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Blended Support of Attachment in Families: A Case Study of FamilieLink

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ABSTRACT

Attachment ruptures, when children struggle to trust in parental availability and support, are linked to increased risk of psychopathology. Preventing or repairing these ruptures is important for fostering secure attachment and promoting family mental health. FamilieLink is a blended intervention that provides attachment-focused knowledge and parenting skills based on the Dynamic Model of the Insecure Cycle, with minimal professional involvement. This case study illustrates its application with Emma, a mother seeking support for her 10-year-old son's anger outbursts and sibling conflicts. Using psychoeducation, reflective exercises, and emotion-coaching skills, Emma developed greater insight into her son's emotional needs. She found the platform effective in raising awareness and offering practical guidance, though she noted a desire for more content on neurobiological underpinnings of attachment. Nevertheless, Emma recommended FamilieLink as a valuable resource for parents facing similar challenges. This case study highlights the potential of low-intensity, blended interventions to foster secure attachment within families.

1 | Introduction

All children have an innate need to seek and receive support from an attachment figure, usually the parent, during distress (Bowlby 1969). When children have the experience that the parent provides consistent and sensitive support during distress, children develop secure attachment, trusting in parental availability and support, which protects against the development of psychopathology and supports physical health, social skills, and academic success (Bosmans et al. 2020; Cassidy and Shaver 2016). However, when children struggle to trust in parental availability and support during distress (i.e., insecure attachment; Bosmans et al. 2020) due to inconsistent, insensitive or absent support and comfort, they show less support-seeking behaviour, making them more vulnerable to develop mental health problems (DeKlyen and Greenberg 2016; Dujardin et al. 2016). While not inherently psychopathological, insecure attachment can be considered a transdiagnostic risk factor for the development of mental health problems (Herstell et al. 2021). Therefore, stimulating secure attachment development can be an important strategy in promoting children's mental health. Stimulating secure attachment development requires a proper understanding of how insecure relational dynamics between parents and children can unfold. Recently, the Dynamic Model of the Insecure Cycle (Kobak and Bosmans 2019) was proposed to explain the nature of insecure relational dynamics.

1.1 | A Dynamic Model of the Insecure Cycle

The Dynamic Model of the Insecure Cycle is a theoretical model explaining how parent–child dynamics can lead to ruptures in trust in parental availability and support during distress (Bosmans et al. 2022; Kobak and Bosmans 2019; Figure 1).

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Highlights

- FamilieLink is a blended intervention designed to support secure attachment development in families.
- In this case, the intervention supported parental reflection on anger-related child behaviour and underlying attachment needs.
- Brief professional contact appeared to add value to the online self-help modules.
- Participant-reported gains exceeded changes observed on questionnaire-based outcome measure.
- The case illustrates the potential of low-intensity blended support in preventive family and parenting care.

According to Kobak and Bosmans (2019) and Bosmans et al. (2022), parent–child interactions are driven by two complementary inborn and universal emotional attachment-relevant needs: (1) *The need to care*: the parent has a strong wish to safeguard the child from any threat and to encourage the child's well-being and competencies; and (2) *The need for care*: the child has a need to rely on the parent in distressing situations. Furthermore, the model suggests that insecure parent–child interactions start with mistuned communication, that is, when the child has the experience that the parent's response does not meet their emotional needs. Such experiences can activate negative expectations about parental availability and support, which in turn promotes negative interpretation biases. Consequently, positive caregiving signals are going unnoticed by the child and cues of unavailability, unresponsiveness, and insensitivity are exaggerated and perceived as threats for the *need for care* (e.g., Bosmans et al. 2013). Defensive strategies to cope with the emotional pain and anxiety associated with these threats develop as a result. In general, two subcategories of defensive strategies can be distinguished (Kobak et al. 1993). First, avoidant strategies that suppress the child's longing for parental availability and support in distressful moments. Second, anxious strategies that cause an excessive focus on and persistent approach to the parent in hopes of receiving support. Finally, these defensive strategies are manifested in insecure attachment behaviours, that is, distorted signals of the child's attachment needs, that either express a reduced need for parental support or have a clingy, demanding, unhappy, and frustrated form of expression to highlight the need for confirmation of parental availability.

Distorted signals of the child's attachment needs are challenging for the parent to respond to in a sensitive and responsive way due to the activation of negative parental expectations about themselves and/or the child. These negative expectations can be linked to the parent's own negative attachment experiences, the feeling of not deserving to be loved, the feeling of parental failure, or the reinforcement of a negative perspective on the child. As a result, the parent misreads the distorted signals as improper behaviour that needs to be discouraged and causes the parent to ignore the child's underlying attachment needs. Consequently, avoidant or anxious defensive strategies in the parent are activated to cope with the *need to care* that is being threatened, leading to non-supportive responses, such as controlling and punitive parenting behaviour (i.e., hyperactivating strategies), and withdrawal and rejection of the child (i.e., deactivating strategies). Such behaviours unintentionally affirm the child's negative expectations of parental availability and support. If the parent and child fail to interrupt this cycle, ruptures in the attachment relationship can occur, and the child no longer expects support and comfort during distress (Bosmans et al. 2022).

1.2 | Interventions to Stimulate and Restore Secure Attachment Development

Given the benefits of secure attachment for a variety of physical and mental outcomes (Cassidy and Shaver 2016), interventions to prevent or correct insecure cycles are important means to stimulate secure attachment development in children or to restore trust after child–parent attachment ruptures. In

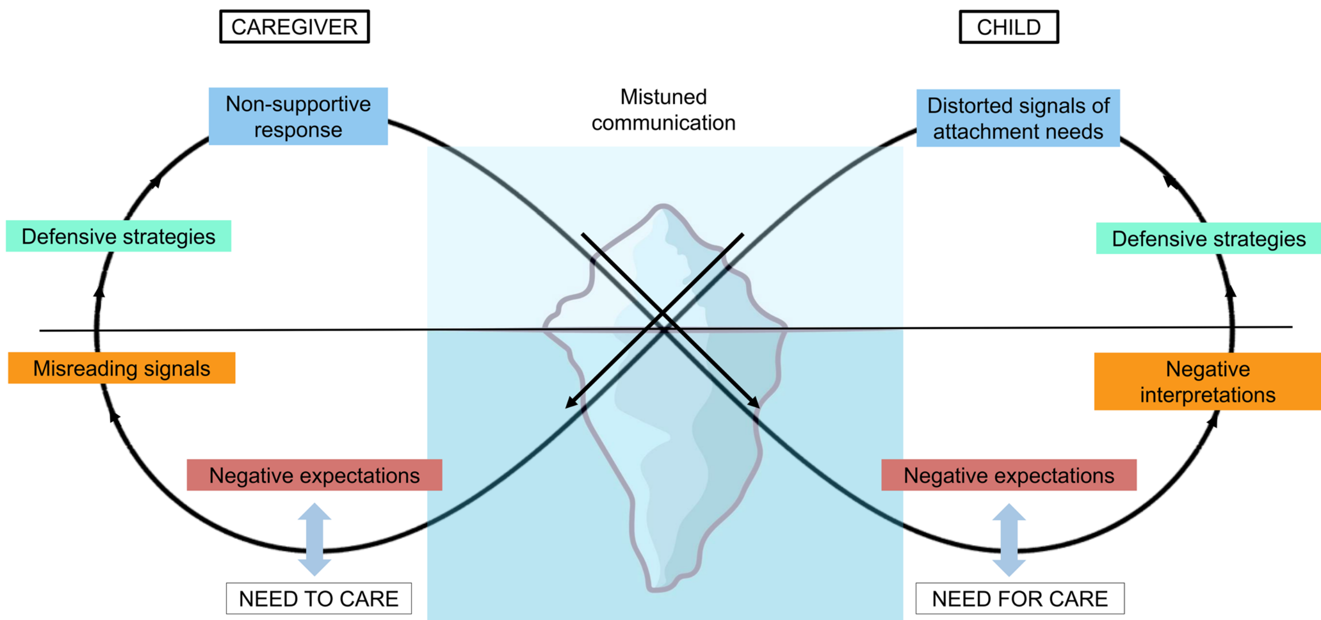

FIGURE 1 | The dynamic model of the insecure cycle. Adapted from Kobak and Bosmans (2019).

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order to stimulate and restore secure attachment development, three intervention techniques have been proposed (Bosmans et al. 2022): (1) Antecedent control strategies, that is, changing the context; (2) Consequent control strategies, that is, changing the consequences of child and parental behaviours; and (3) Exposure strategies, that is, changing the meaning the child ascribes to parental behaviour and vice versa.

1.2.1 | Attachment-Focused Antecedent and Consequent Control Strategies

Antecedent control strategies aim to modify the context in which distorted signals of the child's attachment needs are elicited using clear instructions, rules, or by pre-structuring situations. If the circumstances change and related reinforcers disappear, the behaviour will yield fewer benefits for the child and will occur less often (Forgatch and Patterson 2010). To stimulate children's secure attachment development, it is essential for parents to also address the child's attachment needs in order to avoid setting off insecure relational dynamics (Bosmans et al. 2022).

Attachment-focused consequent control strategies include parental complimenting, rewarding, and gentle discipline practices with the intention of encouraging appropriate child behaviour while acknowledging feelings related to underlying attachment needs (Bosmans et al. 2022; Forgatch and Patterson 2010). What these attachment-focused antecedent and consequent control strategies have in common is the sensitive and responsive way the parent interacts with the child while setting clear rules and boundaries (Bosmans et al. 2022; Forgatch and Patterson 2010).

An evidence-based intervention in which parents learn, among other things, to apply attachment-focused antecedent and consequent control strategies is the Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD; Juffer et al. 2017; Van IJzendoorn et al. 2023). VIPP-SD is a six-session home-based intervention for young children (0 to 6 years) that aims to improve parent–child attachment relationships focusing on two dimensions of parenting: sensitive responsiveness and sensitive discipline. In promoting sensitive responsiveness, the parent is encouraged to respond sensitively to the child's signals using video feedback. The second dimension, sensitive discipline, entails limit setting in such a way that the child's challenging behaviour is prevented or no longer rewarded. At the same time, the parent is encouraged to be attentive and to acknowledge the underlying attachment needs and emotions. As a result, the parent–child relationship is protected from attachment ruptures (Bosmans et al. 2022; Van IJzendoorn et al. 2023).

1.2.2 | Attachment-Focused Exposure Therapy

Adjustments in parental behaviour are not always sufficient to interrupt the insecure cycle, especially for older children, in whom expectations and interpretations could be strongly negatively biased due to the accumulation of insensitive and unresponsive care experiences (Bosmans et al. 2022). Attachment-focused exposure can help to address this by creating corrective attachment learning experiences, that is, feared outcomes are disconfirmed during the exposure to care-related interactions (Bosmans et al. 2022; Tryon 2005). More specifically, the child's negative expectations concerning the availability of parental support are triggered. Similarly, the parent's pain and fear related to perceived parenting failures are also elicited. The overall aim of this process is to interrupt the child's distorted signals of attachment needs and the parent's non-supportive responses. To establish a corrective attachment interaction, the parent, coached by a therapist, encourages the child to communicate attachment needs in a more emotionally regulated way. The parent is encouraged to withhold non-supportive responses in order to recognise the child's latent attachment needs and to respond sensitively and responsively to these needs (Bosmans et al. 2022).

An empirically supported systemic intervention for adolescents using attachment-focused exposure is Attachment-Based Family Therapy (ABFT; Diamond et al. 2014, 2016). ABFT consists of five therapeutic tasks. Task 1, the relational reframe, encourages the family to shift their focus from the presenting problem of the adolescent that ‘needs to be fixed’ towards a solution that partly relies on improving attachment relationships. Task 2, forming a working alliance with the adolescent, consists of co-constructing a coherent attachment narrative, that is, identifying attachment ruptures and exploring related emotions. Task 3, forming a working alliance with the parent(s), consists of helping parents to see links between their own current stressors, their own attachment narratives, and their parenting. Task 4, the attachment task, involves attachment-focused exposure to repair attachment ruptures. The adolescent shares moments when trust in parental availability was hurt, triggering negative attachment-related expectations in both (e.g., the adolescent fears rejection and the parent fears failure). The parent then suppresses unsupportive reactions and uses emotion coaching skills, such as asking probing questions, labelling emotions, and offering support (Gottman and Declaire 1997). Lastly, in Task 5, the adolescent's autonomy is promoted by helping parents and the adolescent discuss challenging issues (e.g., school, hobbies, substance use) using their newly acquired communication skills.

Recently, a middle childhood variant, Middle Childhood ABFT (MC ABFT; Van Vlierberghe et al. 2023), has been developed, building consistently on the previously described insecure cycle. In therapy, the parent's negative attachment-related expectations, defensive strategies, and non-supportive responses are identified. In addition, the child's negative attachment-related expectations, defensive strategies, and distorted signals of attachment needs are explored. MC ABFT has the same therapeutic tasks and aims as ABFT but was adapted for age, taking into account younger children's more limited verbal skills, reduced capacity for abstract reasoning, and stronger focus on the here-and-now.

1.3 | FamilieLink

Attachment interventions such as VIPP-SD, ABFT, and MC ABFT are typically provided to families in which problems

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have already escalated and attachment ruptures are present. This often involves intensive coaching or therapy, which may span a substantial number of sessions. However, intervening earlier may repair or prevent ruptures without the need for intensive therapy. Families may learn how to enhance the quality of their interactions and attachment relationships, which in turn can promote the mental health of all family members (e.g., Bannink et al. 2013). In practice, professionals often lack the time or resources to offer preventive intervention programmes (Kazdin 2017). Moreover, families may be hesitant to seek therapeutic help to improve their attachment-related dynamics. Online self-help interventions are one possible way to reduce existing barriers. These are increasingly being used and are efficacious for a wide range of mental health problems (Van Daele et al. 2021). However, while self-help interventions offer advantages such as ease of access and a low threshold for use, they also come with notable disadvantages, particularly poor adherence and high dropout rates (Baumel et al. 2019). Combining an online intervention with online guidance (i.e., a guided self-help intervention) or with face-to-face consultations (i.e., a blended intervention) increases intervention effectiveness, likely through enhanced participant motivation and reduced dropout (Buelens et al. 2023; Wilhelmsen et al. 2013).

FamilieLink was developed with these approaches in mind. It is designed for both parents and children, ranging from birth to 18 years of age. In the present study, we recruited parents who were not experiencing an acute crisis, as the intervention presupposes sufficient time, stability, and mental capacity to engage. In addition, parents were required to demonstrate adequate proficiency in the language of delivery (i.e., Dutch) to ensure they could understand and apply the material effectively. The blended intervention comprises three parent-oriented modules and one child-oriented module (referred to as Module 4) for children aged 8 years or older. The parent-oriented modules are interspersed with face-to-face conversations with a professional. By and large, these modules follow the five therapeutic tasks of ABFT (Diamond et al. 2014). The sessions with the professional are limited to five, because meta-analytic evidence has shown that attachment-focused interventions and blended interventions with fewer sessions are more effective than longer interventions (Bakermans-Kranenburg et al. 2003; Nunes-Zlotkowski et al. 2024). The content of the different modules is detailed below.

1.3.1 | Module 1: Psychoeducation Module

Module 1 offers psychoeducation on the Dynamic Model of the Insecure Cycle to help parents understand that challenging child behaviours may actually be distorted signals of attachment needs (Kobak and Bosmans 2019). To support this module, an animated explainer video (https://youtu.be/OHNOZLVfLEw) was created to illustrate the relational dynamics and associated emotions of loneliness, failure, and a sense of being unloved in both the parent and the child. Following the animation, the parent is invited to watch a video explaining the insecure cycle step by step and to write down their own concerns and questions for discussion with the professional after completing Module 1.

1.3.2 | Module 2: Application Module

In Module 2, which corresponds to Task 3 in ABFT, the parent applies his or her newly acquired knowledge of the insecure cycle to interactions with their child. To support this process, Module 2 includes a variety of exercises designed to help parents identify the relational dynamics underlying interactions with their child. In addition, parents can listen to testimonials from other parents. These testimonials are divided into four age categories: infancy, toddlerhood and preschool age, middle childhood, and adolescence. The parent can choose to listen to all testimonials or only to the one that corresponds to their child's age. The parent is also asked to complete a 7-day diary in which they rate the quality of the interactions with their child at various times throughout the day. After completing Module 2, the parent meets with the professional to discuss the insecure cycle and their experiences from the past week, based on the diary. This provides the professional with insight and helps guide the parent to focus on the most appropriate intervention level (i.e., attachment-focused antecedent control strategies, attachment-focused consequent control strategies, or attachment-focused exposure).

1.3.3 | Module 3: Repair Module

Module 3 is the repair module and corresponds to Task 4 in ABFT. For infants, information is provided about typical developmental patterns in three major regulatory domains: crying, eating, and sleeping. Parents of preschool-aged children and older are informed about the attachment-focused antecedent and consequent control strategies, presented in Table 1. From middle childhood onwards, parents are also informed about emotion coaching skills. Such strategies aim to interrupt the insecure cycle, help restore the relationship, and promote secure attachment development. While practicing these new skills, the parent can rely on the professional to review and evaluate their application and effectiveness. If the parent feels that he or she has sufficiently mastered the new skills, the FamilieLink programme may be concluded. If desired, the parent will retain access to all modules.

1.3.4 | Module 4

Parents invite children aged 8 years and older to complete the fourth module. First, an audio-visual story is used to introduce the Dynamic Model of the Insecure Cycle. Next, the child undergoes Cognitive Bias Modification (CBM; MacLeod and Mathews 2012) to address negative attachment-related biases. These biases, common in insecurely attached children, hinder the encoding of corrective attachment information (Bosmans et al. 2020). CBM retrains these biases to support secure attachment development through corrective parental interactions (Bosmans et al. 2019; De Winter et al. 2017, 2018; Doolan and Bryant 2021). Two age-specific CBM tasks were developed: one for children aged 8 to 11 years, and one for those aged 12 years and older. These tasks cater to different developmental phases, according to developmental tasks and changing attachment needs in both age groups (Bosmans 2016). In this CBM task, stories are presented that

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TABLE 1 | Overview of Module 3 attachment-focused antecedent and consequent control strategies.

Attachment-focused antecedent and consequent strategies	Explanation
Induction	Explaining the reason for limit setting or their commands to their child
Distraction and providing alternatives	Distracting the child when not allowing a demand by providing an attractive alternative
Kind limit setting	Limit setting by the parent but with acknowledgement of underlying attachment needs of the child
Speaking for the child (Carter et al. 1991)	Subtitling the child's facial expressions, behaviour, and emotions
Supported failure (Bosmans 2016)	Comforting the child while showing understanding for the effort he/she did and not view the child as failing
Complimenting (reinforcing positive behaviour)	Praising the child when he/she does something well, no matter how small the effort is
Sensitive pause	Deescalating tantrums sensitively by removing the parent or child from the situation but with maintaining contact with the child

Note: Adapted from Juffer and Bakermans-Kranenburg (2018).

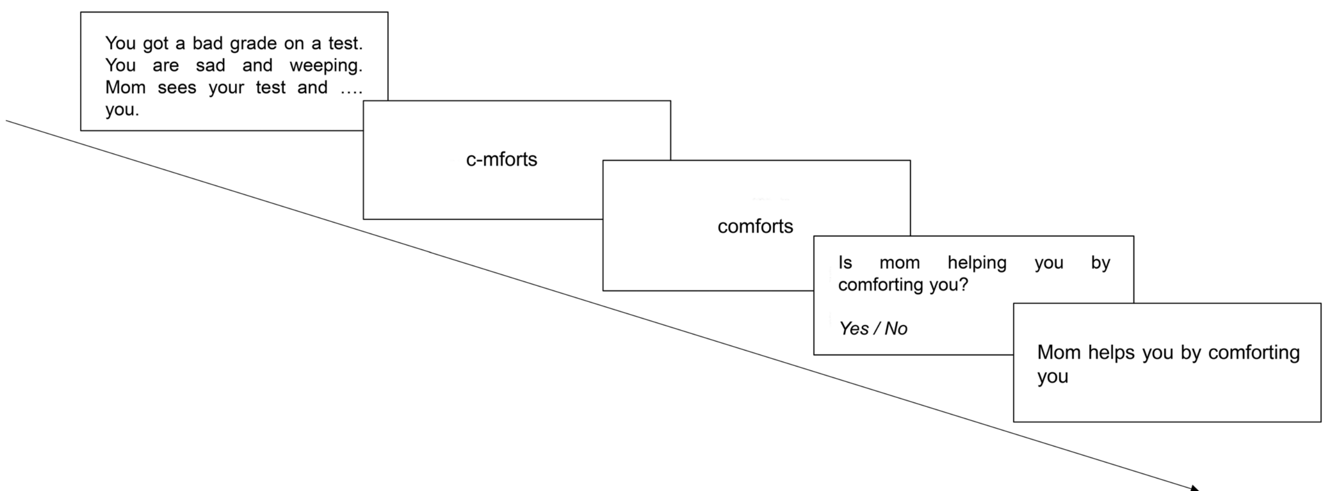

FIGURE 2 | Example of a CBM story for children aged from 8 up to 11 years old. In this example 'mom' is used but children can choose the name of their attachment figure before the start of the CBM task so that the stories are personalised.

describe distressing situations in which parental support is indicated. However, the story is deliberately written to be ambiguous about whether parental support is actually provided. All stories consist of three sentences, with one word missing from the final sentence. After reading the story, the child presses the space bar to reveal the missing word, with one letter still omitted. The child is instructed to press the space bar again as soon as they know the missing letter. Each story is followed by a comprehension question and corresponding feedback. Resolving the word fragment in each story always leads to a secure interpretation of the initially ambiguous information, that is, emotional support is effectively given by the parent. In this way, the child is trained to interpret the stories from a secure attachment perspective. Module 4 includes 45 stories: three demonstration stories and 42 attachment-related stories (Figure 2).

2 | Case Study

2.1 | Objectives

The aim of this case study is to illustrate how FamilieLink can be applied in practice. Specifically, the objectives of this clinical case study are: (1) to describe the implementation of FamilieLink in a case involving the mother of a 10-year-old boy; (2) to outline outcomes related to the intervention; and (3) to explore initial impressions regarding user satisfaction and usability.

2.2 | Measurements

Demographic information on the child (i.e., age, gender, nationality, and type of education) was collected to facilitate account

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creation on FamilieLink. At initial registration, the parent was asked to provide information on their age, gender, nationality, educational level, profession, family composition, and parental role. As part of ongoing research and development, the questionnaires listed in Appendix A are currently being administered to families participating in FamilieLink.

2.3 | Case Vignette

Family X, seeking support for managing their 10-year-old son's anger-related behaviour and stress-related difficulties, volunteered to participate. Informed consent was obtained from the mother, hereafter referred to as Emma. Names and details have been changed to protect their privacy. All conversations were conducted via Microsoft Teams. The use of FamilieLink was approved by the Ethics Committee of UZ Leuven (S66988).

2.3.1 | Module 1

The aim of the first conversation was to gather information about the current family situation and life context, and to gain insight into Emma's request for help regarding her son, James. Emma and her partner, Simon, were raising three children together: James (10 years old), Thomas (7 years old), and Olivia (4 years old). Since James's birth, Emma had faced challenges with him, noting that he cried frequently as a baby. She had always perceived James as experiencing a great deal of stress and tension, which she found difficult to manage. Furthermore, James exhibited frequent anger outbursts, often resulting in physical conflicts with his siblings, particularly his youngest sister. During the conversation, Emma expressed her desire to better understand her son's stress and tension, and to gain tools to support him when he was struggling.

After discussing Emma's request for help, the professional provided information about FamilieLink (i.e., the overall approach, the different modules, and the estimated time per module). Additionally, it was agreed that a follow-up conversation after Module 1 would be scheduled at Emma's request. If she had no questions regarding Module 1, she could proceed directly to Module 2. Finally, Emma provided her child's demographic details, enabling the professional to create an account on FamilieLink.

At the start of Module 1, the mother completed several questionnaires, presented in Table 2. Emma reported depression, anxiety, and stress within the range of the general population, with anxiety being fully absent, as measured by the DASS-21 (Henry and Crawford 2005; Lovibond and Lovibond 1995). Furthermore, Emma's score on the ECR-R indicated a fearful attachment style (Fraley et al. 2000). Her son's conduct problems were reported within the normal range, although emotional symptoms were elevated (according to the SDQ; Goodman et al. 1998; Theunissen et al. 2016). Regarding her cognitions and attitudes towards sensitive parenting and sensitive discipline, she obtained a lower score on sensitivity and an adequate score on sensitive discipline (M. J. Bakermans-Kranenburg, personal communication, June 11, 2024). Finally, difficulties with emotion regulation, as measured by the DERS, indicated above-average scores for nonacceptance, goals, and impulse, and below-average scores for awareness, strategies, and clarity (Gratz and Roemer 2004). The results are presented in Appendix B (Figures B1a,b and B2a–c). After completing Module 1, Emma indicated that she did not require an interim conversation, as she understood the videos and had no further questions.

2.3.2 | Module 2

After completing Module 2 and the diary, an online conversation with the professional was scheduled. The diary revealed that Emma was constantly moving between family members to meet everyone's needs, avoid conflict, or resolve it quickly when it occurred. Moments of conflict and harmony alternated frequently. Reflecting on this, Emma shared that, as a child, she often felt unseen and unheard by her parents. Growing up with seven siblings, there was little room for individual attention. Emotions were dismissed as unnecessary and burdensome. As a result, Emma spent much of her time alone in her room, where she could express her emotions but also experienced a deep sense of loneliness and invisibility. This caused her significant stress, as she had no one to share her feelings with. Additionally, she felt inadequate, receiving comments from her family and teachers that she was stupid, ugly,

TABLE 2 | FamilieLink questionnaires overview and timing.

Questionnaire	Focus	Parent	Child
ECR-R(C)	Attachment style	Onset	≥ 8 years—before & after M4
DASS-21	Emotional distress	Onset	
SDQ	Emotional and behavioural difficulties of child (≥ 4 years)	Onset After M2 & M3	≥ 8 years—before & after M4
DERS	Difficulties with emotion regulation	Onset After M2 & M3	
PAQ	Cognitions and attitudes towards sensitive parenting and sensitive discipline	Onset After M2 & M3	
CSQ	Satisfaction of FamilieLink	At completion	≥ 12 years—at completion
SUS	Usability of FamilieLink	At completion	≥ 12 years—at completion

Note: CSQ, Client Satisfaction Questionnaire (Attkisson and Greenfield 2004); DASS-21, Depression, Anxiety, Stress Scales (Lovibond and Lovibond 1995); DERS, Difficulties in Emotion Regulation Scale (Gratz and Roemer 2004); ECR-R(C), Experiences in Close Relationships-Revised (Child Version) (Fraley et al. 2000; Brenning et al. 2014); M, Module; PAQ, Parenting Attitudes Questionnaire (Bakermans-Kranenburg and Van IJzendoorn 2003); SDQ, Strengths and Difficulties Questionnaire (Goodman et al. 1998); SUS, System Usability Scale (Brooke 1996).

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and less capable than her older siblings. These experiences contributed to her persistent sense of not being good enough.

During the contact moment, Emma acknowledged that her own attachment narrative influenced her parenting. Specifically, she expressed feelings of inadequacy, even to the extent that she avoided reading books to James out of fear that he might think she was stupid. Her tendency to avoid or quickly resolve conflicts between family members stemmed from a strong desire to be perceived as a good enough partner and mother. When she became a parent, Emma committed to being unconditionally emotionally available for her children, something she deeply longed for but lacked during her own childhood. In her efforts to fulfill this promise, she devoted significant time to understanding and supporting James's emotions and needs. However, this focus sometimes came at the expense of attention to her other children.

Emma's relationship with Simon was also discussed. She explained that tensions often arose between them, particularly concerning how to handle James during emotionally charged moments. Simon, she noted, had difficulty remaining calm in such situations and tended to blame James. This dynamic caused Emma to shift her focus back and forth between Simon and James, frequently resulting in her full attention being directed towards her son. This pattern often led to conflicts with Simon, leaving Emma feeling isolated in managing James's anger and intense emotions. At this point in the conversation, the professional raised the question of who cared for Emma. She explained that she had previously engaged in therapy and had worked hard to heal from the past. Following a burnout, she retrained as an orthomolecular therapist and found fulfilment in helping others regulate their nervous system. Additionally, Emma regularly received massages, which she found relaxing and grounding.

Informed by this conversation, the diary entries, and the responses entered on the platform, an insecure cycle between Emma and James was constructed (Figure 3). Skills from Module 3 that could benefit both Emma and James were explored. Specifically, the following strategies were recommended: supported failure (addressing James's sensitivity to failure), kind limit setting (guidance during aggressive behaviour towards family members), speaking for the child (providing language to express James's feelings during emotional moments), sensitive pause (pausing when other strategies are ineffective and tensions are escalating), and emotion coaching (gaining insight into the vulnerable emotions that may underlie James's anger outbursts). A follow-up conversation was scheduled.

At the end of Module 2, Emma again completed several questionnaires (Table 2). According to her reports, James's emotional symptoms were within the normal range, although conduct problems were elevated, as measured by the SDQ (Goodman et al. 1998; Theunissen et al. 2016). Regarding her cognitions and attitudes towards sensitive parenting and sensitive discipline, Emma scored adequately on both scales (M. J. Bakermans-Kranenburg, personal communication, June 11, 2024). Finally, difficulties with emotion regulation, measured using the DERS, indicated above-average scores for nonacceptance, goals, and impulse, and below-average scores for awareness, strategies, and clarity (Gratz and Roemer 2004). Results are presented in Appendix B (Figure B2a–c).

2.3.3 | Module 3

After 3 weeks, a follow-up conversation took place to evaluate Emma's experience with the skills she had been practicing. She noted that not all of the skills were new to her. In particular, she

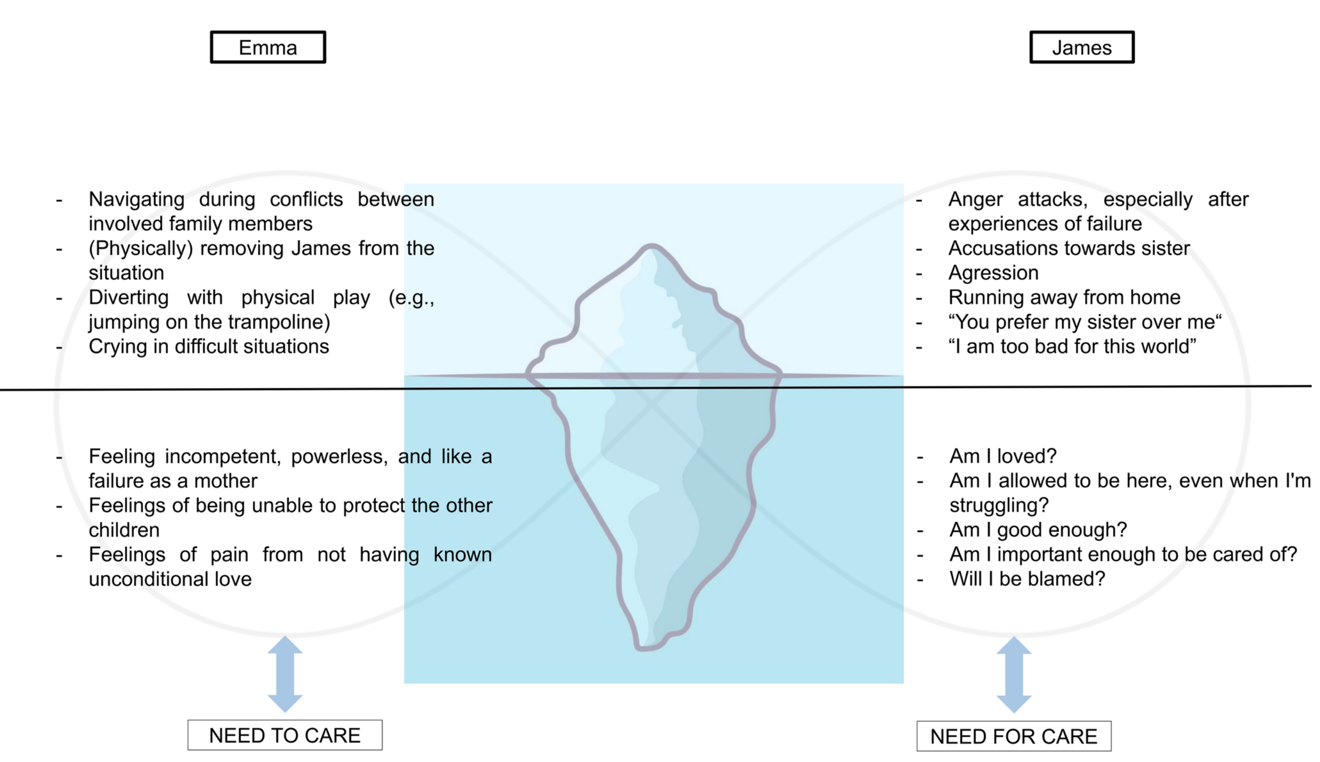

FIGURE 3 | Insecure cycle between Emma and James.

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mentioned that she had already been applying speaking for the child and emotion coaching techniques. She shared that in the past, she often felt overwhelmed by her own emotions and would sometimes react impulsively from those intense emotions. After undergoing extensive therapy, she realised how liberating it can be to no longer feel constantly overwhelmed. This insight is something she hopes to pass on to her son, which is why she finds it important to use these skills to help him understand and regulate his emotions. Emma acknowledged that it is not always easy for her, and that she is still occasionally triggered by some of her son's actions and words. She recounted a recent incident, involving a conflict between James and Olivia that escalated into physical aggression. James ultimately packed his bags and announced that he wanted to leave home. This deeply affected Emma and brought her to tears. In that moment, she used techniques she learned in therapy to calm herself. Afterwards, she applied emotion coaching skills to talk with James. During their conversation, it became clear that James had been afraid of being blamed for the conflict. Because Emma had primarily comforted Olivia during the incident, James interpreted this as a sign that Olivia was more important to his mother, and that Emma preferred Olivia over him. Both the fear of being blamed and the perception of not being important or loved are attachment-related themes that seemed to drive James's behaviour when his *need for care* is at risk. These fears manifested in anger outbursts, physical aggression, conflicts with his siblings, and even (thoughts of) running away. Emma became aware of these attachment themes and committed to addressing James's fears more openly and supporting him in regulating his emotions.

A final meeting was scheduled 3 weeks later, during which Emma provided feedback on the overall process and her experience with the platform. In preparation for this feedback session, she received a questionnaire via email. At this stage, she also completed the final set of questionnaires (Table 2). Emma's scores on cognitions and attitudes towards sensitive parenting and sensitive discipline indicated adequate levels (M. J. Bakermans-Kranenburg, personal communication, June 11, 2024). Regarding emotion regulation difficulties, as measured by the DERS, she reported above-average scores on all subscales (Gratz and Roemer 2004). Data on the SDQ (Goodman et al. 1998) was missing due to technical issues and was therefore collected 5 months after completion of FamilieLink. According to Emma's responses, James's conduct problems were in the normal range, while emotional symptoms remained elevated (Theunissen et al. 2016). Results are presented in Appendix B (Figure B2a–c).

2.3.4 | Module 4

Emma encouraged James to complete the questionnaires and CBM task. James initially expected to watch something related to emotions. He watched the audio-visual story explaining the Dynamic Model of the Insecure Cycle but did not share much about it afterwards. Emma chose not to push him to discuss the story and instead allowed him to take the initiative. She explained that the number of questions in the CBM task caused James to quickly lose motivation. To support him, Emma sat next to him, and they completed the task together, with Emma typing the answers. This support enabled James to successfully complete Module 4.

James completed questionnaires both before and after Module 4. At both time points, his scores on emotional symptoms and conduct problems were within the normal range (according to the SDQ; Goodman et al. 1998; Theunissen et al. 2016). Additionally, his scores on the ECR-RC indicated a tendency towards a secure attachment style at both assessments (Brenning et al. 2014). Results are presented in Appendix B (Figure B3a,b).

2.3.5 | Feedback

Overall, Emma found FamilieLink to be a pleasant and visually appealing platform. She particularly valued the testimonials presented in Module 2, as they helped her feel less isolated in her parenting struggles. She considered the skills introduced in Module 3 to be helpful tools for interacting with her children, although many of these skills were already familiar to her. She also appreciated the intermittent online consultations, which allowed her to gain external perspectives and feel supported throughout the process.

However, Emma indicated that she would have liked to receive more information about the relationship between attachment and the development of the central nervous system. Given her previous experience in therapy, she was seeking more in-depth content, which she felt was lacking in FamilieLink.

Nonetheless, Emma believed that FamilieLink effectively increases parents' awareness of the relational dynamics that can develop between parents and children. She would recommend the platform to parents who are just beginning to explore and understand insecure attachment dynamics.

2.4 | Engagement

Emma completed FamilieLink at her own pace over a period of 9 weeks, including a one-week extension due to illness. She demonstrated consistent engagement throughout the programme, watching nearly all videos that were relevant to her context in their entirety. The platform provided a total of 37 tailored videos. Based on her child's age and the recommendations made during the contact moment after Module 2, 25 of these videos were considered relevant for Emma, of which she fully watched 15. In Module 3, for instance, Emma chose to view explainer videos on supported failure, induction, and distraction. This selection diverged from the suggestions made during the contact moment after Module 2, indicating that she deliberately explored content on parenting skills that were new to her. Her proactive engagement shows she tailored the learning experience to her needs. Her completion of all relevant videos demonstrates the added value of combining an online platform with intermediate professional contact moments, with each component offering complementary contributions in the learning process.

3 | Case Review

Over a 2-month period, Emma completed FamilieLink, supplemented by online consultations. During this time, she focused on gaining insight into the relational dynamics between herself

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and her son, James, and practiced new parenting skills. Having previously graduated as an orthopedagogue, Emma already possessed some theoretical knowledge about parent–child relationships. Consequently, not all content in FamilieLink was new to her. Additionally, her prior engagement in therapy had contributed to increased self-awareness and emotion regulation skills. These factors provided Emma with a strong foundation upon entering FamilieLink. For future research, it would be valuable to include parents with limited theoretical background or therapeutic experience in order to evaluate whether FamilieLink effectively improves their understanding of parent–child dynamics and whether the skills presented in Module 3 are sufficiently accessible and effective for fostering secure attachment development.

Emma's pre-existing emotion regulation abilities supported her participation in FamilieLink. However, some improvement in these strategies was still observed over the course of the programme. One possible explanation is that emotional regulation skills previously acquired were reactivated through exposure to emotional reflection in both the platform content and online consultations. Alternatively, Emma may have become more aware of her own emotional processes and developed more nuanced regulation strategies during the intervention. For parents with less developed emotion regulation capacities, an additional module is available, offering breathing exercises and exercises aimed at enhancing emotional awareness.

The discrepancy between the participant's positive subjective experience of FamilieLink and the limited changes observed in post-intervention questionnaire scores warrants careful consideration. One possibility is that the self-report measures selected for this case study did not adequately capture the primary outcomes targeted by the intervention. Future studies may benefit from including observational assessments of parental sensitivity, such as the Erickson rating scales for supportive presence (e.g., Euser et al. 2020), as well as broader measures of child functioning, such as the Child Behaviour Checklist (Achenbach and Rescorla 2000). A further explanation is that meaningful changes in parental sensitivity and child symptoms may only become evident some time after completion of the intervention. It is possible that the changes subjectively experienced by Emma had not yet been reflected in the questionnaire scores at the time of assessment. Another consideration is that the inclusion of multiple questionnaires on the platform may have contributed to respondent fatigue, potentially affecting data quality. Finally, the participant's relatively high level of prior knowledge about parent–child relationships may have limited the potential for detectable change on the selected instruments, thereby attenuating detectable intervention effects.

This case study highlights the added value of a blended intervention that combines self-paced online learning with intermittent professional support. Emma explicitly expressed benefiting from the interim conversations, a finding consistent with previous research, indicating that even minimal professional support can increase user engagement and satisfaction with online parenting interventions (Day and Sanders 2018). Notably, the entire process was completed within 2 months and included four professional contact moments. In contrast, intensive attachment-focused therapies (e.g., ABFT) typically span a minimum of 4 months and include at least 16 therapeutic sessions. Because FamilieLink enabled parents to complete preparatory work in advance and allowed therapists to review this input beforehand, the conversations could focus more directly on core issues, thereby increasing time-efficiency.

An important limitation of the present case study concerns the absence of paternal involvement. The father did not provide consent to participate, which restricted the information that could be collected and reported. Although the absence of one parent in an attachment-based intervention may affect intervention processes and outcomes, prior research indicates that working with one parent can nevertheless be clinically meaningful. In line with the compensation or buffering hypothesis, a secure relationship with one parent may protect children against the development of internalising or externalising problems (e.g., Boldt et al. 2014; Dagan et al. 2021; Verschueren and Marcoen 1999). Ideally, attachment-based interventions involve both parents to promote shared understanding and coordinated parenting. However, in the present case study, engaging the mother alone may still have offered a viable pathway for supporting the child's attachment development.

Our case study involved a highly educated parent with prior knowledge of parent–child relationships. Although such prior knowledge may have positively affected engagement with the intervention and its outcomes, FamilieLink is intended to be accessible to parents across a broad range of educational backgrounds. Parents with other educational backgrounds may require additional support or may benefit from completing the modules together with a professional. Future research is needed to evaluate how FamilieLink can be effectively adapted and implemented across diverse caregiver populations.

In sum, this case study illustrates the potential utility of a newly developed blended intervention aimed at promoting secure attachment development. While promising, further research should prioritise implementation and evaluation through randomised controlled trials. These preliminary findings offer valuable insights into the applicability and perceived value of FamilieLink in clinical parenting settings.

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Ethics Statement

This study was approved by the Ethical Board of UZ Leuven (S66988). Informed consent was given by the mother in this study.

Conflicts of Interest

The authors of this manuscript were involved in the development of FamilieLink, and the intervention described in this case study. No financial or personal conflicts of interest exist beyond the authors' role in the development of the tool.

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Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Appendix A

The selected questionnaires assess processes that are conceptually linked to the non-observable components of the insecure cycle, namely parents' and children's internal experiences of pain and interpretations that shape their behaviours. For example, higher levels of parental depressive, anxiety, or stress symptoms (DASS-21) may contribute to their maladaptive interpretations of their child's distorted attachment signals. Parents may perceive these behaviours as more painful and rejecting, thereby increasing the likelihood of non-supportive responses (Attkisson and Greenfield 2004; Mills-Koonce et al. 2011). The ECR-R provides insight into the attachment-related defensive strategies used by both parents and children when confronted with children's distorted signals of attachment needs or parental non-supportive responses. The DERS reflects parents' capacity to regulate difficult emotions during stressful parent–child interactions. Emotional dysregulation can impair parents' ability to remain emotionally available and to co-regulate their child's distress, thereby heightening the risk of insecure cycles (Morelen and Suveg 2012). The SDQ was included for two reasons. First, children's emotional and behavioural difficulties may increase parental stress and reactivity, thereby intensifying insecure cycles. Second, reductions in these difficulties may indicate fewer insecure cycles and progress towards more secure attachment patterns. Finally, the questionnaire assessing cognitions and attitudes towards sensitive parenting and sensitive discipline was included to determine whether increased understanding of the insecure cycle, together with skills taught in the modules, promotes greater parental sensitivity, an established predictor of secure attachment (e.g., Madigan et al. 2024).

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Emotional Distress

The Depression Anxiety Stress Scale (DASS-21; Lovibond and Lovibond 1995) was used to assess emotional distress in the parent. The DASS-21 is a self-report questionnaire and consists of 21 items divided into three subscales: depression (e.g., "I was unable to become enthusiastic about anything"), anxiety (e.g., "I felt scared without any good reason"), and stress (e.g., "I found myself getting agitated"). Each subscale contains seven items. Questions were rated on a 4-point Likert scale, with scores ranging from 0 ("did not apply to me at all; never") to 3 ("applied to me very much, or most of the time; almost always"). Subscale scores were calculated by summing item scores and multiplying by two, with a maximum score of 42 for each subscale.

Attachment Style

The Experiences in Close Relationships-Revised (ECR-R; Fraley et al. 2000) questionnaire was used to identify the parent's attachment style. The ECR-R is a self-report questionnaire consisting of two subscales: the attachment-related anxiety subscale (e.g., "I'm afraid that I will lose my partner's love") and the attachment-related avoidance subscale (e.g., "I don't feel comfortable opening up to romantic partners"). Each subscale consists of 10 items rated on a 7-point Likert scale with values from 1 ("strongly disagree") to 7 ("strongly agree"). Each subscale score was calculated by averaging the item scores with a maximum score of seven for each subscale.

The short version of the Experiences in Close Relationships Scale—Revised Child Version (ECR-RC; Brenning et al. 2014) was used for children aged 8 years and older to examine their attachment style. The ECR-RC is a self-report questionnaire consisting of 12 items, six items belong to the attachment-related anxiety subscale (e.g., "I'm worried that my parent doesn't love me") and six items belong to the attachment-related avoidance subscale (e.g., "I prefer not to get too close to my parent"). Each item is rated on a scale from 1 ("not at all") to 7 ("very much"). Scale scores were calculated by summing the item scores with a maximum score of 42.

Emotional and Behavioural Difficulties

To assess emotional and behavioural difficulties in the child, the conduct problems subscale (e.g., "Often lies or cheats") and emotional symptoms subscale (e.g., "Many worries or often seems worried") of the Strengths and Difficulties Questionnaire (SDQ; Goodman et al. 1998) were used. Both the parent-reported and child-reported versions were used. Each subscale consists of five items rated on a 3-point Likert scale ranging from 0 ("not true") to 2 ("certainly true"). Subscale scores were calculated by summing the item scores, with a maximum score of 10.

Difficulties in Emotion Regulation

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer 2004) was administered to the parent to measure emotion regulation problems. The 36-item self-report questionnaire is subdivided into six scales: (1) Nonacceptance of one's own emotional response (six items, e.g., "When I'm upset, I become angry with myself for feeling that way"), (2) Difficulty engaging in goal-directed behaviour, that is, difficulty concentrating and completing tasks when experiencing negative emotions (five items, e.g., "When I'm upset, I have difficulty concentrating"), (3) Impulse control difficulties, that is, difficulties controlling one's own behaviour when experiencing negative emotions (six items, e.g., "I experience my emotions as overwhelming and out of control"), (4) Lack of emotional awareness (six items, e.g., "I pay attention to how I feel"), (5) Limited access to emotion regulation strategies (eight items, e.g., "When I'm upset, I believe that I will remain that way for a long time"), and (6) Lack of emotional clarity (five items, e.g., "I am confused about how I feel"). Items are rated from 1 ("almost never") to 5 ("almost always"). Scale scores were calculated by summing the item scores with higher scores indicating greater difficulties with emotion regulation. A total score was also calculated by summing all the scale scores with a maximum score of 180.

Cognitions and Attitudes Towards Sensitive Parenting and Sensitive Discipline

A 20-item questionnaire was used to assess the parent's cognitions and attitudes towards sensitive parenting and sensitive discipline (Bakermans-Kranenburg and Van IJzendoorn 2003). Parents indicated their position on the statements using a scale from 0 ("totally disagree") to 100 ("totally agree"). Two subscales were extracted: sensitivity (e.g., "Even when my child is furious with me, I try to remain calm") and sensitive discipline (e.g., "My child needs to learn that I will get angry if he/she does not listen to me"), each consisting of 10 items. Total scores were computed by summing the item scores with a maximum score of 1000 for each subscale.

Appendix B

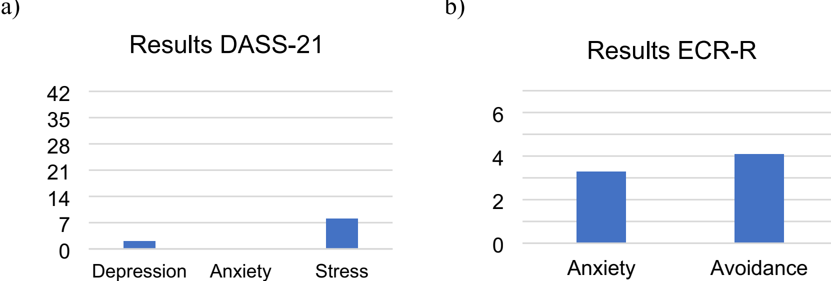

FIGURE B1 | (a, b) Results of the questionnaires administered to the mother prior to Module 1. DASS-21 = Depression Anxiety Stress Scale (Lovibond and Lovibond 1995); ECR-*R* = Experiences in Close Relationships-Revised (Fraley et al. 2000).

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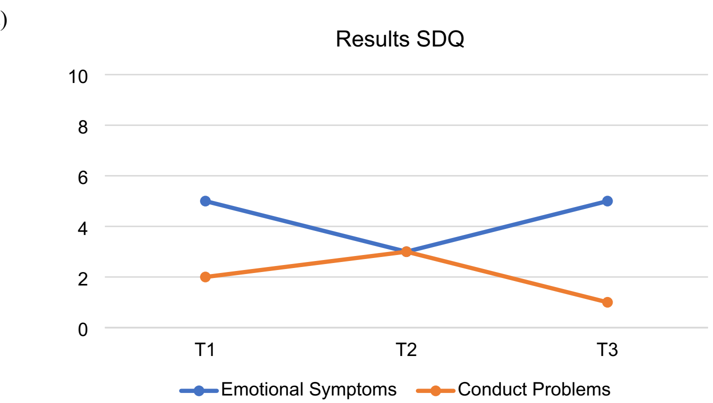

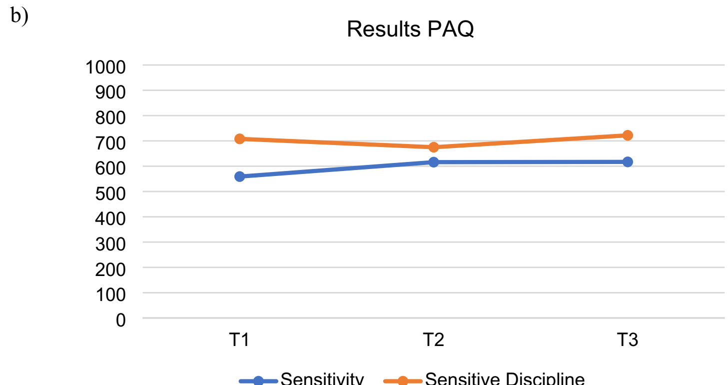

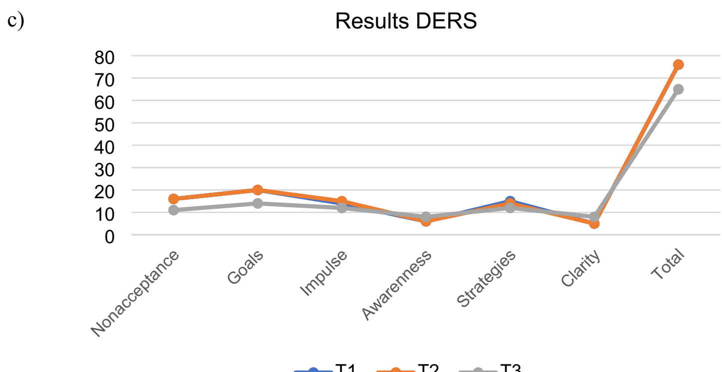

FIGURE B2 | (a–c) Results of the questionnaires administered to the mother at different times. SDQ = Strengths and Difficulties Questionnaire (Goodman et al. 1998); PAQ = Cognitions and Attitudes Towards Sensitive Parenting and Sensitive Discipline (Bakermans-Kranenburg and Van IJzendoorn 2003); DERS = Difficulties in Emotion Regulation Scale (Gratz and Roemer 2004); T1 = Before Module 1; T2 = After Module 2; T3 = After Module 3.

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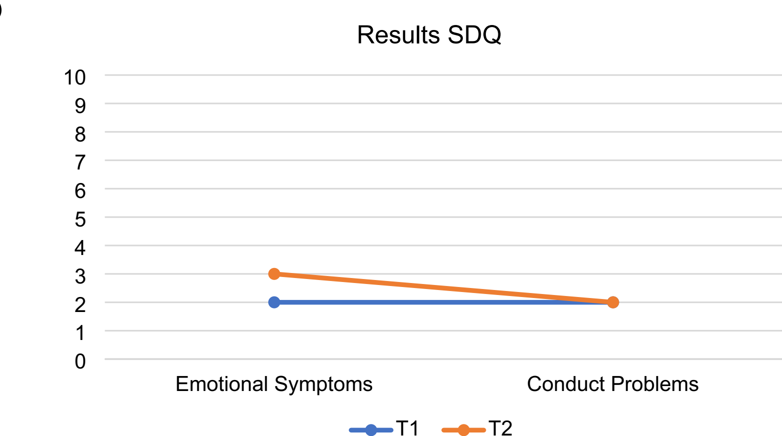
a)



b)

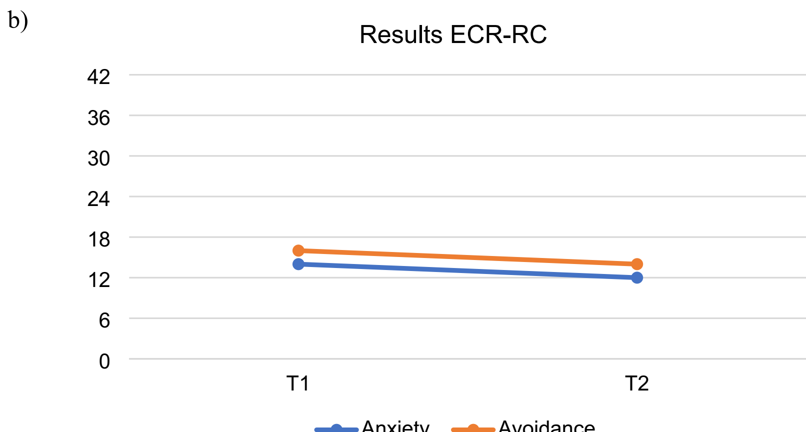


FIGURE B3 | (a, b) Results of the questionnaires administered to the child at different times. SDQ = Strengths and Difficulties Questionnaire (Goodman et al. 1998); ECR-RC = Experiences in Close Relationships Scale—Revised Child Version (Brenning et al. 2014); T1 = Before Module 4; T2 = After Module 4.

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