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How Can the Attunement Needs of Children with Disorganized Attachment Styles Be Supported Through Expressive Arts Therapy?

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How Can the Attunement Needs of Children with Disorganized Attachment Styles Be Supported

Through Expressive Arts Therapy?

Capstone Thesis

Lesley University

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Expressive Arts Therapy

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Abstract

Treatment strategies for school age children with disorganized attachment are not well established. This population exhibits a range of difficulties in social relationships and self-regulation. Additionally, children with disorganized attachment generally rely on defense mechanisms and present with other comorbid conditions, adding to the complexity of treatment. This paper explores current research and theories about disorganized attachment and then, on the basis of evidence provided throughout this paper, proposes the concept of attunement needs in relation to working with children with disorganized attachment. The attunement needs described in this paper, derived from the literature, include safety/security, control/power, consistency, affective release, and unconditional attachment. This paper describes expressive arts therapy as a treatment option for disorganized attachment, and proposes several considerations for structuring sessions with this population based on attunement needs.

How Can the Attunement Needs of Children with Disorganized Attachment Styles Be Supported
Through Expressive Arts Therapy?

Introduction

Treatment for children with disorganized attachment is complex. Children with disorganized attachment, by definition, “have experienced inadequate early care and exhibit an inability to form relationships on which they can depend for security, care, and as a base for self exploration” (American Psychological Association, as cited in Zilberstein & Messer, 2010, p. 85). One of the most fundamental aspects of working with children who have experienced disorganized attachment is the therapeutic relationship. The therapeutic relationship itself is the therapy (Wallin, 2007).

At my current internship site, I work with school age children, ages 5 through 14, at a therapeutic day school. Many of these children have experienced developmental trauma or disorganized attachment patterns with caregivers. From my own clinical experience, I have seen that children with disorganized attachment often rely on defense mechanisms. Defense mechanisms are adaptations, and allow individuals “to cope advantageously with the environment in which they live” (Schamess, 2011, p. 86). Children with disorganized attachment have learned adaptive behaviors for survival, which appear as maladaptive in most social situations. These defenses can make it difficult to build the therapeutic relationship. Furthermore, my experience has been that children with disorganized attachment often display quick shifts in behavior, which may include sudden outbursts, or the tendency to attach quickly or push away.

In order to develop a secure therapeutic relationship, a therapist must attune to their client. Attunement is the ability to read and respond to the communicated needs of another, which involves a synchronous and responsive attention to nonverbal cues (Perry, 2013). From

my own clinical experience, it has been difficult to understand and attune to the needs of children with disorganized attachment because they so often rely on defense mechanisms for survival. These defense mechanisms may cloud the most predominant needs of the child. It is important to note that attunement will look different depending on the child and their experiences, needs, and treatment stage.

Children with disorganized attachment often resist a securely attached therapist, as they have no strategies for this type of relationship. Establishing a therapeutic relationship is one of the main advantages of therapy, but is also one of the main challenges when working with children with disorganized attachment (Wallin, 2007). Additionally, children often enact their disorganized attachment patterns with therapists, either as a defense mechanism or because a disorganized attachment is the only type of relationship they know. This can leave the therapist with a sense of helplessness or hopelessness, as well as a disorganized understanding of what the child needs (Shea, 2015). I can relate to these feelings of helplessness or hopelessness as I often leave sessions with children with disorganized attachment styles feeling disorganized myself. In these scenarios, I consider my own countertransference as relevant information in order to attune to the child and understand their needs. When using my own countertransference as a tool for guiding sessions, I often ask myself, “how am I feeling in session and how might this relate to how the child is feeling?”

At this time, there is research focusing on infants and toddlers, but less on school age children with disorganized attachment (Zilberstein & Messer, 2010). Explaining clinical manifestations or interventions for this population is a difficult task. Although children with disorganized attachment share similar difficulties and presentations, different types of early experiences such as “abuse, neglect, institutionalization, duration and extent of adverse

experiences, different temperamental and genetic traits, IQ, cognitive ability, and varying degrees of caretaker availability and behavior” all have an effect on a child’s presentation and the likelihood for successful treatment outcomes (Zilberstein & Messer, 2010).

This literature review focuses on children, ages 5 through 14, who display disorganized attachment patterns. On the basis of evidence provided throughout this paper, I am proposing the concept of attunement needs in relation to children with disorganized attachment. Attunement needs may be clouded by defense mechanisms or complicated by comorbid diagnoses. This paper describes a course of common behavior patterns that arise when working with children with disorganized attachment, how it can feel to be a therapist working with this population, possible underlying attunement needs of children with disorganized attachment, as well as expressive arts therapy session strategies for addressing attunement needs. If a therapist can anticipate certain behaviors and feelings when working with children with disorganized attachment, and better understand underlying attunement needs, there may be fewer instances of helplessness and hopelessness for the therapist, which in tune may facilitate the therapeutic relationship.

The first section of this paper defines disorganized attachment, and examines how disorganized attachment is related to trauma, how disorganized attachment may affect the neurobiology of a child, and how school age children with a history of disorganized attachment may present in session. This section also discusses common defense mechanisms that children with disorganized attachment may rely on, how it may feel to be a therapist working with children with disorganized attachment, and the importance of processing transference and countertransference. The second section of this paper addresses the importance of attunement in building the therapeutic relationship and possible attunement needs that underlie manifesting

behaviors. The third section of this paper discusses expressive arts therapy as a treatment option, how expressive arts therapy affects the neurobiology of a child with disorganized attachment, and how expressive arts therapy provides a nonverbal experience. The final section of this paper provides strategies that support attunement needs when working with disorganized attachment, and a case vignette that exemplifies how proposed strategies could be used.

Literature Review

Attachment

Bowlby and Ainsworth were the pioneers of attachment theory. Bowlby (1988) recognized attachment as a biologically based evolutionary necessity for survival. Bowlby understood attachment as a motivational system that provides physical and emotional security for the infant (as cited in Wallin, 2007). Ainsworth discovered that “the inborn, biologically driven attachment system is actually *malleable*—and that qualitative differences in the attachment behavior of individuals depend on the differential behavior of caregivers” (Grossman, as cited in Wallin, 2007, pp. 15-16). Thus, infants rely on their caregivers for the development of attachment, and attachment patterns can shift depending on the type of relationship an infant or child experiences.

Ainsworth studied attachment between mothers and their children in Uganda, and then in Baltimore with the development of the Strange Situation. The Strange Situation was an assessment devised by Ainsworth in the 1970s to observe the attachment between mothers and babies, aged 9 months to 18 months. During the Strange Situation, the mother and baby were introduced to a 20-minute laboratory situation in which the baby’s response to the mother leaving the room and then rejoining the baby were monitored. The Strange Situation studies led

to the classification of three attachment styles: secure, avoidant, and ambivalent (Ainsworth & Bowlby, 1991).

Ainsworth and Bowlby (1991) observed that infants with secure attachment had caregivers who demonstrated consistent, sensitive, and appropriate responses to infant signals. These infants were upset when their caregivers left the Strange Situation room and soothed when their caregivers returned. Infants with avoidant attachment had caregivers that were emotionally unavailable or unresponsive to infant signals. These infants avoided their caregivers in the Strange Situation room. Infants with ambivalent attachment had caregivers that were inconsistent in their responses to infant signals. These infants displayed separation anxiety when their caregivers left the Strange Situation room and were not reassured when their caregivers returned (Ainsworth & Bowlby, 1991). Main and Solomon discovered a fourth, separate category of attachment, referred to as disorganized/disoriented attachment (as cited in Cunningham & Page, 2001). Infants with disorganized attachment demonstrated contradictory and confused behavior toward their caregivers in the Strange Situation room (Cunningham & Page, 2001).

Bowlby suggested that children develop internal working models through their relationships with caregivers. Bowlby explained that children may develop internal beliefs such as “(a) one is worthy of love and that the world is a predictable and positive place (i.e., secure attachment), or (b) one is unlovable and exists in a world that is unpredictable and untrustworthy (i.e., insecure attachment)” (as cited in Green, Myrick, & Crenshaw, 2013, p. 91). Internal working models tend to retain their essential qualities over time, however are subject to updating and revision through the experience of new relationships. Internal working models affect how children interact in future relationships (Cunningham & Page, 2001). Therefore, disorganized

internal working models will affect children's behaviors within the therapeutic relationship, and will often complicate their course of treatment (McCluskey, Hooper, & Miller, 1999).

Disorganized Attachment

Children with disorganized/disoriented attachment may have internal working models characterized by inconsistency and fear (Cunningham & Page, 2001). Main suggested that disorganized attachment resulted when an attachment figure was simultaneously experienced as the source of safety and danger (as cited in Wallin, 2007). Children with disorganized attachment generally experience messages that are both comforting and frightening from their caregivers (Green, Myrick, & Crenshaw, 2013). Disorganized attachment has been strongly associated with a history of parental maltreatment (Cunningham & Page, 2001). According to Main (1995), as many as 80% of maltreated children in high-risk samples fit into the disorganized/disoriented category.

Disorganized attachment can occur from interactions in which the parent's anger or abuse is frightening, but also from interactions in which the child experiences the caregiver as frightened (Wallin, 2007). Additionally, disruptions in effective parental communication, such as "mocking or teasing the infant, silent interaction, nonresponse to clear infant cues, unusual changes in pitch/intonation" can all lead to the child's fright without solution, and eventually disorganized attachment (Lyons-Ruth & Jacobvitz, as cited in Shilkret & Shilkret, 2011, p. 196). Therefore, disorganized attachment can occur when a caregiver is frightening, frightened, or dissociated.

Disorganized attachment and trauma. Trauma can have a major impact on the development of children. Experiencing disorganized attachment patterns from a caregiver can compound the symptoms of trauma. Shilkret and Shilkret (2011) have found that a large amount

of research in the past decade has involved understanding trauma through the lens of attachment. Most of this research has centered on disorganized attachment, as disorganized attachment is most often associated with children who have a trauma history. Becker-Weidman (2006) explained, “the individuals at the greatest risk of developing significant psychiatric disturbances are those with disorganized/disoriented attachments and unresolved trauma” (p. 119). Without a secure attachment to rely on, children with disorganized attachment are unable to process their traumas and, therefore, become stuck with many symptoms. According to Perry (2013), the duration and severity of trauma in children is dependent on many factors, one of the most significant being a healthy and supportive caregiver.

Van der Kolk (2005) suggested that there are currently few diagnoses that take into account the various symptoms a child with developmental trauma or disorganized attachment may exhibit. Many of these children have experienced abuse, neglect, or multiple housing placements, causing a host of comorbid symptoms including post-traumatic stress disorder, aggression, oppositional behavior, school difficulties, mood disorders, or attention problems (Zilberstein & Messer, 2010). These children are often given a range of comorbid diagnoses in an attempt to explain the varying symptoms of developmental trauma or disorganized attachment (van der Kolk, 2005). When children carry several diagnoses, clinicians may run the risk of veering away from the most fundamental attachment problems, or applying treatment approaches that are not helpful (van der Kolk, 2005).

Neurobiology of disorganized attachment. The National Scientific Council on the Developing Brain (2014) suggested that the neural circuits for dealing with stress are particularly malleable during the fetal and early childhood periods. Klorer (2005) explained that a baby is born with 100 billion neurons in the brain, although they are not all functioning. The neurons that

are not used become disabled, and the neurons that become part of active neuropathways thrive. The child's brain develops in a use-dependent fashion, meaning that the more any neural system is activated, the more likely it is to become permanent (Klorer, 2005). There are crucial windows of opportunity for development of certain areas of the brain during early childhood. If the neurons are not activated by positive emotional or nonverbal parental communication, they wither.

Schore (2001) suggested that positive emotional or nonverbal communications between the primary caregiver and infant directly impact the experience-dependent maturation of the infant's developing brain. Schore (as cited in Wallin, 2007) stated, "the baby's brain is not only affected by these interactions; its growth literally requires brain/brain interactions and occurs in the context of a positive relationship between mother and infant" (p. 69). Infants and young children with disorganized attachment often lack positive emotional or nonverbal communications with caregivers, thus affecting their earliest brain development.

Schore (2002) postulated that traumatic attachment histories affect the development of frontolimbic regions of the brain, especially the right cortical areas that are prospectively involved in self-regulating functions, such as the processing of social, emotional, and bodily information. Siegel (2012) observed that the right brain requires positive emotional stimulation, such as consistent, sensitive, and appropriate responses from caregivers, in order to develop properly. This is significant because children with disorganized attachment have often lacked positive emotional stimulation. If traumatic attachments are present during infancy when the right brain is developing more quickly than the left, a child's ability to self-regulate will be affected.

The National Scientific Council on the Developing Brain (2014) suggested that, “toxic stress during this early period can affect developing brain circuits and hormonal systems in a way that leads to poorly controlled stress response systems that will be overly reactive or slow to shut down when faced with threats” (p. 2). As a result, children may feel threatened or respond impulsively to situations where no real threat exists. Additionally, children may remain excessively anxious long after a threat has passed. The neurobiological findings of disorganized attachment are alarming. Early traumatic attachments can shape the brain in a way that makes it more difficult for children to process social, emotional, and bodily information, therefore creating a path where attunement is difficult and attunement needs are seldom met.

Presentation of disorganized attachment. Children with disorganized attachment are internally disorganized (Zilberstein & Messer, 2010). They generally exhibit internal worlds that are overwhelmed by unresolved affect and fear (Zilberstein & Messer, 2010). Perry (2013) described common manifestations of children with attachment problems. Children with disorganized attachment may present with developmental delays and odd soothing behaviors, such as hoarding or limiting food, biting themselves, head banging, rocking, scratching, or cutting themselves. Additionally, children with disorganized attachment may display a range of emotional problems, such as depressive or anxiety symptoms, as well as confusion surrounding intimacy. Furthermore, children may exhibit abusive or aggressive behaviors that have been modeled by adults. This behavior is often a result of poor impulse control and a lack of empathy (Perry, 2013).

Malchiodi and Crenshaw (2014) explained that children with disorganized attachment present with the following in several combinations: hypervigilance, hyperarousal, exaggerated startle responses at the slightest trigger, disorganized or agitated behavior, withdrawal, a

hardened or “hard-to-reach” demeanor, and emotional “tuning out” (p. 69). Furthermore, “in such children, therapists are likely to meet a restricted range of feelings, impoverished capacity for play, and repetitive rituals in play (including self-harming or self-denigrating behavior or the reenactment of traumatic events)” (Malchiodi & Crenshaw, 2014, p. 69). Their drawings and stories within session are generally incoherent, spatially disoriented, or disrupted by distractions (Zilberstein & Messer, 2010).

Working with children with disorganized attachment can be challenging. It can be difficult to contain and keep safe a child who is unable to self-regulate (Zilberstein & Messer, 2010). Added to these challenges is the “scattered, fragmented, nonsequential nature of activity in the therapy room. Children may switch from screaming and kicking to remote, dissociative states. These switches are further complicated by the presentation of different stages of development in these children’s behavior” (Malchiodi & Crenshaw, 2014, pp. 69-70). The various presentations of children with disorganized attachment make it more difficult to attune to the child and develop a therapeutic relationship.

Transference. Transference is the redirection of feelings and desires retained from childhood toward a new person (Shilkret & Shilkret, 2011). A therapist may rely on transference in order to help the child with disorganized attachment create a new understanding of a secure relationship. A child with disorganized attachment may feel as though the therapist fulfills a parental role, and may even desire them to do so. Shilkret and Shilkret (2011) explained, “there is a similarity between the role of the parent in an infant/young child and the role of the therapist in that the therapist is trying to create a secure base from which the client can explore her difficulties” (p. 201). This process can be challenging when children with disorganized attachment begin to enact their disorganized attachment patterns within the therapeutic

relationship, especially if the child feels as though the therapist has assumed a role similar to a caregiver. For example, a child may not tolerate nurturing aspects of the therapeutic relationship, and may shift between connecting to the therapist and pushing the therapist away. The therapist continues to offer a secure base so that the child can explore past disorganized relationships within a safer context (Bowlby, as cited in Cunningham & Page, 2001).

Countertransference. Countertransference refers to the therapist's "thoughts, feelings, fantasies, and unconscious reactions to a client" (Berzoff, 2011, p. 225). Countertransference can be a useful tool when working with a child with disorganized attachment. Often, these children are unable to clearly express their feelings and needs, and instead rely on defense mechanisms to cope within session. When a child dissociates, projects their negative feelings, or enacts their traumatic relationships, the therapist may be left with a range of feelings that reflect the child's experience. Berzoff (2011) explained that, "countertransference [is] essential to understand because often our clients cannot speak of trauma or of very painful feelings, other than by the therapist being open to experiencing them" (p. 225).

When a therapist leaves session with a child with disorganized attachment feeling disorganized or fragmented, those feelings are a good indication of how the child may feel. When a therapist feels they need more structure within session, those feelings are a good indication that the child may also need more structure. Therefore, therapists can use countertransference to better understand the child's thoughts, feelings, and desires, and address their attunement needs.

Defense mechanisms. Children with disorganized attachment may rely on defense mechanisms, or behavioral adaptations, that allow them to cope with their environments. Individuals use the most adaptive defenses available to them (Schamess, 2011). Adaptive

defenses generally appear as maladaptive in most social situations. Maladaptive behaviors are learned behaviors that are used for survival. These defense mechanisms can make it more difficult for a therapist to attune to a child or understand their attunement needs. It is important to note that there are several more defense mechanisms that are not covered in this section. This paper focuses specifically on common defenses for children with disorganized attachment, including dissociation, projective identification, and enactment.

Dissociation. Dissociation is an adaptive defense mechanism and is often observed in children who have suffered traumatic experiences (Basham, 2011). Dissociation involves detaching from reality or compartmentalizing different conflicting thoughts and experiences (Basham, 2011). Schamess and Shilkret (2011) explained that, “in dissociation, a painful idea or memory is separated from the feelings attached to it, thereby altering the idea’s emotional meaning and impact” (p. 79). When dissociation occurs regularly, a child’s self-structure may become fragmented. As a result, a child’s memories and feelings become split, leaving “tremendous internal chaos or mental clutter” (Basham, 2011, p. 458). Evidence of dissociation is often apparent when a child stares into space in a trance like manner, experiences memory lapses, or displays internal fragmentation. Children with disorganized attachment may have learned to rely on dissociation during traumatic or unpleasant situations in order to remove themselves from their environment (Basham, 2011).

Projective identification. Klein discussed the power of projective identification as a way to think about how “a child can induce in another (first the mother, then others) what the child feels but cannot say” (as cited in Berzoff, 2011, p. 224). Projective identifications are unconscious relational communications. Children with disorganized attachment often have difficulty expressing their feelings verbally, and may unconsciously project their feelings onto

another person. The therapist may unconsciously find herself holding the child's feelings (Berzoff, 2011). Through projective identification, the therapist may feel the child's "love, hate, deadness, or disturbance" (Berzoff, 2011, p. 224). If a child is bullying or pushing away another person, the therapist might consider the child's own feelings of self-hatred, shame, or confusion (Berzoff, 2011).

Enactment. Children with disorganized attachment often enact aspects of their trauma or attachment problems within the therapeutic relationship. Relational trauma is unconsciously enacted within the therapeutic relationship, such that the therapist and child take on different roles (victim, victimizer, bystander) until the trauma can be processed (Berzoff, 2011). Children with disorganized attachment may use enactment as a way to process their traumatic experiences, or because a disorganized way of relating is the only way they know how to connect (Berzoff, 2011).

Summary of defense mechanisms. Defense mechanisms such as dissociation, projective identification, and enactment may appear like strong barriers that surround the child. It is important for the therapist to understand these barriers in order to attune to the child and develop a therapeutic relationship. A child may rely less on defenses for protection of physical and emotional safety once a strong and secure therapeutic relationship is established. The therapist helps the child create a new concept of feeling secure.

Attunement

Developing a secure therapeutic relationship is a significant, yet challenging, part of treating disorganized attachment. In order to develop a secure therapeutic relationship, a therapist must attune to their client. Attunement is the ability to read and respond to the communicated needs of another, which involves a synchronous and responsive attention to nonverbal cues

(Perry, 2013). It can be difficult to understand a child's attunement needs when they rely on defense mechanisms within the therapeutic relationship. Additionally, children with disorganized attachment may present in several ways due to comorbid diagnoses, adding to the complexity of their treatment. No matter how the child with disorganized attachment presents in session, building the therapeutic relationship is generally the first step.

It is critical for the therapist to notice and encompass the child's present state (McCluskey, Hooper, & Miller, 1999). Attuning to a child throughout their creative process, and assisting them when appropriate, "mimics the neurobiological relationship between a caring adult and a child" (Malchiodi & Crenshaw, 2014, p. 9). Attunement within the therapeutic relationship is imperative for gaining insight into the child's current functioning and developing a more secure therapeutic relationship. This new relationship can begin to repair the damaged neurobiology of a child who lacked an attuned caregiver.

Not only is it difficult for a therapist to attune to the child with disorganized attachment, the child often struggles to attune to themselves and others. Kossak (2015) explained, "traumatic stress, such as long-term chronic abuse and neglect inhibit the ability to tune in" (p. 120). When a child has experienced relational trauma, "there will be difficulty attuning to another person, let alone to oneself" (Kossak, 2015, p. 120). This idea is significant because it suggests that both the therapist and the child will have difficulty tuning in and understanding presenting needs.

Extreme malattuned responses include acting in an insensitive or expert like manner, and telling the child how they should feel. Less extreme malattuned responses include correcting the child's feelings or minimizing their experience. Malattuned therapists may also change or prematurely close a topic, summarize a child's material in a too conclusive manner, or ignore affective clues (Havas, Svartberg, & Ulvenes, 2015). Therapists may not intend to misread a

child, but may ultimately feel disorganized with regard to the child's varying presentations and needs. If a therapist is having difficulty attuning to a child, they may begin to feel helpless and hopeless when determining how to guide sessions.

Attunement Needs for Children with Disorganized Attachment

On the basis of the evidence presented in this paper, I am proposing the importance of addressing attunement needs within the therapeutic relationship. It is important to note that attunement needs will vary depending on the child and their circumstances. This section suggests attunement needs that are prevalent within the literature. These attunement needs include safety/security, control/power, consistency, affective release, and unconditional attachment. This list is only a foundation for possible attunement needs with children who have experienced disorganized attachment.

Safety/security. Safety or security are important attunement needs and provide the foundation for a therapeutic relationship. Children with disorganized attachment may likely have experienced an unsafe or insecure relationship with a caregiver, and therefore may have a difficult time trusting the therapist. Children with disorganized attachment may also exhibit unsafe behaviors in session in order to evoke negative reinforcement. Malchiodi and Crenshaw (2014) suggested that, "without safety, there can be no attachment or relationship" (p. 57). It is important to consider both physical and emotional safety (Malchiodi & Crenshaw, 2014). Rules or expectations may be determined between the therapist and child in order to keep the child, the therapist, and the materials in the room safe.

Control/power. Children with disorganized attachment have generally experienced little to no control or power throughout their childhood. It is common for children with disorganized attachment to seek control and power within session (Landreth, 2012; Malchiodi & Crenshaw,

2014). For example, children with disorganized attachment may control the activity by constantly changing the rules, creating powerful characters within the play, engaging in a power struggle, or refusing to follow limits or cues for redirection. Providing several choices can empower a child with disorganized attachment (Malchiodi & Crenshaw, 2014). Within session, children with disorganized attachment can practice gaining control over their experiences, so that they can eventually gain control over their lives.

Consistency. Children with disorganized attachment have experienced inconsistent interactions with caregivers, and therefore develop disorganized ways of behaving. Modeling a consistent relationship is imperative for children with disorganized attachment, so that they can practice new ways of connecting and behaving within a more predictable, dependable, and secure relationship. Children with disorganized attachment are able to explore and process difficult feelings through the consistency and dependability of the therapist and therapeutic framework (Green, Myrick, & Crenshaw, 2013)

Affective release. Children with disorganized attachment may have difficulty expressing their feelings verbally, and therefore may find it helpful to release these feelings in other ways, such as expressive arts therapy modalities. It is important for therapists to create a safe therapeutic space so that children with disorganized attachment can experience an affective release of thoughts, feelings, and emotions. This release will look different depending on the child and their circumstances, and can include a range of different emotions. Children may display aggression, hatred, anger, jealousy, or joy. Through the expressive arts, children with disorganized attachment can explore thoughts, feelings, and emotions at a safe distance. It is important for the therapist to become comfortable with these emotions, which at times can shift quickly or manifest intensely. Children with disorganized attachment have difficulty regulating

the intensity of their affect (Schore, as cited in Malchiodi & Crenshaw, 2014). By providing a safe therapeutic space and co-regulation techniques, a therapist can assist the child in releasing and regulating their affective states.

Unconditional attachment. Unconditional attachment is similar to unconditional positive regard or even unconditional love. Unconditional positive regard is “acceptance at the deepest level... [a therapist] may disapprove of the behavior of the person, but [they] accept who he or she is at a much deeper level” (Rogers, 1993, pp. 101-102). Children with disorganized attachment may have lacked a caregiver when they really needed one. Within a secure and consistent therapeutic relationship, a child who has experienced disorganized attachment can begin to experience what it means for a person to be there for them no matter what.

As a therapist, it can be difficult to be present for clients who have experienced disorganized attachment, who rely on defense mechanisms, and who display a range of maladaptive behaviors. However, when a therapist shows up time and time again, the child with disorganized attachment can begin to learn what it feels like to be cared for unconditionally. Within these moments, children with attachment insecurities can begin to learn what it feels like to be in a more secure relationship.

Summary of attunement needs. Safety/security, control/power, consistency, affective release, and unconditional attachment are important attunement needs for children with disorganized attachment. A child with disorganized attachment may not clearly express these attunement needs, and may even resist them. However, when addressed, these attunement needs allow a child with disorganized attachment to experience more secure patterns of attachment.

Expressive Arts Therapy

Expressive arts therapy is a form of treatment that utilizes visual art, movement, music, drama, play, and talk modalities within a psychotherapeutic framework as means for communication and processing. The essence of expressive arts therapy is creativity (Donohue, 2011). Expressive arts therapists ask: what are all the ways of expression and how can utilizing these different forms of expression help paint a fuller picture of someone? Expressive arts therapy can be utilized for all ages and populations, and is especially useful for children who have difficulty expressing their thoughts, feelings, and emotions verbally. An expressive arts therapist can choose a specific modality depending on the needs of the child. For example, if a child has high energy and is very active, movement or music may be appropriate modalities. Intermodal expressive arts therapy can also be used within session. This involves switching between modalities in order to deepen the experience by processing through several means of expression (Knill, Levine, & Levine, 2005). Expressive arts therapy is sometimes referred to as creative arts therapy. Malchiodi and Crenshaw (2014) explained, “the creative arts therapies... are experimental, active approaches that capitalize on engaging individuals of all ages in multisensory experiences for self-exploration, personal communication, developmental objectives, socialization, and emotional reparation” (p. 3).

Expressive arts therapy provides a multisensory experience. Activities are visual, kinesthetic, tactile, olfactory, and auditory in nature. Music therapy not only involves sound, but also vibration, rhythm, and movement. Drama therapy not only involves vocalization, but also movement and visual cues. Dance therapy not only involves movement, but also rhythm and a variety of body-oriented sensations. Art therapy not only involves visual images, but also a variety of tactile and kinesthetic experiences (Malchiodi & Crenshaw, 2014).

Sensory based experiences play an important role in early childhood, especially in enhancing a secure attachment, developing empathy, practicing self-regulation, and affiliating with others. These sensory processes are effective in altering neural systems involved in stress responses and developing secure attachment (Perry, as cited in Malchiodi & Crenshaw, 2014). Siegel (as cited in Malchiodi & Crenshaw, 2014) explained the importance of sensory-based expression, such as a client's tone of voice, facial expression, eye contact, and motion, in identifying and formulating strategies for working with disorganized attachment (p. 6). These sensory-based forms of expression are useful in providing clues to a client's psychobiology and attachment patterns.

Expressive Arts Therapy and Neurobiology

“Research on the impact of trauma proposes that highly charged emotional experiences are encoded by the limbic system and right brain as sensory memories” (van der Kolk, as cited in Malchiodi & Crenshaw, 2014, p. 7). Therefore, using expressive arts therapy to process these events on a sensory level is an important part to successful treatment (Malchiodi & Crenshaw, 2014, p. 7). Expressive arts therapy does not rely solely on the left brain for verbal processing and instead includes right brain activation. Perry (2009) suggested that repetitive motor activities such as music, movement, and yoga help to organize and regulate neurological input that would likely diminish trauma related symptoms (p. 243). Expressive arts therapy can help facilitate left and right brain integration, which can help in accessing, articulating, and processing traumatic memories. Additionally, as a child with disorganized attachment establishes new secure attachment patterns within expressive arts therapy sessions, new neural pathways will form.

Expressive Arts Therapy and Accessing Nonverbal Experiences

Nonverbal communication is our most basic form of communication and is how infants and caregivers communicate during an infant's first years of life (Schoore, 2003). Children with disorganized attachment might have missed out on this most basic form of communication, which is vital for brain development and gaining an aptitude for attunement. Furthermore, children with disorganized attachment often have difficulty verbalizing their traumatic experiences. It is now known that traumatic memories are encoded by the limbic system and right brain as sensory memories (van der Kolk, as cited in Malchiodi & Crenshaw, 2014). Traumatic memories are stored in the right hemisphere; therefore, verbal declarative memory of the trauma may be more difficult. Expressive arts therapy can help access nonverbal memories within the right hemisphere, and facilitate right and left brain integration for future verbalization of traumatic experiences when the child is ready (Klorer, 2005).

Klorer (2005) suggested, "nonverbal, expressive therapies can be more effective than verbal therapies in work with severely maltreated children exhibiting attachment difficulties" (p. 213). Furthermore, because thoughts and feelings "are not strictly verbal and are not limited to storage as verbal language in the brain, expressive modalities are particularly useful in helping individuals communicate aspects of memories and stories that may not be readily available through conversation" (Malchiodi & Crenshaw, 2014, p. 6). Rothschild (2000) explained how memories in particular have been reported to emerge through touch, imagery, or carefully guided movements. Although expressive arts therapy includes more traditional talk therapy, it also utilizes nonverbal expression through the arts and play as a means to communicate, process, and attune. Expressive arts therapy provides children with disorganized attachment the nonverbal connection they may have lacked with their primary caregivers as infants or young children.

Furthermore, expressive arts therapy provides a safe outlet for children with disorganized attachment to express and process their thoughts, feelings, and emotions.

Discussion of Clinical Application

When I began this process, I hoped to find specific interventions to use for children with disorganized attachment. I became frustrated when I would bring an expressive arts therapy intervention to session that colleagues, articles, or books recommended, only to find that the child I worked with was not ready or willing to participate. In my own clinical experience, it was difficult to plan specific interventions for children with disorganized attachment because they rarely seemed to align with the children's presenting needs. What started to emerge through my own clinical experience and review of literature were common attunement needs that were consistently important when building a therapeutic relationship with a child with disorganized attachment. Although planning specific interventions was often unreliable, I found that addressing attunement needs was a reliable foundation for working with children with disorganized attachment and building the therapeutic relationship. This is not to say that specific interventions never work for children with disorganized attachment. Rather, there is a complexity to working with children with disorganized attachment that specific interventions often do not account for. Addressing attunement needs provides a foundation for building a therapeutic relationship while also leaving space for all the complexities children with disorganized attachment may exhibit.

There are several reasons why specific interventions are not useful when working with children with disorganized attachment. A child with disorganized attachment may not feel safe within the therapeutic relationship or may refuse certain activities in order to gain control of the session. Additionally, some interventions may be too structured, limiting the natural affective

release of a child with disorganized attachment. Children with disorganized attachment may also have difficulty accessing and sharing emotional content verbally or in a structured way.

Comorbid conditions complicate the presentation of a child with disorganized attachment, making it more difficult for a therapist to choose an appropriate intervention. Finally, children may regress to certain developmental periods during session, especially when processing traumatic experiences. All of these instances make it difficult to rely on specific interventions when working with children with disorganized attachment.

Structuring Sessions for Children with Disorganized Attachment

This section looks at different ways to structure expressive arts therapy sessions in order to attend to attunement needs for children with disorganized attachment. It is significant to note that there are several ways to think about structuring expressive arts therapy sessions, especially with regard to choosing materials, modalities, and interventions. Every child with disorganized attachment will present differently, therefore, attunement is critical in determining the appropriate course of treatment. Expressive arts therapy is an effective treatment option for children with disorganized attachment because it provides a range of options, which can be individualized according to a child's needs. This section looks specifically at The Expressive Therapies Continuum (ETC) and The Attachment, Regulation, and Competency (ARC) Model, which are two possible frameworks for structuring expressive arts therapy sessions with children with disorganized attachment. This section then looks at strategies for addressing attunement needs within expressive arts therapy sessions.

The ETC. The ETC is one way to conceptualize the structure of an expressive arts therapy session when working with a child with disorganized attachment. The ETC provides a theoretical foundation for engaging through creative modalities (Hinz, 2009). The ETC can be

used with any art modality, such as visual art, movement, drama, or music. The ETC consists of four developmental levels: Kinesthetic/Sensory, Perceptual/Affective, Cognitive/Symbolic, and the Creative Level. The Creative Level represents the integration of information in a creative and functional way, and may be present in all developmental stages (Hinz, 2009).

Developmentally, the Kinesthetic/Sensory Level aligns with the sensorimotor stage in which infants and toddlers often process information nonverbally through sensation and movement. In this stage, the focus of the art activity is on the kinesthetic action or sensory experience rather than on the product or image. The Perceptual/Affective Level allows children to understand, identify, and express emotions appropriately, as it corresponds to schematic or concrete operations. In this stage, the focus of the art activity is on more concrete representations of self-expression (Hinz, 2009). The Cognitive/Symbolic Level is the most developmentally sophisticated, as it corresponds to formal operational thought and the ability of adolescents to process information outside of their own personal experience. In this stage, the focus of the art activity is consciously and strategically thought out, and may include more symbolic representations (Hinz, 2009).

The school age children that I have worked with at the therapeutic day school generally present within the Kinesthetic/Sensory or Perceptual/Affective Levels within session. Several factors influence where a child with disorganized attachment presents along the ETC in session, such as a child's current age, the age during which adverse experiences occurred, presenting needs, or stage of treatment. Therapists can use children's art from any modality to determine where they are developmentally and structure their sessions accordingly.

Lusebrink (2010) explained, "the sequence in which an individual moves along the levels of the ETC can be conceptualized as reflecting increased complexity of visual information

processing and corresponding brain structures and functions” (p. 173). Therefore, moving from the Kinesthetic/Sensory Level to the Perceptive/Affective Level in session may show an increase in a child’s ability to process information. Furthermore, the ETC provides an explanation of how creative experiences have the potential to integrate information from both hemispheres of the brain, as the Kinesthetic, Perceptual, and Cognitive components represent left hemisphere development and the Sensory, Affective, and Symbolic components represent right hemisphere development. This is important because left and right brain integration aids in the child’s ability to understand, process, and articulate traumatic memories.

The ARC model. The ARC model provides a framework for working with children with disorganized attachment and developmental trauma (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). The ARC model highlights sequential stages that a therapist and client must work through in order to build a secure therapeutic relationship, such as attachment, regulation, and competency. The ARC model suggests that building a strong therapeutic attachment serves as a foundation for later stages of therapy, such as the development of self-regulation skills and interpersonal competency (Zilberstein & Messer, 2010). Like many frameworks for working with children with disorganized attachment, the ARC model does not outline specific strategies for treatment (Zilberstein & Messer, 2010).

Strategies for addressing attunement needs in session. In the following section, I describe what I have determined to be some of the most important aspects of a session with a child with disorganized attachment in order to support their attunement needs and build the therapeutic relationship. Maintaining clear expectations, creating consistent opening and closing rituals, working in a child-centered approach, and providing transitional objects are all important considerations when working with children with disorganized attachment. These elements can be

used in conjunction with several frameworks, such as the ETC or the ARC model, and adapted to other theoretical foundations in order to support a child's attunement needs.

Maintaining clear expectations. Maintaining clear expectations addresses the attunement needs of safety/security, control/power, consistency, and affective release. Setting limits within session provides the child with physical and psychological safety (Landreth, 2012). When children feel safe within the therapeutic relationship, they can begin to exert control over their situation and experience affective release. Additionally, setting limits creates appropriate boundaries within the therapeutic relationship, demonstrates the therapist's intent to provide safety for the child, anchors the session in reality, allows the therapist to maintain a positive and accepting attitude toward the child, and provides the maintenance of legal, ethical, and professional standards (Sweeney & Landreth, as cited in Crenshaw & Stewart, 2015). Furthermore, setting limits allows the child to express negative feelings without causing harm, offers stability and consequence, promotes the child's sense of self-responsibility and self-control, creates a safe foundation for catharsis through symbolic channels, and protects the room and materials (Sweeney & Landreth, as cited in Crenshaw & Stewart, 2015).

Setting limits should be a carefully thought out procedure designed to convey understanding, acceptance, and responsibility to the child. Landreth (2012) explained, "the objective of the therapist is not to stop the behavior but, rather, to facilitate the expression of the motivating feeling, want, or need in a more acceptable manner" (p. 269). Examples of expressive arts therapy session expectations are that the child should not harm themselves, the therapist, or the materials in the room. Establishing limits to a child's behavior models a safe, secure, and consistent relationship. Clear limits provide the therapist with a sense of security, allowing them

to show up unconditionally. When clear limits are established, both the child and therapist know what to expect within the therapeutic relationship, creating a secure base for treatment.

Creating consistent opening and closing rituals. Creating opening and closing rituals addresses the attunement needs of power/control and consistency. Opening and closing rituals provide consistency between sessions and a reliable container for both the child and the therapist. There are countless expressive arts therapy opening and closing rituals that can be used with children with disorganized attachment. It is important to determine these rituals with the child in order for the child to feel safe and maintain a sense of control over their session.

Examples of expressive arts therapy opening rituals include using creative modalities to check in about current thoughts, feelings, emotions, or moods. A child could draw, move, or play an instrument to convey how they feel. Examples of more specific opening rituals include picking a color or hitting a drum at a specific tempo to represent a current feeling. A child could also add to the same book or canvas each session, allowing the child to track their progress from session to session.

Examples of expressive arts therapy closing rituals include checking in about how the child feels at the end of session, finding a safe spot in the room to store their art, or cleaning up any materials. Closing rituals could also include breathing, meditation, or mindfulness exercises. It is important to consider what opening or closing activities are suitable for the child, especially if the child has a tendency to present as either hyperaroused or hypoaroused. A hyperaroused child may find it triggering to close with a ritual such as quiet breathing or mindfulness meditation. Therefore, it is important to attune to the child's energy level when choosing opening and closing rituals. In my own clinical practice, I have incorporated mindfulness into higher energy level activities for hyperaroused children, such as passing a ball back and forth while

counting to ten. Closing rituals can assist the child in transitioning from session. Additionally, it is important to transition a child from the play or art making in order to ground them in reality before leaving session. Furthermore, an opening or closing ritual that incorporates art could also serve as a transitional object at termination.

Working in a child-centered approach. There is a large body of research on client-centered approaches, such as child-centered play therapy. Working in a child-centered approach addresses the attunement needs of safety/security, power/control, affective release, and unconditional attachment. The child-centered approach is centered on the basic philosophy that children have an innate capacity to strive toward growth and maturity (Landreth, 2012). Child-centered therapists understand children to be naturally curious, self-directed, and interested in self-mastery (Landreth, 2012). In my own clinical experience, using child-centered expressive arts therapy has been an important part to attuning to children with disorganized attachment and developing a therapeutic relationship. Working from a child-centered approach allows therapists to notice a child's usual tendencies, how a child approaches and utilizes the materials, and themes that naturally arise throughout sessions. By noticing the child-directed processes within session, a therapist can begin to assess the child's functional, developmental, and treatment stage. Child-centered therapy allows children to be themselves, and to work through things in their own way and on their own time (Axeline, as cited in Landreth, 2012). This provides a sense of safety and security, while also giving children the power and control to move at their own speed.

During a child-centered therapy session, children may choose to stay within the metaphor of play or art when processing their thoughts, emotions, and feelings. This provides a safe distance from their story (Kottman & Ashby, 2015). Therapists actively reflect the child's

thoughts, emotions, and feelings in whatever metaphor the child chooses to work within. Within the child-centered framework, a therapist continually shows up for the child and models that wherever the child is within the therapeutic process, is right where they need to be (Landreth, 2012).

Providing transitional objects. Providing transitional objects addresses the attunement needs of safety/security, consistency, and unconditional attachment. Children with disorganized attachment may often have difficulty joining or leaving the expressive arts therapy session. Transitional objects (Winnicott, 1953) are physical objects that provide psychological comfort. They serve as a representation of the caregiver-child bond when the caregiver is absent or when the child experiences a new situation. In the same way, a transitional object can serve as a representation of the therapist-client bond when the child leaves session. Flanagan (2011) explained, “the worn, scruffy teddy bear, the beloved chewed-up piece of blanket, the humming of Mom’s favorite tune—these are things that children literally carry with them in order to begin to cross that gap away from complete union...” (p. 128). Clinically, the concept of transitional objects is extremely useful in helping children who have difficulty separating from the therapist (Flanagan, 2011). Children with disorganized attachment often have difficulty creating internal transitional objects, or a sense of continuity and security, when they separate from the therapist (Flanagan, 2011). Therefore, giving a child with disorganized attachment a physical object can allow them to hold on to the connection between sessions.

One of the benefits of expressive arts therapy is that any art created within session can serve as a transitional object. Other examples of transitional objects may include an appointment card, a rock, or a sticker. Transitional objects remind the child of the therapist’s unconditional attachment, as well as the safety that the therapeutic relationship provides. Giving a transitional

object at the end of session can serve as a consistent closing ritual and can assist in the child's transition from session.

Case vignette. Melvin is a 12-year-old boy who presents with disorganized attachment patterns. Melvin has a history of neglect, as well as emotional and sexual trauma. Melvin's biological parents were substance users, and were unreliable in caring for Melvin. Melvin moved in with foster parents when he was 5 years old, and continues to have occasional contact with his biological parents. Melvin is diagnosed with attention deficit/hyperactivity disorder (ADHD) and presents with high energy, exaggerated startle responses, and aggressive, unsafe, and risky behaviors. Melvin's neuropsychological evaluation indicates that he has developmental delays. Melvin has difficulty maintaining appropriate physical boundaries and verbalizing his thoughts, emotions, or feelings.

In session, Melvin is disorganized, constantly testing limits and shifting between activities. Melvin has difficulty expressing or processing his experiences verbally. In session, Melvin has difficulty discussing his biological or foster family. Melvin's connection with the therapist is variable, as he often enacts disorganized attachment behaviors. Melvin is always ready and willing to attend session, however when the session is over, Melvin makes comments that he wishes the therapist would go away or die. Melvin also projects several feelings onto the therapist, such as fear, confusion, and anger. Melvin enjoys startling, scaring, and hiding from the therapist. The therapist often notices holding onto Melvin's feelings throughout session, and generally leaves feeling disorganized. Melvin has difficulty transitioning from session. During these transitions, Melvin displays unsafe and risky behaviors, such as climbing on furniture or running outside.

Melvin demonstrates the need for safety/security, power/control, consistency, affective release, and unconditional attachment in order to develop a more secure understanding of his self and the therapeutic relationship. Movement, drama, and play therapy modalities have been suitable for Melvin's high energy. During the first session, the therapist explained the three expectations for the therapy room: Melvin should not hurt himself, the therapist, or the room. These expectations have served as an anchor, as Melvin constantly climbs on furniture, hits his head, punches the wall, or throws things at the therapist. These expectations have modeled what a safe, secure, and consistent relationship looks like. Additionally, the expectations have allowed the therapist to feel safe within the relationship, which has been essential for providing unconditional attachment.

Melvin is disinterested in participating in consistent opening and closing rituals, however he often chooses to begin session by passing a ball back and forth. This has become an opening ritual and serves as a warm-up for session. During this time, the therapist is able to check in with Melvin about his current thoughts, emotions, or feelings, and gauge his presenting mood. Melvin is also unwilling to participate in a consistent closing ritual. The therapist began providing Melvin with a transitional object, such as paper that he could use between sessions. Providing a transitional object has supported Melvin in the transition from the therapy room, and has served as a closing ritual. The transitional object has also been important for transitioning out of the creative process and grounding Melvin in reality before leaving session.

Working in a child-centered approach has been the most effective way to attune to Melvin's needs. Melvin has been consistently disinterested in specific expressive arts therapy directives, and enjoys having control over his session. By using a child-centered approach, the therapist has been able to assess Melvin's tendencies, his use of the materials, and common

themes throughout sessions. Melvin is often unable to answer direct questions and is disinterested in participating in verbal discussions. However, through Melvin's creative process and play, he is able to delve into his thoughts, emotions, and feelings, and experience affective release.

Melvin is unable to verbally explain his anger, sadness, or frustration, however he enjoys throwing a ball as hard as he can against the wall. Melvin is unable to discuss his biological or foster family, however he constantly plays out scenes of family members being killed or eaten. The therapist has noticed how interwoven love and pain are for Melvin through his creative process and play. For example, Melvin has shifted from caring for a stuffed animal or baby doll to throwing it at the wall. Melvin constantly tests limits and displays defiant behavior toward the therapist, however he never wants to leave session.

The child-centered expressive arts therapy framework allows Melvin to work through his disorganized attachment patterns in his own way and on his own time. The therapist continually provides a secure base for him to enact his disorganized relationship patterns. Over time, the therapist will work to address Melvin's attunement needs, providing him with safety/security, power/control, consistency, affective release, and unconditional attachment. All the while, the therapist and Melvin will work toward establishing a more secure relationship, so that Melvin can release his defenses, tune in to his needs, and develop new patterns of relating.

Conclusion

This paper explores possible attunement needs for children with disorganized attachment, which include safety/security, control/power, consistency, affective release, and unconditional attachment. It is important to note that this list provides only a foundation for possible attunement needs with children who have experienced disorganized attachment, and will differ

depending on the child and their circumstances. This paper proposes a course of common behavioral patterns that arise when working with children with disorganized attachment, how it can feel to be a therapist working with this population, and expressive arts therapy session strategies that support attunement needs.

More research is needed with this population so that a more comprehensive model of their treatment needs can be established. Only a few case studies exist that explore the various difficulties and treatment dilemmas for school age children with disorganized attachment. Additionally, the dilemma of how to treat school age children with disorganized attachment, who are in shifting custody or who do not live with caregivers that can be active in treatment, remains. This research is important so that therapists can anticipate certain behaviors and feelings when working with children with disorganized attachment, address attunement needs, and structure sessions accordingly. This will result in more successful treatment outcomes and a brighter future for school age children who have experienced a challenging start.

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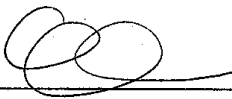
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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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