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Understanding Intergenerational Attachment Disorders: The Use of Filial Therapy and Child Parent Relationship Therapy When Treating Insecure Attachment Styles

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Researchers have thoroughly defined attachment. Currently understood, attachment is conceptualized as a bond created by the parent (primary caregiver) and the child. Bowlby (1969, 1973, 1979, 1980, 1982) and Ainsworth (1973, 1978, 1989) began the early researches and works in the study of attachment. According to Bowlby (1988), “Attachment theory is a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional detachment, to which unwilling separation and loss give rise” (p.5). Based upon Bowlby’s attachment theory, the focus on attachment rests upon two attachment

styles, secure and insecure, with insecure attachment styles encompassing various subtypes. An individual who possesses a secure attachment style often views their world as safe and/or protected; whereas an individual who possesses an insecure attachment style often views their world as unsafe and/or dangerous. These attachment styles, although distinct in nature, have been said to persist across generations.

Researchers have studied attachment patterns over the development of the lifespan.

“Studies show that there are correlations between the attachment representation of the parents, their observable behavior in caregiving and the interaction between their infants and the later development of attachment quality in their children” (Grossmann, Grossmann, & Zimmermann, 1999. p.760-786). According to Snow et al (submitted), a summary of attachment theory indicates:

The parent-child relationship is influenced by the parent’s representational model. Through the interaction of parent-child, the child develops an internal working model (IWM) based on the representational model of the parent. The IWM contributes to the development of a sense of self and self and others. It is from this sense of self and self and others the child develops patterns of relating which come together to form an attachment style. The attachment style becomes the adult’s representational model which then influences the parent-child relationship (p.6).

These patterns of relating between parents and their children have said to be relevant when implementing therapeutic services to children presenting with insecure attachment styles. According to Martin et al (2006), “Becoming aware of one’s attachment style will enable a parent to learn other methods and/or techniques of interaction with his or her children that will produce a different representational model, bringing about a secure

attachment style for the child, thus, ceasing the intergenerational transmission of insecure attachment styles” (p.5). More so, as the clinician becomes aware of such patterns of relating between parents and their children, she/he will be able to assess the need for therapeutic intervention based upon the underlying issue (attachment disorder) before providing services for presenting issues such as behavioral or emotional disorders.

Many children do not initially present with an attachment disorder upon the parent’s initial consultation with the clinician. Parents often discuss various behavioral and emotional issues as the primary concerns in reference to their child’s current behavioral and/or emotional state(s). It is with this discovery that clinicians have become acutely aware that additional assessments need to be administered prior to the initiation of therapeutic interventions. Additionally, taking into account the child as well as the parent’s attachment style serves as a foundation to implementing the treatment of choice. The additional need for the parent, who has developed an insecure attachment style, to begin therapy, services as an intervention in terminating the intergenerational pattern of attachment styles directed toward their child.

There are several instruments designed to assess the child’s and parent’s attachment style. However, there are two instruments designed to measure both the adult’s attachment style as well as the parent-child attachment style. The Adult Scale of Parental Attachment (ASPA; Snow et al, submitted) has been recently developed to measure the adult’s pattern of relating. More so, this scale “assesses the adult attachment relationship to both mother and father by focusing on the individual’s internal working model of his or her

attachment to mother and father. Unlike other adult scales of attachment, which measure attachment styles based on romantic relationships, the ASPA measures the adult's attachment style based on childhood experiences" (Martin, submitted, p.34). Secondly, the Marschak Interaction Method Rating System (MIM-RS; O'Connor et al, 2004) is an observational assessment used to measure the parent-child attachment style. The use of these two instruments serves as an assessment tool when obtaining current information about the individual's attachment style(s).

Based upon the evaluation of these two assessments, the clinician is able to conclude the attachment style of the adult (parent) as well as the child and the dynamics that their attachment style proposes. It is with the conceptualization of the adult's (parent's) attachment style as well as the parent-child attachment style that the clinician is able to propose an effective treatment plan prior to initiating therapeutic interventions with either client. Additionally, the clinician is able to introduce effective therapeutic interventions designed not only to enhance the adult's attachment style with his/her own primary caregiver, but also the parent-child relationship and attachment style based upon the results of the attachment assessments.

There are several interventions that have been proposed to enhance the parent child relationship. Filial therapy is designed to "allow parents to become the primary change agents as they learn to conduct child-centered play sessions with their own children" (vanFleet, 2005, p.1). Filial therapy is designed to assist the clinician when working with parents to allow the parent to develop goals and skills used when establishing secure

attachment styles with their children. Traditional play therapy, often used when providing therapeutic services to children, is designed to allow the therapist to become the *therapeutic agent* when working with children to overcome presenting issues and/or incorporate the ability to self-regulate in the playroom, thus enabling the child to develop the inner sense of control and ability to appropriately interact in his/her environments.

Through the use of filial therapy, the parent becomes the *therapeutic agent* which is viewed more optimal based upon the child's relation with his/her self and his/her self and others. More so, in lieu of becoming dependent upon the clinician to monitor and support the child's emotional states, the parent becomes the primary *therapeutic agent*, thus allowing the child to become more securely attached to the parent as opposed to the clinician, thus creating a more secure attachment bond between parent and child.

According to vanFleet (2005), filial therapy rests upon several core values including "honesty, humility, openness, collaboration, respect, genuineness, empowerment, self-efficacy, education, relationship, playfulness and humor, emotional expression, family strength, balance, empathy, acceptance, and understanding (Ginsberg, 2003, L.F. Guerny, 1997, 2003b; vanFleet, 2004)" (p. 3). Additionally, there are several goals both for children as well as parents in filial therapy. vanFleet (2005) provides such stated goals:

Goals for Children

1. To enable children to recognize and express their feelings fully and constructively.
2. To give children the opportunity to be heard.
3. To help children develop effective problem-solving and coping skills.
4. To increase children's self-confidence and self-esteem.
5. To increase children's trust and confidence in their parents
6. To reduce or eliminate maladaptive behaviors and presenting problems.

7. To help children develop proactive and prosocial behaviors.
8. To promote an open, cohesive family climate that fosters healthy and balanced child development in all spheres: social, emotional, intellectual, behavioral, physical, and spiritual.

Goals for Parents

1. To increase parents' understanding of child development in general.
2. To increase parents' understanding of their own children in particular.
3. To help parents recognize the importance of play and emotion in their children's lives as well as in their own.
4. To decrease parents' feelings of frustration with their children.
5. To aid parents in the development of a variety of skills that are likely to yield better child-rearing outcomes.
6. To increase parents' confidence in their ability to parent.
7. To help parents open the doors of communication with their children and then keep them open.
8. To enable parents to work together as a team.
9. To increase parents' feelings of warmth and trust toward their children.
10. To provide a nonthreatening atmosphere in which parents may deal with their own issues as they relate to their children and parenting. (p.4)

In addition to the stated goals, filial therapy provides basic skills for parents to use when working therapeutically with their children. "Overall, filial therapy aims to (a) eliminate the presenting problems at their source, (b) develop positive interactions between parents and their child, and (c) increase families' communication, coping, and problem-solving skills so they are better able to handle future problems independently and successfully" (vanFleet, 2005, p.4).

Secondly, Child Parent Relationship (CPR) Therapy was designed to incorporate the use of Filial Therapy in a condensed, 10-session model. Based upon the principles of filial therapy, CPR allows parents to receive an educational and experiential model formatted to creating a healthier, more secure relationship between parents and their children. There

are many objectives of CPR including, but not limited to: effective communication between parents and children, conceptualization of the child's play, and an inner sense of understanding of what the child is attempting to communicate to the parent (Landreth & Bratton, 2006). CPR also rests upon a set of goals designed for the parents to become more *keen observers* of their child's emotional states. According to Landreth and Bratton (2006), "specific play session objectives include helping parents:

- understand and accept their child,
- develop sensitivity to their child's feelings,
- learn how to encourage their child's self-direction, self-responsibility, and self-reliance,
- gain insight into self in relation to the child,
- change their perception of their child, and
- learn child-centered play therapy principles and skills (p.12).

Like filial therapy, CPR also demonstrates effective skills for the parent including, but not limited to reflective responding, returning responsibility, limit setting, empowerment, encouragement, esteem building responses, and rules of thumb to follow throughout the incorporation of CPR training (Landreth & Bratton, 2006). The goals and skills are used throughout the 10-session modular format in addition to incorporating actual play sessions at home between the parent and child. CPR services to allow the parent to demonstrate their skills and techniques and to receive corrective feedback from group members and the facilitator.

In conclusion, attachment disorders are interesting, yet complex. According to Bowlby, (as cited in Call, 1999),

Research suggests that children whose parents are available and able to

meet their (infants) needs will develop a representational model of self that permits the child to cope capably and see him or herself as worthy of help from others, often characterizing a secure attachment. In contrast, parents who are not responsive, or who have threatened or actually abandoned the child, will contribute to the child's development of an unworthy and unlovable representational model of self, often characteristic of insecurely attachment children" (p.4).

Clinicians who currently service child and family populations need to first consider attachment disorders when assessing developing treatment plans. The assessment of attachment disorders may service the clinician with valuable information that may often be overlooked. Many behavioral and emotional disorders stem from underlying attachment disorders. Becoming aware of the need to assess not only the parent-child attachment style and relationship, but also the adult (parent's) attachment style, offers clinicians a means of discovering underlying causes of behavioral and/or emotional disturbances children often present in their environments.

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