Understanding Attachment Theory
and Its Application in Treatment

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Presented by

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An Introduction to Attachment-Informed Treatment

The Attachment-Informed Model and Sexually Abusive Behavior

- Ideas about attachment difficulties in adult and juvenile sexual offenders 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.
- This attachment-informed model 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.

Weak Support for a Direct Attachment Pathway

- In fact, there is partial and inconsistent evidence to support attachment as a primary cause of sexual coercion.
- Attachment-based research is inconsistent, weak in instrumentation, and difficult to replicate across studies.
- "Attachment-theoretical models are not yet well developed, and direct empirical support for existing models has initially been mixed and at time inconsistent" (Smallbone, 2006, p. 94).
- Based on the bulk of the evidence thus far, it is unlikely that attachment itself is a direct link to the development of sexually abusive behavior or a factor that can discriminate between sexual offenders and others (McKillop, Smallbone, Wortley, & Andjic, 2012; Stirpe, Abracen, Stermac, & Wilson, 2006).
- Nevertheless, although different studies have arrived at different conclusions, it generally seems clear that there are differences in the strength or pattern or experience of attachment security between a criminal population, including sexual offenders, and a non-criminal population, in which we recognize a far greater incidence of insecure attachment among criminals than the general population.

Treatment Derived From an Attachment Pathway

- In a model of treatment informed by attachment theory, treatment is not simply about psychoeducational and cognitive-behavioral modes of instruction and treatment.
- 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 sexual offenders, and the way in which we come to conceptualize what sexual offenders need in treatment.
- "The development of a secure therapeutic relationship may provide otherwise insecurely attached offenders with a safe haven from which to explore and challenge maladaptive relational schemas and behavioral responses" (McKillop, Smallbone, Wortley, & Andjic, 2012, p. 606)

Elements and Principles of An Attachment-Informed Model of Treatment

- Although attachment theory contains and is built upon a set of principles, elements, and ideas, it is a model of child development, and ultimately human development.
- Attachment theory 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 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

- An attachment perspective can help define the treatment relationship between clinician and client, as well as the actual modes, techniques, and interventions of treatment.
- 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, p. 585).

The Basis for an Attachment-Informed Perspective

- From this viewpoint, attachment-informed work means developing a view of individuals and their needs informed by attachment theory, recognizing that attachment theory is not a theory of pathology.
- Instead, it is a theory of childhood development in which the concept of attachment is a complex construct that significantly contributes to the way we come to experience the world in which we live, and through 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.
- 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.
- Of particular note, attachment theory is unlike other theories of psychological development, because it essentially defines attachment as a primary biological process, and only later a psychological experience.
- Accordingly, attachment theory is truly a biopsychosocial theory.
  "Clients continue to see themselves, the world, and others as a function of their experiences in early relationships, despite much evidence to the contrary. "This anachronistic world view is mediated through the power of negative learning through the early development of the social brain, and is resistant to change. Self-concept is an emotional and conceptual spin-off of the self experienced in a relationship; in other words, the individual begins to emerge from the dyad. "The core sense of the self, world, and others generated from early experience affects all domains of life." (Magnavita, 2006, p.889)

Attachment and Developmental Difficulties

- Sexually abusive children and adolescents experience, and their mental schemas, behaviors, and social relationships are built upon, what we could call “insecure attachment.”
- But the same is also true for children and adolescents who engage in other forms of antisocial behavior, including non-sexual delinquency and general behavioral problems, and the same is additionally true for other clinical populations of children and adolescents who receive mental health services.
- To put it another way, children with secure attachments head along a different trajectory in their development, becoming adolescents and adults who experience a secure sense of themselves and others, and of their own capabilities and capacities.
- On the other hand, children with insecure attachments don’t necessarily wind up experiencing difficulties in life; nevertheless, children with patterns and experiences of secure attachment typically avoid the sort of problems that our clients face, whether in terms of sexually abusive behavior or other forms of significantly troubled behavior.
### Attachment and Developmental Difficulties

- It's no surprise, then, that the children and adolescents, and adults, with whom we work experience insecure attachments, and develop the sort of problems associated with attachment difficulties, in terms of metacognition, empathic experience, moral behavior, self-regulation, trust and confidence in self and others, and in social connectedness.

### Early Attachment and Later Social Functioning

- Levy (2000) has written that beyond the basic function of security and confidence in relationships, attachment and its reciprocal relationship to exploration and ultimately self-regulation contributes to other developmental functions that children must accomplish.
  - Learning basic trust and reciprocity
  - Exploring the environment with a feeling of safety & security
  - Developing the ability to self-regulate
  - Creating a foundation for identity
  - Establishing a prosocial and moral framework
  - Generating a core belief system
  - Developing a defense against stress and trauma
- Levy writes that children who begin their lives with secure attachment fare better in all aspects of their later capacity to function well.
- This is a finding much reported in the literature of attachment theory.
- Siegel (1999) writes that emotional regulation lies “at the core of the self,” and asserts that the development of self-regulatory skills emerges from early caregiver-child attachment experiences.

### The Sequelae of Attachment: Seven Important Elements

- 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:
  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.

### The Complexity of Attachment

- Despite models that categorize types or styles of attachment, we should not assume that defined attachment styles of patterns can be simply superimposed onto clinical phenomena.
- In practice, many of the clients seen in clinical practice show both avoidant and ambivalent patterns at different times and in different circumstances (Holmes, 2001), and it does not make sense to think of clients in terms of single, mutually exclusive attachment classification.
- Similarly, Slade (1999, p. 585) warns that it “simply does not make sense to think of patients in terms of single, mutually exclusive attachment classifications that presumably remain stable within the clinical situation.”

### Working Definitions

- As a psychological construct, attachment not only describes our sense of connection to others and our social behaviors, but also serves as a strong organizing frame for understanding human development and behavior, including the development of criminality and a/s behavior.
- However, it’s important for clinicians to have a clear understanding of attachment theory if they are to consider people they assess or treat meaningfully from this attachment-informed perspective.
Working Definitions

• This is especially true as the use of attachment labels becomes more prevalent in our work, and particularly if
  the use of diagnostic labels like reactive attachment disorder or pseudo-diagnostic labels like “attachment
disorder” become more widespread.
• Without such understanding, we risk losing sight of what the construct of attachment is all about, as well as its
  implications for clinical work.
• Indeed, Prior and Glaser (2006) note “this abundance of usage of the term (attachment disorder) appears not to
  be matched by an abundance of understanding as to what it means” (p. 184).

Working Definitions: Attachment

• As we use it, “attachment” generally describes the sense of social connection that one individual has to
  another, and the sense of social relatedness or belonging that an individual has to a larger reference group.
• Indeed, it may be that as it develops into adolescence and adulthood, “attachment” is really just another way of
describing deeply rooted social connectedness, and the capacity for such relatedness.
• Smallbone, Marshall, and Wortley (2008) describe early attachment problems compromising the capacity for
  empathic concern, emotional self-regulation, moral reasoning, and the development of strong prosocial
  attachments.

Working Definitions: Disordered Attachment

• Disordered attachment does not imply an absence of attachment, but a sense of attachment that is strained,
tenuous, uncertain, and in which there is uncertainty about and lack of confidence in the capacity of others as
reliable, capable, and caring.
• Others may be viewed as untrustworthy and relationships viewed with caution, and the self experienced as
unworthy, incapable, and ineffective, fueling difficulties in self-image and the capacity to understand, trust, or
perhaps care about others and form social relationships.
• In turn, these difficulties may translate into many different types of cognitions, emotions, and behaviors, driven
by a limited and possibly damaged emotional bond and sense of belonging.
• The term “disordered attachment” points to the function of earlier and on-going attachment and related social
experiences in the development of current cognitions, affects, and behaviors.

Working Definitions: Attachment Deficits

• Attachment “deficits” are related to a disturbed or disordered attachment.
• They represent a limited ability to form meaningful and satisfying relationships, engage in intimacy, develop the
skills to understand others, and engage in the behaviors, interactions, and relationships that are required to
acquire what Thakker, Ward, and Tidmarsh (2006) have referred to as “human goods.”

Dimensions of Attachment

As a multi-dimensional construct, and as we apply it the psychosocial functioning of every day life, we can
consider and assess attachment from at least five different dimensions:

1. Attachment **Strength**. The individual’s sense of social connection.
2. Attachment **Security**. The individual’s confidence in relationships.
3. Attachment **Experience**. The individual’s subjective experience in relationships.
4. Attachment **Behaviors**. The manner in which the individual engages in social interactions
5. Attachment **Interest**. The individual’s desire for relationships.
Dimensions of Attachment Assessment Scale

Attachment Strength: Social Connection (weak to strong, with pathological extremes)

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<thead>
<tr>
<th>Pathological</th>
<th>Very</th>
<th>Somewhat</th>
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<tr>
<td>Disconnected</td>
<td>Isolated</td>
<td>Connected</td>
<td>Connected</td>
<td>Isolated</td>
<td>Enmeshed</td>
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Attachment Security: Confidence in Relationships (insecure to secure, with pathological extremes)

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<tr>
<td>Paranoid</td>
<td>Uncertain</td>
<td>Uncertain</td>
<td>Confident</td>
<td>Confident</td>
<td>Grandiose</td>
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Attachment Experience: Subjective Experience in Relationships (unsatisfying to satisfying; pathological extremes)

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<tr>
<td>Alienated</td>
<td>Unfulfilling</td>
<td>Unfulfilling</td>
<td>Fulfilling</td>
<td>Fulfilling</td>
<td>Unrestrained</td>
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Attachment Behaviors: Social Engagement (distant to engaged, with pathological extremes)

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<tr>
<td>Self-Serving</td>
<td>Self-Oriented</td>
<td>Self-Oriented</td>
<td>Mutually-Oriented</td>
<td>Mutually-Oriented</td>
<td>Preoccupied</td>
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Attachment Interest: Desire for Relationships (disinterested to interested, with pathological extremes)

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<th>Somewhat</th>
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<tr>
<td>Schizoid</td>
<td>Unmotivated</td>
<td>Unmotivated</td>
<td>Motivated</td>
<td>Motivated</td>
<td>Expansive</td>
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Attachment and Sexually Abusive Behavior

The Research on Attachment and Sexually Abusive Behavior

- The research on attachment difficulties and sexually abusive behavior largely fails to support the idea that attachment difficulties are specifically or directly linked to the development of sexually abusive behavior, or that attachment experiences play a particular role in the sexually abusive behavior as opposed to the development of other behavioral problems.
- Nevertheless, it is very clear that attachment difficulties and insecure forms of attachment are common among all forms of criminal and emotionally disturbed behavior, including sexual and non-sexual offenses (McKillop, Smallbone, Wortley, & Andjic, 2012; Stirpe, Abracen, Stermac, & Wilson, 2006).
- We can best understand attachment difficulties, not as a condition specifically linked to sexual behavior problems alone, but as a general condition associated with generally troubled and criminal behavior.

Attachment and the Pathway to Sexually Abusive Behavior

- Despite inconsistent research evidence, some models theorize that attachment deficits in some way function to create sexually coercive and abusive behavior.
- The presumption in these models is that difficulties or disruptions that damage the attachment process also lead or contribute to later emotional disturbances and dysfunctional behaviors that, in these cases, function to set in motion a pathway to sexually abusive behavior.
- For instance, Smallbone, Marshall, and Wortley (2008) assert that insecure and weak social attachments lead to general problems with the capacity for and commitment to self-restraint.
- When this deficit in self-regulation interacts with other dynamic situational factors, antisocial behavior may follow, including sexually abusive behavior.

Insecure Attachment as Predispositional to Sexually Abusive Behavior

- He recognizes this as a “developmental vulnerability” factor rather than the cause (Marshall & Eccles, 1993), but considers that when individuals with this vulnerability are exposed to other predisposing or precipitating factors, they are more likely than securely attached individuals to engage in sexual abuse.
- In keeping with attachment theory, Marshall suggests that individuals with disturbed attachments experiences do not adequately develop self-regulatory skills, and thus rely on externally based means of self-regulation.
Marshall and Barbaree’s Integrated Developmental Model (1990)

- Attachment bonds impaired in early childhood attachment bonds result in personal vulnerabilities that grow larger over time, when coupled with other social, situational, and biological circumstances, and the formation of deficits in the capacity for self-regulation and the acquisition of social skills.
- The situation is worsened in families where maltreatment exists, and problems in attachment, social skill development, self-regulation, and the formation of ideas about self and others deepen over time, amplifying biological male predispositions toward physical aggression and sexual behavior, without other restraints on these behaviors or the ideas that accompany them.
- This is especially true, and early vulnerabilities may become further fused and deepened, for children who are raised in environments that model hostile and aggressive behaviors towards others and in which they are exposed to sexual ideation and experiences at an early age or have been sexually abused.
- Deficits in social skills and behavioral interactions and weakened attachment bonds and skills impede the development of peer relationships. As adolescence approaches, physical, emotional, and social changes create a new wave of demands that the child is unable to meet.

Marshall and Barbaree’s Integrated Developmental Model

- Positive early and ongoing developmental experiences and social connections to others restrain the potential for antisocial behaviors and inappropriate and hostile sexual behaviors.
- However, adverse developmental experiences, weakened attachments, low self-regulation, and deficits in social skills, and especially sexualized coping, open the way to engagement in sexually abusive behavior if situational circumstances arise.
- Given the social skills deficits that limit the development of peer relationships, the theory asserts that the sexualization of children serves as a substitute.
- “Exposures to the experiences typical of a sex offender’s childhood, then, can be expected to make them relatively unable to develop intimacy and to feel empathy, and it leaves them socially inept, lacking in confidence, self-centered, hostile (and) aggressive....” (p. 263).
- Marshall and Barbaree comment that it not a surprise that children from such backgrounds become insensitive adults, concerned only with their own interests and needs.


- Barbaree, Marshall, and McCormick theorize that abusive and adverse family experiences lead 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.
- Children who grow up in attached and nurturing families, through the processes of modeling and reinforcement, acquire the skills by which to develop effective, prosocial, and satisfying social behaviors and relationships.
- Children raised under adverse or abusive conditions not only fail to learn effective and satisfying interpersonal skills, but instead learn inappropriate and aggressive behavior.
- Through failures in the early and on-going family and developmental-learning environment, and through the learning processes of modeling and reinforcement, these children:
  - Develop negative self-image.
  - Fail to develop self-confidence.
  - Lack relationship building skills.
  - Experience a sense of masculine inadequacy.
  - Develop antisocial behaviors as a means by which to engage in the social world and get their needs met.
  - Fail to recognize or care about the suffering of or harm to others.
  - Develop cognitive distortions that support antisocial behavior.

Troubled Backgrounds

- Although unable to discriminate between sexual and non-sexual offenders with respect to attachment style, there is support for the hypothesis that sexual offenders have troubled childhood experiences.
- However, early childhood difficulties appear a general risk factor for later troubled, antisocial, and criminal behavior in general, rather than sexually abusive behavior in particular.
- Nevertheless, early insecure attachment experiences may place some men at risk for sexually abusive behavior in the context of other factors present in their lives, supporting insecure attachment as a general factor that is potentiated and catalyzed by other life circumstances.
Sexually Abusive Youth and Social Connection

- Miner and Crimmins (1997) report that although juvenile sexual offenders do not differ significantly than non-sexual juvenile delinquents in either attitude or behavior, they are significantly more isolated from family than non-delinquent youth and more socially isolated from peers than juvenile non-sexual delinquents.
- Miner and Swinburne 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.
- They do not consider juvenile sexual offenders to be more rejecting of social relationships than non-sexual juvenile delinquents, just less competent, and believe that there is a link between attachment, social isolation, and sexually abusive behavior.
- They conjecture that juvenile sexual abuse is driven by socially isolated, normless behaviors rather than by aggression, at least in those who molest children.
- This mirrors the conjecture of Hudson and Ward (2000) that sexually abusive behavior among adults is often more connected to the need for social connection and the acquisition of social goals than deviant sexuality.

Sexually Abusive Youth and Social Isolation

- Miner and Munns (2005) compared differences in attitudes, normlessness, and social isolation among juvenile sexual offenders, non-sexual juvenile delinquents, and non-delinquent adolescents.
- They conclude that juvenile sexual offenders 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.
- Blaske, Borduin, Hengeler, & Mann (1989) also described sexually abusive youth in their study as more anxious than juvenile non-sexual offenders, more isolated in their social relationships, and less emotionally bonded to their peers.
- More recently, Gunby and Woodhams (2010) describe juvenile child abusers experiencing greater deficits in self-esteem and greater social isolation than other juvenile offenders.
- Miner points 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.

Attachment-Mediated Developmental Pathways

- Thus we see a developmental pathway that involves social relatedness and security in social relationships, social competence, emotional dysregulation in the form of anxiety that has resulted from earlier developmental experiences, and 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, and experience feelings of sexual and social inadequacy, as well as feelings of anxiety and rejection.

Attachment-Mediated Developmental Pathways

- The on-going studies of Miner and colleagues further support this etiological model, at least for adolescents who sexually abuse children. 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.
The Victims of Sexually Abusive Youth


Attachment, Social Connection, and Social Skills

The Development of Critical Social Skills: Social Skills Through Social Connection

- As we consider social and personal vulnerabilities and strengths (or risks and resiliencies), we must also ask how people acquire social resources and personal strengths, and how these work.
- The converse question is how does a lack of resources, personal or social, contribute to or equal risk?
- In fact, for all intents and purposes, the acquisition of social skills, personal strengths, and a sense of social relatedness or attachment are protective factors, whereas deficits in each of these areas represent risk factors.

The Development of Critical Social Skills: Social Skills Through Social Connection

- In this context, however, “social skills” don’t simply refer to the etiquette of everyday relationships or the ability to make friends and do the socially appropriate things. The concept of social skills is instead directed towards the full range of skills required to maneuver through the social world.
- These include both the external skills of interpersonal interaction with others and the internal skills of self-regulation, self-awareness, and social comprehension, as well as the skills that connect self to others, such as empathy and moral behavior.

Seven Elements of Attachment and Social Capacity

In addition to being described as the outcome of attachment experiences, each of the seven elements can also be described as an essential social skill:
1. Metacognition.
2. Empathy.
5. Trust and confidence in others.
6. Trust and confidence in self.
7. Social connectedness.
An Attachment-Informed View of Social Skills Acquisition

- An attachment-oriented approach to treatment always looks at the mindset that produces behavior and behavior, as well as the social experiences that shape that mindset. Attachment theory considers not just social relationships and interactions to be central, but the core schemas behind behavior and relationships, and the development of capacity to engage adequately and appropriately in the social world.
- Although attachment theory doesn’t aim to describe criminality in particular, we recognize that attachment difficulties contribute to all sorts of functional problems.
- They contribute to troubling behaviors, dissatisfaction with relationships and social life, and the inability to meet goals or feel satisfaction, as well as inhibiting the development of metacognition, self-agency, and self-regulation, all key elements in the formation of criminal behavior and key in theories of criminality.
- Indeed, self-regulation is heavily implicated by Gottfredson and Hirschi (1990) in their general model of criminology, in which they assert that at the heart of all criminal behavior lies a lack of self-regulation.
- Recall, Smallbone, Marshall, and Wortley’s (2008) assertion that insecure and weak social attachments lead to problems with the capacity for and commitment to self-regulation.
- Social competence, then, is of particular importance – not simply to feel socially adequate and socially connected, but also to tolerate emotional uncertainty and discomfort and modulate our behavioral responses when it’s not possible to meet personal needs.
- This capacity for self-regulation, from the attachment perspective, is initially learned through the early external regulation of our primary caregivers.

Metacognition as a Critical Social Skill

- The development of “metacognition” is an essential social skill, involving the capacity to recognize, understand, and reflect upon one’s own thoughts and feelings and the thoughts and feelings of others.
- Our capacity to “say what we know and know what we think” (Schank, 1999) reflects our ability to be self-reflective and influences our ability to reflect upon and understand the mind of others, resulting, in part, in what is sometimes also known as “theory of mind.”
- Fonagy (2001, 2004) asserts that the capacity to adequately mentalize evolves out of the attachment experience and the child’s opportunity to observe and explore the mind of the caregiver, and that severe deprivation undermines the acquisition of metacognition.

Weak Metacognition and Antisocial Behavior

- Fonagy (1999a, 1999b) describes the skills of “mentalization” as critical to effective social functioning, or the process by which we are able to reflect upon, understand, and make sense of our own mental experiences and the mental experiences of others.
- He proposes that crimes are committed by people with inadequate mentalizing capacities who instead engage in pathological attempts to adapt to a social environment in which mentalization is essential. He describes poorly metacognition contributing to antisocial behavior in four ways.
  1. Those with limited metacognitive skills not only experience a poorly established sense of their own identity and mental states, but also the needs and mental states of others. They “may more readily feel that they are not responsible for their actions because they genuinely lack a sense of agency.”
  2. Reduced capacity for mentalization leads to a failure to anticipate or appreciate the consequences of personal behavior to the victims of such behaviors.
  3. Reduced capacity for mentalization contributes to devaluing or dehumanizing potential or actual victims.
  4. Poor mentalization results in a world view that allows disengagement from prosocial behavior and also allows antisocial behavior to be experienced as appropriate, acceptable, and personally satisfying.

The Development of Metacognition and Other Essential Social Skills

- Metacognition, then, represents one of the essential social skills, required in order to engage in effective and appropriate social interactions.
- Without well-developed metacognition, behavior may be more reactive than reflective. Conversely, the acquisition of metacognitive skills opens the door for the development of other essential social skills.
- How do people gain these others important social skills, and how do these relate to the development of sexually troubled or abusive behavior?
Empathy and Moral Development Through Social Relatedness

- Our acquisition of social skills is made more likely or limited by temperament and cognitive capacity (IQ, for instance), and in extreme cases by biological conditions such as mental retardation or autism.
- However, the social environment is a primary source for learning, fostering, practicing, nurturing, and eventually fully acquiring social skills.
- As we consider the development of sexually abusive behavior, and the risk for sexual re-offense, we must consider as significant the nature of the social environment and opportunities for the acquisition of social skills within that environment.
- In thinking about risk we must understand the social environment in which the child or adolescent has developed and currently functions, as well as the role played by key social skills in the development and possible recurrence of sexually abusive behavior.
- These include the development of metacognition, as well as empathy and moral behavior, each of which are developed in concert with one another and each of which are mediated and influenced through early and ongoing experiences in the environment of social interaction and connection.

Empathy as a Social Skill

- Much has been written about the role of empathy in the enactment of sexually abusive behavior, and especially in adult sexual offenders, and the development of empathy is frequently central in the treatment of both adult and juvenile sexual offenders.
- Further, the presence and role of empathy is nevertheless key to theories about sexually abusive behavior, such as those proposed by Knight and Sims-Knight (2003, 2004) and Malamuth (2003).
- Empathy is described by Feshbach (1997) as an interaction in which one person experiences and shares the feeling of another.
- However, more than just being able to recognize and share the emotions of another person, empathy involves cognitive, emotional, and motivational elements.

The Role of Empathy

- In describing empathy as the basic human emotional faculty that predisposes people to develop concern for others, Vetlesen (1994) describes it as always other-directed, rather than self-concerned.
- Similarly, Rogers (1980) describes empathy “dissolving alienation,” and connecting the individual to others.
- In relating empathy to self-exploration, Rogers is to some degree also describing metacognition, or the capacity to recognize ideas and feelings both within one’s own self and within others.
- Empathy represents a sense of social understanding and social connection, as well as shared feelings.
- From this perspective, a lack of empathy reflects a lack of social relatedness rather than a lack of sympathy or concern for others.

The Convergence of Empathy and Morality

- Moral development is based on respect for and acceptance of social rules and conventions, and a sense of equality, responsibility, and reciprocity in human relations (Piaget, 1997).
- Hoffman (2000) describes the cognitive dimension of empathy, or the ability to take the perspective and become aware of the experiences of others, by which empathic concerns for others are translated into and become congruent with social codes, and hence a basis for both social connection and moral development.
- Similarly, Vetlesen writes that empathy is a precondition for moral decision making, and that perceptions of morality are built on the experience of empathy for others.
- Kagan (1984) also considers the child’s acquisition of standards to be facilitated by the recognition of feelings and thoughts in self and others (i.e., metacognition), mediated through the development of empathy. He thus makes moral development contingent upon the development of empathy.
- Hence, moral development grows from and is an offshoot of empathy.
- Morality becomes the attitudinal and behavioral equivalent of empathy, in which empathy is expressed through behaviors and an understanding of and concern for the effects of decisions and behaviors on others.
The "Moralization" of Attachment

- Stilwell and colleagues (Stilwell, Galvin, Kopta, & Padgett, 1998) describe moral development incorporating social values and integrating emotional, cognitive, and behavioral systems into a dynamic mental model of "conscience."
- This largely involves the transformation of early attachment and social experiences into the values, attitudes, and beliefs that underlie relationships and behaviors, resulting in a moral conscience.

The Moralization of Attachment: Empathy and Moral Development in the Social Context

- However, empathy and morality do not develop in a vacuum, and must be nurtured.
- Stilwell writes that empathy and morality occur in the context of early attachment relationships and later expanding relationships with other family members, adults, and friends, and within the social organizations and institutions in which children are raised and grow to adulthood.
- With a focus on early attachment processes, Stilwell defines moral delay, arrest, and deviancy as developmental disruptions, interruptions, or derailments that result from disruptions in attachment, neglectful parenting, or trauma (Stilwell, Galvin, Kopta, & Norton, 1994).
- Here, moral development is contingent upon the relational and social environment from which all experience is derived.

Attachment Deficits, Social Skills, and the Social Context

- Indeed, Gilligan and Wiggins (1987) are critical of theories of moral development that overlook the implications of attachment, which they assert heavily influences the child’s development of metacognition and mental models, or how the child comes to understand how to behave towards others and how others feel.
- They comment that it is through the process of attachment and subsequent socially connected relationships that the child develops an awareness of being affected by and in turn affecting others, thus recognizing and becoming attuned to moral relationships through social relatedness.
- Travis Hirschi writes that “the bond of affection for conventional persons is a major deterrent to crime” (2002, p.82 ). We are moral beings to the extent that we have internalized the norms of society, and that “the essence of internalization of norms, conscience, or superego lies in the attachment of individuals to others” (p. 18).
- Similarly linking moral development to social attachment, the Commission on Children at Risk describes moral behavior stemming from attached relationships as much as rule acquisition.
- From this perspective, the failure to form secure attachments necessarily means the failure to form a strong moral code.
- Thus, the larger social context in which child rearing and child development occurs is not just an important but passive backdrop to the development of attachment, but an active ingredient in attachment, the development of empathy and moral behavior, and social development in general.

Attachment in the Social Context

- Through their social environments, individuals become attached to the norms and values of their societies, and incorporate these into their identities and character.
- Attachment must thus be understood at the level of the macro-society, rather that just relationships with attachment figures at the micro-level. Social attachment is an entity in its own right, building and giving identity; shaping attitudes and behaviors; and providing cues and directives for the acquisition of selfhood.
- In the social context, we find the role models that influence the development of behavior and personal identity, and the arena in which social lessons are taught and learned.
- Whenever the guiding power of conventional norms is weakened, high rates of deviant behavior can be expected (Passas, 1997).
- The idea that society itself, rather than just the unique experiences of individuals, contributes to how attitudes and behaviors develops offers to us a compelling perspective in understanding juvenile crime from the perspective of self-regulation and attachment.
- In this model, social conditions give rise to and catalyze the very behaviors we are attempting to rehabilitate.
Social Attachment
- The social context is itself an active ingredient in the acquisition or absence of the social skills that contribute to and drive prosocial or, conversely, antisocial behavior.
- From an attachment-informed perspective, suboptimal attachment experiences contribute to deficits in the acquisition of the social norms upon which relationships and behavior are built, and a lack of adequate self-regulation, described by Gottfredson and Hirschi (1990) as central to all criminal behavior.
- With this in mind, we can conclude that individuals considered to be securely attached are also attached to the norms, values, and social rules of their society, and possess adequate self-regulation.
- We have already seen that this is not necessarily the case for juvenile sexual offenders, who Miner and colleagues (Miner & Crimmins, 1997; Miner et al., 2010) describe as socially isolated and normless, yet no different than other youth with respect to their desire to achieve socially acceptable goals.

Social Skills and Sexually Abusive Behavior
- As we consider risk in the real world in which children and adolescents live, we cannot fail to understand that both the development of sexually abusive behavior and the risk for recidivism are strongly influenced by the acquisition of social skills.
- Social skills are formed in the crucible of the social environment in which children and adolescents are raised, and continue to form in their current social environment.
- These skills not only allow us to successfully negotiate the world in which we live and function, but provide the means to achieve socially desirable goals, the self-regulation required to cope with and manage frustrated desires, the empathy that ties us to others, the moral code that allows us to understand and act upon prosocial ideas, and the metacognition that is the basis for insight and judgment.

The Path from Early and On-Going Social Experience to Juvenile Antisocial Behavior
- We can better understand the youth with whom we work, then, as well as the motivations for their behavior, by also understanding the sets of social skills required of each child, the degree to which each child develops and actually possesses such skills, and the social environment through which social connectedness is formed and social skills are acquired.
- As we consider risk for sexually abusive behavior in a highly sexualized social environment, we can also think about how social and sexual ideas are experienced by children who lack judgment, metacognitive skills, moral development, and a sense of deep connection to others.
- It is, of course, a mistake to lump all sexually abusive youth together as a single group, and assume they all suffer the same deficits and are motivated by the same factors.
- We understand that in discussing risk in the real world our children are influenced by many different forces, are capable of many different sets of choices, and are simply not all the same.
- However, recognizing heterogeneity doesn’t mean ignoring both common elements and common pathways.
- It is certainly reasonable to believe that many of the children we see have difficulties with relatedness, and often have early and ongoing histories of experiences that disrupt and damage deep and secure attachment.

The Path from Early and On-Going Social Experience to Juvenile Antisocial Behavior
- Many antisocial and criminalized adolescents are characterized by deficits in the social skills required for prosocial behavior: difficulty understanding or caring about others, demonstrating self-regulation under circumstances where self-regulation is required to maintain prosocial behavior, and buying into and adhering to social norms.
- A simple path, then, from early experience to social relatedness can be seen passing through early attachment and bonding to the development of metacognition, the deepening of empathy, the acquisition of morality, and the sense of social connection and awareness reflected in the development of social conscience, or the moralization of attachment.

A Developmental Pathway to Juvenile Sexually Abusive Behavior
- Smallbone (2006) writes that adolescents who have poorly developed social attachments, are not well equipped, have fewer social and personal resources available than other adolescents, and are unable to negotiate complex interpersonal interactions.
- His perspective is that adolescent sexually abusive behavior is related more to poorly developed social skills, such as self-regulation, than sexual deviance.
A Developmental Pathway to Juvenile Sexually Abusive Behavior

- Smallbone (2006) builds on Marshall and Barbaree’s (1990) developmental model, in which as adolescents, adult sexual offenders lacked the relationship building skills and key attributes of social relatedness, and experienced social anxiety and masculine inadequacy.
- Here, sexually abusive behavior offers a means, not only to meet a perceived social goal (i.e., being sexually or socially accomplished), but also to engage with someone in a social relationship or derive some perceived or imagined social benefit, regardless of how distorted or improper the means.
- Under such circumstances, despite the socially deviant nature of the behavior, the behavior is nevertheless intended to meet social needs that are themselves not necessarily deviant.

An Attachment-Informed Approach to Treatment

Attachment Theory as a Model

- Attachment theory is a theory of human development, and is not focused on the development of criminality in particular, or any pathological behavior for that matter.
- However, we recognize that attachment difficulties contribute to many functional problems and contribute to many troubling behaviors.
- Consequently, it is useful to apply attachment theory as both a framework by which to understand the structure upon which human emotion, thought, and behavior is built, and as a lens through which to examine emotion, thought, and behavior in action.

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.
- With respect to its use as a framework for treatment, rather than a theory of human development, the application of attachment theory to forensic mental health brings with it a client-centered approach.
- From this perspective, understanding, assessing, and treating dysfunctional and antisocial behaviors, including sexually abusive behaviors, looks to the mindset that produces the behavior, as well as the relationships that may have shaped criminal behavior and those that may sustain desistance from it.

The Attachment-Informed Approach

- 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.
- From this perspective, we seek an understanding of the transactions and interactions between the internal world of the client and the external world, in which we recognize relationships, behaviors, attitudes, and ideas as the outcome of this interaction, driven by emotional and cognitive processes.
- For the therapist focusing on building attachment and a more secure mental map, interactions and behaviors are informed by the principles and ideas of attachment therapy.
- 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 Positive Psychology

- As attachment theory is essentially a relational and interactional model, the therapeutic relationship comes squarely back into the foreground in attachment-informed therapy.
- Although cognitive-behavioral work is important in sex offender specific treatment, and will undoubtedly remain central to any sex offender specific treatment program, the attachment-informed 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 Therapeutic Relationship and Positive Psychology

- Ultimately, the emphasis in an attachment-informed therapy is on the development of an understanding, supportive, and caring relationship, marked by attunement between the therapist and the client, or a working treatment alliance.
- In addition to the centrality of the therapeutic relationship and its treatment alliance, also connected to an attachment-informed perspective on treatment are elements of positive psychology.
- 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 (an “avoidance” goal), but also to 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, in an attachment-informed model approach goals are more synchronous with achievement and improvement.

Attachment and the Good Lives Model

- These elements of therapeutic relationship and the pursuit of positive goals are clearly emerging in our work with both sexually abusive youth and adult sexual offenders.
- The Good Lives model, which is designed to work with adult sexual offenders, but also finding a place in work with sexually abusive youth, shifts treatment in focus from a containment and control model to a model of positive psychology.
- In this model, treatment works towards recognizing the identity, values, and beliefs with which the offender identifies so that he can work towards personal fulfillment and the development of prosocial social skills.
- The focus is not solely upon risk reduction, but also upon enhancing the client's capacity to improve his life.
- Thakker, Ward, and Tidmarsh (2006) write “we propose that the key theoretical perspective that guides treatment should be that of human well-being (i.e., good lives), rather than risk management, or relapse prevention” (p. 324).
- They assert that the focus of treatment should be on 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.
- “Human goods” are those aspects of social experience, life, and experience that the individual perceives as desirable. In the good lives model, individuals are regarded as active, goal-seeking beings whose goals are the acquisition of primary human goods.

Attachment-Informed Treatment

- In a treatment model informed by attachment theory, a main goal is to understand insecure attachment and obstructions to secure attachment, and assess whether any of these obstacles can be removed, perhaps through individual, family, or group therapy.
- However, from the attachment perspective, healthy and non-pathological behaviors are recognized as possible only when the client feels secure. Seen through this attachment lens, the development of a security in relationship and confidence in self and others is paramount (or the development of the secure base).
- Simply put, built on an attachment framework, the goals of treatment include developing:
  - A sense of experienced security (secure base) from which to explore and grow.
  - Confidence (security) in and connection to important figures who are experienced as 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 for perspective taking and the unlocking of empathy for others.
  - The capacity to tolerate and regulate frustration and disappointment.
  - A higher level of moral understanding, reasoning, and decision making.
  - The experience of connection and relatedness to other people.
- The overarching goal is, in effect, the rehabilitation of the internal working model.
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.
  - Seemingly irrational behaviors can be understood as variants of insecure or disorganized attachment strategies, triggered under specific conditions.
  - 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 brain is plastic, and neural pathways can develop with new experience and practice.

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.
- However, 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).

The Attachment-Informed Therapist

- McKillop et al. (2012) write that a secure therapeutic relationship may provide otherwise insecurely attached offenders with a safe haven from which to explore and challenge maladaptive relational schemas and behavioral responses.
- The attachment-informed clinician:
  - 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.
  - 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.
  - 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. McKillop et al.(2012) note that treatment effectiveness may be compromised by the offender’s (or clinician's) inability to form a strong therapeutic alliance, especially in fearful-avoidant clients who tend to have the lowest therapeutic alliance ratings.
  - 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.
**Empathy in the Attachment-Based 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.
- Indeed, Elliott, Bohart, Watson, and Greenberg (2011) write that therapeutic empathy is an essential goal for all clinicians, regardless of theoretical orientation, treatment model, or severity of patient psychopathology.
- 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 Empathic Clinician**

Empathic clinicians:

- Understand their clients and demonstrate this understanding through their behaviors.
- Strive to understand experiences rather than words.
- Assist clients to express their experience in words so they can deepen their experience and become more self-reflective.
- Individualize their responses to different clients.
- Know when, and when not, to respond empathically.
- Offer empathy in the context of positive regard and genuineness.

**Attachment-Informed Treatment in Practice**

**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”).

**Required Conditions for Attachment-Informed Treatment**

- Beverly James’ (1994) attachment-oriented treatment model for children is focused on the development of security in attachment figures, security in self, and modes of self-expression and self-regulation that can provide the child with other sources for emotional and behavioral control.
- However, in order to produce change through treatment, she writes that three conditions must be present:
  - Safety and a protective environment
  - Therapeutic parenting and attachment-informed clinical skills
  - Therapeutic relationship.
- James notes that children who have learned not to trust adults and are insecurely attached, and especially those who are avoidant, may not show signs of a bonded therapeutic relationship for many months.
An Attachment-Informed Model as a Model of Practice

• An attachment-informed 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-informed 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-Informed Model in Practice

• An attachment-informed framework does not define treatment theory and technique. It instead defines:
  1. How we understand and relate to our clients,
  2. How we approach the work,
  3. The environment in which the work is carried out, and
  4. The goals of a rehabilitative treatment model that underlies more specific goals, such as the treatment of sexually abusive behavior.
• An attachment-informed model is built on ideas that recognize:
  • The quality and nature of the social environment are central in child 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-informed 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.
• An attachment-informed model recognizes and treats 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-Informed Model Is Rehabilitative

• In an attachment-informed model, sexual abuse specific treatment is embedded within a treatment program, treatment environment, and treatment approach that is rehabilitative, and incorporated into a larger attachment and developmentally-informed model.
• Its target is the rehabilitation of the internal working model, or the mental map.
• Its goals include the rehabilitation of thoughts and beliefs about self and others, and expectations about the world and how one should behave in it.

The Targets of an Attachment-Informed Model

1. The development of a secure and confident sense of attachment to others and society in general.
2. Social competence with respect to social skill development, social interactions, and interpersonal relationships.
3. The ability to overcome and act independently of prior adverse or traumatic experiences that may be exerting strong control over thoughts, emotions, or behaviors.
4. Effective emotional and behavioral self-regulation and management.
5. A rehabilitated sense of self as socially and personally capable, competent, and prosocial in orientation and behavior.
The “Attachment Friendly” Treatment Milieu

• 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 occurs in a caring and supportive manner, through an attachment-friendly environment in which relationships are genuine, respectful, and supportive.
• The message that comes through is one of 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.

Vision Statement for an Attachment-Informed Treatment Model

• Rehabilitation for children and adolescents occurs in an environment that is physically and emotionally safe, and in which they recognize and understand their needs and goals and are able to meet these, in which they feel understood and supported by others, in which there are positive adult and peer role models, and in which relationships are genuine and meaningful.
• In such an environment, the child or adolescent is recognized as a person of value, capable of personal change and development.

Seven Core Elements

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 (healing) 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.

Treating Deficits in Social Skills

• The goal of teaching sexually abusive youth psychoeducational concepts, such as dysfunctional behavioral cycles and thinking errors that contribute or lead to sexually abusive behavior, has been and 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 also include a poorly developed capacity to recognize and understand one’s own mental state and the mental state of others (metacognition), an under-developed sense of moral decision making and behavior, and inadequate self-regulation, or the ability to recognize and manage one’s own emotional state.

The Development of Essential Social Competencies

The basic and essential treatment goals of an attachment-informed 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.
The Development of Essential Social Competencies

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- **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-informed 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 heal, 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 Facilitative 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 heal, care for, and restore to health, and always focused on the needs of the client.
- Builds a collaborative and interactive working alliance and partnership between the treatment provider and the client.
- The mirror and the 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.
The Facilitative Treatment Relationship

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The Application of Attachment-Informed Treatment

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, knowing that most juvenile offenders do not develop into adult sexual offenders.

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, and perhaps especially, 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.


- How do we best engage sexually abusive youth in treatment?
- As clinicians we don’t treat them any differently than we would any child or adolescent whom we are treating.
- In terms of our treatment of them, not the application and provision of psychoeducational ideas, we build the same sort of therapeutic relationship as we would with any client, and individualize treatment.
- This kind of therapy is far more difficult and energy consuming than a therapy guided by treatment protocols or workbooks, and requires good training and supervision.
- This is a therapy of engagement, in which the clinician is a significant conduit for self-realization and change in the client, and in which the therapeutic relationship becomes a crucible in which growth is fermented and from which change emerges.
- Psychotherapy is “at root a human relationship. Both parties bring themselves – their origins, culture, personalities, psychopathology, expectations, biases, defenses, and strengths – to the human relationship. Some will judge that relationship a precondition of change and others a process of change, but all agree that it is a relational enterprise” (Norcross & Wampold, 2011, p. 101).
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


Siegel, D. J. (1999). The developing mind: How relationships and the brain interact to shape who we are. New York: Guilford.


## Dimensions of Attachment Assessment Scale (DAAS)

### 1. Attachment Strength

**Social Connection**

(weak to strong, with pathological extremes)

<table>
<thead>
<tr>
<th>Pathological</th>
<th>Very</th>
<th>Somewhat</th>
<th>Cannot</th>
<th>Somewhat</th>
<th>Very</th>
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<tbody>
<tr>
<td>Disconnected</td>
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<td>3</td>
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<td>5</td>
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</table>

### 2. Attachment Security

**Confidence in Relationships**

(insecure to secure, with pathological extremes)

<table>
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<tr>
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<th>Cannot</th>
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### 3. Attachment Experience

**Subjective Experience in Relationships**

(unsatisfying to satisfying, with pathological extremes)

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<td>Alienated</td>
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### 4. Attachment Behaviors

**Social Engagement**

(distant to engaged, with pathological extremes)

<table>
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### 5. Attachment Interest

**Desire for Relationships**

(disinterested to interested, with pathological extremes)

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<th>Cannot</th>
<th>Somewhat</th>
<th>Very</th>
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</table>

### Attachment Subscale Score

- **Strength**
- **Security**
- **Experience**
- **Behaviors**
- **Interest**

### Overall Attachment Status

- Strong
- Moderate
- Weak
- Pathological/Disturbed
- Cannot Assess

### Consistency Across Attachment Subscales

- Consistent
- Variable
- Highly Variable

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Client: ___________________________ Date Evaluated: __________
Evaluator: ___________________________
Inventory for Attachment-Informed Analysis of Behaviors (IAAB)

1. Representation of Self . . . . . . . . . . . . . . . Sense of self, self image, self esteem, personal identity, etc.
2. Self-Agency . . . . . . . . . . . . . . . . . . . . Sense of self as capable of acting upon the world and others.
3. Self-Efficacy . . . . . . . . . . . . . . . . . . . . Sense of self as capable of satisfactorily accomplishing goals.
4. Self-Regulation . . . . . . . . . . . . . . . . . . Capacity to contain and stabilize thoughts, emotions, and behaviors.
6. Representation of Others . . . . . . . . . Sense of others as reliable, trustworthy, caring, etc.
7. Social Connectedness . . . . . . . . . . . Sense of belonging to social group larger than self.
8. Parental Connectedness . . . . . . . . . . Sense of connection to and relationship with parents.
9. Parental Security/Model . . . . . . . . . . Sense of parents as reliable, trustworthy, competent, caring, etc.
10. Proximity Behaviors . . . . . . . . . . . . Organization of behaviors intended to maintain proximity to others.
11. Signaling Behaviors . . . . . . . . . . . . Methods for expressing and communicating needs to others.
12. Exploratory Behaviors . . . . . . . . . . . Level/type of risk taking behaviors when away from security figures.
13. Capacity for Intimacy . . . . . . . . . . . Ability to feel comfortable and engaged in intimate relationships.
14. Empathic Connection . . . . . . . . . . . . Vicarious understanding, concern, and support for others.
15. Perspective Taking . . . . . . . . . . . . . . Ability to assume point of view of another person.
16. Metacognition . . . . . . . . . . . . . . . . . . Capacity to recognize and reflect upon thoughts & feelings of self/others
17. Goals of Behavior . . . . . . . . . . . . . . Purpose and drives behind sequences or patterns of behavior.
18. Congruency of Social Norms . . . . . . Approval of/desire to conform with common social norms.
19. Response to Social Norms . . . . . . . . . Capacity to meet social norms through legitimate means.

<table>
<thead>
<tr>
<th></th>
<th>Weak</th>
<th>Moderate</th>
<th>Strong</th>
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</tr>
<tr>
<td>Self-Regulation</td>
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</tr>
<tr>
<td>Experienced Security</td>
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<tr>
<td>Representation of Others</td>
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<td>Perspective Taking</td>
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<tr>
<td>Response to Social Norms</td>
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<td>Moral Decision Making</td>
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</table>

Total Attachment-Related Behavior Score: ________
Weak = 20-46; Moderate = 47-73; Strong = 74-100

Client: ___________________________ Date Evaluated: ______________
Evaluator: ________________________
**Attached Relationship Inventory (ARI)**

1. **Desire for Relationship**
   - Does the individual want or seek relationships with others?

2. **Importance of Relationships**
   - Does the individual see social relationships as important?

3. **Security in Relationships**
   - Do relationships enhance satisfaction and confidence rather than increase or produce anxiety or doubt?

4. **Security Through Relationships**
   - Do relationships increase or enhance the individual's sense of self-image and social connection?

5. **Confidence in Relationships**
   - Does the individual believe that other parties in relationships can be trusted to and will care about and make his/her needs important?

6. **Confidence in Relationship Building Skills**
   - Does the individual believe in his/her ability to form and maintain personal relationships?

7. **Perspective Taking**
   - Does the individual have the capacity to recognize the needs, emotional states, attitudes, and thoughts of the other person in the relationship?

8. **Caring and Giving**
   - How giving is the individual with respect to recognizing and meeting the needs of other parties in the relationship?

9. **Reciprocal Mutuality**
   - Does the individual display mutuality and reciprocity in relationships (give and take), or just seek personal gratification (take and take)?

10. **Derived Satisfaction**
    - Does the individual have insatiable relationship demands?

11. **Intimacy and Boundaries**
    - Is the individual capable of close and interdependent relationships without becoming possessive and incapable of separation?

12. **Relationship Independence**
    - Is the individual capable of close and interdependent without over-dependence or enmeshment?

<table>
<thead>
<tr>
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<th>Strong</th>
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<td></td>
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<tr>
<td>Relationship Independence</td>
<td>1 2 3 4 5</td>
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</tr>
</tbody>
</table>

**Total Attachment Relationship Score:**

- Minimal = 12-27; Moderate = 28-44; Strong = 45-60

- Client: ____________________________ Date Evaluated: ________________

- Evaluator: ____________________________

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