Attachment and Developmentally Informed Work with Sexually Abusive Youth

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Introduction

- Even though attachment theory is a theory of child and human development, over the past few years it’s become increasingly common to link disturbed or under-developed early attachment relationships to the later development of pathology.
- Similarly, an attachment-informed perspective has recently and increasingly been introduced into work with both adult and juvenile sexual offenders, with an increasing assumption that disturbed or insecure attachments exist in sexual offenders, with an almost implicit supposition that the onset and maintenance of sexually abusive behavior is fueled by what we might call "attachment deficits."
- Indeed, many have noted and described attachment difficulties in adult and juvenile sexual offenders.
- These ideas suggest that children (and later, adolescents and adults) who have failed to form secure attachments will continue to have difficulties throughout their lives forming and experiencing meaningful relationships, and may fail to appreciably understand or respond appropriately to relationships.
- This may include the failure to develop or experience empathy in relationships, and the lack of true mutuality in relationships.

Attachment Difficulties and the Development of Antisocial, Criminal, and Sexually Abusive Behavior

- Ideas related to the development of early attachment are linked to causal pathways and factors that contribute to the development of antisocial behavior, and attachment needs are implicated as both a “static” risk factor and a “dynamic” risk factor.
- From this perspective, early suboptimal attachment experiences serve as a risk factor because they set the pace for and begin to define the developmental pathway along which dysfunctional and antisocial behavior later develops, in which criminal and sexual offenders become disconnected from the needs of other people or society as a whole.
- Failure to meet attachment needs in early childhood combines with, is amplified by, and itself influences other risk factors that later appear along the developmental path.
- In this formulation, developmentally emerging risk factors drive antisocial behaviors as the individual struggles to meet personal and interpersonal needs.
- When combined with other risk factors, early attachment experiences serve as both a static risk factor and also as a dynamic, but stable, risk factor when attachment difficulties and insecurities continue as the individual ages into adolescence and later adulthood.

An Attachment-Driven View of Sexually Abusive Youth

- Miner and colleagues point to the importance of peer relationships in adolescent healthy and well adjusted behavior, the possibility that juvenile sexual offenders expect adult and peer rejection, and the centrality of attachment difficulties in the development of sexually abusive behavior.
- Miner and Crimmins (1997) report that although juvenile sexual offenders do not differ significantly from non-sexual juvenile delinquents in either attitude or behavior, they are significantly more isolated from family and more socially isolated from peers than both juvenile non-sexual delinquents and non-delinquent youth.
- Miner and Romine (2004) found that juvenile sexual offenders who molest children have fewer friends, feel more isolated, associate with younger children, and have more concerns about masculinity than other juvenile sexual offenders or non-sexual juvenile offenders.
- Miner and Munns (2005) conclude that sexually abusive youth experience a deeper level of social isolation than non-sexual juvenile delinquents and non-offenders, and suggest that the inability to experience satisfaction in social relationships may turn some adolescents to younger children to meet sexual and social needs.
- Miner et al. (2010) hypothesize that juvenile sexual offenders:
  - Are insecurely attached to others.
  - Experience difficulty forming relationships.
  - Have fewer friends.
  - Feel more isolated.
  - Have more concerns about masculinity.
  - Feel socially inadequate.
  - Experience more social anxiety than other adolescents, including non-sexual juvenile offenders, although are not rejecting of social relationships even though not able to easily approach or build peer relationships.
- Miner conceptualizes these elements leading some juveniles, when catalyzed by still other factors, to sexually abusive relationships with children.
### Attachment-Mediated Developmental Pathways

- In an attachment-informed model addressing juvenile sexual abuse, we thus see a developmental pathway that involves: (a) social relatedness and security in social relationships, (b) social competence, (c) emotional dysregulation in the form of anxiety that has resulted from earlier developmental experiences, and (d) an **interest** and **need** to engage in social relationships, including sexual relationships, but deficits in the social and psychological means to do so.

- Important in the model is the element of early maltreatment and especially early or premature exposure to sexual ideation, including the possibility of the juvenile’s own sexual victimization.

- Daversa and Knight (2007) offer support for the elements of this developmental model, suggesting that adolescent sexual offenders struggle with the challenges of adolescent masculinity, are self-conscious about their physical appearance and appeal, and feel or are unable to compete with peers in the social world.

- They, too, conclude that adolescents who sexually abuse children experience social isolation and experience themselves as inadequate, are submissive, dependent, and socially isolated, experience feelings of sexual and social inadequacy, as well as anxiety and rejection.

- Barbaree, Marshall, and McCormick (1998) describe abusive and adverse early experiences in the developmental history of sexually abusive youth leading to deficits in critical social skills and social competence, or a “syndrome of social disability.”

- This includes a lack of secure attachments to adults or peers, low self-esteem, impaired abilities to develop intimate relationships and empathy, and varying degrees of antisocial behavior.

### The Attachment-Informed Perspective

- Attachment-informed work, then, emphasizes the connections and relationships between individuals and important early figures in their lives and how these early relationships set the pace for and influence the development of social interactions, relationships, and behaviors throughout life, including the development and maintenance of sexually abusive behavior.

- In sexual offense specific treatment, an attachment-informed perspective represents a significant shift away from both manual-driven (“manualized”) and strictly harm reduction or containment models of sex offender treatment.

- In an attachment-informed model, treatment does not simply involve the provision of psychoeducational instruction and cognitive-behavioral treatment, or the successful completion of treatment modules by sexual offenders.

- It is also, and perhaps more critically, reflective of the manner in which we think about and understand sexual offenders, the way we interact with and relate to them, and the way in which we come to conceptualize what sexual offenders need in treatment.

### Elements and Principles of An Attachment-Informed Model of Treatment

- From a treatment perspective, attachment-informed work means developing a view of individuals and their needs informed by attachment theory, which is **not** a theory of pathology.

- Attachment theory is instead a theory of childhood development in which the concept of attachment is a complex construct that significantly contributes to the way in which we come to experience the world in which we live and in which we engage in transactions and interactions with others.

- Attachment theory defines the processes by which we form mental representations of ourselves and of others, develop beliefs and expectations about social interactions and relationships, and build the basis for our social behaviors.

- However, although attachment theory contains and is built upon a set of principles, elements, and ideas, it is not a treatment model, and is not a technique nor a set of interventions or activities.

- Similarly, a model of treatment informed by and derived from attachment theory is neither a set of techniques nor comprised of a distinct set or sequence of interventions and activities.

- Instead, drawn from an understanding of the principles, elements, and ideas of attachment theory, models of treatment that are attachment-informed, or “attachment-friendly,” may flow, emerge, and develop.

- Attachment theory offers a means by which to understand the driving forces that shape human psychology, behavior, and social interactions, and thus the basis for how we see, understand, and view our clients.

- Above all, an attachment-informed model of treatment is about relationships and interactions.

- It is not about nor based upon technique or method.
Our Underlying View of Clients

Whether an attachment-informed model, or any other model of treatment, our view as clinicians influences our work in three broad interacting categories, each of which build upon each other:

1. The way we think about and understand our clients, and what they need in treatment.
2. Our ability to think about and plan our treatment interventions.
3. The way that we interact with and relate to the people we are seeking to help.

An Attachment-Informed Approach to Treatment

• Attachment theory offers a broad view of human functioning that can change the way clinicians think about and respond to their clients. An attachment perspective can add to the way that clinicians experience and listen to the stories of their clients and understand their behaviors.

• In its use as a framework for treatment, the application of attachment theory to forensic mental health brings with it a client centered and psychodynamic approach. In particular, an attachment perspective can help define the treatment relationship between clinician and client, as well as helping define the actual modes, techniques, and interventions of treatment.

• From this perspective, we recognize that behind human behavior lie emotional and cognitive schema embedded into a mental map which itself is neurologically configured and hard wired, activated by biologically established and instinctual drives (the internal working model).

• Attachment theory, then, offers a backdrop against which clinicians can understand how individuals construct and deconstruct their world, and thus act upon the world in ways shaped by the emotional and cognitive images they hold of that world and the people in it, and mental representations of themselves and how they should behave.

• However, understanding the nature and dynamics of attachment informs rather than defines clinical thinking.

• "In the same way that diagnosis serves as a guide (but not a recipe) in the treatment situation, notions of attachment organization provide a therapist with metaphors for thinking about early patterns of affect regulation and defense" (Slade, 1999).

An Attachment-Informed Approach to Treatment

• Rather than following a prescribed model of "attachment therapy," clinicians will use an attachment-informed framework against which treatment interventions are applied, with attachment as a target of treatment.

• For the therapist focusing on building attachment and a more secure mental map (internal working model), interactions and behaviors are understood through an attachment "lens."

• Not surprisingly, in attachment-driven clinical work it is not the techniques we use, but the client's experience of therapy and of us, the environment in which treatment takes place, and how we aid their learning and sense of connection that is most significant.

The Therapeutic Relationship and Therapeutic Focus

• As a relationally based, interactional, and largely psychodynamic model, the therapeutic relationship lies squarely in the foreground in attachment-informed therapy.

• Although cognitive-behavioral work is important in sex offender specific treatment, and will undoubtedly remain central to any treatment program, the therapist uses interactional techniques imparted through the therapeutic relationship.

• It is through this relationship, as well as other techniques and practices of treatment, that a treatment environment and alliance is established that can help re-build attachment and social relatedness.

• The emphasis in attachment-informed therapy is on the development of an understanding, supportive, and caring relationship, marked by attunement between the therapist and patient, or a working treatment alliance.

• In addition to the centrality of the therapeutic relationship, lie elements of positive psychology.

• Here, we recognize that people have strengths upon which they can build in making improvements in their lives and are motivated, not just to avoid recidivism (avoidance goals), but to seek and accomplish desired and valued outcomes (approach goals).

• Whereas avoidance goals have long been a central feature in the treatment of sexual offenders and involve avoiding a behavior, approach goals are more synchronous with achievement and improvement.
Attachment-Informed Treatment and the Acquisition of Social Competency

- In an attachment-informed model, the focus of treatment, then, is not solely upon risk reduction, but also on building the capacity of the sexually abusive youth to improve his or her life.
- In their description of the “Good Lives” model, aimed at the treatment of adult sexual offenders, Thakker, Ward, and Tidmarsh write, “We propose that the key theoretical perspective that guides treatment should be that of human well-being... rather than risk management, or relapse prevention” (2006, p. 324).
- The focus of treatment is thus rehabilitative, identifying obstacles to accomplishing "human goods" and the acquisition of the capacities and competencies required to achieve human goods in ways that are socially acceptable and personally satisfying.
- One aim in treatment, then, is to help clients achieve social success, and in so doing select as treatment targets the means by which the individual pursues and accomplishes this goal.

The Sequelae of Attachment: Seven Important Elements in an Attachment-Informed Treatment

- Early attachment experiences, developed in the first 5-18 months of life, build the under layer, or foundation, upon which future relationships, social interactions, social attitudes, and social behaviors are built, including these seven important elements of psychosocial capacity and functioning, each of which also represent targets for intervention in an attachment-informed model of treatment:
  1. The development and enrichment of metacognition.
  2. The development and unfolding of empathy.
  3. The roots and development of morality and moral reasoning.
  4. The development of the capacity for self-regulation.
  5. The experience and development of trust and confidence in others.
  6. The development of trust and confidence in self.
  7. The development of and capacity for a sense of social connectedness.

- These seven elements are intertwined with one another, and come together in an attachment-informed treatment environment.

Global Targets in Attachment-Informed Treatment with Sexually Abusive Youth

- The goal of teaching sexual offenders psychoeducational concepts, remains an important element in sex offender specific treatment.
- However, this work must be embedded into a larger and more complete treatment that also, and perhaps more significantly, addresses deficits in attachment, social relatedness, and social skills.
- Such deficits include a limited ability to form meaningful and satisfying relationships, experience empathy and concern for others, and engage in the behaviors, interactions, and relationships that are the backbone of appropriate social connection.
- These deficits further include a poorly developed capacity to recognize and understand one’s own mental state and the mental state of others (i.e., metacognition), an under-developed sense of moral decision making and behavior, inadequate self-regulation (the ability to recognize and manage one’s own emotional state), and diminished self-agency (internalized locus of control, or the capacity to recognize that attitudes, behaviors, and behavioral decisions are personally determined by each individual).

General Attachment-Informed Goals

Built on an attachment framework, the goals of treatment include developing in sexually abusive youth:
- A sense of experienced security from which to explore and grow.
- Confidence (security) in and connection to important figures who are accurately and consistently responsive, and thus trustworthy.
- A secure and coherent sense of self, including the experience of self-agency and self-efficacy.
- A balance in the use of affective and cognitive problem solving strategies.
- The use of cooperative and non-coercive strategies to get needs met in social interactions with others.
- The capacity to tolerate and regulate frustration and disappointment.
- The capacity for perspective taking and the unlocking of empathy for others.
- A higher level of moral understanding, reasoning, and decision making.
- The experience of connection and relatedness to other people.
The Keystone of Attachment-Informed Treatment: Relationships and Environment

- The treatment environment is the first line of treatment. This environment results from the interactions that occur between individuals involved in the treatment process, both clients and staff, and includes words, relationships, emotions, and behaviors.
- For treatment to be successful, such a climate must foster and support its goals and methods.
- Treatment thus occurs in a caring and supportive manner, through an attachment-friendly environment in which relationships are genuine, respectful, and supportive while at the same time being structured and challenging.
- The message that comes through is care, concern, understanding, and attunement.
- In this environment, individuals are experienced and treated as individuals, and not simply sexual offenders or troubled children who all share the same backgrounds and behaviors, and in which the needs of clients are based on an assessment and interpretation of their individual needs.

The Attachment-Informed Therapist

- An attachment-informed approach provides a means for clinicians to think about early patterns of emotional regulation and behavior, helping them to better understand the developmental and social experiences, expectations, interpretations, and behaviors of their clients.
- Attending to the manner in which attachment themes and organization are expressed changes how therapists observe their clients and make sense of their cases, recognizing that the ability of the client to work with his or her therapist is profoundly shaped by the client's level of attachment security.
- Further, a central task for the therapist is to become a source of security for the client, or a secure base (Bowlby, 1988), demanding "great sensitivity and empathy as the therapist adjusts to or feels his (or her) way into the patient's... attachment needs" (Brisch, 1999).
- Therapeutic empathy is central to the therapeutic relationship, and essential to the facilitative treatment environment through which individuals are able to recognize and modify their attitudes, behaviors, and self-concepts (Rogers, 1980).
- "Analogous to a mother who provides her child with a secure base from which to explore the world... the therapist strives to be reliable, attentive, and sympathetically responsive to his patient's explorations and, so far as he can, to see and feel the world through his patient's eyes, namely to be empathic" (Bowlby, 1980).

Empathy in the Attachment-Informed Treatment Environment

- Empathy dissolves alienation, allowing those who feel empathy for others like "part of the human race" (Rogers, 1980).
- It allows those who experience empathy to feel valued, cared for, and accepted.
- These are the very qualities that we wish to instill, develop, or unlock as we treat sexually abusive youth.
- They are also the same qualities that sexually abusive youth must experience from others in their environment, whether in their own homes, in the therapeutic relationship, or in residential care.
- We recognize that being the subject of empathy is the first step in the development of empathy.

Empathy in Treatment Builds Empathy in the Client

- Warner (1997) describes empathic understanding as crucial in therapy with clients whose ability to contain and process their own experiences has been weakened due to empathic failures in their early development.
- The therapist's empathy to be curative develops and strengthens the client's capacity to relate to others.
- In fact, it is generally believed that the capacity of treatment staff to recognize and empathically respond to distress in the client influences the development of empathy.
- The attachment experiences and elements we wish to develop in sexually abusive youth are dispositional in their interactions with others before they become dispositional in them.
- In teaching empathy, then, it is the therapist and treatment staff who must first demonstrate empathy, described by Fernandez and Serran (2002) as integral to the therapeutic relationship.
The Therapeutic Relationship

• The therapeutic relationship has many qualities of an attachment relationship.
• Parish and Eagle (2003) found that therapy clients admired and sought proximity to their therapists, found their therapists emotionally available, evoked mental representations of their therapists in the therapist's absence, and experienced their therapists as a secure base helping them to feel confident outside of therapy. Clients formed strong emotional connections towards their therapists and regarded them as unique and irreplaceable.
• An additional similarity between attachment-relationships and the therapeutic relationship is the asymmetrical nature of the relationship, in which the therapist is not likely to experience the same sort of bond as the client, nor have the same needs.
• Therapy works because it is an attachment relationship "capable of regulating neurophysiology and altering underlying neural structure" (Amini et al., 1996, p. 232).

Principles of Attachment-Informed Treatment

Through an attachment perspective, we recognize that in treatment:
• There is a need for empathic attunement to the client.
• The client must see his or her value in the minds of other people.
• The client must experience important others as capable and competent.
• Change requires giving up prior adaptive strategies.
• Change comes slowly.
• Healthy, or secure, attachment requires a secure base.
• The development of a secure base results from life experience.

The Attachment-Informed Therapist

• Is experienced by the client as a dependable, consistent, and responsive emotional support.
• Facilitates a therapeutic relationship in which the client can develop security in the therapeutic relationship, form a bond with the therapist, and freely engage in self expression.
• Encourages both self-dependency and help-seeking in the client.
• Provides a secure base through which the client can feel recognized and connected, and from which the client may engage in exploration, recognizing, expressing, and working through problems.
• Becomes attuned to the client's emotional and attachment-related states, aware of the need for emotional connection.
• Helps the client to recognize and explore attachment relationships and strategies for maintaining connections.
• Helps the client recognize that current relationships, experiences, ideas, and attitudes are related to and the result of prior experiences and on-going attachment relationships.
• Challenges and stretches the client, remaining in the immediate learning zone but creating opportunities for new learning.
• Creates and recognizes boundaries, and maintains an appropriate level of closeness fitting the needs and capacities, and the particular attachment style and needs, of each individual client.
• Remains aware of counter-transference issues, using these to better understand the client and the therapeutic alliance, guide treatment interventions, and maintain treatment boundaries.
• Maintains freedom of movement in the relationship, maintaining permeable boundaries, but able to move in and out of engagement with the client as needed.
• Helps the client develop the capacity to experience and tolerate difficulty, uncertainty, and doubt.
• Sensitively dissolves the therapeutic bond when appropriate, so that it will serve as a model for handling separations in life.
Attachment and Social Relatedness as Targets of Treatment

- In our treatment of sexually abusive youth, attachment experiences and related social relatedness and social competency should be targets for assessment and treatment.
- In terms of treatment, the focus is on rehabilitating the mental model that results from the accumulation of poor attachment experiences and their impact on a developing sense of self, others, and self-efficacy.
- It also includes developing the youth’s capacity to acquire and engage in meaningful and satisfying social interactions and relationships ("human goods").

An Attachment and Developmental Model as a Model of Practice

- An attachment and developmental framework must be informed by well-accepted theories and practices of sex offender specific treatment, ideas and principles of attachment theory, and a recognition of the shaping impact of childhood adverse experiences and trauma.
- However, despite its basis in sound underlying and evidence-based ideas, an attachment and developmental framework is not a treatment model.
- It is instead a foundational model upon which the work of treatment and rehabilitation can be built and proceed.

An Attachment and Developmental Model in Practice

An attachment and developmental framework does not define treatment theory and technique. It instead defines:
- How we understand and relate to our clients,
- How we approach the work,
- The environment in which the work is carried out, and
- The goals of a rehabilitative treatment model that underlies more specific goals, such as the treatment of sexually abusive behavior.

An Attachment and Developmental Model in Practice

An attachment and developmental model is built on ideas that recognize:
- The quality and nature of the social environment are central in childhood and adolescent development,
- Problematic child and adolescent social interaction and behavior is influenced and shaped by prior and current developmental experiences, and
- Treatment aimed at bringing about change in children and adolescents is interactive and must be provided in a manner that models and supports the desired change.

In Practice

- An attachment and developmental model recognizes the impact of the social environment on child and adolescent development.
- It is aimed at multiple goals that connect the child or adolescent to the larger social community, including attachment, competency in social skills, the resolution of trauma and other developmental injuries, and self-regulation.
- In operation, the model is aimed at changing behavior and relationships by rehabilitating ideas, attitudes, and beliefs about the world, and through the development of a stronger sense of self-confidence, confidence in others, and a confident sense of social belonging and relatedness.
- An attachment and developmental model recognizes and treat youths as “whole” children whose sexually troubled behaviors are one part of a much larger complex of emotional, cognitive, behavioral, and social problems, many of which are the outgrowth of earlier adverse childhood experiences, attachment difficulties, and insecure and troubled attachments to others.
An Attachment and Developmental Model Is Rehabilitative

- In an attachment and developmental model, sexual abuse specific treatment is embedded within a treatment program, treatment environment, and treatment approach that is rehabilitative, and incorporated into a larger developmentally-informed model.
- An attachment and developmental model reflects a philosophy of and approach to treatment and rehabilitation. In helping youths to create “new” selves, they are enabled to:
  - Form healthy and secure attachments to others,
  - Overcome childhood adversity and traumatic experiences,
  - Build social competency and social skills, and
  - Develop self-regulation and behavioral control.

The Targets of an Attachment and Developmental Model

- The development of a secure and confident sense of attachment to others and society in general.
- Social competence in terms of social skill development, social interactions, and interpersonal relationships.
- The ability to overcome and act independently of prior adverse or traumatic experiences that may be exerting strong control over thoughts, emotions, or behaviors.
- Effective emotional and behavioral self-regulation and management.
- A sense of self as socially and personally capable, competent, and pro-social in orientation and behavior.

Seven Core Elements in an Attachment and Developmental Model

1. The environment, people, and social situations in the environment must be experienced as physically and emotionally safe.
2. Children and adolescents must feel valued and cared for in their environment.
3. Caregivers must be capable of giving care, must be reliable and consistent, and must understand and value the individuals in their care.
4. Caregivers must be experienced by the individuals in their care as reliable and caring people, and a source of help and support.
5. Caregivers must demonstrate a therapeutic approach to relationships.
6. Caregivers must model desired behaviors.
7. Caregivers are “agents of change,” through whom children and adolescents are helped to change, develop pro-social skills and healthy relationships, and thrive in their development.

The Development of Essential Social Competencies

The basic and essential treatment goals of attachment and developmental model aim at the development of social skills critical to social competence, or the ability to successfully and effectively engage in social interactions and manage important social tasks.
- **Relationship building.** The development and maintenance of healthy, satisfying, and positive relationships with peers and adults.
- **Reflective awareness** (sometimes referred to as metacognition). The development of self-awareness and awareness of others, including the ability to recognize, reflect upon, and respond appropriately to the mental and emotional states, wants and needs, intentions and desires, and motivations and goals of self and others.
- **Self-regulation.** The development of several related aspects of self-regulation, including the ability to recognize, tolerate, and manage emotions and behavior; respond to and manage stress; remain attentive and focused; complete necessary tasks and accomplish desired goals; and demonstrate skills in executive functioning.
- **Decision-making.** The capacity to make choices, solve problems, and meet the needs of self and others effectively and in a socially and age appropriate manner.
- **Self-expression.** The ability to recognize and appropriately express personal thoughts, feelings, and beliefs, and engage in the process of meeting personal wants and needs in a socially appropriate manner.
- **Moral reasoning.** The capacity to recognize, value, and adhere to pro-social values and engage in morally mature behaviors.
- **Goal accomplishment.** The establishment and accomplishment of social, educational, occupational, and other personal goals.
The Facilitative Treatment Environment

- Through the warmth, concern, support, safety, and structure provided in the empathic and attuned treatment environment, sexually abusive youth are experienced as children with many complex needs, including the need to be recognized and understood by others.
- Perhaps more to the point, they must experience themselves as being seen and understood by others.
- Through this experience, they are enabled to see and explore themselves in a different light – in turn, they are able to see and experience other people in a different light.
- However, an attachment and developmental model recognizes the impact of the environment in contributing to, creating, and/or maintaining problems in psychosocial functioning.
- It also recognizes the role of the environment in treating and rehabilitating such problems.

The Treatment Environment

- Physically and emotionally safe, protective, and free from the risk of harm.
- Structured, predictable, and well-defined.
- Understanding, supportive, and respectful.
- Therapeutic, designed to care for and restore to health rather than simply control and manage behavior.
- Strength-based, recognizing and building upon strengths, providing opportunities for strength and skill development, and using praise and support to help children and adolescents identify with their strengths rather than deficits.
- Focused on using recognition and praise to support, teach, and reinforce strengths and assist clients in recognizing and building on their strengths.
- Relationship-based and attachment friendly, recognizing the importance and power of relationships and in which relationships are promoted and supported and opportunities provided for connection to others.

The Treatment Relationship

- Supportive, emotionally connected, and safe relationship that models the behaviors, attitudes, and social interactions that we wish to develop in our clients.
- Always therapeutic, designed and intended to care for and restore to health, and always focused on the needs of the client.
- Builds a collaborative and interactive alliance and partnership between the treatment provider and the client.
- The mirror and medium through which clients experience themselves as cared for, understood, worthwhile, and capable.
- Establishes a climate that allows for and supports change.
- Moves and develops at the pace and comfort level of the client.

Elements of Treatment Interventions

Interventions reflect the manner in which treatment is provided, the environment in which treatment is delivered, and the manner in which the behavior of children and adolescents is understood.

- The use of acknowledgment, praise, support, and other forms of reinforcement. These are used to recognize, foster, and reinforce strengths in children and adolescents.
- Consistency and structure. This ensures a safe, predictable, and consistent environment in which children and adolescents receive treatment and engage in relationships with treatment staff, peers, and others.
- Learning opportunities. These recognize the growth potential in children and adolescents, the need to both experiment with and experience success, and that repeated experiences of success lead to an increasing sense of confidence and competence, and build tolerance and acceptance for periodic failures.
- Practice opportunities. These provide the opportunity to practice new skills and reflect upon, evaluate, and discuss these with staff, peers, and others.
- Relationship building and attachment opportunities. These include the opportunity to build relationships and form connections to others, including staff, peers, family members, and other important people.
- Behavioral modeling. These include the demonstration and modeling of desired behaviors, attitudes, social interactions, and interpersonal relationships.
- Staff empathy and support. This includes the staff’s demonstration of understanding, empathy, and support for children and adolescents.
Building Blocks

Adaptation of the building blocks of the Attachment, Regulation, and Competency (ARC) Model. (Blaustein & Kinniburgh, 2010).

The Power of the Environment: The “Snowball Effect”

- Physical, emotional, and social environments that do not support, allow for, or provide opportunities for growth are not likely to help children and adolescents change.
- Treatment environments that are ineffective fail to understand the problems that reside beneath the surface, do not provide elements necessary for change. They may even fuel and amplify existing problems, in some cases making the problem bigger and more entrenched.
- Under these circumstances, problem attitudes, behaviors, and relationships may “snowball” and grow larger, becoming more fixed rather than moving towards change.
- Conversely, effective treatment environments recognize, understand, and provide the elements and relationships that support, promote, and provide opportunities for change, as well as understanding that change comes slowly.

ACORN: An Attachment and Developmental Model

- **Attachment.** The sense of social connection experienced by people in their relationships with others, their sense of confidence and security in those relationships, their sense of relating and belonging to a social group or society as a whole, and the emotional bonds people experience to other people or social institutions, such as a school, an organization, or their larger community.
- **Competencies.** Basic and essential social skills by which people recognize and manage their thoughts, feelings, and behaviors; make decisions and solve problems; establish and accomplish personal and social goals; successfully engage in social interactions and meet social expectations; learn from social situations and relationships (social learning), and build and maintain interpersonal relationships.
- **Overcoming Adversity and Trauma.** The ability to act independently of, and thus overcome, difficult earlier childhood experiences that have been disruptive, unsettling, frightening, neglectful, or abusive, and have negatively affected the manner in which individuals currently experience themselves, other people, and social experiences and events, as well as their current thoughts, emotions, and behaviors.
- **Regulation and Self-Control.** The capacity to self-regulate thoughts, feelings, and behaviors and maintain stability in social behaviors and relationships, effectively accomplish required or expected tasks, and act in a manner that supports personal growth rather than behavior that is harmful to self, others, or interpersonal relationships.
- **New Self.** The rehabilitation of (or positive change in) the sense of self in the individual, or an increase in self-esteem and sense of self-confidence, pro-social attitudes, and ability to engage successfully and positively with others.
Integrating Complex Treatment

“The use of a unified framework demands much of the psychotherapist, as multiple domains of knowledge need to be absorbed and organized. This requires more than technical skills alone; a deep understanding of complex systems and their domains in necessary” (Magnavita, 2006, p. 890).

Treating the Whole Child

• Unless we simply wish to treat the sexually abusive behavior apart from the totality of the youth engaging in those behaviors, or believe we can treat those behaviors in isolation from the youth’s other experiences of self and others, we must find ways to treat the whole child.
• This means recognizing the personal and social needs of each youth and the context of that youth’s life, within which the sexually abusive behavior developed and occurred.
• Most of all, we hope to change the trajectory along which the sexually abusive youth may be heading.

Treating the Whole Problem

• We can teach simplistic concepts and methods to our clients (which has represented a good part of the sex offender specific model until recently), but this is unlikely to engender the changes we seek or transmit ideas about social connection and relatedness.
• It is through a multi-dimensional and multi-theoretical approach that we are more likely to accomplish goals of social skill development, social competence, and social rehabilitation.
• The qualities that we wish to develop in sexually abusive youth, not only of behavioral restraint, appropriate social and sexual boundaries, and belongingness, but also empathy and concern for and the valuing of others, are exactly those qualities that juvenile sexual offenders must themselves experience from others in their environment, including those who provide treatment.
• Our clients are first children and adolescents with the need to feel good about themselves, cared about, and engaged in social relationships.
• The changes in sexual attitude and behavior we want come after these experiences.

Reconstructing Attachment

• Attachment interventions are more than just those interventions and techniques used solely by the individual therapist to build an attached relationship with and instill a sense of attachment in the client.
• Attachment is built through interventions and experiences that permeate the child’s environment and operate on an underlying biological model that resides in the neural substrata.
• Attachment building occurs in the environment and through the interactions between the clinician and the client.
• Attachment, in this respect, is a “felt” experience, imparted through mutual social interactions and the hidden dynamics and regulators present in such interactions.

Reconstructing Attachment

• As we consider the application of attachment theory to treatment, we must also recognize that attachment theory is not a technique.
• It is, instead, a tool that can help us to recognize how connections are made, how they are damaged, and how they took shape in each individual with whom we work.
• Whether in the forensic or the general mental health setting, an attachment-informed framework helps us to better see and understand our clients, and recognize how to re-form or re-activate a sense of being understood, and thus become more attached to others.
• In application at the clinical level, attachment theory is not only about the goals of social competence and connectedness that become the targets of treatment, but also and especially the relationships we form with our clients and the environments we create in which treatment occurs.
• Attachment theory can teach us how to build our treatment programs, so that behind technique lies connection.
References


