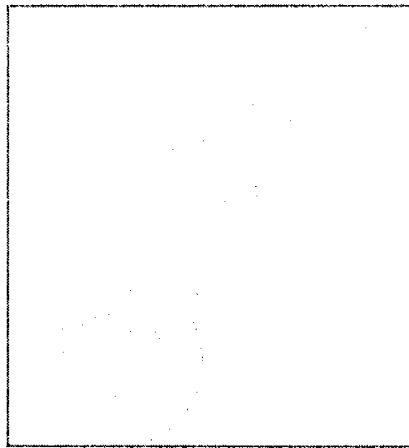


Handbook of Attachment-Based Interventions



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CHAPTER 3

The Circle of Security Intervention

Design, Research, and Implementation

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We begin this chapter with an account of the origins of the Circle of Security® (COS) intervention, including the initial collaboration that led to the first evaluation of the COS program, a description of the families for whom it was initially designed, as well as the underlying assumptions and key intervention goals of the COS intervention. Next, we describe the three initial COS protocols, all of which entail personalized diagnostic and treatment plans for individual parents, with accompanying video review of themselves and their child. We then present findings from research examining each of these protocols, including data related to the efficacy of the three initial COS protocols, research on moderators of the efficacy of COS that help to answer questions about “what works for whom,” as well as recent research on the psychotherapy process and the intervener–mother relationship within COS. Then, we discuss the ways in which implementation considerations led to the development of a new protocol: COS–Parenting. We end with a call for future research on the COS protocols. Throughout, when we use the term *parent*, we include in this usage all of the many caregivers who are not birth parents.

The COS intervention approach was developed as an early intervention group program lasting 20 weeks for at-risk families enrolled in Head Start and Early Head Start. A University/Head Start Partnership grant led to a research collaboration involving an evaluation of the COS intervention protocol as it began to be implemented with parents participating in Head Start. Three psychotherapists in Spokane, Washington—Glen Cooper, Kent Hoffman, and Bert Powell—initiated design of the clinical intervention and delivered it to the parents; Robert Marvin, from the University of Virginia, led the research component for the project. The principal

goal for the project was to create and evaluate a systematic protocol based on attachment theory and designed to reduce the risk of insecure attachment (Hoffman, Marvin, Cooper, & Powell, 2006).

A key moment in the development of COS came several years prior to applying for the University/Head Start Partnership grant, when the Spokane team attended Jude Cassidy's training workshop for the MacArthur Preschool Attachment system (Cassidy, Marvin, & the MacArthur Attachment Working Group, 1992). The Spokane therapists were familiar with attachment theory, but during the training workshop they became intrigued by the degree to which the coding system highlighted children's attachment-related behavioral strategies and by the nuances of behavioral patterns associated with each attachment classification. They were struck by the idea that attachment theory had important implications for clinical intervention. The team began several years of training and reflection to reevaluate, both personally and professionally, the centrality of relationships. When they introduced attachment-related material to other clinicians, many of them reported the same personal and professional reevaluation. This response suggested to the team that learning about attachment could stimulate a process of self-evaluation regarding relationships. It is this process of reflection and reevaluation that guides the COS intervention. The thinking at the time of COS development was: If Head Start parents could be taught the basics of attachment theory, they too would reevaluate their relationships with their children.

The challenge was to teach attachment theory and the fine distinctions of behavioral strategies in a manner that is accessible and engaging for at-risk families. A number of mothers who participated in the project were adolescents who had not completed high school. To maximize the possibility of success, all the materials used in the program had to pass what we called the "16-year-old parent test." Many iterations of the program materials were submitted to the parents for their keen criticism; from this, the COS graphic and other program handouts were born. We are grateful for the feedback that the parents provided us in making COS intuitively understandable, without losing the integrity of the theory. Below we introduce the underlying assumptions and key goals of the COS intervention (shown in Table 3.1).

Underlying Assumptions and Key Intervention Goals of COS

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The COS approach is based on three assumptions:

1. At their core, parents bring positive intentionality to childrearing.
2. All parents have well-established strategies to protect themselves from the painful emotions associated with adverse experiences in their own developmental histories. In some cases, these protective strategies exert a sufficiently powerful effect to prevent the parent from seeing and responding to the child's basic attachment cues, and a secure attachment is not created.
3. Given that a child thrives when the parent is relatively responsive to both attachment and exploratory behavior, it is important that the parent consider

what may hinder his or her capacity to respond to particular aspects of the child's behavior.

The key goals of COS (see Table 3.1) are built on these three assumptions. Note that these five key intervention goals are important for not only the original 20-week protocol but also all of the subsequent versions of COS described later in this chapter. First, parents are asked to develop a better understanding of their children's needs (Goal 1). All versions of the COS use the COS graphic to facilitate communication with parents about children's needs. The COS graphic is also useful in helping parents to enhance their observational and inferential skills (Goal 2), by providing a context within which parents practice describing what they see the child doing, then make meaning of those observations. Once parents develop a foundational understanding of children's needs for attachment and exploration, develop awareness of children's signals, and begin to understand how children behave when their signals are not responded to accurately, the next step is for parents to recognize their own cognitive and emotional responses to child behavior (Goal 3), which is supported by use of the *Shark Music* metaphor (described below). Parents also engage in an active, reflective dialogue about how these responses influence their infant. This process of reflective dialogue tends to allow parents to learn to regulate their emotional responses to their children's behavior (Goal 4). Parents learn new ways of responding to their children's signals, while repairing inevitable lapses in sensitive responsiveness (Goal 5). The starting point of the COS intervention is to use attachment theory to create an individualized treatment plan for the parent that is based on observations of parent-child interactional patterns and, if available, on his or her child's attachment classification (i.e., secure, insecure, disorganized); thus, parents are encouraged to meet the goals outlined here in a way that is tailored to the specific relationships they have with their children.

In summary, the central goal of the COS approach is to provide children with a secure attachment by inviting their parents into a process of reflective dialogue that helps them serve as a secure base when the children's exploratory systems are activated, and as a safe haven when the children's attachment systems are activated. The importance of an attachment figure to whom a child can return for comfort

TABLE 3.1. Key Intervention Goals of Circle of Security

The intervention focuses on working with parents to . . .

1. Develop a better understanding of their children's needs
2. Enhance their observational and inferential skills
3. Recognize their own cognitive and emotional responses to their children's behavior and understand how these responses influence their children
4. Learn to regulate their emotional responses to their children's behavior
5. Learn new ways of responding to their children's signals, while repairing inevitable lapses in sensitive responsiveness

when distressed, then use as a secure base from which to safely explore with confidence, is a central idea in attachment theory, referred to as the *secure base phenomenon* (Bowlby, 1988). For Bowlby, the secure base phenomenon was at the heart of attachment theory: “No concept within the attachment framework is more central to developmental psychiatry than that of the secure base” (pp. 163–164). The key intervention goals of the COS approach are the steps through which parents move to attain a clear understanding of what children need to have a secure base (and safe haven), and are provided in a relational environment within which the parent feels safe enough to engage in a reflective dialogue that ultimately leads to better parental regulation and parental provision of a secure base/safe haven.

Key Components of the COS Intervention

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Individualized Assessment of the Parent–Child Relationship

The COS intervention begins with an assessment of the parent–child relationship. Parents are interviewed using the COS Interview (COSI; Powell, Cooper, Hoffman, & Marvin, 2014) to allow for assessment of parents’ representations of themselves and of their children. For children age 12 months and older, an age-appropriate Strange Situation Procedure (SSP; Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy et al., 1992) provides an assessment of child attachment to the parent. Parents and children enter a room with a box of toys, and the child experiences a series of separations from and reunions with the parent. After the SSP, parents and children complete two additional tasks. First, age-appropriate books are brought into the room, and parents are asked to read a story to their children. Finally, parents and children complete a cleanup task, in which parents are asked to get their children to place all the toys back into a box. For infants below age 12 months, no specific protocol has been developed. Typically, however, there is an analysis of a video of infant–parent interactions, such as face-to-face interaction (gaze, face, orientation, touch, and vocalization) between parent and infant (Beebe & Lachmann, 1994; Beebe, Lachmann, & Jaffe, 1997), or other interactions, such as during free play, after a stressor task (e.g., the infant is seated in child’s car seat and his or her arms are gently restrained; Laboratory Temperament Assessment Battery [Lab-TAB]; Goldsmith & Rothbart, 1999), or videotaped interactions in the home. The COS assessment focuses on identifying *the linchpin struggle*, defined as the central interaction that most interferes with the child developing a secure attachment to the parent.

The COS model recognizes that all parents have what John Bowlby (1973) called a *working model of attachment*. This internal template is used to understand current and future relationships, including the parent’s current relationship with the child. The parent’s representations of self and child are identified from the parent’s responses during the semistructured COSI (Powell et al., 2014). This information is used, along with the observational data described earlier, to create a treatment plan that is compatible with the parent’s procedural belief system about how intimate relationships work (Powell et al., 2014). Importantly, although the COS intervention was originally designed to be offered to small groups of five to six parents, the intervener creates an individualized treatment plan for each parent–child

dyad. A separate, individualized treatment plan is used to guide the work with each parent in the group.

The COS Graphic: A User-Friendly Vocabulary for Talking about Attachment

The initial segments of the COS intervention focus on helping parents feel sufficiently safe to share their thoughts and feelings as they learn basic attachment theory through the use of the COS graphic. Once parents have learned how to use the COS graphic, the group then shifts to a focus on individual parents, one at a time. Each parent has the opportunity to be the focus of three sessions over the course of the 20 weeks. The group members who are not the focus of the session in a given week provide support to the focal parent and learn from the process of observing the focal parent's process of reflection. While viewing videotaped interactions of themselves with their children, focal parents practice creating behavioral descriptions of the interactions (e.g., "He couldn't reach the toy and I gave it to him"; "She is reaching for me to pick her up"). Once an interaction is described, the parents create hypotheses about the principal attachment or exploratory need that is displayed in the clip. This process, called *Seeing and Guessing*, becomes the basic procedure for viewing videotapes throughout the group. The core process in all COS protocols is to reflectively engage parents as they learn the concepts of attachment theory using the COS graphic (see Figure 3.1).

Parents are given a tour of the Circle, beginning with an explanation that parents serve as the *hands on the Circle*; in other words, they are the secure base from which children explore and the safe haven to which children return. Parents are

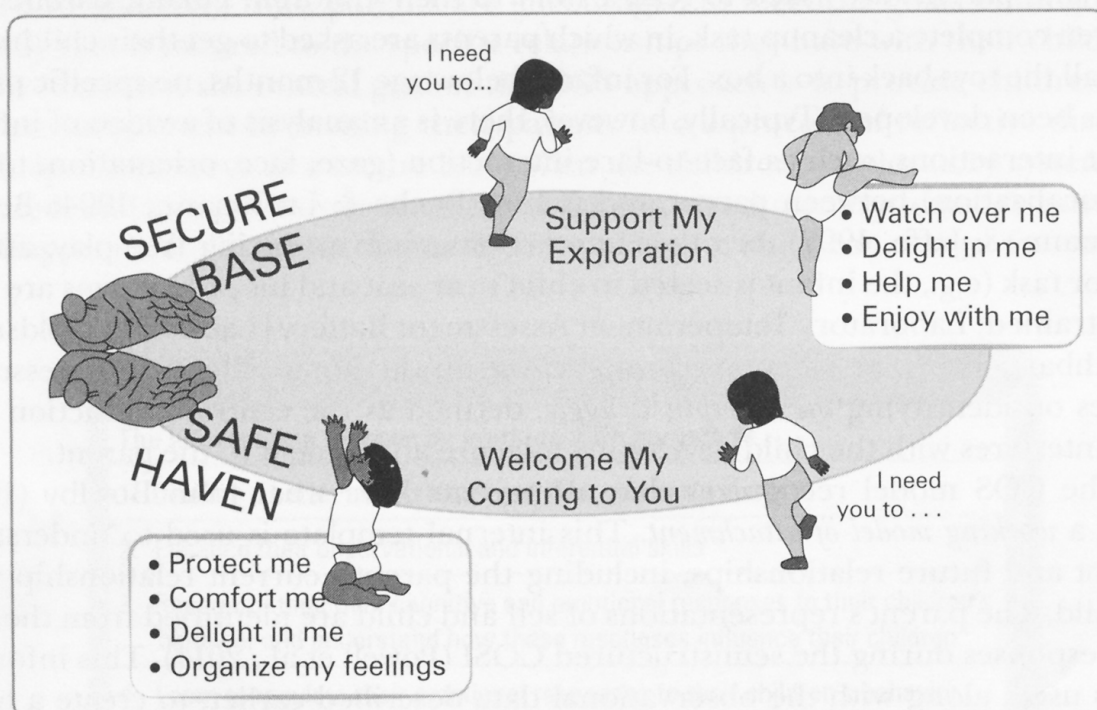


FIGURE 3.1. The Circle of Security: Parent attending to the child's needs. From Powell, Cooper, Hoffman, and Marvin (2014). Copyright © 1998 Glen Cooper, Kent Hoffman, Bob Marvin, and Bert Powell.

then told that when children feel safe and secure, their innate curiosity and desire for mastery is supported. Even when children feel safe, before they begin to explore, they look to their secure base (their parent) for support. This support comes from both having a history of the parent's comfort with separation and receiving a signal in the moment that it is safe to venture out. Children shift between activation of their exploratory and attachment systems rapidly throughout the day, and each system raises a different set of needs. Key to the COS intervention is helping the parent understand that children need their parent as much while exploring as they do when sitting in their parent's lap. When exploring, sometimes children simply need their parent to watch over them. The parent's presence allows the child to maintain the sense of security he or she needs to continue to explore. Sometimes children need help in their exploration. It is the parent's job to scaffold the exploration by offering the child just enough help so that he or she can do it him- or herself. Sometimes children want their parents to enjoy the activity with them by engaging in the exploration. Sometimes they need to experience their parents' delight in them, not for what they are doing but for who they are.

When children have been exploring long enough, their attachment systems inevitably become activated. Children then need to be welcomed by their parent as they approach. As with support for exploration, children need both a history with closeness and a signal indicating that they are welcome in the present moment. Sometimes their attachment systems may be activated by a need for protection from either present or perceived danger. Other times children are distressed by a known cause or event and need comfort. Sometimes children simply need to know that their parents find them delightful, even when they need closeness or care. Often children are distressed and do not have a clear sense of what is causing the feeling. They may well need comfort, but in addition, need help organizing their feelings. Being able to recognize, name, express, and regulate multiple, sometimes conflicting, feelings is an essential skill that is optimally learned within the child-parent relationship.

In addition to learning about the child's needs through the COS graphic, parents are taught a formula for being the hands on the Circle: "Always be bigger, stronger, wiser, and kind. Whenever possible, follow your child's need. Whenever necessary, take charge." Sometimes when parents feel they need to be bigger and stronger, they sacrifice being kind and become mean, perhaps justifying their behavior as "tough love." Parents who act this way often believe they must become aggressive and evoke fear to gain the respect of their children, as if violence deserves respect. Other parents, when they try to be kind, give up being bigger and stronger and become weak, thus requiring children to take charge of the relationship, implicitly asking the child to be the parent. Some parents are so profoundly not available, or *gone*, that the child is left with a significant loss of hands (i.e., parental support) on the Circle. Parents who have a pattern of being "mean, weak, or gone" (as labeled within the protocol terminology) leave the child in a circumstance that is abnormally frightening. It is an ongoing challenge for all parents to be simultaneously bigger, stronger, and kind, and to have the wisdom to understand that a child's need for security rests on the parent's ability to perform this important and multifaceted function.

Reflective Dialogue Regarding the Parent–Child Relationship and Internal Representations of Both the Child and the Self

As mentioned earlier, after the basics of the Circle are presented and parents have built up some experience engaging in dialogue within the group, Phase 1 individual videotape review begins, with the other group members present to provide support to (and learn from) the focal parent. Parents watch edited video clips from their child–parent assessment, while being invited to reflect on what they see their child doing and needing. The COS graphic is used as a model for understanding their child's needs. The use of videos allows the intervention to be tailored to each dyad's specific attachment-caregiving strategy and each parent's specific defensive process. Phase 1 review is focused on video examples of the parent demonstrating success with an underdeveloped parenting capacity (e.g., a parent who is uncomfortable with a child seeking care shares a moment of emotional connection) and a modestly vulnerable struggle (e.g., a parent who avoids taking charge struggles with some success in getting his or her child to cooperate when asked).

Once parents demonstrate competence using the COS graphic to discern children's attachment and exploration needs during the Phase 1 videotape review, they learn the concept of mental representations (*internal working models*), which are the building blocks of parents' responses to the child. Parents are then invited in the Phase 2 review to begin considering their own mental representations and how they may be linked to their own reactions to the child. Parental responsive behavior is likely to reflect multiple representations: an *internal representation of the child* (e.g., a parental representation of "She is a frightened child who seeks comfort" vs. "She's a spoiled child who needs to be toughened up" would likely lead to different parental responses); an *internal representation of the self* (e.g., "I am competent at helping children in distress" vs. "I can't tolerate whining" vs. "I am not tricked by children's tears"); and an *emotional response that ties the representations together* (e.g., empathy, anguish, annoyance). Parents' understanding of how children's needs evoke specific thoughts and feelings within parents lays the foundation for parents to learn skills of *reflective dialogue* and *affect regulation* (i.e., skills of thinking about, talking about, and regulating emotions).

With the combination of the COS graphic as a guide and the video review, parents develop skills to better track, moment by moment, children's attachment needs. In many cases, being able to identify these needs as they occur is enough to enable parents to respond in appropriate ways to meet the needs. In other cases, however, parents may feel so uncomfortable or threatened by those needs that they fail to respond, often without being aware of this struggle. To enhance responsiveness, it is important that parents take the vulnerable step of reflecting on what they do, think, and feel that supports or inhibits their response to particular attachment needs.

When parents are able to reflect on their caregiving, even for a brief moment, a pause is created in their nonconscious procedural caregiving behaviors (*implicit relational knowing*; Lyons-Ruth & the Process of Change Study Group, 1998). This reflective pause increases the likelihood that parents can see their children's perspectives and have empathy for their children's emotional experiences. In addition, the COS intervention invites parents to explore their own mental representations

(internal working models), which are a major factor in shaping their responses to their children. Engaging parents in a reflective process aimed at helping them enhance their *reflective functioning* (i.e., the capacity to reflect on one's thoughts, feelings, intentions and behaviors, as well as those of the child) is one of the principal goals for the program, because higher reflective functioning is linked to security of attachment in infancy, and longer term optimal social and emotional child outcomes (Steele & Steele, 2008).

Reflection about Representational and Emotional Influences on Caregiving

To facilitate parental reflection about the parent–child relationship, it is important to provide parents a way to notice and talk about powerful thoughts and feelings that are aroused while parenting. Bowlby (1969/1982) theorized that one's own attachment experiences color both how social information is processed cognitively and how one feels emotionally in relational contexts. He theorized that internal representations stemming from past relationships tend to be carried forward into new relationships. Unfortunately, when negative representations influence parental caregiving, the responsiveness of caregiving can suffer. In other words, there is increased likelihood that parents will fail to meet their children's current, in-the-moment needs for attachment and exploration if parents interpret their children's behavior in terms of unconscious procedural memories or strong emotional reactions rooted in negative aspects of past relationships. Bowlby (1988) theorized that internal representations can change in the context of the therapeutic relationship, within which it is safe to explore these previously unconscious working models of attachment.

Bowlby (1980) argued that the construct of *attachment representations* (i.e., internal working models of self and other) provided a new way of understanding Freud's (1940/1963) ideas about the dynamic unconscious and defenses, such as repression. He argued that attachment representations, as well as the affect associated with early attachment-related experiences, can guide current behavior in problematic ways. For example, Bowlby (1980) described defensive exclusion of attachment-related information as unconscious processing of information so as to keep out of awareness information that would be painful. Defensive exclusion and other such defensive processes can be adaptive in some circumstances but become problematic if they become chronic and no longer match the current environment. Defensive processes can be particularly problematic when they influence parenting, such that parents are unable to clearly perceive and respond to children's signals regarding attachment and exploration needs.

COS uses the construct of *shark music* to provide parents with a vocabulary for talking about the complex idea of defensive processes and to raise awareness about parents' defensive processes that tend to function outside of conscious awareness yet influence parenting. Parents explore the idea that their past experiences in their own relationships with important attachment figures have led certain situations to feel threatening or scary; thus, often without being consciously aware, parents allow those perceptions of threat to drive their parenting behavior.

Parents are introduced to the shark music construct by being shown the same video with two different audio tracks. In the first showing, the background music

is the soothing *Canon in D Major* by Johann Pachelbel. When the clip is shown the second time, the background music is the cello solo from the theme of the movie *Jaws*. This juxtaposition of pleasant and foreboding music elicits a powerful visceral response, and illustrates for parents how the same scene can appear quite different depending on the emotions in the background. The contrasting background music becomes a metaphor for the parents' internal working models of attachment that make some of their children's needs on the Circle seem welcome and comfortable, whereas others seem frightening and aversive. The shark music metaphor helps to normalize defensive processes and provides a language for talking about parents' own defensive processes.

Recognizing that an experience “feels scary but is not dangerous” creates a choice point for parents—to continue to protect themselves from the frightening but nonexistent sharks to reduce the immediate discomfort of the fear, or to bear the discomfort, while overriding the defensive behavior and meeting the child's needs. By naming a previously undefined negative affect triggered by a child's need with the words “shark music,” parents can momentarily pause a procedural script, name the affect, and create an opening to choose a response based on a more accurate assessment of the child's needs in the current situation. In this way, shark music is a metaphor that makes clear to parents that they, like all parents, are influenced by an emotional soundtrack that is rooted in their history of relationships. Most importantly, parents are helped to experience that when they are able to turn down the volume of the (old) troubling music long enough to allow reflection, it becomes possible for different caregiving choices to emerge. Parents can allow the now nonexistent “shark” to become small enough that the child him- or herself can be seen in terms of the child's actual needs.

Once parents learn to identify the specific needs of their children that induce negative feelings (i.e., that “turn on their shark music”), they are in a position to reflect on how these feelings fit or do not fit with what they now know about their child's needs on the Circle. This process helps parents identify thoughts and feelings that inhibit responding to the current situation rather than reacting with emotional responses learned from past experiences. By identifying and modulating shark music responses, parents can more clearly see the genuine needs that they have been unable to see in their child before, and heighten their empathy.

Discussion of Insecure Relational Patterns

When the parent is uncomfortable with separation and responds negatively to the child's desire to explore, sending the message that the child should not have the positive feelings associated with curiosity, mastery, or autonomy, the child may learn to inhibit exploration and instead focus excessively on needing proximity to the parent as a way to maintain connection and diminish worries engendered by the parent's reaction. COS labels this struggle *Limited Top of the Circle* (see Figure 3.1). Over time, this interactional pattern takes on characteristics that appear clinically to be associated with the type of insecure attachment called *ambivalent attachment*.

A parent who is uncomfortable with providing a safe haven—one who communicates that the child should not have the feelings associated with wanting safety,

comfort, and closeness—will discourage and dismiss care-seeking behavior in the child, resulting in what is called *Limited Bottom of the Circle*. This interaction patterns appears clinically to share characteristics with the type of insecure attachment called *avoidant attachment*.

A parent who has a pattern of being emotionally dysregulated when the child needs him or her to be *bigger, stronger, wiser, and kind* and defensively manages his or her dysregulation by being *mean, weak, or gone* fosters a relationship in which attachment needs on the Circle are associated with fear. This parent's struggle is called *Limited Hands*. Children of such parents tend clinically to behave in ways similar to those with disorganized attachment.

The shark music construct is central to Phase 2 tape reviews, which focus on helping parents reflectively process the *linchpin* from the preintervention assessment and talk about the shark music that is activated by this specific need on the Circle. The parents are supported in their capacity to do this by viewing and discussing key moments in which they are able to more fully respond to this linchpin need; the therapeutic message is always that parents have the capacity to respond, and it is their defensive (protective) management of shark music that interferes.

After Phase 2 reviews, parents and children are again videotaped, so that any new caregiving capacities may be observed. The focus of Phase 3 is celebrating the positive changes in the child–parent relationship, acknowledging ongoing current struggles, and reflecting on the new choices for responding to children's needs that parents are using. In summary, the COS video review and discussion are designed to help parents to reach the five intervention goals outlined earlier.

Through this systematic process of learning core attachment concepts via the COS graphic, developing observational and inferential skills via watching video to identify children's needs, and building empathy for their children through a greater ability to reflect on and regulate their defensive responses, parents learn to make new choices about their parenting behaviors. These new choices help parents become the competent and confident parental presences their children need them to be, and allow parents to provide care that matches their children's needs. As their children learn to trust these changes, they are able to use their parents as a secure base from which to explore and a safe haven to whom they can return when distressed, and their sense of attachment security is therefore greatly enriched.

The Initial COS Protocols: The Use of Individualized Diagnostic and Treatment Plans with Video Review

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COS 20-week Group Protocol

The COS 20-Week Group Protocol (COS-20 week) uses a preintervention relational assessment that begins with an SSP, followed by the parent reading a book to his or her child for 4 minutes, and ends with the parent directing the child to return the toys to the storage box. Approximately six parents meet weekly for 20 weeks in 75-minute sessions to review video-recorded attachment–caregiving interactions between themselves and their children. All the video vignettes reviewed are either from the preintervention assessment or an SSP recorded in Week 15.

The first 2 weeks of the COS protocol focus on helping parents feel safe, valued, and engaged. During the first 2 weeks, the parents learn about the Circle by watching highly edited, successful moments from the preintervention assessment of group members meeting their children's needs on the Circle. Phase 1 videotape reviews begin in Week 3 and continue through Week 8. Each week, edited video clips from one parent's SSP are shown to the group. In Phase 1, parents learn how to participate in the videotape review and most of the vignettes shown are of parents successfully meeting a child's need. One clip in the review is selected to show a struggle that is chosen to help prepare the parent for the more demanding task of reflecting on the linchpin struggle in Phase 2.

In Week 9, shark music and *Limited Circles* (insecure attachment) are introduced. From Weeks 10 through 15, parents participate in Phase 2 videotape reviews. Again, one parent each week is presented with video clips that have been reedited from his or her preintervention assessment, with a focus on that parent's linchpin struggle. Helping parents normalize and identify their linchpin shark music is a central theme for Phase 2. After Phase 2 reviews, the parents are videotaped in a modified SSP from which vignettes are selected for Phase 3 reviews. The focus in Phase 3 is on helping the parent acknowledge current strengths and struggles. Two tape reviews are completed each week during Weeks 16–19.

Week 20 is reserved for the ending and graduation celebration. Each parent receives a copy of his or her videos and a "Certificate of Graduation." Parents are encouraged to discuss their experiences in the group.

COS Perinatal Protocol

The COS Perinatal Protocol (COS-PP; Cooper, Hoffman, & Powell, 2003), a preventive intervention adapted from the original COS protocol, was designed to be part of the Tamar's Children program located in Baltimore, Maryland. Tamar's Children is a jail diversion program designed to address the multiple needs of pregnant, substance-abusing women convicted of nonviolent offenses and their infants (Cassidy et al., 2010). The Tamar's Children program addressed the medical and psychiatric needs of the mothers and the well-being of their infants by creating an integrated network of prenatal and medical care; substance abuse, mental health, and trauma treatment; individual and group psychotherapy; educational enhancement (e.g., general equivalency degree [GED] classes); work skills training; housing assistance; and advocacy. The COS-PP was included to provide parenting education and treatment designed to promote maternal sensitivity and increase the likelihood of secure infant attachment. Mothers met twice weekly for 90-minute group sessions throughout their enrollment in the program. Two therapists, who remained with the group until completion, led each group. The protocol developers trained the therapists and conducted weekly supervision of the groups to ensure fidelity of the protocol.

Video clips of mother–infant interactions were used to facilitate discussion of complex ideas related to attachment theory in user-friendly terms in a safe group setting. While pregnant, mothers were introduced to the basics of mother–infant interaction from the perspective of attachment theory by first watching and discussing 72 stock footage clips of mothers interacting with their babies, edited for this

project. These stock footage clips, which included examples of secure, insecure, and disorganized attachment, sensitive and insensitive parenting, as well as “before and after” mother–infant interactions from women who had participated in previous COS groups, allowed mothers to learn the basics of the Circle and to build a foundation of reflection and observational skills before their babies were born.

Starting when their infants reached 2 months of age and continuing for the duration of the intervention, mothers took turns being the focus of a session. For each session, the therapists selected four clips of the target mother interacting with her infant in a variety of activities in the residential treatment center (e.g., feeding, free play, and face-to-face interactions) to view and discuss during the group session. Like the 20-week protocol, this protocol included Phase 1 and Phase 2 tape reviews. Because the mothers were in residential treatment and would be meeting for a year, the Phase 3 review procedure of recording new interactions and using the tape to acknowledge current strengths and struggles was used multiple times over the course of the year.

COS—Home Visiting–4 Intervention

The COS—Home Visiting–4 Intervention (COS-HV4; Cooper, Hoffman, & Powell, 2000) protocol was designed to incorporate the core COS elements into a protocol that could be delivered in a brief, four-session, home-visiting program with individual parents of infants in the first year of life. Each home visit is scheduled with the baby present and rested and (except for the initial session) begins with a review of the previous session. The intervener and mother then watch and discuss clips from videotapes of the mother and her infant that were filmed the previous day (mothers were asked to “go about your normal routine” for a 30-minute session in the home). In addition, mother–infant interactions (both infant cues and maternal responses) are discussed as they occur during each home visit.

Following the central components of the COS approach, each session has a specific focus, as follows. The first session focuses on engaging the mother affectively, forming an intervener–mother alliance, helping the mother understand her importance as a secure base for her infant and successfully providing her infant with a sense of security, and improving the mother’s skills at recognizing her baby’s signals related to both attachment and exploration. The second visit extends the focus on the importance of maternal sensitive responsiveness to the infant’s signals. At the same time, the intervener begins to help the mother identify the infant signals to which she has more difficulty responding. The intervener introduces the idea that all parents are sometimes insensitive, and that such behavior is human, forgivable, and can be reflected on, discussed, and changed.

The focus of the third session is exploration of the psychological factors that at times interfere with the mother’s capacities to respond sensitively (a teaching of the concept of defensive processes through the user-friendly metaphor of shark music described earlier). Specifically, the intervener discusses with the mother the ways her behavior is influenced by her cognitive and affective responses to the baby’s needs and behaviors. The goal is to increase the mother’s reflective capacity, so that she can consider new options when confronted with situations in which she finds sensitive responsiveness to be difficult. Mothers are also provided “homework”

between sessions (e.g., explain infant needs on the Circle to a friend; observe infant needs on the Circle during daily interactions). During the fourth visit, the home visitor gives the mother a copy of some of the videos used in the intervention and provides the mother with an opportunity to discuss the intervention and any ongoing parenting topics of interest.

COS Intervention Training and Supervision

In each of the three COS intervention protocols described earlier, the basic training requirement for interveners is the COS 10-day training workshop in assessment and treatment planning. The training is offered several times a year in many parts of the world, including Norway, Italy, Great Britain, Australia, New Zealand, Canada, and the United States. The training is for mental health professionals. Information regarding these trainings can be found on the COS International website (www.circleofsecurity.com).

In this training, participants learn to use the SSP to identify parent's strengths and struggles on the Circle. Then, participants must discern the central struggle (linchpin) for each dyad. Participants also learn to appraise internal working models of relationships, core defensive processes, reflective functioning, and capacity for empathy through the COSI (Powell et al., 2014), an interview that taps the parent's representations of self and child. Based on parent-child interactions and the interview-based parental perceptions, participants learn to organize treatment plans.

Participants who wish to receive certification in COS assessment and treatment planning must pass an exam that entails submitting a treatment plan for two parent-child dyads based on videotape of the SSP and the COSI, which the trainers provide. Passing the exam is a prerequisite to receiving supervision. To be considered a COS provider, the facilitator must receive supervision on two 20-week groups or 50 hours of supervision on individual interventions. A detailed implementation manual is provided for the supervisees. All interventions are videotaped, and reviewing these tapes is central to the supervision process. As part of the supervision, trainees also receive technical help in filming the dyads and in editing videotape. To offer the COS model, it is necessary to have facilities and equipment to administer SSPs and/or face-to-face, split-screen interactions. Providing child care during the group helps in recruiting and retaining parents.

Empirical Examination of Initial COS Protocols

Research on the COS 20-Week

Two separate groups of researchers, using independent samples, have examined the COS 20-week. Both studies found that intervention is associated with significant increases in attachment security and significant decreases in disorganization of attachment, as compared to attachment assessed prior to beginning COS (Hoffman et al., 2006; Huber, McMahon, & Sweller, 2015a). Attachment security and attachment disorganization are important variables because they have been linked

to an array of important developmental and mental health outcomes (e.g., Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012; for a review see Thompson, 2016). Thus, it is notable that two independent studies of the 20-week protocol have provided empirical evidence that COS treatment is associated with shifts toward more optimal child attachment.

Hoffman et al. (2006) focused on a sample of 65 low-income toddlers and preschoolers enrolled in Head Start and Early Head Start programs in the United States. Before the COS intervention, only 20% of the children were classified as securely attached; 60% were classified as exhibiting disorganized attachment. Statistically significant shifts in attachment were found from pre- to postintervention. Specifically, Hoffman et al. found that following the COS intervention, the percentage of children who were securely attached increased significantly to 54%; disorganization decreased significantly to 25%. Similarly, Huber et al. (2015a) found significant changes in attachment security and disorganization in an Australian sample of 83 children, ages 13 months to 7 years, who had been referred to a community-based mental health service agency due to existing problems. Those with the least optimal preintervention scores appeared to benefit the most from intervention (Huber et al., 2015a).

Importantly, in addition to finding significant change in attachment outcomes, Huber, McMahon, and Sweller (2015b) found pre-post reductions in both mother-rated internalizing and externalizing symptoms, and teacher-rated externalizing symptoms. These results were exciting because, if replicated in future research, they suggest that the potential benefits of COS could be useful in ameliorating children's existing behavioral health problems, in addition to improving attachment outcomes.

Huber, McMahon, and Sweller (2016) found pre-post changes in maternal emotional function in parents who participated in the COS intervention. These were parents of children who had been referred to the mental health clinic due to behavioral and emotional problems. Huber et al. found pre-post reductions in parenting stress and clinically significant reductions in parent psychological symptoms. Those parents with higher baseline levels of symptoms tended to benefit more than did parents with low levels of symptoms. These results were intriguing because, if replicated, findings suggested that COS could be useful in improving parent mental health, in addition to reducing child behavior problems.

It is important to note that, to date, the only published studies of the 20-week COS protocol (Hoffman et al., 2006; Huber et al., 2015a, 2015b, 2016) used a pre-post design. Additional research using a randomized controlled trial (RCT) design is needed. There are a number of well-known reasons that the RCT design is at the top of the hierarchy of research designs (Gold, 2015). Random assignment to treatment groups and inclusion of a control group allow for both optimal internal validity and inferences about causality. Use of the RCT design allows researchers to infer that the intervention of interest is responsible for the observed outcomes (Kazdin, 2006). It is important to note that although two separate research groups have provided pre-post data showing COS was associated with change in child attachment and child behavioral outcomes, without RCT data, it is impossible to rule out other non-COS explanations for the changes observed.

Research on the COS-PP

The COS-PP was tested in the context of the Tamar's Children jail diversion program, using a pre-post design (Cassidy et al., 2010). The 15-month jail diversion option was offered to women who were identified as being pregnant while in jail or who were pregnant during their sentencing period and were nonviolent offenders. The women in the program had a history of substance abuse, and received extensive wraparound social services in addition to COS-PP, described earlier in this chapter. The program included a phase from pregnancy until the infant was 6 months old, during which time the mother and infant lived on site, followed by a phase in which the mother continued in the program while living in the community, which lasted until the infant was 12 months old. Because there was no control group, attachment outcomes were compared to outcomes identified in other research studies, based on levels of risk. Results for the 20 mothers who completed the full program indicated that program infants showed rates of attachment security and disorganization that were comparable to low-risk, middle-class samples, and better than typical high-risk samples. Specifically, 14 of the 20 infants (70%) were classified by coders blind to sample characteristics as securely attached to mother, and only four infants (20%) were classified as insecure/disorganized. Mothers' sensitivity was similar to that of a community comparison group, and maternal depression improved over time as well. Results of this study suggest that the COS-PP can be used as part of an integrated treatment for extremely high-risk families.

Research on the COS-HV4

Cassidy, Woodhouse, Sherman, Stupica, and Lejuez (2011) conducted an RCT of the COS-HV4 in a sample of 220 economically stressed mothers of irritable infants. Participants in the intervention condition received COS-HV4. Participants in the control condition received three home-visiting sessions that focused on psychoeducational topics relevant for new parents (i.e., infant sleep, feeding, and play) and were given readings on these topics from the popular press. Mother-infant dyads in both the intervention and control groups were videotaped in the home for 30 minutes at the end of each home visit. Because this study by Cassidy et al. used an RCT design, it is possible to make causal attributions about the COS-HV4 intervention. In addition, the study examined two potential moderators of intervention effects: infant temperamental irritability and mothers' own attachment styles. These moderators turned out to be quite important, because the moderators helped not only to shed light on the efficacy of COS-HV4 but also to answer important questions about "what works for whom" in terms of attachment-based interventions.

First, COS-HV4 was found to be efficacious for infants who were at greater risk of insecurity (Cassidy et al., 2011). Specifically, the COS-HV4 significantly improved attachment outcomes only for those infants who were *highly* irritable. These highly irritable infants had levels of irritability that previous research had identified as placing them at risk of insecure attachment in the context of low family income (van den Boom, 1994). In contrast, there was no difference in the percentage of secure infants between the intervention and control groups among the *moderately* irritable infants. The findings of Cassidy et al. (2011) showed that when risk was high, the intervention was efficacious; expanding the definition of irritability to

include more infants (i.e., the moderately irritable infants) did not lead to additional infants benefiting from intervention. It may be difficult to lower risk if risk is not already high.

These results highlighted the idea that infants may be differentially susceptible to environmental influence (Belsky & Pluess, 2009) or have biologically based differences in sensitivity to context (Boyce & Ellis, 2005), and that infant temperamental reactivity can serve as a marker of this differential susceptibility. Thus, Cassidy et al. (2011) demonstrated that it could be important to include factors such as observer-rated infant temperament as a potential moderator of treatment effects in order to understand “what works for whom.”

Second, Cassidy et al. (2011) found that maternal attachment styles assessed with the Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998) also moderated the intervention effects, with important implications for questions about what works for whom. The ECR scale assesses attachment style in terms of two dimensions, attachment *anxiety* (i.e., the degree of preoccupation with rejection and abandonment by close others) and attachment *avoidance* (i.e., the degree of discomfort with closeness, and a tendency to avoid relying on others for support or comfort). It is important to note that Cassidy et al. (2011), following Fraley and Shaver (1997; see also Mohr, Gelso, & Hill, 2005), mathematically rotated the ECR dimensions in order to assess attachment in terms of two alternative dimensions of attachment. The *secure-fearful* dimension is characterized at one end as *secure* (i.e., low attachment anxiety and low attachment avoidance) and at the other end as *fearful* (i.e., high attachment anxiety and high attachment avoidance). The *dismissing-preoccupied* dimension is characterized as *dismissing* at one end (i.e., low attachment anxiety and high attachment avoidance) and as *preoccupied* at the other end (i.e., high attachment anxiety and low attachment avoidance).

Moderating effects indicated that when the combination of maternal attachment style and infant temperament put the infant at risk (as indicated by low security rates in the control group), the COS-HV4 intervention was efficacious in reducing insecure attachment. For example, among mothers who were more *secure*, highly irritable infants benefited more than did moderately irritable infants. For more *dismissing* mothers, the study found that highly irritable infants (as compared to moderately irritable infants) were more likely to be secure if they received intervention and less likely to be secure when in the control group. In contrast, for more *preoccupied* mothers, a treatment effect emerged only for moderately irritable infants; highly irritable infants of highly preoccupied mothers were not at increased risk. In summary, when the combination of maternal attachment style and infant temperament put the infant at higher risk, the COS intervention was efficacious in reducing insecure attachment. Such findings might suggest that in the context of scarce resources, it might be best to focus provision of attachment-based interventions on those mother–infant dyads who are at higher risk. If so, then it would be important to continue to investigate factors that place infants at heightened risk of insecurity. The study by Cassidy et al. (2011) is helpful because it showed that mother and infant characteristics can interact in ways that are linked to risk.

Woodhouse, Lauer, Beeney, and Cassidy (2015) examined videotaped intervention sessions from the Cassidy et al. (2011) study in order to study the intervention process and the mother–intervener relationship, and investigate the links between

intervention process and outcome. Despite decades of theory and research underlining the key importance of the therapeutic relationship to outcome in individual psychotherapy (Norcross, 2011), little research has focused on these factors in parenting interventions (for a review of the few notable examples, see Korfmacher, Green, Spellmann, & Thornburg, 2007). Similarly, despite decades of psychotherapy research focused on links between the process of psychotherapy and the outcome of treatment (for a review, see Gelo & Manzo, 2015), such factors have been virtually ignored in the context of parenting interventions. Because Bowlby (1988) theorized that the therapist serves as a secure base from which the client can explore, Woodhouse et al. (2015) were particularly interested in therapist contributions to the process that would be likely to influence the degree to which mothers would feel safe to explore with the intervener (e.g., therapist warmth or therapist negative attitudes toward the mother), as well as interveners' direct efforts to support exploration. Similarly, given Bowlby's (1988) focus on client use of the therapist as a secure base from which to explore, Woodhouse et al. (2015) were particularly interested in mothers' contributions to the process of intervention reflecting mothers' active engagement, participation, and exploration.

O'Malley, Suh, and Strupp (1983) provided a conceptualization of psychotherapy process that meshed well with the goals of examining the process of intervention from an attachment perspective, as outlined earlier. O'Malley et al.'s conceptualizations can be applied to the COS intervention as follows: Therapists contributed to the process in terms of (1) therapist behaviors that communicate warmth (with higher scores for warmth when that warmth occurred at times that the client was expressing greater vulnerability or affective arousal), (2) therapist behaviors that conveyed a negative attitude toward the mother, and (3) therapist efforts to promote the mother's exploration (e.g., a question asking the mother to consider the meaning of a particular child behavior). Mothers' contributions to process included (1) mothers' behaviors demonstrating active participation and involvement in the session (e.g., talking openly and freely during the session) and (2) mothers' exploration of clinically relevant material.

Woodhouse et al. (2015) coded all available videotaped COS-HV4 intervention sessions from the Cassidy et al. (2011) study for these process variables (O'Malley et al., 1983) and found that observer-rated therapist warmth and therapist support for exploration were positively associated with observed maternal participation/involvement and maternal exploration: Mothers tended to explore more when therapists were warmer or supported exploration more. In contrast, observer-rated therapists' negative attitude was inversely related to observed maternal exploration; that is, if the therapist showed a more negative attitude, mothers tended to explore less. Additionally, therapists' contributions to the process were linked to mothers' ratings of their attachment to the therapist. Specifically, observed therapist warmth was linked to higher maternal ratings of secure attachment to the therapist, whereas observed therapist negative attitude was associated with higher maternal ratings of preoccupied-merger attachment to the therapist. Results suggested that examination of the process of intervention and the mother-intervener relationship could shed light on how COS interventions work.

Although not published in the Woodhouse et al. (2015) study, the researchers also examined whether observer-rated psychotherapy process dimensions (i.e., both

therapist and mother contributions) could distinguish successful versus unsuccessful outcomes of intervention (i.e., infant attachment security vs. insecurity). Table 3.2 presents the results of the two discriminant analyses examining successful versus unsuccessful outcomes of COS-HV4 (while controlling for maternal SES, maternal attachment anxiety and avoidance, infant sex, and maternal psychological symptoms).

As expected, successful versus unsuccessful cases could be distinguished on the basis of therapist contributions to process (Wilks's $\lambda = .66$, $\chi^2 = 22.67$, $p = .004$, Canonical $R^2 = .34$; see Table 3.2). The model correctly predicted 83.3% of those with secure infant outcomes and 66.7% of those with insecure infant outcomes. The therapist behavior that contributed most to distinguishing secure versus insecure outcomes was observer-rated therapist warmth. Such findings mesh with Bowlby's (1988) theory that having an understanding, empathic therapist who can serve as a secure base is crucial in psychotherapy. It is possible that therapist warmth may be more important at certain times than others (e.g., perhaps when mothers are openly exploring parenting struggles); future research can examine this question and allow us to better refine supervision.

Also, consistent with expectation, successful versus unsuccessful cases could be distinguished on the basis of mothers' contributions to psychotherapy process

TABLE 3.2. Discriminant Analyses Examining Observer-Rated Psychotherapy Process Dimensions (Therapist and Mother Contributions) That Distinguish Successful versus Unsuccessful Outcomes of COS-HV4

Analysis focusing on therapist behavior			Analysis focusing on mother behavior		
Variables	Standardized function coefficients	Correlations: Variables and discriminant function	Variables	Standardized function coefficients	Correlations: Variables and discriminant function
SES	-.443	-.510	SES	-.442	-.459
Baby sex	-.483	.332	Baby sex	.281	.299
M symptoms	-.733	.149	M symptoms	.949	.134
M attachment anxiety	-1.048	-.360	M attachment anxiety	-1.274	-.324
M attachment avoidance	.416	.131	M attachment avoidance	.516	.118
T warmth and friendliness	.535	.065	M participation	.632	.188
T exploration	-.386	-.011	M exploration	-.072	.092
T negative attitude	.151	.224			

Note. T, therapist; M, mother. Maternal SES, maternal attachment anxiety and avoidance, infant sex, and maternal psychological symptoms were included as control variables in this analysis. This table did not appear in Woodhouse, Lauer, Beeney, and Cassidy (2015), but is based on data from that study.

(Wilks's $\lambda = .61$, $\chi^2 = 27.10$, $p < .001$, Canonical $R^2 = .39$). The model correctly predicted 83.3% of those with secure infant outcomes and 79.2% of those with insecure infant outcomes. The mother behavior that contributed most to distinguishing secure versus insecure outcomes was observer-rated mother involvement/participation in the therapeutic dialogue. Contrary to expectation, however, observer-rated mother exploration did not appear useful in distinguishing successful from unsuccessful outcomes. In fact, although mother involvement/participation was correlated with mother exploration (35% shared variance), only mother involvement/participation differentiated successful from unsuccessful outcomes. This is an intriguing finding, because it suggests that maternal emotional engagement in dialogue with the intervener, elaboration, and willingness to disclose personal information to the therapist are more important than exploration per se. Thus, a focus on the relationship and on engaging caregivers may be important for outcomes.

Consideration of Mediating Mechanisms

Research examining the COS protocols has yet to examine mediational models that can elucidate mechanism of change. Some empirical attention, however, has been paid to variables that could potentially serve as mediators of treatment effects, and merit additional attention. For example, Huber et al. (2015a) found that caregivers who received the COS-20 week protocol showed significant pre-post changes in caregiver reflective functioning (i.e., awareness of mental states in oneself and others; Fonagy, Gergely, & Target, 2008), as well as significant improvements in caregiver representations of the child and the relationship with the child.

Little attention, however, has been paid to another important potential mediator of treatment effects, quality of parental caregiving. Bowlby (1969/1982) theorized that attachment develops in the context of the child's experiences with the caregiver. In fact, parental sensitivity (i.e., a caregiver's ability to accurately interpret infant needs and to respond promptly and appropriately; Ainsworth, Bell, & Stayton, 1971; National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network, 1999) has been empirically linked via meta-analysis to later child attachment in both mothers (De Wolff & van IJzendoorn, 1997) and fathers (Lucassen et al., 2011). Bakermans-Kranenburg, van IJzendoorn, and Juffer (2003) found that parenting interventions that tended to improve parental sensitivity were those most likely to enhance child attachment. It is important to note, however, that the variance in attachment explained by sensitivity has been found to be smaller than expected, particularly in low-income families (De Wolff & van IJzendoorn, 1997). Woodhouse, Beeney, Doub, and Cassidy (under review) noted that according to the meta-analysis by De Wolff and van IJzendoorn (1997), sensitivity explains only 2% of the variance in attachment in low-income families. Given that interventions are often targeted to low-income families—justifiably so, because attachment security has been found to serve as a protective factor in children's socioemotional development in the context of environmental adversity (e.g., Keller, Spieker, & Gilchrist, 2005)—it would be crucially important to consider how to best assess quality of caregiving across socioeconomic groups. Improvements in assessment of caregiving would enhance the prediction of child attachment and allow for improved testing of mediating mechanisms for intervention effects.

In order to examine caregiving in low-income families, Cassidy et al. (2005) conducted a qualitative study based on mothers drawn from the control group of the RCT testing COS-HV4. Findings revealed that many of the mothers could be viewed as highly insensitive, yet approximately half of the infants were securely attached at 12 months. Cassidy et al. proposed *secure base provision* (i.e., the degree to which a caregiver ultimately meets attachment-related needs [e.g., fully soothing a crying infant] even in the presence of high levels of insensitive behavior) as an alternative to sensitivity. Woodhouse et al. (under review) went on to develop an observational secure base coding system and showed that secure base provision predicted later infant attachment in a low-income sample, whereas sensitivity did not. It will be important to carefully consider how best to assess caregiving in tests of parental caregiving quality as a mediator of treatment results, particularly in low-income families.

Conclusions and Implications for Future Research on the Original COS Protocols

In summary, research on the various forms of COS indicates success in reducing the risk of insecure attachment, but is just beginning. More research is needed, particularly research using RCT designs. It will be important to do research that examines potential mediators and moderators of treatment effects. More research is also needed on the process of intervention and the caregiver-intervener relationship; such research could have important implications for training and supervision. Nevertheless, despite the fact that research on forms of COS is still in its infancy, results suggest that treatment is associated with increased attachment security, decreased attachment disorganization, as well as reduced child symptoms.

COS Parenting: A Move toward Broader Implementation

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The COS protocols described earlier all involve filming parent-child interaction during an assessment phase, using the video to identify the primary strengths and struggles, and creating a series of video vignettes to assist the parent in making new choices with that child—and as such, they are labor intensive and difficult to implement in many settings. For example, during the learning phase, trainees dedicate almost 1 day each week to implementing the program. Once they learn the process, clinicians become more efficient, and even then, the protocol requires more time in preparation than in delivery. It has been difficult for agencies and clinicians to find a way to bill for the preparation time. Such challenges made it clear that it would be highly desirable to have a COS protocol that could be implemented more easily in a variety of types of sites.

To facilitate implementation, and thus allow COS to be available to more families, the Spokane team created COS Parenting (COS-P; Cooper, Hoffman, & Powell, 2009). This protocol was created using the same intervention goals as prior COS programs (listed in Table 3.1), with one critical difference: All of the video clips discussed with the parents have been previously created by the developers (currently provided with training on a DVD); as such, each intervention session requires little preparation time.

This shift to archival video clips yields a stable COS intervention protocol that lends itself to a high degree of flexibility in intervention delivery. COS-P can be used widely and used in many formats (e.g., parent groups, home visitation programs, individual and family therapy) and in many contexts (e.g., the home, community centers, clinics). Prior COS protocols emphasized individualized treatment planning using video segments obtained from interactions between each parent and child. The prior protocols can be considered a “first-person” model of treatment and looking at video of his or her own engagement with the child influences the parent: a “watching us” methodology. The first-person approach to video review has many advantages as parents view their relationship directly. COS-P, on the other hand, takes a video modeling approach. The attachment concepts are presented through watching other parents, children, and sometimes actors. Influencing parents by having them observe “third-person” parent–child interactions is a “watching them” methodology (Coyne, Powell, Hoffman, & Cooper, 2012).

COS-P requires parents to take generalized information regarding children’s needs and apply it to their interactional and internal struggles. Whether parents can make the needed changes in their internal representations, attributions, and behavior without viewing video of interactions specifically between themselves and their children is an important question that had to be considered in developing this protocol.

To facilitate the internalization of the material and to explicitly focus on individualizing the intervention for the parents participating in the group, parents are invited each session to present descriptions of attachment interactions with their child during the past week. The stories are framed as *Circle Stories* and are used by the intervener to help the group members understand and enhance their secure base/safe haven provision. Each time a parent describes an interaction with his or her own child is an opportunity for the facilitator to individualize the material for that parent. The supportive presence of the intervener creates a secure base from which the parent can explore difficult experiences and feelings (Bowlby, 1988) and therefore reevaluate the meaning of distressful situations in parenting.

The COS-P protocol is divided into eight chapters that may be delivered in eight 90-minute weekly sessions. Often the program is delivered over 10, 12, or more weeks, and sometimes multiple times a week for fewer weeks, depending on the requirements of the situation. The protocol is designed for parents of children from birth to approximately age 6.

The eight chapters of COS-P aim to give parents the same capacities in their relationship with their child that are provided by the original COS interventions. The first two chapters of the program introduce parents to the basic concepts of attachment, the use of the COS graphic as a map for parent–child interaction, and the idea of “exploring our children’s needs all the way around the Circle” (Cooper et al., 2009, p. 17). Chapter 3 of COS-P addresses the important concept of *being with* children emotionally. The core of *being with* is providing an emotional safe haven by meeting children in whatever affective state they are experiencing. This emotional meeting allows children both to use their parent as a coregulating other and to build their own parental capacity for emotion regulation. Chapter 4 of COS-P applies this concept specifically to the idea of *being with* infants. The first four chapters parallel the beginning of the original COS protocols by helping

parents learn how to identify the needs of their child and develop the ability to use the COS graphic to track these needs and practice *being with*.

The next three chapters of COS-P are analogous to the second half of the original COS. In Chapter 5 of COS-P, the concept of shark music and its role in perpetuating relationship struggles is introduced. Avoidant and ambivalent attachment styles are also introduced as Limited Circles. In these three sessions, parents are introduced to the importance of reflecting on their struggles, which is hypothesized to lead to different responses that support secure relationships.

In Chapter 6 of COS-P, parents are introduced to disorganized attachment through the concept of *limited hands*, wherein the concept of *mean, weak, and gone* is discussed, as described earlier. In Chapter 7 of COS-P, parents are introduced to the importance of *rupture and repair* in relationships. A useful way of defining security is for the child to have the confidence that when the relationship inevitably has a rupture, a repair is likely to follow. Relationship repair supports the long-term development of emotion regulation and successful functioning in relationships. Chapter 8 of COS-P consists of a summary, an opportunity to discuss the group experience, and celebration of the parents' completion of the protocol. Parents are invited to use their expertise to analyze a video of struggling mother-child dyad. Then they view the mother being successful with her child and listen to the mother's experience of the changes she made through COS-P.

Like all COS protocols, the COS-P protocol is strategically presented so that each section builds on the previous one to provide a complex understanding of children's attachment needs. Focusing first on the child's needs for secure attachment leads to the more vulnerable process of focusing on the self and difficulties in responding to these needs. Developing a working knowledge of defensive process through shark music makes it possible for parents to operationalize this learning in their relationship with their children.

The training requirement to be a registered facilitator who is licensed to use the COS-P DVD, manual, and handouts is completion of the 4-day COS-P training workshop. Participation in reflective consultation/supervision, a model widely used in the field of early intervention (Heffron & Murch, 2010), is considered best practice for COS-P registered facilitators while delivering the program. In addition to English, the COS-P is available in Spanish, Norwegian, Swedish, Danish, Italian, Japanese, Chinese (Mandarin), and Romanian. Training is offered multiple times a year in many parts of the world. The training is for mental health professionals, parent educators, home visitors, social workers, nurses, and other professionals involved in providing early intervention and education for parents. More information is available at the COS website (www.circleofsecurity.com).

Research examining the new COS-P protocol is in its infancy. To date, there have been only two published quantitative studies investigating changes in parenting associated with participation in a COS-P group. Horton and Murray (2015) used a pre-post design and focused on a sample of 15 mothers who participated in a COS-P group while in residential treatment for substance abuse. Results showed that among the nine mothers who attended the majority of the sessions (i.e., six to nine sessions), a significant number of mothers showed improvement in mother-rated discipline practices on a measure of both lax and overreactive/harsh discipline practices. These mothers also showed improvements, on average, in mother-rated

emotion regulation and in parental hostile attributions about the causes of child behavior, although these factors did not have a significant number of participants with improved scores. These data from the Horton and Murray study can only be considered preliminary, because of not only the extremely small sample size but also a number of limitations that affected the internal validity of the study, including lack of an RCT design.

More recently Cassidy et al. (2017), however, published results of a study that used an RCT design to examine treatment effects of COS-P in low-income mothers and their preschool children, who were enrolled in Head Start programs in Baltimore, Maryland. The sample included a total of 141 mothers, with 75 in the COS-P intervention group and 66 in the waiting-list control group. Intent-to-treat analyses (controlling for maternal age and marital status) showed that mothers who received COS-P reported fewer unsupportive responses to preschoolers' distress than did mothers in the control group. It appears, therefore, that COS-P was successful in one of its central goals: that of building parental empathy for child emotional experiences. Reductions in unsupportive responses to child distress are important, because research has shown that parental responses to child distress are linked to later child attachment (e.g., Del Carmen, Pedersen, Huffman, & Bryan, 1993) and child behavioral problems (Leerkes, Blankson, & O'Brien, 2009; see also Spinrad et al., 2007).

In addition to a main effect of COS-P on maternal reports of unsupportive responses to child distress, Cassidy et al. (2017) found a main effect of treatment on one type of child executive functioning (i.e., child inhibitory control, but not cognitive flexibility). Inhibitory control, a form of executive functioning that involves regulation of both attention and behavior, is an important outcome, because higher levels of child inhibitory control are associated with greater school readiness (e.g., Blair & Razza, 2007; Bull, Espy, & Wiebe, 2008) and lower risk for psychopathology (Schachar & Logan, 1990). It is important to note that this main effect was moderated by maternal self-reported attachment style: the difference between the COS-P and control groups on child inhibitory control did not hold if mothers were high on self-reported attachment anxiety (Brennan et al., 1998).

Although the study by Cassidy et al. (2017) found no other main effects of treatment in the outcomes assessed (i.e., child attachment classification as assessed from the Strange Situation, or child behavior problems), results showed that maternal self-reported attachment style and maternal depressive symptoms each served as important moderators of treatment effects with regard to child attachment security, attachment disorganization, and child internalizing (but not externalizing) symptoms. First, for preschool children whose mothers were high (1 standard deviation [*SD*] above the mean) in self-reported attachment avoidance (Brennan et al., 1998), treatment with COS-P was associated with increased attachment security and reduced attachment disorganization in comparison to wait-list control; for children whose mothers were low (1 *SD* below the mean) in attachment avoidance, COS-P was associated with decreased attachment security in comparison to wait-list control. Second, maternal attachment anxiety and maternal depressive symptoms each moderated treatment effects on children's internalizing behavior problems, such that treatment group children whose mothers were either low on self-reported

attachment anxiety or low on depressive symptoms (1 *SD* below the mean) showed lower levels of internalizing symptoms than did wait-list control children.

This first RCT examining the efficacy of COS-P is promising, and results suggest that it will continue to be important to actively examine “what works for whom.” In addition to examining maternal characteristics that may moderate treatment effects, it may also be useful to examine child characteristics and contextual characteristics that may also moderate treatment effects. Given the potential of COS-P to allow for more affordable implementation and wider dissemination of the COS model within existing service systems working with low-income families, it will be important to continue research on COS-P.

There is one RCT of COS-P currently underway that will allow for further empirical examination of the efficacy of COS-P (Vaever, Smith-Nielsen, & Lange, 2016).

Conclusion

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The research thus far supports the efficacy of the various COS protocols, although additional research is needed. As mentioned earlier, additional research on COS employing an RCT design would be particularly useful, as would investigation of potential moderators and mediators of COS efficacy. Such research would allow for a better understanding of “what works for whom,” as well as why COS works.

In addition to RCT designs, other designs can also be used to answer important questions about COS. As Sexton, Kinser, and Hanes (2008) noted, methodological diversity is important in answering questions that go beyond simple questions about efficacy. For example, process-to-outcome studies examine links between processes occurring within the session and outcomes of intervention. Systematic case studies of COS (e.g., Page & Cain, 2009) can allow for an ideographic description of the clinical process, and might have important implications for generating hypotheses about change mechanisms. Research on the role of the intervener–mother relationship (e.g., Woodhouse et al., 2015) would be helpful in delineating aspects of the relationship that are important to attend to, and could be important for training and supervision. Likewise, case study methodology can be used to examine new populations of children who might benefit from parental participation in COS. For example, Fardoulis and Coyne (2016) examined changes in attachment (pre- and postintervention) for two children diagnosed with autism whose mothers participated in COS. One child remained securely attached throughout, and the other child shifted from insecurely attached at baseline to securely attached postintervention. Such initial findings are promising and suggest that future research in this population may be useful.

Given compelling data that individual therapists vary in effectiveness in terms of psychotherapy outcomes (Kim, Wampold, & Bolt, 2006; Wampold & Bolt, 2006), it will be important for future research on COS to examine whether interveners are differentially effective, and examine factors that might be linked to differential outcomes between therapists. Such research could help to refine selection and training of COS interveners.

In some settings, it may be important for researchers to build community trust for parenting intervention and research. In such cases, partnership-building methods drawn from community-based participatory research models (Israel, Eng, Schutz, & Parker, 2013) may be useful in building community-researcher partnerships and community engagement for research on COS and implementation of COS models more broadly.

COS-P was designed with implementation in mind, and as such, research that examines the process of its implementation in real-world settings (i.e., both barriers and facilitating factors) could have important implications for providing wider access to parenting supports for those who need them most. It may be important to consider what might be the best models for delivery of COS in different community settings. For example, in some contexts, groups may provide an efficient delivery model where there are naturally existing groups or opportunities for meeting. In other cases, home visiting may be a better way to ensure appropriate dosage of intervention (e.g., if there are barriers to regular group meetings). Hoffman, Cooper, Powell, and Benton (2017) recently translated COS ideas into a self-help parenting book that families can access on their own. This delivery format offers yet another option for dissemination of COS tools that may be useful for some parents.

In some contexts it may be beneficial to think systemically about the challenges families with young children are facing. Some communities have complex systemic problems, and it may not be enough to intervene at the individual family level with a parenting intervention. In such cases, COS protocols could be embedded within more systemic approaches (e.g., approaches that consider jobs, economics, danger in the community, toxicity/pollution, education), and in fact, COS has already been integrated into treatment across a variety of settings.

In conclusion, it is important to note that COS provides a user-friendly language with which to talk with parents about important aspects of parenting, as well as a model of intervention has been useful with diverse parents and caregivers. A growing body of research suggests that COS is linked to improvements in child attachment and behavioral health outcomes, as well as improvements in parent outcomes, and that it is a useful intervention approach across a variety of contexts. COS-P was designed with implementation in mind and has the potential for wide application.

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