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FAMILY ATTACHMENT NARRATIVE THERAPY: HEALING THE EXPERIENCE OF EARLY CHILDHOOD MALTREATMENT

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Based on attachment theory and research, Family Attachment Narrative Therapy is introduced as a new family therapy modality developed to heal the experience of early childhood maltreatment. Unresolved childhood trauma has been correlated with impaired and delayed cognitive, behavioral and emotional functioning. Gentle, soothing, nonprovocative and nonintrusive narratives told by parents provide an alternative restorative experience designed to shift and change the child's destructive internal working model. The result is improved functioning and the ability to accept nurturing and care in relationships that offer love and safety. A representative case example is used to illustrate theory, practice and outcome. Pre- and posttherapy assessment supports the claim of improved functioning.

Family Attachment Narrative Therapy was developed by the author to meet the challenge of providing effective treatment to the growing number of children who experience early childhood maltreatment. In the not-too-distant past, the prevailing assumption was that children were resilient, and, consequently, they would respond positively when life circumstances changed. We now realize that the problem is complex and that a change in circumstance must also involve changes in the way a child responds to adults that are able to provide care and protection (Fahlberg, 1991; Keck & Kupecky, 1995, 2002; Lieberman, 2003).

Each year in the United States, nearly one million children are determined to be victims of abuse and/or neglect, and it is likely that many more experience adversity that could be classified as maltreatment. In substantiated cases, more than 80% of the perpetrators were parents and 58% were mothers (U.S. Department of Health and Human Services, 2004).

Maltreatment by a parent can have a devastating effect on a child. Clinicians treating children with a history of disruptive attachment relationships, defined by neglect, abuse, or abandonment, frequently note significant behavioral, cognitive, and affective impairments (Greenberg, 1999). Identified areas of concerns include conscience development, impulse control, self-esteem, interpersonal relationships, and emotional stability. Cognitive problems can be observed in apparent deficits in logical and abstract thinking and difficulty in understanding cause-and-effect relations. Developmental lags may be evidenced in auditory processing, verbal expression, adaptive motor skills, and personal and social development (Fahlberg, 1991). Children who experience the chronic stress of neglect or abuse without a loving, attuned caregiver who can modulate their physiological arousal, thus providing a solution to their discomfort, seem to be impaired in their ability to achieve critical developmental transitions (Perry, Herman, van der Kolk, & Hoke, 1990).

A child's ability to separate from a traumatic past and move forward with a sense of purpose and a belief in a better future seems to be dependent on a close relationship with a supportive adult (Egeland, Carlson, & Sroufe, 1993; Sroufe, 1997). Unfortunately, the experience of maltreatment seems to prevent many children from trusting adults that could provide restorative care and protection. All children are born with the genetic predisposition to form strong attachments to their primary caregivers. However, if the child's early experience includes chronic abuse and neglect, the attachment process can be disturbed and negatively affect the child's ability to form healthy relationships in the future (Perry, 2001).

This conceptualization was first postulated in John Bowlby's Attachment Theory and his concept of an internal working model. Children inevitably form expectations of the behavior of others and themselves based on the responsiveness and accessibility of primary attachment figures (Bowlby, 1969/1982, 1973). This means that children approach new situations with a set of preconceptions, interpretive tendencies, and behavioral biases (Sroufe, Carlsonr, Levy, & Egeland, 1999). Maladaptive relationship patterns with primary caregivers tend to be internalized and carried forward in the way affection is received and expressed fortified by associated expectations, beliefs, and attitudes (Carlson & Sroufe, 1995). Bowlby (1973) noted that virtually all children will attach, but that the quality of attachment varies. This concept was investigated by Ainsworth, Blehar, Waters, and Wall (1978), resulting in the identification of secure, insecure/avoidant, and insecure/resistant patterns of attachment. Subsequent research identified children having a disorganized/disoriented pattern of attachment characterized by the lack of a coherent strategy that would ensure protection and physiological comfort from the caregiver (Main & Solomon, 1990). For these children, the parent seemed to be both a source of fear and of reassurance. As might be expected, the histories of children classified as disorganized/disoriented often include abuse, violence, terror, and unpredictability (Main & Hesse, 1990).

The Importance of Narrative

The inability to form a coherent strategy to ensure protection from the caregiver has also been identified in the narratives of maltreated children. Children exposed to disruption and family violence typically construct an incoherent, chaotic life narrative (Osofsky, 1993). Their stories frequently depict terrifying scenarios of violence and death without a comforting solution (Main, Kaplan, & Cassidy, 1985). In contrast, the stories of securely attached children seem to portray a fairytale motif in which the parent and child protagonists struggle, find a solution, and, ultimately, live happily ever after (Solomon, George, & DeJong, 1995). When faced with a frightening situation, the inability to contemplate a solution seems to retard developmental accomplishments and interfere with successful processing of subsequent traumatic experiences (Pynoos, Steinberg, & Goenjian, 1996). A coherent narrative reflects the child's ability to make sense of life experiences. The left hemisphere of the brain is used to tell the events of the story, whereas a right hemisphere function is necessary to incorporate the subjective, social, and emotional meaning of the internal life of the characters. Thus, a coherent narrative involves an integration of both hemispheres (Siegel, 1999; Siegel & Hartzell, 2003). Narrative memory refers to the stories that are used to store and recall life experiences. Children learn cultural roles and expectations by listening to narratives told by parents. Parents also use stories to communicate an understanding of the child's perceptions, beliefs, emotions, memories, and intentions (Siegel, 1999).

The child's emotion, sensation, perception, and internal model of the caregiver are all molded by experiences occurring before the child develops language and an autobiographical narrative. The parent's attunement with the child is primarily physiological during this implicit stage of memory development, As the child begins to use language to communicate, an explicit form of memory emerges that is both factual and episodic. Words used by the parent communicate an understanding of the child's perspective and emotional state. In the process, the emotional connection or attunement between parent and child is enhanced (Siegel, 1999).

The sharing of words between parent and child establishes the meaning of concepts, such as love, freedom, truth, good, and evil. As the child develops the capacity to use language to share thoughts and feelings with the parent, a common perspective is shared and internalized. In so doing, the child gains the capacity to take the point of view of another. This process of verbally interacting with others and with self is essential in the development of the ability to evaluate present behavior and attitudes and plan for change in the future. When this process does not take place, behavior is usually instinctive, impulsive, or learned through imitation and experience (Charon, 1985). Fonagy et al. (1996) hypothesize that some victims of childhood maltreatment cope by refusing to consider the abusive parent's thoughts and consequently, avoid thinking about the parent's wish to harm them. This defensive disruption of the child's ability to decipher mental states in themselves and others leaves them responding to an inaccurate impression of the thoughts and feelings of others. In contrast, parent-child reflective dialogue that identifies the mental state that fuels behavior, perceptions, feelings, intentions, goals, beliefs, and desires seems to promote both a secure attachment and the integrative process of co-construction of narratives. The result is a resilient perspective that promotes social competence, autonomy, and self-determination (Siegel, 1999).

Recovery from Childhood Maltreatment

Although early life experiences are significant, "changes in circumstances can lead to changes in interaction and therefore to changes in relationships" (Vaughn, Egeland, Sroufe, & Waters, 1979, p. 974). Even though the first few years of life are considered the most optimal for restorative interventions, children and adults who later experience a safe, predictable, and nurturing environment can also achieve positive change (Helgeson, 1997; Shore, 1997; Teicher, 2000).

FAMILY ATTACHMENT NARRATIVE THERAPY

Development of the Model

In 1995 a new family therapy methodology was developed by the author to address the difficulties experienced by behaviorally disturbed children and their adoptive or foster parents. This followed almost four decades of experience working with families and children in foster and adoptive homes, residential treatment facilities, and child guidance clinics. Many of these children experienced abuse, neglect, or abandonment while living with their original families. Some had spent months or years living in a crowded, understaffed orphanage. Even though there was now an opportunity for a new beginning with loving, responsible parents, these children seemed forever imprisoned in a maladaptive past. The goal was to develop a nurturing, nonintrusive program that could

heal the child's past and restore the capacity for positive family relationships. A primary component of the initial program design was the inclusion of stories or narratives told by the parent (May, 2000). Although the original theory and methodology were developed by this author, it is the narrative work of hundreds of parents that must be credited with the formation of the current model. The consistent psychological astuteness, articulated in parent narratives, had a direct impact on the refinement of theory and practice (Lacher, Nichols, & May, 2005) and the inclusion of adolescents and biological families in the target population. Eventually, the methodology came to be known as Family Attachment Narrative Therapy (Lacher et al., 2005; Nichols, Lacher, & May, 2002). It is represented in the case example cited below.

Formulation of the theory was initially based on the supposition that an experience that could go back to the beginning of the child's life would have the capacity to heal the destructive consequences of early childhood maltreatment. Although it is impossible to erase the emotional memory of maltreatment, stories or narratives could provide an alternative comprehensive restorative experience.

Subsequent research supported the concept that the experience of narrative is fundamentally the same as being in or observing the real situation (Zwaan, 1999; Zwaan & Radvansky, 1998). To make sense of a narrative or story, there must be an identification with a protagonist that allows a here-and-now perspective to be adopted. In so doing, the narrative has the capacity to travel back and forward in time and space, thus allowing the message to become immediately relevant (Bower & Morrow, 1990; Glenberg, Meyer, & Lindem, 1987). Because the original experience directly or indirectly involved the maltreatment of the child by the primary caregiver (parent), the comprehensive restorative experience of the narrative would require the total participation of the new parent(s).

Initially, academically trained therapists scripted and directed parent narratives. Even though the content did demonstrate the therapist's knowledge of child development and the importance of acknowledging the child's life experience (Brazelton, 1992; Fahlberg, 1991; oilman, 1992), these therapist-generated narratives failed to achieve the essential attachment-building attunement between parent and child. Fortunately, a few parents forged ahead without therapist instruction. Rather than sticking to the script, they began using narratives in ways that had not been considered in the original conceptualization. Instead of the halting, memorized script suggested by the therapist, parents began using language that was remarkably fluid and psychologically relevant in timing and content. Even more significant was the obvious attunement with a child who had previously rejected all parental attempts to connect. These early narratives demonstrated that, in spite of being the constant target of very difficult behavior, the parent had the ability to transcend the present and communicate an intuitive understanding of the child's feelings of fear, shame, anger, and despair. This attunement with the child's internal state was accompanied by the consistent message that the experienced maltreatment was not the child's fault and was not deserved.

It was also observed that the parent's ability to use the narrative intuitively to achieve attunement was not related to intelligence, education, psychological sophistication, or positive growing-up experiences. Rather, it seemed to be an innate function that was repeatedly activated as parent and therapist worked together to identify the impact of maltreatment on the child's motivating internal working model. In the process, the focus shifted from the child's problem behavior to the care, nurturing, and protection the child deserved.

Theoretical foundation. Theoretically, the development of the model is supported by the theory and research of George and Solomon (1999). They posit that, to ensure survival, the parent is biologically driven to provide care and protection in the same way the child seeks proximity to be cared for and protected by the caregiver (Bowlby, 1969/1982, 1973, 1980). Just as the infant is physiologically comforted when the parent is available and responsive, the mother experiences strong emotions of pleasure and satisfaction when she is able to provide protection and heightened anger, sadness, or despair when her ability to be available to her child is threatened. This need to be protected and to provide protection is the basis of the relationship that remains constant in purpose but necessarily develops and changes as the child matures. For instance, mothers of securely attached children are described as flexible and able to change the method of providing protection as the child matures. Implicit in this description is the parent's understanding of the child's emotional and psychological need and acceptance and encouragement of individual capabilities (George & Solomon, 1999).

It was also noted that the parent's intellectual, behavioral, or adjustment problems do not present a barrier to the intuitive understanding of the child's need for protection (George & Solomon, 1999). The motivation to provide protection seems to be present even when the parent has a disturbed and traumatic attachment history. In addition, as parents develop understanding and empathy for their child's fearful feelings, they are able to anticipate and prevent fearful situations (Fraiberg, 1980).

Theoretical assumptions. Family Attachment Narrative Therapy assumes that the parent intuitively knows and understands the fearful emotions and motivations of the child. As the parent realizes this understanding, he or she is able to feel empathy and, consequently, develop narrative strategies that protect and heal. The task of the therapist is to activate the parent's innate need to provide protection and healing in the form of narratives that verbally attune to the child's internal state and explicitly challenge the child's faulty motivating internal working model. To accomplish this goal, therapy begins with an intensive phase. As a rule, this consists of 30 hours spread out over 2 weeks. Depending on the age of the child and the circumstances of the family, variations of this schedule can be considered. Each day, the lead therapist and the parents meet while the child spends time with a nondirective play therapist. The play therapist is a member of the team and notes behavior and attitudes that contribute to the team's understanding of the child. Although we find the team approach most functional, the success of the model is not dependent on the rigid participation of multiple therapists.

Family Attachment Narrative Therapy requires a partnership between parents and therapist, a concept congruent with the emerging influence of narrative and resilience based models of partnership therapy (Minuchin, 1992; O'Hanlon & Weiner-Davis, 1989; Walsh, 1998; White & Epston, 1990).

Although our partnership with parents does require therapist competence, it is not measured by dispensing academic psychological wisdom. Instead, the graduate-trained therapist must assume the position of student, elevating the status of the parent to expert and consequently activating the parent's innate need to heal and protect. When the balance of this partnership is disturbed by an overactive, controlling therapist, it can impede activation of the attachment system.

Technique. The technique of activation begins as the therapist employs an affirming, inquiring, questioning method of eliciting the parent's intuitive knowledge of the child's motivating thoughts and emotions. Rather than providing the parent with a cookbook of techniques that will alter the child's problem behavior, the therapist asks for information that shifts the parent's focus from: "How can I control and change the unacceptable behavior of this child who is not accepting my authority?" to: "Who would my child be had I been there to love and protect her? How did my child think and feel when neglected, abused or abandoned? What conclusions did my child form in response to early maltreatment? What is my child feeling and thinking when she refuses to comply? What is my child feeling and thinking when he sabotages experiences that should be positive? What is my child feeling and thinking when she always has to be in control?"

As this questioning, interactive phase continues, the parent becomes the expert in articulating the intimate features of the child's internal working model. Whatever the behavior, past or present, mild or severe, this process moves the parent from anger and despair to an empathie understanding of the child's thoughts, feelings and behavior. This is illustrated by the parent who tearfully confessed that her total focus on problem behavior had prevented her from realizing the depth of her child's emotional pain.

Procedure. Following the initial activation stage of therapy, child and therapists move together to another room where the parents assume their role as narrative therapists. Therapy rooms are equipped with rocking love seats, and the child is encouraged, but not forced, to lie in the parent's lap in a position that would resemble the way an infant would be held. Although not an essential component of the methodology, physical cuddling by the parent does seem to enhance the affirming verbal content of the narrative. The child's willingness to be held appears to be related to emotional and behavioral development, rather than to chronological age.

Activating Narratives. During the initial activation phase, the components of coherent Claiming, Developmental, Trauma, and Successful Child Narratives are addressed, although parents are not given a script to follow. The classification of narratives is a guide rather than a rigid prescription so that, depending on the circumstance, parents may combine elements of more than one narrative. Frequently, there is no verbal input from the therapist while the parent is telling the narrative. On occasion, a parent may lose his or her train of thought or forget to articulate a particular concept. Should this occur, the therapist will again employ the questioning technique used during the activation phase to affirm the parent's expertise. This would occur during the therapy session with the child present.

As the parent tells a story that communicates an intuitive understanding of the child's perception, beliefs, emotions, memories, and intentions, the connection or attunement between parent and child is enhanced. This attunement is essential for the development of the secure attachment relationship and goaldirected parent-child partnership needed for permanent behavior change. An added benefit occurs as the parent gains confidence and skill and begins to self-correct unhelpful styles of parenting to match the ideal presented in the narrative. In spite of a personal history of abuse or attachment deprivation, the empathie

understanding of their child's internal working model seems to provide symbolic resolution for parents.

Claiming Narratives. The Claiming Narrative is a first-person story that concentrates on conveying the message that every child deserves, from the moment of conception, to be wanted, cherished, celebrated, loved, and cared for by responsible parents. The narrative does not attempt to alter the child's actual history. Instead, the child is introduced to a story that encourages positive beliefs about self and others. This first narrative begins with the parent(s) sharing the thoughts, emotions, and behavior that would have been displayed had this ideal occurred.

The Claiming Narrative is crucial in experientially activating the attachment system. Not only is the child the recipient of the parent's nurturing message of acceptance, this narrative enables the parent to visualize a helpless baby requiring love, care, and protection. Instead of the constant focus on the child's problem behavior, the parent is free to parent symbolically in a way that can only be described as excellent. Following this first narrative, it is common to hear a parent exclaim, "I needed that!"

Developmental Narratives. Developmental Narratives accomplish the dual purpose of continuing the nurturing, attunement-building message of the Claiming Narrative and informing the child about typical age-related adaptive behavior. This educational feature frequently seems to encourage the child to evaluate and change so that behavior is more congruent with chronological age. Most Claiming and Developmental Narratives are told in the first person. This provides the opportunity to educate the child explicitly on the thoughts and feelings of the parent, thus enhancing the child's ability to accurately determine the parent's internal motivating perspective.

Trauma Narratives. Whereas Claiming and Developmental Narratives are designed to enhance attachment to the present parent, Trauma Narratives focus on healing the child's actual history. To accomplish this goal, the narrative now becomes a third-person "Once upon a time" story with a protagonist who experiences the child's history. Typically, demographics are presented that are quite different from the child's actual situation. The reality of the child's early experience may or may not be known. Because it is a third-person story, the narrative does not have to be factually accurate, but it does allow the parent to use the protagonist to demonstrate intuitively their understanding of the child's perceptions, beliefs, emotions, memories, and intentions. In addition, Trauma Narratives challenge the inaccurate destructive beliefs and conclusions that comprise the negative, motivating internal working model.

Successful Child Narratives. These third-person narratives are necessarily instructive and are crafted to help the child to navigate the obstacles of every day life. A common theme is the child who meets a challenge, but prevails and achieves a successful outcome. It is the separation from the negative perception of the problem that defines the Successful Child Narrative. The technique of using a third-person format for the Trauma and Successful Child Narratives is successful in externalizing or providing distance from the problem, a concept central to the Narrative Therapy model of White and Epston (1990). Successful Child Narratives will always be most successful following the activation of the attachment system. Once the need to provide care and protection is activated, the content of the parent's narrative will ignore the difficult presenting behavior and concentrate on shifting the child's negative motivating internal working model. Although Successful Child Narratives are most often used to address ordinary life challenges, they can also be used to communicate understanding and attunement in extraordinary life circumstances.

Narrative Example

The following is a verbatim narrative told to an 11-year-old boy by a terminally ill adoptive mother. This narrative combines elements of a Trauma and Successful Child Narrative and demonstrates the mother's concern with providing care and protection for her child, even when facing her own death. This is evidenced by her concentration on healing the child's destructive internal working model, rather than focusing on the child's violent, dangerous behavior. The attachment system had previously been clinically activated during intensive attachment therapy so that the narrative was told without therapist coaching. This mother was not educated in academic attachment theory, (Bowlby, 1969/1982, 1973, 1980; George & Solomon, 1999). Even so, her narrative clearly demonstrates her recognition of her child's need for protection accompanied by her desire to protect.

Once upon a time, there was a precious little boy. For almost 5 years, he lived with his birth mom. His mom loved him, but she had problems taking care of him because she used drugs and alcohol. Sometimes, she would feed him and play with him and put him in his crib and forget him because she got high or drunk. When he was older, sometimes she would take him to daycare and promise to come right back but would forget because she got high or drunk. One time, she did not come back for almost 3 weeks. This time, a social worker came to the daycare center and took the little boy and placed him in a foster home.

The little boy was very, very scared. His birth mom had always promised she would be there to care for him, but the little boy could not depend on her. These new parents told him that they would care for him, but it seemed too scary to trust them.

Once the foster parents got to know the little boy, they fell in love with him. Meanwhile, the little boy's birth mom still used drugs and alcohol. Finally, she told the little boy that she could not care for him and wanted him to be adopted by parents that could be responsible. The foster parents were very happy, because they loved the little boy. They did not use alcohol or drugs, and they knew how to be responsible and care for him.

The little boy was still very scared. These new parents said they would be there forever and always but so did his birth mom. He loved his birth mom, but he could not count on her. It was very scary to even think about loving his adoptive parents. Finally, even though it was very scary, the little boy started to love and trust his new parents. "At last," thought the little boy, "I have a mom and dad that I can trust to love me and keep their promise to be there forever and always."

Suddenly, everything went wrong. The little boy's new mom got very sick. She had to go the hospital for an operation. When she came home, she had to keep going back for treatments. Even though the little boy's mom and dad tried to explain and tried to make it ok, the little boy started to feel more and more frightened. His mom lost all of her hair and she didn't act like she used to. Sometimes, she was so tired and sick that she couldn't take care of him. Even though it was different, it felt just like it had when his birth mom would leave him and tell him she would be right back. Just like before, he felt that he would be alone, and no one would be there to care for him.

The little boy started to do some very violent and dangerous things. He was so scared and so sure that he was going to be left all alone. When he was scared, he felt very angry. He was angry at his birth mom for not being responsible when he needed her. He was angry at his adoptive mom for getting sick. But most of all, he was very, very scared.

Finally, his mom and dad talked to him and told him that they loved him very, very much. Even though his mom could die, the little boy was told that he would always have a family. Mom and Dad reminded him that brothers and sisters and Dad would be there to care for him. He was a member of a family who would be there forever and always. His mom and dad told him that, whenever he felt scared, it was really important that he come and talk about his scared feelings. The little boy was still very scared, but he didn't feel so alone because he knew that he had a whole family to talk to about his scared feelings and that, even if his mother was gone, he did have a family that would be there forever and always.

Case Study

The following case example illustrates the theory and methodology described above:

Referral information. Jane, (not her real name) a 10-year, 10-month old Caucasian girl and her parents were referred for intensive attachment therapy by a metropolitan clinic of neurology Testing in November, 2001, indicated above-average intellectual functioning. A psychological evaluation at the clinic of neurology dated March 2003, suggested diagnostic considerations of reactive attachment disorder, dysthymia, anxiety disorder, posttraumatic stress disorder, social anxiety, oppositional defiant disorder, and bipolar disorder. In addition, neurotic and characterlogical or passive-aggressive personality features were noted.

In the report, the examining psychologist stated: Jane remains developmentally "stuck" in a narcissistically self-absorbed sphere with an overriding need for primary attachment work that will provide secure containment and socialization and neutralize her paranoid-like distrust. Without the provision of primary experience through extensive attachment therapy, Jane cannot resolve the loss and grief around her biological mother's death and integrate herself into her father's family.

Background. Jane was raised in an emotionally deprived and neglectful environment characterized by exposure to physical violence and adult sexual behavior. Her parents separated and divorced shortly after her birth, and she remained in the primary care of her chemically dependent mother. Following the divorce, Jane's father, Bill, married Carol, who eventually legally adopted Jane.

Jane's life with her biological mother was chaotic. She spent long hours in daycare and experienced many different caregivers. As a young child, Jane was often responsible for her own physical care and the care of her mother. The mother was alcoholic and drug dependent and Jane frequently witnessed the mother's sexual involvement with different men.

When Jane was approximately 5 years old, the mother remarried. Reportedly, there was considerable domestic violence, and it is likely that Jane was the victim of physical abuse and possibly sexual abuse. Although she had been completely toilet trained, she became enuretic and encopretic and also developed a severe eating disorder. Apparently, the mother was unable to cope with her own alcoholism, violent domestic situation, and Jane's regressive behavior. Ultimately, she contacted Bill and asked that he assume custodial responsibility for Jane.

Approximately 2 months after Jane's placement with Bill and Carol, her mother was killed in an alcohol-related automobile accident. Jane showed very little emotion upon hearing of her mother's death, nor did she openly grieve in the months and years that followed.

Behavior. Prior to beginning therapy at the Center, Jane's behavior was characterized by continued enuresis and encopresis. Jane would play with her feces and then put her fingers in her mouth. She failed to report accidents, and she would hide her soiled underwear in her drawers. Medical examination indicated that this condition did not have a physical basis.

Jane persisted in exhibiting serious control issues related to food. She would refuse to eat at home but would steal food at school. At times, she would fill her mouth with food until she gagged or vomited. She would bring her lunch to school but would then go to the nurses' office and complain that her mother did not feed her.

She had frequent nightmares and expressed significant anxiety related to her fear that her father would leave or be killed in an accident.

She refused to follow parental requests and would lie and not accept responsibility for her misbehavior. She was argumentative and oppositional. She would frequently destroy things that had meaning for Carol. She would also destroy gifts from her parents or projects she had made as a gift to her parents. Covert expressions of anger were often followed by counterfeit displays of affection. Overt expressions of anger, such as yelling and screaming, often seemed to be directed at the family pet. In school, Jane would bully classmates, lie, steal, and exhibit oppositional behavior in the classroom.

In the 5 years between Jane's placement with Bill and Carol and the beginning of attachment therapy, several treatment modalities had been tried including, behavior modification, traditional family therapy, individual talk therapy and Filial Play Therapy. Even though several of these therapeutic efforts lasted at least 1 year, parents reported that there was no significant change.

Parents. Jane and her parents began intensive attachment therapy in June, 2003. Prompted by her devout Christian faith, Carol stated that she was willing to do whatever was needed to help. However, she had difficulty imagining that she would be able to understand Jane's thoughts and feelings intuitively.

Carol's childhood experience was less than optimal, and to remain functional, she had learned to discount or dissociate her feelings. In contrast to her childhood home, order and cleanliness were an important component of the way she defined her role as full-time mother and homemaker. Carol stated that logic was her preferred way of operating and that she did not rely on feeling or intuition. She did not feel that relating to children was her gift, but she was willing to try, providing she could be told exactly what to say.

Carol's experience with Jane was not positive. Jane's failure to respond to logic combined with her food control issues and regressive elimination practices was a constant source of stress. In spite of Carol's extensive study on how to be a good parent, Jane seemed to succeed in sabotaging all of Carol's positive efforts. It was common for Jane to go to school and report that she was neglected or abused. Often, this occurred after an incident that had appeared to be a positive interaction between Jane and Carol.

Bill's childhood experiences were described as positive. Bill was comfortable expressing emotion, but he was also bothered by Jane's persistence in maintaining the above-mentioned regressive behaviors.

A strength for both parents was their strong Christian faith and belief that God had a purpose in sending Jane to live with them. The conceptualization of faith as a positive attribute has recently gained support from family therapy professionals. A spiritual dimension moves the emphasis away from treatment externally administered by experts to healing relationships that are at the core of strength-based, resilience models of practice (Walsh, 1999).

Whereas Carol had limited confidence in her own capacity to communicate an understanding of Jane's thoughts and feelings, she did have complete faith in God's ability to change her perceptions and choose her words so that Jane's traumatic past could be healed.

Claiming Narrative. The following is a verbatim example of Carol and Bill's first narrative. Although general themes had been discussed, the specific content and theme was spontaneous.

Carol: When you were born, I would have been so happy because I had always wanted a little girl. I would want to hold you right away and would have a hard time when the nurses took you to be weighed and checked out. The nurses would ask whether I wanted to have my baby in the nursery or in the room with me. Of course, I would want you rooming with me so I could watch you every second. When people came to visit, I would not let anyone hold you until I was sure they had washed their hands. I would want to be sure that nothing would harm you. On the way home from the hospital, I would have to sit in the back seat with you. In fact, I would want to do this every time we had to go someplace in the car. Finally, Dad would say, "Enough already! Baby Jane is perfectly safe in the back seat." Friends and relatives would want to have a baby shower. I would not want anyone to hold you, because I would be afraid of germs and they might expose you to saliva and bacteria.

Bill: I would have to do all of the shopping, because Mom would want to stay with you and hold you all of the time. We probably would have to have the whole house tiled so that we could keep it clean for you.

Carol: I'd hold you all of the time just to be sure you were ok. Most of the time, I would hold you and feed you and look at you. You would probably pee and poop on me, and you know how much I hate dirt and poop and pee, but I wouldn't care because I would love being close to you.

Analysis. In contrast to her self-evaluation prior to beginning the narrative, Carol's affect is warm and animated. Carol's obsessive-compulsive attention and concern about providing a clean environment for Jane covertly contrasts with the biological mother's neglect. For Jane, Carol's focus on cleanliness is reframed as love and concern, rather than a condemnation of Jane's character. This was extremely important because of Jane's regressive elimination practices.

Jane's response. Jane started this session lying stiffly in her mother's lap. As the narrative progressed, Jane began to relax and make eye contact with Carol. Following the narrative session, Jane returned to the playroom. She commented to the play therapist, "I felt like it all really happened. I can't remember being a baby, but I do remember my birth mom drinking, and I remember being beaten with a metal baseball bat."

Developmental Narratives. First Person Developmental Narratives combine Carol's understanding of child development with a continued message of love and care. Age appropriate activities, such as visiting relatives, going to the park, or splashing in the wading pool are the themes of stories. Carol's concerns for safety and cleanliness continue, but they do not restrict or inhibit normal exploration. Narratives continue through every developmental stage until Jane's age matches the age when she came to live with Carol and Bill. The primary theme is that Jane is loved and a source of delight for her parents.

The following are verbatim examples of Developmental Narratives.

Carol: We would have to call Dad so we could have lunch together. We'd want to have lunch at a place that had good food for kids and wasn't fussy. We would want to be sure that it wouldn't be a federal case if you threw some Cheerios on the floor or flipped your spoon across the table.

Bill: Mom would probably want to hold you most of the time because she would be afraid the chair was dirty.

Carol: I'd probably carry one of those bottles of sanitizers around and Dad would roll his eyes and moan because I had to be so sterile.

Jane's response. Jane and parents laugh, and there is a lot of good-natured kidding about Carol's concern about germs. Jane has clearly accepted the reframe so that Carol's obsessive attention to cleanliness is both a positive shared family joke and an expression of love and concern

Carol: I wouldn't even care if everyone teased me because I was so sterile, and Dad would be in big trouble if he didn't sanitize you because I wouldn't want you to get sick. You would be growing up and as you got close to being 2, your favorite word would be "No." You'd really love saying "No." We'd say, "Time for bed" and you'd say, "No." "Do you want a cookie?" "No." You really would want a cookie but you would want to say no even more. Even though you were two and could walk, I would still want to hold you and cuddle you.

Jane's response. Jane turns and faces Carol and melts into her arms. Carol strokes Jane's hair and rubs her back and rocks her. Jane stays in this position for the rest of the narrative.

Carol: Your hair would be getting longer and sometimes I'd put your hair in pig tails and put ribbons in your hair.

Jane's response. Jane's hair is very short. The next day, she comes to therapy with her hair in very short pigtails. Her hair remains that way each subsequent day. The play therapist notes that Jane is more relaxed. Jane does not comment directly on the Developmental Narratives but tells the therapist that she and her Mom are going to cook dinner together. She spends much of the time in play therapy practicing skills, such as cartwheels, which she wants her Mom to see.

Trauma Narratives. The following are verbatim examples of Trauma Narratives concentrating on Jane's experience after her mother's remarriage. The child protagonist is named "Anna."

Bill: Sometimes this new dad was not very nice to Anna. Sometimes she would call her first dad and say, "I'm scared." [Bill begins to cry.] Her dad would say, "God is watching out for you and I know that He has a special plan for your life." Anna's dad knew that Anna was scared and angry and that she was growing up and he couldn't be there to care for her. Anna could not talk to her mom and her new dad when she felt scared or angry. When she tried, she would be hit or spanked and sent to her room. Anna tried to fix her mom and step-dad, but no matter how hard she tried, she only got in trouble. She couldn't figure it out.

Carol: She couldn't figure it out because it wasn't her job. God created parents to take care of kids and kids to be kids. She was expected to take care of everyone and she couldn't do it because it wasn't her job. Kids are supposed to get up and get dressed and eat and go to school and learn stuff and make friends and play. Kids are not supposed to take care of adults and try to make them feel better.

Bill: Anna kept thinking that it must be her fault and that she was doing something wrong.

Carol: Sometimes, Anna would be so mad. She still loved her mom, because that is just the way God made her, but sometimes she didn't even want to love her mom.

Bill: Sometimes, Anna would cry herself to sleep. She would hear loud noises and would blame herself.

Carol: Sometimes things would get so bad and Anna would get so angry that she would wish her mom and step-dad would die. The sad thing for Anna was that this was supposed to be a happy time and her life was not happy. Sometimes she'd be so angry that she would break things. No one even noticed, which only made Anna feel like no one cared. During all of this time, God did have a plan for Anna. Sometimes, it is God's plan that some kids are to be adopted. He must have thought Anna was a very special kid.

Bill: During the very worst time for Anna, her Dad met a lady that loved God and had the same values and goals. Just when things got really bad for Anna, her mom decided that she could live with her dad and his new wife.

Carol: Then Anna's mom was in a car crash and died. This really hurt Anna because of all of the times she had wished her Mom would die.

Jane's response. Jane clings to both parents and sobs loud and long. This is the first time she has openly cried. Parents cradle Jane in their arms and share her

tears.

Carol: Anna felt so bad and was so scared. She was afraid to tell anyone what she was feeling, because she thought her bad thoughts had caused her mother's death. She really believed that wishing her mom dead had caused her to die. This, of course, was not true but that's how Anna felt inside. The truth is that the kind of thoughts Anna had were sort of normal "angry kid" thoughts.

Bill: Anna's dad knew that Anna was hurting, even though she couldn't express it. He knew that God loved Anna and valued her just because she was Anna. God knew that Anna's new family could see how special she was and that she would have a chance to work through the yucky things she had to experience when she was little.

Response. Parents and Jane crying and holding each other.

Successful Child Narrative. This verbatim narrative was a necessary follow-up to the Trauma Narrative but it also has many of the characteristics of a Successful Child Narrative.

Carol: Anna felt really sad that her mother had died because she loved her mom. She was having a hard time, because she believed that she had caused her mom's death, but she could never let anyone know what she was feeling. She began to believe that, deep inside, she was so bad that she could never be forgiven for what she had thought and that she would always be a failure. Anna's new mom sort of figured out why Anna was so troubled so one day, she told her this story: "There was this guy that started out pretty good. He went to really good schools and grew up to have a job he though was very important. He got so he believed some bad things about some people and he did some bad stuff. He even helped to kill some people he didn't agree with. He was really mean, so lots of people were afraid of him. He had lots of bad thoughts and he did some really crappy things. Then one day, he saw the light and learned that he had been doing all that bad stuff, because he didn't know what was true. When God showed him what was true, he totally changed and God forgave him for all of his past and, the rest of his life, he was mightily used by God."

Jane: Who was he? What was his name?

Carol: He wrote most of the New Testament. His name was the Apostle Paul.

Jane knew all about Paul from summer Bible school and Sunday school.

Carol: Just like Paul, Anna began to realize that, even if she did have bad thoughts, and even if she had done some things that weren't right, that God loved her and her parents loved her. Anna came to believe that she could accomplish great things in her life. She knew she wasn't perfect and that she would make mistakes but that, no matter what, she was a special creation, and she was loved. Sometimes, she would get really angry and think she was stupid or bad, but then she would remember the story of Paul and how he was forgiven and used by God. Anna came to believe that, even when she made poor choices, that her parents loved her. Sometimes she might do things that her parents were not happy with, but they loved her. She began to believe that she had special gifts and that some of the bad things that had happened to her could be used for good. Anna started to keep a journal and would write down all of the bad things that had happened to her. Her parents helped her to see that bad could be a way to plan for good. She had known what it was like to go without food or clean clothes, so she began to gather clothes she had outgrown to take to the thrift store, and she set aside canned food to take to the food shelf. As Anna shared her journal with her parents, everyone would pray, and turning the bad times into good became an important family time. Everyday, Anna grew and was able to trust a little more. She came to believe that her parents really loved her and wanted the best for her. Finally, she was able to be more open and tell her parents when she was hurt or felt sad.

Bill: Sometimes Anna's mom and dad would pray together and thank God for their little girl. They noticed that Anna had a good heart and didn't want others to hurt as she had been hurt. Anna was able to share more of her feelings with her parents. She sometimes would think about her birth mom and finally, she came to realize that she could love her birth mom and her new mom and dad, and this was God's plan all along.

Jane's response. Although Jane did not respond verbally to the concluding narratives, she listened intently, maintained eye contact, and clearly enjoyed being

held and cuddled by her parents.

INITIAL RESULTS

Within the first week of therapy, Jane's behavior started to improve. Almost immediately, encopresis and enuresis ceased. Gradually, most of the control issues related to food disappeared. Although behavior and communication were not perfect, they were vastly improved.

The parents frequently observed Jane self-correcting. Even though they had not addressed a problem, they would hear her say to herself, "That wasn't a very 10-year-old thing to do." Emotionally, Jane exhibited affection and indicated that her capacity for trusting the good intentions of her parents was improving.

By the end of the 2-week intensive therapy process, parents were skilled Family Attachment Narrative therapists and continued the daily use of narratives at home. The construction of specific narratives was an intuitive task accomplished by parents. In most cases, these narratives resembled the Successful Child Narratives described above, but they concentrated on problems of daily living. Follow-up with the lead therapist consisted of brain-storming sessions so that parents could continue to focus their efforts on identifying and communicating their understanding of Jane's internal working model.

PRE- AND POSTTHERAPY ASSESSMENT

Prior to beginning treatment, the Vineland Adaptive Behavior Scale (Sparrow, Balla, & Cicchetti, 1984) was administered to assess whether Jane's adaptive behavior was congruent with her chronological age. Adaptive behavior is defined as the performance of daily activities required for personal and social sufficiency. Performance is related to age, rather than ability, and is determined by the standards and expectations of others (Sparrow et al., 1984).

The Vineland Adaptive Behavior Scale requires a structured interview with the primary caregiver(s) that assesses adaptive behavior across three broad areas: Communications, daily living skills, and socialization. Results are given as an age equivalent that is indicative of whether the level of functioning is congruent with the child's chronological age. There is also a 27-item scale that assesses behavior that is considered maladaptive for children 5 and older. Scores above 13 on this scale are considered to be maladaptive.

Approximately 2 months after starting therapy, a second Vineland Adaptive Behavior Scale was administered. Table 1 contains a comparison of pre- and posttherapy age equivalents.

DISCUSSION

Case Study

Pretherapy assessment suggests that Jane's traumatic early life experiences had a significant impact on her behavioral, social, and emotional functioning. The improvement in the posttherapy assessment implies that the comprehensive restorative features of Family Attachment Narrative Therapy were successful in providing a replacement for the original experience of maltreatment.

The essential attachment-building component of having the parent articulate an understanding of the child's perspective and emotional state (Siegel, 1999), was consistently evident in the parent narratives. The narratives also made explicit the thoughts and feelings of the parents (Fonagy et al., 1996), thus enhancing the child's ability to decipher mental states in herself and in others.

None of the narrative work was scripted. Although common themes of Claiming, Developmental, Trauma, and Successful Child Narratives were addressed, the specific application and content was not known to the lead therapist or to the parents, until the narrative gained momentum. This included the identification of Jane's interior thought process surrounding the death of her biological mother.

Carol started the process convinced that she did not have the required aptitude or skill to assume the role of a Family Attachment Narrative Therapist. Although intuition and feeling were not her preferred method of relating, she consistently demonstrated her ability to transcend the visible facts and attune to

Jane's internal process. Even though Carol cognitively expressed doubt and concern, her narrative work was consistently spontaneous, animated, eloquent, and relevant.

Without therapist instruction, she was able to reframe her obsessive-compulsive tendencies from judgment and condemnation to love and protection. Her consistent narrative theme of providing protection is congruent with the supporting research of George and Solomon (1999).

The noted rapid improvement in Jane's problem behavior was accomplished without direct intervention. Instead, Bill and Carol's intuitive knowledge of Jane's thoughts and emotions made it possible for them to use narratives to challenge and shift Jane's motivating negative internal working model. The interwoven message of God's love and forgiveness also contributed to the narrative message of resilience and hope for a positive future.

Theoretical and Methodological Limitations

Family Attachment Narrative Therapy does not claim a uniform treatment outcome for every child with a history of early childhood maltreatment. Some children are compromised by prenatal exposure to drugs and alcohol. Others have genetically influenced temperament, psychiatric, or neurological challenges. Although such conditions may affect the level of functioning, they do not necessarily compromise the child's capacity to respond positively to attachment figures that offer love and protection. Even though the parent-child response is commonly positive, there are exceptions.

The methodology does require a parent who is committed to being the primary agent of healing for the child. The parent does not have to be verbally fluid to assume the necessary role of narrative therapist. Some parents are animated and eloquent, whereas others are more constricted. The importance of the narrative is that it demonstrates parents' desire and ability to love and protect and their intuitive ability to understand the perceptions, feelings, intentions, goals, beliefs, and desires of the child. The activation of the attachment system necessarily results in the attunement-building components of the narrative that promote a secure attachment and a new resilient internal working model.

An angry, discouraged parent is not a serious impediment. However, if the parent retains a desire to punish the child for the pain he or she has caused the family, this attitude would be a serious contraindication. Parents who want to wait to see whether the child's behavior improves before committing to the relationship may guard against activation of the attachment system. Finally, the parent without a support system may also resist full participation. This can be an emotionally isolated single parent or a married parent whose spouse is not in agreement with the focus of the program, the child's need for nurturing and healing, or the child's presence in the home.

The methodology can be used for all family constellations. If the participating parent were also the maltreating parent, the key feature would be that maltreatment is no longer taking place. An example would be the parent who, in the past, was abusive when drinking. If the parent is in recovery and can use the narrative to communicate that the original maltreatment was not the child's fault and was not deserved, restorative healing can occur.

Therapist training. The methodology described above has been presented in workshops and training seminars throughout the United States. Therapists that come to the center for 2 weeks of intensive training have been able to implement the methodology, in their home communities, with congruent positive results.

Other therapeutic modalities also assume that the parent has the basic skill and desire to be a good parent. For instance, competency-based therapies strive to increase the parent's recognition that they possess the skill necessary for understanding their child's needs Although the descriptive goal is similar, the therapist must assume the role of teacher to achieve the desired outcome (Erickson & Kurz-Riemer, 1999; Waters & Lawrence, 1993). Filial Play Therapy (Guerney, 1969) actively involves the parents in the child's treatment. However, the professional therapist directs the intervention and serves both as a teacher and a support person for the parents. In contrast, Family Attachment Narrative Therapy concentrates on activating the parent's innate need to provide care and protection; it then trusts that the parent has the intuitive ability to develop coherent narratives that protect, heal, and shift the child's negative internal working model.

Although Narrative Therapy (White & Epston, 1990) and Family Attachment Narrative Therapy share some similar techniques and conceptualizations, there are substantial differences. For instance, even though the Family Attachment Narrative Therapy goal of shifting the child's negative internal working model is reminiscent of the re-storying concept of Narrative Therapy (White & Epston, 1990), the Family Attachment Narrative Therapy model uses parent narratives

specifically to shift and heal the child's faulty negative beliefs and attitudes, whereas Narrative Therapy would advocate a collaborative, nonspecific narrative re-storying. These differences are theoretically defined. Narrative Therapy is a social-constructionist, postmodernist therapy that would be suspicious of ultimate truths and would support an inquiring discovery process (White & Epston, 1990). In contrast, Family Attachment Narrative Therapy posits a belief in the ultimate truth of the child's innate need for a primary attachment relationship in which the child is the recipient of the parent's attuned care and protection. This core belief is the impetus for the goal directed parent narrative methodology and is supported by the basic premise of attachment theory (Bowlby, 1969/1982, 1973, 1980; George & Solomon, 1999) and research correlating patterns of early childhood attachment with narrative construction (Bretherton, 1987, 1990; Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Main, 1991; Main et al., 1985; Solomon et al., 1995).

Finally, it is important to separate Family Attachment Narrative Therapy from some of the other therapies treating children with attachment disorders (O'Connor & Zeanah, 2003). The techniques most in question include shame induction, rage induction, and forced holding (Dozier, 2003). Family Attachment Narrative Therapy does not employ any of the above-mentioned techniques and is distinguished by being firmly grounded in attachment theory and research (Bowlby, 1969/1982, 1973, 1980; George & Solomon, 1999). Coherent narratives told by the parent(s) consistently illustrate the gentle, nurturing, noncontrolling, nonprovocative, nonintrusive, soothing methodology. This focus provides an atmosphere of safety for the child that promotes the regulation of negative affect and the adoption of a new positive internal working model.

Family Attachment Narrative Therapy was originally developed to address the difficulties experienced by behaviorally disturbed children and their adoptive or foster parents. Clinical observation and parent reports have consistently been positive, and it is expected that qualitative and quantitative research projects, still in process, will support the efficacy of this new family therapy.

In the years since its inception, theory and methodology have been refined and successfully applied to a variety of family constellations. Possible future application to specialized populations, such as incarcerated parents and their children, could require a parent to tape restorative narratives for his or her child. If successful, such adaptations will undoubtedly lead to focused research and further refinement of the methodology.

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