Clinical Social Work Journal (2019) 47:343–352
https://doi.org/10.1007/s10615-019-00701-7

ORIGINAL PAPER

# An Attachment-Informed Approach to Trauma-Focused Cognitive Behavioral Therapy

**Kristin E. Pleines**[1]

Published online: 13 March 2019


## Abstract

Trauma-focused cognitive behavioral therapy (TF-CBT) is a widely utilized evidence-based practice for treating children exhibiting symptoms of trauma. The model is theoretically grounded in principles of cognitive behavioral therapy (CBT) and incorporates a safe caregiver throughout treatment. TF-CBT's use of a safe parental figure is supported by attachment theory, but the model does not fully address the complex needs of the families frequently served by social service organizations. Through the lens of attachment, the TF-CBT model holds more potential by directly supporting the parent/child bond and enhancing a caregiver's role as a secure base. As the field of neuroscience advances rapidly, new research supports attachment based interventions, and thus, also supports the importance of enhancing the parent child bond in trauma treatment. The purpose of this paper is to highlight ways that attachment theory, if made more explicit in training and education programs, could enhance clinicians' understanding and involvement of the caregiver in TF-CBT, thus making the model more applicable to families who have experienced complex, intergenerational trauma. An overview of literature related to attachment and trauma and the efficacy of TF-CBT will be provided, as well as a case illustration integrating TF-CBT and attachment principles with a highly complex family.

**Keywords** Attachment · trauma-focused cognitive behavior therapy · Trauma · Complex trauma · Child therapy · Intergenerational trauma

Trauma-focused cognitive behavioral therapy (TF-CBT) has been a widely utilized and evidence-supported method of treating children impacted by trauma for well over a decade (Cohen et al. 2012). The model is built around the concept of gradual exposure to trauma triggers and is often successful in reducing alarming behaviors associated with post-traumatic stress disorder (PTSD) in school-age children. This short-term model incorporates conjoint parent–child sessions with greater frequency as treatment progresses. While the model was developed initially to treat children who had experienced sexual abuse (Cohen et al. 2012), over the last two decades it has been modified for many different populations and types of trauma, including children exposed to natural disasters such as Hurricane Katrina (Jaycox et al. 2010), youth in foster care (Dorsey et al. 2014; Weiner et al. 2009), and children with an incarcerated parent (Morgan-Mullane 2017). These adaptations vary widely. For example, Dorsey et al. (2014), comparing the use of traditional TF-CBT with TF-CBT with additional engagement strategies to support foster parents, found that the families who received an additional engagement intervention (consisting of a phone call assessing barriers along with a follow-up on this call during the first session) were more likely to stay in treatment longer than four sessions.

Attachment theory, with its focus on understanding the attachment style of individuals and providing opportunities for change in attachment over time with corrective relationships, is relevant to clinical practice with traumatized children and their parents. TF-CBT's involvement of a safe parental figure is grounded in attachment theory, which is based on the work of John Bowlby and focuses on the importance of the caregiver in a child's development (Bowlby 1969). TF-CBT may not fully address the complex needs of families frequently served by social service organizations, who have often experienced both complex trauma and intergenerational trauma; these families may benefit from

✉ Kristin E. Pleines
KP1984@nyu.edu

[1] New York University, 1694 2nd Ave., Apt 5s, 10128 New York, NY, USA

more intensive parenting support, which will be described in greater detail below.

Complex trauma is often interpersonal, and includes long-term, chronic exposure to traumatic experiences (van der Kolk 2005). Herman (1992) posits that complex PTSD must take into account a more complicated symptom presentation than traditional PTSD, notably characterological changes such as difficulty in relating to others and vulnerability to future harm. Intergenerational trauma, a phenomenon initially studied in the offspring of Holocaust survivors, refers to the transmission of PTSD from one generation to the next (Barocas and Barocas 1973). Intergenerational trauma has also been studied in Indigenous populations and takes into account how collective or cultural trauma has socioeconomic repercussions, as well as impacts on parenting; also essential to this concept is the idea of telling and retelling traumatic stories (Bombay et al. 2009). Both complex trauma and intergenerational trauma are important concepts for clinicians implementing TF-CBT, as they more accurately capture the experience of many of the families served by social workers.

While TF-CBT is indicated for use with children and a nonoffending caregiver, this is often more complicated in practice. For example, a mother and child residing in a domestic violence shelter might seek TF-CBT after leaving an abuser. In such a scenario, the mother is the nonoffending parent, but her own trauma may have impacted her emotional availability to her children and her ability to be a secure base. Felitti et al. (1998) identified that four or more adverse childhood experiences (ACEs) are linked to poor outcomes later in life. ACEs include various traumas that may occur until age 18, including physical, psychological, or sexual abuse, and exposure to substance use or domestic violence. Facilitating TF-CBT may become more challenging when a parent has a high ACEs score. Murphy et al. (2015) found that parents with higher ACEs scores were more likely to have unresolved trauma, as measured by the adult attachment interview (AAI). Van der Kolk and Fisler (1994) discuss the impact of trauma on attachment and emotional regulation, noting that creating safe attachments mitigates the somatic fear response. Enhancing safe attachment is a critical component of TF-CBT, and an attachment perspective is useful for clinicians who may feel ill-equipped to engage a parent with his or her own significant trauma history.

The purpose of this paper is to identify specific ways that attachment theory can enhance the clinician's understanding and involvement of the caregiver in TF-CBT. For example, attachment theory concepts can be applied to the pacing of parent–child conjoint sessions to make them more productive. At the time of this writing, no literature applying attachment concepts to TF-CBT could be found. This paper will begin with an overview of literature related to attachment and trauma, followed by a brief discussion of literature supporting the efficacy of TF-CBT. I will draw on a case example in which TF-CBT was applied and attachment principles were integrated, and then summarize the ways this approach added depth to the model. Finally, recommendations for future discussion and research will be offered.

## Attachment

Before discussing TF-CBT, it is essential to review the history and theoretical foundations of attachment theory, as well as current research. This section weaves together the important work of early attachment theorists as well as current leaders in the field, providing an overview of the classic Strange Situation experiment (Ainsworth et al. 1978) and the subsequent development of attachment categories for infants and toddlers, followed by a discussion of the link between attachment and healthy development. Finally, additional recent research, particularly regarding the AAI, and relevant developments in neuropsychology will be discussed.

### Attachment Theory and Categorization

Attachment theory provides a valuable framework for clinicians to understand human development and the impact of healthy connection with others. Attachment relationships begin at birth and continue throughout the lifespan. Bowlby (1969) believed that infants are equipped with complex behavioral systems, some of which provide the foundation for the later development of attachment. From birth, humans exist in relation to one another; a child relies on a safe caregiver to survive. Similarly, Ainsworth and Bell (1970) opine: "The long, helpless infancy of the human species occasions grave risks" (p. 51). Early studies on infant development demonstrated the devastating impact when infants are deprived of nurturing. Spitz (1949) compared the development of infants raised by their mothers with infants raised by a nurse responsible for eight to 12 infants. The infants in the latter group never learned to talk, speak, or feed themselves, and many died. Further, an infant's earliest relationships create his or her internal working models (IWMs) of attachment and relationships, which impact a child long after he or she has reached adulthood (Bowlby 1969).

A discussion of attachment literature would be incomplete without describing Ainsworth's Strange Situation (Ainsworth et al. 1978). In this groundbreaking study, Ainsworth et al. (1978) observed infants during separation and reunion from their mothers, and also in the presence of a stranger. This study led to the categories commonly understood and utilized by mental health professionals today. Categorization of attachment patterns was further enhanced by Main and Solomon (1986) upon development of the insecure

disorganized attachment category. Disorganized infants exhibit high-intensity disoriented or disorganized behavior in the presence of the parent during the Strange Situation, and may freeze, move away from the parent in the presence of the stranger, and/or cry out for the parent but resist them upon reunion, thus presenting as conflicted (Main and Hesse 1990).

The conflicted pattern of behavior in disorganized attachment is best explained by the paradox created when a parent is the source of comfort as well as alarm (Main and Hesse 1990). A mother with her own unresolved trauma or loss may demonstrate frightened and frightening behavior, an experience which creates conflict and confusion. Schore (2009) describes the impact of this frightened/frightening behavior, showing how this behavior sparks negative affective arousal in the child. Disorganized attachment is of particular importance to clinicians implementing TF-CBT, as these early patterns will present themselves during conjoint sessions.

### The Adult Attachment Interview: Linking Past and Present

Main et al. (1985) sought to explore how children develop their working models of relationships through the use of the AAI, which provides insight about how one's early (IWMs) of attachment figures impact adult relationships. Clients are asked a series of questions related to childhood and attachment figures, such as "Why do you think your parents behaved as they did when you were a child?" and "When you were upset as a child, what would you do?" and responses are scored based on their coherence (George et al. 1985). With treatment, unresolved trauma and loss may be healed and secure attachment to a loved one may be developed in adulthood, reflected by more cohesive narratives. In another study conducted by Main et al. (1985), families who had participated in the Strange Situation when their children were infants met with researchers again when the children were 6 years old. At the same time, the AAI was used with parents. Parents' IWMs of attachment, as determined by the AAI, were compared to their child's early attachment. For both mothers and fathers, Main et al. (1985) found that security in the parent's mental representation of the self in relation to attachment was significantly linked with the security of the child's attachment 5 years prior, highlighting the connection between adult attachment and a child's future attachment security. Steele and Steele (2008) point out that this creates an important shift for attachment research, as the AAI is of great interest to clinicians treating not just infants, but to those treating adults as well.

Advances in neuropsychology, particularly related to how healthy attachment impacts the brain, are now generating evidence to explain how attachment provides security on a physiological level. Tucker and Smith-Adcock (2017) stress that attachment and love are necessary components of healthy right brain development, emphasizing that attachment is critical for emotion regulation and overall well-being. Thus, advancements in neuroscience are relevant to attachment, as early experiences, healthy brain development, and response to stress are intertwined. Esposito and Gunnar (2014) describe the developmental cascade that may result from early deprivation, outlining various physiological and neurological consequences of attachment trauma. McClelland et al. (2011) describe the long-term repercussions of enhanced care versus chronic stress early in life, citing the ways in which science has begun to identify the epigenetic mechanisms that link these early experiences to learning and memory, as well as resilience to stress. In addition, Schore and Schore (2008) explore the neurobiology behind attachment and describe the complex processes that occur when one's early relationships are encoded in the right side of the brain. They also offer an overview of the nonverbal "right brain to right brain" communication that occurs between patient and therapist. McEwen et al. (2015) also explored brain development and neural functioning, noting that this development contributes to how one responds to challenges and stress. Individuals may respond in an efficient or dysregulated way to stress, which is related to the development of self-esteem, locus of control, and good self-regulatory behavior. A recent study of 85 young adults by Dagan et al. (2017) utilized childhood trauma histories, the AAI, and DNA from cheek swabs to measure telomere length (an indicator of cellular aging). They found an association between reduced telomere length and childhood adversity for young adults classified as insecure dismissing, but no association for adults classified as secure autonomous or insecure preoccupied (Dagan et al. 2017). Their work highlights the possible long-term health benefits of helping children and parents establish secure attachment, as well as the importance of attachment-informed interventions for practitioners. This growing body of research and ever-developing understanding of epigenetics support the use of attachment-informed interventions and provide a clear scientific rationale for applying attachment principles to TF-CBT.

## Trauma-Focused Cognitive Behavioral Therapy

TF-CBT is a short-term, evidence-based model created to serve children and families impacted by violence and trauma. This manualized approach incorporates traditional CBT skills in a developmentally appropriate, trauma-informed way, and includes the following modules: psychoeducation and parenting, relaxation, affect modulation, cognitive coping, trauma narrative development and processing,

in-vivo exposure, conjoint sessions with parent and child, and enhancing safety and future development (Cohen et al. 2012). Cohen et al. (2012) state that the model is generally delivered in 8 or 16 weeks, which includes weekly child therapy sessions as well as weekly parent sessions. As the treatment progresses, conjoint parent–child sessions are included with greater frequency.

There has been extensive research published on TF-CBT. In their systematic review of TF-CBT, Cary and McMillen (2012) identified three randomized controlled trials (RCTs) of manualized TF-CBT, as well as several studies that included versions of TF-CBT that shared four out of five core components, or all five core components. For inclusion, studies needed to have a PTSD measure, but the number of symptoms varied across studies. While they did not have enough data for meta-analysis and were unable to examine the impact of specific TF-CBT components, Cary and McMillen (2012) demonstrated that the pooled outcomes indicate that TF-CBT effectively helps youth experiencing symptoms of PTSD in the short term as well as at a 12-month follow-up. The results also suggested that TF-CBT is more effective than attention control, standard community care, and waitlist control conditions at reducing symptoms of depression as well as problem behaviors immediately after treatment.

While the outcomes outlined above are promising, there is a critical gap in research, particularly regarding complex trauma. Recommendations have been made for modifying TF-CBT for complex trauma (Ford and Cloitre 2009; Cohen et al. 2012; Kliethermes and Wamser 2012), but there has been limited research on outcomes for children with complex trauma who engage in TF-CBT. In a study examining the development of a complex post-traumatic stress disorder (CPSTD) diagnosis, Sachser et al. (2017) found that youth with both PTSD and CPTSD responded equally to TF-CBT, but those with CPTSD had more clinical symptoms at the end of treatment. Jensen et al. (2014) examined the use of TF-CBT in a clinic setting in Norway, citing the importance of conducting RCTs in community or clinic settings where children are more likely to experience multiple traumas. While the results were also promising, there is a need for RCTs specific to families who have experienced complex trauma.

Insight about the link between complex trauma and attachment is essential for social work practitioners. This connection is described by Cook et al. who note that children may have insufficient internal resources for managing stress and collaborating with others when their relationship with their primary caregiver has been impacted by the caregiver's own chronic stress and trauma (Cook et al. 2005). The importance of the parent's support during TF-CBT is highlighted by Yasinski et al. (2016), who found that positive parental behavior during trauma narrative sessions were linked to better child outcomes. Meanwhile, less adaptive behaviors such as avoidance and blaming of the child were linked to poor maintenance of therapy gains (Yasinski et al. 2016). Thus, successfully including a caregiver in treatment is critical to a child's long-term outcomes.

In sum, these bodies of research explicate that the following factors are critical for enhancing positive attachment, which the author argues is needed to effectively use TF-CBT with children who have experienced complex trauma: (1) relationship with a caregiver who has a secure attachment style, or who is actively in counseling with a clinician who can provide support in parenting with a secure attachment style; (2) ability to tolerate frustration; (3) parental reflective functioning, or mentalization; and (4) understanding and ability to notice affect regulation needs in themselves and in their children. In the following case example, the author shares her experience of working with a parent, Alicia, to develop these attachment-based skills. This case example demonstrates how a clinician can ultimately help a child through a secure attachment to both the parent and the child, as well as by supporting the parent's increasing ability to be a secure base over the course of TF-CBT.

## Case Example

In the following example, an overview of clinical work with a young family who had resided in the shelter system will be provided in order to illustrate the need for a new clinical approach when working with families that have experienced complex trauma. All identifying information in this vignette has been altered to protect the family's confidentiality. Following this case example, attachment concepts will be summarized to highlight how an attachment lens enhances a valuable and worthwhile evidence-based model of therapy.

### Presenting Problem

Nathan was an 8-years-old African American male child residing in an urban shelter system with his mother Alicia and younger brother, Sam. Nathan and Sam's father had been physically, financially, verbally, and sexually abusive towards Alicia, and the violence had resulted in several hospitalizations and emergency room visits, with both children in tow. Alicia sought therapy for Nathan after she had been called to pick him up several times from school due to impulsive, aggressive, and sometimes dangerous behavior. At times, teachers reported that he was throwing furniture and occasionally attempting to flee school grounds. On numerous occasions upon pickup he could be heard running and screaming down the hallways. In addition to several suspensions, Nathan also struggled academically. He hid his homework, threw it away, or left it at school, but was not

receiving any additional support and had not been assessed for an individualized education plan.

After several gentle recommendations from school staff that Nathan meet with a therapist, Alicia begrudgingly agreed to give it a try, and Nathan was referred for play therapy. In my role as a child therapist, I began play therapy with Nathan and supportive work with Alicia each week. Additionally, he was enrolled in a therapeutic after school program, where he participated in support groups run by my clinical team. Nathan had never been given a diagnosis related to his mental health or learning, and he initially presented as much younger than eight. He ignored adult direction and generally experienced difficulty sitting still. His frustration tolerance was extremely low, and he often broke toys or slammed furniture when presented with a limit, even a familiar one. Occasionally, he hit himself or tried to punch walls. Further, his attention span was limited, which prevented him from completing homework or finishing games. He was also hypervigilant. The complexity of Nathan's symptoms following long-term exposure to violence, his difficulty building relationships with children or adults, and explosive, occasionally self-harming behavior suggested complex PTSD (Herman 1992).

## Initial Assessment of Parent and Child

It was apparent that Alicia wanted to help Nathan, but she herself had limited frustration tolerance, and she admitted that she had a difficult time imagining how Nathan was feeling, which I interpreted as low reflective functioning due to her own trauma history. Parental reflective functioning, or mentalization, is essential for secure attachment, as it involves the parents' ability to tune into the feelings of a child (Fonagy and Target 1997). After approximately 2 months of little progress, I began using TF-CBT, as I hypothesized that the structure and predictability of this model might be a good fit for both Nathan and his mother. For assessment, I used the Child PTSD Symptom Scale (Foa et al. 2001), which I conducted with both parent and child, and the trauma history screen (Carlson et al. 2011), another tool with a child and caregiver version. Nathan's scores were very high via self-report as well as caregiver report, supporting my earlier suspicion of a PTSD or complex PTSD diagnosis. The long-term exposure to domestic violence and chronic homelessness suggested it was possible that Alicia was also experiencing complex trauma. The assessments supported my decision to use TF-CBT.

## TF-CBT Treatment

The most difficult part of implementing TF-CBT with this family was helping Alicia understand that Nathan's behaviors and lack of emotional regulation were not personal attacks on her. Specifically, it was essential to enhance Alicia's capacity for reflective functioning, which developed gradually over the course of treatment. I gently helped Alicia imagine how she might feel in Nathan's shoes, all the while validating her efforts, as well as her feelings of frustration and helplessness. Role reversal also frequently emerged, as is typical in many families where complex trauma is present, and I worked to help Nathan and Alicia learn their roles in the child/parent relationship. Psychoeducation modules allow for a useful structure to teach these important aspects of recovery from complex trauma. The model suggests at least six sessions, with frequent revisiting of previous sessions.

For illustrative purposes I will share an example of what this looked like in practice. On many occasions, Alicia stopped by my office unannounced to share what Nathan had "done to her" (i.e., punching someone at school and needing to be picked up during the work day). On one occasion, Nathan had been hit in the head with a rubber ball at the park. When the ball bounced off him, he had lunged at the child closest to him. With support in session, he was able to understand his response to this threat, and to articulate his experience. However, helping Alicia to understand this behavior as a symptom of Nathan's trauma was much more difficult. At this point in treatment, I chose not to include Alicia in the discussion of what had happened at the park, because the idea of including her caused Nathan to panic. As suggested above, when attachment is disorganized, a parent is a source of security as well as a source of danger. Further, based on my observations, it appeared that Alicia's attachment style was disorganized and unresolved, which resulted in impulsive, shaming responses to Nathan (i.e., "What's wrong with you?"). Even halfway through treatment, Nathan panicked at the thought of Alicia being updated when he had a hard time getting along with peers or completing his homework, as she often responded with anger and accusations that Nathan was picking on her. Because of Alicia's high level of need, I often completed more than one parent session with her each week, and we spent a significant amount of time preparing for each conjoint session. As Alicia began to develop a secure, trusting relationship in therapy, she was able to utilize the supportive phrases and interventions I modeled with Nathan. The goal of the practice in these situations is to lend support to the parent, the child, and the dyad so they can function without the therapist.

I attended school meetings with Alicia and helped her through the process of having Nathan evaluated for special education services. Alicia herself had been a special education student and struggled to navigate the school system. She also felt self-conscious in these meetings and found herself yelling at school personnel out of frustration and insecurity. As I became a source of secure attachment for Alicia, I was able to model ways to "fake it till you make

it" in uncomfortable situations and then process them with her afterwards. In one particularly stressful school meeting, Alicia reached out to squeeze my hand under the table, a previously agreed-upon sign that she was beginning to lose control of her anger and needed support. This physical sign of support also indicated that my presence helped Alicia regulate her own emotional response, which helped her later to do the same with her children. This was also a turning point for Alicia, as she started to gain confidence that she could tolerate frustration, even in stressful settings.

Over time, I learned more and more about Alicia's own trauma history, including a physically abusive mother who died of cancer when Alicia was a child and a father who had not wanted a relationship with her prior to dying of AIDS. She was raised by a grandmother who also had custody of several older cousins, some of whom used drugs or were physically abusive towards Alicia. She described her grandmother as the only positive role model she had had and was devastated by her recent passing. Alicia had been married twice, and described both marriages as unhealthy, sharing painful memories of violence in both relationships. Healthy relationships in adulthood are an opportunity for healing attachment wounds (Steele and Steele 2008), but the majority of Alicia's relationships had been sources of additional trauma, with the exception of the relationship with her grandmother. Alicia and I discussed how the secure attachment with her grandmother gave her resilience and spoke often of the important role she had played in Alicia's life. We discussed the safety she felt with her grandmother, and what it might mean to create that safety and security for her own children.

### Individual Sessions

In my sessions with Nathan, the progress was slow. His attention span required quite a bit of creativity in planning the sessions in such a way that he could master the skills needed. At times, sessions were shortened so that they could end on a positive note before Nathan impulsively ran out of the office. True to the model, I revisited parenting strategies during each individual session with Alicia. Rewards systems were implemented at home, at school, and in Nathan's after school program, and occasionally Nathan was tasked with teaching his peers skills he had learned individually during support group. He took great pride in teaching his peers a relaxation technique called Spaghetti Limbs learned during the relaxation component. By reinforcing positive behaviors, empowering him, and helping him become a leader among his peers, I was slowly able to make my way through the various modules.

### Conjoint Sessions

The most meaningful moments in Nathan's treatment occurred during the conjoint sessions. As Alicia became more equipped to respond to Nathan appropriately, there were brief moments when he reached out to her for comfort and she was able to provide it, an indication that their relationship was shifting and the attachment might be shifting away from disorganized. Over the course of several months, the intensity of Nathan's negative behaviors declined. He learned ways to soothe himself and enjoyed working on his trauma narrative, eventually sharing it with his mother. His nightmares stopped, he was able to complete his homework nearly every day, and his aggression towards peers declined significantly.

### Modifications

While I did have to lengthen my work with Nathan and Alicia, we were able to complete the entire model successfully in 35 weeks. It is also important to note that when considering the complex nature of Nathan's trauma as well as his mother's, I was fortunate to have multiple settings in which to implement the model, as I was also involved with his after school program and support group. This type of creativity and adaptability seems to be encouraged by the creators of TF-CBT, as they offer modifications for various settings (Cohen et al. 2012).

## Discussion of Attachment Principles

In the case example described above, I was able to successfully complete the TF-CBT model from start to finish, with some modifications related to time, frequency, and setting. Within that adaptation of the model, however, the application of attachment principles was essential. In traditional TF-CBT, the child is the identified client. However, I had three clients: the child, the parent, and the parent/child relationship. This allowed me to meet the needs of a highly traumatized parent and her child, both of whom presented with signs of disorganized attachment. Both parent and child had experienced complex trauma through exposure to domestic violence over the course of several years. They also experienced intergenerational trauma, as Alicia's family had experienced homelessness, drug use, poverty, child maltreatment, and domestic violence for several generations, and Alicia found herself resenting Nathan, as his childhood had been better than hers. In the sections below, I have identified specific recommendations for attachment-informed TF-CBT practice, which vary slightly from the original model.

### Assessment of Caregivers

Kliethermes and Wamser (2012) argue that it is the therapist's responsibility to assess caregivers and make sure they are capable of being appropriate and supportive during conjoint TF-CBT sessions. However, it seems little guidance is provided as to how to assess appropriate caregivers. Amatya and Barzman (2012) further expand on the significance of a "safe" caregiver, suggesting that if emotionally engaging with trauma during therapy helps clients resolve trauma, then a healthy relationship with a primary caregiver should create comfort and safety, thus facilitating the processing of trauma and decreasing related symptoms. They also point out the reverse: that engaging with trauma while in an emotionally unsafe attachment relationship may actually increase symptoms of PTSD.

While Alicia was Nathan's only "safe" caregiver, when viewed from an attachment perspective, I suspect that his trauma did occur in the context of an unhealthy attachment relationship due to Alicia's unresolved trauma. Improving Alicia's ability to respond to Nathan in a supportive, attuned way was essential for therapy to succeed. The criteria for "safe" caregivers would likely rule out a good portion of families served by social workers. Because this type of complicated trauma history is not unusual, it is essential to think about ways one might enhance the attachment bond through the course of treatment. For clinicians to identify whether a trauma has occurred in the context of an unhealthy attachment relationship, they must have the tools and education for properly understanding and assessing the child's caregiver. As noted above, during my initial assessment, I completed the THS and CPSS, but did *not* complete any measurements or assessments with Alicia. To better understand a dyad when beginning TF-CBT, it is helpful to think about the AAI (George et al. 1985).

In Alicia's case, an AAI framework offered insight about her unresolved trauma and disrupted attachments, which included various family members and occurred over the course of many years. It also highlighted a strength: the relationship with her grandmother, which demonstrated Alicia's capacity and desire for secure attachment. In addition to her adult trauma (domestic violence), there was significant trauma throughout her childhood as well. As described by Fraiberg et al. (1975), Alicia still had "ghosts in the nursery," and while she articulated a desire to be a better parent than she had ever had, in practice, this was often out of her control. It is helpful to reference Boulanger's (2007) work, as she distinguishes between childhood trauma, which is stored and processed much differently than adult trauma, as adult trauma involves coming to terms with the lingering state of helplessness and fear of death triggered by trauma. Childhood trauma, on the other hand, is often stored in dissociated "self states" (Boulanger 2007, p. 29). Alicia's own PTSD symptoms decreased as she participated in Nathan's treatment, which was focused on his childhood trauma and her *adult* trauma (domestic violence). Over time, we explored her childhood trauma as well, and I became a safe attachment figure to her. In the example described above, my presence in challenging school meetings helped her regulate her own emotional response.

### Relationship-Building with the Caregiver

Another facet of my work with Nathan and Alicia included suspicion of any social service providers. Alicia had been in "the system" for her entire life and had been diagnosed by various providers with many different serious diagnoses, none of which were ever explained to her. She had never fully engaged in mental health services, and it was important for me to carefully consider possible barriers that have been illuminated in research as I began working with her (Munson and Jaccard 2018; Munson et al. 2012). For example, I learned that Alicia's family had never trusted mental health professionals. Alicia attributed this to both cultural factors and family norms, noting that this was a common attitude among friends and family. She was fearful I might call child services or give her son a potentially harmful diagnosis or label, as had happened to her at various times in her childhood. Steele and Steele (2008) highlight how use of the AAI early in treatment can help frame the treatment early on and demonstrate to a hesitant client that current difficulties might be best understood as a response to early relationships, *not* as pathology.

### Pacing Conjoint Sessions with Reflective Functioning Growth

As discussed above, Alicia's capacity for reflective functioning emerged slowly; thus, clinicians' ability to assess for reflective functioning is essential, and clinicians must stay flexible based on parental progress. Reflective functioning is essential for sensitive caregiving (Slade 2005), as it allows one to imagine how another person might be feeling (Fonagy and Target 1997). This is quite a challenge for a parent whose own trauma is still so present. As Alicia began to have her own feelings and experiences heard, she had more emotional space for the experience of her children. Thus, later in treatment, statements such as "Wow, look how Nathan lights up when you give him a hug" or "He looks so sad. What do you think he's thinking about?" allowed for meaningful discussion of their relationship, Nathan's needs, and Alicia's own experience as a child. Staying "in tune" with parents, particularly their progress in developing reflective functioning, helps clinicians appropriately tailor the preparation for conjoint sessions.

### Assessing the Clinician–Parent Attachment

While my clinical eye had been on the interactions between Alicia and Nathan, I initially paid little attention to Alicia's response to me. Beebe and Lachmann (2002) application of infant/mother microanalysis to the clinical dyad might have provided me with a wealth of clinical information. They describe analyzing this dynamic with clients, highlighting the wealth of knowledge that can be gathered through understanding body language and nonverbal communication of both client and therapist. This nonverbal communication, combined with the information gleaned from the AAI, has the potential to quickly create a much clearer clinical picture of Alicia. In the context of my work with Alicia, this additional information about the complex processes occurring between patient and therapist further reinforces the importance of working with her and not just her child. In this regard, the work with the parent becomes just as important as the work with the child.

### Assessing the Parent–Child Relationship

As the relationship between therapist and parent strengthened, so did the relationship between parent and child. The clinician should be mindful of small shifts and enthusiastic about praising the parent's efforts. A turning point in treatment with Alicia and Nathan occurred after an incident in the after school program in which Nathan had gotten into trouble, which resulted in a phone call to Alicia. Historically, Nathan had been inconsolable, crying until he vomited, when he thought he would be punished, speaking to the "frightened/frightening" parenting behavior often present with disorganized attachment relationships. At this turning point, Nathan did not panic, freeze, or appear disorganized in any way when his mother was called and updated about his homework refusal that day. During after school pickup that evening, Alicia's response to Nathan was completely appropriate: a loss of "screen time" until homework was completed. This interaction demonstrated a shift in the direction of attachment security, and in our next parent session, I praised Alicia and explored the significance of this shift with her.

## Conclusion

Attachment theory and research has the potential to provide depth and knowledge for practitioners working with families impacted by trauma. While there are certainly valuable attachment-based interventions, TF-CBT is an evidence-based model of therapy easily accessible to many social workers. It seems a logical answer for social workers hoping to find a model to help their highest need, treating the most complex families. In a world that continually encourages social workers to utilize evidence-based models, many relational and psychodynamic therapists have struggled (Tosone 2013). By incorporating attachment-informed strategies and measures, TF-CBT will likely feel more accessible to psychodynamically oriented therapists and may even be able to help an even larger population of families. Much of what has been recommended in this paper is consistent with good social work practice; by applying attachment principles to TF-CBT, these social work principles become more integrated into a model used by other professions as well. It is also possible that by applying attachment principles to TF-CBT, the model might fit well into an integrated care model, such as the substance use and PTSD intervention studied by Amaro et al. (2007), which delivered promising results for improving PTSD symptoms and substance use in women.

This paper serves as a starting point, as there is a need for research in the area of TF-CBT and attachment. There is presently no empirical data to support the use of the interventions described above in TF-CBT, although Cohen et al. (2018) have recommended research on measuring outcomes of TF-CBT other than PTSD symptoms, such as attachment and parent–child relationships. There is also limited research on the use of TF-CBT for complex trauma. It should be noted that the feasibility and cost of training social workers in the AAI and other attachment measures must be considered and discussed in greater detail; perhaps the more time- and resource-intensive interventions are most appropriate for an identified subset of at-risk or high-need families. Such categories might be determined by trauma symptoms or ACEs.

It will also be useful to consider the use of attachment-informed interventions with caregivers other than a biological parent, given the large numbers of children placed in foster care or with extended family. While there is certainly a need for further discussion and research, this paper seeks to advocate for this important conversation about trauma, attachment, and treatment that has the potential to interrupt the intergenerational cycle of trauma. This advocacy is critical, as "service plus advocacy equals change" (Coltoff 2006, p. 99) and change is very much needed if the field of social work is going to effectively meet the needs of increasingly complex families.

## Compliance with Ethical Standards

**Conflict of interest** The author declares that she has no conflict of interest.

## References


Ainsworth, M. D., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment*. Hillsdale: Lawrence Erlbaum.

Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development*, *41*(1), 49–67.

Amaro, H., Dai, J., Arévalo, S., Acevedo, A., Matsumoto, A., Nieves, R., & Prado, G. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health, 84*(4), 508–522.

Amatya, P. L., & Barzman, D. H. (2012). The missing link between juvenile delinquency and pediatric posttraumatic stress disorder: An attachment theory lens. *ISRN Pediatrics*. https://doi.org/10.5402/2012/134541.

Barocas, H., & Barocas, C. (1973). Manifestations of concentration camp effects on the second generation. *American Journal of Psychiatry, 130*(7), 820–821. https://doi.org/10.1176/ajp.130.7.820.

Beebe, B., & Lachmann, F. (2002). Co-constructing inner and relational processes: Self-and interactive regulation in infant research and adult treatment (Chap. 6). In *Infant research and adult treatment: Co-constructing interactions*. Hillsdale: Analytic Press.

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma. *Journal de la santé autochtone, 5*, 6–47.

Boulanger, G. (2007). *Wounded by reality: Understanding and treating adult onset trauma*. New York: Routledge.

Bowlby, J. (1969). *Attachment and loss: Attachment*. New York: Basic Books, Inc.

Carlson, E. B., et al. (2011). Development and validation of a brief self-report measure of trauma exposure: The Trauma history screen. *Psychological Assessment, 23*, 463–477.

Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review, 34*, 748–757. https://doi.org/10.1016/j.childyouth.2012.01.003.

Cohen, J., Deblinger, E., & Mannarino, A. (2018). Trauma-focused cognitive behavioral therapy for children and families. *Psychotherapy Research, 28*(1), 47–57. https://doi.org/10.1080/10503307.2016.1208375.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma-focused CBT for children and adolescents: Treatment applications*. New York: Guilford Press.

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Practical strategies: Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect, 36*, 528–541. https://doi.org/10.1016/j.chiabu.2012.03.007.

Coltoff, P. (2006). *The challenge of change: Leadership strategies for not-for-profit executives and boards*. York: The Children's Aid Society.

Cook, A., Spinazzola, J., Blaustein, M., Ford, J., Lanktree, C., Cloitre, M. & … Van Der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398.

Dagan, O., Asok, A., Steele, H., Steele, M., & Bernard, K. (2017). Attachment security moderates the link between adverse childhood experiences and cellular aging. *Development and Psychopathology*. https://doi.org/10.1017/S0954579417001705.

Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann, E., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing trauma-focused cognitive behavioral therapy with evidence-based engagement strategies. *Child Abuse & Neglect, 38*(9), 1508–1520.

Esposito, E. A., & Gunnar, M. R. (2014). Early deprivation and developmental psychopathology. In *Handbook of developmental psychopathology* (pp. 371–388). Boston, MA: Springer.

Felitti, V., Anda, R., Williamson, D., Spitz, A., Edwards, V., Marks, J., & Koss, M. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8.

Foa, E. B., Treadwell, K., Johnson, K., & Feeny, N. (2001). Child PTSD symptom scale (CPSS): Validation of a measure for children with PTSD. *Journal of Clinical Child Psychology, 30*, 376–384.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 4*, 679–700.

Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy with children and adolescents. In C. Courtois & J. Ford (Eds.), *Treating complex traumatic stress disorders: Scientific foundations and therapeutic models* (pp. 59–81). New York, NY: Guilford Press.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child & Adolescent Psychiatry, 14*(3), 387–421.

George, C., Kaplan, N., & Main, M. (1985). *The Adult Attachment Interview*. Unpublished manuscript. University of California at Berkeley.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–391.

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., & … Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress, 23*(2), 223–231. https://doi.org/10.1002/jts.20518.

Jensen, T. K., Holt, T., Ormhaug, S. M., Egeland, K., Granly, L., Hoaas, L. C., … Wentzel-Larsen, T. (2014). A randomized effectiveness study comparing trauma-focused cognitive behavioral therapy with therapy as usual for youth. *Journal of Clinical Child & Adolescent Psychology*, *43*(3), 356–369.

Kliethermes, M. D., & Wamser, R. (2012). Adolescents with complex trauma. In J. A. Cohen, A. P. Mannarino & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 175–196). New York: Guilford Press.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti & E. M. Cummings (Eds.), *The John D. and Catherine T. MacArthur foundation series on mental health and development. Attachment in the preschool years: Theory, research, and intervention* (pp. 161–182). Chicago: University of Chicago Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of The Society for Research in Child Development*. https://doi.org/10.2307/3333827.

Main, M., & Solomon, J. (1986). Discovery of a new, insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. Yogman (Eds.), *Affective development in infancy* (pp. 95–124). Norwood: Ablex.

McClelland, S., Korosi, A., Cope, J., Ivy, A., & Baram, T. Z. (2011). Emerging roles of epigenetic mechanisms in the enduring effects of early-life stress and experience on learning and memory. *Neurobiology of Learning and Memory, 96*, 79–88. https://doi.org/10.1016/j.nlm.2011.02.008.

McEwen, B. S., Gray, J. D., & Nasca, C. (2015). Recognizing resilience: Learning from the effects of stress on the brain. *Neurobiology of Stress, 1*, 1–11.

Morgan-Mullane, A. (2017). Trauma focused cognitive behavioral therapy with children of incarcerated parents. *Clinical Social Work Journal*. https://doi.org/10.1007/s10615-017-0642-5.

Munson, M. R., & Jaccard, J. (2018). Mental health service use among adults: A communication framework for program development. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(1), 62–80.

Munson, M. R., Jaccard, J., Smalling, S. E., Kim, H., Werner, J. J., & Scott, L. D. Jr. (2012). Static, dynamic, integrated and contextualized: A framework for understanding mental health service use among young adults. *Social Science and Medicine, 75*(8), 1441–1449.

Murphy, A., Allman, B., Bonuck, K., Steele, H., Bate, J., Nikitiades, A., & Meissner, P. (2015). Group attachment-based intervention: Trauma-informed care for families with adverse childhood experiences. *Family and Community Health, 38*(3), 268–279. https://doi.org/10.1097/FCH.0000000000000074.

Sachser, C., Keller, F., & Goldbeck, L. (2017). Complex PTSD as proposed for ICD-11: Validation of a new disorder in children and adolescents and their response to trauma-focused cognitive behavioral therapy. *Journal of Child Psychology & Psychiatry, 58*(2), 160–168. https://doi.org/10.1111/jcpp.12640.

Schore, A. N. (2009). Relational trauma and the developing right brain. *Annals of The New York Academy of Sciences, 1159*, 189–203. https://doi.org/10.1111/j.1749-6632.2009.04474.x.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*(1), 9-20.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development, 7*(3), 269–281.

Spitz, R. (1949). The role of ecological factors in emotional development in infancy. *Child Development, 3*, 145. https://doi.org/10.2307/1125870.

Steele, H., & Steele, M. (2008). Ten clinical uses of the adult attachment interview. In H. Steele & M. Steele (Eds.), *Clinical applications of the adult attachment interview* (pp. 3–30). New York: Guilford Press.

Tosone, C. (2013). On being a relational practitioner in an evidence-based world. *Journal of Social Work Practice, 27*(3), 249–257.

Tucker, C., & Smith-Adcock, S. (2017). Theraplay: The evidence for trauma-focused treatment for children and families. In R. Steene (Ed.), *Emerging research in play therapy, child counseling, and consultation* (pp. 42–59). Hershey: IGI Global.

Van der Kolk, B., & Fisler, R. (1994). Childhood abuse and neglect and loss of self regulation. *Bulletin of the Menninger Clinic, 58*(2), 145.

Van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401.

Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review, 31*(11), 1199–1205.

Yasinski, C., Hayes, A. M., Ready, C. B., Cummings, J. A., Berman, I. S., McCauley, T., & … Deblinger, E. (2016). In-session caregiver behavior predicts symptom change in youth receiving trauma-focused cognitive behavioral therapy (TF-CBT). *Journal of Consulting and Clinical Psychology, 84*(12), 1066–1077. https://doi.org/10.1037/ccp0000147.



**Kristin E. Pleines** is a doctoral candidate and adjunct lecturer at the NYU Silver School of Social Work. Kristin works in private practice, and specializes in working with traumatized families. She also works with youth on the Autism spectrum and provides clinical supervision for an agency that serves this population.