

A preliminary evaluation of the Triple-A Model of Therapeutic Care in Donegal

Colby Pearce and John Gibson

Synopsis of article

This paper represents a brief description of the Triple-A Model of Therapeutic Care, an implementation programme that occurred in Donegal between December 2015 and March 2016, and some preliminary outcomes and discussion of these.

Introduction

Upon arriving home from his full-time job as an insurance salesman, Bill quietly enters the home and immediately looks for each of his children. As he approaches them, he observes what they are doing and their experience of the activity, as reflected in their verbal and non-verbal gestures. As well as greeting each child, he makes a comment about the child's experience of the activity, saying it with congruent feeling, then moderating his tone and projecting calm as he advises each child that he is off to change before dinner. Bill changes out of his work clothes and joins the family for the evening meal. During the meal Bill suggests to the children that they choose a card game to play with him and reminds them of the roster of the order for this evening. After the meal Bill spends at least five minutes with each child in turn, playing a card game of their choice. At bedtime, Bill prepares their toothbrushes and pulls back their covers. He reads a book to the younger ones and engages in a best-of-five thumb wrestle and rock-paper-scissors with each child before making sure that they are covered and tucked in. He puts on some quiet, classical music in their bedrooms. Bill reminds each child that he will check in on them after he has put the kettle on to make himself a hot drink. He advises them that they can stay awake until he returns. He returns to the bedroom of each child approximately five minutes after leaving them and wishes them goodnight. The children who are still awake are advised that he will check in on them again after he has had his drink and they can stay awake if they like. He returns again 10 minutes later. In the morning, he places their preferred cereal in their bowl on the kitchen counter before leaving for work.

Melissa is a busy mother of two children. She rises before her children and enters their

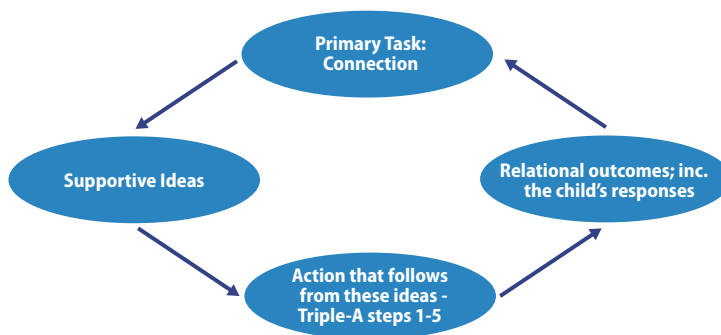
bedrooms, whereupon she lays out their clothes for the day. She gently rouses each child, commenting that they look as though they were appreciating their sleep. She acknowledges with congruent emotion that it is not fair that they have to get out of their warm bed, before gently and calmly encouraging them to do so. She directs them to the clothes she has laid out and advises them that she will get their breakfast ready. As she leaves the room, she turns off the CD player that has been playing soothing classical music during the night. During breakfast, Melissa advises the children of where she will collect them from at the end of the school day. At school pick-up Melissa offers a small snack and a juice box, as she always does. Upon arriving home with the children, Melissa suggests they unwind a little, including changing out of their school clothes, before they do their homework. At homework time, Melissa regularly checks in with each child, observing their manner, making comments about their experience, and offering help where it is observed to be needed.

Rachel and Craig are parents to two teenage boys. On weeknights at 9:30pm they prepare a hot drink and snack for the boys in anticipation of their habit of dropping into the kitchen around that time in search of food. They remain in the kitchen and, as always happens, the boys duly arrive. The boys are generally chatty and Rachel and Craig listen and make comments about this or that aspect of each boy's story and associated experience. They understand that there is an informal "three question rule", so they are judicious about what questions they ask. The tone of the interaction is generally happy and relaxed.

Bill, Melissa, Rachel and Craig are all *Triple-A* caregivers. By *Triple-A* we mean that their approach to parenting, as encapsulated in these scenarios, is reflective of the conventional approaches to the care and management of children and teens that form the Triple-A model (Pearce, 2010). Having been utilised to facilitate understanding of the presentation and care requirements of children who have experienced intrafamilial trauma (Pearce, 2009) and care that promotes resilience in children (Pearce, 2011), the Triple-A model has itself evolved into an organised model of therapeutic care. Now known as the Triple-A Model of Therapeutic Care, Triple-A (as it is most commonly referred to) was recently delivered to 29 foster caregivers in Donegal as part of an implementation programme commissioned and supported by local Tusla authorities.

The three "A's" in Triple-A stand for Attachment, Arousal, and Accessibility to needs provision. As the name implies, Triple-A is drawn from knowledge and endeavours in

attachment theory and neurobiology (of trauma). The origin of the third aspect is not as obvious. The construct of accessibility to needs provision is drawn from what learning theory tells us about the effects of different learning environments. This especially relates to what children learn about the reliability and predictability with which their needs will be met in the context of their first dependency relationship(s). This is an obvious point of difference from other approaches to understanding children who have experienced abuse and neglect, which tend to focus on attachment theory or neurobiology alone, or a combination of the two. Incorporating this construct into the Triple-A model arose in response to the need to better understand one of the most salient and difficult-to-shift aspects of the presentation of children recovering from abuse and neglect: the fact that they are inordinately preoccupied with their needs and wishes and seemingly driven to compulsively satisfy them. In short, they are difficult to satisfy through conventional caregiving. But, in order to be happy and satisfied on a day-by-day basis, these children need to learn to be satisfied with conventional caregiving as that is what the world will offer them in most, if not all, interpersonal transactions they enter into. Triple-A incorporates conventional caregiving and relational practices which, delivered in a way that enriches the child's experiences of them, is expected to promote their satisfaction with conventional care and needs provision.



The landscape in which Triple-A operates is relationships. In Triple-A, meaningful human connection with others is viewed as optimal for psychological wellbeing and adherence to conventional standards of behaviour (Pearce, 2009). The primary task (Kahn, 2005) for a Triple-A caregiver is to achieve and maintain a healthy connection with children who are recovering from abuse and neglect. This is achieved through conscious adherence to a way of thinking about children that, in turn, promotes a way of interacting with them and associated responses in the children that allow connection. In turn, a self-perpetuating therapeutic care system is established.

“*The goals of this self-perpetuating therapeutic care system are the promotion of secure attachment, optimal arousal for performance and wellbeing, and acceptance of conventional caregiving for the satisfaction of needs and wishes.*”

These goals are achieved in the context of a therapeutic care environment and dependency relationships. Participant caregivers are instructed in how aspects of conventional caregiving and relating behaviours can be enriched for greatest therapeutic effect. There is a focus on what caregivers already do that helps!

In Triple-A, we also know and accept that without looking after the caregivers themselves all endeavours on behalf of the children are doomed. In confining ourselves to (and enriching) what caregivers already do that is therapeutic, Triple-A promotes positive self-awareness and a sense of competence in the role. We maintain a core belief that a validated caregiver is one who is freed to best consider the needs and interests of those who depend on them, and to be responsive to those needs (Pearce, 2012). In addition, validation promotes experiences of worth that are critical, creating a psychological buffer against vicarious trauma (also known as secondary traumatisation and compassion fatigue) and burnout. Furthermore, Triple-A incorporates training in the development of a mindset and self-care behaviours that are expected to support caregiver wellbeing.

Triple-A follows a step-by-step implementation protocol, with five modules that address different aspects of caregiving and relating. There are modules for adults in a direct care role and professionals who work with and support them in this role. Alternate modules exist for adults who interact with children in the classroom environment and for the care of children overcoming other forms of adversity, such as a disability. Each module is inclusive of training in therapeutic care and relating practices and approaches to self-care. There is a monitoring and evaluation protocol that consists of pre- and post-questionnaires and daily monitoring during the formal training and implementation period.

Methodology

An implementation programme for the Triple-A Model of Therapeutic Care was piloted in Donegal, Ireland across the period December 2015 to March 2016. The pilot

implementation programme was funded by Tusla (the Child and Family Agency) and delivered by Mr John Gibson of Secure Attachment Matters Ireland, with content and materials provided by the programme's author, Mr Colby Pearce (Secure Start®, Adelaide, Australia). Mr Gibson met with key personnel of Donegal Tusla in December 2015 in order to establish an implementation timetable, at which time two Tusla staff members were nominated to act as liaisons for the programme.

Formal implementation began with a full-day training session for professional staff of Donegal Tusla on 20 January 2016 in Letterkenny. Staff who participated in the training day included those whose primary work role is the support of Tusla foster caregivers in the Donegal region. Thereafter, two groups of Tusla-registered foster caregivers participated in five, weekly, half-day workshops scheduled across the period, 1 February 2016 to 1 March 2016. Workshops were delivered in two locations: Buncrana and Stranorlar.

Caregivers who participated in the programme received formal training in the Triple-A Model of Therapeutic Care, inclusive of:

- an orientation to establishing a self-perpetuating, therapeutic, care environment
- therapeutic caregiving and relating practices targeting the promotion of secure attachment, optimal arousal, and acceptance of conventional caregiving for needs provision, and,
- self-care strategies targeting caregiver wellbeing.

Caregivers were invited to complete an evaluation protocol in two parts:

- A questionnaire completed at the end of each workshop addressing satisfaction with the training; and
- A series of online questionnaires to be completed before, during and after the delivery of the programme to gather information about progress towards achieving the joint goals of (1) improved adjustment in the children of the participant caregivers and (2) improved wellbeing of the caregivers themselves.

Results

Satisfaction with the training

We who are associated with the Triple-A Model of Therapeutic Care consider that foster

caregivers must be offered training that they see as valuable. Offering training that foster caregivers experience as valuable promotes feelings that they are valuable. Experiences of being valued are central to good mental health and wellbeing and optimal performance in the role of foster caregiver.

In each week of the delivery of the programme, participant foster caregivers were asked to complete a questionnaire seeking their views about the content, delivery, usefulness, ease of implementation, appropriateness to experience, overall perception, and whether they would recommend the training to others. Ratings were consistently very positive across both groups and for every session; 100 per cent of participant caregivers across both locations reported in each of the five weeks of implementation that the programme was communicated effectively to them and that they would recommend the training to others. All but one participant in one session reported that the programme was appropriate to their level of experience. Representative written comments sought from participants in the fourth and fifth sessions, in response to the invitation to provide general comments about the programme, include the following:

I think it helps to identify, clarify and to implement strategies in a focused manner – with an expectation of an outcome. I think one of the most positive aspects is galvanising actions and ideas and practices that we are already doing but in a manner which held us to be more mindful of the manner in which we are doing them – with a greater understanding or appreciation of the need to do so – and benefit of doing so.

I really enjoyed this training, I find it very user friendly, practical and most important effective. I feel the training should be done prior to any placements in any foster home, part of the entire training. Also social workers should be doing this training as well and any other professionals to ensure everyone is gelling together for the benefit of the child involved. It would be great if this training spread out to the community, schools, public health nurses, preschools, and schools, especially to all the children in the community.

Progress questionnaires

Critical to any programme of delivery of a therapeutic intervention is ongoing monitoring and evaluation of progress towards a desired goal and outcomes. Triple-A incorporates pre- and post-questionnaires and daily 'Keeping Track' questionnaires. This pre, post and daily monitoring methodology allows for both group and single-case evaluation, the latter reflected in the case that follows.

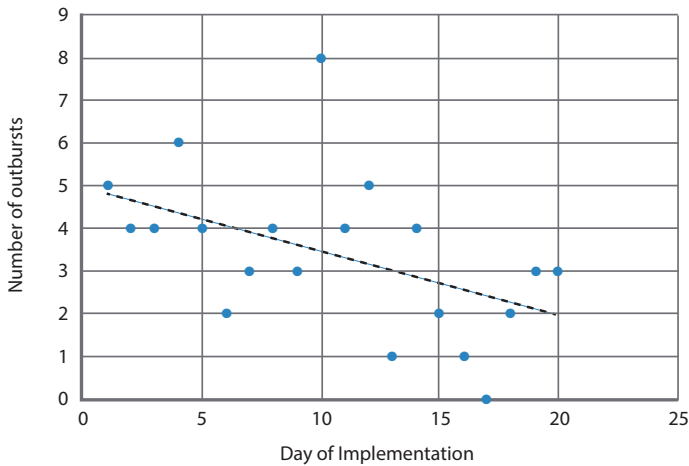
BG is a nursery-school-aged child of a foster caregiver who participated in the programme. On the pre-questionnaire, the foster caregiver recorded that BG typically had 10 emotional outbursts (tantrums/meltdowns) per day, each lasting an average of 15 minutes. The foster caregiver also recorded that BG was, typically, physically aggressive towards persons and objects on average five and four times per day respectively. BG was recorded as ignoring or refusing directions up to 30 times on a typical day and was inordinately demanding, making up to 40 requests in a typical day and otherwise seeking the caregiver's attention 20 times in a typical day. BG was recorded as engaging in independent play only three times per day. In short, BG was inordinately demanding!

“*In contrast, on the post-questionnaire, the responses of BG's foster caregiver were indicative of a 50 per cent reduction in the incidence of emotional outbursts in a typical day, and a 67 per cent reduction in the duration of emotional outbursts. Similarly, there was an 80 per cent reduction in physical aggression towards persons and BG was no longer hitting objects in a typical day.*”

BG's foster caregiver's responses on the post-questionnaire were indicative of an 80 per cent reduction in ignoring and/or refusing directions, an 85 per cent reduction in requests of the caregiver, and a 60 per cent reduction in attention-seeking behaviour. Independent play was up 200 per cent.

In terms of the Triple-A model, BG was less prone to emotional outbursts and they were of shorter duration, potentially reflecting lower *arousal* levels by the end of the formal implementation period. BG was less aggressive and defiant which might also reflect lower arousal levels. BG was less demanding, perhaps reflecting greater acceptance of his carer's *accessibility* and responsiveness. BG was showing an increase in independent (exploratory) play, a possible precursor of a secure base and *attachment* security.

Triple-A's monitoring and evaluation methodology allows one to take a closer look at BG's progress across the period of formal implementation. For example, in the graph overleaf we can see the incidence of BGs' emotional outbursts across 20 days of formal implementation of Triple-A.



Discussion

The Triple-A Model of Therapeutic Care was implemented with the support of Tusla across two locations in Donegal, Ireland. Implementation included a full day, training workshop for professional staff who support foster caregivers registered with Tusla in Donegal, and five, weekly, half-day workshops for almost 30 foster caregivers. Participant foster caregivers were trained in the theoretical basis of Triple-A and in therapeutic caregiving, as well as in a mindset and practices that make a therapeutic care environment. In addition, foster caregivers were trained in practical self-care strategies and were asked to complete monitoring and evaluation protocols at various intervals. The programme of implementation received practical support from delegated Tusla liaisons.

Overall feedback from the foster caregivers about the Triple-A programme was extremely positive. It is of particular note that 100 per cent of participant foster caregivers consistently advised that they would recommend the programme to others, with related written feedback recommending the programme, not only for foster caregivers, but for all adults with a caring concern or in a caring role with children. There was very little negative feedback, though such as there was, this related to:

- the duration of the programme of implementation
- the homework requirements, and,
- the request that participants complete online questionnaires.

It was originally anticipated that the timetable for foster caregiver training would occur over eight weeks. In reflecting on comments that relate to the intensity of the

programme, particularly the implementation components of therapeutic caregiving and relating, self-care, and the monitoring and evaluation protocol, a longer implementation period for future projects may be warranted.

Completion of the full package of online monitoring and evaluation questionnaires was low, with only six protocols (which include pre- and post-questionnaires and a proportion of 'Keeping Track' questionnaires) completed at the time of writing. Notwithstanding arguments around convenience and the safeguards afforded by an online data-collection protocol, future implementation programmes could clearly benefit from a revised monitoring and evaluation methodology and/or a longer implementation timetable which involves fewer daily requirements of participant foster caregivers.

Nevertheless, data received thus far is indicative of the potential of the Triple-A programme to achieve meaningful change in the emotional and behavioural functioning of children recovering from abuse and neglect, thus reducing caregiver stress and promoting their sense of competence in the role. Extensive caregiver feedback clearly demonstrates that the Donegal implementation of Triple-A was worthwhile to them, thus reinforcing their experience of their own worth to those who make decisions regarding the funding and implementation of such programmes.

Acknowledgements

The authors wish to acknowledge the support of the Donegal branch of Tusla and, in particular, Caroline Byrne and Siobhan Duffy, who assisted us in liaison roles. The authors also wish to acknowledge and thank all foster caregivers who participated in the programme and contributed to its success. Finally, the authors wish to thank Rebecca Pearce and Inke Jones of Secure Start® for assistance in the collation of monitoring and evaluation data.

Please note: An expanded evaluation document, with extensive data tables and written caregiver feedback, has been provided to Tusla authorities in Donegal.

About the authors

Colby is an Australian clinical psychologist and author. Colby's interest in the relationship between psychological health and connection with others spans more than 25 years as an applied researcher (1991-1995) and clinician (1995-2016). Colby's published works

span the fields of teen suicide and mental health, attachment and childhood trauma, and the promotion of resilience in children. Colby owns and operates Secure Start®, an independent psychology practice in Adelaide, South Australia.

John (Johnnie) is an Irish independent social worker and trainer based in Donegal, Ireland. He has almost 40 years' experience of working with children and carers in residential and foster care. He is a faculty member of the Residential Child Care Project at Cornell University, New York. He has published journal articles and book chapters. He trained in the Child Attachment Interview at Anna Freud Centre, London.

References

- Kahn, W. A. (2005) *Holding Fast: The Struggle to Create Resilient Caregiving Organisations*, Hove and New York: Brunner-Routledge.
- Pearce, C. (2009) *A Short Introduction to Attachment and Attachment Disorder*, London: Jessica Kingsley.
- Pearce, C.M. (2010) 'An Integration of Theory, Science and Reflective Clinical Practice in the Care and Management of Attachment-Disordered Children – A Triple-A Approach', *Educational and Child Psychology (Special Issue on Attachment)*, vol. 27, no. 3, pp. 73-86.
- Pearce, C. (2011) *A Short Introduction to Promoting Resilience in Children*, London: Jessica Kingsley.
- Pearce, C.M. (2012) 'Repairing Attachments', *BACP Children and Young People*, December, 28-32.