multitude of factors, which interact with one another in a very intricate and complex way, making each child's developmental needs and progress particular to them. Furthermore infants can only communicate through behavior, sound and affect; and young children, think, process, understand, act and communicate in ways that are most often indirect and vastly different than how adults behave and think. Thus primary caregivers need to be particularly able to place themselves in the mindset of infants and children, and be very alert to their needs, experiences, peculiar personalities and characteristics, to be able to attune, or intuit, what the child needs at any particular time, and then respond to that need in a prompt or even anticipatory manner.

Scaffolding. Davies (2011) stresses and details how supporting a child's development involves a very complex and intricate process of scaffolding the child's experience. *Scaffolding*

involves initially providing near total care and support to a child, and then very slowly and gradually removing these supports as the child develops and moves toward independence. Every single element of development requires extensive modeling, teaching, and the provision of extensive support. Then, through a very involved and tedious process of countless repetition, primary caregivers very carefully and seamlessly adapt the level of support they provide to their infants/children, as the infants/children move forward and backwards, and gradually progress toward mastery of a particular element of their development, and toward their overall gradual independence. The ability to properly scaffold a child's development also requires the kind of extensive and involved knowledge of the child mentioned above. Lastly, a child's development is extremely slow, intricate and involved. Nowadays, it requires close to two decades of tireless, difficult, demanding, attuned and responsive consistent support that is well scaffolded. Caring for one's child is truly a "labor of love". The amount of time, energy and dedication required can only be found in those that are extremely affectively invested; that is, those that are attached to their infant/child.

It is also important to note that attachment is not an inherent, static phenomenon that magically appears simply because of one's role as primary caregiver or because of one's biological relationship to an infant/child. Though the concept may seem relatively simple to grasp, the development of attachment is far from simple. Rather, secure attachment is a complex process that forms and evolves over time. And as mentioned earlier, attachment does not occur in a vacuum. Secure attachment progressively develops through the countless interactions that take place between an infant/child and their primary caregiver(s). These interactions are the very process of a child's development, possibly as early as the child's conception, and certainly as a child's primary caregivers attune and respond to the child's needs, which in the first years of life

are essentially all related to the child's development. Davies (2011) asserts that the quality and security of the attachment that forms profoundly affects the outcome of a child's development

Normative (securely attached) child development. It should be clear by now that attachment and development are intricately interwoven into one another. It is because of this that any attempt at treating attachment problems inevitably requires a thorough understanding of normative child development. Rather than detail all of the particulars of infant/child development, the most significant aspects of development that Davies (2011) details are summarized in table 1 (see Table 1 for human development during first five years of life). Presenting development in such a fashion undoubtedly does not capture all of the complexities and countless details involved in development. However, it is hoped that this information will help the reader in getting a much clearer understanding of the progression and most salient points of development during the first five years of life. For the sake of clarity, development is broken down according to three major periods of development that occur with the age population of this study (infancy, toddler, preschool) and seven major areas of a child's development (motor, brain, cognitive, language, social and play, self, and self-regulation).

Table 1

Human Development during First Five Years of Life

Area of Development	**Infancy**	**Toddler**	**Preschool**
Motor Development	Gradual muscle development from top to bottom (e.g. neck muscles until able to support independently; ability to sit independently; all the way to able to walk with assistance). Development of rudimentary coordination. Fastest period of growth.	Dramatic improvements in coordination, though often requires a lot of effort and concentration, especially at beginning. Certain areas of fine motor skill have yet to develop. Often there is a discrepancy between what they want to do and what they can do. Growth continues to be rapid, though less dramatic than during infancy.	Growth continues, but at a much slower pace compared to previous periods of development. Significantly greater rapidity, synchronization and fluidity of movement. Coordination becomes even more refined, and requires less effort. Major improvements in fine motor skills and hand–eye coordination leading to the ability to cut, draw, manipulate objects relatively well, and handle most of the fine points of dressing (e.g. zippers, buttons and Velcro straps). Physical activity becomes an important part of child's life. Development of the ability to climb, skip, hop, run, throw, catch, kick and ride a tricycle.
Language Development	Imitation of sounds. Receptive language is far more developed than expressive language. Eventually able to speak several words.	Dramatic expansion of vocabulary. Pronunciation dramatically improves. Eventually is able to communicate relatively well, using short multiple word sentences.	Vocabulary continues to increase at a steady pace. Progressively speaks in grammatically correct sentences that make use of the correct tense. Pronunciation becomes very clear.

(table continues)

Table 1 (con't.)

Area of Development	Infancy	Toddler	Preschool
Brain Development	Most extensive and rapid period growth of the brain. Certain reflexes present at birth lead to abilities, like communication (e.g. crying and smiling to communicate need and satiation). All senses function at birth. Connections between different areas of the brain slowly progressing. High reactivity at first, in part due immaturity of the nervous system.	Growth of the brain continues, though at a slower pace. Major development and rapid expansion of the connections between different areas brain, including right and left brain. Major acceleration of the myelination process (an insulating layer around the axon of the nerve cells). These changes allow the child to increase coordination, memory, rapidity and fluidity of movement, and many of the child's developing capacities.	Most of the brain growth has occurred by this point, though slow and steady growth will continue for years. The brain's specialization and efficiency of function continue to increase significantly, which improves perceptual abilities, cognitive functions and memory, motor skills and coordination; all of which allow and facilitate other areas of development.
Cognitive Development	Emergence and rapid expansion of awareness. Orientation to environment rapidly increasingly. Clear evidence of memory developing within first six months. Emergence of object permanence toward end of infancy. Learning is mostly through imitation and physical experience.	Cognitive development continues and becomes more sophisticated. Thought becomes more organized due to language development. Magical thinking (equating wishes, fantasy, intention and feelings with reality and action) becomes the means of processing and interacting with the world. Perspective/thinking is egocentric (reference focused on the self). Understanding is primarily limited to what is observable. Memory improvements support greater understanding, language development, and anticipate.	Magical thinking still predominates, especially when child is taxed (stress, illness, fatigue, etc.). Becoming increasingly capable of more rational and objective forms of thinking. Egocentric perspective is also dominant, but the ability to appreciate the perspective of others progressively increases. The ability to understand cause and effect properly and without distortion gradually increases.

(table continues)

Table 1 (con't.)

Area of Development	**Infancy**	**Toddler**	**Preschool**
Social/Play Development	Primary caregivers are the focus of most interactions. Interactions are predominantly dyadic. Play is mostly initiated by primary caregivers. However, toward the end of this phase, the child begins to increasingly initiate play.	Play with primary caregivers continues to be important and preferred. Interest in play with peers progressively increases. Play with peers tends to be parallel in nature (side by side play, as opposed to interactive play). Play and interactions with peers tend to quickly result in conflict due to egocentric nature of the toddler, and great difficulty in sharing and appreciative the other's perspective. Play tends to be concrete and focused on objects at first. Pretend and fantasy play emerge and progressively become a more common and important form of play.	Peers become more important, and eventually start to occupy a more central role. Friendships form based on mutual interests. Conflicts progressively decrease as preschoolers' egocentric perspective lessens, and as they come to value the need to lessen and resolve conflicts, and as they learn and practice conflict resolution skills. Cooperative play emerges and slowly develops and gradually supplants solitary and parallel play. Pretend/fantasy play develops and becomes central. Very active and physical play also becomes an important form of play.
Development of the Self	Merged with primary caregivers. With every aspect of development that occurs, infant progressively moves toward independence and differentiation (e.g. ability to sit upright allows infant to reach things on his own). Visible signs of a self observed toward the end of infancy.	Clear emergence of a sense of self, though high dependence and symbiosis with primary caregivers continues. Use of the pronoun "I" emerges and becomes prominent. Strong motivation to try and do things on their own (e.g. the ubiquitous and insistent "Do it by myself!" of toddlers).	Focus is increasingly outward and toward peers, though primary caregivers very important. Clear sense of own interests becoming rooted. Parental standards/values becoming firmly internalized. Self-esteem deriving from sense of competence. Racial, gender and sexual identity starts to develop.

(table continues)

Table 1 (con't.)

Area of Development	**Infancy**	**Toddler**	**Preschool**
Self-Regulation Development	Heavily dependent on parents to self-regulate. Habituation progressively helps to decrease reactivity and anxiety. Relatively quickly develops some state modulation and begins to adjust to other patterns, rythms and cycles. Eventually slowly develops some ability to self-regulate (e.g. turning away gaze or closing eyes to decrease stimuli; playing to distract self from stressful experience; etc.).	Continues to depend heavily on primary caregivers for self-regulation, but increasingly tries to self-regulate first, before turning to primary caregivers. Significant progress with memory and language development allow toddlers to understand, organize and anticipate experiences, which helps to reduce anxiety. These developments also help with using thought to delay impulse, and language as a means to soothe. Play rapidly becomes an important outlet for stress, and means to process stressful, difficult or traumatic events. Slowly and progressively assimilating self-regulatory capacities borrowed and learned from primary caregivers, through the process of countless repetition as the caregiver helps the child self-regulate.	Assimilation of self-regulatory functions becoming increasingly internalized, allowing the preschooler to eventually be significantly more independent with self-regulatory functions, especially if system is not compromised and stressors are not overwhelming. Increasingly able to control impulses and first think through consequences of actions. Fantasy and play quickly become the central means to process and manage affectively charged and stressful stimuli and experiences. Psychological defense mechanisms develop and become an important means of coping as well.

Note: Information in table derived from Davies, D. (2011). *Child development: A practitioner's guide (3rd ed.)*. New York, NY US: Guilford Press.

The above is merely a broad summary of child development. It is important to understand that a child's development is far more complex, extensive and intricate. Furthermore, in reality, breaking down development into categories, specific terms and timelines are only arbitrary constructs that help us understand this complex human phenomenon. By default, these are bound to have limitations in regards to truly representing what actually occurs. Development is not so clearly delineated. Davies (2011) explains that development is a fluid and interwoven process. One area of development affects many other areas of development, and vice versa. Previous development affects subsequent development. Thus, developmental progress in one area will support developmental progress in other areas, as well as future development. Conversely, developmental delays in one area of development will likely hinder development in several other areas, as well as future development overall. Davies (2011) also specifies that it is important to understand that there are so many individual, biopsychosocial, genetic, risk and protective factors that can affect development, and therefore there are inevitably variances between individuals across an entire population in regards to specific age and certain details of development.

Illustration of the complexities of development: Language development. Development is so complex that iterating all the details of the different areas of development, and their interwoven effects on one another is beyond the scope of this study. Nevertheless, it is important to understand to understand the progressive nature of development, and the complex interplay that occurs between different areas of development. Because of the central role it plays in a child's life, language development, one of the seven areas of development, is used to illustrate how different areas of development are interwoven, affect one another, and affect

subsequent development. In addition, the critical role of attachment in supporting development is highlighted.

Language development during infancy. Davies (2011) explains that initially, infants' brain development allow for the ability to decode receptive language. Infants listen and observe as their primary caregivers communicate with them and others. They tirelessly repeat and point to show what they mean, need or want.

Teaching and supporting development is hard, tedious, prolonged repetitive work for primary caregivers. It requires tremendous and fastidious practice, as well as will and determination on behalf of the child. For the child, it is the affective bond with their primary caregiver that ignites their drive to develop and continues to fuel their motivation to do so. For the caregiver the same affective bond fuels their drive and motivation to teach and support their child's development. It is not unusual for caregivers to marvel at and celebrate each small incremental developmental victory. Children react with delight and excitement as they experience their caregiver's positive regard. This further fuels their motivation to progress in their development, and the cycle of mutual positive influence continues.

Davies (2011) further explains that over time, infants begin to make associations between the sounds, the words and the context in which they are used, which leads to progressive retention and understanding of the meaning of certain words. By approximately eight to nine months of age, they often understand many key words that their primary caregivers use in interactions with their child. They begin to gradually initiate and practice vocalizations of vowels and consonants, which eventually leads to speaking their first words by nine to twelve months.

Language development during toddlerhood. Davies (2011) details that in toddlerhood, expressive ability and vocabulary dramatically expand, as caregivers continue to communicate and interact with their child, and scaffold their language development. Single word communication is quickly followed by use of short and simple two or three word sentences. By the end of toddlerhood, the child is usually able to speak in multiple word sentences that are relatively grammatically correct. They make use of the correct tense, conditional clauses, etc. All of these abilities reveal important cognitive developments, such as a beginning understanding of cause and effect; a progressive understanding of the temporal realm; etc.

Language development during the preschool years. According to Davies (2011), during the preschool phase of development, vocabulary continues to expand at a fast and steady rate. Pronunciation becomes clear. Sentence structure becomes more sophisticated. Increasingly, multiple sentences are joined and organized into “paragraphs”, demonstrating a cognitive evolution toward greater and more complex, sophisticated and abstract expression and understanding.

Interplay of language with other areas of development. In discussing the complexities of development, Davies (2011), describes how two important areas significantly affected by language development are self-regulation and social/play development. As primary caregivers attune to what their child is feeling and the circumstances that have given rise to such feelings, they name these feelings and help their child make the connection to what has led to experiencing such feelings. The ability to name emotions helps toddlers better understand and organize what they are experiencing. As a result, their experiences feel less chaotic and random. Anxiety is reduced. Language then enables toddler to express feelings and ask for help in dealing with these (e.g. “Daddy, I’m scared.”).

Davies (2011) elucidates yet another benefit of language development in regards to self-regulation. Language allows toddlers to ask for what they need. Thus, as their caregivers respond to their needs, their state of need decreases; and they experience a greater sense of control. Their emotional arousal also decreases as a result of having their needs met. As this process is repeated countless times throughout toddlerhood and into the preschool years, children gain experience and confidence in their being able to live in a calm state, and in being able to modulate difficult emotions and return to a calm state. They experience and learn what it is to calm down. They begin to develop faith that it can and will happen. They begin to learn what is required to calm themselves down. They learn that their needs will be responded to and met. They learn that they can have an impact and have some control over their needs being met. A sense of agency begins develops. They inherently come to believe that their needs, and they themselves, are worthy of attention and being responded to. Davies (2011) underlines how all of this contributes to the development of self-esteem; a sense of being in control; the development of trust; and also contributes to the development of self-regulation.

Davies (2011) explicates how the development of language also gives toddlers and especially preschoolers the increasing ability to delay impulse. Children are now able to speak rather than act out their needs and feelings. Furthermore, the addition of words, and therefore thought, to what was previously solely emotion, helps to interrupt, buffer and slow down the immediacy of reaction. Impulse control also allows preschoolers to progressively develop the ability to think through the consequences of their actions. As the power of language becomes increasingly evident to preschoolers, and as they develop their proficiency with language, their ability to get their needs met and negotiate conflict also increases. By decreasing conflict, increasing their ability to get their needs met, and increasing their experience of feeling in

control, preschoolers decrease their level of activation and modulate their baseline level of affect. The positive effects of operating at a lower level of activation helps to further propel the development of self-regulation and other areas of development. Energy previously expanded on modulating high arousal, can now be devoted to other areas development. This ability to modulate progressively helps to build competence and self-confidence. In addition, because energy is increasingly conserved, the ability to handle stress is increased.

Davies (2011) expands on the compounding effects of the development of language, and now self-regulation, and how they in turn positively influence children's social and play development. During infancy, sensory motor play, which focuses on the experience and exploration of the properties of objects, is the dominant form of play. This kind of play also involves naming objects. Play tends to be limited to interactions between primary caregivers and their child. As language develops in toddlerhood, interest and interactions with peers emerge. However, these interactions are typically fraught with conflict, partly as a result of the limitations in their language development. Toddlers often engage in parallel play. Such play is characterized by side-by-side playing in the presence of each other, but mostly focused on their own individual play. Only sporadically do interactions occur, and these often quickly disintegrate into conflict. As language evolves, children are better able to communicate and interact through words rather than just action. As noted above, this eventually leads toward the fledgling but developing ability to ask for what they want; to delay emotional responses; to speak rather act out their emotions; and to negotiate conflict. Though other areas of development play an important role, as is the case with all aspects of development, the development of language helps preschoolers in their ability establish rules of play; take turns; and share. This further helps prevent and/or resolve conflicts.

Davies (2011) further emphasizes the influence of language on other areas of development, as children are now able to move to mental representations, abstraction, and pretend play. Language development thus becomes critical to the play of preschoolers, as imaginary and fantasy play take center stage. This form of play is heavily dependent on the use words, as rules and scenarios are established, and plots develop and change. Fantasy play in turn helps self-regulatory abilities, as it becomes one of the central means of processing and coping with difficult emotions and experiences. Fantasy play, and thus language, also allows preschoolers to rehearse and practice social roles, empathic behavior, and new social skills. They develop further social competence, socialization, and self-esteem.

Impact of attachment problems on development. Thus far, development has been presented in the context of secure attachment. However, it is important to appreciate what can happen to development when there are problems with attachment. There are many reasons why problems with attachment may occur. The most common are primary caregiver history of significant mental health problems, such as major depression or dissociative disorders; primary caregiver insecure and/or disorganized attachment; primary caregiver maltreatment of their children; and maladaptive parenting behaviors, such as harsh punishment, expression of negative views and/or frequent rejection of the child (Carlson, 1998; Davies, 2011; Lyons-Ruth et al., 1999; Main & Hesse, 1990), and over-expectations that the child repeatedly fails to measure up to (Davies, 2011).

Such issues with primary caregivers are often the result of an intergenerational transmission of insecure and/or disorganized attachment patterns (Davies, 2011; Fonagy, Steele, & Steele, 1991; Lieberman, 2007; Main et al., 2005). Davies (2011) explains that because of their own problems with attachment, primary caregivers in turn have trouble attaching to their

own children. That is because primary caregivers are insecure and/or disorganized in the way they relate to their own child. Primary caregivers' energy and ability to focus on their child is significantly compromised, because it is tied up in their insecurity. That is, caregivers do not feel they, themselves, have a secure base from which they can explore, and thus they do not feel safe to explore their own child. As a result, these primary caregivers have trouble being attuned and responsive to their child.

Davies (2011) adds that these caregivers' reference point for parenting, that is, the parenting they received when they were children, was also poor and distorted. In addition, they internalized and assimilated negative views of themselves and others, as well as negative parenting behaviors. To use attachment terminology, these primary caregivers' own internal working models (templates) have led them to have distorted views of about themselves and others, including their own child. These caregivers thus anticipate negative outcomes from relationships, including with their own children. This stance often leads these primary caregivers to project their negative views of themselves onto their child. Lastly, because the parenting they received was poor, it interfered with their own development. Thus these primary caregivers are likely to have problems with self-regulation, social, self and other areas of development. These delays and/or deficiencies in their own development, in turn, interfere with their ability to properly support the attachment and development of their child. They often feel overwhelmed by their children's needs.

Davies (2011) explains that if a child's primary caregivers have difficulty being attuned and responsive, then the child will likely not receive the proper support and scaffolding for their development. These children may experience many forms of neglect and may feel they are not worthy of attention and care. If a child's primary caregivers project their own negative views of

themselves, and/or anticipate a negative relationship and/or negative behaviors from their child, then the child will likely be criticized, shamed, and/or abused by his primary caregivers. Consequently, the child will likely develop poor self-esteem and self-doubt. The same will occur if their primary caregivers have unrealistic expectations of their child that exceeds their developmental ability. Davies (2011) states that if a child's primary caregivers behave in negative and/or aggressive ways, then the child will likely internalize those characteristics and values into their self-representation. They will likely have a poor sense of control. When primary caregivers behave in any of the above ways, their children tend to pay more attention to their primary caregivers' intense emotions, and to their own fear and intense emotional reaction. These children tend to focus on avoiding punishment or being hit, rather than understanding what the primary caregiver is trying to teach them. They tend to become defensive with everyone, unable to accept constructive criticism, and to be aggressive with others. Children whose primary caregivers punish them for expressing distress, frustration, or anger develop poorer capacities for regulating feelings and more externalizing behavior problems.

Using language development again as an example, as Davies (2011) indicates, if primary caregivers do not talk much to their child, or do not adapt their language to the child's ability, or tend to engage their child mostly to give them orders, criticize or punish them, then language delays will likely occur. Because of these delays, these children will have greater difficulty playing; expressing themselves; feeling organized; thinking; controlling impulses; and expressing themselves with words. They will tend to act out their needs and feelings, rather than speak them. All of these issues will likely lead to greater difficulty self-regulating. They will likely also have greater difficulties with social interactions. Their relationships will likely be more conflictual, and they will likely make more use of physical aggression. As a result, peers

and others will likely have a tendency to avoid these children. As a consequence, these children will likely develop poor self-esteem. They will likely feel more out of control. They will likely have less energy available to deal with stress, further impeding their ability to self-regulate. In short, all areas of their development will suffer.

Davies (2011) expounds how these delays will place these children at a disadvantage with their peers. This disadvantage will likely further impede their sense of competency, control and self-esteem. Their primary caregivers, being already ill-equipped to handle normal developmental needs, will likely be even more ill-equipped to handle a child that now has developmental delays and many problematic behaviors. The child will likely have even more conflictual relationships with their primary caregivers, further compromising their attachment and development. It should be clear how all of these issues compound the negative effects of one another, and negative consequences on development can quickly snowball and become out of control, further fueling attachment and development problems. The risk then is high that a negative and self-fulfilling cycle of developmental delay, insecure attachment, problematic behaviors and relationship problems can become established.

The importance of treating attachment problems. Clearly, things can really go wrong when there are problems with attachment. It can have very negative consequences on development. It is in part because development is so dependent on attachment that identifying attachment problems and treating them is so critically important. It is also why it is important to understand child development when discussing the treatment of attachment problems. Primary caregivers and other concerned entities rarely seek help because they are concerned about attachment. Help is more often sought because of concerns about maladaptive behaviors and/or

developmental delays. Even the main diagnostic tool of the mental health system focuses mostly focuses on behavior problems or developmental delays rather than attachment problems.

As will be detailed later, most treatments aimed at addressing attachment problems inevitably involve helping primary caregivers become more attuned and responsive to their children's needs. Children's needs and abilities are imbedded in their development. While it may be possible to be attuned and responsive to a child without having knowledge of normal child development, having such knowledge certainly helps to facilitate and improve attunement and responsiveness. As Davies (2011) advocates, knowledge about childhood development is definitely indispensable for any clinician who aims to help primary caregivers address attachment problems. Any treatment that aims to improve attachment will focus on the relationship and interactions between primary caregivers and their child, and these interactions all occur in the context of the child's development. Attuning and responding to a child's needs inevitably requires some understanding of 1) what the child's behavior means, 2) how the child experiences and reacts to the caregiver and events; 3) the child's abilities, and 4) their particular developmental needs.

Evidence-based Treatment: Rationale and Definition

Why a study about evidence-based treatments? Based on the preceding, it should be clear that treating attachment problems is of critical importance. Indeed, there is an abundance of research related to attachment. However, until the new millennium, there was a paucity of interventions or even treatment guidelines that had been developed to address attachment problems; and of those that existed, most demonstrated modest effectiveness (Bakersman-Kranenburg et al., 2003; Cook et al., 2007; Cornell & Hamrin, 2008). Given how important secure attachment is to one's mental health, it seems critical to develop interventions or

treatment guidelines that are proven to be effective. Since the new millennium, there has been a significant increase in studies that focus specifically on treatments designed to address attachment problems, and that demonstrate the effectiveness of these treatments (Bernard et al., 2012; Boggs et al., 2004; Hoffman et al., 2006; Kinniburgh, Blaustein, Spinazzola, & van, 2005; Lieberman et al., 2006; Sanders, Baker, & Turner, 2012; van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2008; Zeanah et al., 2011) Many of these studies focused on evidence-based treatments (EBTs) designed to treat attachment issues. Thus, when it comes to effective attachment interventions, it appears that most studies of the past decade focus on attachment-focused evidence-based treatments (AF EBT).

EBTs are controversial (Anderson, 2006; Graybeal, 2014; Hagemoser, 2009; Kazdin, 2008), as will be discussed shortly. However one may feel about EBTs, it remains that they are becoming an increasing reality of the mental health service delivery system in the United States. In the last two decades, policy makers and the insurance system have placed an ever increasing focus on making use of interventions that have been proven to be effective (Anderson, 2006; Kazdin, 2008; Walrath, Sheehan, Holden, Hernandez, & Blau, 2006). Perhaps one of the most significant examples of this increased focus is the President's New Freedom Task Force that produced a final report in 2004, calling for, amongst other things, the need to provide treatments proven to be effective (Huang, Macbeth, Dodge, & Jacobstein, 2004; von Esenwein et al., 2005) Kazdin (2008), also points out that most clinicians and researchers, regardless of theoretical, clinical and philosophical orientation, likely agree that providing effective treatments is an important priority. Increasing concerns about limited health care resources; increased consumer knowledge and empowerment; as well an increased demand for proof of effectiveness of care

provided are all fueling evidence-based health care delivery (Walrath et al., 2006). How to go about this remains a hotly debated question, however.

However controversial they may be, EBTs are nonetheless a means toward trying to deliver effective interventions. There is increasing support and sound arguments in favor of moving toward evidence-based practice (EBP) as an overarching process that includes evidence-based treatments (EBT). Thus, EBTs are one component of the evidence in regards to what is considered EBP (Anderson, 2006; Kazdin, 2008).

Arguments for evidence-based treatments. One of the most important arguments in favor of EBTs is that clients have a right to and should receive good and effective treatment (Huang et al., 2005; Kessler, Gira, & Poertner, 2005). In fact, this principle is part of the National Association of Social Workers (NASW) Code of Ethics (NASW, 1999). Clients should be aware of their options in regards to which effective treatments are available, and clients should be able to decide which ones they wish to receive (Huang et al., 2005; Kessler et al., 2005). Kessler and his colleagues (2005) argue that there is an ethical imperative to ensure that effective treatments are used, if in fact research has shown that such treatments exist.

Another, if not more important reason for the use and promotion of EBTs is to prevent provider bias and establish a legitimate rationale for the interventions used in treatment (Deegear & Lawson, 2003; Kendall, 1998). Practitioners should not just assume or guess that they are providing good and effective treatment; they should know that they are based on objective science. Kessler and his colleagues (2005) argue that information regarding which interventions and practices are proven effective can be obtained through rigorous scientific research. Trust in the legitimacy of interventions used demands that there be evidence regarding the effectiveness of interventions (Kendall, 1998). We also know from past experience that

some therapies that were assumed to be good practices have actually turned out to be harmful (e.g. holding therapy) (McClellan & Werry, 2003). Furthermore, in a 2006 study, Weiz and his colleagues found evidence that "usual care" was not as effective as EBTs.

Proponents of EBTs also argue that they can help set standardization of training in educational settings, which ultimately can lead to greater uniformity in the standards of care provision (Kendall, 1998). In addition, while it may seem that EBTs have led to a dizzying increase in various treatments, if one considers individual differences from one therapist to another without a prescribed treatment protocol, then it can be said that EBTs actually help to reduce the amount of treatment options to those that are proven effective.

Yet another reason that supports the use of EBTs is that, regardless of personal opinion or theoretical orientation, the fact remains that today's policies and healthcare reimbursement increasingly require the use of treatments that have been proven to be effective (Anderson, 2006; Deegear & Lawson, 2003; Hogan, 2003; Kendall, 1998). Resources are increasingly limited when it comes to healthcare delivery. Cost-effective treatments are increasingly sought.

Arguments against evidence-based treatments. Perhaps one of the most common arguments against EBTs is that they tend to be too rigid, manualized, and do not allow for enough flexibility to apply to the real world population (Anderson, 2006; Graybeal, 2014; Kazdin, 2008; Kendall, 1998). There is great variance from one client to another. Furthermore, the therapeutic process tends to be very dynamic, fraught with resistance and complex issues including prolonged periods when clients are stuck or in crisis. Consequently, a manualized, often sequential, and even session specific, type of treatment does not lend itself well to all of the complex and dynamic issues related to the therapeutic process (Anderson, 2006; Kazdin, 2008). Most EBTs are designed to target one or two specific diagnoses; however many clients are far

more complex, and present with multiple diagnoses and complex clinical issues (Graybeal, 2014; Kazdin, 2008). However, it should be noted that one of the potential benefit of AF EBTs, unlike most other EBTs, is that by definition, they do not focus on just one or two problems, but rather the complexity, and what lies at the root of the problems. That is, attachment is not a diagnosis, but rather a phenomenon that affects all areas of an individual's life.

EBTs are also often critiqued in regards to their limitations in generalizability to a clinical population that is culturally diverse. Research samples are often limited to a particular demographic (often white and middle class) while in the real world the population is diverse, and most often is not represented in research samples (different ethnicity, cultures, values, low socio-economic status [SES], etc.) (Anderson, 2006; Kazdin, 2008).

The research itself maybe questionable, despite use of randomized controlled trials (RCTs) (Anderson, 2006; Hagemoser, 2009; Kazdin, 2008). Critics argue that there can be problems with the conclusions that are drawn; measures used; focusing on measures that do not translate into real life improvements; biases of researchers; unintended influence on research subjects; problematic definitions of what constitutes evidence or significant effect; measuring statistical effect which does not necessarily translate into real life effect; and potential conflict of interest of researchers (Kazdin, 2008).

Some argue that the research is based on clinicians who fervently believed in the method, were experts, extensively trained, and/or were closely monitored and received extensive supervision (Anderson, Lunnen, & Ogles, 2010). Many studies, even those conducted by EBT proponents, discuss common issues of research results not translating into effectiveness in the clinical world (Karlin & Cross, 2014; Kendall & Beidas, 2007; Self-Brown et al., 2012; Walrath

et al., 2006). Other studies ask where one should start in making a decision as to which EBT to focus on and use, when there are so many EBTs claiming to be effective (Kessler et al., 2005).

Placing evidence-based treatments into a historical context. Deegear & Lawson (2003) place the evolution the evidence-based movement in a social, political, and historical context (Deegear & Lawson, 2003). They point out that a fervor to produce research to determine the effectiveness of psychotherapy was the result of the American Psychological Association's (APA) Division 12 Task Force's recommendations. Deegear & Lawson indicate that it is important to understand the context and intentions that were behind the Task Force's recommendation, specifically that of managed care. Indeed, the Task Force and its principal authors made explicit that they wanted to urge the APA to validate the effectiveness of psychotherapy, given that at the time, (the early 1990's), biological, medical and pharmaceutical methods were being promoted, valued and favored (Chambless et al., 1993; Chambless & Hollon, 1998). The intention was an attempt to save existence of psychotherapy, given such a context. The APA and researchers responded to this call to action. The research concluded that generally psychotherapy was equally effective to medication treatment, and in some cases even more effective (Anderson, 2006; Barlow, Levitt, & Bufka, 1999; Karlin & Cross, 2014).

Deegear and Lawson (2003) note that what occurred afterward is that the insurance industry and certain policy makers began to use the findings of this research as a means to demand and dictate that certain treatments be used over others for insurance reimbursement. This change led to a new focus, interest and fervor in research and development of EBTs. These changes led to new and now ongoing concerns regarding insurance companies, politicians and bureaucrats making decisions regarding treatment, because they generally are not trained, nor do these entities have the skills required to understand the research and subtleties of the clinical

environment (Anderson, 2006; Deegear & Lawson, 2003). Deegear and Lawson (2003) identify additional concerns relating to EBTs' historical context, such as the medical model being the preferred standard for determining the development and efficacy of EBTs. This model does not lend itself well to the particulars of the psychotherapeutic model (e.g. many clients present with comorbidity; the particulars of clients require clinical judgment, and thus do not lend themselves well to specific manualized and sequenced treatments). Other related concerns are that the EBT movement has been used by insurance companies and policy makers to favor short term and behavioral therapies; constrain therapeutic practice at the expense of the client; restrict access to care; etc.

When seen in this context, the original intent to provide evidence for the effectiveness of psychotherapies could be seen as having gone awry and having exceeded its scope, and steered psychotherapeutic work only toward a certain kind of evidence, and certain kinds of psychotherapies (Anderson, 2006; Deegear & Lawson, 2003; Kendall, 1998). Furthermore, the Task Force was clear in its intentions and recommendations, stating listings of EBTs and funding for training in psychotherapies proven to be efficacious would be needed (Chambless & Hollon, 1998; Chambless et al., 2006). However, funding remains a major concern that has impeded dissemination (Herschell, McNeil, & McNeil, 2004; Kendall & Beidas, 2007; Schoenwald & H., 2001). There is now recognition that investment is needed from both the clinical and research environments, so that they can work together to define standards regarding evidence-base, as both camps recognize that there is a need to deliver good and effective treatment, while avoiding the dangers involved when bureaucrats make decisions based on a limited understanding of research (Anderson, 2006)

Difficulties in defining evidence-based treatments. Many researchers agree that first of all, there often is a lot of confusion and disagreement regarding evidence-based terminology and what it means (Kazdin, 2008; Kendall, 1998; Kessler et al., 2005; Self-Brown et al., 2012). There are different terms, and research has shown that clinicians are often confused and do not know what the terms mean (Self-Brown et al., 2012). Some of the most common terms used are evidence-based practice (EBP), evidence-based treatment (EBT), and empirically supported treatment (EST). Some researchers point out that there is even disagreement within the research field about the meaning of different terminology (Self-Brown et al., 2012). Nonetheless, amongst a significant amount of researchers, there now appears to be somewhat of a growing consensus, at least in regards to the definition of evidence-based practice (Anderson, 2006; Hagemoser, 2009; Kazdin, 2008; Kendall & Beidas, 2007). Per the APA Presidential Task Force on Evidence-Based Practice, *evidence-based practice* (EBP) is "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (Anderson, 2006, p 273).

Evidence-based practice is not to be confused with evidence-based treatment. As noted above, evidence-based practice relates to an overall approach to treatment. Unlike evidence-based practice, there appears to be less of a consensus when it comes to defining evidence-based treatments (defined below), though a majority of researchers perhaps concur that there is a difference between the two terms. There is perhaps somewhat of an agreement that evidence-based treatments pertain to a set of protocols for a particular treatment (Barlow et al., 1999; Deegear & Lawson, 2003; Graybeal, 2014; Hagemoser, 2009; Hollon, Miller, & Robinson, 2002; Kazdin, 2008; Kendall & Beidas, 2007) . There even appears to be somewhat of a consensus that Evidence-Based Treatments (EBT) and Empirically Supported Treatments (EST) mean

essentially the same thing, and are often used interchangeably, though this seems to only complicate the definitional problems (Barlow et al., 1999; Hagemoser, 2009; Kendall & Beidas, 2007). Further adding to the confusion, are other terms that most often appear to be related to EBTs: evidence-based interventions and evidence based programs (the latter producing the most confusion, because it is abbreviated as EBP, which are the same abbreviations for evidence-based practice). In general, researchers tend to set the standard for "evidence" in regards to EBTs as being randomized controlled trials, though even this is not universal (Anderson, 2006; Barlow et al., 1999; Hagemoser, 2009; Hollon et al., 2002; Kendall, 1998; Kendall & Beidas, 2007; Kessler et al., 2005; Self-Brown et al., 2012) . Furthermore, there are no universal agreed upon standards for how many RCTs are required; whether there should be replication of results, and if these should come from independent studies and/or researchers; or whether other standards must also be met (Self-Brown et al., 2012).

This lack of consensus is reflected in the difference in standard for "evidence" set by some of the most popular websites which list EBTs (Self-Brown et al., 2012). For example, the California Evidence-Based Clearinghouse for Child Welfare (CEBC) uses a "scientific rating scale" of 1-5 to rate EBTs, with 1 being programs that are well supported, and 5 being programs that are of concern (CEBC, 2009). To receive a rating scale of 1, a program needs to have at least 2 RCTs that were performed at different sites of care. These must be published in peer-reviewed literature. The results must show that the intervention is more effective than an appropriate comparison practice. At least one these RCTs needs to show a sustained effect of at least one year beyond end of treatment, compared to a control group. There must be no evidence of harm, and no legal case related to the treatment. Finally, there must be some form of documentation that describes how to administer the program (CEBC, 2009). On the other hand,

the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (SAMHSA's NREPP) sets the following standard as "evidence": the intervention must have produced a positive effect (p < or = .05) compared to a control group, and the effect must be sustained over time, as shown in at least one published and peer reviewed study using an experimental or quasi- experimental design (SAMHSA's NREPP, 2014).

Evidence-based treatment definition. Despite all of these issues and difficulties related to defining EBTs, it is nevertheless important to provide a definition of EBTs, if one is to study them. Kazdin (2008) defines EBTs as "interventions or techniques that have produced therapeutic change in controlled trials" (p. 147). The APA's 2006 Presidential Task Force on Evidence-Based Practice defines ESTs as "specific psychological treatments that have been shown to be efficacious in controlled clinical trials" (Anderson, 2006, p. 273). Hagemoser (2009) defines ESTs as "the use of standardized procedures (treatment manuals) for specific disorders and relies heavily on experimental randomized clinical trial methodology." (p.602). The APA's 2002 Criteria for Evaluating Treatment Guidelines states that "Although randomized clinical experiments can make an important contribution to the evidentiary base for treatment guidelines, a single experiment from one setting does not provide sufficient evidence of efficacy. Replication across multiple settings is desirable." (Hollon, 2002, p. 1055). Barlow and his colleagues (1999) state that "The most methodologically sound tool for determining efficacy is the randomized clinical trial in which a given intervention is demonstrated to be better than some credible alternative treatment." (p.156), and later adds that "Confidence in treatment efficacy is based on both: (a) the absolute and relative efficacy of the treatment and (b) the quality of the studies on which the judgment is made, as well as their replicability." (p.156) Thus, the common

element of various EBT definitions is the use of RCTs, and in some cases, the replicability of findings via independent research. All of these authors also reference the use of manuals as being needed to reproduce the treatment protocol that yielded the evidence of efficacy (Anderson, 2006; Barlow et al., 1999; Hollon et al., 2002; Kazdin, 2008).

Thus for the purposes of this study, *an evidence-based treatment* will be defined as an intervention which is based on a minimum two independent randomized controlled trials, and has a manual that describes the application of the intervention. However, there will be one exception: the Circle of Security intervention. This AF EBT does not meet this standard, but has research to show it is effective, and is generally identified as a promising treatment. A decision was made to include it because it appears to be one of the better known treatments (at least in the Northeast U.S.), and is one of the main EBTs that the attachment literature tends to cite (Zeanah et al., 2011).

Attachment-Focused Evidence-Based Treatments

There are several attachment-focused evidenced-based treatments (AF EBT) that have been developed (Doughty, 2007; Zeanah et al., 2011). This study will focus on four of these interventions: Child-Parent Psychotherapy (CPP), Attachment and Behavioral Catch-Up (ABC), Video-feedback Intervention to promote Positive Parenting (VIPP), and Circle of Security (COS).

Child-Parent Psychotherapy. Child-Parent Psychotherapy (CPP) was created to treat children who have experienced trauma, suffer from mental health problems, and/or have attachment problems (Busch & Lieberman, 2007; Lieberman, Weston, & Pawl, 1991; Lieberman & Pawl, 1993; Lieberman et al., 2006; Zeanah et al., 2011). CPP is also known as Infant-Parent Psychotherapy (Fraiberg & Fraiberg, 1980; Lieberman et al., 1991; Lieberman &

Pawl, 1993) and Toddler-Parent Psychotherapy (Lieberman, 1992; Toth, Rogosch, Manly, & Cicchetti, 2006). While CPP integrates many elements from multiple theoretical perspectives, much of its focus and rationale are based on attachment theory (Busch & Lieberman, 2007; Liberman, Van Horn, & Ippen, 2005; Lieberman et al., 1991; Lieberman et al., 2006). CPP therapists meet with both children and primary caregivers on a weekly basis, typically for approximately one year (Liberman et al., 2005). This is a manualized treatment that varies according to the child's age, the nature of the trauma, and whether or not the caregivers also have suffered trauma of their own. The older the child, the more he/she can be involved in the treatment. CPP's published book that details the intervention is called *Don't Hit My Mommy* (Lieberman & Van Horn, 2004)

One of the major goals of the CPP is to strengthen the attachment between the child and primary caregiver (Lieberman et al., 2005; Lieberman et al., 1991). It is believed that the child's mental health and protection will be improved through improvements in the attachment (Lieberman et al., 2005). Improvement in attachment is accomplished in part by helping primary caregivers see and understand how their own trauma can distort the way they perceive and respond to their child. Therapists then help the primary caregivers find more realistic and developmentally appropriate ways of responding to their children (Lieberman et al., 2005). Therapists help primary caregivers discuss the trauma openly with their child, so that the caregiver-child dyad can create a joint narrative of the trauma, and change the misrepresentations they have of have of each other (Lieberman et al., 2005; Lieberman et al., 2006). Therapists help the dyad identify traumatic triggers and find better ways of responding to them (Lieberman et al., 2005; Lieberman et al., 2006). Another important focus of CPP is that it addresses risk factors, such as poverty, caregiver isolation and lack of support, immigration problems, etc.

CPP has been proven effective in at least three different randomized controlled trials, one of which was conducted by different researchers (Lieberman et al., 1991; Lieberman et al., 2006; Toth, Rogosch, Manly, & Cicchetti, 2006). Studies have shown significant reduction in children's behavior problems and PTSD symptoms (Liberman et al., 2005; Lieberman et al., 2006). Children in the experimental group of another study also had decreases in anger, resistance, avoidance, negative self-representation and perceptions of their caregivers, as well as better cooperation with their caregivers and better expectations of relationships (Lieberman et al., 1991). CPP has also been found to help decrease caregiver stress, avoidant behavior, and PTSD symptoms (Lieberman et al., 2005; Lieberman et al., 2006). Primary caregivers have also had increases in their empathic ability (Lieberman et al., 1991). CPP was also shown to decrease attachment insecurity, while increasing secure attachment (Lieberman et al., 1991). Improvements were observed in families, but those who were at highest risk appear to benefit the most.

Attachment and Biobehavioral Catch-up. Attachment and Biobehavioral Catch-up (ABC) was first developed to help foster care infants and toddlers with attachment problems, and has since been adapted to assist infants and toddlers who have experienced early adversity, particularly maltreated children and those born to mothers with substance abuse problems (Berlin, Shanahan, & Carmody, 2014; Bernard et al., 2012; Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008; Dozier et al., 2009). As the name implies, ABC is heavily based on attachment theory and research, neurobiology research, and also makes use of some behavior modification concepts (Dozier et al., 2006; Dozier et al., 2008). The goal of ABC is to help improve the ability of infants and toddlers to regulate their physiology and behavior, by organizing and improving the security of their attachment to

their primary caregivers, thus improving the dyadic regulatory ability of the attachment system. More information about the intervention is available in *Zero to Three's 2002 Bulletin 22* (Dozier, Dozier, & Manni, 2002)

In their 2012 study, Bernard and her colleagues detail how the ABC intervention is designed. Parent trainers visit primary caregivers and their children in their homes to deliver the intervention over 10 one hour weekly sessions by using a structured training manual. Parent trainers help primary caregivers learn and practice new skills that focus on three major parenting practices. One parenting practice focuses on behaving in ways that are not frightening to children. Another concentrates on helping primary caregivers override their own issues and reinterpret their distressed children's alienating behaviors, so that primary caregivers may help their children, and provide them with nurturance. The third practice focuses on being sensitive and responsive to children when they are not distressed, by being interested in them and following their lead. Other family members who live in the home are encouraged to participate. Each session makes use of concrete real examples of other primary caregivers and children; feedback regarding live and previously recorded caregiver-child interactions; research that supports what is being taught; and weekly homework assignments.

The ABC intervention has been shown to be efficacious in treating significant issues related to neglect, maltreatment, and disrupted attachment. The intervention has several randomized controlled trials (RCT) that demonstrate its efficacy. Though the body of research making use of rigorous standards is impressive, one of the weaknesses of the research related to this AF EBT is that it lacks replication by independent research groups. Nevertheless, perhaps one of the most impressive findings is that it has been

demonstrated, through an RCT study, that the ABC intervention can be effective in organizing and improving the security of attachment (Bernard et al., 2012). Recall that attachment patterns are very difficult to change; disorganized attachment correlates with many serious negative outcomes; and secure attachment is linked to many positive outcomes. Another RCT study has found that the intervention can help regulate the physiology, and thus reduce behavior problems of foster care toddlers, by improving the primary caregiver's ability to help their children with dyadic regulation (Dozier et al., 2006; Dozier et al., 2008). Yet another RCT study has found that the ABC intervention can help decrease, avoidant behavior (Dozier et al., 2009). Lastly, yet another RCT, though with a very small sample size, indicates the intervention may have a potential positive effect on improving parenting in mothers with a substance abuse problem who were now abstinent following the completion of a residential substance abuse program (Berlin et al., 2014).

Video-feedback Intervention to promote Positive Parenting. The Video-feedback Intervention to promote Positive Parenting (VIPP) is a brief intervention that makes use of video feedback, and some written materials, to help improve interactions between parents and their children (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2005; Kalinauskiene et al., 2009). The rationale and focus of the VIPP intervention is heavily based on attachment theory; focusing in particular on attunement and responsiveness, sensitivity, as well as awareness, reflection and empathy. Like the ABC intervention, its rationale for a short intervention is based on a 2003 meta-analysis of attachment interventions (Bakersman-Kranenburg et al., 2003) There is a book, titled "Promoting positive parenting: An attachment-based intervention.", that provides details about

the VIPP intervention, and which is authored by the main developers of VIPP (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008)

Kalinauskiene and her colleagues describe the VIPP intervention in their 2009 study. VIPP involves of a total of six home visits by master's level clinicians. The protocol begins with a pre-intervention assessment visit, which also produces video material for the following first treatment visit. There are a total of four monthly 90 minute treatment visits. The visit begins with videotaping the primary caregiver interacting with their infant. This material is then used at the next visit. In the second part of the visit, the primary caregiver and clinician examine the previous visit's recording. The clinician provides positive feedback as they review the primary caregiver's interactions with their child. The goal is to help improve awareness and understanding of the interactions between and caregiver and infant, and to support/promote sensitive actions by primary caregiver toward their child (Kalinauskiene et al., 2009)

The first two sessions/visits focus exclusively on providing feedback on what primary caregivers did well. During the last two sessions, feedback is also provided on interactions that can be improved, but whenever possible, the primary caregiver's own previous positive actions are used as examples of how to improve, so that they may serve as their own positive model. The clinician also raises the caregiver's awareness and understanding by being a voice for the infant, as a means to indicate what the baby's behavior means (Kalinauskiene et al., 2009). Each session focuses on particular topics: the baby's contact seeking behavior, playing behavior, exploration and crying behavior and possible reactions to it, understanding the feelings of the baby, sensitive responsiveness to the baby's signals, and sharing emotions (Kalinauskiene et al., 2009). Written materials on

attachment are also provided and discussed as part of the intervention. The intervention concludes with a sixth and final session with caregivers, to summarize all that was learned and observed previously.

The intervention has several versions, including one called VIPP-SD, which adds an additional two 90 minute visits, and includes a focus on how to provide discipline in a sensitive manner (Bakermans-Kranenburg et al., 2008; Van Zeijl et al., 2006); VIPP-R, which incorporates discussions about the primary caregiver's childhood attachment experiences, and how these affect the caregiver's parenting with their own child (Bakermans-Kranenburg, Juffer, & van Ijzendoorn, 1998; Klein Velderman, Bakermans-Kranenburg, Juffer, & van IJzendoorn, 2006); and various adaptations for particular populations, including adoptive families (Juffer et al., 2005), and professional caregivers (Groeneveld et al., 2011).

The findings of several randomized controlled trials demonstrated that the VIPP intervention increases maternal sensitivity (Juffer et al., 2005; Kalinauskiene et al., 2009; Klein Velderman et al., 2006; Van Zeijl et al., 2006). One RCT showed that the VIPP-SD intervention can lower cortisol levels in children who have a specific mutation of a gene that affects the efficiency of dopamine receptors (Bakermans-Kranenburg et al., 2008). However, this study's details about its sampling, control group and intervention were unclear and confusing. This study made use of a subsample of a prior study. It also appears that none of these studies are from independent research groups. In addition there are several studies that failed to demonstrate effect, and yet the authors were liberal in the nevertheless favorable conclusions they reached. Several studies assessed for change in attachment security, but the intervention was not effective in this area

(Kalinauskiene et al., 2009; Klein Velderman et al., 2006), and no long term effect on maternal sensitivity (Kersten-Alvarez, Hosman, Riksen-Walraven, van Doesum, & Hoefnagels, 2010)

Circle of Security. The Circle of Security (COS) intervention uses a group format to provide parent education and psychotherapy that is based on attachment theory, and extensively focuses on attachment (Hoffman et al., 2006; Marvin, Cooper, Hoffman, & Powell, 2002). Prior to the COS intervention, participants are screened; have their interactions with their child recorded; and are assessed along with their child for their respective attachment categories. Groups consist of two therapists who meet weekly with five to six primary caregivers for 75 minutes over the course of twenty weeks. The first two weeks focus on providing psycho-education regarding attachment and what the intervention will entail. The remainder of the 18 weeks focus on each caregiver for three weeks to provide individualized interventions based on their respective individual attachment category and that of their child. The main developers of COS have recently published a book, which details the intervention (Powell, Cooper, Hoffman, & Marvin, 2014)

Marvin and his colleagues (2002), as well as Hoffman and his colleagues (2006), summarize the protocol for the COS intervention. The COS intervention focuses on five major elements of attachment theory: 1) a secure base from which to explore, 2) attachment needs, 3) attunement and responsiveness, 4) self-reflection and empathy and 5) the ability to connect and make use of one's own past experiences and developmental history to further increase their ability to be attuned and responsive to their child. Primary caregivers are given an illustration called the Circle of Security that serves as a simple visual guide to help them understand their child's core attachment needs and patterns. The intervention also teaches caregivers language to

help them better understand their child's and their own defensive behavior when either feels anxious (Hoffman et al., 2006; Marvin et al., 2002).

Mirroring the attachment relationship between a primary caregiver and their child, the intervention first seeks to establish the group as a secure base from which primary caregivers can explore (Hoffman et al., 2006; Marvin et al., 2002). Participants are then better positioned to benefit from the four other aspects of the COS intervention. These aspects all have the goal of increasing a primary caregiver's attunement and responsiveness to their own child. One aspect of the intervention focuses on educating caregivers about their child's attachment needs. Another focuses on increasing a caregiver's ability to recognize and respond to their child's cues, as well as to function as a secure base for them. Yet another focuses on increasing a caregiver's empathy by supporting their reflection about their own behavior and feelings in regards to attachment related interactions, as well as those of their child's. Lastly, the intervention attempts to increase caregivers' reflection about how their own developmental history affects their current caregiving behavior (Hoffman et al., 2006; Marvin et al., 2002).

The intervention has been modified to adapt it to other treatment contexts. One version is the Circle of Security-Parenting (COS-P), which involves only 8 sessions; does not assess for attachment; and does not make use of personalized video (Pazzagli, Laghezza, Manaresi, Mazzeschi, & Powell, 2014). It can be used with groups, primary caregiver-child dyads, or individuals; and can be adapted for use in clinics or in client homes. Furthermore, the intervention makes greater use of the psychoeducational model, and is thus less intense, more adaptable, and easier to use with a wider array of clients (Pazzagli et al., 2014). Another version of COS is called The Circle of Security-Home Visiting-4 Intervention (COS-HV4) (Cassidy, Woodhouse, Sherman, Stupica, & Lejuez, 2011). Because the intervention only

focuses on a primary-caregiver dyad, rather than six different members of a group, all the key elements of the original COS are retained in this version, but accomplished in only four home visits. This intervention establishes the therapeutic relationship as the secure base from which primary caregivers may explore, rather than the group. However, it makes extensive use of video-recordings, and the focus is on the caregiver-infant dyad, rather than just caregivers (Cassidy et al., 2011).

There are several distinctive aspects to the COS intervention (Hoffman et al., 2006). First, COS is the only attachment intervention reviewed in this study that uses a group format. COS is also the only intervention that uses information regarding attachment categories during the assessment to tailor the intervention to each individual. Furthermore, COS is the only intervention that solely targets the caregiver for intervention. Lastly, the intervention focuses on a combination of caregiver behavior and caregiver mental representation, versus most other interventions that tend to focus on either one or the other, but not both.

It is important to point out that this intervention does not meet the definition of evidence-based treatment defined in this study. To date, only one study made use of a randomized controlled trial (RCT), and this was only for an adapted version of COS, the COS-HV4 (Cassidy et al., 2011). The main issue thus far, has been not producing research that makes use of a control group. This is finally being addressed, and a study protocol has been submitted this past year, indicating that there is an RCT study underway, comparing COS to treatment as usual (Ramsauer et al., 2014). However, the authors did not make use of a no treatment control, stating they felt it would have been unethical to withhold care. Though the exact circumstances of the study are not known, researchers often make use of clients on waitlists to create a no treatment control that is ethical.

This being said, there are several reasons why an exception was made in regards to including COS in this study, despite it not meeting this study's standard for an AF EBT. COS is one of the few interventions that is often mentioned in the attachment literature, and thus it may be one of the better-known interventions. COS also makes such an integral use of attachment theory in all its aspects, that it has fundamental value in detailing how central concepts of attachment theory can be applied as an intervention. Furthermore, not making use of RCTs in a study does not mean it has no value. There are several well-designed studies that have been conducted in regards to COS, and one of these has demonstrated remarkable results (e.g. changes in organization and security of attachment) (Cassidy et al., 2010; Cassidy et al., 2011; Hoffman et al., 2006).

Specifically, in their 2006 study (n=65), Hoffman and his colleagues found that the intervention was effective in organizing the attachment of close to 70% of children with previously disorganized attachment. This study also found that 44% of previously insecurely attached children became securely attached to their primary caregivers. Such numbers are impressive, given how hard it can be to change attachment patterns. The one RCT study by Cassidy and his colleagues (2011), which studied an adapted version of the COS (n=220), found no significant overall effect from the intervention. However, when maternal attachment and child irritability were considered, intervention efficacy was demonstrated. Infants with high irritability and either secure or insecure/dismissive (avoidant) mothers were much more likely to have been affected by the intervention, than moderately irritable infants (Cassidy et al., 2011). The authors indicate that susceptibility to treatment effect of highly irritable infants was expected, as there have been similar findings in other studies. Yet another study of 20 mother-child dyads in a jail diversion program found that 70% of the children were securely attached post intervention, and

20% had disorganized attachment, both of which are reportedly about the same as the average non-clinical, low risk samples found in literature (Cassidy et al., 2010). However, the inability to generalize, small sample size, and the fact there are many other interventions and factors that could have led to such results, indicate that nothing conclusive can be drawn from this study.

Dissemination and Implementation of Evidence-based Treatments

While there are AF EBTs that have been shown to be effective through research, these have yet to be shown to be effective in the clinical setting. It is one thing for any evidence-based intervention to be shown to be effective in the research setting. It is quite another for the same intervention to be found effective in the clinical setting. The process of moving an evidence-based intervention from the research setting into a well implemented and broadly utilized intervention that continues to be as effective in the "real world" clinical setting is a very lengthy, costly, time and labor intensive process that is fraught with problems. This process is commonly referred to as *transportability* in the research literature (Elkins, McHugh, Santucci, & Barlow, 2011). Transportability is such an involved and problematic process that it is actually a field of research of its own, often referred to as *dissemination and implementation* science, which has now been in existence for more than a century (Bowen et al., 2009; Flaspohler, Lesesne, Puddy, Smith, & Wandersman, 2012; Tabak, Khoong, Chambers, & Brownson, 2012).

Previous research has shown that, in the medical field, it takes an average of 17 years for an EBT to move from the research setting to its established, widespread and effective use in the clinical setting, and many EBTs take longer or never become adopted into widespread use; and it can take longer, up to 25 years for EBTs designed to address mental health problems (Karlin & Cross, 2014; Kendall & Beidas, 2007). As will be later discussed, there is very little to no research regarding the dissemination, implementation and transportability of AF EBTs, which is

why this current study is needed. To put it bluntly, it does not matter how effective an EBT is proven to be in research, it will be of little use if it is not used effectively by a significant amount of clinicians (Edmunds, Beidas, & Kendall, 2013; Kendall & Beidas, 2007).

A discussion of the details of dissemination and implementation will follow shortly. While the terms will be separated, this is being done solely for the sake of clarity, and it should be noted that these concepts are so complex and interwoven, that in reality such delineation is not so clear, nor are the systems responsible for each process so clearly divided as presented.

Issues related to dissemination.

The role of researchers. While there is no consensus regarding a single definition of *dissemination*, the term is often used to describe activities related to the broadcasting and diffusion of an EBT (Bowen et al., 2009; Tabak et al., 2012). The dissemination process goes well beyond simply publishing the results of a study in a peer reviewed journal for it to be successful, and involves active, intensive, and sustained efforts using many strategies, from informational/advertising campaigns to training and ongoing consultation, that target many systems (Karlin & Cross, 2014; Kendall & Beidas, 2007; Tabak et al., 2012). While responsibility lies beyond that of only the developers and researchers involved with a particular EBT, they basically bear the brunt of the burden for ensuring the success of transportability (Kendall & Beidas, 2007). Often, the lack of funding leads to problems with being able to properly disseminate an EBT, even when outcome data is impressive (Kendall & Beidas, 2007; Schoenwald & H., 2001). There have to be massive, intensive, and multisystem level (policy, agency, provider, client, etc.) approaches to disseminate effectively; and this requires significant commitment, time, funds, etc. (Karlin & Cross, 2014; Schoenwald & H., 2001; Self-Brown et al., 2012)

More specifically, there are concrete areas that have been identified as critical to dissemination efforts. First and foremost, whether or not there is funding and support to disseminate, an EBT will have a dramatic impact on the likelihood of a successful dissemination and implementation of an EBT (Flaspohler et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007; Schoenwald & H., 2001). The funding and support of dissemination efforts is often overlooked and/or unavailable. Researchers typically operate within higher education systems, most having focused on and rewarded publication, but not dissemination efforts. In addition, the intensity of sustained efforts, as well as methods used to broadcast the existence, details, effectiveness and usefulness of the intervention are of great importance as well (Allen, Gharagozloo, & Johnson, 2012; Karlin & Cross, 2014; Self-Brown et al., 2012).

Many strategies can influence the success of broadcasting efforts, such as widespread publication of studies in peer reviewed and respected well known journals; sustained and intensive media campaigns; use of a dedicated and well-designed website; presentations at critical and well attended conferences; use of webinars and learning collaboratives (e.g. NCTSN) and well known EBT broadcasting websites (e.g. CA evidence-based clearinghouse; SAMHSA's NREPP) (Allen et al., 2012; Self-Brown et al., 2012). Advertising and educating consumers directly can be tremendously, if not even more useful than solely focusing on providers (Bowen et al., 2009; Karlin & Cross, 2014). Obtaining buy-in for a particular EBT from well recognized and respected professionals and/or organizations in particular fields, communities, agencies, etc., and then using their assistance to broadcast and promote the use of that EBT can also have a dramatic impact (Karlin & Cross, 2014). Yet another critical factor affecting the chances of success regarding the dissemination, acceptance and implementation of EBTs is whether the

EBT itself, or at the very least, the importance, value and some details regarding use of EBPs and EBTs in general is being taught in higher education institutions (Self-Brown et al., 2012).

Issues pertaining to training are also of great importance (Allen et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007). The ease of access, cost and length of time required to be trained in an EBT are important factors (Allen et al., 2012; Kendall & Beidas, 2007). The kind of training provided has to include active types of learning for it to be effective (e.g. role playing, modeling, practicing, interactive discussions, etc.) (Self-Brown et al., 2012). The provision of follow-up training and consultation is just as critical as providing initial training in a particular EBT (Edmunds et al., 2013; Karlin & Cross, 2014). The specific design of an EBT and its manual, how easily it can be learned and how flexibly it can be applied while nevertheless respecting fidelity are equally important as well (Kendall & Beidas, 2007). Researchers are often focused on theory, clinical issues and proving efficacy when designing EBTs; but of equal importance is having knowledge of dissemination and implementation issues, and foresight of these during the design of the EBT; as opposed to these being only considered and focused on after an EBT has been shown to be effective (Hoagwood, Hibbs, Brent, & Jensen, 1995; Schoenwald & H., 2001). Furthermore, while it may be obvious that studies must be well designed, as free of bias as possible, careful of avoiding assumptions and drawing wrong conclusions, use the correct measures to identify effect, etc., it is nevertheless important to point out that these concerns are all the more critical when it comes to the studies related to EBTs, because of the implication for affecting clinical care delivery and the associated scrutiny, skepticism and criticism that are in existence regarding EBTs (Hagemoser, 2009; Kazdin, 2008; Kendall & Beidas, 2007).

Issues related to implementation.

The role of organizations. The organizational culture, amount of support and investment related to an organization's efforts to implement one or more EBTs is another and equally critically important part of the process. Specifically, an organization's value of innovation, EBTs, EBPs, as well as its investment and value in supporting its workers have been found to have dramatic impact on successful implementation (Aarons & Sawitzky, 2006; Edmunds et al., 2013; Karlin & Cross, 2014; Self-Brown et al., 2012). Much of this translates into an organization's willingness and ability to fund, support, and be committed to new initiatives (Karlin & Cross, 2014; Self-Brown et al., 2012). Concretely, implementation involves administrators developing appropriate policy; as well as investing in securing buy-in from all. Successful implementation also necessitates commitment to extra funds and supports to ultimately provide the resources and time needed to train staff, and consequent compensatory measures resulting from lower caseloads due to decreased productivity while the staff learns new interventions. Also, implementation requires investment in media campaigns to promote client and clinician awareness, acceptance and use of these new interventions and entails the need to provide ongoing support through supervision, additional follow up training and consultation (Edmunds et al., 2013; Karlin & Cross, 2014) Additional resources also need to be committed to monitoring, to ensure compliance, fidelity, and that the interventions are indeed as effective in the clinical setting than as in the research setting (Karlin & Cross, 2014) The demands on an organization are so great, that they must be truly committed to improvement and interventions that produce results (Self-Brown et al., 2012).

The role of clinicians. Many factors in regards to clinicians have been identified as significantly impacting the implementation of EBTs. Clinician attitude toward EBTs is perhaps

the most often cited issue (Allen et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007; Self-Brown et al., 2012; Walrath et al., 2006). Most of these studies have identified, in large part, clinicians' educational and professional exposure to EBTs and EBPs, as one of the most significant element affecting their openness to EBTs, as these can significantly affect their awareness and value of EBTs and EBPs. Specifically, higher education institutions are identified as holding important responsibilities in regards to training clinicians to value results, accountability, research, empirical evidence, etc. (Self-Brown et al., 2012). Clinicians often report that EBTs are typically designed to target only one or two specific diagnoses, and are too inflexible to apply to the culturally diverse and/or diagnostically complex population they work with (Graybeal, 2014; Karlin & Cross, 2014; Kazdin, 2008; Mitchell, 2011). They also report that the circumstances of the research setting do not reflect those of the clinical setting, and therefore, results cannot be replicated in the clinical setting (e.g. differential amount of training and supervision; insurance companies not covering the amount or length of sessions required by the EBT protocol; etc.) (Karlin & Cross, 2014; Kendall & Beidas, 2007; Self-Brown et al., 2012; Walrath et al., 2006). Clinicians may be at a loss in regards as to which EBTs to incorporate into their practice given the plethora of existing EBTs (Karlin & Cross, 2014; Self-Brown et al., 2012). Time, energy, and financial resources available to them to browse and obtain training in particular EBTs are also commonly cited issues (Karlin & Cross, 2014; Kendall & Beidas, 2007), in addition to poor procurement of follow up training, supervision and/or consult (Karlin & Cross, 2014; Walrath et al., 2006). Studies have shown that many clinicians will selectively choose certain elements of an EBT or adapt manual protocols, thus affecting the effectiveness of the intervention in the clinical setting (Kendall & Beidas, 2007; Walrath et al., 2006).

Conclusion

Given the controversies involved with EBTs, it is important to place all of the above issues and concerns in the appropriate context. While these are important factors influencing the transportability of EBTs into the clinical setting, they are not indications that transportability is impossible. Rather, they are factors that need to be considered and addressed in order for dissemination and implementation of EBTs to be successful. Perhaps the most compelling evidence that EBTs can and do work in the clinical setting come from the largest healthcare provider in the United States: the Veteran's administration (VA). Karlin and Cross (2014) detail the efforts and very positive and impressive results related to the VA's decision to implement the widespread use of EBTs across their entire system. This particular article highlights the importance of multi-systemic, comprehensive organization led and funded approach to dissemination and implementation. Studies regarding Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), one of the most widely disseminated and used EBTs, also indicate that EBTs can be successfully disseminated and implemented is cost effective way, though fidelity and effectiveness in the clinical setting, while significant enough, may not be as optimal as desired (Fritz et al., 2013; Greer, Grasso, Cohen, & Webb, 2014; Webb, Hayes, Grasso, Laurenceau, & Deblinger, 2014).

Two other EBTs and their related dissemination and implementation studies require mention: Positive Parenting Program (PPP or Triple-P) and Parent-Child Interaction Therapy (PCIT). These two EBTs were given significant consideration in regards to inclusion to this study, as they are EBTs that are somewhat based on attachment. Ultimately a decision was made to exclude them from the study because they are much more behaviorally focused than attachment focused. There were also concerns regarding survey participation and completion,

and thus keeping the survey as short as possible was a significant priority. While creating a more thorough survey would have been favorable, this could not be done at the potential expense of poor survey response and/or completion. Triple-P and PCIT are of particular interest however, as both of these interventions have been successfully disseminated and implemented, with accompanying studies documenting some of these efforts, results, as well as information regarding barriers and facilitators of such efforts (Herschell et al., 2009; Lanier, Kohl, Benz, Swinger, & Drake, 2014; Leung, Sanders, Leung, Mak, & Lau, 2003; Pearl et al., 2012; Sanders, Turner, & Markie-Dadds, 2002; Sanders et al., 2012; Sanders, 2012; Self-Brown et al., 2012; Shapiro, Prinz, & Sanders, 2012; Travis & Brestan-Knight, 2013; Turner, Nicholson, & Sanders, 2011).

As demonstrated above, AF EBTs do have empirical studies that show effectiveness in addressing attachment and/or maltreatment problems. One potential advantage that AF EBTs may have over other EBTs is that they do not focus on one or two diagnostic problems, but rather a constellation of complex problems, thus potentially addressing some of the concerns regarding found in the literature. However, it is clear that there is a significant difference between an EBT having empirical data supporting that it is effective in the research setting versus it being successfully disseminated and implemented with research results being transported into the clinical setting. There are little to no studies regarding the dissemination and implementation of AF EBTs. Only one study was found to be closely related to the proposed study, surveying provider knowledge of maltreatment EBTs and mentioning some of the interventions surveyed in the currently proposed study (Allen et al., 2012). This study was not specifically targeting AF EBTs, but rather EBTs determined to address maltreatment. Its results indicated that most clinicians could not correctly identify the EBTs, and that knowledge of these

was low. Given that most studies regarding AF EBTs are still relatively new, and the absence of dissemination and implementation studies, as well as what is known regarding known dissemination issues related to broadcasting and diffusing information about EBTs in general, which lead to problems with clinicians and organizations even being aware of their existence, it is hypothesized that most clinicians will lack awareness of AF EBTs. Being aware of the existence of an EBT, and associated dissemination efforts, are essential starting elements that are required in order to improve the possibility of successful implementation of EBT. As such, the currently proposed study is needed, as a starting point from which to launch studies regarding dissemination and implementation of AF EBTs.

CHAPTER III

Methodology

This study was an attempt to determine if and to what extent are clinicians using certain attachment-focused evidence-based treatments (AF EBT) that treat children, aged five years and under, and their caregivers; and what barriers may impede the effective use of these AF EBTs in the clinical setting. More specifically, this study asked: 1) What are clinicians' level of awareness, training, use, fidelity versus adaptations, and perceived effectiveness of four of the AF EBTs in existence at this time and 2) What are some of the factors that may impede their implementation in the clinical setting? For the purpose of this study, a *clinician* was defined as any licensed mental health professional with a corresponding Master's degree level of education or higher who works with children under five years of age and their caregivers. The purpose of the study was to expand currently limited research regarding the use of AF EBTs in the clinical setting, and identify some of the potential barriers that may contribute to a gap between researching these interventions and their application in the clinical setting.

Given the scarcity of research regarding the dissemination and implementation of AF EBTs in the clinical setting, this was an exploratory study. This was a descriptive, quantitative study because such methodology can be useful in exploring if there is a potential indication for the need for future studies, and in serving as a starting point for issues that have yet to be researched (Rubin & Babbie, 2010). This study made use of a web-based anonymous survey, comprised of mostly close-ended questions, and a few open-ended questions.

Sample

Recruitment. Availability/convenience sampling techniques were used for this study. This less rigorous sampling method was used because of limited time and resources (Rubin & Babbie, 2010). Certain organizations were targeted because of the likelihood that many of their members would meet the eligibility criteria for the study, without unduly biasing the sampling pool (e.g. only targeting agencies that focus on treating children with attachment issues). Organizations were queried for permission to post and/or broadcast the recruitment letters (see Appendices A and B). Agencies that required applying for approval of the study through their own Internal Review Board, in addition to the approval that was already obtained from the Smith College School of Social Work HSR Committee, were eliminated as potential recruitment sites, again due to limitations in time and resource. Recruitment letters were not posted and/or broadcasted until permission was received in writing from any particular agency. Any agency that did not grant permission was eliminated as a recruitment site.

The following agencies were first targeted: the National Association of Social Workers (NASW), NASW's Help Pro, Zero to Three, Childtrends.org, the Child Welfare Information Gateway, The National Child Traumatic Stress Network (NCTSN), Substance Abuse and Mental Health Administration (SAMSHA), National Resource Center for In-Home Services, National Resource Center for Child Protective Services, and the National Resource Center for Community-Based Abuse Prevention. Since only the NASW and NCTSN gave permission, and with rather restrictive means of recruitment (posting the recruitment message on the NASW LinkedIn page and retweeting this message via NCTSN's Twitter account), attempts were also made to seek approval from some, but not all of the

providers that belong to the following Massachusetts provider categories: Children's Behavioral Health Initiative (CBHI); Early Intervention; Head Start providers; and child therapists.

In addition, snowball sampling techniques were utilized, again because of limited time and resources. This sampling method was added to help increase the likelihood of obtaining responses to the survey. This sampling method is typically used to reach members of a population that are difficult to locate (Rubin & Babbie, 2010). Licensed mental health clinicians who work with children are not considered a difficult to locate population. However, clinicians, including those who work with children, aged five years and under, and who will respond to online surveys can be considered difficult to locate, given that response rates to online surveys are, in general, notoriously low (Dykema, Jones, Piché, & Stevenson, 2013; VanGeest & Johnson, 2013).

Thus, for this study, I directly contacted, through email, mental health professionals who were colleagues and either met the inclusion criteria or knew of other professionals who met the criteria. These emails contained the recruitment letter; and depending on their professional status and the relevant client population, requested that they either take the survey, and/or help distribute it to their own contacts, agencies, associations, etc.; and that they also request their contacts to potentially take the survey and/or distribute the recruitment letter, and so on. In addition, all survey participants were asked to distribute the recruitment letter as well (i.e. part of the "Thank you" pages of the survey contained a request to distribute the recruitment letter, which was included as well, so that participants could copy and paste it).

Selection criteria. To be eligible for the study, participants were required to be licensed clinicians with a corresponding Master's level of education or higher who provide psychotherapeutic services to children five years of age or under and their caregivers in the United States. Thus, individuals who did not meet these criteria were excluded. The reason for these criteria were as follows: 1) Most of the AF EBTs that were part of this study target infants, toddlers, preschoolers and their caregivers and 2) Also require Licensed Master's level or higher clinicians to conduct the psychotherapeutic work with these populations.

Ethics and Safeguards

Risks. Participants were licensed clinicians, and the nature of the survey did not involve any sensitive or potentially traumatic subjects. Thus, participants were not considered to be part of any federally defined vulnerable population. There were no potential risks identified, other than that some participants could potentially feel inconvenienced and annoyed as a result of taking the survey. It was estimated that the survey would take no longer than 10 minutes to fill out, and that most participants would likely be able to complete it in less than five minutes.

Benefits. There were several potential benefits to participants, particularly because they were mental health clinicians. They may have learned about some of the AF EBTs that were reviewed in the survey, which may have been useful to them and their professional development.. Consequently, it is possible that this could have led to their seeking to obtain more information and/or training in one or more of these interventions; and/or suggest that their agency explore adopting their use as an additional means to help their clients. Furthermore, participants who were social workers fulfilled one of the core values of their code of ethics: competence, which involves increasing one's knowledge base, and

contributing to the knowledge base of the profession. Though it is a minor benefit, participants were eligible to receive a $5 gift card, which given the average amount of time estimated to be required to complete the survey, was perhaps somewhat comparable to a social worker's average hourly rate of compensation.

Protection of confidentiality. All responses were recorded via a survey posted on the SurveyMonkey website. This data was password protected, secure, encrypted, confidential, anonymous, and no email addresses or IP addresses were collected. Responses from each survey were then stored in an Excel database, which was also held confidential and secure via password protection and encryption. All research materials including recordings, transcriptions, analyses and consent/assent documents are being stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data was and will continue to be password protected during the storage period. Since the survey was anonymous, no identifiable information that could potentially link any participant to the survey was nor will be included in any report that is published regarding the study. The survey was also designed to prevent multiple entries from the same computer, as a means to help ensure that there was only one survey per participant that was being completed.

In order to increase chances of participation, and in order to compensate participants for their time, participants in the survey were offered a $5 Dunkin Donuts Reward Gift Card. Participants were directed to a different webpage to enter their contact information, which was needed in order to mail them the gift cards. This separate page allowed the original survey to be kept anonymous, as there was no link between the two web pages, and thus no identifying information could be linked to participant answers. However, the identity of

the participants wishing to get a gift card could not be kept anonymous since they needed to provide their contact information. Their information however was solely used for the purpose of gifting, and was immediately permanently destroyed once gift cards were issued them. The information was held confidentially on the secured, password protected and encrypted SurveyMonkey website. There were no direct interactions between the participants and myself, unless they chose to contact me regarding questions/concerns related to informed consent/decision as to whether or not participate in the study.

Procedures for withdrawal from the study. Participation in this study was entirely voluntary. Participants could refuse to take part in the study simply by exiting the survey at any time. They had the right and ability to refuse to answer any and/or all questions. However, participants were also made aware that the survey made use of "skip logic" technology. This feature, which skips over certain "redundant" questions based on a participant’s answers to prior questions, does require that certain questions be answered in order for the technology to work effectively. This feature was built into the design of the survey to make participation as brief as possible, and in order to reduce potential frustration resulting from having to answer “redundant” questions. Participants were thus urged to answer these questions, which were marked by an asterisk. However, participants still had the option to refuse to answer such questions. Given the anonymous nature of the study, participants were informed that it would not be possible to withdraw their answers once the survey was completed. Participants were fully informed of the details involved with taking the study via an Informed Consent Page (see Appendix C). They were also given the opportunity to ask questions and contact either myself or the Chair of the Smith College School for Social Work Human Subjects Committee.

Data Collection

Process for accessing the survey. As indicated above, data was collected through an anonymous online survey designed and accessed through the SurveyMonkey website. Potential participants were informed about the survey via the recruitment letters, which included a link to a Welcome Page (see Appendices D and E) that provided a brief welcome message thanking potential participants for their willingness to consider participating in the survey, and briefly summarizing the study and process. If potential participants wanted to continue with taking the survey, they then clicked on a "yes" checkbox, which automatically redirected them to an Eligibility Page (see Appendix F). If they did not want to participate, they clicked on a "I've decided not to participate and I am choosing to exit the survey" checkbox, which automatically exited them from that page prior to taking part of the survey, and automatically redirected them to a Thank You Page (see Appendix G), thanking them for their participation and requesting that they consider distributing the recruitment letter.

Once on the Eligibility Page, potential participants were informed of the three eligibility criteria to participate in the survey, followed by a brief statement indicating that they met the criteria. Potential participants that checked the "Yes" checkbox were automatically redirected to the Informed Consent Page (see Appendix C). If they clicked the "No" checkbox to indicate that they did not meet the criteria, they were automatically exited from that page prior to taking part of the survey, and automatically redirected to the Thank You Page, thanking them for their participation and requesting that they consider distributing the recruitment letter.

Once on the Informed Consent Page, participants were provided with full informed consent information, detailing the study, risks, benefits, rights, contact information, etc.,

followed by a brief statement that read as follows "By checking the box below that says 'I agree', you are indicating that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above; and you will be sent to the actual survey. Clicking on the 'I disagree' box will exit you from the survey." If they chose the "I agree" checkbox, they were automatically redirected to the actual Survey (see Appendices H to BB). By checking the "I disagree" checkbox, they were automatically exited them from that page prior to taking part of the survey, and automatically redirected to the Thank You Page, thanking them for their participation and requesting that they consider distributing the recruitment message.

Questionnaire. The SurveyMonkey website was used to administer the survey and collect the data. The participants spent approximately 5-10 minutes filling out a survey containing six demographic questions, and a maximum of 39 survey questions. That is, many of the questions made use of Skip Logic technology, and thus, depending on a participant's answers, they could skip over some or possibly most of the questions. All questions with Skip Logic functionality were flagged by an asterisk. All questions were ultimately optional and answering them was at the discretion of the participant. All but one question were multiple choice; however sixteen of them had an "other" option which allowed participants the option to type in an answer. The one exception was a demographic question about the participant's years of experience as a licensed mental health clinician working with children. For exact details of each question and answer option, please see Appendices H to BB. All participants were treated equally and asked to answer the same survey.

Process after completing the survey. Once a participant completed the survey, they were automatically redirected to the Dunkin Donuts Gift Card Page (see Appendix CC),

where they informed about all the details related to the gift card, and given the option to either enter their contact information to receive the gift card, or remain completely anonymous and opt out of their right to receive a gift card. If a participant provided their contact information, their gift card was mailed to them within one week of their completing the survey, and their contact information was permanently deleted and destroyed immediately after. After completing their contact information, participants were automatically redirected to a Thank You Page for survey completers who requested a Dunkin Donuts card (See Appendix DD), thanking them for their participation and requesting that they consider distributing the recruitment message. If a participant opted out of their right to receive a gift card, they were automatically redirected to a Thank You Page for survey completers who did not request a Dunkin Donuts card (See Appendix DD), thanking them for their participation and requesting that they consider distributing the recruitment message.

Data Analysis

Once all surveys were collected, data was exported into an Excel spreadsheet. The Excel spreadsheet was then given to the Smith College School for Social Work research analyst for statistical analysis. Since the design of the study was descriptive, the statistics run were descriptive in the form of frequencies (i.e. percentages, totals, range, mean). The excel sheet was read into SPSS and the statistics were run by the SCSSW research analyst.

Later, certain corrections had to be performed with the data in the survey, directly in SurveyMonkey. A copy of the original data was first saved in an Excel File. The corrections were made in the survey. Data had to be reanalyzed. However, since all that had to be analyzed were simple descriptive statistics, I performed the computations myself by hand and/or with the

use of a calculator. All results were triple-checked for accuracy, and were reported in the Findings chapter.

CHAPTER FOUR

Findings

The overarching goal of this exploratory, descriptive, quantitative study was to gather initial data on clinicians' use of attachment-focused evidence-based treatments (AF EBT) that treat children of five years of age and under in the clinical setting. Eligible licensed mental health clinicians voluntarily participated in an online survey regarding their awareness and use of four of these AF EBTs..

This chapter reports the results from this survey. The first section is a summary of the major findings. The second section summarizes the responses to recruitment efforts and survey participation. A section detailing demographic information about the survey participants follows. The next section presents the details of responses about each AF EBT: Child-Parent Psychotherapy (CPP), Attachment and Biobehavioral Catch-up (ABC), Video-feedback Intervention to promote Positive Parenting (VIPP), and Circle Of Security (COS). The chapter concludes with a brief summary of the three most significant findings.

Summary of Findings

Overwhelmingly, respondents had little to no familiarity with virtually all of the AF EBTs reviewed, despite the fact that the majority of the participants were both very familiar with attachment theory and very favorable toward evidence-based treatments. Close to 80% (Range: 5.3%; from values of 76.3% to 81.6%) of the respondents had little to no familiarity with three of the interventions. Even in the case of the intervention with which respondents were most

familiar, Child-Parent Psychotherapy (CPP), more than two thirds of respondents (26 participants or 68.4%) had little to no familiarity with CPP.

Results were even more dramatic when it came to actual use of the interventions. More than 84% (Range 10.7%, from values of 78.9% to 92.1%) of the participants did not use three of the interventions (ABC, VIPP and COS). Even with the best known of the four interventions (CPP), more than three quarters of respondents (29 participants or 76.3%) did not make use of CPP.

However, participant clinicians that did use the interventions found them to be relatively effective. More specifically, with the exception of the ABC intervention, 100% of clinicians who used the interventions found them to be at least somewhat effective. In fact, a majority of these respondents found the interventions to be very to extremely effective. Reports on the effectiveness of the ABC intervention by those who made use of it, though less impressive than the other interventions, were nevertheless relatively good. Six of the eight clinicians who made use of the ABC intervention (75% of users of ABC) said it was at least somewhat effective. In regards to fidelity with the interventions and following interventions' manuals, over 90% of respondents who used the interventions (Range 14.3%, with values from 85.7% to100%) adapted them.

Without exception, being unaware of the existence of an intervention was by far the most commonly cited barrier that impeded the use of these AF EBTs. More than 55% (Range: 5.8%, with values from 55.3% to 61.1%) of participants identified this as a barrier, with the exception of CPP, where 48.7% of participants said it was a barrier. The other three most commonly cited barriers were: agencies not supporting the use of the intervention (mean: 13.4%); difficulties

regarding access to training (mean: 11.5%); and not having a need for a new intervention (mean: 11.4%).

Lastly, more than 78% of participants reported being very to extremely familiar with attachment theory; and more than 60% were very to extremely favorable toward EBTs (over 94% were somewhat favorable to more).

Recruitment Response and Survey Participation

A total of 72 potential participants responded to the study recruitment message and accessed the Welcome Page of the survey. Of note, seven of the eight potential participants who accessed the Welcome Page in response to an NCTSN “retweet” (Twitter message) of the study recruitment message chose not proceed after reading the Welcome Page. Though no conclusion may be drawn from such a small number, this striking differential response according to recruitment medium does raise the question of whether the 140 character limit of Twitter make it a less effective recruitment tool. Overall, 63 of the potential participants showed interest in participating by requesting to determine their eligibility. Of these, only 46 were eligible and read the Informed Consent Page. Two of these 46 potential participants did not consent to participate in the survey. Thus a total of 44 licensed mental health clinicians participated in the survey, though only 38 of them completed the entire questionnaire. Questionnaires that were incomplete or that had more than three skipped questions were discarded. Thus 38 participants comprised the final sample.

Demographics

A majority of the respondents, (sixteen participants or 42%), were aged 25-34. Eleven participants (29%) were between 35 and 54 years of age. The other 11 participants (29%) were aged 55 years or older (see Figure 1 for age demographic).

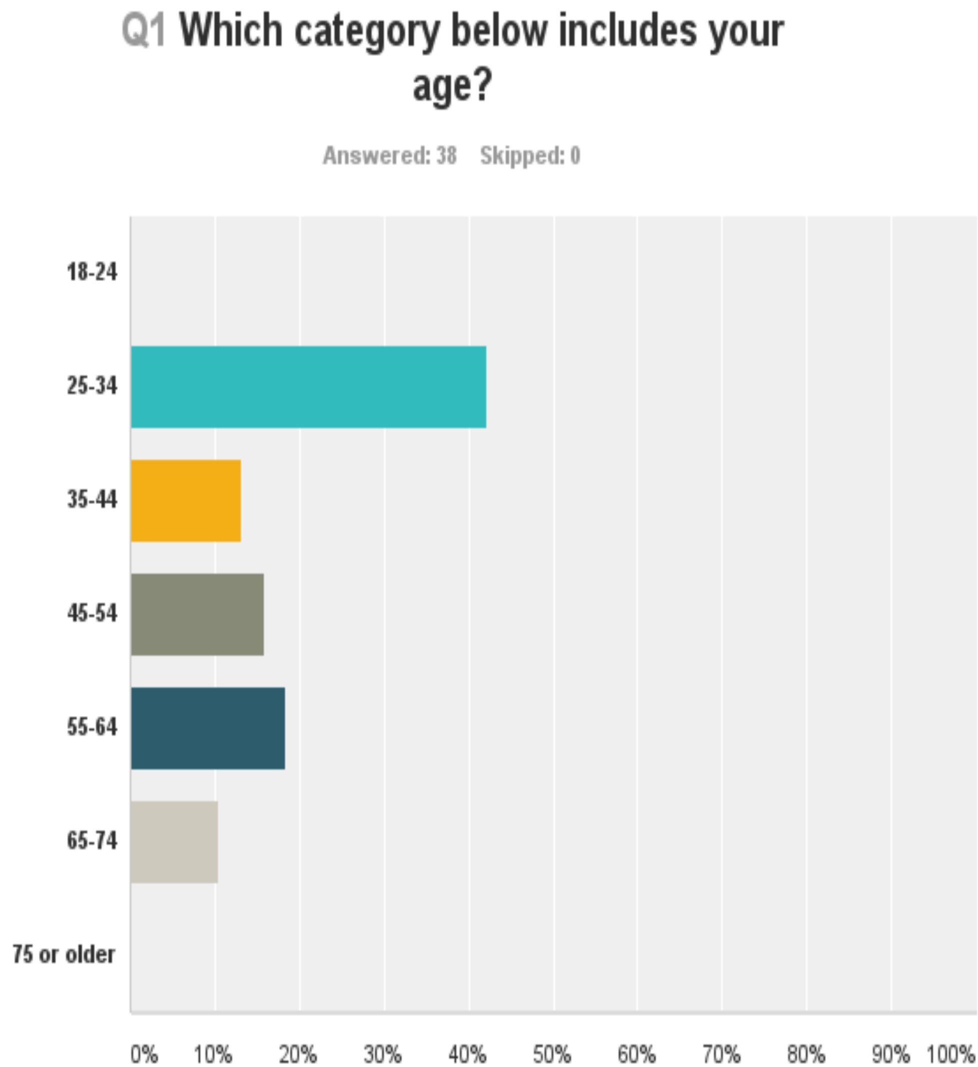

Figure 1. Age Demographic

Most of the respondents were female (32 participants or 84.2%). Only six participants (15.8%) were male (see Figure 2 for gender demographic).

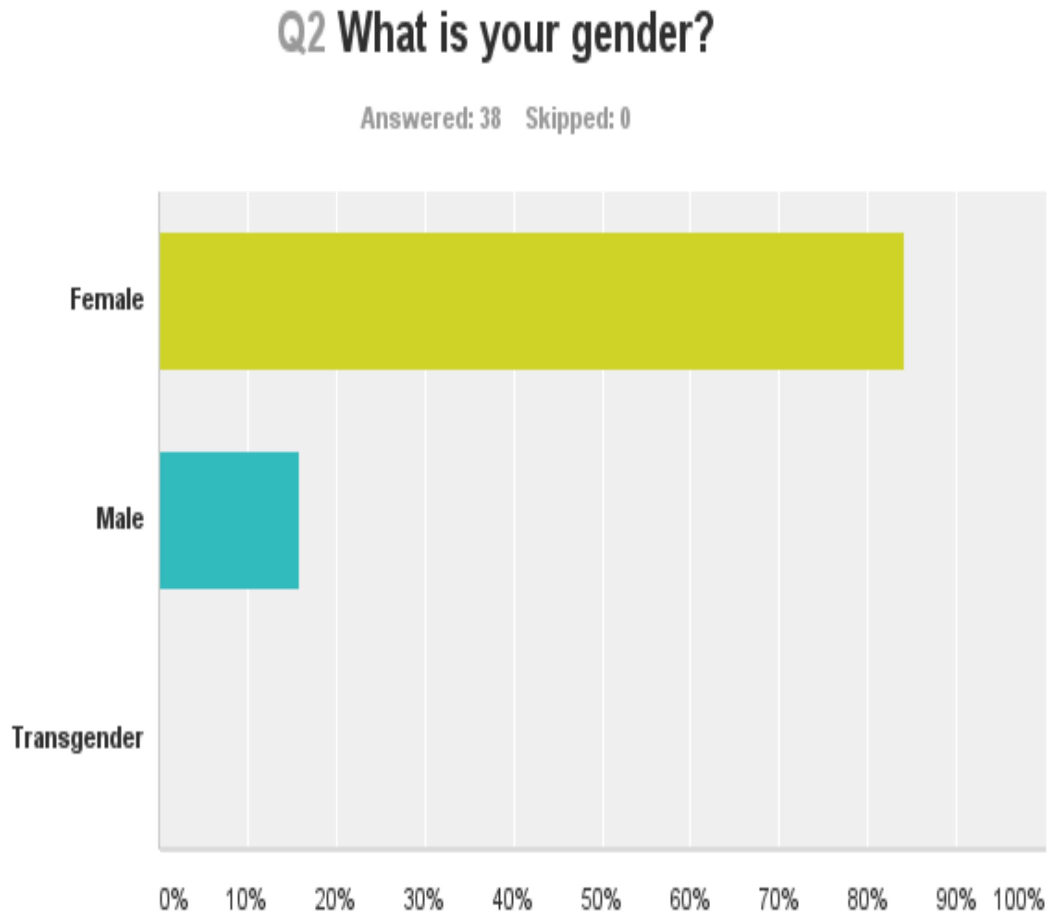

Figure 2. Gender Demographic

Respondents could select multiple categories for their ethnicity. The majority of respondents reported their ethnicity as White/Caucasian (34 participants or 89.5%). Of the remaining four participants, one identified themselves as Black/African American, one as South Asian, one as American Indian/Alaskan Native and Black/African American, and one as American Indian/Alaskan Native and White (see Figure 3 for ethnicity demographic).

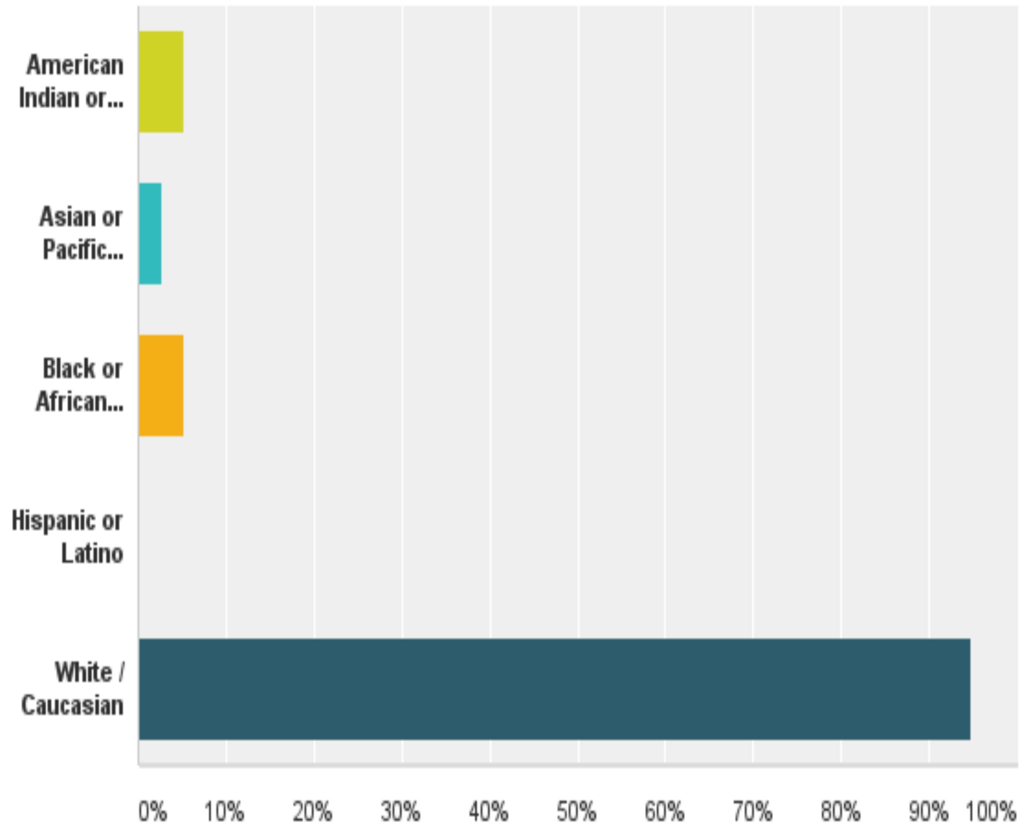

Figure 3. Ethnicity Demographic

Most participants, 34 (89.2%), were social workers. One reported that s/he was a Doctor of Osteopathic Medicine (DO) under the category "Other" (see Figure 4 for degree demographic).

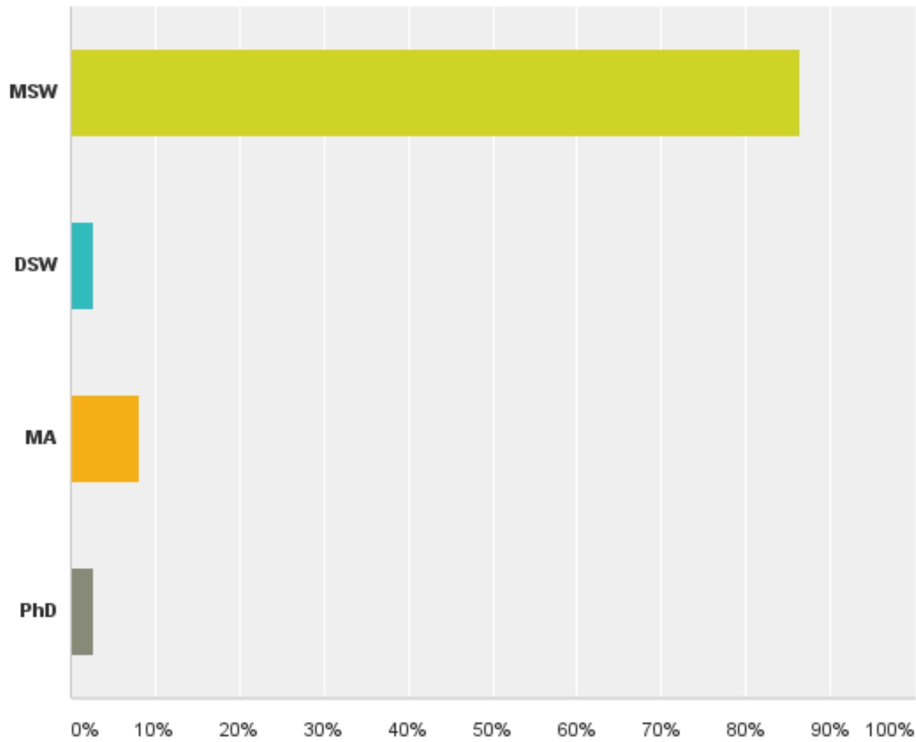

Figure 4. Degree Demographic

The average length of experience as a licensed mental health professional working with children was 12 years, with a standard deviation of 12.622. Eighteen participants (47.37%) had five or less years of experience; and 12 (31.57%) had 15 or more years of experience (see Figure 5 for years of experience working with children demographic).

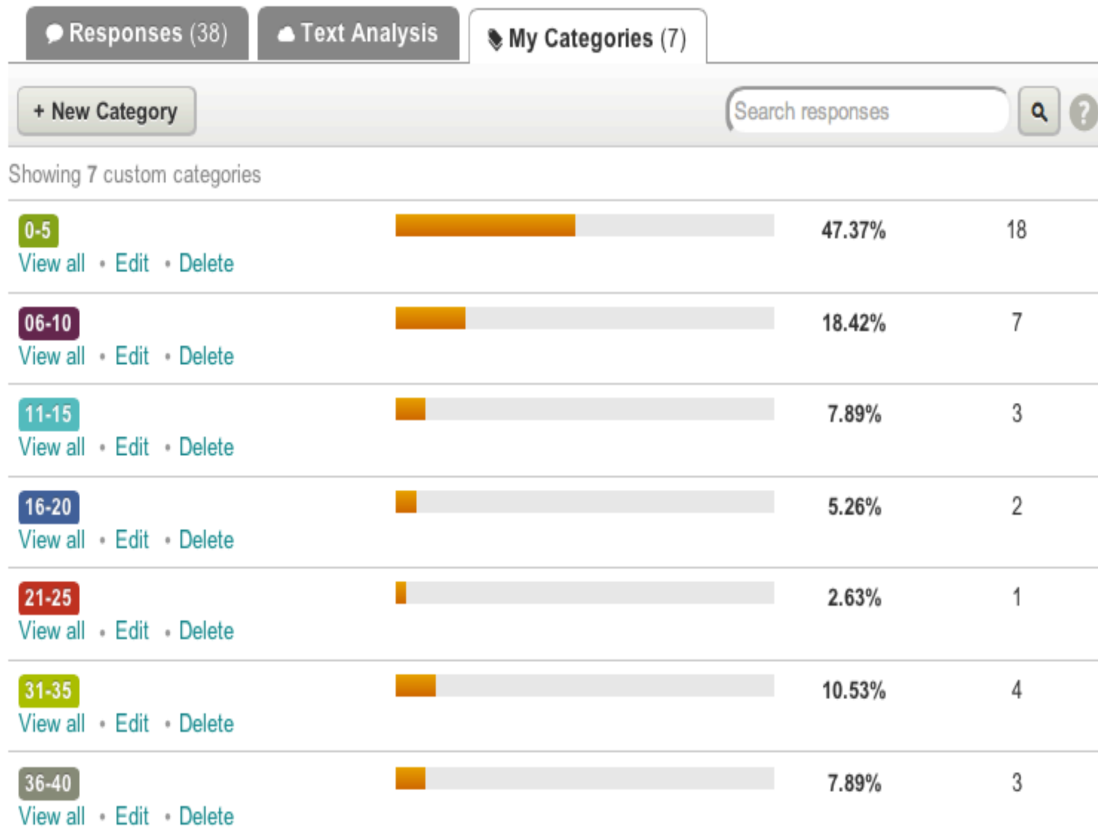

Figure 5. Years of Experience Working with Children Demographic. **(**Note. For display purposes, the 26-30 category was eliminated; it had no respondents)

Respondents were able to select multiple categories to report their therapeutic approach. The top five therapeutic approaches of participants were Cognitive-Behavioral Therapy (63.2%), Psychodynamic (57.9%), Client-Centered/Solution-Focused (50%), Mindfulness (50%) and Eclectic (44.7%) (see Figure 6 for therapeutic approach demographic).

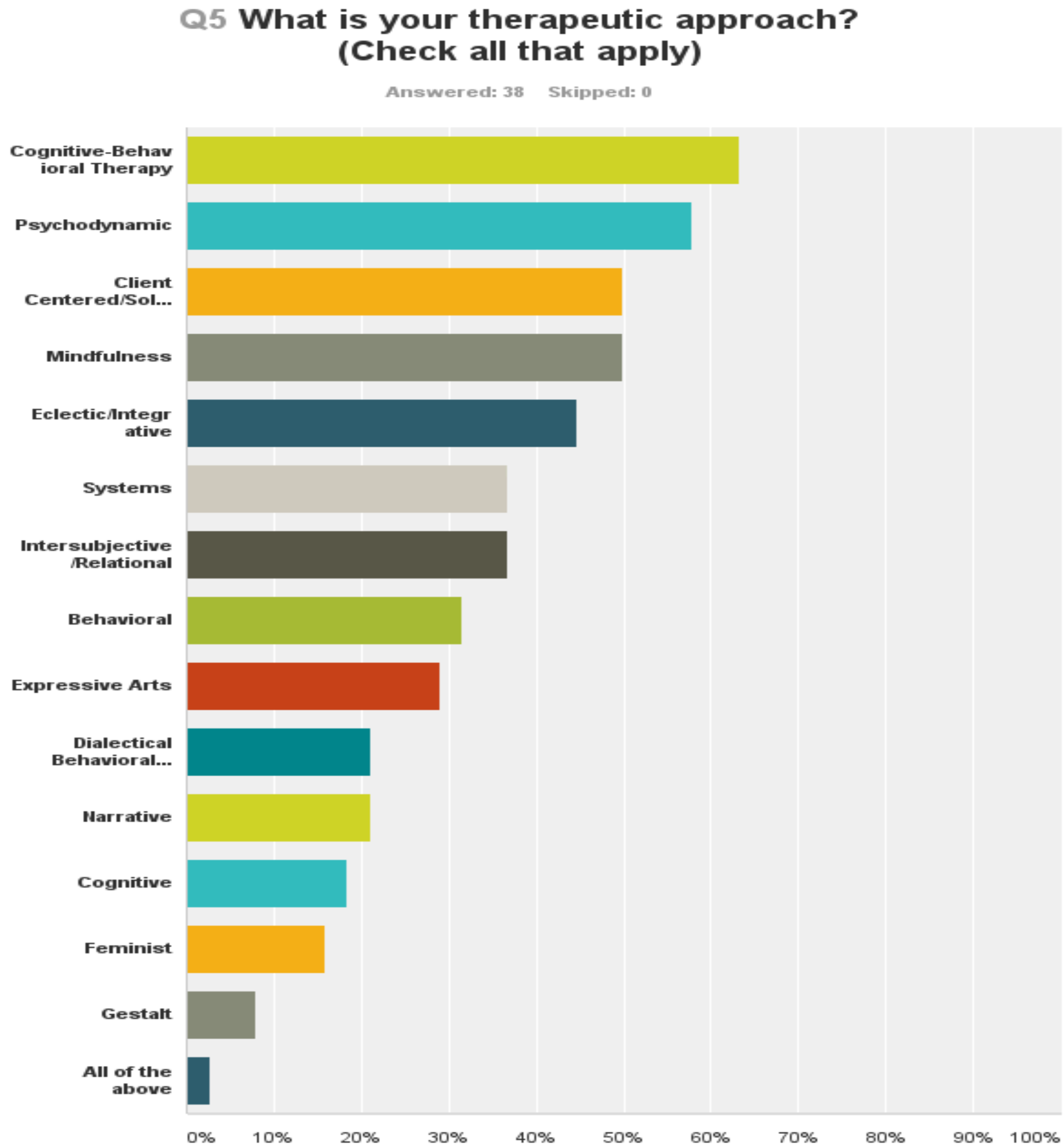

Figure 6. Therapeutic Approach Demographic

Respondents provided the following other therapeutic approaches under the category "Other": attachment informed dynamic; attachment-focused emotion-focused interpersonal neurobiology sensorimotor psychotherapy; dyadic developmental psychotherapy (DDP); parent behavior training EMDR; routine based; trauma-focused cognitive-behavioral therapy (TFCBT); the attachment, self-regulation, and competency framework (ARC); and trauma therapy.

Twenty-nine participants (78.4%) reported they were at least very, and up to extremely familiar with attachment theory. One respondent did not answer this question (see Figure 7 for attachment theory familiarity demographic).

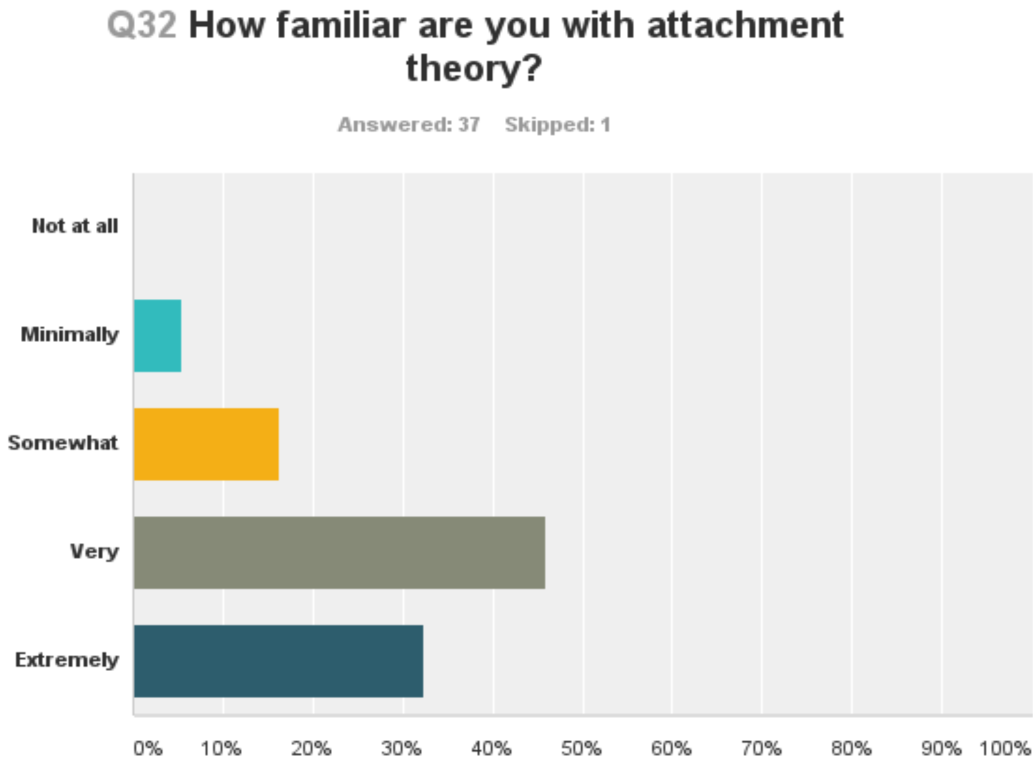

Figure 7. Attachment Theory Familiarity Demographic

Twenty-three participants (60.5%) were very to extremely favorable toward evidence-based treatments (EBT). Only two participants, (5.3%) were minimally or less favorable (see Figure 8 for favorability toward EBTs demographic).

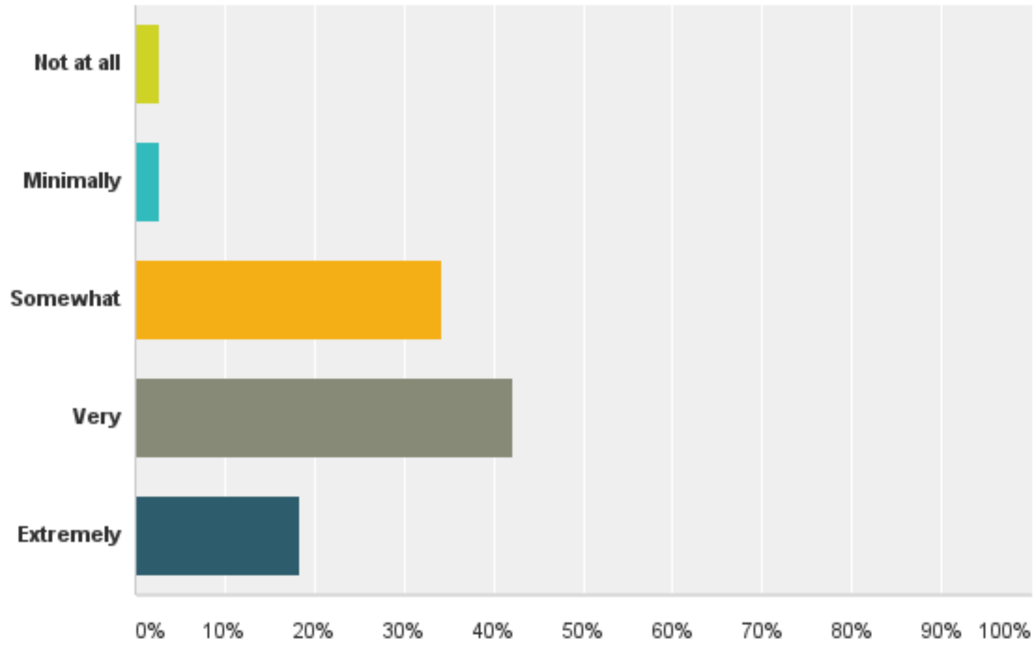

Figure 8. Favorability toward EBTs Demographic

Finally, 21 respondents (55.3%) reported that 50% or more of their clients had attachment related problems (see Figure 9 for clients with attachment problems demographic).

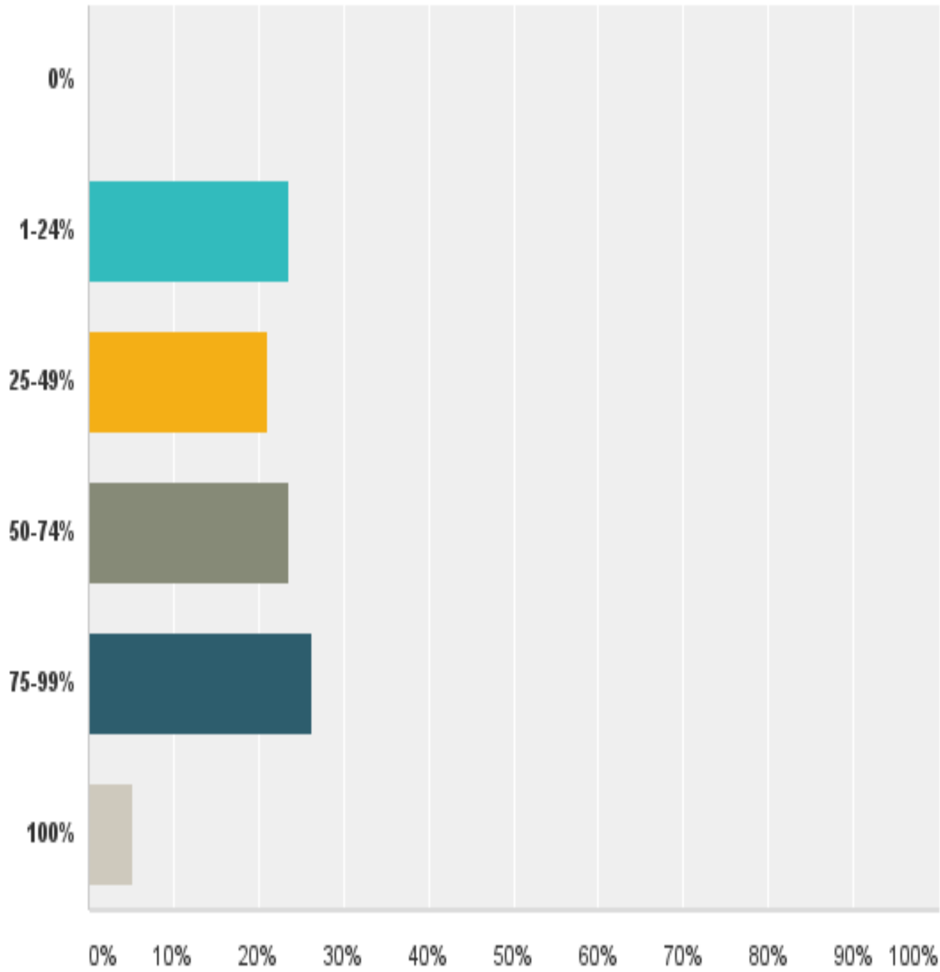

Figure 9. Clients with Attachment Problems Demographic

Interventions

Child-Parent Psychotherapy: More than two thirds of the survey participants (26 respondents or 68.4%) were either unaware or only minimally familiar with the Child-Parent Psychotherapy (CPP) intervention. The remaining 12 clinicians who took part in the survey (31.6%) knew at least some of the basic elements of the intervention, if not more. Seven of them (18.4%) had been trained in CPP; but only one (2.6%) was also certified to use it.

Only nine of the 38 participants used CPP (23.7%) to treat their clients. However, the respondents who used CPP unanimously found it to be at least somewhat effective. In fact, more than half of CPP users (five participants or 55.6% of CPP users) reported the intervention was very effective. Three of the nine respondents who used CPP (33.3% of CPP users) felt the intervention positively affected all of the outcomes it was designed to target; the other six participants (66.6% of CPP users) felt it affected only some of the outcomes. One CPP using participant (11.1% of CPP users) felt it was also effective in treating clients' DSM diagnoses. All but one of the respondents making use of the CPP (eight participants or 88.9% of CPP users) adapted the intervention. Seven of the participants who used CPP (77.8% of CPP users) treated less than 50% of their clients suffering from attachment problems with this intervention. One respondent (11.1% of CPP users) used CPP to treat all their clients who had attachment problems.

It is important to note that three or 25% of the 12 participants who had at least some knowledge of the basic elements of CPP did not use the intervention at all. Two of them were only somewhat familiar with the intervention, and thus were not trained to use it. They respectively cited the intervention's rigidity, and lack of agency support as the barriers interfering with their use of CPP. However, the third respondent reported being very familiar

and trained to use CPP, but nevertheless did not use it, citing that the training was too expensive as the barrier that interfered with their use of CPP. Findings in regards to participant awareness and use of the CPP intervention are summarized in Table 2 (see Table 2 for CPP stats).

Table 2

CPP Statistics

Familiarity with CPP (n=38)	**None** 31.6% (12)	**Minimal** 36.8% (14)	**Somewhat** 13.2% (5)	**Very** 15.8% (6)	**Extremely** 2.6% (1)
Percentage of clients treated with CPP (n=9) (***note: 3 participants answered 0%***)	**1-24%** 44.4% (4)	**25-49%** 33.3% (3)	**50-74%** 11.1% (1)	**75-99%** 0% (0)	**100%** 11.1% (1)
Effectiveness of CPP (n=9)	**Not effective** 0% (0)	**Minimal** 0% (0)	**Somewhat** 44.4% (4)	**Very** 55.6% (5)	**Extremely** 0% (0)
Outcomes positively affected by CPP (n=9)	**All** 33.3% (3)	**Some** 66.7% (6)	**DSM dx** 11.1% (1)	**N/A**	**N/A**
Following manualized version (n=9)	**Manual** 11.1% (1)	**Adapt** 88.9% (8)	**N/A**	**N/A**	**N/A**

As a whole, a little less than half of the respondents (eighteen respondents or 48.7%) listed the primary barrier to using this intervention was that they were not aware of its existence. The other five most commonly cited barriers were: clinicians' agencies did not support the intervention (six participants or 16.22%); difficult training access (five participants or 13.5%); intervention is too rigid to apply to "real world" clients (four participants or 13.5%); costly training (three participants or 8.1%); and no need for a new intervention (three participants or 8.1%). All but two possible barriers were identified as being a barrier by at least by one participant, if not more. Not believing that EBTs are effective and length of training were not identified as being barriers to using this intervention. One respondent did not report the existence of any barriers. The only participant that was certified to use CPP had been using it for ten years and explained that "the barriers to using it are actually related to clients' capacity to engage for the time required to complete the work. For all who could manage the time commitment, this intervention has been highly effective." Findings in regards to barriers to use of CPP by respondents are summarized in Figure 10 (see Figure 10 for barriers to using CPP).

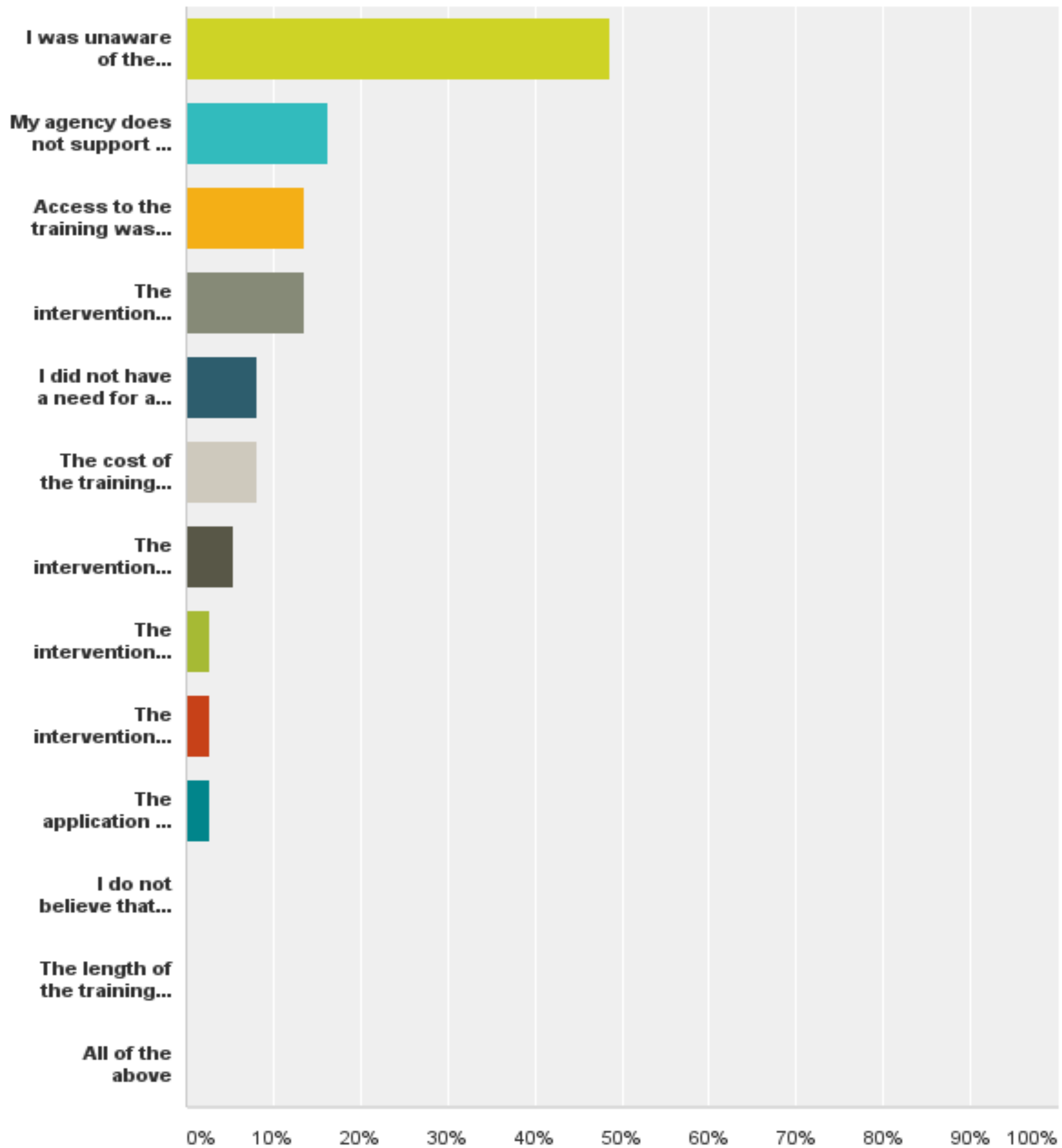

Figure 10. Barriers to Using CPP

Attachment and Biobehavioral Catch-up (ABC)

More than three quarters of respondents (29 respondents or 76.3%) were either unaware or only minimally familiar with the Attachment and Biobehavioral Catch-Up (ABC) intervention. Only nine participants (23.7%) had at least some knowledge of the basic elements of the intervention. Only one participant had been trained and certified in the ABC intervention; all others lacked training.

Only eight of the 38 participants (21.1%) used the ABC intervention to treat clients with attachment problems. Seven of those (87.5% of ABC users) used the intervention with less than half of their clients who had attachment problems. Only one of the ABC users (11.1%) treated more than half of their clients with attachment problems. None of the participants used it to treat all of their clients struggling with attachment problems. Only two participants (25% of ABC users) found the intervention to be very effective. Four respondents (50% of ABC users) found it somewhat effective. Two participants (25% of ABC users) felt it was only minimally effective. One respondent (12.5%) reported the intervention positively affected all areas it was designed to target. The other seven participants who used ABC (87.5% of ABC users) felt it was only effective in treating some of the outcomes it was designed for. All but one of the respondents who used ABC (seven participants or 87.5% of ABC users) adapted the intervention, and only one (12.5% of ABC users) followed the manual. It should be noted that one participant who was somewhat familiar with the intervention did not use it to treat their clients. They were not trained to use the intervention and cited its lack of effectiveness as a barrier to making use of the intervention. Responses are summarized in Table 3 (see Table 3 for ABC stats).

Table 3

ABC Stats

Familiarity with ABC (n=38)	None 50% (19)	Minimal 26.3% (10)	Somewhat 21.1% (8)	Very 0% (0)	Extremely 2.6% (1)
Percentage of clients treated with ABC (n=8) ***(note: 1 participant answered 0%)***	**1-24%** 75% (6)	**25-49%** 12.5% (1)	**50-74%** 12.5% (1)	**75-99%** 0% (0)	**100%** 0% (0)
Effectiveness of ABC (n=8)	**Not effective** 0% (0)	**Minimal** 25% (2)	**Somewhat** 50% (4)	**Very** 25% (2)	**Extremely** 0% (0)
Outcomes positively affected by ABC (n=8)	**All** 12.5% (1)	**Some** 87.5% (7)	**DSM dx** 0% (0)	**N/A**	**N/A**
Follow manual (n=8)	**Manual** 12.5% (1)	**Adapt** 87.5% (7)	**N/A**	**N/A**	**N/A**

The most commonly cited barrier impeding the use of this intervention was once again being unaware of the existence of the intervention. Twenty one participants (55.3%) identified this issue as being a barrier. The five other most commonly cited barriers were that there was no need for a new intervention (six participants or 15.8%); lack of agency support (four participants or 10.5%); difficult training access (four participants or 10.5%); and cost of training, cost of applying intervention, complexity of the intervention, and rigidity of the intervention (tied as the fifth most commonly cited barrier, each with two respondents or 5.26%). Length of training and

conflict with therapeutic approach were not identified as barriers. The findings are summarized in Figure 11 (see Figure 11 for barriers to using ABC).

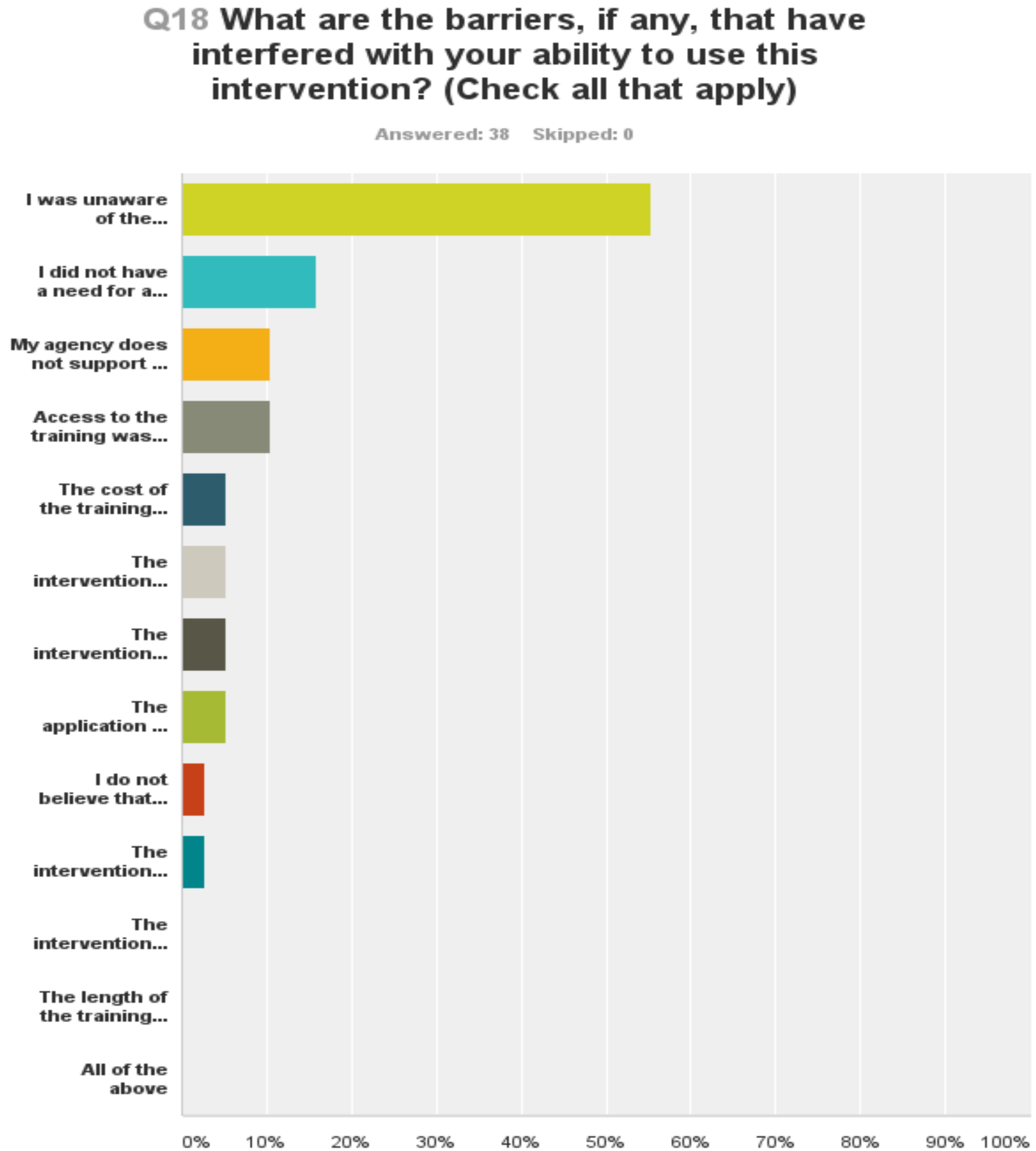

Figure 11. Barriers to Using ABC

Video-feedback Intervention to promote Positive Parenting: More than 80% of respondents (31 participants or 81.6%) either did not know or were only minimally familiar with Video-Feedback Intervention to Promote Positive Parenting (VIPP), making it the least known of the four interventions reviewed in this study. The other seven participants (18.4 %) knew at least some of the basic elements of the intervention, if not more. Only two respondents (5.3%) had been trained in VIPP, and none were certified.

Only three of the 38 participants (7.8%) used this intervention. All three users of the intervention found it at least somewhat effective; two of them stating that VIPP was very effective. One user of VIPP reported that it positively affected all areas it was designed to target. The other two who used VIPP said it affected only some of the outcomes. Only one participant used VIPP to treat 50% or more of their clients suffering from attachment problems. None used it on all their clients with attachment problems. All three users adapted the intervention.

It should be noted that four of the seven participants who had at least some knowledge of the basic components of VIPP, if not more, (57.1% of those with basic knowledge of VIPP or more) did not make use of the intervention. All four lacked training in VIPP. Three of those cited the barrier that impeded their ability to use VIPP was that their agencies did not support the intervention. One of these three participants also cited rigidity of the intervention and cost applying of it as additional barriers that prevented them from making use of VIPP. The fourth participant cited difficulty of access to training as the barrier that prevented them from using the intervention. Survey participant responses regarding VIPP are summarized in Table 4 (see Table 4 for VIPP stats).

Table 4

VIPP Stats

Familiarity with VIPP (n=38)	**None** 55.3% (21)	**Minimal** 26.3% (10)	**Somewhat** 13.2% (5)	**Very** 5.3% (2)	**Extremely** 0% (0)
Percentage of clients treated with VIPP (n=3) (***note: 4 participants answered 0%***)	**1-24%** 33.3% (1)	**25-49%** 33.3% (1)	**50-74%** 33.3% (1)	**75-99%** 0% (0)	**100%** 0% (0)
Effectiveness of VIPP (n=3)	**Not effective** 0% (0)	**Minimal** 0% (0)	**Somewhat** 33.3% (1)	**Very** 66.7% (2)	**Extremely** 0% (0)
Outcomes positively affected by VIPP (n=3)	**All** 33.3% (1)	**Some** 66.7% (2)	**DSM dx** 0% (0)	**N/A**	**N/A**
Following manualized version (n=3)	**Manual** 0% (0)	**Adapt** 100% (3)	**N/A**	**N/A**	**N/A**

Over 60% of participants (23 respondents or 60.5%) listed that being unaware of the existence of the intervention was a barrier to using VIPP. The top five other barriers that interfered with the use of VIPP were the lack of agency support (six participants or 15.8%); not having a need for a new intervention (four respondents or 10.5%); the intervention's being too rigid to apply to "real world clients" (three participants or 7.9%); difficulty accessing training (two respondents or 5.3%); and the intervention being too complicated (two participants or 5.3%). Participants did not feel the following were barriers: lack of belief that EBTs are effective; conflicts with therapeutic approach; length of training is too long; and intervention is

not effective enough. The responses of participants in regards to barriers to use of VIPP are summarized in Figure 12 (see Figure 12 for barriers to using VIPP).

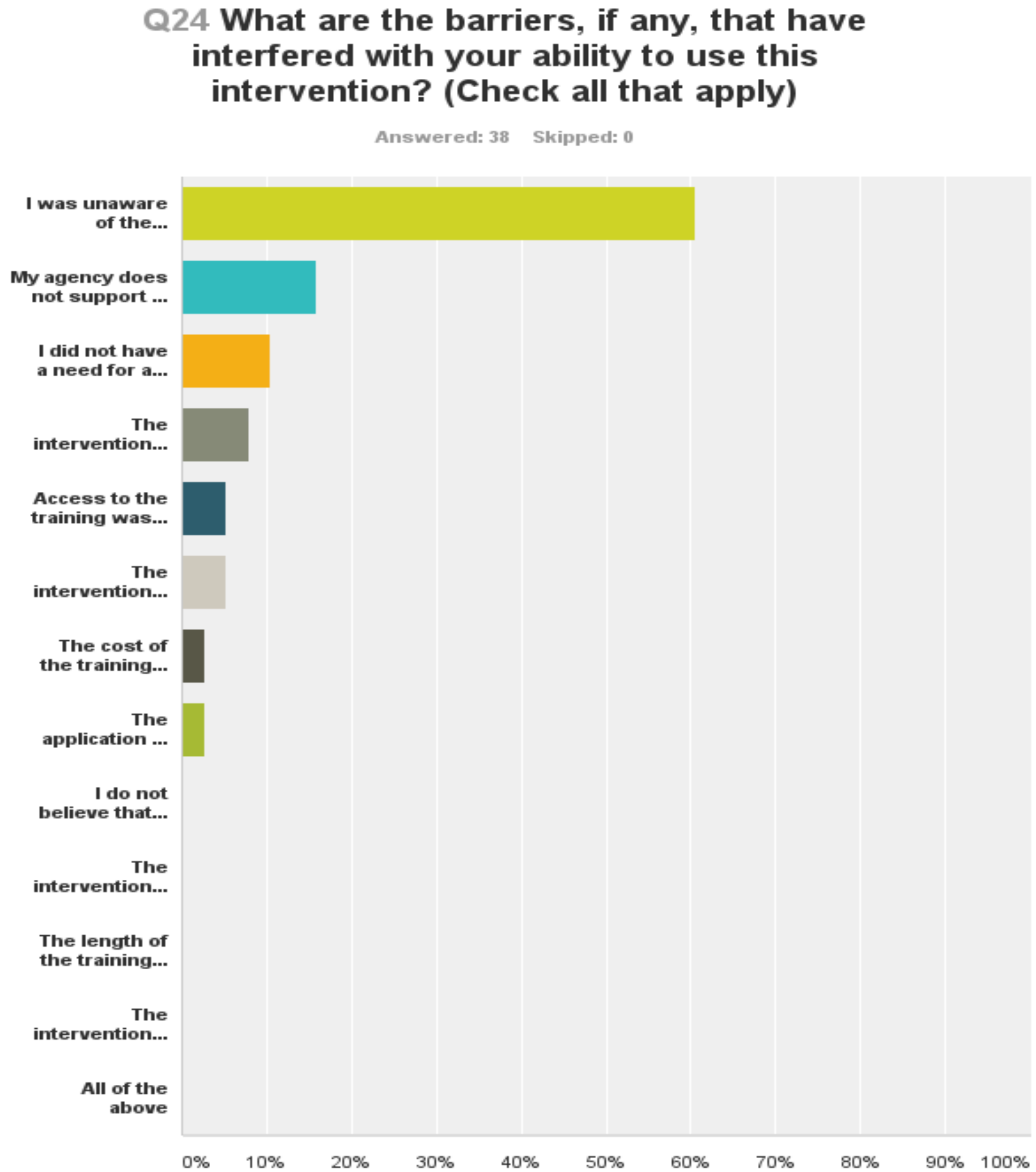

Figure 12. Barriers to Using VIPP

Circle of Security (COS)

A vast majority, that is, 30 respondents (79%) were either unaware of the Circle of Security (COS) intervention, or only minimally familiar with it. Just a little over one fifth or eight participants (21%) knew some of the basic elements of COS or more. Only half of those who knew about knew about the existence of COS (four participants or 10.5%) had been trained in COS, although one of them was also certified to use it.

Although only seven respondents (18.4%) had made use of COS, yet again all of them felt the intervention was at least somewhat effective, if not more. Three of the respondents who used COS (42.9% of COS users) found the intervention to be very effective or better. Two of the participants using COS (28.6% of COS users) felt it positively affected all areas it was designed to target. The other five respondents (71.4% of COS users) reported it only affected some of the outcomes. Five of the seven participants who used COS (71.4% of COS users) treated less than 50% of their clients with attachment problems with this intervention. No participant used COS to treat all of their clients suffering from attachment problems. Only the respondent who was certified to use COS (14.29% of COS users) followed the manual; all others (six respondents using COS or 85.7%) adapted the intervention. The one participant who knew at least some of basic elements of COS but did not use it because other clinicians at their agency were already trained in COS, and cases were assigned based on recommended treatment and clinicians who are trained in the corresponding model. Results are summarized in Table 5 (see Table 5 for COS stats).

Table 5

COS Stats

Familiarity with COS (n=38)	**None** 60.5% (23)	**Minimal** 18.4% (7)	**Somewhat** 10.5% (4)	**Very** 7.9% (3)	**Extremely** 2.6% (1)
Percentage of clients treated with COS (n=7) (***Note: one participant answered 0%***)	**1-24%** 57.1% (4)	**25-49%** 14.3% (1)	**50-74%** 28.57% (2)	**75-99%** 0% (0)	**100%** 0% (0)
Effectiveness of COS (n=7)	**Not effective** 0% (0)	**Minimal** 0% (0)	**Somewhat** 57.1% (4)	**Very** 28.6% (2)	**Extremely** 14.3% (1)
Outcomes positively affected by COS (n=7)	**All** 28.6% (2)	**Some** 71.4% (5)	**DSM dx** 0% (0)	**N/A**	**N/A**
Following manualized version	**Manual** 14.3% (1)	**Adapt** 85.7% (6)	**N/A**	**N/A**	**N/A**

Twenty two respondents (61.1%) listed the primary barrier to using COS was not being aware of its existence. The other five most commonly cited barriers to use of COS were: difficult training access (six participants or 16.7%); no need for a new intervention (four participants or 11.1%); clinicians' agencies did not support the intervention (four participants or 11.1%); and not being trained enough to use COS (including during professional graduate degree) (three participants or 8.3%). A participant indicated a barrier to its use is honoring the client's choice to use other interventions. Another respondent stated that the group design is logistically difficult to apply; but that however they adapt the intervention to use it with

individuals, and feel it is the most effective of all four interventions in that setting. Two participants did not answer the COS barrier question, but it appears evident that they did not do so because they likely felt there were no barriers to using the intervention. The barrier findings for COS are summarized in Figure 13 (see Figure 13 for barriers to using COS).

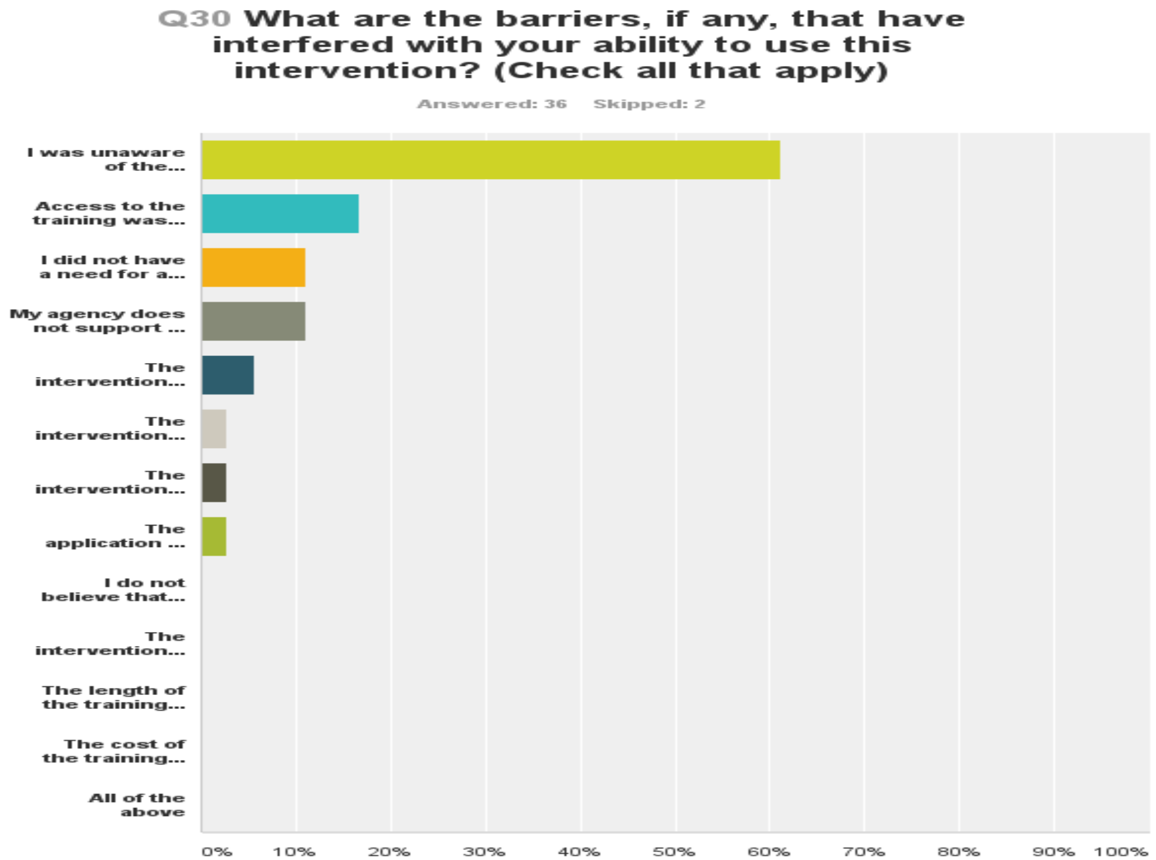

Figure 13. Barriers to Using COS

Comparison Findings

Intervention use. Less than one quarter of the clinicians surveyed in this study (nine participants or 23.7% of total respondents) made use of the most popular of the interventions, CPP. The second most used intervention, ABC, had 21.1% of total respondents (eight participants) treating their clients suffering from attachment problems with this EBT. This was followed by COS, with seven participants (18.4% of total respondents) making use of this intervention to treat their clients' attachment problems. VIPP was the least used of the four interventions, with only three participants (7.9% of total respondents) making use of the EBT.

Interventions not used despite having awareness of them. Over half of those aware of VIPP did not make use it (four of the seven respondents who were aware of the intervention or 57.4%). Lack of agency support was the most commonly cited reason for not using it. One quarter of respondents aware of CPP (three of the 12 participants who were aware of CPP) did not use it. The barriers to use cited in this case were different in each case (lack of agency support, cost of training, rigidity of intervention). The other two interventions, ABC and COS, had only one participant each who was aware of these respective interventions, but did not use them.

Trained users versus untrained users. Comparing trained users versus untrained users yielded potentially interesting observations, though the number of responses is too small to draw conclusions with any certainty. In the case of CPP, clinicians who were not trained used it on less than 25% of their clients with attachment problems; whereas all but one who were trained used it on at least 25% or more of their clients suffering from attachment problems. Untrained users unanimously felt it only affected some of the outcomes; whereas 50% of trained users felt it affected all outcomes, and one felt it also affected the DSM diagnosis. CPP users who lacked

training were less likely to feel the intervention was very effective (33.3% of untrained CPP users versus 66.7% of trained users). Most trained users still adapted the intervention, though in their case, one did indicate that they follow the manual. No comparison could be drawn with ABC, since only one participant was trained. With COS users, no untrained user felt the intervention was more than somewhat effective. Only trained users felt COS was very effective, although two of the five trained users 40% felt it was only somewhat effective. Likewise, only the trained users felt COS was effective in treating all outcomes it was designed to target, although again only 40% of them felt as such. Once again, all untrained users treated less than 25% of their clients suffering from attachment problems by making use of COS. Whereas, all but one of the trained users of COS used it on at least 25% or more of their clients with attachment problems.

Summary

In conclusion, an overwhelming majority of the participants were not aware of the existence of any of the interventions. This impeded their ability to use these interventions. However, with the exception of the ABC intervention, all participants who were aware of an intervention reported the intervention as having at the very least a moderate degree of effectiveness in the clinical setting. In most cases, and especially when clinicians were trained in the interventions, respondents reported the interventions as being very or extremely effective. This was the case despite the fact that most of the respondents adapted the interventions and did not make use of strict manualized versions.

CHAPTER FIVE

Discussion

The findings of this exploratory study regarding clinician use of attachment-focused evidence-based treatments (AF EBT) with children, five years old and under, and their primary caregivers, matched most of those found in the research literature regarding dissemination and implementation of EBTs in the clinical setting. The vast majority of clinicians who participated in the study's survey did not know about or use the four AF EBTs reviewed in this study. The predominant reason why clinicians did not use the interventions was because they did not know they existed. The other most commonly cited barriers impeding use of the interventions were related to lack of agency support; difficulties accessing training; and clinicians feeling they had no need for a new intervention.

However, clinicians that used the interventions unanimously found them to be at least somewhat, if not very or extremely effective. Trained clinicians were more likely to feel the interventions were more effective, and to use them with more of their clients, than untrained clinicians. Most clinicians adapted the interventions. Nevertheless, they still felt the interventions were effective; one of the findings that diverged from prior research. A majority of clinicians of this study were favorable toward evidence-based interventions, which also differed from prior research. Most were also familiar with attachment theory. When considered together, these findings suggest that, at least for this study, if clinicians were made aware and trained in the interventions, they would likely use them and find them effective. Thus this exploratory study provides a compelling reason to further research this topic with a more representative

sample, because if the results can be replicated, there now would be a very good reason to consider investing in dissemination and implementation solutions for these interventions.

Discussion of the Major Findings

Major findings of this study will be compared with the previous literature. Some of the implications of these findings will be discussed in this section, with broader implications to be discussed later. The major findings that will be highlighted are as follows. Most clinicians were unaware of the existence of the interventions. There were barriers that impeded the use of the interventions. Most clinicians did not use the interventions. Those that did use the interventions found them to be effective. Trained participants felt the interventions were more effective and used them more often. Most users adapted the interventions. Lastly, most participants were favorable toward EBTs.

Most clinicians did not know about the interventions. The most significant finding of this study was that a vast majority of the participants were unaware of the existence, or knew very little about the four AF EBTs reviewed in its survey. This conclusion was expected, given the vast body of research regarding dissemination and implementation of EBTs as a whole that preceded this study. This study's finding matched what has been previously reported in literature, which identifies awareness of an EBT as a central issue impeding the successful widespread adoption of EBTs in the clinical setting (Allen et al., 2012; Karlin & Cross, 2014; Self-Brown et al., 2012). As a result of being unaware of the interventions, very few of the clinicians who participated in this study used the interventions. For this study, the intervention that clinicians were the least familiar with was VIPP. This was closely followed by COS, and then ABC. The intervention with which the greatest number of clinicians had at least some degree of familiarity was CPP.

The survey did not include questions that would help elucidate the reasons why clinicians were unaware of the interventions. It is possible, if not likely, that one of the main issues may be related to a lack of investment by developers/researchers in properly disseminating the interventions. Such a possibility becomes salient when considering that more than three quarters of respondents were very to extremely familiar with attachment theory; close to two thirds were favorable toward EBTs; and only 10% felt they did not have a need for a new intervention. Problems with dissemination related to researchers/developers of EBTs are well documented and supported by empirical studies (Allen et al., 2012; Karlin & Cross, 2014; Self-Brown et al., 2012).

There are many other issues that can interfere with the proper dissemination of EBTs, and AF EBTs are likely to be just as vulnerable to EBTs as a whole, if not more. The degree of difficulty involved in simply finding information about AF EBTs may contribute to the lack of awareness toward these EBTs. Attachment-focused EBTs are competing with a plethora of EBTs aimed at addressing childhood problems (Karlin & Cross, 2014; Self-Brown et al., 2012). There are 162 EBTs listed on the California Evidence-Based Clearinghouse for Child Welfare (CEBC) website alone (CEBC, 2009). One is likely to find more child-related EBTs by looking at all interventions claiming to be child focused EBTs found through various search engines, websites, etc. Thus, it is hardly surprising that both clinicians and agencies may have trouble identifying which EBT to focus on and, indeed, research has shown that these circumstances can interfere with the ability to be aware of any specific EBT (Karlin & Cross, 2014; Self-Brown et al., 2012). The amount of time and resources that may be involved with training and other implementation requirements may also further dissuade one from even looking for EBTs (Karlin & Cross, 2014; Kendall & Beidas, 2007). Furthermore, the fact that there are many issues that

can potentially compromise the effectiveness of EBTs in the clinical setting, such as fidelity, proper follow-up training, supervision, consultation, etc., may also function to further dissuade clinicians and/or agencies to seek out EBTs, including AF EBTs, to help improve their practice (Graybeal, 2014; Karlin & Cross, 2014; Kazdin, 2008; Mitchell, 2011). In fact, a significant amount of the respondents in this study actually cited one or more of the above listed issues as being a barrier that impeded their use of one or more of the AF EBTs reviewed in this study. One of the potential implications of the above listed issues is that, given all of this, it is likely that many clinicians, despite being favorable toward EBTs, would be overwhelmed by the saturation of available EBTs and/or hurdles involved in becoming proficient with any given EBT. The consequence could conceivably be a tuning out of most, if not all EBTs, despite being favorable toward EBTs, thus leading again to being unaware of any or all EBTs.

To stress the issues regarding dissemination of AF EBTs, it may be helpful to consider the following facts. Until recently, most of the attachment research had focused on theory and descriptions of attachment itself (e.g. measuring attachment; supporting theory through empirical research; effects of secure and insecure attachment; etc.) (Powell et al., 2014). Articles regarding the treatment of attachment problems were scant. Perhaps a particularly telling observation is the fact that even the latest edition of *The Handbook of Attachment* (Cassidy & Shaver, 2008), considered to be an essential resource regarding the latest developments regarding the field of attachment (Miller, 2010; Woodhouse, 2009), offers less than a few chapters related to actual interventions that treat attachment problems, and the information contained in these chapters is far from comprehensive. To be fair, it is important to note that this latest edition is already six years old, and much has changed in the field of attachment during that time, especially in regards to the development of AF EBTs. Nevertheless, *The Handbook of*

Attachment (Cassidy & Shaver, 2008) remains a major reference source for those interested in attachment. Its lack of focus and information about AF EBTs likely contributes to poor awareness of these interventions. Karlin and Cross (2014) discuss how important it is to make use of respected and recognized professionals, organizations and resources to help with broadcasting and dissemination efforts.

Another issue to consider in regards to poor awareness of EBTs pertains to the potential lack of focus, value and/or teaching of EBTs in general or specific EBTs by higher education institutions (Self-Brown et al., 2012). It is likely that the very same issues are at play in regards to AF EBTs. The potential role of higher education institutions in regards to the lack of awareness of EBTs was highlighted in this study as two of the 38 respondents specifically referenced this as being a barrier to making use of the interventions, and several others mentioned not having been exposed to opportunities to be trained in these interventions (which would include higher education institutions) as additional barriers. Furthermore, given that there is a trend away from psychodynamic theory being taught in most schools of social work (Berzoff, Flanagan, & Hertz, 2011), it is suspected that most schools do not focus much on teaching attachment theory, despite an overwhelming body of empirical research supporting the credibility, importance and value of the theory. Thus, AF EBTs are likely at even greater disadvantage than other EBTs in regards to clinicians' awareness.

It should be clear by now that there are significant hurdles to overcome when it comes to the successful and effective implementation of any EBT. However, surely the first and most significant of these is making sure clinicians, agencies and clients are aware of their existence. It should be self-evident that if clinicians are not aware of the existence of an intervention, they most certainly cannot make use it. If clinicians are not using the interventions, then clients

cannot benefit from them. If clients are not benefitting from them, then one has to seriously question what the point of developing and continuing to fund research regarding these interventions is. This is not to say that funding EBT research should not occur. However, how we go about funding these may be a wise consideration when it comes to funding policies and use of tax payer money, which will be further discussed shortly.

While much of the above discussion is well grounded in the previous research and in some albeit scant evidence in this study, it is important to note that there may be other explanations for respondents being unaware of the existence of EBTs. It cannot be ruled out that respondents may not have had the time, interest or will to search for a new EBT, let alone AF EBTs. They may not have known where to search for new EBTs. These and other potential issues affecting awareness of EBTs in general are also found in dissemination and implementation literature (Allen et al., 2012; Self-Brown et al., 2012). The point is that this study did not specifically explore these reasons, and until they are explicitly explored in a study making use of a representative sample, no conclusive and definitive assertion may be made regarding why clinicians are unaware of the existence of AF EBTs.

Other barriers impeded the effective use of interventions in the clinical setting. Another finding that mirrored conclusions found in previous literature in regard to EBTs in general, was that clinicians who participated in this study felt there were many barriers that impeded their ability to effectively use AF EBTs in the clinical setting. The most commonly cited barrier, by far, was not being aware of the intervention. As discussed in detail above, such an obstacle is generally caused by problems pertaining to dissemination issues. However, clinicians in this study cited many other barriers, most of which are more related to implementation issues. These other barriers have also been previously identified in research

regarding EBTs. As such, at least for clinicians of this study, effective implementation of AF EBTs in the clinical setting faced the same hurdles, to greater or lesser degrees, that have plagued EBTs in general.

Respondents of this study felt that the many barriers previously identified in the literature for other EBTs were also an issue for the interventions reviewed in this study, except for the length of training, which was not seen as an obstacle to use for any of the interventions. Though there were differences from one intervention to another, believing that EBTs are not effective, the intervention conflicting with therapeutic beliefs were not seen as barriers by the study participants for three out of the four interventions reviewed. All participants of the study felt each intervention had at least one barrier that impeded their ability to use the intervention effectively, except for two respondents who did not list COS as having any barriers. However, it is important to keep in mind that, aside from being unaware of the existence of an intervention, reports of all other barriers was relatively low. That is, no other barrier had more than one 20% of respondents identifying it as such. Furthermore, the percentage of participants who identified barriers that were not in the top five most commonly cited barriers for this study (unawareness of an EBT, lack of agency support, difficulty accessing training, high cost of the training, and not having a need for an EBT), were in the single digits, and thus such barriers likely have no statistically significant value, especially given the already low number of participants who took part in this study.

Few participants used the interventions. Given that most of this study's participants were not aware of the interventions presented in the survey, it should be no surprise that another finding was that few of the respondents used any of the interventions. Fewer than 25% of the clinicians surveyed in this study used any given intervention reviewed. The low usage rate is

even more striking when one considers that a majority of the participants were both familiar with attachment theory and favorable toward EBTs. It is possible, if not likely, that a more a representative sample would have yielded an even lower usage rate, because it is suspected most clinicians may not be as familiar with attachment theory, based on a trend away from psychodynamic theories (Berzoff et al., 2011), as well as suspected lower favorability toward EBTs, based on the literature (Allen et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007; Self-Brown et al., 2012; Walrath et al., 2006).

Again, the findings of this study mirror those found in the literature regarding EBTs as a whole. At least for the participants of this study, AF EBTs again appear to behave as EBTs in general when it comes to use. Studies have shown that despite policy and insurance pressures toward making use of EBTs, use of EBTs in the clinical setting remains low (Kazdin, 2008). On average, it can take more than 25 years before a mental health focused EBT becomes widely used in the clinical setting, and many never achieve this milestone (Karlin & Cross, 2014; Kendall & Beidas, 2007). The results of this study were anticipated, given that most of the EBTs it reviewed were only created in the past decade or so.

Being unaware of the existence of the interventions was not the only issue cited as impeding use. There were clinicians who were aware of the existence of the EBTs, but nevertheless did not use them. In fact, one quarter of those aware of CPP did not use it. More than half of those aware of VIPP did not use it. Lack of agency support was the most commonly cited reason for not using VIPP. Other barriers to use cited by respondents aware but not using interventions were not cited enough for them to be of any statistical significance.

Nevertheless, with the exception of VIPP, at least for this study, respondents who were aware of an EBT were likely to use it. All but one of the participants who were trained in the

EBTs used them. Thus, at least for this study, it may be reasonable to conclude that if all users had been made aware of the existence and basic components of the EBTs, most would have likely used them. It appears that if their agencies had supported the use of the EBTs, then perhaps even more participants would have used the EBTs. Had the study's clinicians been trained in the EBTs, it is conceivable that just about all may have used them. Thus for this study at least, it appears that making sure that dissemination efforts are sufficient enough to make clinicians aware of the existence of the four AF EBTs is a critical element to dramatically increasing use of these EBTs. Furthermore, ensuring that users are trained in these EBTs appears to almost guarantee the chances that the EBTs will be used. Certainly there is evidence in the literature to support such conclusions in regards to EBTs in general (Allen et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007).

When used, the interventions were found to be effective. All respondents who used the interventions felt they were at least somewhat effective, and many reported the EBTs were very or extremely effective. While this is not an objective and scientific measurement of effectiveness, the perception of effectiveness is nevertheless rather telling. That is, at least for the participants of this study, the findings suggest that if one knows at least of some of the basic elements of the interventions, they can then use the EBTs to effectively treat their clients' attachment problems, which have been shown, in turn, to be critical in positively affecting development, mental health, relationships and many other outcomes throughout individuals' lives. The findings of this study in regards to effectiveness of the interventions support what is documented in the literature in that, at least in the research setting, the interventions were shown to be effective (Bakermans-Kranenburg et al., 2008; Bernard et al., 2012; Cassidy et al., 2011; Hoffman et al., 2006; Kalinauskiene et al., 2009; Liberman et al., 2005; Lieberman et al., 1991;

Lieberman et al., 2006; Van Zeijl et al., 2006). There is also some evidence in the literature that, at least when applied as indicated in their manuals, EBTs in general can be effective in the clinical setting (Fritz et al., 2013; Greer et al., 2014; Karlin & Cross, 2014; Webb et al., 2014).

Trained users felt the interventions were more effective and used them more often. In general, participants of this study who received training in the implementation of these interventions, made use of them with a greater number of their clients than did untrained users. Training also dramatically affected usage rate. For this study, all but one respondent who had been trained made use of the EBTs. Untrained participants were not as likely to use the interventions. Furthermore, trained participants generally felt the interventions were more effective than untrained participants. It makes sense that the more one is trained and skilled in any intervention, the more likely they are to effectively treat problems the intervention is designed to treat. Indeed, once again, these results are similar to those found in the literature, which has demonstrated that the amount, quality and type of training received, as well as continued support, follow-up, and supervision regarding application of an intervention positively affects the effectiveness of an intervention (Allen et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007).

Most users of the interventions adapted the EBTs. It was extremely rare that clinicians who participated in the study used the manualized version of the interventions. The vast majority of participants adapted the interventions. Nevertheless, users of the interventions felt the EBTs were at least somewhat, if not more effective. The tendency to adapt interventions matches research regarding the clinical application of EBTs as a whole (Kendall & Beidas, 2007; Walrath et al., 2006). However, results of this study differ from other research when it comes to effectiveness of EBTs when they are adapted. The literature reviewed generally identified lack

of fidelity, or adapting interventions rather than following their manualized versions, as being a significant source negatively affecting the effectiveness of interventions in the clinical setting (Kendall & Beidas, 2007; Walrath et al., 2006).

There may be several potential explanations for the divergence between the findings of this study and other studies. As previously noted, this study focused on perceived effectiveness, rather than objective, standardized and controlled measurement of specific outcomes. It is possible that training could have biased users into perceiving the interventions to be more effective than they really are. Also, the majority of participants in this study who made use of the interventions were favorable toward EBTs and familiar with attachment theory, a potentially different and non-representative demographic, which could have also further biased the perceptions of effectiveness of these users. This point perhaps becomes salient if one considers how clinicians may feel about the effectiveness of these interventions if they were forced to use them (e.g. because of mandatory agency or state policy), especially if they did not believe in the interventions, or felt the EBTs conflicted with their theoretical and/or therapeutic approach/beliefs.

Another potential explanation is that historically, studies often identified clinicians' unfavorable attitudes toward EBTs as being a major contributing element affecting the failure in application of EBTs. However, an increasing number of more recent studies are beginning to question, if not refute such claims, suggesting that those studies may have been biased in their conclusions (i.e., researchers may have assigned blame for poor clinical outcomes to clinician attitudes, when there may have been many other factors that could have also played a role) (Graybeal, 2014; Kazdin, 2008).

A majority of participants were favorable toward EBTs. An overwhelming majority of participants were at least somewhat favorable toward EBTs. In fact, most were very to extremely favorable. This was perhaps the most surprising finding that vastly differed from the literature, which details the generally unfavorable views of clinicians toward EBTs (Allen et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007; Self-Brown et al., 2012; Walrath et al., 2006). The literature also highlights that many clinicians do not believe that EBTs are effective, and that this then becomes a significant barrier to widespread use of EBTs (Karlin & Cross, 2014; Kendall & Beidas, 2007; Self-Brown et al., 2012; Walrath et al., 2006). However, for this study, only one of the 38 participants indicated this was a barrier, and for just one of the four interventions. This study yielded the same result in regards to not using an intervention because it conflicted with clinicians' therapeutic approach/beliefs.

These divergent findings may be due to a potentially non-representative sample in the present study. A majority of clinicians who took part in this study identified the psychodynamic model as one of the theoretical orientations that guided their practice. This therapeutic approach was second only to Cognitive-Behavioral Therapy (CBT). Literature suggests that many clinicians, agencies and higher education institutions may no longer favor such a theoretical orientation to practice (Berzoff et al., 2011). Given that it was clear from recruitment message that this was a study about attachment and EBTs, it is possible and perhaps likely that this in and of itself biased the sample. That is, perhaps the recruitment message mostly attracted clinicians who believed in EBTs and attachment theory (a theory often associated with psychodynamic theory). There was some indication of this potential response/sampling bias being the case in a few interactions that occurred with potential disseminators of the recruitment message. In the process of providing clarification about the study's eligibility criteria, it was made clear that

being knowledgeable about EBTs, or the four AF EBTs reviewed in this study, or even attachment theory were not at all part of the eligibility criteria. It was reiterated that the only criteria for participation was being a Master's level or greater licensed clinicians who works with children five years of age or under. Nevertheless, potential disseminators of the recruitment message reiterated that their intention was to send the message only to those who knew about such interventions.

Summary

Almost all of the findings of this study regarding the use of AF EBTs in the clinical setting mirrored what is found in the literature regarding dissemination and implementation of EBTs in the clinical setting. Thus, for the participants of this study, the four AF EBTs reviewed in this study were plagued by the same dissemination and implementation issues that negatively affect the effectiveness EBTs in general. Most the clinicians surveyed in this study did not use the EBTs in the clinical setting. The main reason was because they were not aware of the existence of these EBTs. However, when clinicians knew some of the basic components of the EBTs, most of them made use of the EBTs. Almost all of the clinicians reported barriers that impeded their effective use of all the EBTs. The top five barriers cited were unawareness of an EBT, lack of agency support, difficulty accessing training, high cost of the training, and not having a need for an EBT. All but one of the clinicians who had received training in the EBTs made use of the EBTs. All clinicians who used the EBTs reported they were at least somewhat effective. Generally, clinicians trained in the EBTs used them more often and reported greater effectiveness. Just about all clinicians adapted the interventions. Nevertheless, they reported they felt the EBTs were effective interventions, which is one of the few findings of the study that was divergent from the literature. This difference may be attributed to the other divergent

finding: the majority of participants of this study were favorable toward EBTs. Thus for this study, AF EBTs suffered from the same dissemination and implementation issues as EBTs as a whole. While some of the implications of these results have been discussed this section, they are further elaborated upon in the sections that follow.

Implications for Social Work Practice

While the results cannot be generalized, this exploratory study does provide some initial, preliminary and potential evidence that AF EBTs may have many similar characteristics as EBTs as a whole, especially in regards to dissemination and implementation hurdles that need to be overcome in order for the EBTs to be adopted into widespread effective use in the clinical setting. These results may serve as a compelling reason to invest in perhaps as little as two or three studies that make use of more representative samples, so that results may be generalized. If these studies produced similar findings, then it could potentially be reasonable to assume that AF EBTs have similar dissemination and implementation issues as other EBTs as whole. Having scientific evidence to support using the findings of prior research regarding dissemination and implementation of EBTs could potentially help save precious time and resources. That is, such findings could be used to inform and focus future efforts on the solutions that have been shown to help overcome the barriers known to impede the dissemination and implementation of EBTs. Research could concentrate on the findings related to such efforts. In this sense, investment in only a few more studies related to this topic can be seen to be very cost-effective.

The findings of this study suggest that, at least for the participants of this study, had clinicians been aware of the interventions, and received training to use them properly, they likely would have used the interventions and found them to be effective. Should these findings be supported by studies that made use of more representative samples, then there would be

compelling evidence that it would be worthwhile and cost-effective to invest in efforts to help promote awareness of these EBTs and provide training in their effective use. That is, such investments would have been shown to produce commensurate results, and thus they could provide assurance that proper investment could lead to the widespread use of these interventions in the clinical setting.

Conversely, if results were not replicated, then precious time and resources could again be saved. That is, if this were the case, then there would be evidence to show that investing in dissemination and implementation efforts would not translate into commensurate results. Rather than invest in such futile efforts, such precious resources could perhaps be best used toward qualitative studies that could potentially help identify issues that would help improve their ease of transportability into the clinical setting (e.g. modifying the interventions to make them less complicated and easier to use, while ensuring their efficacy is not compromised). Or perhaps findings would indicate that these interventions have such significant transportability issues, that it may not be a worthwhile invest in them any further.

The importance of this study becomes salient when one considers that there is a mandate from the federal government and many professional mental health associations, including the American Psychological Association (APA) and the National Association of Social Workers (NASW), to be accountable for treatment outcomes; provide high quality and effective treatments; and to base practices, at least in part, on empirical knowledge. At the very least, there are three compelling reasons why such a mandate is so important: client well-being; tax-payer demands for accountability; and to promote faith in our professions' therapeutic competence and preserve its integrity. Clearly, it is important to identify practices and possibly treatments that are effective. The four interventions reviewed in this study have empirical

evidence that supports their efficacy in the research setting. These interventions perhaps have particular value over other EBTs because they focus on treating attachment problems, which research has demonstrated to be central to children's development, mental health, and positive outcomes throughout an individual's life (Davies, 2011; Sroufe, 2005). In addition, their particular value also lies in the fact that they do not solely treat one or two diagnoses, a common critique of EBTs (Graybeal, 2014; Karlin & Cross, 2014; Kazdin, 2008; Mitchell, 2011), but rather one of the critical elements responsible for an individual's well-being, and therefore a wide spectrum of diagnoses. Given all of the above, it becomes clear that it is very important to obtain conclusive evidence regarding the dissemination and implementation of these AF EBTs. This study is the first step toward that goal.

Social workers are uniquely and ideally suited for therapeutic work that is focused on attachment (Arnd-Caddigan & Pozzuto, 2008). That is, the most fundamental element of the profession is the same as what is at the core of the concept of attachment: that nothing is more important and critical to human beings than relationships. Part of the core of the profession's therapeutic model is centered on the relational aspects of treatment (Dewane, 2006; NASW, 1999). One of the main therapeutic tools of social workers is their use of self to attune to clients' experience (Dewane, 2006). In addition, the profession uses a multi-faceted, systems and ecological framework when considering client problems and solutions (NASW, 1999). All of these elements are central to AF EBTs. Since social workers are particularly well suited to make use of AF EBTs, it is important to help ensure that they become aware of such interventions. If social workers become aware, and better yet, trained in AF EBTs, this will likely help improve their ability to help their clients, and improve their practice and effectiveness. Thus this study is

particularly important to social work, because it specifically focuses on the dissemination and implementation of AF EBTs.

Importance of the Study

Dissemination and implementation research shows that significant resources are required to develop EBTs; demonstrate their efficacy; and successfully disseminate and implement them into the clinical setting (Karlin & Cross, 2014; Schoenwald & H., 2001; Self-Brown et al., 2012). All of this requires taxpayer and other sources of money, time, significant human capital, and other resources. But are these investments wise and worthwhile if the interventions that are developed do not end up being widely used effectively in the clinical setting? As originally argued, it really does not matter how good and effective an EBT is proven to be in the research setting, if it is not going to be successfully disseminated and implemented in the clinical setting. For these interventions to be truly useful, attention and investment in their dissemination and implementation should be at least equally matched.

If there are indeed major problems with dissemination and implementation of AF EBTs, then we need to first be aware of these problems, so that we can have the ability to address them. It is imperative that problems with dissemination and implementation of these EBTs be addressed for clients to have any chance of benefitting from these interventions. Otherwise, resources will be wasted, and clients will not end up benefitting from such interventions. There have been arguments made that when planning for the development and research any EBT, consideration should also be given to an equally and critically important part of the project, which is the dissemination and implementation of these EBTs (Karlin & Cross, 2014; Schoenwald & H., 2001; Self-Brown et al., 2012). Without such planning and prior commitment, we are wasting our time and precious resources, and delaying or possibly

preventing interventions proven to be effective in the research setting from being used effectively for our clients. One could argue that there is a moral, ethical and fiscal imperative to look at this issue.

Implications for Policy

Dissemination and implementation research has shown that, in general, EBTs are plagued with problems affecting their transportability from the research to the clinical setting. While the results of this study cannot be generalized, they provide initial and preliminary evidence that AF EBTs may also be plagued by similar problems. If there are tools already in existence that can help clinicians be more successful in treating children, then it is imperative that clinicians become aware and receive training in regards to these EBTs. This does not happen on its own. Investments have to be made to disseminate and implement these EBTs. This study points to a need for research regarding the dissemination and implementation of AF EBTs.

It is only logical that one cannot use something they do not know exists. If clinicians are generally not aware of the existence of an EBT, they naturally won't be able to use it. While this may seem like it should go without saying, sometimes the obvious is overlooked, perhaps because it is so obvious and thus assumed. Indeed, it appears to be a general and widespread problem that so much energy, time, and resource goes into creating and developing interventions, as well as producing research that demonstrates their effectiveness, yet such investments are generally not matched in regards to making sure that clinicians become aware of their existence, trained their application, or implemented successfully in the clinical setting at large (Hoagwood, Hibbs, Brent, & Jensen, 1995; Schoenwald & H., 2001). This study sought to highlight the problems associated with making such assumptions.

This study has important implications from a policy standpoint. It does not make sense to fund research and development of EBTs, if planning, funding and action is not also taken to disseminate and implement the interventions that are shown to be effective. If care is not taken to ensure that EBTs are successfully transported into the clinical setting, then all prior investments and research are essentially wasted. When it comes to the funding of mental health research and services, resources are too precious and limited to waste on poor planning or fruitless efforts. We need to be good stewards of these resources.

Part of the reason why there is a mandate from our society and professional associations for practice to be supported by empirical evidence, is to ensure that we provide services to client in the most cost-effective way possible, given that resources are so limited. Another part of the reason is to ensure that clients receive the best care possible. There is too high a need for effective treatments on the part of our clients, for us to fail to move EBTs beyond the research setting. While such a mandate may be well intended, it will do little good if it is not funded or carried out in a thoughtful and thorough manner. It is not sufficient to fund and perform research on the development of EBTs. Funding, planning and care also need to be taken to successfully transport EBTs from the research setting into the clinical setting. Failing to do so would not only defeat the mandate, but cause it to actually backfire and lead to even greater waste and lack of funding for critically needed mental health care. Yet, considerations and funding of dissemination and implementation of EBTs is often overlooked (Flaspohler et al., 2012; Karlin & Cross, 2014; Kendall & Beidas, 2007; Schoenwald & H., 2001).

This study is perhaps the first step toward calling attention to the need for investment in the dissemination and implementation of AF EBTs. Research, attention, focus, investment and funding are badly needed for dissemination and implementation of AF EBT currently in

existence. When it comes to future research and development of other AF EBTs, or EBTs in general, it may be wise to consider requiring a plan for dissemination and implementation to be included in applications for research grants. There are several important factors to consider in regards to planning for dissemination and implementation, such as research; funding; means of dissemination; ease of implementation; fidelity and/or replication of results in the field; adaptability to a wide array of clients and situations; suitability for the often complex and culturally diverse clientele in the field; access and length of training; proper follow-up training, supervision and consultation; proper support and funding to allow agencies and clinicians to adopt and implement new EBTs; possible incorporation of these into higher education curriculum; etc. The study's participants referenced many of these factors.

When one considers what is required to truly disseminate and implement EBTs on a nationwide scale so that widespread adoption and effective use of these occurs, funding such efforts is likely to far exceed the funding that EBTs require for their creation and research. Thus policies and mandates need to be revised or created to factor in the importance of funding of dissemination and implementation research and efforts regarding EBTs, including AF EBTs.

Strengths of the Study

This study provides an initial step and establishes a foothold in regards to dissemination and implementation research related to AF EBTs. It highlights the need, rationale and preliminary evidence regarding such research. Until now, there had been little to no research in regards to this important area.

Another important aspect of this study lies in its simplicity. That is, the study focuses on something that is obvious: if you are not aware of something, you cannot make use of it. While this should go without saying, often times we can miss the obvious, partly because we fail to take

it into consideration. That is, we assume that is obvious, and fall into the trap of overlooking it. It is obvious that you cannot use something you are not aware of. And yet, we appear to consistently fail to make sure that we make sure that clinicians are aware of and trained in the EBTs that are already in existence. By focusing on the obvious and not making assumptions, this study brings attention and highlights a fundamental problem: the failure to focus on dissemination and implementation of EBTs, and its consequences.

Another strength of the study lies in the fact that the results match existing research on EBTs as a whole. Again, results of this study cannot be generalized. However the findings of the study indicate that it may be likely that more representative samples will support these findings. It is logical that AF EBTs would need the same kind of funding, support, care and attention as any other EBT in regards to making sure that they are effectively transported into the clinical setting, and that without these, they would be shown to have a low transportability rate. Again, if representative samples were used in at least one or two well- designed studies focusing on effective transportability of AF EBTs in the clinical setting, then it would be reasonable to use the impressive body of research regarding dissemination and implementation research of mental health EBTs as a whole to help guide and focus efforts on solutions to the problems that likely plague the effective transportability of these interventions into the clinical setting.

Limitations and Biases

There are a number of limitations to this study. Chief amongst these were issues related to sampling and data collection methods. Convenience/availability and snowball sampling techniques were used. Such forms of sampling result in the inability to generalize the results (Rubin & Babbie, 2010). Because participants were not randomly chosen from a pre-determined sample frame, they cannot be considered to be representative of the general

population of clinicians. Participants may have had different characteristics than the general population. For example, they perhaps lived in different regions; had different values; had different theoretical frameworks; favored different practices; had different attitudes; had different training; etc. All of these potential differences can affect participants' responses. Convenience and snowball sampling are also very vulnerable to the introduction of significant biases (Rubin & Babbie, 2010). For example, the study's recruitment message was broadcasted via the NASW's LinkedIn page, but not through social media of other mental health professions' associations. As a consequence, participants were mostly social workers. Other mental health professionals may have a different perspective, and therefore may have responded differently.

Personal/researcher biases were accentuated by the fact that I contacted clinicians I knew. These clinicians were more likely to be aware of AF EBTs, and more favorable toward them. However, most of these clinicians were contacted toward the end of the data collection period, and such outreach efforts resulted in few responses. Personal bias was further compounded by the fact that I purposely did not contact certain institutions and agencies, specifically because I knew they were using one of the interventions, and I was concerned that having this knowledge and targeting these specific agencies would have biased the results. While the intention was to increase randomization and decrease bias, the means of going about it were not scientific and actually contributed to more bias. The very decision to not contact such agencies may have biased the study toward the results I actually obtained. Either action, contacting or not contacting such agencies, would have been biased, because the bias lies not only in the researcher being blind to potential participant perspectives, awareness and use; but

also in targeting certain potential participants over others, rather than using a randomized representative sample of clinicians who met the eligibility criteria.

Another limitation and source of bias was solely making use of an online survey. Such surveys are extremely vulnerable to low response rate and non-response biases (Rubin & Babbie, 2010). It is possible, if not likely, that clinicians who participated in the study responded differently than clinicians who chose not to respond to the recruitment message. For example, participants may have been more favorable toward AF EBTs than those who did not respond. There is potential evidence of such bias in the initial response of several agency directors/CEOs. Many initially confused the subject of the survey with its criteria. That is, many initially believed that one needed to be familiar with AF EBTs, and actively using these, in order to participate. In fact, the criteria for participation were solely that one needed to be a mental health clinician; licensed to practice in the United States; and working with children five years of age and under. Thus it is likely that at least some, if not many potential participants were under the same impression after initially reading the recruitment message and considering whether or not to participate.

Another limitation of the study is that there may be many possible explanations for the results, but few can be ascertained with any degree of certainty, because the study did not explore many of these. For example, it would have been useful to ask about participants' continuing education practices; whether or not they actively sought information about EBTs, and if so, how do they go about doing so; where participants who used an intervention learned about it; the extent of one's training in an intervention; what motivated clinicians to become trained in an intervention; etc. However, these omissions were on purpose, so that the length

of time required to complete the survey could be kept to a minimum, with the goals of both increasing the participation response rate, and increasing the rate of survey completion.

Meaningful statistical analysis could not be performed because only 38 surveys were completed. Statistical significance was further compromised in regards to use of these interventions, given that any particular intervention had fewer than ten respondents make use of it. One of the significant barriers to obtaining higher response rates was that one of the criteria for eligibility was so stringent and limiting. That is, only clinicians who worked with children of five years of age and under could participate in the survey.

The survey was designed with skip logic functionality. This technology logically skips participants over certain questions based on a participant’s answers. For example, if a participant did not use an intervention, they were skipped over questions about the interventions effectiveness, because it makes sense that they could not comment on such questions if they did not use the interventions. Skip technology was used to help shorten the length of time required to complete the survey. It was also used to avoid asking participants to answer certain questions that most likely would have felt redundant and needless to most participants, and thus increased their level of frustration in taking the survey. However, it is possible that skip logic technology perhaps prevented some users from answering certain questions that may not have been as one would expect. For example, some users perhaps used the intervention in the past, but no longer made use of it, either because their current agency did not support the intervention, or because they tried it and felt it was not effective, and thus stopped using it. The input of such participants would have been particularly important. In a sense, one could argue that the design of the survey was biased to produce results indicated interventions were effective. However, getting rid of the skip technology would have likely come at a great cost. Most of the participants would have

required significantly more time to complete the survey. They likely would have experienced a fair amount of frustration at the redundancy of the questions. The negative impact of research on participants is something that researchers must always strive to avoid as much as possible. Furthermore, the participation and especially the completion rate would have likely significantly suffered, thus making the study a failure. The decision to introduce skip technology was yet another conscious trade-off. The input regarding of such potential participants could be sought via a separate study that focuses on such participants, or through a better design of a similar, better funded, larger scale study.

Many of the limitations of the study were seen as acceptable trade-offs. Some of these have already been discussed. However further elaboration of these trade-offs is worthy of consideration. There were limitations in time and resources. The study had no funding. There was a very limited amount of human resource available. Time was limited. These were unfortunate but very real issues that had to be contended with in regards to the scope and design of the study. Despite the limitations of the study, it has value. This was an exploratory study, and thus the need for generalizability was not as critical as other types of studies (e.g. studies seeking to demonstrate efficacy). There is lack of research regarding the application of AF EBTs in the clinical setting. While the results cannot be generalized, they nevertheless provide a potential indication of the need for such studies in the future. Many of the study's results matched those found in the literature review of other studies regarding dissemination and implementation. The exploratory nature of this study may also provide useful information regarding potential areas to focus on in future research on the implementation of AF EBTs (Rubin & Babbie, 2010).

Recommendations for Future Research

Should this study lead to further interest in regards to research regarding the dissemination and implementation of AF EBTs, one of the key issues to address would be generalizability of the findings. The most rigorous way to work toward producing findings that can be generalized is to both randomize the sample population and increase the sample size. However, to make this daunting task slightly more manageable, perhaps it would be helpful to first limit the sample frame to licensed social workers with a Masters level or higher degree, rather than all mental health professionals. Each state has a board of licensed social workers, and databases of licensed social workers. This is public information, and thus all of these databases should be available. This is reportedly a common means of accessing physicians for surveys (Dykema et al., 2013). It should thus be possible to obtain these databases, and by using Excel software, randomly select the potential participants. If enough time and resource were available, obtaining the database of each state's board of social work would be ideal.

There are advantages and disadvantages to various means of administering surveys. Postal surveys appear to have highest response rate (Cho, Johnson, & VanGeest, 2013; Dykema et al., 2013), but are most costly, time consuming and have less flexibility (Dykema et al., 2013). It appears that up to two follow-up contacts are optimal for increasing response rates (Dykema et al., 2013). Dykema and colleagues (2013) report that providing prepaid, monetary incentives are the optimal form of incentive; and that generally the higher the incentive, the better the response rate; and these incentives do significantly help improve response rates. However, they also report mixed findings regarding what is an ideal incentive, but it appears that approximately $10 may be the ideal cost-effective amount.

Based on the above, the recommendation would be to use multiple approaches to help attain an ideal response rate. It should be clear that the following recommendations are ideal and unrealistic, and that a study would obviously have to adjust these recommendations according to their available budget. Social workers could be contacted via email, with both a link to a web-based survey, and an attachment of survey. It would be best to also contact them by mail as well, and include a paper copy of the survey with a self-addressed envelope, as well as information about filling out the survey online. In addition, this mailing should ideally contain a $10 prepaid monetary incentive. If the project could afford to provide higher incentives, then doing so with likely increase response rates, and thus would be ideal. Up to two follow-up contacts should be attempted, ideally both by mail and email.

There is a wide range of reports on response rates, and it appears that the average web-based survey response may be as low as 10%. However, reports of response rates of 60-75% if not higher are also not uncommon, particularly when all above attempts to increase response rates are taken. If the project could afford it, targeting 20,000 randomly selected social workers would be ideal, given that the response rate could be as low as 10%. Thus one could expect to get as few as 2000 responses, and perhaps as much as 10,000 responses or more. Such numbers would help produce data of great statistical value; findings that could be generalized; and greatly help reduce non-response bias. Obtaining buy-in, support and endorsement from the NASW and its state chapters would likely greatly help improve response rates. Advertising on their websites, social media and newsletters would again likely help increase response rates. Obtaining support from leading authors in the field of social work, attachment and evidence-based practice would likely further help response rates. Despite all such efforts, it is difficult to

imagine how non-response bias could be completely eliminated, particularly when it comes to any research involving surveys.

Obtaining results from three independent studies would be ideal, and hopefully would produce relatively conclusive findings. That is, two quantitative studies involving surveys, to compare results; and one qualitative study (perhaps with a higher reward incentive), to get at more detailed and elucidating responses. As noted earlier, there are many questions that this study did not ask, as a means to shorten the length of the survey, and help improve response and completion rates. Future studies, particularly qualitative studies, may help provide a more thorough understanding regarding use and non-use of AF EBTs. The following are suggested areas of explorations. Determine how did participants become aware of an EBT, and what motivated and helped them become trained in a particular EBT over another. Find out what kind of training did trained users of the interventions receive (e.g. was it a brief intro to the EBT as part of their graduate degree; a short CEU/CME training; the full official training; etc.). Determine whether their educational institution and agencies focused their training on EBTs or EBPs; and if so, to what extent (e.g. were actually trained in any EBTs or EBPs; and if so, which ones, and do they know why those were focused on more than others; etc.). Ascertain which EBTs, including but not limited to other AF EBTs, were participants aware of, trained in, using, and how effective do they feel they were. Find out what do they feel contributed to their being unaware of these and/or other EBTs. Investigate how clinicians determine the effectiveness of an EBT. Find out about how clinicians feel these EBTs or other EBTs compare to whatever other method they use. Determine what methods/interventions do clinicians find most useful. Learn about what recommendations clinicians would make to the developers of these AF EBTs.

There are several specific recommendations in regards to improving the design of the survey. These were discovered only after the survey was launched and/or completed, and are the result of learning from insights and/or errors, as well as feedback from the participants. One significant improvement could be to make better use of skip technology. The survey would benefit from being designed to ask different questions for participant who were skipped over the effectiveness questions (e.g. have you used the intervention in the past; what are the reasons why you do not use the intervention despite being aware of it; etc.). In addition, the survey would benefit from collecting demographic information regarding the state in which one practiced, so as to identify if there were different patterns of response, or any relationships between awareness, training, and use, according geographic location. Similarly, it would have been very valuable to include information about the extent to which one's graduate school taught about EBPs or EBTs, and more specifically, any of the EBTs reviewed in this study.

In addition, the survey could be improved by modifying the response options of certain questions. These options help reduce potential bias involved in design, and do not lengthen the time required for survey completion. The effectiveness questions should include "None of the outcomes" as a response option. It is conceivable that one could use the interventions because they must do so per agency, court order, insurance, state or other guideline/order/mandate, and yet do not feel it is effective in any way. Similarly, adding "None" as an option for the barrier questions would be important, so that participants may have the option of reporting that they do not feel there are any barriers to using the interventions. It appeared that the question regarding how many clients with attachment problems one treats with an intervention was unclear. Thus it would have been better to word the question differently, so that it was clear that it only refers to clients with attachment-related issues.

In closing, it is important to reiterate how important attachment has been shown to be to human development, positive outcomes, and good mental health. It is also important to reiterate that treating attachment problems has been shown to be effective in addressing maltreatment problems, externalizing problems, mental health problems, and parenting problems. Given the importance and power of attachment, it is worthwhile to find proven, efficacious, and effective ways to prevent or treat attachment problems. Attachment-focused evidence-based treatments may be interventions that can help with this goal, given that they have been proven to be efficacious in the research setting. Now we need to make sure that they can be effectively transported in the clinical setting. The reader, the research community, and the clinical community are all urged to invest in this area of research. If AF EBTs should indeed be found to be effectively transportable into the clinical setting, then there would be compelling evidence to make significant investments into these EBTs to disseminate and implement them in the field at large. However, should it be found that they cannot be transported effectively into the clinical setting, then it would perhaps be worthwhile to invest in designing AF EBTs that, at the onset, have had transportability figured and planned into their design. On the other hand, should such negative findings be discovered regarding AF EBT transportability, it might perhaps be more advisable to invest in finding evidence-based practices that are attachment-focused, rather than AF EBTs.

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Appendix A

Recruitment Letter for Twitter

Help by taking a 5-10 min anon survey re: attachment evidence-based programs and get a $5 gift card.
https://www.surveymonkey.com/s/YX2GZ6S

Appendix B

Recruitment Letter for All Others

Dear Mental Health Professional,

I am conducting a study to explore the application of attachment-focused evidence-based programs in the clinical setting. Your participation could potentially help bridge the gap between the research and clinical settings regarding such interventions. The data collected in this study will be used for my Master of Social Work Thesis and presentation, and possibly for publication. Participation will require approximately 5-10 minutes of your time to complete a brief demographic questionnaire and multiple-choice anonymous survey. You will receive a $5 Dunkin Donuts gift card as a means to thank you for your time and effort.

To participate in this study, you must be a clinical mental health professional licensed to practice in the United States, with a corresponding Master's level of education or higher. You must also provide psychotherapeutic services to children five years of age or under and their caregivers.

The link to the survey is: https://www.surveymonkey.com/s/8WM7STY

If you have any questions about the study, I can be reached at jfaucher@smith.edu or xxx-xxx-xxxx.

Sincerely,

Jean Faucher, Smith College School for Social Work MSW student

Appendix C

Informed Consent Page

Use of attachment-focused evidence-based interventions in the clinical

Informed Consent

Dear Participant,

My name is Jean Faucher, and I am a Smith College School for Social Work MSW student. I am conducting a study to explore the use of attachment-focused evidence-based interventions in the clinical setting. The data collected in this study will be used for my Master of Social Work Thesis and presentation, and possibly for publication.

To participate in this study, you must be a clinical mental health professional licensed to practice in the United States, with a corresponding Masters level of education or higher. You must also provide psychotherapeutic services to children five years of age or under and their caregivers.

Participation will require approximately 5-10 minutes of your time to complete a brief demographic questionnaire and multiple choice survey.

Since you are a mental health professional, and the study does not contain any traumatic subject matter, there are no foreseeable risks.

Your participation will help bridge the gap between research and the clinical setting in regards to attachment-focused evidence-based interventions.

This study is anonymous. I will not be collecting or retaining any information about your identity, IP addresses, or any information that could link you to the study. All research materials, including results of the survey, will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected and encrypted during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

You will receive a $5 Dunkin Donuts gift card as a means to thank you for your time and effort. You should know that in this case, so that the gift card may be mailed to you, your identity will need to be provided; however, it will not be linked or traceable back to your answers. Your personal information will be password protected, encrypted, stored in a secure location, and held in confidence, and solely used for the purposes of gifting. As soon as the gift card has been mailed to you, any information collected for this purpose will be permanently destroyed.

Participation in this study is voluntary. You may refuse to take part in the study simply by exiting the survey at any time. You have the right not to answer any particular question. However, you should be aware that the survey makes use of "skip logic" technology, as a means to help make your taking the survey as brief as possible. This feature, which skips over certain "redundant" questions based on your answers in prior questions, does require that certain questions be answered in order for the technology to work effectively. You should also note that once the survey is completed, I will not be able to withdraw your answers, because of the anonymous nature of the study.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, please feel free to contact me, Jean Faucher, at jfaucher@smith.edu or by telephone at 781-789-7564. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may also contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Sincerely,

Jean Faucher, Smith College School for Social Work student

Page 1

Appendix D

Welcome Page for Twitter Redirect

Welcome!

Welcome and thank you for your time and interest. I am conducting a study to explore the application of attachment-focused, evidence-based programs in the clinical setting. Your participation will potentially help bridge the gap between the research and clinical settings regarding these kinds of interventions. The data collected in this study will be used for my Master of Social Work Thesis and presentation, and possibly for publication. Participation will require approximately 5-10 minutes of your time to complete a brief demographic questionnaire and multiple-choice anonymous survey. You will receive a $5 Dunkin Donuts gift card as a means to thank you for your time and effort.

To participate in this study, you must be a clinical mental health professional licensed to practice in the United States, with a corresponding Masters level of education or higher. You must also provide psychotherapeutic services to children five years of age or under and their caregivers.

When you are ready, you will first be directed to an eligibility page; then to an informed consent page; and then to the actual survey. After the survey, you will be directed to a page where you can sign up to receive a $5 Dunkin Donuts gift card.

Sincerely,

Jean Faucher, Smith College School for Social Work MSW student

***I am ready to verify my eligibility for the survey**

◯ Yes

◯ No; I have decided not to participate and I am choosing to exit before taking the survey.

Appendix E

Welcome Page for All Others

Use of attachment-focused evidence-based interventions in the clinical

Welcome!

Welcome and thank you for your time and interest in the survey. This survey will require approximately five to ten minutes of your time. It will explore the application of attachment-focused evidence-based interventions in the clinical setting. Your participation will potentially help bridge the gap between the research and clinical settings regarding these kinds of interventions. When you are ready, you will first be directed to an eligibility page; then to an informed consent page; and then to the actual survey. After the survey, you will be directed to a page where you can sign up to receive a $5 Dunkin Donuts gift card as a means to thank you for your time and interest in participating in the survey.

Sincerely,

Jean Faucher, Smith College School for Social Work MSW student

***I am ready to verify my eligibility for the survey**

- ◯ Yes
- ◯ No; I have decided not to participate and I am choosing to exit before taking the survey.

Appendix F

Eligibility Page

Use of attachment-focused evidence-based interventions in the clinical

Eligibility

To be eligible to participate in this study, you must meet all of the criteria below:

1) You are a licensed mental health professional with a corresponding Masters level of education or higher.
2) You are licensed to practice in at least one of the states of the United States.
3) You provide psychotherapeutic services to children five years of age or under and their caregivers.

***I have read the above statement, and attest that I meet all three of the eligibility criteria to participate in the survey.**

◯ Yes

◯ No

Appendix G

Thank You Page for Disqualified Participants

USE OF ATTACHMENT-FOCUSED EVIDENCE-BASED INTERVENTIONS

THANK YOU

THANK YOU FOR TAKING THE TIME TO CONSIDER PARTICIPATING IN THIS SURVEY.

PLEASE CONSIDER FORWARDING THE FOLLOWING RECRUITMENT MESSAGE TO ANYONE, OR POSTING IT ON SOCIAL MEDIA, WEBSITES, LISTSERVS, RSS FEEDS, ETC.:

Clinical Social Work Research Survey

Dear Mental Health Professional,

I am conducting a study to explore the application of attachment-focused, evidence-based programs in the clinical setting. Your participation will potentially help bridge the gap between the research and clinical settings regarding these kinds of interventions. The data collected in this study will be used for my Masters of Social Work Thesis and presentation, and possibly for publication. Participation will require approximately 5-10 minutes of your time to complete a brief demographic questionnaire and multiple-choice anonymous survey. You will receive a $5 Dunkin Donuts gift card as a means to thank you for your time and effort.

To participate in this study, you must be a clinical mental health professional licensed to practice in the United States, with a corresponding Masters level of education or higher. You must also provide psychotherapeutic services to children five years of age or under and their caregivers.

The link to the study is: https://www.surveymonkey.com/s/8WM7STY
If you have any questions for me about the study, I can be reached at jfaucher@smith.edu

Sincerely,

Jean Faucher, Smith College School for Social Work MSW student

Page 1

Appendix H

Survey Page 1

Survey regarding the use of attachment-focused evidence-based

IMPORTANT NOTE

QUESTIONS MARKED WITH AN ASTERISK (*) SHOULD BE ANSWERED. DOING SO WILL LIKELY SIGNIFICANTLY SHORTEN THE LENGTH OF TIME NEEDED FOR YOU TO COMPLETE THE SURVEY. These questions make use of skip logic technology, which logically skips over certain upcoming questions based on your answers to particular questions. However, should you so choose, you still have the option to refuse to answer any question.

Appendix I

Survey Page 2

Survey regarding the use of attachment-focused evidence-based

Demographics

Which category below includes your age?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75 or older

What is your gender?

- Female
- Male
- Transgender

Other (please specify)

Appendix J

Survey Page 3

Survey regarding the use of attachment-focused evidence-based

What is your ethnicity? (Check all that apply)

- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black or African American
- Hispanic or Latino
- White / Caucasian

Other (please specify)

What is your profession/degree for which you are licensed as a mental health practitioner?

- MSW
- DSW
- PsyD
- MD
- MFT
- MA
- EdD
- PhD

Other (please specify)

Appendix K

Survey Page 4

Survey regarding the use of attachment-focused evidence-based

What is your therapeutic approach? (Check all that apply)

- [ ] Eclectic/Integrative
- [ ] Cognitive-Behavioral Therapy
- [ ] Psychodynamic
- [ ] Systems
- [ ] Dialectical Behavioral Therapy
- [ ] Client Centered/Solution Focused
- [ ] Intersubjective/Relational
- [ ] Feminist
- [ ] Behavioral
- [ ] Cognitive
- [ ] Gestalt
- [ ] Narrative
- [ ] Mindfulness
- [ ] Expressive Arts
- [ ] All of the above

Other (please specify)

How many years of experience do you have as a licensed mental health professional working with children?

Appendix L

Survey Page 5

Survey regarding the use of attachment-focused evidence-based

Child-Parent Psychotherapy (CPP)

*** How familiar are you with Child Parent Psychotherapy (CPP)?**

- ◯ No familiarity: I have never heard of this intervention.
- ◯ Minimally familiar: I am aware of the intervention, but do not know much about it.
- ◯ Somewhat familiar: I know some of the basic elements of the intervention.
- ◯ Very familiar: I have received training regarding this intervention.
- ◯ Extremely familiar: I am trained and certified to use this intervention.

Appendix M

Survey Page 6

Survey regarding the use of attachment-focused evidence-based

Child-Parent Psychotherapy (CPP)

*** What percentage of your clients who have attachment related problems do you treat by making use of this intervention?**

- ○ 0%
- ○ 1-24%
- ○ 25-49%
- ○ 50-74%
- ○ 75-99%
- ○ 100%

Appendix N

Survey Page 7

Survey regarding the use of attachment-focused evidence-based

Child-Parent Psychotherapy (CPP)

How effective is this intervention?

- ○ Not effective at all
- ○ Minimally effective
- ○ Somewhat effective
- ○ Very effective
- ○ Extremely effective

What outcomes or problem areas are positively affected by the intervention? (Check all that apply)

- ☐ All outcomes the intervention is designed to target.
- ☐ Some of the outcomes the intervention is designed to target.
- ☐ DSM diagnosis for which the client is being treated.

Other (please specify)

Do you use the manualized version of this intervention?

- ○ Yes: I follow the manual.
- ○ No: I adapt this intervention.

Appendix O

Survey Page 8

Survey regarding the use of attachment-focused evidence-based

Child-Parent Psychotherapy (CPP)

What are the barriers, if any, that have interfered with your ability to use this intervention? (Check all that apply)

- [ ] I was unaware of the existence of this intervention.
- [ ] I did not have a need for a new intervention to help my clients.
- [ ] I do not believe that evidence-based interventions are effective.
- [ ] The intervention conflicts with my therapeutic approach/beliefs.
- [ ] My agency does not support the use of this intervention.
- [ ] Access to the training was too difficult.
- [ ] The length of the training was too long.
- [ ] The cost of the training was too expensive.
- [ ] The intervention is not effective enough.
- [ ] The intervention is too rigid to apply to “real world” clients.
- [ ] The intervention is too complicated.
- [ ] The application of the intervention is too expensive.
- [ ] All of the above

Other (please specify)

Appendix P

Survey Page 9

Survey regarding the use of attachment-focused evidence-based

Attachment and Behavioral Catch-Up (ABC)

*** How familiar are you with Attachment and Behavioral Catch-Up?**

- No familiarity: I have never heard of this intervention.
- Minimally familiar: I am aware of the intervention, but do not know much about it.
- Somewhat familiar: I know some of the basic elements of the intervention.
- Very familiar: I have received training regarding this intervention.
- Extremely familiar: I am trained and certified to use this intervention.

Appendix Q

Survey Page 10

Survey regarding the use of attachment-focused evidence-based

Attachment and Behavioral Catch-Up (ABC)

*** What percentage of your clients who have attachment related problems do you treat by making use of this intervention?**

- 0%
- 1-24%
- 25-49%
- 50-74%
- 75-99%
- 100%

Appendix R

Survey Page 11

Survey regarding the use of attachment-focused evidence-based

Attachment and Behavioral Catch-Up (ABC)

How effective is this intervention?

- ◯ Not effective at all
- ◯ Minimally effective
- ◯ Somewhat effective
- ◯ Very effective
- ◯ Extremely effective

What outcomes or problem areas are positively affected by the intervention? (Check all that apply)

- ☐ All outcomes the intervention is designed to target.
- ☐ Some of the outcomes the intervention is designed to target.
- ☐ DSM diagnosis for which the client is being treated.

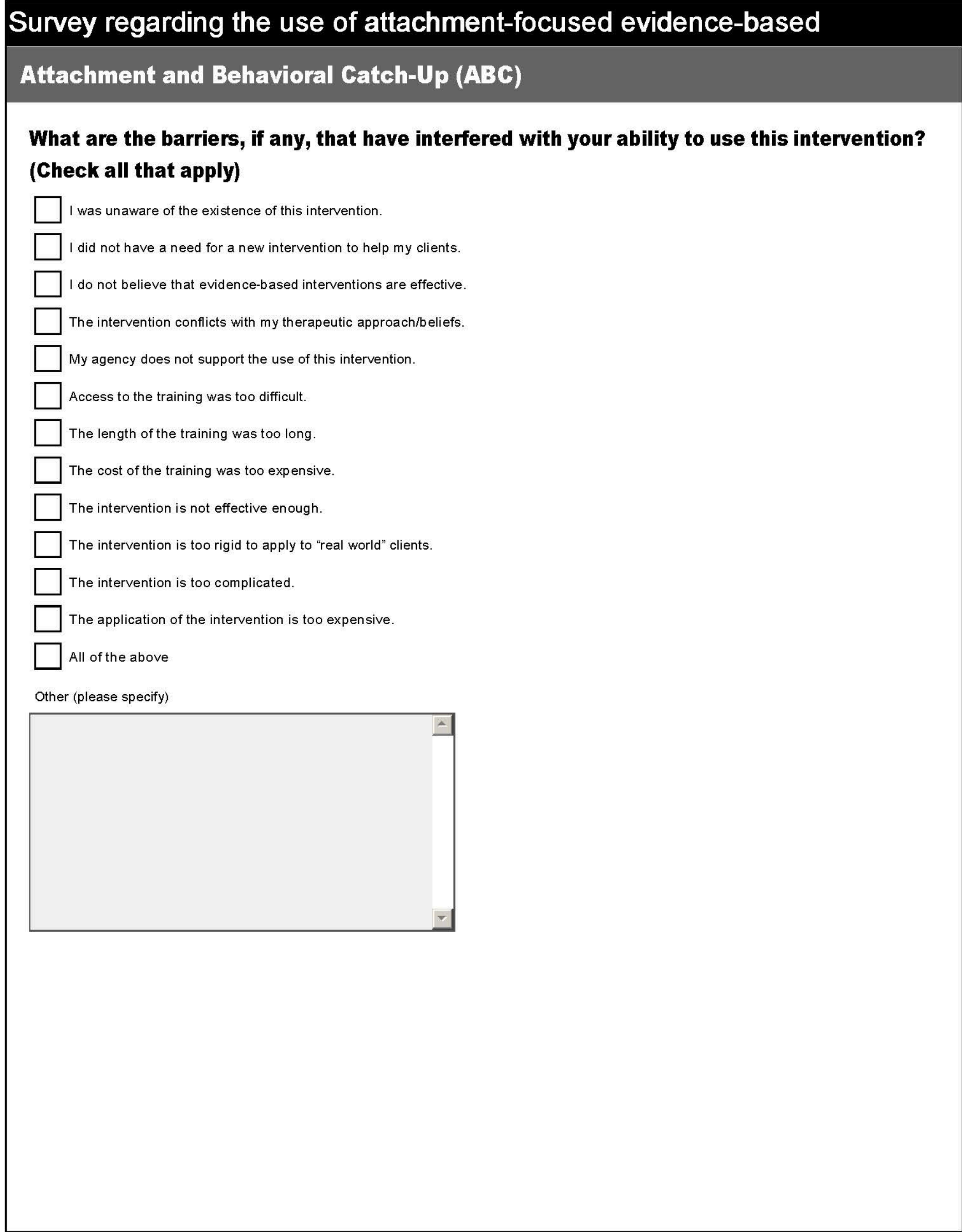
Other (please specify)

Do you use the manualized version of this intervention?

- ◯ Yes: I follow the manual.
- ◯ No: I adapt this intervention.

Appendix S

Survey Page 12



Survey regarding the use of attachment-focused evidence-based

Attachment and Behavioral Catch-Up (ABC)

What are the barriers, if any, that have interfered with your ability to use this intervention? (Check all that apply)

- [ ] I was unaware of the existence of this intervention.
- [ ] I did not have a need for a new intervention to help my clients.
- [ ] I do not believe that evidence-based interventions are effective.
- [ ] The intervention conflicts with my therapeutic approach/beliefs.
- [ ] My agency does not support the use of this intervention.
- [ ] Access to the training was too difficult.
- [ ] The length of the training was too long.
- [ ] The cost of the training was too expensive.
- [ ] The intervention is not effective enough.
- [ ] The intervention is too rigid to apply to "real world" clients.
- [ ] The intervention is too complicated.
- [ ] The application of the intervention is too expensive.
- [ ] All of the above

Other (please specify)

Page 12

Appendix T

Survey Page 13

Survey regarding the use of attachment-focused evidence-based

Video-Feedback Intervention to Promote Positive Parenting (VIPP)

*** How familiar are you with Video-Feedback Intervention to Promote Positive Parenting (VIPP)?**

- ◯ No familiarity: I have never heard of this intervention.
- ◯ Minimally familiar: I am aware of the intervention, but do not know much about it.
- ◯ Somewhat familiar: I know some of the basic elements of the intervention.
- ◯ Very familiar: I have received training regarding this intervention.
- ◯ Extremely familiar: I am trained and certified to use this intervention.

Appendix U

Survey Page 14

Survey regarding the use of attachment-focused evidence-based

Video-Feedback Intervention to Promote Positive Parenting (VIPP)

*** What percentage of your clients who have attachment related problems do you treat by making use of this intervention?**

- 0%
- 1-24%
- 25-49%
- 50-74%
- 75-99%
- 100%

Appendix V

Survey Page 15

Survey regarding the use of attachment-focused evidence-based

Video-Feedback Intervention to Promote Positive Parenting (VIPP)

How effective is this intervention?

- ◯ Not effective at all
- ◯ Minimally effective
- ◯ Somewhat effective
- ◯ Very effective
- ◯ Extremely effective

What outcomes or problem areas are positively affected by the intervention? (Check all that apply)

- ☐ All outcomes the intervention is designed to target.
- ☐ Some of the outcomes the intervention is designed to target.
- ☐ DSM diagnosis for which the client is being treated.

Other (please specify)

Do you use the manualized version of this intervention?

- ◯ Yes: I follow the manual.
- ◯ No: I adapt this intervention.

Appendix W

Survey Page 16

Survey regarding the use of attachment-focused evidence-based

Video-Feedback Intervention to Promote Positive Parenting (VIPP)

What are the barriers, if any, that have interfered with your ability to use this intervention? (Check all that apply)

- [ ] I was unaware of the existence of this intervention.
- [ ] I did not have a need for a new intervention to help my clients.
- [ ] I do not believe that evidence-based interventions are effective.
- [ ] The intervention conflicts with my therapeutic approach/beliefs.
- [ ] My agency does not support the use of this intervention.
- [ ] Access to the training was too difficult.
- [ ] The length of the training was too long.
- [ ] The cost of the training was too expensive.
- [ ] The intervention is not effective enough.
- [ ] The intervention is too rigid to apply to "real world" clients.
- [ ] The intervention is too complicated.
- [ ] The application of the intervention is too expensive.
- [ ] All of the above

Other (please specify)

Appendix X

Survey Page 17

Survey regarding the use of attachment-focused evidence-based

Circle of Security (COS)

*** How familiar are you with Circle of Security (COS)?**

- ◯ No familiarity; I have never heard of this intervention
- ◯ Minimally familiar; I am aware of the intervention, but do not know much about it
- ◯ Somewhat familiar; I know some of the basic elements of the intervention
- ◯ Very familiar: I have received training regarding this intervention
- ◯ Extremely familiar: I am trained and certified to use this intervention

Appendix Y

Survey Page 18

Survey regarding the use of attachment-focused evidence-based

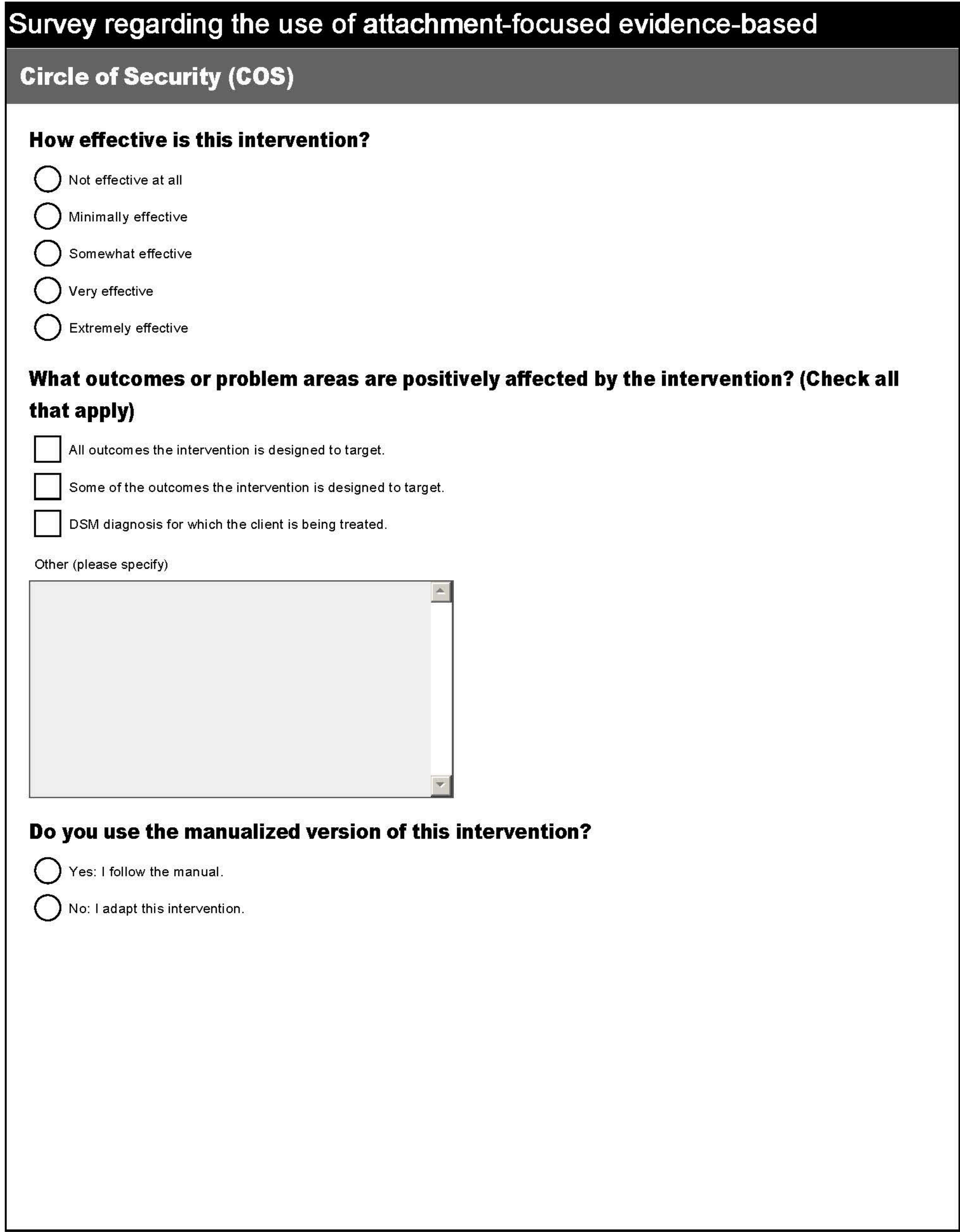
Circle of Security (COS)

*** What percentage of your clients who have attachment related problems do you treat by making use of this intervention?**

- 0%
- 1-24%
- 25-49%
- 50-74%
- 75-99%
- 100%

Appendix Z

Survey Page 19



Survey regarding the use of attachment-focused evidence-based

Circle of Security (COS)

How effective is this intervention?

- Not effective at all
- Minimally effective
- Somewhat effective
- Very effective
- Extremely effective

What outcomes or problem areas are positively affected by the intervention? (Check all that apply)

- All outcomes the intervention is designed to target.
- Some of the outcomes the intervention is designed to target.
- DSM diagnosis for which the client is being treated.

Other (please specify)

Do you use the manualized version of this intervention?

- Yes: I follow the manual.
- No: I adapt this intervention.

Page 19

Appendix AA

Survey Page 20

Survey regarding the use of attachment-focused evidence-based

Circle of Security (COS)

What are the barriers, if any, that have interfered with your ability to use this intervention? (Check all that apply)

- [ ] I was unaware of the existence of this intervention.
- [ ] I did not have a need for a new intervention to help my clients.
- [ ] I do not believe that evidence-based interventions are effective.
- [ ] The intervention conflicts with my therapeutic approach/beliefs.
- [ ] My agency does not support the use of this intervention.
- [ ] Access to the training was too difficult.
- [ ] The length of the training was too long.
- [ ] The cost of the training was too expensive.
- [ ] The intervention is not effective enough.
- [ ] The intervention is too rigid to apply to "real world" clients.
- [ ] The intervention is too complicated.
- [ ] The application of the intervention is too expensive.
- [ ] All of the above

Other (please specify)

Appendix BB

Survey Page 21

Survey regarding the use of attachment-focused evidence-based

Final Questions

What percentage of your clients have attachment related problems?

- 0%
- 1-24%
- 25-49%
- 50-74%
- 75-99%
- 100%

How familiar are you with attachment theory?

- Not at all
- Minimally
- Somewhat
- Very
- Extremely

How favorable are you toward evidence-based treatments (EBT)?

- Not at all
- Minimally
- Somewhat
- Very
- Extremely

Appendix CC

Dunkin Donuts Gift Card Page

Use of attachment-focused evidence-based interventions in the clinical

Request for Dunkin Donuts Gift Card

Thank you for participating in the attachment-focused evidence-based interventions survey. As a means to thank you for your time and interest in taking the survey, I would like to send you a $5 Dunkin Donuts gift card. Please enter your name and mailing address below, so that I may mail you the gift card.

Once you have completed this page in full, you should receive the gift card within one to two weeks. Your personal information will be kept confidential and held securely until I have mailed the gift card to you. Once this has been done, your personal information will be permanently deleted. Your personal information will not be shared with anyone, and will solely be used for the purposes of mailing you the gift card. This information page is separate from the survey, and cannot be linked to it; thus your answers to the survey will remain completely anonymous.

Providing your personal information is completely voluntary, and you may choose not to do so, simply by exiting this page or selecting question #2 as your choice. However, I cannot mail you the gift card without this information, and thus such a decision will mean you are voluntarily choosing not to receive the gift card.

Once again, thank you for taking the time to participate in the survey.

Sincerely,

Jean Faucher, Smith College School for Social Work MSW student

1. NAME AND MAILING ADDRESS

Name:

Address:

City or Town:

State:

Zip Code:

2. I prefer not to provide my personal information.

◯ I willingly opt out of my opportunity to request a $5 Dunkin Donuts gift card. I understand that choosing this option will exit me from this page, and I will not be able to change my decision once I choose this option.

Page 1

Appendix DD

Thank You Page for Gift Card Recipients

USE OF ATTACHMENT-FOCUSED EVIDENCE-BASED INTERVENTIONS

THANK YOU

THANK YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS SURVEY.

YOUR $5 DUNKIN DONUTS GIFT CARD WILL BE MAILED TO YOU WITHIN THE NEXT FEW DAYS. YOU SHOULD RECEIVE IT WITHIN ONE OR TWO WEEKS.

PLEASE CONSIDER FORWARDING THE FOLLOWING RECRUITMENT MESSAGE TO ANYONE, OR POSTING IT ON SOCIAL MEDIA, WEBSITES, LISTSERVS, RSS FEEDS, ETC.:

Clinical Social Work Research Survey

Dear Mental Health Professional,

I am conducting a study to explore the application of attachment-focused, evidence-based programs in the clinical setting. Your participation will potentially help bridge the gap between the research and clinical settings regarding these kinds of interventions. The data collected in this study will be used for my Masters of Social Work Thesis and presentation, and possibly for publication. Participation will require approximately 5-10 minutes of your time to complete a brief demographic questionnaire and multiple-choice anonymous survey. You will receive a $5 Dunkin Donuts gift card as a means to thank you for your time and effort.

To participate in this study, you must be a clinical mental health professional licensed to practice in the United States, with a corresponding Masters level of education or higher. You must also provide psychotherapeutic services to children five years of age or under and their caregivers.

The link to the study is: https://www.surveymonkey.com/s/8WM7STY
If you have any questions for me about the study, I can be reached at jfaucher@smith.edu

Page 1

Appendix EE

Thank You Page for Those Declining Gift Card

USE OF ATTACHMENT-FOCUSED EVIDENCE-BASED INTERVENTIONS

THANK YOU

THANK YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS SURVEY.

PLEASE CONSIDER FORWARDING THE FOLLOWING RECRUITMENT MESSAGE TO ANYONE, OR POSTING IT ON SOCIAL MEDIA, WEBSITES, LISTSERVS, RSS FEEDS, ETC.:

Clinical Social Work Research Survey

Dear Mental Health Professional,

I am conducting a study to explore the application of attachment-focused, evidence-based programs in the clinical setting. Your participation will potentially help bridge the gap between the research and clinical settings regarding these kinds of interventions. The data collected in this study will be used for my Masters of Social Work Thesis and presentation, and possibly for publication. Participation will require approximately 5-10 minutes of your time to complete a brief demographic questionnaire and multiple-choice anonymous survey. You will receive a $5 Dunkin Donuts gift card as a means to thank you for your time and effort.

To participate in this study, you must be a clinical mental health professional licensed to practice in the United States, with a corresponding Masters level of education or higher. You must also provide psychotherapeutic services to children five years of age or under and their caregivers.

The link to the study is: https://www.surveymonkey.com/s/8WM7STY
If you have any questions for me about the study, I can be reached at jfaucher@smith.edu

Sincerely,

Jean Faucher, Smith College School for Social Work MSW student

Page 1

Appendix FF

HSR Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

April 22, 2014

Jean Faucher

Dear Jean,

You have made all the requested changes and clarifications to your HSR application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor