CHILD-CENTRED ATTACHMENT THERAPY

The CAT Programme

Alexandra Maeja Raicar
with contributions by Pauline Sear and Maggie Gall
CHILD-CENTRED ATTACHMENT THERAPY
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and Maggie Gall

On behalf of the United Kingdom Council for Psychotherapy

KARNAC
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Child-centred Attachment Therapy (CAT) was developed and piloted in Essex during 1995–1996 as a brief therapy programme. Its aim was to foster mutual attachment in adoptive families where placements of children were in jeopardy because of the child’s failure to attach to her new carers, despite their apparent willingness to meet her needs. Over the past ten years CAT has been used independently with birth, extended, foster, adoptive and step-families.

The programme is based on attachment theory, derived from the work of the late Sir John Bowlby and his successors. I am indebted for the following concepts to: Vera Fahlberg: “Positive/negative interaction cycles” and fostering attachments; Selma Fraiberg: “Ghosts in the nursery” and attachment/child protection work; Charles Whitfield: “Inner child healing”.

My grateful thanks to Clair Pyper, Children and Families Service, Essex County Council, for permission to reproduce here materials from earlier publications written during 1995–1997 for the CAT pilot project; and also to

● my three enthusiastic colleagues who helped to co-develop and pilot CAT at Southend Family Finders during 1995–1997, and
for their significant contributions to this book: Pauline Sear, Dr Maggie Gall and Margaret Saxby;

● our team leaders, Carol Collis and Di Hart, who allowed us time to test CcAT;

● Tony Sharp, County Adoption Manager, Essex, for facilitating the pilot project and leading a County Focus Group of adoption practitioners to reflect on our learning;

● Lesley Smith, senior researcher, Essex Social Services, who evaluated the project;

● Mike Leadbetter, then Director of Social Services, Essex, for his encouragement.

I am grateful to Dr Hisako Watanabe and Dr Stella Acquarone for modelling family attachment work, and all the teachers and therapists and writers I have learned from over the years, unconsciously as well as consciously.

My thanks to the many, many children and families whose stories are shared anonymously here to help illustrate our learning from CcAT work, and to all who have contributed to this book for sharing their thinking and experience and stories so openly and generously, especially “Rose”, “Gemma” and “Emily”; see also list of “Permissions”, below.

I thank Dr Stella Acquarone and Bernie Laschinger for their insightful supervision throughout, and colleagues who, despite their very busy schedules, took time to read and comment so helpfully on an earlier draft or parts of it: Angela Reynolds, Anne Wardrop, Bernie Laschinger, Colette Salkeld, Eve Menezes Cunningham, Franca Brenninkmeyer, Inger Gordon, Jasmine Shekleton, Maggie Rogers, Monica Duck, Richard Bowlby, Rosie Ingham, Sue Dromey, and Vivien Nice. Any errors or omissions remain my responsibility.

Grateful thanks to Eve Menezes Cunningham, for her invaluable support and ever helpful advice and comments; and finally, thank you to Christelle Yeyet-Jacquot and Pippa Weitz at Karnac for their editorial help, patience, and encouragement throughout this writing project, and to the copy-editor and the production team.

Permissions

My special thanks for permission to include their own perspectives on CcAT to: Angela Reynolds: “A clinician’s perspective” (in
Chapter Eight); Colette Salkeld: “A music therapist’s perspective” (in Chapter Eight); Linda Fowler: “A fostering agency’s perspective” (in Chapter Seven); Sir Richard Bowlby: “An attachment researcher’s perspective” (in Chapter Eight).
To Tim, Eve, and Alan, who have taught me about building healthy attachments; to Angela, Tony, Melita, Frank, Flora, and our parents for helping me to start this journey all those years ago; and to “Rose” and “Emily” whose family stories were the inspiration for The CAT Programme.
ABOUT THE AUTHOR AND MAIN CONTRIBUTORS

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Maggie Gall worked in various social services settings for thirty-five years; these included mental health, disability, the elderly, child protection, fostering and adoption, and hospital social work. Maggie has a CQSW and an MSc in Social Administration and Social Policy from the London School of Economics, where she gained her first degree, a BSc in Social Anthropology with Psychology. Maggie obtained a PhD in the “Psychiatric, psychological and sociological aspects of plastic surgery” through Bedford College, University of London. She carried out research on mental
health issues for Essex Social Services, and also for London Roehampton Hospital on the long-term effects on the family of psychiatric illness.

**Pauline Sear** worked in Social Services for twelve years, supporting struggling families, before co-developing The CAT Programme with Maeja Raicar, Maggie Gall and Margaret Saxby in the mid-1990s. Pauline trained in counselling and play therapy, and her contributions to CAT through play and family work have been invaluable in shaping the Programme.
Child-centred Attachment Therapy (CcAT) is a brief, focused, family programme for children with attachment and related behavioural difficulties. These include children who, without therapeutic intervention, remain at risk of significant harm or family breakdown with multiple moves. In our experience over the past twelve years, we have found family attachment work to be very effective in helping troubled children.

CcAT is a social work initiative that was developed during 1995–1997 and successfully piloted at a family-finding unit with a small number of struggling adoptive families. Our experience since then has shown that the programme can be effectively adapted to meet the needs of birth, extended, foster, and step-families, too, where parents are committed enough to engage in such collaborative work with them and the identified child client.

CcAT was initially developed as post-placement support for very hurt children in adoptive or long-term foster families where disruption and further moves otherwise seemed likely. CcAT has also been used very successfully in carrying out exploratory work, preparation, and support for children and birth families where reunification is being considered, as well as in “therapeutic assessments” for
Social Services and/or the Courts of placements at risk of breakdown, sibling and family attachments, and complex contact arrangements.

CAT is a compassionate and cost-effective service in that it combines assessment, treatment and support from the start, through working in partnership with the family. We seek to empower troubled families by encouraging them to draw on their own creative resources in finding solutions to what they perceive to be the child’s problems.

The success of The CAT Programme, therefore, depends on the carers’ commitment to the child, and their willingness to explore not only the context and triggers for the child’s problematic behaviours, but what may be very difficult issues for themselves. These include family relationships, parenting styles, and their own childhood legacies of hurt and loss, which might be inhibiting their attachment to the child in the present, and, consequently, their ability to care for and protect him effectively.

CAT is based on the premise that a child who feels securely attached to her family is likely to be rewarding to care for and, therefore, well parented. Sadly, the opposite is also true and the primary focus of the programme is, therefore, to foster mutual attachment between child and carer through identifying and correcting dysfunctional patterns of interaction.

Our experience shows that issues of attachment, protection, separation, and loss for both child and parent are crucial to such work. CAT seeks to address these through discussion, play-work, family and inner child healing in a programme specially adapted to each family’s needs. CAT Programme therapists aim to model open communication and honest feedback in the sessions.

The initial contract is usually for eight two-hour sessions, weekly or fortnightly, of parent-child, family, individual, and couples work. This is then reviewed with the family to assess any future needs. Follow-up support is offered at three, seven, and twelve months afterwards.

Most importantly, CAT combines assessment and therapy in the one programme and so offers a secure base to families in crisis who need continuity and support in exploring, grieving, and changing their reality.
Maeja and her colleagues have written about the development of the CAT model of working with children with attachment difficulties. They describe, in a vivid and accessible manner, the complexities involved in supporting parents in their struggles to respond positively to the needs of children who have been traumatized by their early experiences.

After many years of working with a number of families with children who “act out” their hurt through difficult behaviours, the authors offer their insights to help both parents and professionals to understand and deal more effectively with such behaviours. The CAT therapists give an impressive account of their belief in a therapeutic approach that focuses on attachment and protection as prerequisites for promoting healthy relationships.

Through the descriptions of their work with a number of clients, the reader is encouraged to gain an insight into the complex challenges encountered by individuals, families, and professionals. Major strengths of the book are the authors’ clarity in describing the theoretical perspectives that underpin their model and their huge knowledge base of the issues directly related to children fostered or adopted through the “care” system.
In sharing their experiences, the authors’ descriptions of their interventions convey a warm and empathic approach, demonstrating their ability to join together with families in order to bring about positive change.

I believe that this book will provide excellent learning material for parents and professionals alike. It highlights the need for both parents and children to be able to recognize, verbalize, process, and understand the unconscious feelings that are acted out in challenging behaviours. Only then can positive changes be achieved through the building of reciprocal and trusting relationships.

Monica Duck
Director, Post-Adoption Centre
London
October 2007
Calling Home

The telephone rings.
Our daughter on the line.
I lift the receiver
From its cradle,
Check that she is fine,
Pass her to her mother
As before. No need to feed,
No nappies to be changed,
But she touches it
Tenderly as skin.
The cord stretches
Umbilically.
She listens, breaks
Into that primal smile,
Translates excited,
Articulate words
Into a gurgle
Or a cry.

[Cunningham, 2006]
CHAPTER ONE

The long-term impact of attachment difficulties on families

Introduction: learning from family stories

All carers and therapists—like the children, families and adults we work with—will have had to deal with key attachment, separation, and loss issues at some time or other in their lives. Many might have joined the caring professions in an unconscious attempt to rework their family scripts, heal from deep wounds of the past, or, as wounded healers, to try to understand or make reparation to others representing hurt children and other family figures from their childhood, as in “Emily’s story”, below.

It is likely that John Bowlby’s prodigious work, Attachment, Separation and Loss, was fuelled by his early life experiences. His sensitivity to the plight of young children separated from their parents, and his intuitive awareness of the importance of mourning, may have been deepened by his own unacknowledged loss at the age of four of his beloved nursemaid, Minnie, who had helped to care for him since birth.

Louis Cozolino (2006, p. 19) argues that therapeutic work requires the inclusion of our personal experience, which is just as
important as scientific evidence. As therapists, we learn all the time from our clients, and we are likely to be more affected by certain stories that echo our own family narratives. Such stories tend to inform our therapy practice, consciously or not, and add to a rich and inexhaustible source of learning about the human condition and our varying reactions to it.

And so it was that, through my gradual learning about “Rose’s story”, below, I, too, came to realize the importance of openly acknowledging and mourning family losses, and the corrosive life-long impact of family secrets on each and every member of that family. The power of this tragic story fuelled my own unconscious search for ways to help rebuild mother–child attachments.

* * *

Rose’s story

Once upon a time, long, long ago, in a far-off land in Africa, there lived a young Indian, Tom, with his wife and their four small children. Tom’s mother had died in childbirth, and his father died when Tom was only twelve. An aunt in India grudgingly offered Tom a home until he was sixteen and thought to be old enough to make his own way in the world. Tom loved music and heard he could get a job as a pianist in Singapore, playing accompaniments to silent movies. So he worked in Singapore until “talking pictures” made him redundant there. Tom then travelled to be near relatives in a British colony in Africa, where he got a day job as a clerk and played music in the evenings.

Tom was now able to get married and start a family of his own at last. After living for several years in Africa, his young wife, Marie, longed to return to India and visit her family again. She was still grieving for their first-born daughter, Tina, who had been tragically killed in an accident. As an expatriate worker, Tom was allowed a paid passage back to India by ship once every five years, and eventually he and Marie thought they could afford to arrange a six-month holiday back home. The couple were so excited and busy preparing for weeks ahead that their two older children, Jenny and Peter, realized that this holiday would be different from the short trips the family sometimes took by railway to the coast.
After travelling by land and sea for almost two weeks, the family at last arrived at Marie’s parents’ home where they were all welcomed and the children made much of by relatives and friends. However, almost at once disaster struck. Marie suddenly became so dangerously ill that the doctors predicted she would soon die, and the children were gathered round her bed to say goodbye to her.

Jenny and Peter, only eight and five years old, were immediately sent away to live with different aunts, one in the north and one in the south, and so they could not meet. Three-year old Emily sensed that she, too, might be sent far away to live with strangers; she soon stopped walking and would only crawl, so that a worried Tom began to carry her around with him. The baby, Rose, was only seven months old and had fast become a great favourite with her grandparents, whom she learnt to call “Papa” and “Mama”. Emily and Rose were no longer allowed to see their mother, since her illness was contagious and it was feared that they might contract it.

Miraculously, Marie did not die, but she remained too ill and weak for the remainder of their holiday even to play with her children, especially Rose. The baby no longer seemed to know who her Mama was and so avoided going to Marie, who felt very hurt by this rejection. However, Emily had learnt to stay by Marie’s side, while Jenny and Peter were very glad to be brought back from their aunts to join their parents and little sisters again. The older children were now eager to return to their home in Africa.

The grandparents remained concerned that their daughter would not survive the long journey back, and they persuaded a reluctant Marie to leave Rose with them until she was strong enough again to carry her baby, already a year old. They reasoned that Tom could soon return to collect Rose, forgetting that he would not qualify for a paid passage to India for another five years.

No one knows how the parents explained this life-changing decision to the children, who never afterwards spoke about it, not even among themselves when grown up, until long after both Tom and Marie had died. Jenny loved her baby sister and did not understand why Rose was not returning with them to Africa. But she was shushed angrily by the adults whenever she tried to ask, and Jenny became afraid that she, too, might be left behind. She had not liked living with her aunt, who was very strict, while her cousins teased her for not speaking their language and for crying for her mother at night.
Peter remained silent about their leaving baby Rose behind. Being an only son, he was Marie’s favourite and he had greatly missed being with his mother for so many months. However, Peter was a placid child and he had got on well with his caretaker aunt and cousins.

Little Emily may not have understood what was happening, except that she was back with her beloved mother, who could only carry one child at a time, and that would now be her. So Emily clung tightly to Marie and to Tom, afraid that she too might get left behind like Rose, who always got all the grandparents’ and relatives’ attention for being so cute.

And how could baby Rose understand that, in her need to survive the sudden separation from her mother at seven months old by forming strong attachments to her grandparents, and in later turning away from a convalescing Marie, she was co-creating a tragic new history for herself and her family: one of lifetime abandonment and disrupted relationships.

Their was a long and tragic story, with lasting impact on each family member, who remained indelibly scarred, not only by their sudden separation from, and loss of, baby Rose, but even more by the parents’ inability ever to talk to the children truthfully about what had happened and why.

Five years later, when Tom obtained another paid passage by ship to travel back to India and reclaim his youngest daughter, the damage had already been done. He took with him Peter, now aged ten, as a companion for little Rose, but she was not used to sharing adult attention or treats. Jealous that their grandmother had begun to favour Peter, who was still a very placid child, Rose would tantrum and scratch and bite him. Her reputation as “a naughty child” preceded her return to Africa with Peter and Tom.

Marie soon began to dread Rose’s rejoining their family. The little girl gradually became a scapegoat for the parents’ early abandonment of her. Marie convinced herself that their “bad” little daughter was the reason that Tom became increasingly ill. He died when Rose was only twelve; this was another major and unacknowledged loss for her.

Neither Rose nor Marie trusted each other by then, or had any help to rebuild their long-disrupted attachment. Rose, at six years old, was expected simply to slot back into her birth family, who were by now complete strangers to her. Overnight, she lost her beloved grandparents, relatives, and friends, a country that had become home to her,
its culture and even its language, since Tom forbade her to speak it at all. He had become anxious that this little daughter was already behind in her schooling and would not learn to speak English correctly, which he knew to be essential from his experience of being a foreigner in a British colony.

Years later, on returning to live and work in India as a young adult, Rose must have unconsciously remembered her father’s injunction to her as a child, for she never relearnt the mother tongue in which she had once been so fluent. Her now hesitant use of it and anglicized accent were a constant source of amusement to native speakers.

Growing up as a stranger to her own family, pretty little Rose sought comfort and attention from neighbours and family friends, who kept bringing round new clothes and gifts for her to her surprised and increasingly mortified parents. Naturally warm and nurturing, Marie felt branded as “a rejecting and abandoning mother”. In turn, she projected all her bad feelings about herself and anger at what had happened on to this youngest daughter, who, not surprisingly, became more and more difficult for Marie to manage or love. Rose’s constant lying was particularly hard for her mother to tolerate, given her own valuing of honesty. Their “negative interaction spiral” was never interrupted. Rose remained the bad, unwanted child and emotionally outside her family, even when living with them.

Marie became increasingly preoccupied with caring for Tom, whose health had greatly deteriorated. He died a few years later, leaving Peter, at sixteen, to provide for the family. Jenny had never forgiven her parents for their abandonment of baby Rose in India, and her unconscious blaming of Marie for this got in the way of their relationship from then on. After Tom died, Jenny left home to get married and she soon became pregnant and busy with her new family, determined never to abandon her own children.

Emily, at nine, had resented her little sister’s return to the family and displacement of herself as the favoured youngest child, since Rose was cleverer and prettier, and much admired by relatives and family friends in Africa, too. Emily retreated into a world of books and only gradually became aware that Rose and their mother did not get on at all. Marie still favoured Emily, to whom she confided her distrust of the little girl, so sowing the seeds of lifelong conflict between the two sisters. Emily, like Peter, was too loyal to their beloved mother to realize that not all Marie told them about Rose was true.
Instead, the family secret of these ongoing losses and how they came about was maintained by the parents. An unspoken injunction was placed on the children never ever to question what had happened. Peter’s deep love for, and loyalty to, his mother prevented him from ever admitting the truth, even to himself; he died relatively young from a corrosive bone disease.

So, poor Rose remained outside the family and unconsciously sought to emphasize her difference when growing up by speaking English with an affected American accent and using slang from the cowboy comics they read. She became more eccentric in her ways as she grew older, justifying Marie’s description of her as “odd” and “not quite right in her head”. By her early twenties, Rose had acquired a psychiatric label that stuck to her, making it even more difficult for her family to embrace her difference.

Rose returned to India on her own at nineteen, but now felt just as alien in her former homeland because of her independent thinking, western ways, and strange accent. She lived in various institutions thereafter, forever abandoned by her family.

* * *

I have chosen this particular family story to illustrate how easily attachments can be disrupted, and with such tragic results, even in a relatively normal family with kind and well-intentioned parents. This has been powerfully demonstrated in James and Joyce Robertson’s deeply poignant films, made in the 1950s, about the immediate and long-term impact of sudden separation and loss on two previously “securely attached” toddlers, “John” and “Laura” in A Two-Year-Old Goes to Hospital (1952).

It must be remembered that, in “Rose’s story”, Marie remained a loving and caring mother to Peter and Emily in particular, and that Rose must have been securely enough attached to Marie for those crucial first seven months of life to be able then to develop strong bonds with her grandparents, who became her substitute carers. However, Rose’s inability at a year old to reclaim a convalescing Marie as her primary attachment figure, and her mother’s felt rejection by Rose, sealed their fate. Neither had help thereafter to acknowledge and mourn their losses and rebuild their early attachment.
The unheard story of this “lost sister” divided the family forever; however, their scripted version was of being a loving and united family. As John Byng-Hall points out, “the family myth is the family’s consensus about which home truths cannot be told” (1995, p. 139, my emphasis). Anyone who challenges the truth of this myth is likely to be scapegoated, as Rose continued to be even as an adult.

Rose was neither neglected nor abused in infancy, but the impact of sudden separation from her very ill mother at seven months and the loss of her birth family at only a year old, followed by that of her grandparents at six years old, must have been more than her developing psyche could deal with, especially as she then became the unwitting scapegoat for all the family’s problems after her return to them in Africa.

Fifty years on, an early diagnosis of “attachment difficulties” might well have been made about a child such as Rose, given her behavioural problems as a result of the traumatic maternal and family losses she suffered in her first few years of life. Any therapeutic help for Rose and her family would have needed to address the painful truth of the ongoing losses for her as a child, and to work on rebuilding positive relationships with her parents and siblings to help them all to heal and move on as a family.

* * *

There is an intriguing counterpart to Rose’s story in that of her sister, Emily.

Emily’s story

Emily must have learnt very early on from the family’s abandonment of baby Rose not to be openly rebellious. She readily accepted her father’s oft-repeated dictum: “A laughing child is a portrait of happiness.” Emily kept any sad, bad, mad feelings to herself and looked down on little Rose for not being able to do the same. Their rivalry when growing up soon petered out for Emily as she left school and began working, achieving some independence from family mores and beliefs.

As “the chosen daughter”, however, Emily felt increasingly uneasy about Marie’s continued scapegoating of Rose for all the family’s
problems, especially after this youngest daughter was sent back to India on her own at nineteen in what became a lifelong exile. Their mother’s divide-and-rule tactics made friendship between the two sisters impossible until much later in their lives, long after Marie died in her late eighties. Emily gradually came to realize that the story of the “lost sister” she had grown up with—Marie’s continual recounting to her of a much earlier and greatly mourned family loss of her first-born daughter, Tina—masked that of Rose, whose loss was never openly acknowledged or mourned by anyone in the family.

Emily drifted into social work, and was soon drawn to working with foster and adoptive families in an unconscious wish to help children outside their birth families to find a new and loving home. Was it simply chance that Emily then married a man with early parental losses of his own? Decades later, he suddenly discovered that he, too, had an unacknowledged lost sister, given up for adoption at birth, who had grown up unknown to him on the outside of his family.

Rose’s story became Emily’s unconscious motivation for learning more about how disrupted attachments can be rebuilt. Even after training some years later in adult psychotherapy, her focus remained that of helping to heal mother–child relationships. The answer came to Emily very simply one day after her own openly rebellious teenage daughter, Zoe, left home to go to college. Their conflicted attachment had always surprised Emily, who believed she had a good role model in Marie of a warm and nurturing mother. However, Zoe’s open rejection of her mother in her teens left Emily feeling increasingly bad and inadequate, perhaps just as Marie had felt when, at six years old, Rose was brought back unwillingly to her care.

Zoe decided to go to a distant college, as far away from home as possible, and only reluctantly involved Emily in moving her there. However, Zoe soon became homesick and began to write very affectionate letters to her mother, letting her know openly at last how important Emily was to her. It was an “aha” moment for Emily, both as a mother and a therapist. Now that she was at last being given positive cues by Zoe, Emily could respond affectionately, too. It was the start of their rebuilding in the second generation a disrupted mother–daughter attachment. This took years of mutual commitment and honest communication, but it provided a new model for Emily’s family work.

* * *

My growing awareness of the relevance of Rose’s and Emily’s stories helped me to understand at heart level about disrupted
attachments and how, as with Emily and her daughter, they can be
rebuilt. The “needs” or “arousal–relaxation” cycle, of which I had
been intellectually aware for at least a decade from Fahlberg’s (1981,
p. 16) and other attachment therapists’ work, now made complete
sense to me. I had the building blocks at last for an attachment ther-
apy, and so The CcAT Programme was conceived (Figure 1).

A working model of attachment theory

John Bowlby, the father of attachment theory, wrote over fifty years
ago:

what is believed to be essential for mental health is that the infant
and young child should experience a warm, intimate, and continu-
ous relationship with his mother (or permanent mother-substi-
tute—one person who steadily “mothers” him) in which both find
satisfaction and enjoyment. [1953, p. 11, my emphasis]

Bowlby already knew from his and other studies of young children
in hospitals and other institutions in wartime Britain that, despite
adequate physical care, they often failed to thrive, showing signs of

![Diagram of basic bonding cycle]

Figure 1. Basic bonding cycle.
marasmus (a wasting away of the body) as if they were starved. Child evacuees, suddenly removed for their protection from their families in blitzed cities, provided further evidence of the crippling effects of separation and loss on their emotional, social, and mental development when substitute carers could not meet their basic emotional needs.

Based on their wartime work with emotionally deprived children placed in hostels, Donald Winnicott and Clare Britton (1947) suggest:

Without someone specifically oriented to his needs, the infant cannot find a working relation to external reality. Without someone to give satisfactory instinctual gratifications the infant cannot find his body, nor can he develop an integrated personality. Without one person to love and to hate he cannot come to know that it is the same person that he loves and hates, and so cannot find his sense of guilt, and his desire to repair and restore. Without a limited human and physical environment that he can know he cannot find out the extent to which his aggressive ideas actually fail to destroy, and so cannot sort out the difference between fantasy and fact. Without a father and a mother who are together, and who take joint responsibility for him, he cannot find and express his urge to separate them, nor experience relief at failing to do so.

This does not mean that only a woman can fulfil the “mothering” role, or that there has to be a “parenting couple” or, indeed, a heterosexual one, for optimal care of a child. What is more important is “mothering of the mother” (Winnicott): the primary carer should be adequately supported by another caring adult in the ongoing and very demanding task of providing loving attunement and consistent care to a child.

In the late 1940s, an American researcher, Rene Spitz (1947), filmed Hispanic babies before and after separation from their mothers in penal institutions. These babies soon lost their early developmental gains, unless they were restored to their mothers’ care within a few weeks. Beyond this “sensitive” period, the babies increasingly showed signs of mental retardation and autism, which soon became irreversible.

Spitz’s film proved to be politically unacceptable and was banned from public showing in America. This reaction was similar
to that in some English medical circles to the early showing of the “horror” films produced in the 1950s by Bowlby’s research collaborators, James and Joyce Robertson, on the traumatic impact of sudden maternal loss for even a few days on previously secure “family children”.

In the two films, John, about a “family child” who goes to a residential nursery for eight days while his mother is in hospital for the birth of her second child, and Laura: A Two-Year-Old Goes to Hospital (1953), both toddlers are initially friendly, co-operative, and hopeful, able to hold on to their memory of a good and loving mother. With each day of separation, however, as their successive institutional carers come and go, their distress becomes unbearable. Their protest, anger, and searching give way to despair and apathy, and then to withdrawal from, and distrust of, their mothers on eventual reunion.

Bowlby also learnt from the research of ethologists like Lorenz (1952), who got newly-hatched goslings to “imprint” on him as their care-giver; and Harlow (1958), who tested baby monkeys reared in isolation for their preferences for food or “love” (represented by soft, fabric-covered wire monkeys). These primates’ early separation from their mothers led to long-term impairment of their ability to relate to peers and, eventually, to care for their own young.

Bowlby was convinced that human beings, too, have an innate biological need for proximity to preferred attachment figures. In times of perceived danger, this “drive” overrides those for food, sex, or exploration (our other main instinctual needs). Moreover, in all phases of the life cycle we show normal attachment behaviours: dependence on, and protest at, sudden separation from our attachment figures, anger at their leaving us, and pining for them if the loss is prolonged. When tired or unwell, our dependence on our attachment figure increases, and, for a mutually satisfactory adult attachment, partners normally have to take turns in care-giving and care-seeking.

Early attachment researchers like Ainsworth (1982), who continued Bowlby’s work in America, showed that babies and toddlers need a secure base, often, literally, their mother’s lap. From this springboard, they can safely explore the immediate environment and return to her for emotional “refuelling” and sharing of their
new discoveries, as described in Mahler’s *rapprochement* phase (Mahler, Pine, & Bergman, 1975). To feel secure, the infant needs to be within easy physical and emotional reach of its mother, as if attached to her by an invisible umbilical cord.

Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) and, later, Main and Solomon (1986), studied one-year-old babies’ reactions to sudden separation from their mothers in “a strange situation” (a room with some toys and an observer who joined them), and to reunion after three minutes. The twenty-minute observation included comings and goings by the mother and observer, without any preparation of the child for these.

Their findings led the researchers to categorize as *securely attached* those children who protested strongly at their mother’s leaving, clung briefly to her on reunion, and were able to accept comfort from her before resuming play on their own in her presence, although perhaps with increased watchfulness. It must be remembered that even previously securely attached children (like John and Laura in the Robertson’s films) can be traumatized by prolonged separations if they have no consistent substitute carer.

*Insecure attachments* in “the strange situation” test were categorized by Ainsworth and her team as being *anxious-avoidant* or *anxious-resistant*. Later, Main and Solomon (1986, pp. 95–124) added a third category: *chaotic-disorganized*. (See descriptions of these categories below.)

* * *

There has been such a wealth of research and thinking about attachment, separation, and loss issues since Bowlby and his British collaborators, James and Joyce Robertson, began publishing their seminal findings in the mid-twentieth century that any Google search on the Internet on these subjects will yield a treasury of resources. What follows, therefore, is a brief working model of attachment and loss theory, and it includes terms in common usage in those contexts.

*Attachment* is a strong emotional bond to another person, independent of place and time; this may not always be reciprocal, as when we experience unrequited love.

The insecurely attached children in the strange situation studies carried out by Ainsworth and, later, Main and colleagues, showed
three very different constellations of attachment behaviours from those of children who were considered to be securely attached:

1. **Anxious–resistant (ambivalent)** children were both clingy and angry with the mother on reunion, unable to accept comfort from her or to resume play even in her presence.

   It is now known that anxious-resistant children show ambivalent or “mixed” attachment behaviours: When faced with separation from their **attachment figure**, they tend to be clingy/angry, dependent/hostile, and find it difficult to trust, settle, explore, concentrate, or take risks. They are constantly preoccupied with a fear of rejection or, worse still, abandonment by him.

2. **Anxious–avoidant (dismissive)** children in the strange situation test seemed preoccupied with a toy and withdrawn from the mother, avoiding her gaze, perhaps fearing retaliation if they showed their anger at her leaving them. Their play was inhibited and, although they seemed not to react to the mother’s leaving them or to her return, it was noted in subsequent physiological tests that their pulse rate was high, indicating great anxiety.

   Anxious–avoidant children tend to act as if they do not wish to be close to their attachment figure, since they fear rejection and/or abandonment if they show any neediness. They might, therefore, display a pseudo independence, even rejecting their attachment figure before they can be rejected.

3. **Chaotic–disorganized clusters of behaviour** were noted in a third group of insecurely attached children. These included frozen watchfulness, terror, confusion, helplessness, and a fear of seeking or accepting comfort from either the mother or the observer in the room.

   Chaotic–disorganized attachment behaviours are shown by children who have learnt no strategy for keeping themselves safe and close to their attachment figure, since this person might also be their source of danger. These children often seem both to want to move towards and avoid the same danger; they may be “frozen”, wary children, unable to help themselves or to seek help.

*Attachment cues*: anger, crying, cooing, calling, clinging, smiling at, or following/keeping close to an attachment figure are all spontaneous
biologically inherited attachment behaviours. They are necessary for our survival, especially when we are young and vulnerable and need protection from predators, just as in the animal world.

These attachment behaviours can be attractive to carers and, thus, encouraged and so reinforced, establishing learnt patterns of interaction for the child. However, if the child’s positive attention-seeking cues are ignored by a preoccupied, dismissive, or neglectful or abusive carer, she may then seek attention through negative behaviours that are aversive; so the carer will act to stop her repeating these (Cairns, 2002, pp. 48–49).

Beth’s story

Beth was only nine weeks old when I met her and her mother, Carla, who had rejected her soon after birth because the baby was diagnosed with a genetic disorder that leads to mental and physical retardation. Carla was an intellectual, and believed that the family’s future was blighted because of Beth’s diagnosis. She felt she dare not attach to this baby since she could not possibly mother her, so she was considering giving up Beth for adoption. Carla added that, if she had known about Beth’s medical condition during pregnancy, she would have terminated it at once. All she could do now was care for Beth physically, but not look at or engage with her at all. Carla knew that this was not good for the baby, and she feared that she was already harming Beth through her emotional neglect.

While Carla was telling me this sad story, I became aware of Beth on the floor between us cooing at her mother. I pointed this out to Carla, who at once disagreed, saying that Beth was simply looking at her chair while making noises. We continued to talk, but I was now fascinated by the baby, who kept gazing at her mother while making soft cooing sounds. I pointed this out again, and Carla continued to ignore Beth and what I had said.

I then noticed that the baby, placed casually on her mother’s folded coat on the floor, was somehow sliding towards Carla, who had also become aware of this and had moved her feet away. When this happened a second and third time, I pointed out to a resistant Carla that Beth was undoubtedly claiming her through this constant calling and movements towards her.

Carla seemed angry and upset at this, and later telephoned to cancel a follow-up appointment. However, I then learnt that she had decided to
keep Beth and was researching local support services for them both. It was an amazing example of a baby continuing to claim her hurt and rejecting mother, and so succeeding in getting more positive responses through her persistence in reaching out to Carla through voice and gaze and movement.

* * *

Cues and responses

Cozolino (2006) explains almost lyrically how the “right hemispheres” of child’s and carer’s brains are linked “through eye contact, facial expressions, soothing vocalizations, caresses, and exciting exchanges”. Interestingly, Cozolino also notes the plasticity of the mother’s brain after birth, so that she, too, grows “emotional synapses” to help her to be more attuned to her child’s needs.

Our development of our core or “true self” depends from babyhood onwards on positive affirmation by our carers: that it is all right for us to be who we are; to have feelings and needs; to know that these will be met safely, consistently, and appropriately; that our carers will be there for us when we need them for empathy, support, and understanding; that they will respond positively to us, enjoy being with us, and feel proud of us and our achievements.

All this caring makes us feel safe, protected, warm, loved, respected, and worthwhile as individuals. Our carers thus provide a secure base from which we feel able to explore the world, find out who we really are and what we can do, and enjoy this learning and take on new challenges. We grow in self-esteem and respect for ourselves and others.

In turn, because we trust them to meet our needs and acknowledge our feelings as valid, we are able to express these (cues) openly and directly to our carers, who can then respond appropriately. We learn to be predictable and make them feel good and proud that they can care for us so well. We give them love and appreciation and they enjoy being with us, being likely to spend more time in play or fun-time with us.
So, in summary, when we feel securely attached (Figure 2):

- we trust our attachment figure to be there for us;
- we feel good about ourselves, as we are special to someone;
- we believe we deserve love, care and acceptance as we are;
- we feel worthy of protection and, therefore, learn self-preservation;
- we come to believe that the world is an innately good place, and trust others;
- we feel it is safe to explore and learn about new things, and take on challenges;
- we seek out our attachment figure when we are anxious, tired, or unwell.

*Figure 2. Development of attachment and predictability in child and carer.*
Good enough caring

The importance of the endless repetition of the basic bonding cycle (see Figure 1) for a baby’s healthy physical, mental, emotional, social, and spiritual development cannot be over-emphasized. There needs to be enough consistency of care for a “good-enough mother” (Winnicott, 1985, pp. 11–12) to develop with her infant a mutually predictable and rewarding relationship in which cues and responses are appropriately matched.

Cozolino explains how the infant develops emotional self-regulation:

Sensitive caretakers learn to regulate their interactions with their child, respond to the child’s responses, and allow for synchronized engagement and disengagement. As children and caretakers move in and out of attunement, the cycle of joining, separating, and reuniting becomes the central aspects of developing psychobiological regulation. Caretakers intuitively slacken their scaffolding as their children’s self-regulatory capacities increase. Through these separations and reunions, their children learn that they can survive on their own, that caretakers return, and that they (the children) have some ability to regulate their bodily and emotional states on their own. [2006, p. 72]

This is similar to the concept of “the good enough mother” (Winnicott, 1985, pp. 11–12), who has to adapt to her baby’s changing needs as he grows. Her total preoccupation with her newborn infant, meeting his every need at once, will not be so beneficial for him at six or twelve months old. Her attunement to his developmental needs will necessarily change over the months as the conflicting demands of the outside world intrude. However, the baby gradually learns from having enough good experiences with his mother or primary carer to wait for gratification and to trust that his needs will continue to be met appropriately.

Feelings of trust, self-worth, and a belief in a generally benign world outside are thus fostered. These shape the baby’s self-image and expectations of herself and her carer and others with whom she comes into contact. If all goes well for the child, her early experiences and relationships will mirror (Winnicott, 1985, pp. 131–132) her developing sense of herself as a lovable and unique little person, with gifts and needs that are respected (Figure 3).
Sills goes further in describing this quite naturally occurring developmental process from a spiritual perspective. Sills draws on the work of Frank Lake, a perinatal psychologist, to describe the concept of "a good enough womb of spirit" in which the infant's innate needs of being and well being are adequately met by an attuned carer. Sustained "empathic failure" through neglect or abuse to meet these basic developmental needs will result in an obscuring for the child of her innate sense of being and inherent connection to source (Sills, 2008, pp. 132–136).

Figure 3. Developing a “true sense of self” through positive mirroring.

Our capacity to function in “true self” requires positive mirroring when growing up. The “mirrors” held up by our parents, family, culture, community, school, peers, environment, religion, media, workplace, society, etc., generally determine whether we function more or less in “true self” or “false self” mode. Internalized oppression can make us feel that we are living in a “hall of distorting mirrors”, unable to recognize who we really are and our full potential.

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Disconnection from true self

Winnicott explains the profound implications of the “mirror-role” of the baby’s mother and family:

What does the baby see when he or she looks at the mother’s face? I am suggesting that, ordinarily, what the baby sees is himself or herself. In other words, the mother is looking at the baby and what she looks like is related to what she sees there. . . . I can make my point by going straight over to the case of the baby whose mother reflects her own mood or, worse still, the rigidity of her own defences. . . .

The baby quickly learns to make a forecast: “Just now it is safe to forget the mother’s mood and to be spontaneous, but any minute the mother’s face will become fixed or her mood will dominate, and my own personal needs must then be withdrawn, otherwise my central self may suffer insult”. [Winnicott, 1985, pp. 131–132]

If our attachment figure is emotionally unavailable (through depression or self-preoccupation) or is unreliable or inconsistent, and we cannot predict their responses to our cues, or we fear their anger, avoidance, or punishment for our neediness, we learn very young—even as babies—to suppress our real needs and feelings from them and, increasingly, from ourselves. Growing up, we may then not know when we are cold, hungry, angry, sad, in pain, etc., or, indeed, who we really are, since we have become so disconnected from our core or true self, or what Sills refers to as Being (Sills, 2008).

Abuse and/or neglect by the carer is a distorted response to the child’s expression of need, and hence affects his capacity to communicate it effectively (cue). One infant observer was horrified to note that a six-week-old baby was smiling with the mother as she pricked him with a safety pin each time she changed his nappy. He had already learnt that it was not safe to cry, a natural response of displeasure to the pain she was deliberately inflicting on him.

In this way, a child’s ability to give the right cues and responses can become so skewed that neither he nor the carer knows how he really feels or what his unmet need is. Similarly, babies’ and small children’s mixed responses of laughter/displeasure or excitement/fear to over-tickling, or rough-and-tumble play by adults, can be misconstrued as simple enjoyment, instead of being interpreted as
a cue to the adult to stop such over-stimulation when it has reached a point of discomfort for the child.

Where infants and children are not so fortunate as to have had their needs met safely, consistently, and appropriately by a parent or carer, they may develop insecure attachments which shape their view of themselves and the world. If they learn very young that their baby needs and dependence on their carer are pushing him away, they will try to be independent prematurely in an anxious–avoidant style of attachment. If they are constantly neglected or threatened with abandonment by their carer for being too needy, they are likely to feel highly ambivalent, seeking to cling to him but getting no comfort from doing so; they might become passive–aggressive, afraid to express their frustration openly.

* * *

It is believed that repeated failure, for whatever reason, to complete the arousal–relaxation cycle (see Figure 1) inhibits the healthy development of neural connections to the “emotional brain” with its mood regulating functions. Fahlberg (1991) notes that there are several points where completion of the arousal–relaxation cycle can be interrupted:

- a neglectful or abusive parent might ignore or meet the baby’s needs inconsistently or inappropriately;
- an overprotective carer might consistently meet a child’s needs before she feels discomfort;
- he might not even allow her to have any stimulus that could be disturbing.

Thus, the child is deprived of her part in recognizing a sensation/need and communicating it (giving a cue) and therefore of any sense of agency in having it met.

The child’s ability to communicate need may also be impaired because of illness or retardation (Acquarone, 2005, pp. 25–26) or non-attuned care-giving, as described above.

Separation and loss

Since attachment and loss are opposite sides of the same coin, any previous separation, or even the fear of losing a significant
attachment figure, can greatly inhibit our willingness, even as adults, to risk a new relationship. We can reflect on our own experiences to help us empathize with how a child might similarly react to separation and loss, but without having our verbal resources to articulate how s/he feels.

We are likely to feel very angry, upset and rejected if our attachment figure leaves us. If separated for too long, we may start to feel hopeless, guilty, depressed, despairing, withdrawn, detached, and lose trust in our attachment figure. We may become forgetful, preoccupied, unable to concentrate, or become “busy” in order not to feel or think about our loss. Grieving children may become hyperactive for the same reason.

We might feel “not good enough”, or really bad in some way, and blame ourselves for being left. We might feel punished for being who we are and/or for our neediness. We might then become afraid to show dependence on anyone, or our true feelings and needs, in case we are rejected and abandoned again. Instead, we put on a “false self” with a tough exterior to pretend we do not care.

**Reactive attachment disorder**

A baby’s first attachment is to his mother, literally through the umbilical cord. If this is damaged or severed prematurely—before he can breathe or feed or excrete on his own, or artificially—the baby’s future development or life itself could be threatened.

Similarly, if a baby’s first emotional bonds with his mother, father, or other primary carer are damaged or suddenly severed before a new attachment can be sensitively developed between him and a new carer, his emotional growth might be inhibited for a while or even permanently stunted. He might have problems around trust and the making and sustaining of satisfying relationships. This is likely to result in the child feeling increasing anger, frustration, and low self-esteem, and lead to “acting out” accordingly.

By the mid-1950s, researchers like Bowlby, Spitz, and James and Joyce Robertson had documented very powerfully the traumatic impact of maternal loss on babies and toddlers. More recently, American therapists in the field of adoption, such as Lifton (1994) and Verrier (1994), have described the *primal wounding* that occurs
when a child is separated early on from his mother. Verrier believes
that early parental loss has an impact on the infant similar to the
stress experienced by people living in a war zone, although the
child’s trauma is generally not recognized as such by the adults
around, or its damaging effects on the development of his “social
and emotional brain”.

The popularized American description of “reactive attachment
disorder” is sadly familiar to many foster and adoptive families
who have found themselves increasingly baffled, deskilled, and
helpless after struggling for months or even years with very hurt
children placed with them. The analogy has been made that
“parents and families of attachment-disordered children often
develop post-traumatic stress disorder symptoms, in a similar way
to those living in close proximity to the battlefront” (Parent to
Parent Information on Adoption Services [PPIAS] [now Adoption
UK], 1993, p. 15).

In the experience of such children, “Attachment is associated
with loss and let-down . . . love is a Trojan Horse—a gift full of
hidden dangers” (Delaney, 1991).

**Internal working models**

Attachment-disordered children have internalized *negative* models
of parental care and availability; these are very different from the
healthy “internal working model” of reciprocal attachments
proposed by Bowlby (1969). The concept of an internal working
model was derived from another scientific explorer, Kenneth Craik,
who suggested that:

> Thought models, or parallels reality . . . the organism carries a
small-scale model of external reality and its own possible actions
within its head, it is able to try out various alternatives, conclude
which is the best of them, react to situations before they arise,
utilize the knowledge of past events in dealing with the present or
future, and in every way to react in a fuller, safer, and more compe-
tent way to the emergencies which face it. [Craik, 1943, p. 61]

Having internalized a negative working model of a malignant
carer and/or environment, “children and adults, who experience
neglect, physical and or sexual abuse, frequently have paratactic distortions”. Van Gulden (2002) explains these are disconnected (from the word *parataxis*) but instinctive survival responses in which “Sensory stimuli are (mis)perceived as toxic to our health. We react before processing the stimuli completely. This is an automatic, conditioned response”.

Van Gulden makes an important distinction:

Paratactic distortions are not PTSD (Post-Traumatic Stress Disorder). The process by which the individual experiences the environment as threatening is similar to the process in PTSD, but the child experiencing a paratactic distortion will experience the current parent as threatening, not as the parent of the past. Children can experience both paratactic distortions and PTSD. Both are strong inhibitors to attachment.

Van Gulden recommends patient observation of sensory triggers to such “paratactic distortions” and changing them, e.g., lowering the voice when speaking to the child, slow movements towards her, etc. She warns that this process of change-work is a very gradual but necessary one, since paratactic distortions are extremely distressing to both child and parent:

these children react with anger, rage, aggression and/or flight responses to seemingly innocuous stimuli. A tone of voice, a sound, a body movement or position, a facial expression, a smell. Tragically, the child cannot feel safe, warm and secure in the care of an adult who unknowingly is triggering these defensive responses.

PPIAS (1994) lists the causes of reactive attachment disorder as follows:

Any of the following conditions, especially if they have happened to a child under 18 months old, put a child at high risk of developing an attachment disorder:

- pre birth and birth traumas
- sudden separation from primary caretaker (e.g. illness or death of mother or sudden illness or hospitalization of child)
- frequent moves and/or placements (foster care, moves in and out of the care system)
- undiagnosed and/or painful illness, such as colic or ear infections
- chronic maternal depression
- teenage mothers with poorly developed parenting skills
- inconsistent or inadequate day care
- neglect
- abuse (physical, emotional, sexual)

In endless studies, the following issues have been examined as causative issues in early developmental problems:

- intra-uterine factors (before the child is born)
- genetic factors
- hereditary issues
- the child’s effect on the mothering figure
- the mothering figure’s effect on the child

and “Common Symptoms of Reactive Attachment Disorder”:

- superficially engaging, charming (phoniness)
- lack of eye contact
- indiscriminately affectionate with strangers
- lacking ability to give and receive affection (not cuddly)
- extreme control problems: often manifest in covert or “sneaky” ways.
- destructive to self and others
- cruelty to animals
- chronic, crazy lying
- no impulse controls
- learning lags and disorders
- lacking cause and effect thinking
- lack of conscience
- abnormal eating patterns
- poor peer relationships
- preoccupied with fire, blood, gore
- persistent nonsense questions and incessant chatter
- inappropriately demanding and clinging
- abnormal speech patterns
- passive-aggression; provoking anger in others
- unusually angry parents

Few children with Reactive Attachment Disorder will exhibit all of these symptoms!
Attachment disorder

Brenninkmeyer (2000) notes that the terms “reactive attachment disorder” (RAD) and “attachment disorder” (AD) are often used interchangeably, although they describe different syndromes:

The Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, provides only limited help for the assessment of AD. Among a number of categories for childhood disorders and their diagnostic criteria the DSM included the category “Reactive Attachment Disorder” for the first time in its third edition (1980). The description of this diagnosis referred to infants younger than eight months who fail to manifest attachment behaviours; the cause for this was assumed to be a lack of parental care during those first eight months.

In the revised third edition of the DSM (DSM III-R, 1987), the category “Reactive Attachment Disorder” was altered to include older children, whose main trait is a “markedly disturbed social relatedness in most contexts that begins before the age of five and is not due to Mental Retardation or a Pervasive Developmental Disorder such as Autistic Disorder”. The cause for this disorder is defined as “grossly pathogenic care preceding the onset of the disturbance”. It is further explained that the evidence for the disturbance has two forms: the child either persistently fails to “initiate or respond in an age-expected manner to most social interactions” or the child manifests “indiscriminate sociability; e.g. excessive familiarity with relative strangers, as shown by making requests and displaying affection”.

In the fourth edition of the DSM (1994) the two forms of “RAD”, as it is sometimes abbreviated, are named “inhibited” and “disinhibited type” respectively. The definition of “RAD” remained unchanged otherwise. . . . The DSM definition of RAD does not mention any of the exceedingly difficult, destructive behaviours the AD children present, and neither does it specify that the disruption in attachment took place during the first two years of life.

Randolph (1999) therefore argues that AD and RAD can be considered different psychiatric disorders; at best AD consists of the combination of the RAD category described by the DSM, plus at least one of two other DSM categories for childhood disorders: “Conduct Disorder” or “Oppositional Defiant Disorder”. In addition, most clinical cases of AD present with at least one further
psychiatric disorder, such as Post-Traumatic Stress Disorder, Bipolar Disorder, Attention Deficit/Hyperactivity Disorder, Dys-thymia, etc. [Brenninkmeyer, 2000, pp. 13–14]

Attachment disordered children may have had a number of moves within the “care” system, each move resulting in multiple separations and losses. It seems likely that the carers of these children get very mixed messages about their need for closeness and comfort when distressed or hurt. These children might have been discouraged or even punished by previous carers for grieving their losses or seeking proximity, e.g., showing attachment behaviours (cues), so they now reject new carers in a distorted response to caregiving (Figure 4).

* * *

Attachment therapies have proliferated over recent decades, offering despairing children and families a range of treatments from traditional play and talking therapies through grief therapy to the more controversial “Holding” and “Intrusive” therapies, used by Keck and Cline (1992), among others.

For families and professionals who consider such therapies too extreme or invasive, there are gentler techniques advocated by therapists such as Fahlberg (1991) for building attachments between bereft children and new carers. Theraplay™ (Theraplay Institute) is currently widely regarded as an effective treatment for children and parents who need help in thus connecting. Most parents in societies throughout the world know these ways intuitively as they learn to bond with their newborn babies through a spontaneous meeting of needs and increasing positive interaction, including loving, safe, and playful touch.

However, if either baby or carer is unable to play her part in signalling need (cues) or following cues (responses), their mutual attachment, confidence in each other, and self-esteem are likely to be impaired. The carer’s growing feelings of rage, impotence, and worthlessness may offer a clue to the baby’s. If the relationship then ends, and the child is not helped to express his feelings of sadness, anger, self-blaming, and loss, and to believe that his needs are valid and can be met, his next placement is already in jeopardy, thus
perpetuating a negative spiral of deprivation. Both the child and the new carer may need help in synchronising signalling (cues), responding, and claiming behaviours in order to create a mutually rewarding relationship, and help the child to trust again.

The contributions of neuro-science: attachment and the development of the brain

Clinician–scientists such as Schore (1994) in the USA and Sunderland (www.naturallynurturing.co.uk) in the UK have helped
professionals on both sides of the Atlantic to understand how nature and nurture interact to influence the crucial early development of pathways (synapses) between the limbic brain and the frontal cortex, so necessary for self-regulation of mood and healthy emotional and social functioning. In this way, our brain is both shaped by, and shapes, our relationships and environment.

Intriguingly, Acquarone (2004) concludes from reviewing research on “paternal” and “maternal” brain cells,
cells in the brainstem appear to be the work equally of maternal and paternal genes. The maternal brain, or neo-cortex, would be a neural buffer for instinctual drives and demands arising in the limbic, paternal brain. [p. 22]

Schore’s work pioneered the integration of neuroscience findings with attachment theory. His and other studies (Holmes, 1993, pp. 192–196, 2004) suggest that early “borderline attachment” or disorganized attachment histories, which include abuse and neglect, are likely to inhibit the healthy growth of regulatory circuits in the child’s developing right brain. This hypothesis seems to be borne out by neurobiological research that show right brain and orbito-frontal deficits in people diagnosed as having borderline personality disorder. It seems that their brain is likely to be overstimulated in interpersonal situations, putting it on “high alert for danger while simultaneously decreasing inhibition, reality testing, and emotional control” (Cozolino, 2006, pp. 260–264).

Cozolino notes that “damage to the right hemisphere compromises our ability to interpret the (emotional) significance of facial expressions, hand gestures, and tone of voice”. In effect, severe attachment disorders in young children, if left untreated, can lead to them as adults having ongoing difficulty in “reading” other people’s cues and/or controlling their own mood and angry impulses, and, thus, in making and sustaining healthy relationships. Studies of those prone to domestic violence and uncontrollable “road rage” incidents might also point to links between early attachment failure and the impact on their developing brain’s capacity to regulate emotions. (See Cozolino, 2006, pp. 269–279.)

Cairns (2002) points out that

Traumatised people are unable to have intentions of their own beyond the will to survive; this supersedes all other intentionality.
They are also unable to judge the subtle intentions of others, for their whole being is focused on the possible threat others may present. [p. 107]

There is, however, hope for attachment-disordered children, as indeed for adults. Cozolino (2006) advances the theory of interpersonal neurobiology to demonstrate that the brain is “a social organ”. It is therefore dependent on interactions with others to develop “social synapses” for interrelating and, indeed, for survival. Cozolino believes that healing relationships, both personal and professional, can facilitate the healthy development of the “emotional brain”, despite previous impairment caused by early trauma.

Identity, multiple selves, and the body–mind paradigm

A leading American biophysicist and neuroscientist, Candace Pert, expounds the new “body–mind” paradigm about the quantal exchange of information, not just in our brain, but at cellular level throughout the body, through emotions that both shape and are informed by our experiences. Our “reality” and social interactions can, thus, be differently interpreted, and reacted to by us depending on what mood or altered state we are in. Pert and Marriott (2006) consider that it is “normal for us to have subpersonalities, or altered states of consciousness, with whole bodymind changes from one to the other being triggered by our varying emotions”. They go on to define emotions as “the flow of information perceived to be essential for the survival of any particular state of consciousness being observed” (ibid., p. 136).

In the 1990s, Southgate, co-founder of the Institute for Self Analysis (now renamed The Bowlby Centre) in London, had proposed that “the associating multiple person is the healthy norm” (1989). Multi-tasking demonstrates an everyday faculty we take for granted when we divide our conscious attention between completely different activities. Similarly, steering a car “on autopilot” is a common trance-like experience for most drivers on familiar routes while part of their consciousness is engaged elsewhere.

We regularly journey in our minds to other times and places in much the same way as when we carry out everyday tasks that do
not require all our attention. We can thus be preoccupied with thoughts of something totally at variance with what we are doing. This distracted state is more evident when we are worried about something, and negative thoughts intrude at inopportune times despite every effort by our conscious mind to keep them at bay.

In Pert and Marriott’s view, we have multiple selves, each with its own “thoughts, emotions, physical reality, and even the soul or spirit” (2006, p. 135). They suggest that, through meditation and other centring practices, we can become more aware of and “anchor” our “inner helper” or “higher self” as our “central organizing consciousness”. They believe that this can assist us to understand, accept, and forgive our hurt or dysfunctional aspects in order to develop healthy selves-esteem.

The idea of having different selves or parts or levels of consciousness between which we switch constantly and without awareness, and from which we act, react, and interact, is not new. Freud had suggested an id, ego, and superego hierarchy; Perls coined the terms “top dog” and “under dog” to describe dominant and submissive aspects of our personality, while transactional analysis (Berne, 1961) postulates an elaborate structure of adult, parent and child selves to explain how we tend to operate, functionally or not, when we heed our critical “inner voices” that judge and condemn us without pity.

Hitlin (2002) refers to “Edge-figures—subpersonalities, shadows, demons, gremlins, introjects, Inner Children, archetypes—who are invested, for better or for worse, in keeping you from going past your edges” (p. 29). Hitlin defines “edges” as psychological barriers or self-limiting beliefs learnt from parental figures and previous negative experiences.

Hitlin recommends making affirmative statements that acknowledge both the difficulty and our innate potential for overcoming it while tapping on certain acupressure points, as in emotional freedom technique (EFT) or Tapas acupressure technique (TAT). Both therapies draw on western cognitive therapy and the eastern (Chinese) meridian system of energy. They aim to rebalance blocked energies in the body and connect right (emotional) and left (thinking) hemispheres of the brain.

Ford (1998) believes that it is vital to acknowledge our “shadow” aspects:
To get past your ego and its defences you need to get quiet, be brave, and listen to your inner voices. Behind our social masks lie thousands of faces. Each face has a personality of its own. Each personality has its own unique characteristics. By having internal dialogues with these sub-personalities you will turn your egotistical prejudices and judgments into priceless treasures. . . .

Examining our sub-personalities can be a tool to help us reclaim the lost parts of ourselves. First, we must identify these parts and then we must name them, then we’ll be able to disengage from them. Actually naming them creates distance. [pp. 92–93]

Following Whitfield (1987), I consider it essential for us to connect with and heal our hurt “inner child selves”, as experienced at different ages (perhaps visualized as in a set of Russian nesting dolls). We can then fully utilize our adult competencies and skills in everyday functioning instead of being helplessly driven by our hurt child aspects. Through play and meditation, we can develop

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**Figure 5.** Selves in development.
our magical, wise, and playful child aspects, since these link us to
our creativity, in-tuition and inner knowing, and, indeed, to the
divine being in us all: what Pert and Marriott and others refer to as
our higher self, or even soul or spirit.

Identification with the oppressor

The power imbalance between a child and abusive or dismissive
adults in her life can lead to her developing a very negative self-
view and inhibit her exploration of her real potential. The adults’
“judgement” of her may be enforced consciously or unconsciously
through processes of external or internalised oppression (re-evalu-
atation counselling; see www.michelinemason.com for a discussion
of internalised oppression). These can so distort her self-perception,
as in a hall of mirrors, that it may come to bear little or no resem-
blance to her reality.

Alleyne (2007) has developed the concept of “internal oppres-
sor” specifically in relation to racism. She argues that, “The oppres-
sor is an aspect of the self that functions as an inhibitor, an internal
adversary and enemy. It is distinct from internalised oppression,
which is the process of negative racial internalization” (p. 271).

This dynamic occurs so commonly, and usually unconsciously,
in other global oppressions, such as adulthood, sexism, ethnocen-
trism, ageism, ablism, heterosexism, etc., that it might be very diffi-
cult for a person oppressed in one or more of these ways to achieve
and/or maintain awareness of her core or true self and feel liber-
ated enough to claim her inherent right to self-definition and, there-
fore, self-judgement. Continued abuse or social oppression of any
kind can completely distort our innate sense of who we are and
what we are capable of, so leading to self-putdowns, self-sabotage
and even selves-oppression.

A mother or primary carer does not have to be clinically
depressed, or narcissistic, or have a personality disorder to damage
or stunt the growth of a baby’s true self. If a parent has internalized
oppression of any kind and accepted a false judgement about
himself, he is likely to hold up the same “distorting mirror” to his
children (Figure 6). A common version of this phenomenon might
be the harsh superego (Freud) or parental voices (Bowlby), which
unremitttingly attack or criticize the child self.
Without informed support, it might be very difficult to see or acknowledge systematic oppression. Our false self/selves tend to be abusive to the true self in oneself or others, devaluing and denying innate self-worth and potential. Social institutions come into being which reinforce distorting images of the self and others who are similar. These maintain the status quo, which is inherently in favour of the dominant majority and, therefore, oppressive to minorities.

Language is a primary tool of oppression or liberation, since it can distort or clarify images of the self, and the other. Unsurprisingly, therefore, minorities of any kind are often described in unflattering terms in relation to the majority. There are few positive connotations of “black” in contrast to the multitude for “white”; similarly for feminine and masculine; gay and heterosexual; old and young; child and adult; disabled and able-bodied, etc. As neurolinguistic programming (NLP) reminds us, language is seldom neutral, being coloured by our acquired view of the world around us: “The map is not the territory”.

Figure 6. “A hall of mirrors”: distorted sense of self.
Dissociative identity disorder

Children who are physically, emotionally, and/or sexually abused by their parents or carers are caught in an impossible dilemma, since the very person who should protect them and meet their needs is a danger to them. The child has no workable strategy to keep himself safe and attached to his abusive carer, and so he might develop chaotic or disorganized attachment behaviours.

A child in this situation might split off her needy aspects, and identify with the abusive carer against her vulnerable self and others like her. Miller (1987, pp. 281–284) and other writers on child abuse have described this common psychological defence of identification with the aggressor: unable to protect herself from abuse or invasion (physical, sexual, emotional, or psychic) or to end it, the child might learn to survive her maltreatment by justifying it. She internalizes the abuser’s negative view of herself and others like her, and maltreats herself and/or them in a similar way.

If a child’s persisting neediness and/or vulnerability become intolerable to her abuser self, it may then seek to punish the abused victim part of herself for continuing to hold up this “mirror”. Self-splitting is, thus, a useful way to think about incidents of severe self-harm where one “self” might literally seek to punish or kill off another “self” that is blamed for the abuse suffered, because of the unbearable levels of emotional pain associated with it (Sachs, 2005).

The child may dissociate and identify with the oppressor against her perceived negative aspects so as to protect her true self from further violation and what might be experienced as a threat of total annihilation. The more severe and prolonged the abuse, the more splitting occurs, with the likelihood of multiple identities being spontaneously created by the self for survival in different threatening situations.

Gloria Steinem explains the development of multiple personality disorder (MPD), now commonly referred to as dissociative identity disorder (DID):

As is now known, MPD is almost always the result of frequent, sadistic, erratic, and uncontrollable abuse in childhood by someone on whom the child is dependent; abuse so intolerable that children learn to dissociate from it through a form of self-hypnosis and so escape into a “different” person who does not feel the pain. Having
once split off from the core personality, this “alter” begins to acquire a separate life history, complete with distinctive mannerisms, behaviour, and social relationships, almost as if it were a person born at the moment of “splitting”. Once this ability to dissociate has proven to be a valuable way of surviving and dealing with the world, alters continue to be born to meet different needs and demands. [Steinem, 1992]

Selves-splitting is a complex defence mechanism to which persons with DID may resort as a creative but extreme response to repeated and unbearable early trauma. Sadly, what helps their psyche to survive in their early life may be inimical to their everyday functioning later on.

**Verena’s story**

I worked with a highly intelligent and creative young woman for several years, during which we became aware of her unconscious facility for switching personae if she felt under threat of any sort. This led to “her” frequent loss of time and history when in another “personality”. Hearing Verena’s stories of multiple abuse within her own family, and then in the care system, which totally failed her time and time again during her childhood, adolescence, and young adulthood, I realized how her very being had been repeatedly assaulted by adults to whose care she had been entrusted. DID became her survival strategy, her only alternative to death or going totally insane.

As I learnt more about her mother who had also been severely abused as a child, I realized that, perhaps from infancy onwards, Verena had needed to develop different personae to relate to her mother’s changing alter states in order to survive their murderous attacks on her core self. The wonder was that Verena was not only still alive, but had not become completely mad herself, and that, despite all her hurt, she was very strongly connected to her intuitive and spiritual selves. The self that brought Verena to therapy was a deeply wounded but very sensitive, empathic, articulate, clear-thinking, and compassionate person. However, she already feared having a child herself and, unawarely, treating him as she had been.

So, a victim of abuse may resort to self-harm and/or become an abuser himself if he unconsciously displaces his own justifiable
rage at the abuse and his hatred of the abuser onto himself or others whom he perceives to be vulnerable and from whom he does not fear retaliation. These might include babies, small children, pets, elderly persons or those with physical or mental disabilities or other negatively viewed aspects in various oppressions, as in racism, ethnocentrism, homophobia, etc.

People with DID can switch personalities quite dramatically, and without any “central organizing consciousness” orchestrating such shifts or even being aware that other “selves” may be “impersonating” them (Costner Sizemore & Sain Pittillo, 1979; Pert & Marriott, 2006, p. 133, describing Frank Putnam’s work). As a generalization, it seems that very young children, and girls in particular, might be more likely to dissociate in response to repeated and unbearable trauma, while older traumatized children, and especially boys, may be in a permanent state of hyper-arousal (Cairns, 2002, p. 61).

* * *

Attachment-disordered children are hypervigilant, alert to any perceived threat of abandonment or attack as affecting their very survival. Their biochemically programmed survival responses of fight, flight, or freeze are constantly triggered by primitive emotions that flood their whole being at cellular level, not just their limbic brain. Pert and Marriott (2006, p. 136) consider that such feelings are as powerful as drugs, with similar impact on our physiology.

This could explain such children’s lightning changes in mood, behaviour, and, it seems, in personality, too, when they can suddenly switch before their carer’s astonished eyes from a calm and pleasant child to a raging out-of-control house-wrecker, like a Dr Jekyll–Mr Hyde character.

I recall a small, severely abused six-year-old boy in a foster home explaining his table and chair-throwing exploits with mingled pride and puzzlement: “I am very strong when I am angry!” Foster carers will sometimes comment on how such a child might roll her eyes upward before these sudden mood swings. It is as if she has spontaneously learnt to put herself into a trance state in order to deal with what might feel like a threat to her very existence or core self. (See p. 23, above, Van Gulden, 2002, on “paratactic distortions”.)

* * *
Roet (2000, pp. 91–92) compares the hyper-aroused states of traumatized persons, who are constantly on “red alert”, to leaving an alarm in a previously burgled house switched on indiscriminately all the time. This would be both inefficient and cause a lot of distressing noise for the occupants and neighbours.

Roet recommends the use of trance work by skilled hypnotherapists to help the conscious mind communicate with that part of the unconscious that might be stuck in time (often going back to childhood, when the original trauma may have occurred). Roet suggests that this “part” or “self” needs updated information, based on a realistic assessment of the current level of danger and the adult’s resourcefulness in the present, in order to deal more effectively with such eventualities than would have been possible for her child self in the past. This is, in effect, a rewriting of her personal narrative.

It is important to note that such work requires great care and skill and is often part of “inner child healing”. This can include self-hypnosis, which is extremely powerful since—as in NLP change-work—it combines visualization, auditory suggestions, and kinaesthetic experiences, linking left and right hemispheres of the brain. Such therapy can be used to heal painful memories from childhood through the adult’s revisiting the past in imagination as an advocate for his child self while having full access to his current resources and knowledge, as well as compassion for his younger self in that traumatic situation. Like other energy work, inner child healing should only be undertaken within a safe therapeutic framework and by appropriately qualified and experienced practitioners.

* * *

Neurolinguistic programming (NLP) specializes in emotional “change-work”, which is often done in light trance. Thus, NLP offers valuable background pieces of the body–mind jigsaw puzzle of quantal healing. As children, we internalize adults’ views of ourselves and our families and the outside world; these may be liberating or oppressive, e.g., critical parent voices and family mirroring. NLP gives us the tools with which to challenge mistaken or outdated thinking, boost our self-image, set goals for ourselves more consciously, and generally improve the quality of our lives, irrespective of family scripts.
NLP is the study of how we perceive “reality” (through our senses) and, through our acquired views and selective use of language, give meaning to the world and our experiences of it. Our perceptions of reality are, thus, shaped by the stories we hear about and tell ourselves, and the family scripts, values and beliefs, and role models we adopt. We may communicate positively or negatively with ourselves and others to co-create our ongoing “reality” in an often unconscious, but self-reinforcing way. Thus, our “map” might not represent at all the “territory” we seek to traverse.

The name “NLP” is derived from neurological: our “body–mind” and sensory processing of information; linguistics: our use of language and its impact on our thoughts and feelings and physiology, as well as on other people, and theirs on us; and programming: how we sequence our thoughts and actions to achieve our goals, consciously or not.

To achieve more challenging goals, we can model ourselves on others who have achieved them by observing how they speak and act and copying exactly what they do.

The founders of NLP, Richard Bandler and John Grinder, began by studying brilliant communicators. They sought to model excellence and resourceful states through their keen observation of the work of such geniuses as Virginia Satir, Milton Erikson, and Fritz Perls. Bandler and Grinder wished to explore whether others could replicate the results of these outstanding therapists by mimicking exactly what they did and said, and, most importantly, how: through imitating their body language, including posture, facial expression, tone, breathing, etc.

NLP emphasizes pacing before leading: first building rapport with the client through paying close attention to his “eye-accessing cues” and the verbal predicates used—whether mainly visual, auditory, or kinaesthetic (feeling) words and phrases—in order to establish and match his preferred mode of communication, including non verbally. Only then will habitual language and thought patterns and behaviours be challenged to help a depressed patient, for example, to radically alter his negative thinking, feelings, and physiology (including posture and breathing) and get himself into a more resourceful state of functioning.

Indeed, the thinking behind NLP “parts reframing” and “neurological levels” change-work assumes that we all have different
states or aspects, some of which may appear to be dysfunctional and even self-sabotaging. However, the intention behind our behaviours is usually benign and self-protective, as in the concept of defences in psychoanalysis. Van Gulden (2005) recommends working with troubled children in a way that makes them aware that they have more resourceful “parts” that they can choose to develop and access “if not now, then some day soon” to resolve a particular behaviour problem.

Gloria Steinem, a radical seer, reframes in a thought-provoking way the human capacity for “dissociation”, noting that this can include even gender changes:

what would happen if the rest of us could acquire for positive reasons the abilities these accidental prophets have learned for negative ones. If such extraordinary abilities can be summoned to help survive the worst of human situations, they are also there to create the best. What if we could harness this unbelievable potential of body and mind? . . .

People in different alters can change every body movement, perfect a musical or linguistic talent that is concealed to the host personality, have two or even three menstrual cycles in the same body, and handle social and physical tasks of which they literally do not think themselves capable. [Steinem, 1992, p. 318]

**Storytelling, myths, metaphors, and scripts**

Survivors of abuse or oppression often remain stuck in their initial reactions to trauma or loss, when they experience shock, numbness, and/or denial, sometimes with somatic symptoms. This deadening response to intense pain might help them to get through otherwise intolerable situations, but they then pay the price in existing rather than living.

Weil (2002) explains that

Traumatic experiences are stored in different areas of the brain at the same time . . . The person is captivated by the trauma. The amygdala stays extremely sensitised . . .

In the area of the neocortex (front brain) coping strategies are developed, in an attempt to overcome the traumatisation by
unconsciously re-enacting measures. Those script patterns, that were developed in an attempt to cope with conflicts, are experienced as cognitive, emotional, behavioural and physiological limitations.

Beneath every basic belief of the life script lies a specific set of trauma blocks within the limbic system. Every trauma block in turn provokes processes of script formation and script maintenance within the frontal area of the brain . . . the life script can be understood as “avoidance attitudes”—motivated by the illusionary intent to avoid retraumatising experiences in the future.

To cure the script, integrative therapy must address both areas of the brain, where traumatizations are stored . . .

Meridian-based Psychotherapy and Counselling (MPC) procedures allow to directly address the limbic system. They resolve blocks between amygdala and hippocampus and withdraw the energetic basis of the script . . . the trauma moves to a far distance, that is, finds an adequate place in the person’s history. [Weil, 2002, p. 168, my emphasis]

**Story telling**

A primary task in therapy is to help the individual or family to be aware of their (usually unconscious) personal or family beliefs, myths, or scripts, and decide how functional these might be and what might need changing. Erikson’s use in his hypnotic work of storytelling and creating new metaphors for healing was noted to be particularly effective in accessing more resourceful states (“parts” or “selves”) in his clients, since stories help to connect left and right hemispheres in the brain.

Connor (2001) explains this commonly-used NLP process:

Stories, analogies and parables are the best way of accessing unconscious resources and Erickson was a master of telling stories that not only engaged the client, but also held the key to solving their problem. He would construct metaphors where the story line paralleled the client’s problem and then, as the story was resolved, the client was able to bring the resources that were suggested in the story into their own situation.
A simple use of metaphor in the Milton Model is where objects are credited with powers they do not have. These are used extensively in fairy stories and legends, for example: “The walls have ears . . .” “See how time flies.” “Be still and let the room tell you its secrets . . .” [p. 182]

A common way to help a survivor to move on from traumatic or disabling experiences is to encourage her to “tell her story” to a safe and supportive audience in the context of counselling or therapy or in a self-help group, where she is not disbelieved, or judged and condemned for what has happened. Whitfield (1987) explains that, through the experience of feeling heard, a person gets to hear the “story” herself. In then “retelling her story”, she can explore different versions and her full range of emotional reactions until, eventually, she feels able to let go the hurt and to heal and move on. The client in “Verena’s Story”, above, would often say that she was “bored” with having so much pain, and wanted to just get on with living; this felt like her natural impulse towards health.

Cozolino (2006, p. 32) describes how, as an adult psychotherapist, he serves as “an external neural circuit or auxiliary executive system”. He helps his clients to piece together their previously unarticulated stories from seemingly random clues to repressed traumatic memories and their sensory cues from the environment. Cozolino believes that “Therapy and other healing relationships utilize all levels of connection—from metabolic regulation to narratives—to alter neural network activation and balance” (ibid., p. 33).

Creating shared family stories

In presenting his work with a bereft family, Byng-Hall (1995, pp. 250–257) has highlighted the importance of “telling stories” as a shared task. Since children may be at very different levels of development and understanding, he helps the family to create a shared, coherent story; in this way, even very young children can, as they grow up, learn “what happened”. Byng-Hall believes that the story has to be fundamentally true, though not necessarily the whole truth. So, the story must have “room to grow” in order that the children can hear more bits of it as they get older and have increased understanding.
The story has also to be congruent with the family’s culture and beliefs about death and/or other losses. So, the therapist’s task is to find out what the *grieving script* is for the family, and also to construct her own story of “what happened”. Such an approach can be usefully applied to doing gradated life story work with children and families.

* * *

Daniel Stern (1985, p. 110) has observed how, from infancy on, everyday care-giving rituals and interactions gradually serve to create a RIG (representation of interaction that is generalized). RIGs build up for the baby over time an internal working model (Bowlby, 1969; Craik, 1943) of how her family operate, and the particular role or *identity* she is allocated in it.

A child may be typecast, so that only certain behaviours and attitudes of hers are selectively attuned to, reinforced, or sanctioned by her parents. Gender stereotyping is common in many cultures, with girls being socialized to smile and “look happy”, while boys are discouraged from crying or showing any vulnerability. Counter-identities, or other selves, may develop in opposition to such typecasting, if it is felt to be too restrictive or oppressive towards the core or true self.

Byng-Hall (1995) notes that family scripts are historical, usually intergenerational, and tend to lead to unconscious *replication* in adult life, so requiring more conscious attempts at *correction* or *improvisation* to adapt to changed circumstances.

Marcia’s story

I worked briefly with a mother, Marcia, who had survived repeated assaults on her, including rape, by the father of her youngest son, Gino. Marcia presented as an independent and feisty woman with a mind of her own. She had a strong network of “sisters” in the neighbourhood, who supported her care of her children by providing regular respite as and when needed until Gino started having such violent outbursts that no one would help Marcia out any longer with childcare for him. She became increasingly ill with stress and her children then became carers
for her in a reversal of roles. This totally undermined her authority as a parent over them.

Marcia had always had a conflicted relationship with her own chronically ill mother, and so she initially chose a corrective family script of “a strong mother” to help her to be a more effective parent to her children. However, whenever Gino showed any aggressive impulses, Marcia began to identify her small son with his violent father, who had terrorized her throughout that pregnancy. For his part, having been continually “alarmed” by his father’s assaults on Marcia while in her womb and during his first few months of life, Gino was very difficult to soothe. His “fight” responses were quickly triggered by any perceived threat to his being.

By the time he was a year old, Gino had already been typecast as a budding young psychopath who would follow in his father’s and grandfather’s footsteps. True to role, which he could not give up without adult help, Gino began to terrorize his mother and much older and bigger brothers and sisters with his increasingly violent assaults on them whenever they teased or thwarted him.

Predictably, Gino ended up in the “care” system and went through a series of foster homes, which he disrupted through his aggressive behaviours, before being placed at ten years old in a small children’s home in a different county. After a very difficult start when he continually assaulted members of staff, Gino began reluctantly to settle down and accept the unit’s rigid structure. With few and far between visits from his mother, Gino could now try out new roles that were less aggressive and even quite disarming.

Marcia’s projections were so powerful that, at first, it was difficult for me and other adults to separate Gino from them and see him for the sad, lonely, and frustrated child he actually was. Marcia, however, could not accept him in another role and, during her infrequent visits to the home, she would quite unconsciously provoke him into reverting to more aggressive behaviours towards her or staff. Or Marcia would get into “sick” role, requiring nurturing and attention from staff as well as Gino.

The professionals reluctantly decided to suspend her contact with her young son until Gino could feel more confident in his new non-aggressive role at the unit and engage in a more appropriate child–mother relationship with Marcia. She was offered counselling locally to help her look at how she was unconsciously replicating her sick mother’s
script and, instead, to *improvise* new and healthier ways of relating to her children, especially Gino, who was meanwhile being supported by the staff in rewriting his personal story.

* * *

Feinstein (2002) suggests that “personal myths function not only as biochemically-coded models of reality, but also as fields of information” (p. 99). Personal myths are “organising models that shape perception, understanding and behaviour and emerge from four sources: biology, personal history, culture and transcendent experiences” (*ibid.*, p. 100).

Feinstein believes that “psychophysiological forms and mythic fields are linked by resonance” and that new “mythic fields become established when new patterns of understanding are initiated and repeated” (*ibid.*, p. 102). More intriguingly, and perhaps controversially, Eden, who can “see” mythic fields in colour in a person’s aura, describes this transition:

> When a new myth has become more than an idea and has begun to take a stable physical form, it begins to infiltrate the auric bands changing some of their colours. Its energy will be less dense and move more quickly than the energy of the old myth. As a new myth begins to take hold, at first it looks faint to me, but with time it becomes more distinct. . . . I can see the energy of an old myth doing all it can to hold on, like hot tar. If it gets stuck that way for a long period, physical illness often follows. [ibid., p. 103]

*Energy psychology*

“Energy psychology” is a generic term given to a range of treatments of the body’s energy system that address emotional difficulties and self-limiting beliefs in a prescribed format. These treatments include thought field therapy (TFT), created by Roger Callaghan; emotional freedom technique (EFT), by Gary Craig); EmoTrance (ET), by Sylvia Hartmann); and Tapas acupressure technique (TAT), by Tapas Fleming).

Pert (2005), the neuroscientist and biophysicist who coined the term “molecules of emotion”, explains the interplay of mind and body:
Emotions and thoughts initiate a series of cascading chemical and cellular events—including the formation of new neurons—that are the basis of other emotions and thoughts. Some studies suggest, in fact, that meditation may cause neurological shifts that are as potent as our most effective medications for alleviating anxiety and depression. . . . Energy interventions impact the body’s intricate electrochemical system as well as more subtle energies. [Pert, 2005, pp. xi–xii]

EFT, which draws on acupressure and cognitive therapy, and eye movement desensitization and reprocessing (EMDR), created by Francine Shapiro, are among the newer “energy therapies” that seem to offer amazingly rapid results (Mollon, 2005).

EFT is quite simple to use and can easily be taught for self-help purposes, even to children. It is increasingly being used with children as well as adults in Europe and the USA to address “core issues” arising from early abandonment and abuse and to facilitate emotional and even physical healing sometimes, often with quite dramatic results. (See Gary Craig’s website, www.emofree.com and Conference proceedings on “Psychological trauma and the body”, September 2007, London, CONFER.)

EFT and EMDR are among the repertoire of therapies used in the Traumatic Stress Service at the Maudsley Hospital in London. Both therapies facilitate body–mind connections, bridging left hemispheric thinking and language functions with right hemispheric emotional and somatic processing of often repressed early memories.

It is generally accepted that, in order to heal from pre-verbal traumatic experiences stored in the body, they need to be safely recalled and articulated: “Those who cannot remember the past are condemned to repeat it” (Santayana, 1905, p. 1).

NLP and some of the newer “energy” therapies like EFT and EmoTrance seek to deal with the emotional impact of repressed memories without retraumatizing the client. As with inner child healing and other specialized forms of therapy, such work should only be carried out by skilled and appropriately qualified practitioners within a strict therapeutic framework.

Interestingly, NLP emphasizes the importance of “anchoring” resourceful states rather than painful and vulnerable ones. So,
trauma work tends to be done using a technique of “dissociation” and distancing words or even numbers to represent the painful experience being talked about. The intention is to minimize the risk of retraumatizing the client, and possible abreaction.

* * *

Any therapy that can anchor more positive emotional states in attachment-disordered children, to replace their early learnt instinctual responses of terror and rage, should help to reduce their destructive mood shifts by “rewiring the brain” to create new “emotional” synapses to their underdeveloped front brain. Such optimistic views of the plasticity of the “social and emotional brain” tend to inform parent–infant psychotherapy and attachment therapies, whatever their orientation, rather than the social determinism that sometimes seems to be implied in studies of mothers’ attachment styles to predict their babies’ future relationship patterns.

The reality is that there are many variables which can influence the outcome: the child’s temperament, genetic endowment, natural resilience, physical and mental capacity, and environmental influences, including attachments to other significant adults and siblings. The parent’s recourse to family scripts (Byng-Hall, 1995), her own resources and support network, as well as her innate capacity for healing, will all contribute to shaping her developing relationship with her child.

Interestingly, meditation practice at school assemblies has been introduced in a number of primary schools in England with reportedly calming effects on pupils. (Presentation of new initiatives in schools at a Ministry for Peace public meeting at the House of Commons, London, in December 2004.) Safe massage techniques are also being taught to children in British schools through the fast-developing “Massage in Schools Programme”, created by Mia Elmslater of Sweden and Sylvie Hetu of Canada. Their belief in the beneficial effects of touch on the body–mind is so great that their “vision is that every child attending school experience positive and nurturing touch every day . . . everywhere in the world” (see MISP website, wwwmassageinschools.com).

The global interest in traditional healing practices is already linking eastern and western medicine and complementary thera-
pies. Energy psychology therapies such as EFT and TAT integrate acupressure with cognitive therapy. Similarly, through “tapping” on the Chinese meridian energy system, the American creators of Brain Gym describe the benefits for children, adults, and even business organizations of various simple exercises that link different parts of the brain. For instance,

Positive Points are acupressure points located above the centre of each eyebrow. They are specifically known for diffusing the fight-or-flight reflex, thus releasing emotional stress. Touching these points transfer the brain response to stress from the midbrain to the front part of the brain, allowing a more rational response. [Dennison, Dennison, & Teplitz, 1994, p. 51]

In this way, bodywork and other touch-based and energy therapies are finding validation in the new body–mind paradigm of healing (“Power of touch” Conference, November 2007, London: CONF-ER). So, ironically, neuroscience research has provided a meeting ground for more traditional psychotherapists as well as complementary therapists, NLP, and the newer energy psychology practitioners who consciously work towards integration of right and left hemispheres of the brain.
CHAPTER TWO

Background to the development of CAT: a programme for fostering mutual attachment between child and carer

The story of CAT. Phase 1: 1995–1996

Just as each family has its own complex history, with members contributing different perspectives, so do projects such as this one. The four CAT therapists involved in the pilot (Maggie Gall, Margaret Saxby, Pauline Sear, and myself) came to it with our own family stories, and conscious and unconscious motivations for wanting to make a difference to children living outside their families by helping them to form healthy new attachments.

All four of us were agreed that we wanted a “child-centred attachment therapy”; hence the name, CAT, rather than the adult- or parent-centred therapies that seemed to prevail at the time. This did not mean that control-hungry children should be allowed to take over, but that the carers should be supported in staying in charge as parents while respecting their child as a little person in his or her own right, with individual needs and feelings and personal and family stories.

Therefore, we felt very strongly that intrusive holding therapies were contraindicated for children who have already been physically, sexually, and/or emotionally abused. We agreed at the outset that
physical holding would not be part of the therapy, unless it occurred spontaneously in a session, initiated by either the child or carer. In any case, as CcAT therapists, we would not engage in such holding.

Maeja’s story

I qualified as a social worker in London in 1974 and soon began to specialize in adoption and fostering work. This background experience complemented my training in the early 1990s, both as an attachment-based psychoanalytic psychotherapist with the Institute for Self-Analysis (now known as The Bowlby Centre), and as a parent–infant psychotherapist at The School of Infant Mental Health in London. What I did not know at the time was that Rose’s and Emily’s stories were pivotal to my professional development and interests.

I had felt greatly inspired when reading, in the early 1980s, about Fraiberg and her multi-disciplinary team’s pioneering attachment work in the USA with struggling young families. Then, in the early 1990s, after watching videos of Acquarone’s and Watanabe’s psychotherapy with babies and mothers in London and Japan, I began to believe that negative attachment patterns formed by adults through their own childhood experiences do not have to define and limit their relationships with their own children in turn.

My own struggles as a parent made me more compassionate towards others, and I became increasingly interested in helping to foster parent–child bonding wherever possible. Like Emily, I had an “aha” moment when I suddenly realized the healing implications of helping stuck families to understand and implement the basic bonding cycle (Figure 1, p. 9).

I was very fortunate to be based at the time at a local family-finding unit where three of my Social Services colleagues—Pauline Sear, Dr Maggie Gall and Margaret Saxby—were immediately enthusiastic about putting CcAT into practice and contributing their very different skills, knowledge, and experience to it.

Pauline’s story

Pauline came to CcAT with several years’ experience of supporting struggling families whose children were considered by social workers to be especially vulnerable. In Pauline’s words:
Along life’s road other people also shape and put into focus things we may have not tapped into in our unaware mind. So it was for me, years ago now, when I attended an “Inner Child” workshop facilitated by Maeja. Little did I consciously know then that this day would change my life. Through work and new friendships, I realized a new passion, still with me today, to work alongside struggling children and families. These experiences provided a safe haven for my own Inner Child to heal, although of course I did not know that at the time, nor how greatly I was affected by learning about Gemma’s story.

Somewhere deep inside, though, my Inner Child could identify with little Gemma’s thoughts and feelings. Without being in any way conscious of how I would use my own childhood experiences to advantage years later, somewhere, somehow, a strength was forming. In a strange way, this worked alongside old hurt and anger, which provided me with the gut-essential tools to much later work alongside troubled and hurt children.

I began to assemble some bits and bobs of things in a box to start to do some direct work with children and families as a way of helping them to communicate when perhaps they were unable to say what they meant or even know how they felt. This seemed a fitting way in which to begin to work more closely with families through observing the attachment/interaction between them rather than asking direct questions, as was usually the case then for most workers involved in family work.

In some small way, this seemed to work with most of the families, and made good use of the time spent with troubled children as they dived into the box of “goodies” and made up all sorts of stories, where otherwise they would have been reluctant to talk for whatever reason. This time was both fun (especially if the parents or carers participated), moving, and spoke volumes about the children’s inner self, as each child made sense of their world as it really was, without prompting or telling them what to do. A box of sand, a box of toys or “creatures” will do more than any amount of spoken words when you are working with a very hurt and/or angry child. It provides a safe haven for the child “to be”, as we would discover over time.

Time moved on with my direct work with children gaining momentum. I began training at a London college in Play Therapy, and made more use of the toys and “creatures” in my day-to-day work. I was soon fortunate enough to be invited to spend one day a week at a local family-finding unit, which was engaged in preparing children for new
adoptive families. As it happened, Maeja was already working there, and soon we were supporting our first “attachment-disordered” child and his parents. Serendipity or what, but that was the start of CAT.

Time passed until the day came when Maeja and I “set up shop” locally to provide support to foster families, adoptive families, and birth and step-families. The CAT Programme was now in full swing.

Maggie’s story

When I first became involved in what was to become CAT, I was working as a Senior Social Work Practitioner at a small family-finding unit. With colleagues in the adoption team, my work focused on supporting adoptive parents post placement, and encouraging them to form strong and lasting attachments to their new family members.

At first I felt that the CAT Programme simply represented what I considered to be good practice: what every social worker should be doing during home visits. However, the structured ways of working and the actual way the Programme is put together makes it a unique and specialized form of intervention, one which I would later commission on an independent basis for another local authority.

Margaret’s story

Margaret now lives in France and runs a guest-house there, still helping families with her generous hospitality and (in)famous sense of humour. She came to CAT with twenty years’ experience of working with children at the family-finding unit, and supporting their new carers. Margaret soon discovered that she had a gift for such work, having started it on an informal basis; she went on to specialize in “direct work with children”. Margaret is pragmatic, so her belief in CAT from the outset lent it a much-needed “grassroots” seal of approval.

* * *

The CAT Programme came into being initially as a conceptual framework for working with bereft children and adoptive parents, who each have to acknowledge and mourn their losses before they can move on to form positive new parent–child attachments (Figure 7a,b).
BACKGROUND TO THE DEVELOPMENT OF CAT

ADOPTERS LOSSES

- Child does not meet adopter’s ideal of how his child should be. There might also be the loss of having no birth child to carry on the family tree, etc.
- Adopter experiences hurt, anger, shame, loss of status, self-worth, self-esteem, helplessness, or inadequacy. These feelings exactly mirror the child’s experience of loss and are a good guide to how she feels too.
- Adopter needs continually to “tell the story” of his hurt to a supportive listener, feel heard, and so get to hear it himself; and express feelings of sadness and anger at loss of his ideal or “fantasy child”.

CHILD’S LOSSES

- Child does not dare to re-attach and so risk more family and other losses, rejection, pain.
- Child fails to relate to, trust, be comforted by, or respond appropriately to adopter, and is rejecting of him. (Miscues)
- Child’s rejecting behaviours make adopter feel a failure: impotent, ashamed, very angry, and also rejecting in turn, possibly even quite abusive or neglectful to the point of emotional or physical abandonment, so repeating child’s original experience of loss and confirming her distrust of any new carer.

ADOPTER needs supported in seeking new solutions to his difficulties with child, and gains greater awareness of himself and child.

Having been supported in his grief work, adopter feels more able to allow child to also grieve. This fosters their attachment by meeting the child’s need to express sad/bad/mad/scared feelings about self and others, and her past.

Figure 7(a). Loss and grief work for adoptive parents of very hurt children.
Figure 7(b). Separation and loss issues for bereaved children. Griefwork needed in fostering and adoption placements.
Ghosts from the past: the carer’s or child’s previous history of relationships, can get in the way of either one being able to give the other appropriate cues and responses. Old hurts and unmet expectations from the past may distort current communication between child and carer. The child may not meet the “fantasy” of the carer, and interactions then become increasingly negative. This will force the child into false self, or people-pleasing, mode to survive, until she cannot repress her real feelings any longer and explodes in frustration, to her and everyone else’s dismay.

Equally, the carer may not be the “fantasy parent” of the child, and so he does not get validation as being good enough. He might then reject the child and the placement could end, with the child having to move to another family, where this negative cycle starts all over again.

The timing for our CcAT proposal was fortuitous: The Director of our local Social Services Department at that time was particularly interested in Vera Fahlberg’s work on attachment, and CcAT had freely incorporated her ideas on “positive and negative interaction cycles” (1991) and for fostering attachments. We had a new County Adoption Manager who was willing to act on the Director’s interest and help our small team combine theory and practice to pilot the CcAT Programme for the county. And we had agreement from our local managers to allocate precious time to developing, piloting, and evaluating CcAT over the following twelve months.

We began with experiential training for ourselves by answering an abbreviated version of Main’s adult attachment interview (AAI) questionnaire. This had a powerful impact and made us aware of the need to first test on ourselves any such exercise in gaining self-awareness before expecting families to do the same. It remained an important principle in our work with CcAT families. I was therefore interested to learn that Byng-Hall encouraged his trainee family therapists at the Tavistock Clinic in London to do their own genogram in group supervision; “the aim is to explore the supervisee’s ‘caring’ script—that is, the script that brought them into the caring profession, and in particular into family therapy” (Byng-Hall, 1995, p. 133).

We had initially intended that one of us would train in administering the AAI questionnaire ourselves, so that we could use it as a research measure at the beginning and end of work with each
family. However, time and money constraints made this impossible. So we devised “Child and parent attachment behaviours” questionnaires for parents to complete (see Appendices A1 and A2). These were derived from Fahlberg’s very helpful developmental guides to attachment behaviours (1991, Appendices).

Conceiving and co-developing the project in one year from theoretical framework to therapeutic practice was an amazing story of synchronistic events:

- a child care social worker’s sudden labelling as “attachment-disordered” of a child already on referral to me;
- the recent dissemination of new learning from the USA about reactive attachment disorder by PPIAS, a self-help group of adopters (now known as Adoption UK); and
- our very useful learning from the Post-Adoption Centre in London, which had included our “attachment-disordered” child and family in their own new attachment therapy pilot project during the summer of 1995. Pauline Sear and I provided the necessary preparation, support, and follow-up to the family after their “intensive week” (see family C, Chapter Four).

These events were followed by a series of unexpected encounters with various colleagues around the county, all of whom boosted our belief in the therapeutic value of our proposed child and family attachment programme. However, during the first six months of our developing the project, Family Finders staff suffered an unprecedented number of accidents, serious illnesses, and even deaths in their immediate families. These almost totally disabled our small CcAT team, since three members and our team manager suffered concurrent personal and family losses.

Nevertheless, we felt that CcAT was “a gift from the universe”, which we had a responsibility to develop and share in order to help families struggling with attachment difficulties. This remained our ethos through all the trials and tribulations of the following year, although I often felt I was scouting ahead through very difficult terrain on my own.

The pilot project was very small as a result, and this may have influenced our managers’ views on CcAT’s potential, despite a positive evaluation by a senior Social Services researcher at the time.
Pauline and I then decided to offer CcAT independently, and we continued to do so for the following ten years.

We learnt slowly but surely that we had been inspired. CcAT is based on very simple attachment principles that can be easily taught to families and professionals who are willing to learn. It is a cost-effective, brief family intervention (four to six months usually) that can make a positive difference to a lot of unhappy children and parents. We have also used the CcAT framework for therapeutic assessments of several struggling families to salvage failing placements, and to assess sibling and family attachments, and complex contact arrangements, in order to make recommendations to placing agencies and the Courts. (See Chapter Six.)

Dealing with loss

There were enormous gains through our making new professional friendships and the cross-fertilization of our varied learning and experience. These were, however, almost offset by the series of losses suffered by staff at the family-finding unit where CcAT was based. In the first six months of the project, seven of the eleven staff members experienced a major loss of this kind through a sudden accident to, or the serious illness and/or death of, a family member. These disasters, one almost every week, became a major threat to the survival of the project right at its inception.

It was as if we as CcAT therapists had to be reminded of the incapacitating effects of loss, and the need to acknowledge and mourn it, before we could move on to work with our chosen pilot families, the As and the Bs. Coincidentally, each of those two families in turn experienced the loss of a parent, which set back our starting date for the project by several weeks. So it came as no surprise to me that, when writing about CcAT twelve years later, this book, too, had to be set aside for some months while I was compelled to do my own griefwork following an unexpected family bereavement.

Rationale for developing CcAT: a programme for fostering mutual attachment between child and carer

Many of the children who come to Social Services’ attention and are subsequently fostered or adopted, or end up in institutional care
when families are no longer able to hold them, are already deeply scarred by their experiences of multiple separations, losses, rejections, and abandonment as they are moved from one placement to another. If they have also been physically, emotionally, and/or sexually abused in one or more families, their ability to trust carers and form meaningful attachments is likely to be greatly impaired. This in turn undermines the confidence, competence, and commitment of their new parents.

With ever diminishing placement resources for such children, the practical and emotional costs of yet another breakdown are considerable, both in the short and long term. Children who dare not attach need to feel in total control of their frighteningly unpredictable world and are likely to “act out” from fear in ways that are increasingly dangerous to themselves and others.

Attachment-disordered children generally grow up with very low self-esteem and might end up in abusive relationships, so perpetuating the cycle of rejection, abuse, loss, and abandonment that they are so desperate to escape. Current neurobiological research suggests that some of these adults may subsequently be diagnosed as having borderline personality disorder (Cozolino, 2006, pp. 256–268). This is a distressing condition that is not generally well understood, and which severely affects their ability to make and sustain healthy relationships.

Holmes (2004) links the psychopathology of children with disorganized attachments with that of adults with borderline personality disorder. In his view, both start with:

(1) parental unresolved/traumatized states of mind;
(2) moves to the D (Disorganised) infant caught in an approach–avoidance bind, with no secure base refuge when threatened either from without, or by her own unmodulated feelings;
(3) then shifts to the controlling 6-year-old who has eventually found a security strategy based on role reversal and providing pseudo-secure base for herself [see Gino in Marcia’s story, Chapter One];
(4) includes repressed terror and inability to repair interpersonal discontinuities and loss as revealed by picture completion studies;
(5) and then moves to adolescence and early adulthood in which the individual is controlling, aggressive, unable to self-soothe when faced with emotional turmoil and loss, liable to dissociation, and cannot extricate herself from pain-producing relationships. [Holmes, 2004, p. 183]

_Emotional holding or physical containment?

Reactive attachment disorder is a _DSM-IV _diagnostic label that has been increasingly applied in the USA to attachment-disordered children and covers a multitude of behaviours that are very familiar to frustrated foster and adoptive parents in the UK, too. (See Chapter One for a description of common causes and symptoms.) Attachment therapies of all kinds have developed, including the controversial and aptly-named “intrusive therapy” in Colorado, where treatment techniques have included holding down a child physically and inciting him to express anger, as in the rage reduction therapy pioneered by Dr Foster Cline in the USA.

However, the danger that such forceful treatment is in itself abusive was tragically proved a few years ago during a “rebirthing” session in the USA with a ten-year-old child, Candace Newmaker, which ended in her death. The therapist, Connell Watkins, is reported to have admitted to the judge during her trial in 2001 that she herself would not have undergone such “therapy” as it would be “too traumatic”.

Anger is an emotion that abused children are often afraid to express openly, but project on to their carers and other adults who end up feeling frustrated, enraged, powerless, and out of control. The rationale for holding therapy seems to have been that, through provoking the child to express negative feelings while physically holding him until he was too exhausted to fight the adult (therapist/parent/carer) any longer, he would end up in a quiescent state where he could finally trust a carer to safely assess _and _meet his emotional needs. This, it was thought, could also lead to his giving up his obsessive attempts to control the adults and everything in his hitherto unpredictable world.

Neurobiological research on the healing effects of touch provides a theoretical understanding of why some “nurturing holding”
techniques might prove to be effective if carried out in a respectful and non-abusive manner (Seifert, 1992). Terry Levy and Michael Orlans (Post-Adoption Centre workshop in London, 2006) advocate a “holding nurturing position” which, if matched by a caring attitude, could possibly feel therapeutic to children as well as to adults who have never felt emotionally “held” by, or attuned to, a parent.

However, any recourse to invasive treatment techniques is likely to be counterproductive and give dangerously contradictory messages to the child: “We are adults and in control because we are bigger and stronger than you and can hold you down.” The child may interpret this as meaning: “It’s okay for me to control/hurt others less powerful than me.” Since many of these children are already apt to vent their considerable frustration on smaller children, pets, and objects, this could be taken as licence to do so openly.

The involvement of their carers in invasive therapies could also be perceived by the child as betrayal by adults she is being told to trust. As Jan Hunt (see (www.naturalchild.com/jan_hunt) writes, “It can be immensely difficult for a child to regain full, genuine trust after being forcibly held—regardless of the parent’s ‘good intentions’ or the resulting surface behaviour”.

* * *

Aware of such parental and professional dilemmas, Cairns (2002) has some useful insights on the precautions to be taken during the long journey towards re-attachment. She offers very helpful “health warnings” about the need for “therapeutic carers” to feel sufficiently “held” by their own attachment network and supervision in order to provide safe and secure emotional holding for the very hurt children they care for:

Step 1: commitment

Each child needs us to commit ourselves to sharing a journey with them, a journey which we undertake in the full knowledge that it will change us forever. . . .

Some of the time, and it must be only some of the time, we will need to experience the world as the child does. This will produce a dizzying sense of dislocation, followed, if all goes well, by an expansion of perspective.
Step 2: personal support

It is essential when living and working with children with unmet attachment needs that we establish and maintain our own close, confiding, intimate relationships. This is the source of our own sanity and a resource to sustain our own resilience. The work may challenge and destroy both. It will also challenge the durability and flexibility of our own secure attachments.

Step 3: Professional supervision

It is even more important that direct carers—parents, family network care-givers, adopters and foster carers—have access to professional supervision and support than it is for child care professionals whose work with the children is not carried out in their own life space . . . to provide the essential overview of the system which will reveal the direction in which we are moving, will alert us to any risks, and will propose systemic solutions which will be beyond the scope of our own vision.

Step 4: Working with others to build an environment which promotes secure attachment

It will be an environment in which all those close to the child are adopting a consistent approach which meets the child’s needs, adapting the approach to fit their own role with the child, but providing great consistency in the basic structures surrounding the child. [Cairns, 2002]

Salzberger-Wittenberg (1970, pp. 142–155) refers to Winnicott’s concept of the mother providing a holding environment for the infant, and to Bion’s view of the need for the mother to provide emotional containment of the baby’s unbearable feelings of fear, rage, anxiety, and aggression. Salzberger-Wittenberg explains that:

This model is based on an infant being held both physically and emotionally by a mother. For instance, hearing her baby’s terrified screams mother responds by picking up, holding and carrying the baby, her arms around him forming a cradle which expresses that he is not falling to bits, but being held together and saved. Note that it requires both the mother’s understanding of his fear and a response in terms of physical handling which meets his emotional need. [ibid., p. 144, my emphasis]
So, in this way, endless repetition of the basic bonding cycle (Figure 1, p. 9) enables the child to internalize both physical and emotional holding by the carer; to develop self-regulation of mood, including learning to calm and comfort himself when in distress; and to grow those all-important “emotional synapses” to his brain to reinforce this learning.

**CAT’s philosophy**

Given the fully justified controversy about some of the “intrusive holding therapies” in the USA, the question for us as attachment therapists in the UK was: can a child and family be helped to attach in a mutually respectful way? The CAT Programme was developed with this philosophy in mind.

If a child is to attach securely to a new carer, she needs to be treated with respect and her wishes and feelings validated in an appropriate way, so that she is supported in uncovering and expressing her true self. That is the only basis for an honest and mutually satisfying relationship. Otherwise, the child will conform through fear to the carer’s wishes, relating only superficially with a false self/selves constructed over years of reacting to hurt and deprivation by previous carers.

The new carers of such a child might themselves require much skilled support and emotional holding by professionals while they learn to identify the child’s feelings, help her to express these appropriately and claim her right to have basic needs met in a non-abusive way. Years of neglect could have left a child completely unable to discriminate between various bodily states and sensations, let alone her confusion of emotions and feelings. Like a new baby and mother, child and carer might need to be supported in learning to give and respond to cues about needs that the child has learnt to suppress, perhaps even from her own consciousness, because it was not safe to express them previously.

Through consistently meeting the child’s needs, the carers can gradually teach the child to trust them to do so appropriately. The child might then begin to feel more secure and slowly reveal her true self and feelings, including “negative” ones like anger or sadness, which she might have been disapproved of, or even
punished by previous carers, for expressing. As her feelings and needs are recognized and validated, the child learns that she too is acceptable as she is, and her self-esteem increases. The more she is respected, and so learns to respect herself, the more she will respect others, too.

Grief at her losses, and rage at what has been done to her, will also need to be expressed as part of her mourning process. Therapeutic life story work is an essential part of this, helping to clarify for the child the roles of significant people in her past. If previous carers were neglectful or abusive, the child might need help in sorting out quite ambivalent feelings about them. Birth parents may have been idealized or vilified, and carers might themselves need help in presenting to the child a realistic but compassionate picture of her family, who remain, ultimately, part of her psyche.

If birth parents are portrayed as totally evil, abusive, neglectful, etc., how will the child learn to feel good about her origins and therefore about herself, and develop a positive self-image and feelings of self-worth? The adults’ denial of her parents’ importance in her internal world will be likely to encourage the development of a false, compliant self that tries to conform to the new carers’ expectations of her. A strong physical or temperamental resemblance to either parent, if also decried, will make it even more difficult for the child to develop a positive and integrated self-image.

The new carers might also need skilled support in rewriting their own family scripts, doing inner child work as appropriate, and grieving the loss of their ideal or fantasy child, so as to accept the reality of the child placed with them and attach to her in turn. Some parents might never have felt entitled to this child, and so will need help in now claiming her.

**The power of attraction**

Beth’s and Rose’s stories (Chapter One), as well as Alicia’s story (Chapter Four), illustrate the crucial part which the infant has to play in shaping relationships, through providing *attachment cues* to attract and claim their carer.

Foster carers and adoptive parents have long believed intuitively in the potential of healthy new family attachments for
healing a child’s woundedness from a traumatic birth history, although it is widely accepted now that “love may not be enough” to heal very troubled children (Thomas, 1997).

As a therapist working for some years with troubled children in specialist foster care placements, I would often read their placement histories and wonder how they could ever be helped to heal from the deep hurt they had suffered through early parental abuse and/or neglect and rejection. Their unconsciously learnt patterns of interaction tended to be repeated in subsequent foster and/or adoptive homes or even children’s units. There seemed to be no hope for them, given their damaging histories.

These very challenging children came from all over the UK and were estranged from their families, friends, communities, culture, and sometimes even language. They were placed with “specialist” foster carers locally because their own Social Services Departments had no more “care” resources to contain their generally aggressive and destructive behaviours. However, I never ceased to be amazed by the spontaneous healing, even without therapy, that some of these children seemed to experience within a year or so of living with a foster family who actually liked them. I was reminded, thus, of John Bowlby’s prescription for mental health: that a child needs a continuous relationship with a carer in which both find satisfaction and enjoyment. (Bowlby, 1953, p. 11).

The foster carers had somehow been attracted to the child placed with them and managed to see her as being more than the “problem behaviours” that had led to the disruption of her previous placements. This helped to give the child a new feeling of self-worth and a real sense of belonging to the foster family. In brief, the carers had succeeded in helping the child to create a healthy new attachment and so to feel less rejected and abandoned and, therefore, more willing to please her new family by giving up some of her unwanted behaviours.

Parents for Children, the first specialist adoption agency in London, discovered early on from their experience of placing children with special needs that a “chemical attraction” between child and new carer is essential to the success of adoptive placements (see annual reports for 1979–1980). Other key factors include realistic expectations of the child, and willingness by the adopters to work co-operatively with the agency.
Thus, I came to recognize the innate healing potential of families, and the need for professionals and therapists to acknowledge this and work in partnership alongside them in order to help hurt children to heal through providing timely, well-informed, and skilled support as part of a team approach. However, re-attachment work is neither easy nor quick (Figures 8 and 9).

For safe griefwork with a family (detachment from past, real or “fantasy” losses), support and safe holding are necessary in order to undertake therapeutic life story work with children, and inner child work with carers who may have “ghosts in the nursery” (Fraiberg, Adelson, & Shapiro, 1975).

For re-attachment to new carers to occur, both child and carer will need to grieve and release emotional energy invested in child’s wish to return to own family, or carer’s wish to have a different kind of child.

Figure 8. Detachment and re-attachment work.
1. **Griefwork:**

   Carer
   "Ideal child"
   "Perfect parent"
   has to give up fantasy of
   "Ideal parent"
   "Perfect child"

   TO BECOME

   "Good-enough carer"
   "Good-enough child"

2. **Holding:**

   Re-attachment (Holding/support)
   Grieving/letting go/moving on
   A SECURE BASE
   Truth-telling (no collusion)
   Boundary-setting; safe holding by carer or therapist
   Permission to express sad/bad/mad/scared feelings about self/past

3. **Moving on:**

   Detaching/Re-attaching Child
   Grieving of fantasy child and parent
   A SECURE BASE
   Parent
   Detaching/Re-attaching
   Attachment of actual child to actual parent

*Figure 9.* Re-attachment and grief work (detachment).
CHAPTER THREE

From theory to practice: CAT as a "working model"

A child-centred perspective

Gemma’s story

Born in the war-torn East End of London, Gemma spent her first three years in a house shared by two families: Aunt Doris, Uncle John, and two cousins, Ronnie and Frances, occupied the downstairs. Upstairs lived little Gemma with her Mum, Dad, and Nan. She was a happy little girl until the day she was sent to a faraway county called Yorkshire, evacuated there to keep her “safe from all the bombing”, the grown-ups said. But no one ever explained to little Gemma why she was the only child in the whole family to be sent away for three long years.

Decades later, travelling by train to Yorkshire as an adult suddenly brought back to Gemma all the repressed memories of her painful exile as a small child. As soon as she entered St Pancras Station in London, Gemma had a flashback to being very small and frightened. She suddenly remembered standing all by herself on a platform crowded with crying children who were being sent away like herself, with no parents to comfort or reassure them.

Gemma hated everything about Yorkshire, especially the strange family she was forced to live with and their odd speech and ways of
doing things; they even served Yorkshire pudding differently from the way her Mum and Nan and Aunt Doris did. The people in Yorkshire spoke in a strange way that little Gemma could not understand, and they then outraged her by laughing at her Cockney accent. She became self-conscious when speaking, and very soon began to stutter badly.

There were no telephones readily available then to help Gemma keep in touch with her beloved family. By the time she returned to London after the war, they were like strangers to each other. Her Nan wept when she saw the state of Gemma’s neglected teeth, and heard her stammer each time she spoke. And now it was Gemma’s own family who laughed at her strange accent and some of the things she did differently, so that Gemma learnt very early on that she was a misfit wherever she went, an outsider, even in her own family. Her special place there had been usurped by her new baby sister, Susan, whom she grew to dislike for that reason.

Gemma learnt to keep silent and watch the adults around her. In her words:

We knew at an early age not to answer back, have an opinion, or talk about feelings. (I did not know the word “Feeling” at that time, of course.) Simply, that we could not half-way say how it was. So, “Button the lip, and get on with it”, appeared to be the family motto, and indeed was so for many families. With men away at war, women struggling to cope, rickets, malnutrition, shortage of rations, bombs dropping, who had time to talk about the way it must also have been for the children?

There was an ongoing time when things were uncomfortable at home. Visiting “uncles” while Mum was at work and Nan “sleeping”, my innocence was taken. Who to tell, who would listen to a child who already talked too much, said the wrong thing, and wanted to but didn’t argue, to get across how I felt? Suffice to say that nail-biting, bed-wetting and stuttering became a pattern that would last into adulthood. Who noticed, who cared, who did anything about it?

Little Gemma got into increasing trouble at school and once, when she stuttered while reading aloud, the impatient teacher slapped her head hard against the classroom wall. She ran home crying to tell her mother, only to be slapped again for being punished at school. Gemma stopped going into her classroom after that, and would take her books
and lunch to the local marshes and read happily for hours. She was soon expelled from that primary school and then two more because of her refusal to accept adult authority any longer.

Fortunately, an English teacher at secondary school then recognized Gemma’s hurt and potential; she quietly encouraged the girl to resume her studies. It was a turning point for Gemma, and she learnt to attach to and trust this teacher who understood and respected her. This provided a new beginning for her at school and in life.

**The child**

Many long-term accommodated children who have developed attachment-related difficulties are perceived by carers and professionals as just being disruptive and generally unmanageable at home and at school. The adults may not understand where the child is coming from, or where he is at. There may be very little intervention for the whole family to help them understand and acknowledge the dynamics of the hurt child in their care, and how they can all be supported. If the placement then breaks down, the child risks further wounding.

Such children may have a series of moves and different carers within a short space of time because of the unpredictable behaviours and negative “baggage” the child carries with her. Since she anticipates unavailability of, or rejection by, each new carer, she becomes rejecting for self-survival and her negative expectations are self-reinforcing. Before long, the child’s negative internal working model of parents can bring about the very outcome she fears: her removal from this new family, too.

Such a child’s negative self-view makes the likelihood of her forming secure attachments in any family unlikely, and so each subsequent placement is unconsciously sabotaged by her. The hurt child thus becomes part of the “pass the parcel” syndrome within the “care” system.

**The carers**

Every carer of hurt children carries with them their own inner child. When a child displays rejecting or disruptive behaviours towards
them over a period of time, many carers feel unable to manage. They may feel despairing and deskilled and, at times, isolated with these feelings. Their inner child self may feel threatened and hurt, not coping, not in control of the situation; or, even worse, hurt and angry that the child in their care has rejected them before being rejected by them. The carer’s hidden feelings from their own past hurts are re-awakened by the presence of the hurt, disturbed child within their current family. Like him, they may “act out” their fear and rage unawarely.

“In every nursery there are ghosts. These are the visitors from the unremembered pasts of the parents; the uninvited guests at the christening” (Fraiberg, Adelson, & Shapiro, 1975).

Without an understanding of these natural reactions, and without adequate tools to handle the situation, some foster carers give up on the child and ask for him to be removed. Or a carer may emotionally withdraw from the child, ending any chance of their forming a positive attachment (Figure 10).

In such situations these difficulties can be exacerbated if the child is seen for therapy on his own, excluding the carers who may have no real knowledge or understanding of the child’s inner world. Moreover, because of their own blocked inner child feelings, or need still to grieve for their unborn “fantasy” child, the carers may feel unable to fully claim the child as their own. And when the child is seen as the one who needs “sorting out”, this serves to reinforce his negative view of himself, the world, and his carers. Thus, this damaging pattern of interaction is likely to repeat itself, and follows the child through each disrupted placement.

Child- and family-centred interventions

Hurt children in placement and their carers have a right to be supported. In working through child and adult issues at the onset of behavioural difficulties, an intensive therapeutic programme of interventions should be seen as major preventive work. This can result in positive changes from previous negative patterns, and help both the child and carer to maintain their place within the family and promote their feelings of self-worth.
In cases where children move on to adoptive parents, attachment therapy that includes child and carer can provide a framework for direct family work, so encouraging the bonding process to develop. This should include individual therapeutic sessions for child and carer, with inner child work for the carer, as well as joint carer/child work. Work with other children in the family, or with the carers as a couple, may also be needed.

Therapy can be carried out within the home to promote continuity of work within the child’s natural environment. Alternatively, a child-friendly venue elsewhere that is suitable for such work can provide a separate “safe place” for the family to explore their difficulties together. (See Chapter Four, “Alicia’s story”; and Chapter Five, “Frankie’s story”. In both cases, sessions carried out at home yielded crucial information that might not have been
available to us if we had confined ourselves to office sessions with these families.)

The therapeutic work needs to be experienced by the family as supportive, encouraging, and enabling them to grieve over their past losses and to work towards positive objectives and forming secure attachments with the child. Since such work encompasses the child and his carers, it provides a secure base for the child to claim his adoptive parents, and for them to claim him as their son.

*Reparenting skills*

Children who exhibit out-of-control behaviours usually find this as frustrating and anxiety-provoking as their carers. Most of all, they need reassurance that they are loved and valued and can be contained appropriately by parents who can act as responsible adults and not let their own “child selves” get pulled into battles which no one wins.

Carers can monitor their own strong feelings (countertransference) when helping a child to deal with unbearable feelings of rage, grief, or fear at being out of control and powerless in an unpredictable and threatening world.

Verrier (1994) describes the strength of such unconscious communications:

adoptees use projective identification, not only as a defense mechanism and a primitive form of object relations, but also as a means of communication. What that means is that anyone in a relationship with him will begin to experience his feelings and react to them. The adoptee uses projective identification to communicate what he really feels inside because he has no words to describe those feelings. The feelings originated before he had language.

Adoptive parents are very familiar with the technique of projective identification, as are reunited birthmothers, although they may not have known what it is called. Those projected feelings trigger the parents’ own sense of rage, hostility, sorrow, or helplessness, causing them to react in ways they consider totally out of character for them. [Verrier, 1994, 184–185]

If the carers can contain their own strong feelings and express them appropriately, verbalizing perhaps for the child how she might be
feeling the same, they will provide a different model for her of dealing with conflict and gaining self-control.

As Jeremy Holmes explains:

Parents who can contain and attune to their children have children who can put their feelings into words and who are able to resolve conflict. Those who cannot contain and attune are more likely to have children who are at risk of dealing with their feelings by splitting and projective identification . . . [Holmes, 1993, p.131]
Finding safety valves in fraught situations, lowering the emotional temperature with gentle humour, and allowing a raging child to save face and self-determine through choosing from options acceptable to the carer, may defuse some conflicts (Figure 12). Networking with other parents can help carers let off steam and build up a repertoire of creative responses to challenging behaviours. (See Archer, 1999a,b; Cairns, 2002.)

**The CAT approach**

The CAT Programme has three main intertwining strands.

1. **Helping carer and child match Cues and Responses to improve their communication and strengthen their attachment.**

   1. **Fostering of attachment:**
      - Practise synchronizing: Carer and Child
        - Identifying child's needs: naming
        - Supporting direct and appropriate expression of feelings and needs
        - Validating child and accepting her as she is.
      - Positive interaction: Play
        - Mutual liking and responsiveness grow through fun interactions

2. **Griefwork**

   "Ideal child" ➔ Has to give up fantasy of

   "Perfect parent" ➔ "Ideal parent"

   AND SO BECOMES

   "Good-enough carer" ➔ "Good-enough child"

3. **Safe "holding"/protection from abuse**

   Carer/Therapist creates "a secure base" from which the child and family can safely explore fantasies of child and carer; what her real needs are; how to express them directly and appropriately, trusting that they will be met consistently and safely, i.e., predictably, by carer.

   Carer finds Child more predictable, responsive, and gratifying to parent, claims her as own, feeling entitled to protect and care for her, so minimizing the risk of child "acting out" to provoke care/protection from strangers.

*Figure 12.* Child-centred attachment therapy work.
2. Griefwork for the child (life story work) and carer (inner child and child loss work).
3. Play-work with child and carer to build up their fun-time together and promote mutual liking and understanding.

_Fostering mutual empathy and honest communication between carer and child_

This helps them to identify and synchronise their cues and responses, and practise care-giving/care-seeking behaviours, so claiming each other in an attachment dyad (Figure 13).

![Carer–child mutual claiming spiral (based on Fahlberg's work).](image_url)

_Figure 13._ Carer–child mutual claiming spiral (based on Fahlberg’s work).
Since a very hurt or neglected child is unlikely to have had her basic instinctual needs met appropriately and consistently, she might well not recognize her own bodily sensations as indicating a need for food, warmth, defecation, etc. Her awareness of her body may have become so distorted through abuse or gross neglect that the carer may have to treat her for a while as if she were an infant. The child may actually be unaware of why she is in discomfort, and so will need help to express what she is feeling, to name and recognise bodily sensations before and after her basic needs are identified and met appropriately by the carer.

If the child has previously had her bodily sensations and feelings discounted or misnamed, deliberately or otherwise, this process needs to include “unnaming” and correctly renaming what she is feeling. Through consistently helping the child to complete the “basic bonding cycle” (see Figure 1, Chapter One) the carer provides a secure base from which the child can develop trust that her needs are valid and will be met. In this way the child can learn to identify both the source of her discomfort and the remedy for it, and so ask to have her need met appropriately by the carer (Fahlberg, 1988, pp. 38–40).

In this way, as in a baby’s first year of life, crucial neural connections can be made between the child’s left hemisphere of the brain, which controls her thinking and language functions, and the right hemisphere, which is responsible for her emotional and physical functioning.

Recent neurobiological research suggests that mothers also grow new “emotional synapses” in their brain through engaging in natural bonding interactions with their babies after birth such as “eye contact, facial expressions, soothing vocalizations, caresses, and exciting exchanges” (Cozolino, 2006). This process helps the mothers to grow in empathy and stay attuned to their babies, and it might also apply to other primary carers of children who feel very strongly committed to them (Cairns, 2002, p. 67).

* * *

Attachment-disordered children may never have felt safe enough with previous carers to express anger or negative feelings about hurts or losses directly. In their often unconscious frustration at this,
they may vent their aggression on less threatening "objects", such as smaller children, or pets, or the furniture. The child who insists "I don’t know", when asked to explain destructive acts, is probably being quite truthful, since the real cause—deep, ungrieved hurts—is safely repressed in the unconscious.

Cairns (2002) explains this process of dissociation very simply:

Dissociation is the process by which the brain protects the organism from becoming totally overwhelmed by generating patterns of automatic splitting of awareness in response to repeated experiences of an overwhelming nature. [pp. 42; 60–61; 113–115]

When babies have no empathic carers who can attune to and contain their distress, helping them to regulate intolerable emotional states, they either dissociate from these feelings or remain hyper-aroused. From being a defensive strategy, dissociation can become an ingrained response to emotional stress and, hence, dysfunctional. So, a child who habitually dissociates from his own angry feelings is likely to find himself surrounded by very angry adults.

Hurt children may project their unbearable feelings into a receptive carer, who becomes the unconscious “container” for their hate, anger, and destructive feelings. The carer may already be feeling bad and useless as a parent because the child placed does not resemble her fantasy or “imagined child” and will not accept care from her. The carer’s feelings of frustration, inadequacy and helplessness may then mirror the child’s fear and rage at not being in control in a world that she perceives as being hostile to her.

Moreover, if the carer has not digested similar feelings from her own childhood, never having had these contained and metabolized (Bion, 1978) by her parents in turn, she may end up projecting them on to the child placed. This is in addition to not being able to process what she has received from the child in the present, and so returning it undigested. The child might then end up with a double dose of bad feelings about himself, and have no help to process them. (See Figure 4, p. 27.)

The carer can start to recognize the child’s emotional state by monitoring her own powerful feelings in countertransference. If the carer can be supported in containing these safely, and not retaliate by “acting out” angrily on them towards the child, she may be able
to go on then to process ("metabolize": Bion, 1978) the child’s unpalatable feelings and return them detoxified. Thus, the child is supported in exploring feelings that were previously too unbearable or unsafe to "reflect on" and could, therefore, only be "acted out" unconsciously.

Griefwork is essential for helping both carer and child to identify ungrieved hurts and losses of the past, to express their sadness and anger and hurt, and move on through repeated “telling of their story of what happened” to a supportive listener (Whitfield, 1987). The grieving cycle (Figure 14a,b) can be seen as a necessary counterpart in Attachment work to the basic bonding cycle (Figure 1, p. 9). (See also Figure 7a,b.) As Miller (1987) teaches: “Mourning is Nature’s way of healing”.

Griefwork for the child is encompassed in skilled and sensitive life story work, carried out at a level appropriate to her age and understanding and kept up to date. It needs to include her carers, whose support is essential for her to undertake such painful work. This will help the child to express her confusion of sad and angry feelings about what has happened to her, clarifying her understanding of her past, the roles of significant persons in it, and her probably ambivalent feelings towards them. Ultimately, whether neglectful and abusive or not, her birth parents remain part of her psyche and need to be portrayed with both realism and compassion if she is to develop a positive self image, thus reclaiming their good aspects for herself.

Griefwork with the carers can be more complex as they may need to exorcise “ghosts from the nursery” (Fraiberg, Adelson, & Shapiro, 1975), so as to disentangle from their current relationship with the child placed their own ungrieved experiences of hurt and loss, rejection and abandonment, from their childhood. Inner child work may be needed to help them get in touch with their unconscious child selves (both hurt and creative aspects), to mourn appropriately, and so to move on to reclaim the positives of their pasts, thus “rewriting family scripts” (Byng-Hall, 1995). Mourning their loss of an idealized parent or childhood may help carers to empathize with the child’s need to do the same, and support her in doing similar griefwork on her past. (See Figures 8 and 9, pp. 65, 66.)

The carers, whether they have other children or not, might need to mourn the loss of the ideal or fantasy child they dreamed they
would parent, and perhaps even ritually say goodbye to this imagined child. Only then can they totally accept the reality of the child placed as she is and so derive satisfaction from matching her actual needs for care, empathy, and positive interaction, instead of rejecting her for not being the child they longed to have, or of being themselves to their critical parents.

Play work with carer and child can help both to get in touch with the origins of the child’s unconscious angry feelings. Just as

Figure 14(a). Grieving cycle. When feelings remain unexpressed, we remain locked in this cycle of hurt/angry/sad/fearful feelings until, in extreme frustration, we explode verbally or physically—only to blame and hate ourselves more, ‘acting out’ even more dramatically on our unacknowledged negative feelings of hurt and or loss.
inner child work can help the carer to identify and separate his own hurt child self feelings. Otherwise these may be expressed inappropriately towards the child placed, so undermining the carer in his role as a responsible parent who needs to take charge as the adult in the situation. CAT therapists prefer the use of the term “taking charge” to “taking control” of a frightened, raging child who needs to be helped to acquire self-control. (See “NLP four pillars of childhood”, Chapter Eight)

Playing together, or having fun time together, is such a simple healing practice for families in conflict that Theraplay\textsuperscript{TM}, developed in America, now has a worldwide following (www.theraplayinsti-
Theraplay™ is a body–mind therapy that has four main dimensions: structure, engagement, nurture, and challenge. Through specific “play” programmes, Theraplay™ helps carers attune to the unmet infant needs of non-attached children and facilitate the bonding process in a more relaxed and boundaried way.

We all know that when we get on well in an adult relationship we want to spend time together with our partner or friend, to please each other and do things that both enjoy. All this strengthens our attachment. The opposite occurs when we are not getting on well, since we no longer want to spend time with our partner (who is now not regarded as our friend). We cease to do fun things together, and we are then more likely to drift apart in a downward “spiral of negative interaction”, with increasing time to dwell on each other’s failings.

The same applies to parents and children in conflict. They do not want to spend any quality time together, and the rift between them grows, often to the point of the placement disrupting. No matter how busy a carer might be, investing time in doing something that both child and parent enjoy is a pre-requisite to building a mutually satisfying relationship. Playing or having fun time together is a rewarding way of completing the basic bonding cycle (see Figure 1, p. 9). It provides a necessary balance for the carer, who has so much of the time to contain the child’s anger and hurt, listening to her pain and acknowledging her feelings of hurt or loss, even if her expressed need cannot be met in the present.

Winnicott believed that psychotherapy was about two people “playing together”, and that where patients are not able to play, it is the therapist’s task to help to bring them into a state where they can do so (1985, p. 44). Many hurt and neglected children are described by their carers as unable to play, and having no imagination or sense of humour. Most probably, these children take things literally because of their early experiences of deprivation and abuse. It is the carer’s task, as in therapy, to help the child to learn to relax and play and smile and laugh. These are all spontaneous baby behaviours that have been inhibited in the child by abusive or non-attuned carers.

It makes sense that an abused child will constantly be on “red alert”, hypervigilant to any signs of threat from people around him or the environment, since that has been his early experience,
triggering “fight, flight, or freeze” survival responses even when he is with new carers. Laughter may not be part of his repertoire of learnt behaviours, except in bravado or at hurt to others. Constant reassurance, treating such a child with respect, and gently joking with him (laughing with, and not at him), playacting, miming, and telling playful stories (perhaps those intended for a much younger age group), can all help him to start to relax and learn that it is safe to have fun and to develop his innate creativity and imagination.

There is enough research currently to show how emotionally and physically healing such playful behaviours and laughter are, even for adults, in releasing endorphins that make us feel good, so helping to create new pathways to our emotional brain and boosting our positive mood and immune system. (Robert Holden’s Happiness Project—visit www.happiness.co.uk. There are dozens of websites for individuals and organizations on the importance of laughter in reducing stress and promoting health.)

And so, through playing and spending fun-time together, a child might begin to trust the carer enough to then open up and begin to express her pain or discomfort and real needs and feelings, revealing more of her “true self”. Carers sometimes notice that a child will start suddenly to disclose painful experiences from the past, perhaps while engaged in other activities, as when looking out through the window on a car journey. Or, in the middle of a crowded market or shopping centre, a child will confide something significant to the adult she is with, as if testing to see how the carer will respond to her disclosure. Such moments, if handled well, can lead to further time spent quietly later on in talking and listening, cementing their new and growing attachment.

Fostering entitlement to the child

So much is expected of adoptive parents. They have to deal with so many outside pressures, as well as trying to bond with a complete little stranger who has already learnt that trusting adults can be a painful experience. The adopters have to deal with sometimes quite extreme behaviour, and the rewards are often small. And all this without the lovely cuddly years of baby cuteness!
In the first few weeks of a new placement, professionals need to indulge the adopters in their acceptance/rejection of birth parents. We cannot expect adopters to claim both the child and her family straightaway. Adopters have to go through a process of “owning” and claiming their child, and it is difficult for them to also include the birth family until they feel attached to their new child. Otherwise, it may feel to them like “kidnap” of the child, if the birth family is perceived by them in very positive and accepting terms.

That is not to say that adopters will continue in this mode, but time is needed to readjust until they can comfortably embrace the positives of the child’s birth family and truly enable the child to feel positive, too. Especially where a child is expressing anger and hurt towards their birth family, the new protective feelings of adoptive parents towards the child will help them to “own” and attach to her.

Adopters become the “everyday” parents, but initially have no legal parental responsibility for the child. The adoption process can feel very disabling, especially if legal proceedings are contested and long drawn out. Sensitivity has to be shown to the adopters’ need to embrace “their” child, if the split between good parents/bad parents is not to be made by themselves as well as by the child.

Previous foster carers who may have become very attached to the child will also need help in letting him go “with a blessing” and permission to attach to new parents. Otherwise, adopters may have great difficulty in ever claiming the child as being truly theirs to parent. See “Edward’s story” (Chapter Four), where Mr and Mrs C felt they had “stolen” their little son from the family he really belonged to, his foster carers.

**Notes**

1. The part of this chapter from “Gemma’s story” as far as the section headed “Reparenting skills” is contributed by Pauline Sear.

2. This final section of the chapter is contributed by Maggie Gall.
Phase 2 of the CAT programme (1996). Brief evaluation of the pilot project: our learning from adoptive families

Our local Social Services Department accepted an initial proposal to pilot CAT, over a six-month period in 1996, with two adoptive families in the north-east and two in the south-east of the county. However, almost immediately there was a change in plan as the north-east team had staff changes and withdrew from the project. The CAT team of four therapists in the south-east, based at a family-finding unit, worked in pairs with families A and B, with the intention of then taking on a further two families for the pilot.

This plan proved to be untenable since three of the workers had recently suffered bereavements, as had their team leader. Each of them needed time off to deal with their grief. Where this was not fully acknowledged, the worker herself then became ill, so that subsequent work with the CAT family had to be carried out at a slower pace to allow her more time off for grieving.

Grief work cannot be rushed

This was such important learning for CAT that we did not get it at first, despite the many family losses through illness, accidents, and
death that staff at the family-finding unit had suffered from the outset of the project. We reluctantly postponed for a few weeks the start of work with our pilot families, but only because, coincidentally, Mr A and Mrs B had also suffered parental losses, which meant the additional loss of a grandparent for the children in their new families.

Writing this twelve years later, after recently experiencing an unexpected family bereavement, I am much more aware of how intrusive grief is. The reviewing and reworking of lost relationships can become a major preoccupation, making everyday living and work or study seem a distraction from the griefwork that demands its own process and pacing. When this learning is applied to work with bereft children in new families, the need for flexible timing and support for child and carers by skilled and empathic therapists cannot be overemphasized.

What we have also learnt through experience is that the loss of a "conflicted attachment" is likely to stir up a much more complex mix of emotions. It might require a far longer period of mourning and reworking of the past than relationships that have been relatively straightforward and mutually rewarding. However, this mourning, though perhaps more painful, can ultimately be just as transformative and enriching.

*Life story work is an ongoing process*

Griefwork can be done through therapeutic life story work (Figure 15) with child and carer. It will need to acknowledge the importance of the child’s often “conflicted attachments”, and his probable confusion of emotions and preoccupation with the past, before he can start to settle in his new “family” and feel safe enough to trust and form new attachments there. (See Figures 8 and 9, pp. 65, 66.)

Life story work should carry a “health warning”: carers need to be prepared for the possibility that, because such griefwork is so painful, their child might regress in behaviours and act much worse before things start slowly to improve. The carers might need to be reminded of our reactions as adults to reviewing painful events and losses, and our natural reluctance to undertake such work. Indeed, for adults to appreciate the magnitude of the task we expect bereft children to
undertake, we would have to compare, if not the loss of our own parent, that of another much loved adult, whom we are now expected to replace with a complete stranger, and not of our choosing.

If such work is done sensitively with children and their adoptive parents, it can really help to build their attachment. Ironically, this is a circular process, as shown in Figures 8 and 9, pp. 65, 66. For a child to feel safe enough to undertake such painful griefwork, she will need to feel sufficiently settled and supported, with her new family providing a secure base. Moreover, in order to foster her beginning attachment to them, she will need to “detach” to some extent from previous carers, or even her birth parents, in order to review those relationships and, if appropriate, to withdraw some of the emotional energy she had invested in previous attachments.

The timing is, therefore, crucial when starting life story work, and there are different views on this. The manager of the family-finding unit commented at the time of the CAT pilot project:
It has raised many questions for me about why children suffer such attachment difficulties when they have lived in their present homes for a considerable time. Therefore, is it the right answer to deliver this service when the child is in a permanent home or should a part of the work be completed either at the rehabilitation stage or to help children to adjust in foster homes? It has also reconfirmed a strong view I have that ALL children should have a “life story book”, regardless of whether they are moving on or returning home. And that all social workers need to be aware of its value and to actively promote the use of this book in order to prevent children from having gaps in their background history due to the lack of continuity suffered in placement.

Ideally, life story work should be able to draw on background information and photographs provided by the birth and extended families and previous foster carers. This helps the child to piece together where he has been previously and why he has had to move, with so many losses of people and places, including neighbours and school friends and perhaps pets, too, that were special to him. (See also Appendix B.)

Life story books, when prepared by a child care social worker or adoption or other specialist worker, are often regarded as the be-all and end-all of therapeutic work with a child and might be “frozen in time”, so that there is no ongoing link to the child’s current life with a new family. However, these books can be excellent tools for undertaking griefwork with the child, with support for him being provided by the new parents, who should in turn be supported by professionals through this often quite painful process. If members of the birth family can also be involved, there could be some mutual healing.

Some workers organize “A life appreciation day”, when significant people—family members, foster carers, and professionals—are invited to come together to share their memories of a child and significant information about her background to add to her story in a celebration of her life. A video or other recording of this day can then be added to the child’s “Treasure Chest” of memories. It would be prudent to make a copy of any such recording for everyday use, as indeed of life story material, since these precious and often irreplaceable treasures might be attacked and even destroyed by the child in a fit of temper or self-hatred.
Life story work with Alicia

Family B, who had adopted Alicia as an abandoned baby from an institution abroad, made every effort to obtain as much information as they could about her family and her homeland. They took videos of her in the institution on their first visits to her there, as well as after she joined their family in Britain. Despite the language barrier, they managed to locate her parents and travelled to meet with them, taking precious photographs of them and her older siblings. These became very important to share with Alicia as she grew older.

Although reluctant at first to bring up a very painful past for Alicia, Mrs B prepared a life story book during our work with the family. We were interested to note that she had integrated photographs of Alicia’s birth family and her homeland with those of the child in her new home and adoptive family. So, although not chronologically in order, the book was current and relevant and able to be more easily spoken about and shown to Alicia from a very young age. In recent years she and the Bs have revisited her homeland, giving her, as a teenager, a much-needed opportunity to learn at first hand about its culture and language and people, and so to form a better sense of who she is and literally where she has come from.

A manager’s perspective

Following the pilot project in 1996, the manager of the hard-pressed family-finding unit had commented:

The CAT Programme has been a pulling together of theories, hopes, and ideals that often lie dormant for many workers. Most practitioners want to improve their own practice and, likewise, Local Authorities want to maximize on the skills and commitment of their workers, thus providing a quality service.

If ideas are to be developed, the best way is through practice rather than theory: using techniques that have been tried and tested as well as trying out complementary innovations. In the Family Placement Service there is probably more opportunity to take an overview of the whole of the Services for Children, as, sadly, we are most often dealing with the effects of less than ideal parenting and children who have been both traumatized and damaged by their experiences. The Adoption Agency has the unique opportunity to
look at the whole of the child’s life, including periods of being “accommodated” and living with birth families.

It is with regret that I have to say that there have been, and are still, times when I consider that the Service to Children can be unintentionally abusive because it is thought that there are no local resources to meet the individual needs of specific children. The Department has then made placements with specialist Agencies at enormous cost when it could provide those services “in house”. I have experienced at first hand children returning from expensive “out of county” placements where the marketing of facilities and skills far exceeds the actual return for the child. The question that this raised for my team centred around the notion that it was also because there is often insufficient recognition of the skills of the workers as well as a lack of confidence on their part as individuals to challenge the “experts”.

The CAT Programme has, on the positive side, focused thinking, raised morale, and challenged many ideas. It has also given the workers the confidence to recognize their skills and to use them in a more creative way that is both child-centred but also time-limited. I am aware of similar work that is ongoing with an adult focus, but not one which specifically focuses on the child.

The reverse of this has been the need to constantly remind the CAT team that there is a lack of time that can be specifically allocated since the Programme cannot take precedence over our responsibility to also fulfil the other statutory functions of the Adoption Agency.

As a manager, it has been difficult to grapple with the changes that are an inevitable part of such a project, and to constantly assess and fine-tune what is an incomplete Programme at this stage, due to the small number of cases that have been involved. [The team, consisting of two pairs of CAT therapists, were unable to work intensively with more than two families during the six-month pilot project.]

I have no doubt that the Programme will be of benefit to many families and that the workers in turn will continue to grow in confidence as CAT develops.

Learning from family A1

When we became involved with the CAT Programme, the couple that we chose to work with had actually had their children in place-
ment for six months. So, in a sense, the study for us has been retrospective. When children are placed for adoption, work begins immediately within the new family group, so we saw the Programme as being preventive, as well as curative of any attachment problems. Using CAT preventively, we consider its importance lies in helping parents view attachment problems as a difference in family dynamics, given the new relationships, rather than pathologizing the child placed.

During the standard “Form F” assessment, prospective adopters are encouraged to look at their parenting capacity; once children are in placement, the theory, so to speak, is put to the test. When providing post-placement support, we encourage adopters to look at their perceived parenting skills in relation to the child or children’s actual behaviour and responses. For new parents it is very often “trial and error” in working out how to handle behaviour problems. Through helping parents to isolate particular disturbing forms of behaviour, and concentrating on those, small goals can be set and are seen to be achievable. Star charts include both parent and child interactions.

Observing children with new parents, and particularly children with attachment difficulties, it is important for parents to acknowledge that the children newly placed cannot be expected to have a sense of belonging to them, and that a lot of the child’s anger and hurt, often expressed through bad behaviour, belongs more appropriately to previous carers, including birth parents.

We encourage parents not to take the misbehaviour as being personally directed at themselves, but to deal with it on a more practical level: certain thought-through responses to a particular behaviour. Placements are then less likely to fail because the adopters do not feel so overwhelmed and rejected on account of the child’s chaotic behaviour.

The CAT Programme helps parents to identify specific responses to various “non-attached behaviours”. They can then explore with the worker ways in which they can create a sense of trust in their child by responding positively and encouragingly, rather than with anger and rejection. It is also very encouraging for parents to look back and acknowledge their parenting skills and to witness positive changes, however small, in their children’s behaviour.
We see the elements of the CcAT Programme as essential in work with families post-placement. We feel that by building on the already established skills of their adoption workers, all families could be offered this type of intervention with varying degrees of intensity.

Further thoughts on CcAT²

Looking at attachment research, and understanding how any break in the early “bonding cycle” can cause such destructive interactions, helps to focus the work with both the child and the parents. The beauty of this intervention is that it combines assessment with treatment and involves the whole family in a potentially healing experience since it promotes communication and mutual understanding.

Chloe’s story

Family A, with whom we worked on the CcAT pilot project, had a recent adoptive placement of two small, very damaged, attachment-disordered siblings. Chloe and Darren were chaotic and would quite happily have gone home with me or the postman or anyone who was nice to them! They had no sense of danger and their sensory development was stunted. They were beautiful children but demanding and exhausting.

We had started the pilot project by giving a questionnaire to Mr and Mrs A to complete (see Appendix A1). They scored the children very low on “attachment behaviours”, as demonstrating little or none. This questionnaire proved to be a lifeline for the adopters, since it was updated every few weeks and they could then identify small changes in the children’s behaviour that would otherwise have been missed. Mr and Mrs A could now positively identify change, however little. They were learning to read the cues their children presented to them, and their responses (Appendix 1B) became more and more appropriate, further encouraging their bonding with the children.

I could give many examples, but the following one always sticks in my mind. I was reading a story to Chloe (aged three), a pop-up book about
insects. On one page there was a beef-burger with lettuce in it, and inside the lettuce was a caterpillar. Darren, at five, was delighted to see this and immediately started to frighten his little sister. Chloe’s face crumpled. She began to cry, scrambled off my knee, ran over to her adoptive mother’s lap and snuggled up to be comforted.

Mrs A was too concerned with Darren’s teasing to appreciate the significance of Chloe’s spontaneous behaviour, so I asked her, “What do you think happened there?” “He’s such a wind-up,” she replied. Mrs A was amazed and tearful when I pointed out that Chloe had sought comfort from her and not cuddled up to me, as she would previously have done. Chloe now identified Mrs A as a source of safety and comfort, evidencing her growing attachment and trust. It was such a simple thing, but the adoptive mother had missed the cue. Her response was directed towards the offending sibling, rather than holding this precious moment of bonding with her distressed daughter.

One of the most valuable aspects of CcAT has been that it teaches all family members to be aware of cues and responses, since if cues are misread, they can inhibit attachment rather than foster it. It sounds simple, but how many times do parents say, “I just don’t understand them!”; or children complain that their parents do not understand them, or are unfair. If cues are read correctly, responses become positive and mutually satisfying.

Within the attachment dyad, if interactions are not mutually pleasing, the relationship breaks down. Parents need to feel needed and loved just as children need to feel secure, safe, and loved. If parents get nothing but negative responses, the gap between parent and child grows bigger so that mutual distrust and rejection become the only way each knows how to respond to the other. (See Figure 10.) If this pattern can be interrupted and a new cycle of mutually satisfying behaviours engendered, the relationship can be healed and parents become protective of their children who, in turn, start to feel more secure and trusting.

The CcAT Programme works with family members individually and jointly, as needed. Many therapists work with the child only, simply feeding back to the parent, or sometimes giving no feedback at all. Our belief is that there aren’t “problem children”, but “families with problems”. The parents must be part of any therapeutic work that seeks to modify challenging or negative behaviours, because unless the parents change the way they respond to their
child, i.e., reading cues successfully, the child will be unable to break the negative interaction cycle on their own. Even if the child’s behaviour can be changed, repeated negative responses from the parents will prevent true healing.

When I worked with CAT families, we would look at cues and responses in the context of the family’s dynamics, since the child was never “the problem” on their own. Incorporating any stranger into your home is difficult, and each member of the family needs to be aware of their role in it and how they view other members. Sculpting is one very visual way of letting families see how relationships actually are: where family members position themselves in relation to others, how they perceive each other’s roles, and what their expectations are of each other. These must be open and understood for family life to succeed and healthy attachments to form.

The CAT Programme takes everyone’s views into account and feeds these back, however painful for the parents to hear, so that defensive stances and beliefs can be explored and rectified. The therapeutic work is intensive and often difficult, but it really does move families forward.

During adoption assessments, couples/families feel they are under the microscope and that their very souls are laid bare. This is a cathartic process, and essential if parents are to be able to foster attachments to emotionally damaged and distrustful children. Adopters need to fully understand how they have come to be the people they are and why they hold certain values and beliefs. Adults who show an ability to form and maintain secure attachments themselves will be more successful in parenting emotionally hurt children. The CAT Programme spends time with the parents and helps them to see how their own upbringing can impact on the way that they then go on to parent.

Parents often repress difficult feelings and memories of the past that have never been dealt with. These may suddenly be re-awakened when they themselves become a parent (Fraiberg, Adelson, & Shapiro, 1975). So, adults who have never had satisfying parenting themselves might find themselves being expected to provide just that! The negative responses they received when young are then more likely to be unconsciously transferred in replicative scripts (Byng-Hall, 1995) to their birth or adopted children, often with devastating consequences.
The attachment cycle also becomes a sort of inheritance line, with dysfunction passed from one generation to the next. This is amplified where adopters take on already damaged children with conflicted attachment histories. This can lead sometimes to further risk of harm, since insecure attachments negate the feelings of protection normally felt by parents with strong and healthy attachments to their children. (See Figure 4, p. 27.)

*Learning from family B*

*Alicia’s story*

Alicia was referred to Cc AT at three years old because of her “irrational violent responses”, attributed to the severe neglect and ill treatment she had experienced during her first eighteen months of life, lying confined in a cot in a hospital abroad. When Mr B had first visited its “Abandoned Children’s Ward” he had chosen Alicia to be their adopted daughter. She was only six months old then and, of all the babies in the ward, she had been most responsive to him (cues and responses). However, Alicia subsequently lost her early developmental gains because of the gross neglect she experienced in that ward over the following year.

Videos taken by Mr B during his two visits to Alicia in that hospital over a ten-month period confirmed a general deterioration in her state. At sixteen months, Alicia was barely able to sit up without support, let alone pull herself into sitting or standing or even crawling position. She made no eye contact and stared at her hands with a vacant look, just like a “Spitz baby”. Alicia seemed now to be also visually and hearing-impaired, showing no reactions to overtures or noises. She sought no attention and, unlike the other babies in that ward, she did not ask to be picked up whenever strangers appeared. She had, in effect, given up hope of interacting with a caring and responsive adult.

The medical director of the hospital described Alicia to the Bs as “mentally handicapped”, and indeed their video pictures suggested institution-induced autism or “hospitalism” (Spitz, 1945). The Bs did not know if this were reversible or whether their toddler was already too brain-damaged by her first year and a half of privation to ever catch up developmentally.

I already knew the Bs, having carried out their adoption assessment during the previous year. So within a few days of her joining her new
family in Britain, I visited Alicia as her “welfare supervisor” for the purpose of the adoption proceedings. She could now sit in a high chair and maintain eye contact with the Bs, but she looked through me as if I were invisible. There had been concern about her hearing ability, since she had seemed impervious to the noise of crying babies and the loud voices of the staff in the institution when the Bs had visited her. Now, they speculated that Alicia’s apparent non-hearing and non-seeing were self-protective, to shut out the constant impingements on her sensitive self in that harsh environment.

On subsequent visits, I observed marked gains in the toddler’s development. Alicia was bright and able to understand simple instructions; although she had no speech as yet, she could communicate her needs non-verbally. She was friendly and approached me at once when I visited, even though I was a stranger. Alicia began to relate to me directly, lifting her arms to be picked up. Standing on my lap, she would then minutely examine my face, neck, and hair, turning my head this way and that, as if I were a doll, and she were still a baby.

Alicia’s global developmental delay necessitated a lot of one-to-one attention and teaching by the Bs. Her eye contact and interactions steadily improved, as did her physical co-ordination and progress. The Bs’ early concerns that she might have cerebral palsy or autism soon proved to be unfounded. Alicia learnt to sit up on her own, then crawl, stand, climb, and, in time, to walk and even run, always showing great curiosity about everything. She loved being outdoors, as she had been confined for her first eighteen months in a hospital cot with very little besides cockroaches on the wall to observe.

Alicia was obsessed with creepy crawlies, skin blemishes (like moles), spectacles, and rings worn by people. She had to be taught by the Bs that she could not have people’s spectacles, if they were being worn, or their rings! She would try to pull mine off, treating my hands as if they were objects that were not attached to me. Alicia refused to be confined by a seat belt when travelling by car, and she preferred to wear no clothes. All of these behaviours could be linked to her early experiences of prolonged confinement, but they were exhausting to the Bs.

Within fifteen months of Alicia’s arrival, Mrs B admitted to having severe problems in managing the little girl’s behaviours to the point where she felt that their new daughter was destroying their family. Alicia’s almost miraculous progress with the Bs and her lively and responsive personality had masked the increasing difficulties they were experiencing in dealing with her wilfulness and mega-tantrums.
Alicia was, in brief, controlling and very aggressive, especially towards Mrs B. She was indiscriminately affectionate with strangers, with a tendency to wander off at will. She was unable to comply with simple requests for co-operation by the family, draining them all with her prolonged screaming outbursts from morning till night.

Knowing the Bs were very experienced in child care, I was at first surprised to learn that this charming little girl could cause such havoc in their previously well-ordered household. Nearly three years old by now, Alicia did not speak any English but clearly understood it and was frustrated by her inability to express her feelings and wants verbally. Her explosive tantrums would begin from 5 a.m. when she woke up; they sometimes lasted all day. Her frustration often centred around Mr B, whose sole attention she demanded whenever he came home from work, effectively “capturing” him, to the detriment of their other family relationships (Byng-Hall, 1995, p. 163). Alicia was correspondingly quite dismissive towards Mrs B, who felt increasingly rejected by, and angry with, the little girl and Mr B for his greater tolerance of her misbehaviours.

**CAT interventions**

We identified with the Bs that the major issues for them were currently:

- *Effective management of Alicia’s escalating tantrums*, including a consistent approach, since there was a tendency by Mr B in particular to be very permissive with her, perhaps in an attempt to compensate for her eighteen months’ confinement in a hospital cot;
- *Alicia’s primary attachment to Mr B*, who had chosen her from the many babies in the hospital ward, needed to be shared with Mrs B, who had full time care of her;
- *Protection*: the child’s reluctance to accept any restraints when outside, and her overfriendliness with strangers, put her at risk of harm.

We felt there were other issues for the family which included:

- *Losses*: these were multiple for Alicia (family, culture, language, country) and for the Bs (the need to extend their family
through adoption because of their second son’s hereditary illness, and the recent death of Mrs B’s mother). All these losses needed to be acknowledged and mourned.

We co-worked with the family over a six-month period: in individual, couple, and parent–child sessions, and, through discussion and play-work, in weekly two-hour sessions either at their home or at the family-finding unit.

Play-work, with boundary-setting, proved to be crucial to the success of our work with Alicia and Mrs B in particular. The little girl seemed intuitively to know that the play sessions were her “special time” with her mother, not to be encroached on by adult preoccupations. She would shush us if we spoke! As a play specialist, Pauline was quickly able to engage with Alicia, maintaining clear boundaries, and gradually drawing in her mother into nurturing play that the little girl spontaneously initiated. Mrs B was able to see Alicia in a different light, and therefore to offer her appropriate nurturing and a chance to regress to baby behaviours before expecting her to move on as a three-year-old.

In Pauline Sear’s words:

Ground rules were established at the onset of the sessions within a boundaried play space which afforded Alicia containment in a non-threatening environment. This boundaried area provided a safe inner haven for the little girl which, over time, proved that Alicia was able to explore and accept limitations in play. This led to increased positive interactions with her mother who was able to observe and respond to her daughter’s requests for nurturing (cues).

Alicia enjoyed exploratory play, often in silence, while she chose which toys she would use. She appeared to have a great need to be nurtured, and showed this in her play with baby dolls. Alicia could be very loving and needed close physical contact with her mother, but she was also very demanding if she wanted something NOW! If her demands were not met at once, she would tantrum like a much younger child.

As the weekly sessions progressed, it became evident that Alicia was able to play happily, with very few tantrums. The joint play with her mother was managed within the same ground rules and
limits. Shared, spontaneous play initiated by Alicia was reinforced by Mrs B, who felt “freed” to enjoy and encourage this positive side of her daughter. Early on in one session, after wrapping a small blanket around herself, Alicia sought the comfort of Mrs B’s lap, curled up, and went to sleep for the duration of the session.

Mrs B was then able to use this time to explore her own unacknowledged inner child feelings about this little daughter who was now being given special time and attention in a way that she, as an eldest daughter in her own birth family, had never had the luxury of enjoying. I felt that Alicia had intuited her mother’s need and so allowed Mrs B “special time” with me while she slept.

Subsequent sessions were then geared for Alicia and her mother to play together, for instructions to be given and understood, and consistency to be maintained. Mrs B was able to observe the toys that Alicia chose, how she used them, and how she was able to communicate her unspoken needs. The mother was encouraged to focus on some of Alicia’s demands and to change negative patterns of interaction in which they had both been stuck.

Mrs B was thus able to see the value of this special play-time with Alicia in building their attachment as mother and daughter. Alicia also learnt to cope with frustration in the sessions, e.g., not being allowed to take a pair of sunglasses from the toy box away with her, or Maeja’s rings. This, too, provided modelling for Mrs B.

**Family work.** Relationships had, almost inevitably, become skewed in this family, given the very different and competing needs of Alicia and the B’s two teenage sons; one was totally disabled and the other extremely capable. The Bs had been mentally prepared for a smaller version of their disabled son, but not for the volatile, aggressive, and lively little girl that Alicia had turned out to be. Mr B now felt very guilty about so burdening his wife and sons. Having spent three weeks on his own with Alicia while abroad, he had developed a close relationship with her. This made it much more difficult for Mrs B to take over the mothering role with the little girl, who kept pushing her away (miscues and responses. See Figure 4, p. 27).

Both parents were very aware of Alicia’s history of privation and physical restrictions, including being routinely swaddled in her cot. They had, therefore, been reluctant to apply normal restraints when she misbehaved, as she increasingly did with them. However,
their lack of boundary-setting provoked even more alarming behaviours by Alicia, including running away, in her unconscious attempts to elicit secure holding by them. Caught in an increasingly “negative spiral of interaction”, these previously confident parents had become quite bemused by the confusing cues Alicia was giving them both.

We therefore focused on helping the family to reinforce normal boundaries of behaviour. We also encouraged Mr B to relinquish the “mothering role” to his wife and to support her in setting limits for Alicia.

The Bs did some very sensitive life story work with Alicia, using videos taken of her while abroad to begin to tell her story during one of our home visits. Despite her limited vocabulary, the little girl seemed to understand a little as, silently, she watched herself on screen in the institution and then with the Bs both abroad and later in Britain. We all recognized this was only the start of ongoing work that the parents would need to do with Alicia over the years to help her understand more and more of her story as she got older.

Making positive changes. The Bs were in crisis over Alicia’s escalating tantrums when they agreed to participate in the CcAT pilot project. Their willingness to try new strategies soon helped them to take charge appropriately as adults and “hold” Alicia both physically and emotionally. This assisted her, in turn, to acquire much needed self-control and social skills. Joining a playgroup also greatly helped, along with her acquisition of a growing English vocabulary to communicate her feelings and needs more effectively than throwing tantrums.

The B’s elder son, William, aged fourteen, proved to be an excellent ally in this family work, since he could be more objective than his parents, who got caught up emotionally in Alicia’s tantrums. William himself pointed out the need for Alicia to be treated consistently, regardless of the context (e.g., car travel), so that she knew what to expect and felt more secure. (Alicia was brought by car to Britain from abroad by the Bs, who were strangers to her. At an unconscious level, therefore, she might have associated car travel with confinement and being taken away by strangers. She might also have had an unconscious resistance to learning a “foreign” language, since she was three years old by now but barely spoke any English.)
Mrs B fed back that she had found some of our CAT interventions intrusive, and she questioned our linking of issues from the past with their difficulties in parenting Alicia more effectively in the present. However, Mrs B acknowledged that participation in the project had helped to change their attitude to discipline as well as her own to “growing closer through play in a peaceful environment” with her forceful little daughter.

Mrs B also acknowledged that her now altered expectations of Alicia’s behaviour in potentially problematic situations did make some difference to the outcome. It seemed likely that Alicia herself felt safer since her mother was taking charge of the situation as a parent, instead of being undermined by her tantrums and perhaps then responding inappropriately. (See Chapter Seven.)

Learning from “control group” families C and D

It was enormously helpful to us in this pilot project to compare the effectiveness of brief focused therapy with CAT families A and B and that of ongoing work with two families, C and D, not included in the project, but with whom we were involved over a much longer period.

Work with family C

Edward’s story

Edward was only seven when we first met him, but he already had a history of playgroup and infant school failures. As a bright five-year-old, he had been expelled from his first infant school after only three weeks there, since he could not be safely contained in that setting. We learnt that the large classroom was open plan in layout which, not surprisingly perhaps with hindsight, added to Edward’s own anxieties about being contained there safely.

His behaviours were soon deemed to be too disruptive to be managed in an ordinary primary school setting, and he had no schooling for almost a year before spending a few weeks in a small educational assessment unit. It was then decided that Edward had “special educational needs”, and so he was placed in a school for children with
“moderate learning difficulties”. This assessment was based on Edward’s behavioural and emotional presentation, despite his considerable intelligence and an innate resourcefulness.

Edward had been removed from his mother’s care soon after birth because of her gross neglect of his older brothers and sisters. He was placed shortly after with experienced foster carers, and Mr and Mrs C were introduced to Edward when he was just eleven months old. His adoption by them, heavily contested by the birth parents, had taken four years to finalize. This prolonged period of uncertainty about Edward’s future with the Cs seemed to have left the new family in an emotional limbo. We learnt much later that the adopters had indeed never felt able to claim Edward as their son. He had been so attached to his foster carers when the Cs met him, they almost felt that they had stolen him.

The teachers, like his parents, were having considerable difficulty in containing this seven-year-old, who kept running away, at every opportunity it seemed, from school as well as from home. Edward disliked changes of any kind, and, if not properly prepared for a new situation, he would simply run away. Edward had also begun to shoplift, and, as he ran further and further away on his own to local parks, his sexualized behaviour raised considerable concerns for his safety during these escapades. Edward was verbally and physically aggressive towards his parents, teachers, and his peers, and he quite often posed a danger to himself and others.

The police were frequently involved, not only because they were called out when Edward went missing, but also because he had begun to dial 999 himself from public call boxes and would usually ask for the Fire Brigade or another emergency service. The parents and school were naturally annoyed and embarrassed by Edward’s constant raising of an “alarm” to professionals of one sort or another, and there was much blaming of each other for his misbehaviours.

In his drawing of a house for us in an early session, Edward made sure it included a burglar alarm and had strong fences, indicating his general feelings of insecurity at home. Mr and Mrs C then informed us that they did not feel safe in their neighbourhood. Edward had clearly picked up their anxieties about living there.

The parents’ inability to “metabolise and contain” (Bion, 1978) their own anxious feelings had led to a role-reversal for Edward, who felt unheld by them.
The Cs felt with increasing despair that they were the wrong parents for Edward and, unfortunately, the school had come to the same conclusion. After his every misdemeanour, the head would call the parents to task as if they were naughty children who needed correction, just like Edward himself. The Cs were a modest and unassuming couple who felt increasingly undermined and deskill in their parental role. They were completely unable to predict what Edward would do next to alarm or shame them further. They believed that the whole neighbourhood knew about their inadequacies as parents.

Pre-\textit{CAT} Pilot Project work

The Cs’ anxiety about not being the right parents for Edward began to transfer itself to us, too. Were they able to protect him? Were they committed to his placement with them, or was it near breakdown because of his ongoing misbehaviours? Why was he acting like this anyway in “a nice family”, which, if anything, over-indulged him as their only child. We had yet to learn from our \textit{CAT} work with family B about the crucial importance of boundary-setting to help a child feel safe and contained.

The Cs then described to us how, on a recent day trip to London, Edward had not only refused to sit with them when travelling by tube, but then began to play a game where he would get off the crowded train on his own when it stopped at each station before jumping on board again just before the doors closed! The parents remained seated, doing nothing to intervene, as they had felt so mortified by Edward’s earlier vociferous rejection of them. They seemed unaware of just how dangerous his behaviour was, or that they were failing to protect Edward by not claiming him publicly as their son and holding him firmly, despite embarrassment at his likely protests.

As with Family B, it was the parents’ over-permissiveness which alerted us to the absence of the attachment-protection dynamic in Edward’s case. Like Alicia, he was running further and further afield and putting himself at ever greater risk in a desperate and unconscious attempt to provoke safe containment by the Cs. However, in their feelings of shame and inadequacy, they distanced themselves even more from him.

We learnt much later that the couple had had very little time to grieve over their inability to have a child of their own before
Edward was placed with them. The Cs themselves had only recently been helped during their intensive “attachment therapy” week at the Post-Adoption Centre in London to grieve over the loss of their “ideal child”. This, they had imagined, would have been a quiet, blonde, blue-eyed little girl, whom they felt would have been the perfect match for them.

Instead, Edward, as their “real child”, was stockily built, dark-haired, and boisterous. The Cs had never been able to claim Edward as their adopted son. They thought from the start that he did not fit into their family. They still felt he belonged to his foster parents, who had cared for him from soon after birth.

We later learnt that even using his name had been problematic for the Cs, since a disliked relative was called “Edward”. However, they did not feel entitled to give their new son a different name since he had been known as “Edward” for eleven months already. The positive aspect of this was that the Cs had been able to empathize with how confused the little boy might have felt about the sudden and simultaneous loss of his name and identity as well as of his foster family and home and all that he was familiar with.

We could now better understand why Edward found changes of any kind so difficult. Finding Edward too much to manage on her own, even in his first few months with them, Mrs C sought to address the problem by taking him to three different mother-and-toddler groups each week. The constant change in environment and people must have been overwhelming for this sensitive little toddler, who, more than anything, needed stability and security. Edward reacted with tantrums to any change, alarming his worried adopters even more. His increasingly challenging behaviours since placement had fully taxed all their resources.

Meanwhile, the Cs remained highly ambivalent towards Edward throughout the protracted adoption proceedings, believing—perhaps even unconsciously hoping—that he would soon be returned by Court Order to his birth family. After a last-minute courtroom drama involving his very angry and distraught mother, the Cs could scarcely believe that they were Edward’s legal parents at last and now fully responsible for him. It seemed that their thought of “losing” Edward in the contest for him with his birth parents had got in the way of their attaching fully to him and claiming him as their son.
The Cs’ thinking may also have been conveyed unconsciously to the little boy, who proceeded to “act out” being lost by frequently running away from the puzzled adopters. In what had become a negative spiral of interaction, they felt more and more rejected by Edward and less and less able to claim him as their son and protect him appropriately, containing him physically and emotionally as he so desperately needed.

Nevertheless, Mrs C must have retained some hope for Edward, since she persuaded me quite early on to refer the family to “experts” for treatment. She had heard that the Post-Adoption Centre in London was offering attachment therapy, and they accepted the Cs in their pilot project in August 1995. Pauline Sear and I got some useful learning from our observations there, which helped us to design our own “child-centred” model of attachment therapy.

CAT-influenced work with family C

Mrs C had found the intensive week of treatment at the Post-Adoption Centre in London very helpful and empowering. However, we still needed to continue to support the family locally. Pauline and I learnt, through working in this way, that careful planning and preparation for intensive therapy, with a routine follow-up period to reinforce new learning, monitor progress, and provide skilled support, are essential to the success of any programme of family intervention.

The Cs disclosed that they often felt undermined as adults by Edward’s challenging behaviours, so they would end up responding to him quite inappropriately in child self mode. This was not surprising, and we later heard the same from his headmaster and a very experienced respite carer who knew Edward well. His forcefulness, logic, and constant challenges to adult authority tended to wear down otherwise competent and confident adults, including his teachers, in their belief that they were right in any conflict with this seven-year-old child.

The Cs increasingly ineffectual responses to Edward’s miscues (see Figure 4, p. 27) had the effect of reinforcing his very early feelings. These were of being frighteningly out of control in a dangerously unpredictable world where any change was alarming.
Edward, therefore, sought to control every aspect of his life, while treating his parents as other children whom he needed to look after (see Holmes, 2004, p. 183).

This was very poignantly illustrated by Edward’s behaviours when the Cs suddenly decided, quite foolhardily we thought, to take this runaway child on a week’s holiday abroad. They reported no major incident until one morning when Mrs C’s parents, who had accompanied them, remained in the hotel while the couple and Edward strolled to a nearby shop to buy a local paper. As they were about to leave the shop, the skies opened and there was a sudden and very heavy downpour. Before they could decide what to do, Edward had disappeared.

Frantic that he could easily get lost in a foreign country, Mr C went in search of him while Mrs C hurried back in the rain to the hotel to tell her parents that they would all have to go searching for him. But Edward was already back, desperately trying to convince his bewildered grandparents that he needed a large towel to run back with to the shop so that he could provide shelter for his parents from the rain! Edward could not have expressed more eloquently how much he loved his parents, but also that he perceived them as rather inept children whom he needed to protect. He had indeed claimed the Cs, but not in a parental role!

**Play-work**

Pauline’s play-work with Edward was invaluable in helping the parents to set appropriate boundaries to hold and protect him. We continued to see the couple jointly for a year in all to support them in taking charge as his parents. In Pauline’s words:

Edward presented as a chaotic child when he first came in for play sessions. He was unable to settle for even the shortest time, choosing instead to walk and run around the play area. He did this for the first two sessions, and his anxiety seemed very high. He spoke little to me then, but would pick up various toys and quickly put them down again, barely looking at them.

After Edward gradually began to settle and look comfortable, I scheduled weekly sessions for the following two months. I structured these very carefully in order to establish a secure base for
Edward, maintaining firm boundaries, consistency, and ground rules so that he would have some sense of containment within the session.

We then moved on to indirect, less structured play within a tight therapeutic framework. This enabled Edward to gain in confidence and make choices, as he developed a growing sense of “self”. He began to recognize his positive and negative choices, to change direction in his play, and his behaviours, too, over time. Edward then began to communicate his feelings verbally. Previously, he had “acted these out” quite negatively and often very dangerously, as when he would run away from school for long periods at a time and cause his parents and teachers great concern for his safety.

The picture that emerged over time was of a strong-willed, but sometimes scared young boy who was often confused by his parents’ and the school’s somewhat inconsistent holding. Edward needed firm boundaries to correct the role reversal that sometimes occurred in his family, with him acting as “controlling parent” and Mr and Mrs C responding in “helpless child” mode. The Cs were encouraged to participate in some joint work with Edward, taking charge verbally and non-verbally as his parents, and setting clear rules. This helped to relieve him of his perceived responsibility for them, and to enjoy being more of a child himself.

Making positive changes

Life story work. Pauline supported the family in doing a new life story book with Edward to include his seven years with them, since his original book had been prepared by a social worker before his move as a baby to the Cs. This time, Edward could choose what went into his book, and he decided to exclude all photographs and references to his birth family. He wanted to belong to his adoptive family and was not yet ready to tolerate the ambivalence inherent in the adoptive child’s position of straddling two families.

Mr C needed reinforcement in his role as Edward’s father, and to support his wife in her mothering of this very challenging young child, who could still “act out” his anxieties quite dangerously at times. However, Mrs C’s more relaxed and creative responses to Edward made a considerable difference. His teacher, too, learnt to deal with his disruptive behaviours at school by de-escalating conflict. Edward proved responsive to greater structure in his life.
and clearer boundary-setting by his parents, as indeed he had been in play sessions with Pauline. As with Alicia in family B, Edward knew what he needed and had been unconsciously “acting out” his anxieties to elicit this containment.

Pauline and I decided that further involvement by us with this family was contraindicated, since Mrs C was expressing the family’s dependence on us for functioning well, although in reality she and her husband had always had to deal with their child’s recalcitrance and consequences. We ended work with the family a year after their intensive week’s therapy at the Post Adoption Centre in London. We were now confident that the Cs had the resources to continue to parent Edward more effectively. A twinkle in her eye at our final session made us realize that Mrs C had benefited from having so much professional attention, although she actually enjoyed rising to challenges herself.

As a postscript to Edward’s story, we learnt a few years later that Mr C had a sudden heart attack one day, soon after leaving their home with his wife and son. It was Edward, now just eleven years of age, who recognized the signs from watching medical dramas on TV and rushed to a neighbour’s house to ask her to call an ambulance at once. Edward undoubtedly helped to save his father’s life by getting him immediate treatment.

_Learning from family D_

_Donna’s story_

Donna was a single parent with “moderate learning difficulties”. I had worked with her for many years, initially as an adoption worker in helping to place her baby, and later through psychotherapy to help her grieve her many child and family losses. When Donna became pregnant again, old childhood and adult hurts resurfaced. My increasing concerns about her ability to care safely and effectively for her new son prompted me after some months to involve Pauline Sear in working with both mother and child. This period overlapped with our starting work on the CAT pilot project, so that we became increasingly clear about our objectives in working with Donna, and how to set about achieving these.
In Pauline’s words:

Donna and Charlie, aged one, began play sessions with me because of concerns about the baby’s delayed development and the mother’s seeming inability to meet his needs.

Donna had received very little positive parenting herself, and she had difficulty in coping with Charlie in a calm and encouraging way. I sought early on to engage Donna in interactive play with her baby, but she did not seem to know what to do. Her anxiety about appearing “stupid” might have been transferred to Charlie, who would pick up toys and simply throw them around. Embarrassed, Donna would then tell him off sharply, and Charlie would start to scream, confirming her in her feelings of failure as a mother.

In a following session, Donna ventured to play with the dolls house and small family figures on her own. I encouraged her in this “free play”, and gradually included Charlie in it to help them interact more positively. As her own “inner child” needs began to be met, Donna would laugh out loud when Charlie began to share toys with her. Simple ball-rolling across the floor gave both a great deal of pleasure.

On her first visit with me to a local park, Donna felt too anxious to allow Charlie the simple pleasure of walking on grass; she chose instead to carry him between the different play facilities. Her anxiety might have communicated itself to Charlie, who screamed for a couple of minutes, without tears; he only quietened after being put by her in a baby swing and rocked gently. Later, she was able to let him toddle around a little on his own.

We then learnt that Donna could only ever remember being taken once to the park as a small child. Her mother died shortly after, and she was put in a local children’s home while the rest of her family emigrated. An abandoned child herself, she did not know how to meet her real baby’s needs. Donna responded reluctantly to my firm expectations about her parental role, and was very slow to engage in nurturing and stimulating play with her son because of her fear of failure.

With hindsight, this intervention with mother and child may have been much more effective if condensed into a very focused and time-limited programme of our co-working, with ongoing
therapeutic support from me for Donna’s learning much-needed parenting skills from Pauline, since I had already established with her a relatively “secure base” from the years we had worked together. What I learnt now was that, while my previous psychotherapeutic work with Donna had been boundaried and containing, I had somehow drifted into relatively woolly social work mode since the birth of her baby.

As Donna had no childcare support, I sometimes saw her with the baby and at other times he was looked after by a worker downstairs. We had no agreed focus for our work together at this time and, being less boundaried now, I could not contain her own anxiety or mine about her actual parenting capacity. I slowly and painfully learnt that the more I responded in “helpful” mode to Donna’s learnt helplessness, the angrier and more disabled she felt. Caring for a helpless baby had brought up all her own disabled, abused, neglected, and rejected child self issues, her “ghosts in the nursery” (Fraiberg, Adelson, & Shapiro, 1975). Afraid of being shown up as stupid, Donna refused to learn new, playful ways of interacting with her baby, or how to parent him more effectively.

Salzberger-Wittenberg (1970) describes the predicament of the caseworker in such cases and recommends:

> It is important to strive to do as little as possible, for any active intervention tends to infantilise the client, lead to inertia, to resentment and persecution as well as to promote despair about not being able to cope oneself. The worker has constantly to sort out whether she is being manipulated, drawn into fitting in with the unrealistic wishes of the client, colluding with his destructive parts, and/or helping him to avoid facing inner conflicts by externalising his problems. In all these instances, she would not be helping the client to cope with anxiety and would undermine the struggle towards growth. [p. 159]

**Conclusion**

For a short while, it had seemed that moving from helpless, hurt, and bereft child self mode to developing her more competent adult potential was greatly boosted by Donna’s own healthy wish to learn how to be a better mother to her new baby. Realistically,
however, even with more focused and sustained therapeutic support, this may have been too big a task for Donna, given her own learning impairment and the child’s greater need for stimulation because of his global developmental delay.

My increased expectations of Donna, and the everyday demands made on her as a parent, were more than she could cope with. Our work together ended when I introduced her to a HomeStart befriending scheme for local support. Sadly, we later learnt that Charlie, too, was removed from her care and placed for adoption, since she was not able to meet his developmental needs.

I might have needed to acknowledge much earlier that Donna was so badly damaged by her childhood and young adult experiences of repeated rejection, abandonment, and abuse that she could not offer safe parenting to her own children. In that case, CcAT could have been used for necessary “detachment” work to help Donna prepare for the loss of this son, too, and carry out further griefwork.

Contact with Charlie after adoption could also have been negotiated in a way that would have been beneficial to both him and his mother, but these are all after-thoughts. We were no longer in touch with Donna and so, sadly, we were unable to offer her any further support.

**Overall learning from the pilot project**

The CcAT team, like the County Focus Group of senior adoption practitioners, which had met bi-monthly to reflect on the work carried out with families A and B, learnt a great deal about the potential of attachment therapy even in the limited timescale of six months for the pilot project.

1. From a co-ordinator’s point of view, I realized how important it was to set aside a consistent time each week to carry out such challenging work and to reflect on it with colleagues afterwards. Monthly consultation with Dr Stella Acquarone, an experienced parent–infant psychotherapist, had fortunately been agreed from the start. Her insights were invaluable in helping us to understand the family dynamics when we felt
stuck. Thus, we were able to make important breakthroughs to help the parents move on.

2. From a management point of view, and with hindsight, more time should have been allowed for the pilot project to include provision for peer supervision and CAT team meetings, as well as the inevitable holidays, sick leave, and other contingencies that arose. This would have facilitated our intensive family work, and the planning, preparation, and reflection that were needed to carry it out effectively. The concurrent family losses experienced by four of the five CAT team members meant that additional time off was needed for bereavement work by the workers themselves before we could attend to the pilot families' losses and help them with their griefwork.

3. We learnt that, for effective work, the family have to be equal partners in our joint venture. We have to share information honestly with them, thus providing a secure base from which to explore the perceived problem(s), and foster trust and attachment and shared learning (Figure 16.)

4. Firm holding of personal, professional, and family boundaries is crucial in this work, which often uncovers child protection issues.

5. We realized more clearly the interdependence of the different quadrants of the attachment–protection cycle (Figure 17): the direct expression of feelings by the child; consistent and appropriate meeting of her needs by the carer to create a secure base, with firm holding of boundaries. This helps the child to feel safely held, worthy of protection, and so to act more predictably, giving and receiving appropriate cues and responses to have her needs met. In turn, the carer feels validated as parent, and entitled to provide care to this particular child; so he claims and protects the child as his own, thus providing safety for the child and the whole family.

6. We learnt—through comparing our longer and more open-ended work with our control group families C and D—about the value of doing focused time-limited work, since time is also an important boundary. This counteracts the tendency for individual or family work to otherwise be more woolly and drift indefinitely, with fewer long-term benefits for families in crisis and overburdened workers.
7. The child’s overt problem may indicate the focus of work needed with the family. In the case of family B, the child’s unmanageable temper tantrums were the original reason for referral to CAT. Work with the family helped Alicia to express her feelings and needs appropriately, and this was facilitated by her learning to speak English. However, we were then left with the underlying issue: the parents’ inability to speak for themselves. They had so much unexpressed grief, as she did, too, and unconsciously they might have projected their inadmissible feelings and needs on to Alicia, which she then had to express for the family without language.
8. We learnt from Edward and his parents that life story work is an ongoing process, which requires the workers to be attuned to the changing developmental needs of a new family, and to support the child’s growing attachment to them. In this way, his necessary mourning for the loss of his birth family and previous foster carers could be supported by his adoptive parents at a more opportune time for them all in the future.

9. When considering the griefwork that needs to be undertaken with hurt children who suffer multiple family and other losses each time they are moved to a new “home”, there are enormous resource implications for providing timely and skilled therapeutic support for them and their carers (Figure 18).

*Figure 17.* Attachment–protection cycle: creating “a secure base” and safety.
10. I had worked with the Cs over a period of two years, the second year overlapping with our involvement with the CAT pilot project. Inevitably, there was cross-fertilization of learning and insights from the Cs and our pilot family B, which informed and enriched our work with both families. What was most helpful in changing our approach to working with Edward and his parents was our learning from the pilot project to do time-limited and focused work with them, too. This helped us to wean the Cs off dependence on us, since, in reality, they were a competent and resourceful family.

Notes

1. This section of the chapter is contributed by Maggie Gall and Margaret Saxby.
2. This section of the chapter is contributed by Maggie Gall.
3. This section of the chapter was co-authored with Pauline Sear.
Phase 3 of the project (1997–2007)  
CAT as an independent attachment therapy with birth, extended, foster, and step-families: our further learning from families

**CAT as therapeutic assessment**

Our pilot project with adoptive families taught us that truth-telling is an essential boundary in our therapeutic work with children, adults, and families, keeping both them and us safe. (see Figure 16 and Chapter Six). They could otherwise find themselves in potentially abusive situations through our collusion with their parenting failures or “acting out” of old unconscious scripts in response to the child’s learnt behaviours.

Our ongoing work with our control group families C and D (described in Chapter Four, above) highlighted these points of learning, as we realized that the CAT Programme could easily be adapted to meet the needs of birth, extended, foster, and step-families too.

Indeed, the “child protection” element integral to attachment work suggested that CAT could be used very effectively in “therapeutic assessments”, by helping struggling families to safely contain children who might otherwise have to be removed from them because of Social Services’ concerns (see Chapter Six).
Family E’s story

Our thinking about therapeutic assessments arose from our involvement quite early on with family E, who separated after allegations were made by an older adopted daughter against the father. She was moved to a foster home near her birth family, from whom she had been removed as a small child after severe sexual abuse by them.

Mrs E immediately left the marital home with their younger daughter, whose weekly contact thereafter with Mr E had to be supervised by a social worker, who happened to be me. I became increasingly aware of the family’s distress after they were referred to prominent psychiatrists for protracted child, parent, and family assessments. These, like the Court proceedings, dragged on for well over a year, while Mr E got more and more depressed living on his own. The deterioration in his state and living conditions seemed to be taken as evidence of his guilt, which we were not able to comment on.

What became clear to us was that assessments for the Court, like any other intervention, can be therapeutic or not. The moment we begin to ask questions, memories that are called to mind and shared are already being reflected upon and altered, consciously or not. We therefore decided very early on that, in our joint explorations with families of their stated difficulties, CAT would combine assessment and treatment from the outset. This then led to our offering “therapeutic assessments” where children were at risk of harm (Figure 19).

The schooling of families

Frankie’s story was educational, in more senses than one.

Frankie’s story

Mr N, a legal executive, came to our first CAT session carrying two huge files. They were filled with correspondence with the local education authority about what he regarded as the school’s failure to meet his adopted son’s need. This was countered by the school’s views about the parents’ failure to curb Frankie’s disruptive behaviours in class.
The parents had also got into a “negative spiral of interaction” with Frankie at home, where he was totally unco-operative. As we worked with them, we realized that Mr and Mrs N had no effective boundaries to contain Frankie safely. He seemed very immature for thirteen, and showed little potential for change. However, for the third session, we made a home visit, and then saw Frankie in literally a different light. In an aside to Mr N about a forthcoming parents’ evening at school later that week, and the need for him to obtain appointments for them with each of his teachers, Frankie warned his father, “And you’ll have to be on time—it’s a school rule!” We all listened in astonishment to Frankie, whose stated problem was that he seemed incapable of following rules either at home or at school. It was now evident that the problem was home-based, since Frankie had learnt that the school stuck by its rules while his parents did not abide by theirs.

In an aside to Mr N about a forthcoming parents’ evening at school later that week, and the need for him to obtain appointments for them with each of his teachers, Frankie warned his father, “And you’ll have to be on time—it’s a school rule!” We all listened in astonishment to Frankie, whose stated problem was that he seemed incapable of following rules either at home or at school. It was now evident that the problem was home-based, since Frankie had learnt that the school stuck by its rules while his parents did not abide by theirs.

We knew that, if Frankie could follow rules in one setting, he was capable of doing so in another. The work that needed to be done with the Ns was to help them to prioritize their needs as a family and do some simple rule-setting with Frankie that they could all follow. Feeling more securely held at home, his behaviours improved both there and at school.

Figure 19. CAT as an assessment, treatment, and review in partnership with the family.
Family-generated solutions can work better

Families have innate healing resources that can be accessed by them to create new solutions to old problems. These solutions, because they originate from within the family, are more likely to be congruent with its culture than those suggested by professionals, and therefore more acceptable to its members.

We discovered early on that some of the foster carers had a perhaps unconscious vested interest in our suggestions not working for them. The reasoning seemed to be that, if we succeeded where they had failed, they would be shown up as less than effective parents. So, the child whose placement was near disruption tended to be pathologized, and our efforts to help the family would be rubbed out outright or simply ignored.

We had to learn how to help families access their own creative resources, and our teachers were family J.

Ben’s story

Mr and Mrs J were older, experienced foster carers with grown-up sons and daughters and young grandchildren. They had offered a home some months previously to Ben, the younger brother of a teenage girl, Gilly, whom they had cared for since she was little. We already knew that Ben had been through multiple placements, and seemed likely to add this one to his list of disruptions. He was aggressive and unruly at home, and had joined a group of delinquent boys at school. Ben was unsettled in the family and very jealous of Gilly’s long-standing relationship with the carers, who were over-protective towards her because of her learning difficulties.

Mr J had traditional views on child-rearing. His sanctions for the children, and Ben in particular, included getting them to write 1000 times: “I will not do (the offending behaviour)”. Since the subconscious mind tends to ignore negatives, this punishment seemed more likely to reinforce the offending behaviour. Indeed, Ben often ended up being given 5000 lines to write before he had even set off for school in the morning. This would undoubtedly have left him in an unco-operative mood and more likely to misbehave for the rest of the day.

We were curious to know what actually occurred to cause these early morning upsets, and we soon discovered that the family had got stuck
in a negative spiral of interaction. Mr J would wake the children up early and they would start arguing from then on: over their choice of cereals, where they would sit to watch television, jostling each other to get first through a doorway, and then insult each other as they ate their breakfast.

The teenagers also fought physically, and Ben was invariably blamed for hurting Gilly, who quietly provoked him, unknown to the parents. There were other issues of safety, too, since both children had been sexually abused while living with their birth family. We had to encourage Gilly and Ben to maintain firm personal boundaries, including in their bedrooms, as neither currently had any privacy from the other.

We did not seem to be getting very far with the family. Whatever we suggested, Mr J’s immediate response would be that they had “been there, tried it, and it did not work”! Then Gilly herself suggested a variant of the usual “behaviours” star chart they had previously tried and dismissed. Her idea was accepted: that they be given two gold stars for each time she and Ben said something nice to or about each other. This was a turning point for the family who started to reinforce positive behaviours instead of focusing on negative ones.

Ben was allowed to find his own place in the family, instead of having to fight with Gilly to share hers. Their sibling rivalry diminished, and they became good friends, protective of each other.

Like Edward in family C (see “Edward’s story” in Chapter Four), Ben went on to help save Mr J’s life a year or so later. He ran to call out a nurse who lived nearby when the foster carer had a heart attack and needed immediate resuscitation. Waiting for an ambulance to arrive would have been much too late. A hero in the family now, Ben settled down at school, too, and later went on to college, just as the J’s older children had done. Ben was now happily following the family tradition and Mr and Mrs J were immensely proud of his achievements. They had claimed him as their son.

Mrs J generously attributed the success of Ben’s placement to CAT, but each family member had to play their part in working towards making positive changes and maintaining them.

**Marital difficulties might be the real problem**

We worked with some families where, although the concerns expressed were about the child, the real problem lay in the parents’ marital relationship.
Molly’s story

Molly was thirteen when she was referred to CAT, as her long-standing foster placement had disrupted. The carers stated their concerns for Molly’s safety, both if she remained with them and if she returned to her still chaotic and emotionally abusive birth mother in another part of the country. Molly kept running away to be with her mother, just as her older sister had done the previous year. She would get unsettling telephone calls from both, and she was painfully torn between her conflicting loyalties to birth family and foster carers.

Molly was very clear-thinking and articulate, but we were unable to do any family work since the carers would not engage honestly with us. We then discovered that they themselves were at crisis point, as their marriage was ending. They did not want to look at their own difficulties, which had contributed to the breakdown of what they described as a previously stable and mutually rewarding placement.

Child protection concerns can be exacerbated in situations of marital conflict

Rico’s story

Mr and Mrs F were professionals from abroad and had referred their three-year old son, Rico, to us as they were concerned about his social withdrawal. They believed that he was autistic and had been sexually abused by the caretaker at the nursery he attended. However, we were not clear whether their complaint had been investigated.

Rico was difficult to engage in interactive play, and he did seem to be obsessional: he kept miming a lift going up and down, with doors opening wide and closing; later, we wondered if this play represented hope appearing in, and disappearing from, his young life.

Mr F spoke English well, but his wife did not. So Mr F acted as interpreter in our early sessions, and conveyed in a matter-of-fact way what his wife said, including that he was deliberately making her mad. She seemed obsessively jealous and to suspect him of having girlfriends everywhere, at college during the day and in their block of flats at night. He added casually, as a further indication of her irrational thinking, that she also accused him of sexually abusing Rico. It was not until
we spoke to Mrs F on her own in a subsequent session that we realized she meant this.

We advised her to contact her local Social Services—which she did. We had been misled by Mr F’s apparent openness as spokesman and not realized in time that they were actually seeking help to be a safe family for their son. Following Social Services involvement, the family split up and Mrs F returned to her homeland with Rico. Mr F remained in England to complete his college studies. We were not informed of the outcome of the Child Protection Investigation in this case, or whether the parents were offered any therapeutic support, separately or together.

The child referred may not be the only one in the family who needs help

This situation occurred frequently, so that we were constantly shifting attention from the identified child client to others in the family who also needed help, or were somehow maintaining the problem. So much so that, if a child was described as the only one in the family with behavioural problems, we would take it as a cue to explore how the better-behaved siblings were contributing to this situation.

In “Ben’s story”, above (see family J), Gilly used to quietly wind up her brother to get him into trouble with the carers, because she had resented his joining their family and her then having to share their attention with him. As the family work progressed, Gilly’s temper tantrums became more frequent and we offered her some individual sessions to help her express her feelings. Despite her inherited “learning difficulties”, Gilly was emotionally intelligent and able to articulate her frustration at not being listened to by Mr J in particular. We were then able to address this issue in family sessions and help them to communicate better.

Some of the carers we worked with, however, were not willing to end the scapegoating of a particular child and to look at our sometimes serious concerns about other children in the family. Family G was among those unwilling to commit themselves to such painful exploration with us, although the wife went on to train in marital counselling.
Christy’s story

Mr and Mrs G were experienced foster carers. They had adult children from their previous marriages and a teenage daughter from this one. She was the same age as Christy, who had been referred to CAT for ongoing behavioural problems. Christy was another displaced young person, exiled from her birth family, community, and county, as she was moved from one disrupted placement to another.

The Gs were genuinely fond of Christy and wanted to help her to settle in their family. However, our sessions soon revealed that the Gs’ own daughter was depressed and also needed help. The parents were unwilling to address her difficulties, and so Christy had become a scapegoat for the family’s malfunctioning. Predictably, her placement with the Gs soon ended, although she was able to stay in contact with them and seek their support when she became pregnant not long afterwards.

Birth families, like family T, can demonstrate the same dynamic.

Rachel’s story

Rachel was thirteen and referred to CAT by her mother for increasing behaviour problems. In individual work with Pauline, and a joint family session, Rachel was able to convey her view of the family difficulties clearly and calmly. It seemed that an older brother, reported to be adversely affected by her misbehaviours, contributed to these, but Mr T did not want to hear this. He would not attend further family sessions, leaving the burden of change to rest on Rachel’s young shoulders. She saw Pauline twice more on her own.

Mrs T was torn between conflicting loyalties to her husband and daughter. Without the parents’ commitment to making positive changes that would have benefited them all, Rachel could not succeed on her own. As with so many mislabelled children, her “naughty” behaviours were an unconscious cry for help for the family.

Johnny’s story

There was a happier outcome for this adoptive family.

Johnny was only ten years old when he was referred to CAT for severely disruptive behaviours at home and at school. We learnt that
he had mega-tantrums that would often end in his throwing some of his bedroom furniture downstairs, while his adoptive parents helplessly telephoned Mr M’s elderly parents for adult reinforcement. Increasingly, that did not work for them, and they now resorted to summoning the police for help in containing Johnny. We heard that it had taken six adults to restrain him in a recent outburst, although Johnny presented as a pleasantly spoken and quite playful child, easy to engage with.

We were intrigued when we learnt that Johnny was in a swimming squad at school with early morning training sessions starting promptly at 6 a.m.; if he got there even a minute late, he was not allowed to join in. Yet Johnny readily accepted the coach’s tough discipline, reminding us how Frankie N (see “Frankie’s story”, above) had been able to follow school rules while remaining unruly at home.

Mr and Mrs M were very family-centred and worked well as a team. They needed to do so in order to chauffeur Johnny to his daily morning or afternoon swimming sessions or the regular Saturday “swim meets” in which he took part; as well as transporting their older son, Daniel, to his scouting activities. The Ms were a mild-mannered couple who did not seem able to take charge as parents and enforce clear boundaries. Daniel was a sensitive and intelligent boy who had apparently been well behaved until recently. He was now vying with Johnny for negative attention, perhaps jealous of his younger brother’s swimming prowess.

The parents had adopted the boys as babies, and did not seem to know why they had now become so aggressive. Daniel’s joining Johnny in tantruming behaviours seemed to be new. The older brother was typecast as the “good, quiet child” while Johnny had always had the role of “naughty boy” in the family. In fact, Daniel was quietly provocative of his brother’s over-the-top outbursts, and Mrs M often sat between the two boys on a settee to stop them kicking at each other! We had to demonstrate to her that they were quite capable of sitting next to each other and playing a game together quietly, and that this was our expectation of their behaviour on our premises.

We then learnt that, as a child, Mrs M had dreaded going home after school since she could not stop her older brothers from fighting in the absence of their mother, who was at work. So, Mrs M had begun to revert to helpless child mode whenever she saw her two sons now in conflict. This gave them an increasing sense of power over her, and Mr M often had to leave home late for work in the mornings in order to
ensure that both boys were in the car ready to be driven to school by their mother. This meant he returned home too late in the evenings to have any leisure time to spend with the boys then. Thus, Mrs M had little respite from their continual squabbling, and was both physically and emotionally exhausted.

With so much daily hassle, the Ms did not find their sons rewarding to care for and the boys were equally unhappy. They attended a church-run school where bullying was the norm, as were insults about pupils’ mothers. For an adopted child like Johnny, who had never known his birth mother, this was like holding up a red rag to the bull. He was in constant fights and resulting trouble at school. The Ms felt so badly about themselves as adoptive parents, they seemed unable to claim their sons as their own and be strong advocates for them in this very unsatisfactory school situation.

It took several sessions of individual and joint work with the whole family before the situation eased at home and both boys were able to sit together in the back of a car without coming to blows. In one family session, when we asked them to draw a picture of themselves having a day out together, their isolation from each other was poignantly depicted in their drawings. The pictures showed them sitting quite separate from each other, even at the picnic meals drawn by the boys and their father. Mrs M drew a seaside scene, with her and her husband sunbathing on deckchairs while the boys played separately on the beach; this was the most positive of their pictures.

Things did get better over time. Johnny felt heard by us and his parents and his behaviours gradually improved both at home and at school, where he had become a swimming star. Daniel developed an interest in computers, and the boys squabbled less.

Mrs M was considering taking up part-time work. We encouraged this, as we felt it would improve her self-esteem and give her a much-needed sense of achievement. She had been a full-time mother since the boys were babies, and had felt a failure in this role once they had grown older. Mrs M needed permission to be a “working mother”, as her mother had been, and not to be worrying about the boys always fighting, as her brothers used to; in effect, to withdraw from Johnny and Daniel her child self projections of her violent brothers.

Mr M now returned earlier from work since he could leave home on time in the mornings. He was able to go on cycle rides with the boys and generally spend more “fun-time” with them, reclaiming his role and authority as their father. This freed Mrs M further from feeling
totally responsible for Johnny and Daniel, and their interactions with each other. She began to explore her own potential as a person.

**Siblings can help each other**

We had some moving sessions where siblings were helpful to each other.

**Leonie’s story**

Family O were referred to CAT because of their concerns about their two unrelated adopted children, Andrew, who was eight, and Leonie, who was just five years old. Her placement was near disruption as Mrs O could not manage her tantruming behaviours at home and seemed to regard the child as a little monster. Both children had been removed from their respective birth families because of severe neglect of them as babies. They had each been in foster care for a while before being placed separately, when toddlers, with the Os. There were still medical concerns about Andrew, who was very underweight.

In one session, while we were talking to the parents, we noticed that the children were quietly playing “mummies and babies” together. They had pulled together cushions to make a “bed” on the floor and Andrew lay on this, covered by Leonie with a light baby blanket. She then came to ask Pauline Sear to fill a baby bottle with orange squash, and proceeded to give this to Andrew. He drank it contentedly, while Leonie held the bottle to his mouth as if he were a baby. The little girl had known intuitively that he needed nurturing.

We suggested that Mrs O do the same for Andrew at home, giving him a bottle of milk each evening. Despite his father’s embarrassment that Andrew should be encouraged to regress in this way, Mrs O clearly enjoyed the nurturing time that she had missed out on with her son when he was a baby. She was then able to offer Leonie the same for a while, too, which improved their relationship.

It seems appropriate to end this section with our learning from family L.

This was a birth family of four siblings who had survived gross neglect in their first few years of life with their alcoholic and often violent birth
parents. Daisy, at four years old, used to steal money from her sleeping mother’s purse to buy milk and bread for her starving brothers, especially the baby who was “failing to thrive”. Daisy continued to be fiercely protective of him in contact meetings, once they were removed from home and placed separately in foster care because no one carer could cope with all of them.

The siblings continued to look out for each other during these family contacts, and remained loyal to their birth father, who underwent counselling and rehabilitation in order to reclaim his children. Four years later, after each child had gone through a series of disrupted placements and Daisy’s frenzied attacks on adults could only be contained safely in a children’s home, Social Services was able to acknowledge the damage done to the siblings in the “care” system.

The Department supported the return of the two younger boys to their father’s care.

Their hope was that Daisy would be placed in a local foster home where she could see her beloved father and brothers more often, too. The eldest brother, just twelve years old, chose to remain in his latest foster home where he could appreciate having undivided care and attention from a very committed carer.

We felt that, with ongoing individual and family therapy and practical help, Mr L would probably manage better with his children now than anyone could have foreseen.

Further thoughts on CAT work with families

Over the past several years, many children and young persons came through our door. The patterns and behaviours of their struggling families were all different and yet the same, it seemed. Their attachment, or perhaps the lack of it, provided us with many insights as to how and why some families really struggled to make it work. Always the same thread of “detachment”, in so far as the real relationship between child and parent manifested itself. This was more so when a fostered or adopted child felt isolated, somehow not really fitting in, maybe treated a little differently to birth children. This difference was experienced at the very core, or soul, of the child, and it demonstrated almost every time where the real difficulties lay in the families we worked with.
If the very soul of a child is not nurtured, and she feels unwanted, unloved, misunderstood; if the child is not “fed” love and nurture, then a negative cycle of interactions between child and adult will become the norm. This could lead to the breakdown of the placement. (See Figure 4, Chapter One.)

So it was with the struggling families we worked alongside, trying to change the stuck negative patterns that had brought the family to crisis point in the first place. Most of the families who came our way were in this very situation, scarcely understanding how things could be so bad when the “bonded” family members always got along so well: that is, until the difficult child arrived. Now, it seemed, the family and household were in constant turmoil.

“Normal/OK” families will interact naturally between one another. When a disadvantaged child, or children in some cases, enters the family, the dynamics change considerably. Everyone needs to adjust, and this applies even more to the fostered/adopted child or children. These children will, in most cases, have had several moves, each family different in some, or often many, ways from the placement before. The child feels him/herself already to be the outsider, once again having to “fit in” with a new family.

We all take our day-to-day family life in our stride, saying and doing what we have always known, without giving it a second thought. However, the “stranger” child entering the family has no concept of how this particular family behaves at mealtimes or bedtimes; their bathroom routines; socializing norms; whatever. All this is often utterly bewildering and fraught with anxiety to the newcomer, and “acted out” in misbehaviours, with the child feeling left out and not really belonging. It becomes just another placement in which the child has hardly begun to settle in before she is moved on yet again.

It may seem less rejecting to such children if they consciously or not disrupt the placement through their misbehaviours, rather than wait to be rejected by yet another family. No wonder, then, that these children carry heavy baggage, being moved around like “pass-the-parcel” in the “care” system for most of their young lives.

Many of these children speak the same silent language of sadness and despair, expressed in difficult, often abusive behaviours to themselves or others. And so, the scene will already be set: a constant round of “‘Getting to know you”; “How long will I be
here?”; “I’m the odd one out”; “They all talk and act different to the last family”; “What do I do, who will I ask? Can I ask?”; “Who am I in this family?”; “What am I?”, and so on.

If only grown-ups would listen, really listen, to children, really identify with how a child might be feeling. Listen at a deep level, not simply at the words spilling out, but recalling for ourselves a feeling or experience when we were young to identify with how it might be for that child. How the child may not have the adult words to articulate and explain . . .

Often, we came across families who really cared, who would pull out all the stops to make a foster child feel like part of the family, often sacrificing their own family needs in order to assure her that she was liked and welcomed. Of course, this sometimes had the reverse effect when the family members perhaps said and did things unnaturally for them because there was now a stranger living with them.

The knock-on effect could often be negative reactions by all, despite the good intentions at the outset. A pattern then evolved from the natural core element: attachment or the lack of it. The child’s core self feels unnurtured, misunderstood, threatened. Foster carers struggle to be natural, to like and, ideally, love, and to understand this strange child. It is an unnatural struggle to achieve what should be perfectly natural: the most basic interactions between parent and child fuelled by attachment.

From an adult viewpoint, having grown up in an “OK family”, it may be easy to assume that most children “in care” (“looked after” or “accommodated” children, in current Social Care terminology in England and Wales) would adapt to their new family after the usual honeymoon period. The real test, of course, is when that time is over and reality kicks in. Experience taught us that, for these fostered children, “normal” did not mean much, if anything to them. What, after all, was normal? Each placement had differing expectations, with few being met.

Most adults expect some reward for taking in such hurt children when, instead, there is often a price to pay for their disruptive behaviours. Such children punish before being punished; run away so that their feet, not their tongues, do the talking; lash out before being hit; and are even abusive before being abused, either verbally, emotionally or sexually, or all three.
In all cases, the very reasons CcAT became involved was because some or all of these factors were prevalent—the older the child, and the longer he had been in the “care” system, the more hurt and angry he was likely to be.

And what about the child’s birth family? Most of the children referred to CcAT, while recalling how awful it had been at home, nevertheless wanted to return to their “natural” family. Where children in the care system had contact with their birth families, the very act of leaving them each time to return to their foster homes became an issue, as they were torn between divided loyalties: “Do I belong here or there?” Some children had had a series of family moves before reaching adolescence. How can such children have formed secure attachments to any one carer from early childhood? It would appear instead more like abuse within the “care” system.

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Putting CcAT into practice. There were, in many cases, a real hope and expectations that we could work alongside and support some of the families to better understand together how to help children in these circumstances. I like to think that our Programme offered a unique, tailor-made package of support for each family, since no two families had exactly the same issues. It did not always go according to plan on either side, I am sure. However, there were very few families who did not respond to our way of working.

The CcAT sessions were generally for two hours per session and, depending on the seriousness of concerns, held at weekly or fortnightly intervals. We used each session as ongoing assessment and treatment, and shared our overall findings with the child and family at the tenth session, inviting their feedback, too, so that we could then incorporate it in our final report, and learn from them.

Each session would usually start and end with our seeing the child and parents jointly, or the whole family together for about half an hour. In between, Maeja would work with the adults, while I would engage with the child or children in “play” sessions for an hour.

As with Mrs B in our pilot project, and family D in our control group, I sometimes involved the parents, too, in nurturing play with the child.
Afterwards, we would talk through with the child and parents about their and our understanding of what had transpired, with myself acting as advocate for the child and supporting him in presenting his point of view to the parents. It is often the child who can pinpoint the exact difficulty, as well as the solution. This usually requires a change in behaviour on the part of the adults, which they are not always willing to consider. They might then rubbish what the child says, as well as ourselves as therapists.

All was not gloom and doom, despite what must have been very difficult for some families, airing their hurt and anger and frustration in public, so to speak. And how much more frightening for the children, who were labelled “naughty” and/or “difficult” or “unmanageable”? These children, who perhaps had never been asked an opinion before or deemed worthy of acknowledgement, were now faced with having to be “theraped”. They were expected to tell all in “play”, although this was often referred to as “a waste of time” or “only for little kids” by sceptical parents and sometimes even the older children.

Our aim was to establish a secure base with the child and family over a number of sessions. We encouraged each to contribute very honestly their own thoughts and feelings about the difficulties at home and more realistic expectations of change. An achievable goal for child and parents would usually then be agreed on, with them all reporting on progress in the following session. We found, as might be expected, that the most successful outcomes were related to the full engagement of the child and family, with them proposing their own creative solutions to the problems they experienced.

Informal family meetings held at a set time each week at home, to agree rules and sanctions and monitor progress, often proved to be very helpful in improving their communication all round. The children would often remind the parents about these meetings, and the ground rules for them, including speaking one at a time and respecting each person’s opinion. Once over the immediate crisis, such meetings could incorporate “fun-time” too, e.g., playing a board game together or doing something else together in play.

Over time, our work did have many lighter moments, as families interacted with greater ease and trust in us. Sometimes, for longer lunchtime sessions involving observation of sibling and family attachments and mediation of contact arrangements, we
would suggest that the adults brought food to share and we would also provide some.

Sharing food symbolizes the “breaking of bread” together and mutual nurturing. It was very revealing how some individuals and families interpreted this activity, and whether they were willing to share or not with the other party. Some brought lunch only for themselves and “their” child or children, and were unwilling to taste anyone else’s food. Others generously brought food for all members of the group, indicating their more inclusive attitude to child-rearing. The packed lunches provided also revealed the children’s regular school diet, whether this was healthy or not, and, in any case, their own obvious preferences for certain foods, usually sweets and crisps and chocolate!

The children’s play was also very meaningful. Often they spontaneously began to reveal little nuggets of their untapped inner selves, as sad and not-so-sad memories surfaced in sometimes silent play. The souls of even outwardly tough children seemed to be touched in such play through their unconscious knowing. A slight shifting by hand of a small toy or animal in the sand tray, a change of toy scenery in what might be a war zone or zoo would be so telling (without any words) of how that particular child has perceived, or still perceives, her world. This silent communication, sometimes with an invitation to me or another observing adult to participate, speaks volumes. It goes a long way in telling us how it is for that child without anything being said.

To be allowed to enter a child’s world is indeed a privilege, and must be respected as such. Put another way, how often, as grown-ups, do we expect children to enter our adult world with our demands, and without our paying any attention to whether the children fully understand what exactly we mean. We know, but do they? A wrong word said here and there can alter the whole interaction between child and adult, but do we ever take the time to ask this of ourselves? When once we have said the word, issued the order, as far as the adult is concerned, that is that. There will usually be no concern as to whether the child, in his young mind, understands exactly what we mean, and do we really care at that moment?

On the other hand, how often have we heard the words of a child “You don’t understand”. Easy for adults to dismiss what the
child is communicating when we are so intent on getting our own views and instructions across. Taking time, then, to enter the child’s young world is a giant step to gaining trust, understanding, and the attachment so necessary in making adult–child relationships work. This actually takes no more time, in fact much less time than the endless back-and-forth in arguments and residue of negative feelings.

In summing up attachment or the lack of it for “accommodated” or “looked after” children, one is left to reflect on the reality for many within the “care system”. So many of these children still do not have a voice that is listened to. We expect so much from our children, their capacity to “fit in”, to behave and settle into whichever families are prepared to take them. These children instinctively know that, in many cases, they are merely tolerated, not loved as they deserve to be.

We, as adults, also have a responsibility, which is to ensure that all vulnerable children in our care are listened to on all levels; that they are understood and are fully included in our family, warts and all.

Further learning from children

Yvonne’s story

Years ago, when I first started doing play-work with children, I began to visit a five-year-old girl in her adoptive home as the parents were experiencing difficulties with her tantruming behaviours. I did not know about reactive attachment disorder at the time, and that one of the common traits is having “very angry parents”! Yvonne had a nice, caring, and seemingly “normal” family and home, but why were her parents so angry with her all the time? It only occurred to me much later that this was probably due to a displacement of her negative and therefore unacceptable feelings. Yvonne’s anger and frustration were transferred on to the nearest available emotional “container”, usually her much put-upon adoptive mother.

Yvonne was a pretty little girl, very bright and articulate and with a delightful sense of humour; the sort of child that caring social workers
often said they themselves would want “to take home” and adopt! Again, I only learnt much later that this, in itself, was a warning sign that the child was splitting: being very charming to professionals and outsiders, while revealing all her hurt aspects to her new parents, usually the person in the “mother” role, because of all the rejections and disappointment that the child had experienced in the original birth family.

Yvonne’s birth mother had been very young and mentally ill. She had grossly neglected her baby until Social Services intervened and took the child away, placing Yvonne in a foster home where she was much loved and well cared for. A year or two passed while attempts were made to rehabilitate Yvonne back at home with her mother, but little had changed there and, once again, the child was removed on an emergency basis, even more hurt and neglected this time.

Placed with “emergency” foster carers who could keep Yvonne for only a few months in their very busy household, she was lost there and her needs unnoticed. By three years old, and her next “bridging” placement, Yvonne realized that she could only get attention if she screamed and fought and bit the other small children in the foster home. The foster carers were experienced in dealing with such misbehaviours, but were also very glad to have Yvonne on a temporary basis only, while permanent adoptive parents were sought for her countrywide.

A local family, seeing her picture in a Be My Parent publication (BAAF), were immediately drawn to Yvonne’s pretty face and winning expression. They already had three young sons and desperately wanted a daughter too; Yvonne seemed perfect for this role. A year or more later, the bewildered parents were asking themselves why they had ever thought this. Yvonne came into their lives like a whirlwind, creating chaos and consternation in their hitherto calm household. A sturdy tomboy rather than the feminine little girl they had dreamed of, Yvonne was jealous of the older boys. She fought with them, broke their toys, tantrumed constantly, pushed the exhausted mother away, and was generally unco-operative, so that this placement, too, was now near disruption.

Not really knowing what to do about all this, I intuitively offered to play with Yvonne, with the intention of observing her behaviours myself. I set up weekly sessions at her home and followed her lead in indirect work with her. For a while, I could not really understand what the family’s problem with her was. Yvonne was delightful, and only occasionally a little challenging towards me as an adult.
Then, in our fourth session, bored with our usual activities, Yvonne said she wanted to play a particular board game, one that I was not familiar with. She said it belonged to her brothers and she offered at once to show me how to play the game. Yvonne could not read as yet, and would not let me read the rules myself, so she dictated how the game was to be played. Even according to her own changing rules, Yvonne cheated constantly, leaving me feeling unusually frustrated at losing however I played. I was even more put out by her triumph at this. Since I am not usually competitive when I play with children, I was puzzled by my strong reactions to her winning all the time.

Reflecting on this session later, I realized that Yvonne had unconsciously given me an experience of what it felt like to be her: being moved from one family to another to another, with the adults making up rules she was not aware of or did not understand, so that whatever she did she ended up being in the wrong. Was it any surprise that Yvonne should then tantrum and become so controlling in this, her fifth placement? It was very powerful learning for me that a small child could convey so eloquently, and quite unconsciously, through play what her living experience was like.

Harry’s story

Harry was just five years old when we met him and his adoptive parents after his placement with them disrupted; they were no longer sure that they were the right family for him. We heard that, while still only four, he had told his social worker that he did not need parents. We were less surprised at this when we learnt that his predominant memory of his warring teenage parents was of himself, little more than a toddler, standing between them and shouting at them to “Stop!”, while they threw saucepans at each other in their kitchen.

Like Edward in family C (Chapter Four), Harry genuinely did not see the difference between adults and children or why he should do as he was told to by grown-ups. As far as he could see, the only difference was that the adults were big and he was still very small. So, all he had to do was to grow bigger as quickly as possible. He could then return home and look after his birth parents. Clearly, they had not known how to look after each other or him, which is why he had been removed from their care when little.

We then noticed that Harry seemed to be growing taller at such a pace between our fortnightly or monthly sessions that we began to comment
on it. Each time, his adoptive father, who was tall and strong, would respond by laughingly pressing Harry’s head down as if to squash him and keep him from growing up. It turned out that growing big quickly was a burning issue for this little boy, who had not been able to stop his battling parents from hurting each other when he was only two and still living with them. His adoptive parents had generously told him that they would help him to find his birth family once he reached the age of eighteen, so all Harry wanted to do now was to grow big as fast as he could.

What we then realized was that both Harry and his adopters were allowing his birth parents so much emotional and mental space in his young life that he could not relinquish them and claim his new parents. The adopters, in turn, did not feel they could claim Harry as their son, which led to a whole new spiral of negative interactions . . . and the eventual ending of another placement for him.

Note

1. This section of the chapter, as far as the sub-heading “Further learning from children” is contributed by Pauline Sear.
CHAPTER SIX

Re-evaluating CAT: its potential in child protection work

Risk assessments in child protection work

There are unrealistic public and legal expectations that the risk of child abuse and/or severe neglect can always be accurately predicted by social workers and/or medical, health, and/or psychological experts. These unremitting outside pressures highlight fundamental concerns and contradictions in child protection and fostering and adoption work:

- workers’ personal, professional and social values and accountability;
- the wish to give vulnerable children an optimal experience of family life, even if this means placing them with complete strangers;
- the impossibility of ever being sure that an abused child will not be at risk again, either within his birth family or with new carers who have been assessed as being “safe”.

Social workers have a duty to protect children from suffering “significant harm” through severe neglect or abuse by carers who
may well have been exposed to the same while growing up. Such parents might even themselves have been in the “care system” when young. Despite the Department’s best intentions and endeavours, they may not have been adequately nurtured or even protected from abuse and/or neglect while in foster care or children’s homes.

Awareness of our contribution as professionals, however involuntary, to maintaining this tragic intergenerational cycle of neglect and abuse may spur us to ever greater efforts to ensure the long-term safety and well being of the children of such parents. This has quite often meant their removal from the birth family when young, or even soon after birth, to protect them from parents already known to be failing. Of course, the younger the child is, the easier it is to place her for adoption, and professionals often seem to share the adopters’ fantasy that this fresh start in a new family will wipe out the child’s chequered birth history. For the same reason, all meaningful contact with parents and family members is often quickly severed, as if to avoid ongoing contamination by them.

The sad reality is that “substitute families” are not always that much safer for such hurt children. About twenty years ago, a children’s charity in the north of England (Barnardos, Humberside) discovered that a large percentage of the sexually abused children they had placed were being re-abused in their new families. It was such a shocking finding that the agency rigorously overhauled its assessment procedures to screen out potential sexual offenders. However, even experienced adoption workers and panels cannot totally predict safety or successful outcomes of placements. The most sophisticated preparation and assessment procedures will not guarantee these.

Without blaming the victim, it seems that an already abused child is very vulnerable to further abuse, not just by adults who deliberately set out to exploit his known vulnerability, but by better-intentioned carers who might get drawn into abusive interactional patterns which the child has internalized (see Figure 4, Chapter One).

In counselling adult adoptees who wish to trace their birth families, we repeatedly hear how placements, described as “successful” at the time the Adoption Order was made, have turned out very differently in reality following inevitable family changes: the birth
or placement of another child; the break-up of the adopters’ marriage; the illness or death of an adoptive parent, etc. Quite often, mutual bonding and claiming by child and adopters were not strong enough to survive these blows, and the adoptee was rejected and abandoned again, left with no family to turn to, except the ideal of a birth family whom she now seeks in desperation, despite being informed that she was grossly maltreated by them when young.

Of course, changes can occur in the birth family, too: the support of a new partner or “significant other”, increasing self-awareness, greater maturity and competence, improved self-esteem, and positive models. All these help a parent labelled as “inadequate” or abusive to become more nurturing and protective towards other children in the family. Indeed, the resilience and resourcefulness such parents need to overcome their own adverse childhood experiences tend to be taken for granted, so that risk assessments often stress parenting deficits rather than coping strengths.

Assessment is an intervention that, in itself, can be therapeutic or abusive to the child and family. Crisis theory (Caplan, 1964) suggests that families are most open to change when they are in crisis, and attachment theory indicates that families are more likely to develop an attachment to workers by whom they feel listened to and supported through such difficult times (Fraiberg, 1981). This can earn much-needed trust by the family for further painful work, including possible acknowledgements of abuse or neglect by a perpetrator. Moreover, where harm to the child cannot be proved, the investigation itself might be so traumatizing that the family will need skilled and sensitive support afterwards to regain normality for themselves and their child in their community.

Instead, what often seems to happen is that, following the initial Child Protection investigation, the social workers involved do not undertake any ongoing therapeutic work themselves with the family. The case may be passed quite quickly to a “continuing care team”, where the child care worker may or may not feel able to undertake such skilled work.

The burden of accountability in child protection cases can feel overwhelming and quite deskilling, with more attention being paid to carrying out bureaucratic procedures (“ticking boxes”) as an unconscious defence against organizational anxieties rather than promoting the actual well being of the child and family (Menzies...
Lyth, 1988). With a high risk of burn-out in such work, and the constant turnover of staff in Child Protection Teams, young and/or relatively inexperienced child care workers may be left to carry the brunt of responsibility for the child’s safety. They can end up feeling incapacitated with anxiety about the risks involved, and therefore unable to offer any of their learnt social work skills in helping troubled children and families to explore the pain of their situation and grow together through it.

Instead, an initial referral may be made to a local family centre for “observation and assessment” of parent–child interactions, rather than any therapeutic support being offered to the parents. If family centre staff feel similarly deskilled through anxiety in high risk or controversial cases, a referral may then be made to outside named “experts” to carry out “risk assessments” of the family. These are often more acceptable to the Courts in contested care proceedings, but the emotional costs can be high, especially for the child.

A family might go through assessment after assessment, sometimes with contradictory conclusions, for a year or longer, with intermittent Court hearings for directions about rehabilitation attempts or permanent removal of the child from the family. Meanwhile, the subject of all these protection procedures—the child herself—might be increasingly abused emotionally by default. While lengthy assessments and adversarial proceedings follow their course, the child and her family are often left without therapeutic support to help them deal with what has occurred.

Such assessments may run consecutively or in tandem, thus extending beyond many struggling parents’ endurance the period during which they are observed or remain “on trial”. Ironically, the disempowering and deskilling impact of protracted assessments and legal proceedings can actually increase the risk for some children, who may incur their immature parents’ wrath for being the “cause” of such stressful investigations. Failure to stay the course might then be interpreted as evidence of the parents’ incapacity or lack of commitment to care for the child safely and well enough.

There is also a view that counselling or therapy could reduce the chances of achieving a successful prosecution against perpetrators of abuse. So, parents who deny responsibility for the initial abuse or neglect suffered by the child might have to undergo this whole
process without even social work support. Counselling or family therapy is likely to be offered only to parents who acknowledge their guilt, and/or with whom rehabilitation appears to be a realistic option for the child.

Thus, those families most in need of therapeutic help are least likely to get it, so placing any other children they may have at even greater risk of harm. Furthermore, even severely hurt children might want to renew contact at some time in the future with their birth families. These, however, could still be stuck in what is very often an intergenerational cycle of abuse and neglect.

The more severe the harm suffered, the greater the risk of it occurring again, either within the birth family or with new carers, because of the child’s learnt patterns of behaviour and interaction. Life-changing decisions about a child’s future placement with foster carers or adoptive parents, rather than supporting rehabilitation with birth parents, are often based on the opinions of experts in the field. They have to weigh up the risks of each option and might tend to favour the unknown: the child’s capacity to heal from harm already suffered and to form healthy new attachments to complete strangers. However, these new parents are likely to have their own “ghosts in the nursery” (Fraiberg, Adelson, & Shapiro, 1975) that might surface once the placement is made.

As a social worker, I, too, have believed in giving hurt and deprived babies and young children a fresh start in life through adoption or “permanent” foster care. It was only after I began to work as a therapist with older children whose adoptive and long-term foster placements had broken down, entailing several more moves and multiple losses for them, that I realized how strong the pull remained to their birth family, no matter how damaging or damaged they might have been.

Some of them had come from unsafe communities where children were introduced to drugs very young, and were even bribed to steal cars to fund their addiction. One endearing eight-year-old I briefly worked with was already a gang leader on his council estate, and notorious for terrorizing elderly visitors to the local general hospital. His response to being put in foster care was to keep running back home, several counties away, to make sure that his young mother, a drug-user, was all right. Like other professionals working in this field, I heard many such sobering stories of role...
reversal, with even small children worrying about their failing parents’ safety and well being.

Of course, the very strength of the child’s bond with the birth family, however insecure her attachments to them might have been, would have inhibited her from being willing to trust new adoptive or foster parents and risk putting down roots in her new family.

Robert’s story

Robert, a young boy in foster care, expressed this pull to birth family most poignantly to me: “You don’t know what it’s like . . . when other children at school ask you: ‘Where’s your family?’ It’s like a hole here” (pointing to his stomach). “It will never be filled up unless you can live with your family again when you are grown up.”

Robert and his five siblings had been removed some years previously from a home where the father terrorized and routinely abused, both physically and sexually, all the children, from the smallest one up, as well as their mother. She was completely unable to protect herself or them from her husband’s almost daily assaults on his petrified family. Nevertheless, all Robert wanted was to return home to his mother’s care while placement after placement disrupted because of his inability to settle in a new family, as well as his increasingly sexualized behaviours towards younger children.

Robert was sent at thirteen to a psychiatric unit for disturbed adolescents, for containment until he was eighteen. It is unlikely that any therapeutic work was undertaken at any time with either of his birth parents, who had long separated and gone on to have new relationships. Robert’s older sisters already had young children of their own. These were also considered to be at risk of ongoing abuse by their grandfather who, despite a Court injunction to keep away from his family, kept stalking the children whose local whereabouts he knew.

Helping struggling families to heal and move on

Phase 1 of the CAT pilot project clearly showed how attachment and protection are inextricably linked: Parents or carers need to feel able to claim a child as theirs to protect in order to set appropriate
boundaries to keep her safe. Such claiming and protection can be learnt through fostering mutual attachment: child and family are “held” therapeutically by skilled workers who can facilitate safe exploration of past and present through necessary griefwork. This may involve doing life story work with the child and carers, as well as inner child work to exorcise “ghosts in the nursery” (Fraiberg, Adelson, & Shapiro, 1975) from the parents’ own troubled childhoods (see Figures 16 and 17, pp. 113, 114).

During the 1970s, Fraiberg (1981) and her colleagues developed an innovative attachment therapy programme with failing parents in the context of child protection work in the USA. This offered a skilled and compassionate team approach to both assessing and treating the family from the point of referral onwards, usually starting in the hospital where the child had been admitted because of injuries or severe neglect.

The multi-disciplinary team stressed the importance for parents in crisis of continuity in “attachment” to a therapist to provide a secure base for what is inevitably very difficult and painful work where there has been or may be further “significant harm” suffered by the child. In the UK, Cullen and Batty (1996) brought together British social work, legal, and medical perspectives with the aim of therapeutically supporting the child and non-abusing parent, instead of simply focusing on offenders.

However, the reality for most hard-pressed Children’s Services is that opportunities for doing such crisis intervention work are usually not utilized to the full because of the lack of suitable in-house or local therapeutic resources. The nature and/or extent of harm already suffered can feel so overwhelming that workers, managers, and/or the Court will rightly regard an assessment of further risk as the highest priority before the child’s future placement is determined, within or outside her family.

However, this can lead to the children, as in Family E and Family L (Chapter Five) being left in a legal and emotional limbo for months, if not years, while the parents’ capacity to protect and care adequately for the child is assessed. A series of outside “experts”—psychologists, therapists, psychiatrists, as well as independent social work consultants—may be engaged in an ongoing effort to predict the level of risk if the child remains with, or returns to her family.
Where Social Services can realistically honour their public commitment to keep a child within her nuclear or extended family, it seems far more cost-effective to offer adequate therapeutic resources at the point of the initial child protection investigation. If structures can be put in place to safeguard the child at home, or in an existing foster care or adoptive placement where the child has begun to put down her roots, it makes more sense to build on any existing healthy attachments and so increase the carer’s capacity to claim and protect the child effectively.

The value of CAT in carrying out brief therapeutic assessments

We have long believed that “therapeutic assessments” in some Child Protection cases could be more beneficial to the child and family than what seems to be the norm: protracted assessments by experts before any diagnosis can be made, with appropriate treatment facilities then needing to be identified and funding for their use agreed by the local authority. Starting from the premise that attachment and protection issues are inextricably linked, our stance has been that families who are not too damaged themselves can heal and learn to attach to a hurt child, claiming and protecting her as their own (Figure 20).

Sophie’s story

Our belief was severely tested when we were asked to carry out an assessment of the sibling attachment and placement needs of two little brothers with a failing prospective adopter, Sophie. She had already been informed that they would most probably be removed from her care, since she seemed unable to meet the boys’ physical, emotional, or developmental needs, despite having been offered a lot of post-placement support by experienced and competent social workers. Indeed, our hearts sank when we first visited Sophie’s home and realized that Social Services’ concerns were fully justified.

Over a three-hour visit, we mainly listened to Sophie, attempting to build rapport with her before suggesting any changes in her management of the children. She was very angry at being judged by their social worker who was “not a parent himself and had no idea” of the
Figure 20. Application of the CAT Programme to child protection work.
considerable pressures she had been under since the boys were placed with her the previous year. She had fallen ill soon after and had a series of setbacks, while her hoped-for network of support disintegrated. All this had left her feeling depressed, hopeless, and totally unable to prioritize the children’s needs. If Social Services had not already been carefully monitoring the children, we would have needed to express our own concerns and perhaps even suggested ending the placement straightaway.

We tried hard to look for positives in the home and Sophie’s strengths, as these must have been evident in the past when she was being assessed for adoption and had obviously led to the placement of the two brothers with her. Sophie was known to be a competent businesswoman, but she was clearly not a housewife. And she was only just learning how to be a mother to two very needy little boys who had already suffered neglect in their previous foster placements and birth family.

Jack, aged two, was overfriendly and interacted with us at once, showing no inhibition even though we were complete strangers to him. He was barely walking and talking, while Joey was nearly four but had only recently begun to attend playgroup regularly. He was very anxiously attached to Sophie and found separations from her for any length of time extremely distressing.

My co-therapist, Anne Wardrop, a former Child Protection worker, and I strongly disagreed about Sophie’s and the children’s potential for positive change in what was such a sensitive period for their development. Anne felt very concerned about both children, while I took heart from reports by the health visitor and playgroup leader who were both very encouraging towards Sophie.

A month later, when we next visited, there were a few visible improvements in both children and in Sophie’s demeanour. She may have felt heard by us and was feeling physically stronger. Joey was tantruming a little less, while Jack was now more mobile and Sophie was getting some respite care for him and time to herself at long last.

However, Sophie’s responses to both boys’ demands during our second session were still far from satisfactory: She tended to “baby” Jack, spoon-feeding him on her lap, and she kept him confined in his high chair or in a buggy for much of our visit, before putting him in his cot upstairs for a post-prandial nap. Jack seemed too passive to protest, and only kept calling out good-naturedly for a long time before eventually falling asleep. By our third session, however, Jack was literally
all over the place, refusing to be confined or shushed by Sophie. He was now also getting in the way of his exasperated big brother and competing for Sophie’s attention. We had to regard this as progress for Jack.

Sophie had obviously bribed Joey to “be good” for us, but then withdrew the reward he thought was his already when he kept demanding it. This led to further tantruming by him and more punitive responses by Sophie. Feeling quite helpless, Anne and I witnessed the distress of both mother and child at being locked in this “negative attachment cycle of interaction”. Joey’s hyper-aroused state was matched by Sophie’s increasing anger with him, and they would then connect briefly in mutual remorse and “have a cuddle” before his next tantrum began.

After a while, Anne went to an adjoining room and sat on the floor to engage with Joey, who still seemed to be quite distressed. However, he was responsive to Anne’s overtures and gentle speech, and he seemed to feel understood by her. I focused on Sophie, mainly listening to her tirades against social workers and other professionals (including ourselves), and for being on trial for well over a year. I sought to reinforce the positives we had noted in both boys’ behaviours, and in her own functioning, before suggesting a few changes.

Sophie would not attend any parenting group, but she had found her own resource: a correspondence course in child development. Knowing that social workers were also visiting her and the children regularly, we could relax a little and continue to encourage Sophie in the small steps she was taking towards parenting them more effectively. We realized that she, too, was painfully aware of her failings and, despite her anger, making real attempts at positive changes.

Anne and I continued our debate about the likely damage to the boys if they remained with Sophie or were moved to yet another placement with strangers after a year of starting to form new attachments to her. We seemed to be mirroring the split among other professionals involved with this family. My countertransference to Sophie left me at the end of each visit feeling bad, inadequate, and isolated, while Anne continued to feel very identified with the little boys and sad and upset for them, as did their Child Care Worker, who had known them since they were babies and was very committed to them both. However, she had continued to monitor their placement instead of handing over “welfare supervision” to the Adoption Worker, who was less critical and more supportive of Sophie. Needless to say, these workers did not get on!
Anxiety about the boys’ well being remained high both in our office and in Social Services. We maintained close communication with the social workers as well as with the health visitor and playgroup leader, who were also monitoring the children’s progress. Despite our widely differing perspectives, we managed to work as a “team” to hold this placement, although it still felt very near disruption.

We visited Sophie twice more at monthly intervals and, despite some remaining concerns, felt able to recommend that both boys remain with her provided she was adequately supported by a package of care, including a local therapeutic service and respite care as needed. Nine months later, Sophie informed us with great pride that she had been allowed to adopt them.

Writing about this family now, it seems incredible that Sophie managed such a turnaround in just a few months. I believe that our main contribution was to contain the social workers’ anxiety about the children’s well being by working through our own splitting on the case, which reflected splitting by the other professionals involved too. Anne provided a child-centred perspective by acting as advocate for the children, while I continued to believe in Sophie’s potential for change. Most importantly, Anne and I communicated honestly and respectfully with each other and the other professionals, and so functioned as a multi-disciplinary “secure base” to hold the family during this crucial period when their future together was at stake.

The timing of our assessment was felicitous in that Joey was attending playgroup regularly for the first time in a year. He could now engage in more age-appropriate activities and separate from Sophie in a healthy way, while Jack was able to have “special time” with Sophie for the first time on their own. This helped their bonding, as we noted when she commented on his little achievements and “cheekiness” with pride. Sophie was also now getting more positive comments from her family and others on the boys’ progress, which reflected well on her parenting ability and increased her self-esteem. Most importantly, however, she had new hope of success.

Groopman (2005, p. 193) has researched “hope” for years, and its effect on his cancer patients. He distinguishes hope from optimism, which he believes is not based on reality. Groopman quotes Richard Davidson in describing hope as having two components: cognition and feeling, which are not separate in the brain but interweave and modify each other. Neurolinguistic programming (NLP)
has long taught that, to effect positive changes in our life, we need to change either our thinking, or our feelings, or our physiology: changing one will lead to changes in the other two (“Mercedes model”).

The role of social workers and other professionals in influencing the outcomes of children’s placements would be an interesting subject for research, since self-fulfilling prophecy—either positive or negative—is seldom considered to be a contributing factor. Yet carers, especially if they are inexperienced and lacking in confidence as new parents, can be enormously affected by professionals’ criticism or encouragement of their parenting.

As that very wise and experienced family therapist, Byng-Hall, notes, “I have observed more important shifts in family functioning arising from praising the family’s struggle to manage better than from any other intervention. This is especially important for parenting skills” (1995, p. 200, my emphasis). Byng Hall emphasizes that any “positive labelling” must be genuine and is a necessary first step to then helping parents to reflect on and change dysfunctional and possibly dangerous aspects of their behaviour.

The general rule that whatever is focused on is likely to be reinforced, while whatever is ignored will fade is a useful one. Competent aspects of family behaviour can be noted and labelled. The dysfunctional aspects can be acknowledged, but the focus remains on the strengths. . . . It is easier for parents to talk about those painful issues for which they were expecting criticism if they discover that instead their parenting skills are being supported in front of their partners and their children. [ibid., p. 205]

The reality remains that, whether child or adult, we all respond more positively to genuine praise than to blame and criticism, which simply put us on the defensive. Feeling unheard, we may then continue to seek to justify our behaviours, however reprehensible these may seem to others. Encouragement, however, softens our resistance and makes us more open to looking at options, leading to safer and better ways of functioning.

As Dr Andrew Taylor Still, founder of osteopathy, taught, “To find health should be the object of the doctor. Anyone can find disease.”
CAT therapists’ learning and users’ perspectives; professionals’ perspectives

A local authority perspective

When I left the family-finding unit where CAT had been developed, I did independent work using the same principles to help adoptive families facing disruption. The results were positive and, by stripping relationships back to the bare bones, families learnt to reappraise their ways of reacting to each other. In 1999, I was appointed as a local authority Permanence/Adoption Manager. In this role, I commissioned the CAT team to work with some of the adoptive placements near breakdown. The team were also invited by the child-care team to do family assessments for the courts where parenting was not considered to be “good enough” to keep the child safe.

The CAT philosophy offered struggling birth mothers a chance to explore their own experiences of being parented when young. Rather than just assessing their current parenting skills, which were poor, by allowing mothers the opportunity to address long buried traumas in their own childhood, the team helped these mothers to recognize the reasons why they felt and acted as they did. Abuse, bereavement, domestic violence, dysfunctional family life, and
poverty; we all know these create vulnerable young adults but, when they go on to have children of their own, we somehow expect them to parent well! Social Services will often commission psychological or psychiatric assessments of failing parents, often in tandem with parenting assessments, but such assessments do not equate with *treatment*. That is the uniqueness of the CAT Programme.

CAT is co-worked by two therapists: one who does “play-work” with the child, and the other who works with the parent/carer(s). After about an hour of such individual work, the parent/carer(s) and child come together and are supported in communicating what each has discussed or demonstrated individually with the therapist. These meetings can be painful, but they are safe and contained and enable family members to face each other’s expectations and failings. Strategies for management are agreed and the families are then seen weekly or fortnightly, as appropriate. The Programme is intensive to start with, and families are then weaned off dependence on the therapists by having later sessions at longer intervals, followed by a review at the tenth session of the work done together.

The feedback we received on CAT from families was generally very positive, and we saw major changes in the way the families interacted. For example, one family was brought back from the brink of disruption, and a young birth mother had her toddler returned to her after a year in foster care, although adoption had long been planned by the Child Care Worker. Without CAT involvement, these two outcomes would have been very different.

From a commissioning point of view, referral to CAT led to an immediate offer of an appointment to families in distress, usually with them being seen within two or three weeks. There were no lengthy waiting lists or daunting assessment procedures, whereas with referrals to hard-pressed local Child and Adolescent Mental Health Services (CAMHS) clinics, the wait could be up to a year before even an initial assessment was made. The assessor would then decide what sort of intervention was to be offered, if any. Then it would be back to the waiting lists to see a therapist. Often no therapeutic work was offered until the child was considered to be settled, in a “permanent placement”. By then, placements would most probably have broken down and children moved on, suffering
further losses and damage. The “care system” fails so many young people and families.

My experience of the work and philosophy of the CAT team has been one of growing appreciation. As a practitioner, I see it as an effective way of working, as it has a clearly identifiable impact on family interaction. For adoptive placements, it hugely increased the chances not only of success and stability, but also of mutual satisfaction and deepening relationships which endured. For birth families, it represented the possibility of changing the dysfunctional inheritance line, and preventing children coming into care due to protection issues. It could not always effect change in extreme cases of attachment disorders, but it did enable carers to understand their task and to ease their expectations and help them to appreciate very small changes.

A fostering agency’s perspective

As an organization, we have used the CAT Programme over the years with some of our foster families, as well as for individual work with children and young people placed with them.

Many children placed in foster care are traumatized and, as such, their development is impaired. CAT therapists have helped several such children on referral to our agency to come to understand their feelings of loss and bereavement, and to move on to make healthy new attachments to their foster families. We have worked together with local authorities in situations where the CAT Programme was used successfully with families where placements were at risk of breakdown. Such help is invaluable where children would otherwise have to be moved on again.

As well as offering individual therapy and the CAT Programme, Maeja has offered experiential workshops to foster carers on “Attachment, separation and loss”. Reflecting on their childhood and adult experiences in this way helps new foster carers to empathize with the children placed with them, as well as reintroducing more experienced carers to this essential topic. Staff and our sessional workers have also found this training to be of great value.

[Linda Folwell, Regional Development Manager, Futures for Children]
Users’ perspectives

The researcher undertaking an evaluation of the CcAT pilot project (see Chapter Four) in late 1996 noted the following.

Family A

In assessing the children’s development at the beginning and at the end of the project, the workers noted marked improvement in their schooling, linguistic, and motor skills. Moreover, whereas initially Chloe had inappropriately attached herself to total strangers, by the end of the project she displayed appropriate attachment behaviours to her new parents. She was now more circumspect in her affections towards strangers and extended family members. All these changes were confirmed in the evaluation interview with Mr and Mrs A.

The couple recognized their tendency to “indulge and spoil” the children because of their traumatic past. They were also able to allow the children to regress. The interactive play sessions with both children and parents, therefore, became important in helping to establish firm boundaries.

Life story work enabled the parents to be more open with the children about their family background. Just one year after placement, they were able to have an open contact with the birth family in which Mr and Mrs A “could stand back and allow the birth mother to have her day”.

Family B

At the beginning of the project Mr and Mrs B were very aware of Alicia’s tenuous attachment to them. Despite his closer relationship with the little girl, Mr B did not enjoy parenting Alicia, while Mrs B did not feel entitled to parent her newly placed daughter.

By the end of the project the couple acknowledged that their attitudes towards discipline had changed. Mrs B also felt that she and Alicia had grown closer as a result of the play sessions. A beneficial change in family interactions was noted as Mr B assumed more responsibility for setting boundaries for Alicia, while Mrs B felt more able to relate to the little girl as her mother.

Although the couple initially resisted the idea of doing life story work, they came to appreciate the need for Alicia to learn about her past and
her country and culture. Mrs B then produced a beautiful book, integrating the child’s past and present. (In recent years, they have revisited Alicia’s homeland to give her, as a teenager, a personal perspective of her history and culture.)

Through “inner child” work, Mrs B could acknowledge how her caretaking role in her family of origin had led her to taking on too many responsibilities, even as an adult.

Mrs B’s own view of participation in the pilot project was unequivocal:

You can’t imagine what it was like. If Maeja had not suggested the programme I don’t know what we would have done. Something had to happen. I could feel myself getting more and more depressed. I used to dread each day, which has never happened to me before. But I could feel myself getting so depressed and I couldn’t understand why it was happening. We are both such experienced parents and I’ve given so much advice over the years to my friends. It never occurred to me that we would be unable to cope.

It was affecting everyone in the house. Even my oldest son was upset by it all and the younger one couldn’t understand what was happening. He got so upset because I was with Alicia all the time. She would just sit there screaming and screaming. You felt so helpless and I used to get so frightened in the car because she started attacking me. It was like one long nightmare that you thought would never end. Each night I went to bed feeling totally exhausted and woke up the next morning dreading what would happen.

You can’t imagine the change there has been in Alicia’s behaviour. She still has her obsessions and we both have to be firm with her. But all the screaming has gone and she will do what you tell her. Her language is so much better now and she is doing well at play school.

The researcher speculated that

Mr and Mrs B’s positive image of themselves as “experienced and competent” parents had initially led them to deny the scale of their despair and the disruption of their family life. Arguably, it was only when the programme had ended and they could reaffirm their image as “able and loving parents” that they felt able to acknowledge how desperate they had been for help.
Reflecting now on Alicia’s screaming episodes, her attempts to run away, and attacks on Mrs B in the car in particular, it is likely that the little girl had pre-verbal memories of being suddenly removed by strangers (the Bs) from her familiar setting—bleak and comfortless though the hospital ward was—and driven by car to a foreign country with a completely different language and tonal sounds.

Perhaps Alicia was also screaming at her multiple losses, which no one could understand or help her with, until she began play sessions at three years old with Pauline Sear. The Bs then began to show Alicia a video taken of her in the hospital ward that had been her home for her first eighteen months of life. The video included pictures of herself with the Bs abroad and in her new home. Painful discontinuities between past and present could now be bridged, and new connections literally formed in her brain. Learning to verbalize her feelings in English, rather than tantruming, was also a major help to Alicia at this time. Most importantly, however, the B’s dramatic rescue of their daughter from institutional disablement gave her new hope of a fulfilling life in a caring family.

*Reflections from families ten years on*

We were aware that families in crisis might be much more positive about the benefits of CcAT immediately after the programme ended, and so we wanted to know what the longer term impact was. Before writing this book, feedback questionnaires were sent to about fifty families we had worked with over the years; we got a twenty per cent response rate. (Some of these families had been due to move for various reasons after we stopped work with them, and we did not have their new addresses.)

Several of the families had two or more children who had been involved with CcAT. Most were foster or adoptive families, but a few were birth and extended families, and there were some step-families, too. The latter tended to self-refer and paid for the work themselves; they seemed able to benefit from fewer sessions overall, demonstrating their strong motivation to work on their own issues.

To illustrate this last point, one step-father described the child referred as being “worried about everything in life”. Contact issues with his birth father had been a particular source of anxiety to him and his mother. The family’s feedback was that, during an initial
session, I (Maeja) “spoke to Tyler directly and got to the root of the problem straightaway. He was then ready to take on matters himself, and so no longer needed the programme.”

A long-term foster carer commented on CAT work with her warring teenagers: “The children had been in separate foster homes for some time and did not relate as brother and sister when brought together (at fourteen and fifteen) in one home again.” The carer had found of particular value the “individual support and help to understand each other’s point of view. Also positive reinforcement to the children that nothing was their fault—they both felt they were to blame for being in care.”

CAT comment: The children had been removed from a very abusive and neglectful home situation when just four and five years old. We ourselves felt that the separate work we did with the carers had also helped them to reframe what they had previously seen as just the children’s problems.

Another foster carer had four “short-term” children (unrelated) whom we had worked with at various times. Her comments on CAT work were:

I think they (children) found it hard to start with, speaking to someone about their feelings, but they felt better when they had. It was probably the first time the child and their family had sat down and talked to each other about their problems, and all feedback from the family was good. Unfortunately, only one child returned home. I feel the problems with the other children were more to do with the mothers than the child.

CAT comment: This foster carer had not seen it as part of her role to be involved with our work with the children, especially as she usually had other child care commitments at home. However, this led to her feeling somewhat excluded from the work we did; she felt “there should be more feedback, while still maintaining confidentiality.”

Another foster carer, with two sibling pairs who were referred to CAT at different times, fully participated in the sessions herself and commented:

The children went on an assessment only. We, the carers, benefited from the assessment feedback, which we felt was very useful to us.
It gave us an insight into how the children were feeling about being in care, and the discussion time after the assessment was good.

Another foster carer had three challenging adolescents referred to us at different times. One had individual weekly work over a period of months, with only a few sessions involving the carer. This was pre-\textit{CAT} work, and he was a very troubled young man whose placement sadly disrupted after a few years. He chose to return to his very damaging birth family and deviant community, getting into increasing trouble with the law himself.

The other two adolescents were siblings, whose previous “long-term” placement had just broken down. The older girl (aged fifteen) was desperate to attach to her new carer, and we did some \textit{CAT} work with them and her sister. This enabled the girl to return to full-time schooling and she began to do really well there. The younger sister (aged twelve) was just beginning a rebellious phase and, sadly, the foster carer decided to end both placements as she had undertaken heavy new work commitments. The carer commented that “\textit{CAT} had done all they could for my placements.” She was a down-to-earth carer and found of particular benefit “the kind and tactful way they helped my children cope with their feelings and situation.”

A single foster carer with an extremely challenging nine-year-old, who was sent two years later to a “therapeutic community”, did participate in \textit{CAT} work over a period of time. She commented: “It was very beneficial to both child and carer. We worked together to improve areas that needed extra attention.”

The child had attention deficit hyperactivity disorder (ADHD) and extreme post traumatic stress disorder (PTSD). He and his younger siblings suffered from severe parental neglect and abuse, and were placed in separate foster homes. The carer found \textit{CAT} helpful: “being able to discuss with ease ongoing therapy and any problems.”

An adoptive parent of three siblings had a mixed response: The initial \textit{CAT} work had been favoured because it “made G aware of what a mother’s responsibilities should be. We felt at the time that, with love and consistency, G would adapt into our lifestyle.” However, the adoptive placement ended some years later as “G became resentful and harmful towards his siblings. After numerous
episodes of shoplifting, drug abuse, malicious damage, and arson, we took a decision to seek Social Services help and G currently resides in foster care. His siblings remain with us. Unfortunately they have decided that they no longer wish to have anything to do with G.”

CcAT comment: The adopters attended only a few sessions with the children, and wished to focus exclusively on G’s disruptive behaviours at home and at school. As the eldest “parentified” child in a very neglectful and abusive birth family, he had continued to feel responsible for their removal from home. G had too much emotional energy still invested in his relationship with his birth mother to attach to his new family. They therefore favoured his younger siblings, who were able to make “a fresh start” with them, and this may have angered G further.

In recent feedback from our CcAT pilot project, family B revealed that Alicia (Chapter Four) continued to be a very challenging child over the intervening ten years. Now fourteen, she is at last settling at secondary school and making “real friends who genuinely like her for who she is”. Mrs B commented that she was determined never to give up on Alicia, who is still scarred by her first eighteen months of institutional privation. Through consistently being there for Alicia, Mrs B has finally earned her daughter’s trust. The family recently revisited Alicia’s homeland with her, having actively continued her life story work over the past ten years.

Conclusion: Feedback we have received, as above, made us realize that the carers’ and our focus in CcAT work sometimes diverged, with the child often continuing to be a scapegoat for ongoing problems in his new family rather than being supported in feeling fully part of it, as Alicia now is in family B.

Our major learning at this point is that CcAT is very useful as a brief intervention at a time of family crisis, but the attachment work needs to be reinforced by the carers themselves afterwards. Some children will need ongoing individual therapy for some time, while carers might also benefit from follow-up sessions—at least at annual intervals—to monitor progress and provide further therapeutic support as needed. Follow-up over the years is, in fact, essential to help families to continue to hold very hurt children.

Ultimately, however, therapists like social workers, foster carers, and teachers will never know for certain what impact they may
have had on a child, not just in the short term but over a lifetime. We are all indebted to a large number of people, remembered or not, for snippets of advice, encouragement, teaching, and modelling that we have benefited from over the years. We hope that CAT interventions have planted the seeds of many new positive attachments, or helped to nourish those that already existed.

Note

1. The first section of this chapter, “A local authority perspective”, is contributed by Maggie Gall.
CHAPTER EIGHT

A future for CAT: spreading the word among professionals

We had discovered early on the flexibility of CAT in work with birth, extended, foster, adoptive, and step-families. We went on to use the Programme in therapeutic assessments for Social Services and the Courts where the placement or attachment needs of a child or siblings were in question. Often, there were also child protection concerns, and/or contact, identity, and multi-cultural issues to be considered. CAT principles have provided a useful framework within which to assess any or all of these. Ironically, I have carried out some of this work in recent years with colleagues at the Post-Adoption Centre in London, whose own pilot project twelve years ago inspired us to create a Child-Centred Attachment Therapy programme for local use.

A further development was to introduce CAT in 2005 to an independent therapy clinic which was already well established in providing adult mental health services locally. As waiting lists for local Child and Family Consultation Service appointments extend up to a year or longer, we had wondered whether CAT could collaborate with the clinic and help to reduce this waiting time for children and families who might benefit from brief attachment therapy.
A therapy manager’s perspective

Angela Reynolds has a BSc in Social Work and was a team manager in Social Services for ten years before going on to train as an adult and couples counsellor. A BACP accredited therapist and supervisor, Angela has also trained as a Life Coach and NLP Master Practitioner. Angela, then principal psychotherapist at the Atrium Clinic in Southend-on-Sea, agreed to explore the potential of CAT for their work. In her words,

As the Clinical Counselling Manager of the Atrium Clinic and Therapy Centre, it was necessary for me to be aware of the facilities available for children, adults and families in the area where I work. In addition, as I came from a social work background dealing mainly with older people, I had an interest in other disciplines and services locally.

So I was pleased when I was given the opportunity to visit CAT in Rayleigh, Essex, some years ago, and to find out more about this Programme.

I could also recall my own experiences as a mother of an adopted child when I was a young woman. This made me curious on a more personal level to learn any new skills, any new techniques available to reflect upon, or pass on to others in a similar situation. Or, indeed, to refer them to CAT if it seemed that they might benefit from this Programme.

The CAT venue was large (a whole floor), unassuming, comfortable, and fairly central for families to access. It was bright and welcoming, with many smaller rooms off a large central room. Each room had a theme for different age groups and, to me, it seemed inviting to youngsters because there was so much to interest them: toys and games, practical things to do as well as reading areas, and a place for the family to engage in therapy all together with skilled workers. It seemed interesting and rewarding both on a professional and a personal level.

On that visit, Maeja and I discussed a range of therapeutic interventions favoured by the therapists. We exchanged views about the benefits of different theories that underpin CAT practice. These include the work of John Bowlby, Donald Winnicott, and Melanie Klein, all eminent authors and psychoanalysts who were interested in the journey we each have to make from dependence
to independence. I remember talking about my passion for neuro-linguistic programming (NLP) and how this has more recently influenced my work as a psychotherapist and life coach at the Atrium Clinic. So, our caring and sharing of resources and an interest in ongoing learning started a friendship, including our working together with some families.

**CAT training:** I have learnt a lot from the methodology used by the CcAT Programme, having had the opportunity to co-work it with Maeja. So I was pleased to have her arrange a training day in 2005 at our clinic for myself and colleagues to reflect on the complexities of attachment, separation, and loss. We were a small select group of dedicated counsellors, all interested in learning about the theoretical base as well as the practical elements of this important Child-centred Attachment Therapy programme that offers hope to struggling families.

In the past, I had attended a workshop with Sir Richard Bowlby, son of Sir John Bowlby, who, through his work in the Second World War and post-war years at the Tavistock Clinic in London, became concerned about the quality of life and prospects for British children within the institutional care system. He wrote very powerfully about the effects of attachment and loss on children, and how these might affect their future relationships. Bowlby provided a positive way of conceptualizing the tendency in human beings to make strong “affectional bonds” with others, and of understanding the powerful emotional reactions that occur when those bonds are threatened or broken.

The training day with Maeja gave myself and my colleagues a real understanding of Bowlby’s theories and the methodology of CAT. We considered the behaviours that could be exhibited by children with secure and insecure attachments within foster families and adoptive families, as well as from the bringing together of children from two different families. We reflected on a likely range of reactions by children, depending on disturbances in parenting or the type of relationship they have with the attachment figure.

We went on to look at the different developmental stages of children and young people, and the importance of using a variety of materials to engage them and their families in play-work. This can be a very effective, yet subtle, form of psychotherapy. Bowlby had emphasized the area of “potential space” and the overlap of the two “play areas” as being the overlap between the patient and the therapist.
We then began our own “play-work” so that we could experience for ourselves the purpose, the benefits, and the fun of creating and learning experientially through sand-tray work.

This was such a pleasure for our child selves: we were encouraged to use our imagination to indulge ourselves for a short while in our own world, and to then share our sandscape in pairs, and then with the group, analysing further what we had depicted.

My scene, I believed, was simple. I chose a green tray and covered it with a thick layer of golden sand and then, using a range of shiny pebbles, proceeded to cover the whole space with the pebbles, depicting initially my husband and myself, and my four children and their partners. I then added their children—my thirteen grandchildren—choosing a different colour and size for each unique person. The whole showed the fullness of my life and the importance of the family to me both personally and professionally. But the scene was also tinged with sadness at the loss of my father, to whom I had been so special when growing up, and who had instilled in me his own strong family values and optimism about life and people.

CAT family work: I remember my excitement when we saw our first children and family at the clinic. The preparation of the therapy venue was so important, and we worked to create a room that had a welcoming ambience for families. Our child selves chose stuffed toy animals to place on each of the chairs arranged in a circle. The room was bright yet relaxing, inviting and interesting, to help family members all feel at ease. We had soft music in the background, a table with a few children’s books and writing and colouring materials, plus another area on the floor with assorted toys. We, too, were ready to play.

At the start, it was the family and us having fun choosing where we would sit, as this could indicate the closeness (attachment) each child felt to their parents when in “a strange situation”. After introducing ourselves, we asked the children if they knew why they had come to see us. Our aim was to be open and honest with them and the family, and to model this for the parents who might have found it difficult to talk to the children about their reasons for visiting the clinic. I soon realized that my observational powers, as well as my active listening skills, would be very useful, especially when recalling the session later for debriefing with Maeja.
Liam's story

The identified child client, Liam, was eleven and still experiencing emotional difficulties a year after the family had been involved in a serious car accident. While the trauma still affected them all, the mother needing extensive surgery, Liam had been particularly affected. He had nightmares and was fearful, worried about his own and his family’s safety. He was also having difficulty settling at his new secondary school and making friends. He could not concentrate at all at school and had become disruptive there. Liam was very clear that he wanted to be just like his Dad and go to work and earn money, and not go to school at all!

After our preliminary introductions, we all had a variety of drinks to choose from: tea and coffee for the adults, and juice or water for the children. Maeja then invited the children to use the play materials available in “the family room” while I took the parents to an adjoining room to chat. The doors of both rooms were left open, so that the children could access their parents if they felt they needed to.

The parents and I then got down to the real work of exploring family dynamics and considering the levels of parental and child power and control. An hour passed by very quickly as I became engrossed in hearing the couple’s story, how they managed their lives, their experiences of parenting, and the roles and relationships they had with each other as well as with their extended families. I used my skills as a therapist to build rapport with the couple as we considered their parenting styles, as well as any other issues they wished to pursue.

It was clear that this family were fairly traditional, with Dad being the breadwinner and Mum the homemaker while also holding down a part-time job. They had strong values, which included being “open and honest”, and they said they wished to pass these on to their children. However, family work of this nature was new to them and we had yet to see whether they could commit themselves to it.

We rejoined the children and Maeja for the final part of the session, and we discussed what they wished to share with their parents, including their drawings. We agreed small changes that family members could make individually or collectively. I really liked this way of supporting positive changes for the family in a caring and sharing environment.

Finally, when we had agreed a date for a following session and the family had left, Maeja and I discussed our recollections of the session, and our own hopes, fears and expectations for future work with them.
In a subsequent session, I was able to teach Liam and his little sister some brain gym exercises to encourage crossover between the right and left hemispheres of the brain and so aid effective learning. My favourite is “Lazy 8s”, as this requires the whole body and both arms to be used quite vigorously. The children were then able to demonstrate these exercises to the parents and Maeja, so we all had a go at doing them! Doing such fun activities together helps to develop connections both in the brain and in the family. We also discussed how the parents could promote a healthy life style for the children, with themselves as role models.

For such family work, we have used a range of soft toys and glove puppets, and I always enjoy seeing the faces of the children when they first come in and the room is set out like a playroom, encouraging them to explore it all. I like the range of activities available to engage with children of different ages and abilities. These include creative play with miniature figures, crayons and paper for younger children, with board games for older children who are able to read.

A firm favourite of mine is a board game, with each player throwing a dice and moving coloured counters on the board. The numbers on the board correspond to cards with questions they must answer honestly with information about themselves, their feelings, a memory, or situation. Forfeits might include doing something silly or more challenging physically, especially for the therapists! This play usually produces a wealth of information to work with, while engaging the children in a competitive game of skills, which they often win. Parents are encouraged to join in such games with the children, perhaps borrowing one to take home for play-work and improved communication with and understanding of their children.

While Maeja worked with the child or children, I would engage with the parents as a couple, specifically to look at parenting and relationship skills. We worked initially on improving their communication, going on to the challenge that gender issues present, and then learning how to compromise and what commitment means to them, as well as exploring how they manage conflict as a family.

I have personal experience as a parent, grandparent, and great-grandparent, as well as being a counsellor, life coach, and master practitioner of NLP. This enables me to draw on different methodologies to promote improvement in parenting and communication.
skills and I always encourage carers to be consistent in using these skills. I often recommend reading resources, and might lend parents books that I think will be of help to them, for example, *The Incredible Years*, by Caroline Webster-Stratton (2006).

Or I will talk to parents about the NLP concept of “Four pillars of childhood”:

1. Unconditional love.
2. Encouragement.
3. Discipline (boundaries).
4. Self control (control of self).

* * *

Reflecting on those earlier days, I know that the CAT Programme has continued to evolve, incorporating learning from therapies as varied as NLP and emotional freedom technique (EFT). I believe that ongoing learning is invaluable, and that therapists need in turn to be able to model this for parents.

While my work with Maeja has been *ad hoc* and time limited, I learnt a lot about myself through this style of working. I know that the children and families we engaged with did as well. To my mind, CAT is a tried and tested way of helping children with attachment issues as well as training the carers in parenting and relationship skills. I believe it has been of real benefit to many unhappy children and their families, helping them to manage their lives better in times of adversity while creating greater hope for the future. [Angela Reynolds]

**A music therapist’s perspective**

Colette Salkeld has an MA, focusing on “the effectiveness of music therapy as a tool to build secure attachment in adopted children”. Colette is a professional clarinettist and trained as a music therapist at Anglia Ruskin University, Cambridge, working mainly in schools for children with learning disabilities. Colette has also worked for Social Services, focusing on adopted children with attachment problems. She contributed a chapter for a book, *Music Therapy with*
Children and their Families (2008, Jessica Kingsley). Here, she comments on the CAT Programme.

I have found the CAT Programme invaluable in my work as a music therapist within the area of post-adoption support. One of the main strengths of this therapy is the focus on the family as the catalyst for emotional healing and therapeutic change in children with attachment problems. Using this type of intervention, the music therapist facilitates musical expression of quite difficult feelings and improved child–parent interactions. Using the CAT Programme, music therapy sessions offer the opportunity for family members to focus on their relationships, building trust and empathy with one another. When this takes place, therapeutic change is then demonstrated within therapy sessions as well as within the home and in the child’s peer relationships.

Attachment problems stem from failed relationships and trauma within birth families, leaving a child unable to trust adoptive parents to be available and responsive to their needs. This can lead to negative patterns of interaction within adoptive families, as parents feel rejected by their adopted child. The CAT Programme fosters mutual attachment between carers and children through helping them to synchronise cues and responses and encouraging them to “play” together wherever possible. In this way, the core values of the CAT Programme and music therapy are the same.

A central belief in music therapy, as in many other psychoanalytically informed therapies, is that it is the “evolving relationship between the client and the therapist in which changes occur” (Association of Professional Music Therapists, 2000). The thinking contained within the CAT Programme challenges this philosophy because the music therapist’s role changes to provide “a secure base” for family work while focusing on the development of the relationship between the adopted child and their new family.

The music therapist, using improvised music as a tool, enables dyads of adoptive mother and adopted child or adoptive father and adopted child, siblings and family groups, to make music together. This unique medium can then enable families who have previously been caught up in negative patterns of interaction to find healthier ways of interacting through music.

Music therapy can sometimes help to recreate early mother–baby interactions, which can enable adoptive parents to bond with their
adopted child. Many of them have not had the opportunity to share these early experiences with their child. Equally, because of trauma or inconsistent parenting in the past, some adopted children may never have shared these earliest experiences with an adult. By facilitating such interactions through musical improvisation, the therapist can enable the adopted child to feel emotionally contained by her adoptive parent, thereby initiating a new and healthy attachment cycle.

Grief work within the CcAT Programme is also seen as essential in order that positive attachments can be developed. Sometimes, when a traumatized child improvises within music therapy sessions, past trauma that has remained suppressed for long periods of time can come into his awareness. In some cases, it might be significant that the trauma was experienced before the child could speak. The music therapist and the adoptive parents, using improvised music, are able to contain the child’s feelings, holding him emotionally as he processes his grief. In this way, the therapeutic space is safe both for the child and the adoptive parents, providing a secure base for such painful work.

Over the past few years, I have combined music therapy with the CcAT Programme and the clinical results have been rewarding, as adoptive parents and their adopted children have found new, positive ways of being together. [Colette Salkeld]

An attachment researcher’s perspective

Sir Richard Bowlby qualified in medical and scientific photography in 1968, and spent his subsequent career illustrating research in those fields through his photography and video productions. Since retiring in 1999, Richard has promoted through lectures and seminars, nationally and internationally, a wider understanding of attachment research. Thus, he is continuing the work of his late father, Sir John Bowlby, who pioneered research on the importance of early attachment relationships, and the long term impact on children of separation and loss. Richard’s comments on the CcAT Programme follow.

The CcAT Programme is a distillation of personal and professional knowledge and experience which Maeja and her colleagues have
intuitively combined to create a very convincing model of brief family attachment therapy.

They have fully embraced John Bowlby’s belief that feelings of attachment and protection must be linked to keep children safe. CAT therapists believe that, where there is a potential for building healthy attachments, it would be emotionally and financially more cost-effective to support this in a child’s existing family (with birth, foster, or adoptive parents) rather than risk moving her on to a new family in the “care system” and hope that she will transplant with ease.

CAT combines assessment with treatment from the start of work with troubled children and families. The reasoning is that, while the child’s behaviours may be the visible cause for concern, it is the mutual attachment with the current family that needs to be encouraged, and which can help the child to develop new ways of reacting to familiar triggers for fight or flight survival responses.

CAT therapists have, therefore, not waited for formal diagnoses by a series of experts to be made before beginning attachment therapy with the child and family. The programme is a prompt but measured response to the client’s needs. The therapists work in true partnership with families, encouraging self-empowerment and harnessing their own resources for healing, even though the families’ solutions might not always be what professionals would have chosen.

CAT is based on optimism and hope that even a traumatized child can be helped, through skilled and committed parenting, to become more securely attached and heal from old wounds. It would seem that, based on the therapists’ experience of working with a number of very troubled children and families, this can happen, thus interrupting intergenerational cycles of neglect and abuse.

An important question for me has been: how has CAT bypassed the formalities of referral to psychiatric and psychological experts for diagnosis? The reality is that, through word of mouth, where social workers have felt that the programme can be of benefit to a struggling child and family, referrals have been made direct to CAT, with some impressive results. As the therapists have learnt, however, some of the children and families referred have needed ongoing therapeutic support on an individual or family basis, while others would have benefited from regular follow-up.
Overall, CAT appears to offer help when it is needed most: at the time of referral, when child and family are in crisis and therefore more open to change, before mutually destructive patterns of interaction become reinforced and need more time-consuming and costly interventions. [Richard Bowlby]
CHAPTER NINE

Overall learning from CcAT: who can benefit

Initial learning from the pilot project (1995–1996)

Even as early as our six-month pilot project in 1996, through our work with just four families we got increasing confirmation of our initial thinking about how CcAT could work, and of our intuitive belief in its effectiveness as prevention and early treatment of attachment problems. So, to recap from our learning, following the pilot project (see Chapter Four), the following is a summary.

1. Our belief is that there are not “problem children” but “families with problems”. The parents must be part of any therapeutic work that seeks to modify challenging or negative behaviours, because unless the parents change the way they respond to their child (i.e., reading cues successfully), the child will be unable to break the negative interaction cycle on their own. Even if the child’s behaviour can be changed, repeated negative responses from the parents will prevent true healing.

2. Within the attachment dyad, if interactions are not mutually pleasing, the relationship breaks down: parents need to feel needed and loved just as children need to feel secure, safe, and loved. If parents get nothing but negative responses, the gap
between parent and child grows bigger, so that mutual distrust and rejection become the only way each knows how to respond to the other. If this pattern can be interrupted and replaced by a new cycle of mutually satisfying behaviours, the relationship can be healed and parents become protective of their child again, while she begins to feel more secure and trusting of them.

3. CcAT teaches all family members to be aware of cues and responses, since if cues are misread, they can inhibit attachment rather than engender it.

4. When children are placed for adoption, work begins immediately within the new family group, so we see the Programme as being preventive, as well as curative of any attachment problems. Using CcAT preventively, we consider its importance lies in helping parents to view attachment problems as a difference in family dynamics, given the new relationships, rather than pathologizing the child placed.

5. It is important for adoptive and foster parents to acknowledge that children placed cannot be expected to have a sense of belonging to the new family. A lot of the child’s anger and hurt, often expressed through bad behaviour, more appropriately belongs to previous carers, including their birth parents.

6. By encouraging parents to not take the misbehaviour as personally directed at themselves, and to deal with it on a more practical level (i.e., certain thought-through responses to particular behaviours), placements are less likely to fail because the adopters do not feel so overwhelmed and rejected on account of the child’s chaotic functioning.

7. The CcAT Programme helps parents to identify specific responses to various “non-attached behaviours”. They can then explore with the worker ways in which they can create a sense of trust in their child by responding positively and encouragingly rather than with anger and rejection.

8. It is also very encouraging for parents to look back and acknowledge their parenting skills and to witness positive changes, however small, in their children’s behaviour.

9. Hurt children in placement and their carers have a right to be supported. In working through child and adult issues at the onset of behavioural difficulties, an intensive therapeutic
programme of interventions should be seen as major preventive work. This can result in positive changes from previous negative patterns and help both the child and carer to maintain his place within the family and promote their feelings of self-worth.

10. Where a child, for whatever reason, feels unattached and insecure, she is likely to seek help through unconsciously “acting out” her sadness, hurt, anger, and frustration in ways that adults perceive as misbehaviour (MisCUES).

11. Feeling rejected, the child will reject the carers in turn, so that their interaction becomes mutually ungratifying and, being painful to both, decreases. They have little or no “fun-time” together, leading to a further deterioration in their relationship and his behaviours.

12. The carers, if stuck in this downward “spiral of negative interaction”, will distance themselves emotionally from the child and are then unlikely to claim and protect the child as their own. If this continues, the carers place the child and themselves at risk of developing abusive interactions. This could lead to the child having to leave the family, so suffering further losses and hurt, and feeling even less able to trust again and form healthy new attachments.

13. What is therefore essential is to change the focus of the work from the child’s stated problem behaviours to improving family communication and relationships: in brief, their attachments.

14. We realized more clearly the interdependence of the different quadrants of the attachment–protection cycle (see Figure 17, p. 114): the direct expression of feelings by the child (cue); consistent and appropriate meeting of her needs (response) by the carer to create a secure base, with firm holding of boundaries. This helps the child to feel safely held, worthy of protection, and so to act more predictably, giving and receiving appropriate cues and responses to have her needs met. In turn, the carer feels validated as parent, and entitled to provide care to this particular child; so he claims and protects the child as his own, thus providing safety for the child and the whole family.

15. Firm holding by CAT therapists of personal, professional, and family boundaries is crucial in this work, which often uncovers child protection issues. (See Figure 16, p. 113.)
16. We learnt, through comparing our longer and more open-ended work with our “control group” families C and D, about the value of doing focused time-limited work with families A and B, time also being an important boundary. This counteracts the tendency for individual or family work to otherwise be more woolly and drift indefinitely, with fewer long-term benefits for families in crisis and overburdened workers.

17. Play-work with children and families is an essential part of the CcAT Programme. It provides a means of communication between child and adult, a safe way of accessing the unconscious for both and of learning how to articulate that which could not be previously spoken about, or even thought of. It helps the adult to come down to child level, since both have to use play and imagination to depict their situation and empathize with each other. Parents are often astounded at the depth of understanding even very small children reveal through such play about how they feel and how they really view themselves in the family.

18. We learnt very early on about the value of co-working with every family in order to avoid collusion with either parent or child, or with couples in conflict. Having a therapist to work with the child individually, or in parent–child or family sessions, ensures that he has a “voice” of his own, and an advocate to represent his view to parents, who often do not wish to hear from a child what the underlying problems in the family are.

19. Especially where there are child protection concerns, it is imperative that we, as CcAT therapists, do not get drawn into countertransferenceal “acting out” of the parent’s childhood scripts or hooked into the child’s re-enactment of his old family scenarios. This means that the therapists co-working in pairs can take on different aspects of the child–parent split and, in peer supervision or external consultation, reflect on their own feelings and biases and share these, in a more digestible form, with the family (see “Sophie’s story”, Chapter Six).

20. Although we had devised “Child and Parent Attachment questionnaires” as quantitative tools for use with the families at the beginning and end of the CcAT Programme, we feel that ongoing self-assessment by family members is more respectful and valid. As Maggie Gall commented in her work with family A,
regular reference to the questionnaires helped the parents to monitor for themselves little changes in their and the children’s attachment behaviours, and so confirmed for them the mutual bonding that CAT supported.

Further learning from CAT work (1997 to 2007)

In the ten years following the CAT Programme pilot project, we continued to learn from each child and family we worked with, individually and jointly: but mainly that families are families, whether birth, extended, adoptive, foster, or step-families, and they can be very damaging or healing in their attitudes and interactions:

Some children and families, as in “Rico’s” and “Robert’s” stories (Chapters Five and Six), might be too deeply wounded to benefit from a brief, focused programme such as CAT, without longer term individual and family therapy for parents and child to help them deal with their separate issues. Moreover, without the adults’ commitment to undertaking such painful exploration in order to move on and heal, the child is likely to continue to “act out” the family’s dysfunction in an unconscious cry for help (see “Christy’s” and “Molly’s” stories in Chapter Five).

Social Services monitoring is essential in Child Protection cases and has a direct impact on CAT work, depending on whether it is valued by the child care workers and management or not. In some cases, where we raised new concerns about a child’s safety and well being, we were quite often left feeling that we had done something really bad, just like the child who discloses abuse in her family. We have needed to be really sure of our facts and stand our ground, especially in legal proceedings if our recommendations differed from the local authority’s care plan for the child.

Ongoing peer supervision and skilled and regular consultation are essential ingredients for CAT work to succeed. These have enabled us to contain our own anxieties and provide emotional “holding” for the child and family, especially where there might be child protection concerns. As in “Sophie’s story” (Chapter Six), we have had to stand back from our work and understand the dynamics in the child and family system, as well as the mirroring of these by the other professionals involved as well as ourselves.
Working in genuine partnership with the family and a “team” of professionals supporting the child helps to create a necessary “secure base” for the sensitive and often painful work that has to be done to keep him safe. The child needs to know that the adults working on his behalf can communicate honestly and respectfully with each other for his benefit, setting aside personal issues and professional jealousy.

Sharing information appropriately between child and parents, and family and Social Services where child protection issues arise—and they almost always do with damaging attachments—needs to be written into our initial contract with the family.

We are aware that some traditional child and adult psychotherapists do not work in this way, and regard what they perceive as a “breach of confidentiality” to be detrimental to their work and therapy culture, as well as a major ethical issue. We learnt that not to share information appropriately was collusive and could put the child and family at grave risk of harm or abuse, intentional or not, which is why “truth-telling” has had to be a cornerstone of our work. (See Figure 16, p. 113.)

Follow-up needs to be written into the contract with the family and referring agency, and not just during the twelve months after CAT work ends. Feedback from the family is essential to let us know what they have continued to find helpful or not, both in the short term and longer term. Routine annual follow-up can help to monitor the family’s progress and provide timely interventions, with built-in therapeutic support and much-needed continuity of care for families at times of developmental crises.

New learning for CAT therapists

Inevitably, our thinking about CAT has evolved over the years as we have learnt more about the efficacy of certain other therapies, especially those involving body–mind or “energy” work such as EFT and Emotrance (Sylvia Hartman) as well as early precursors such as NLP and inner child healing. All these now make more sense to me as interconnecting pieces of the “body–mind” jigsaw of new “truths” gleaned from neuroscience research and their application to attachment theory.
Much of this learning has been fortuitous and synchronistic: a cross-fertilization of knowledge and experience and techniques through meeting other therapists, hearing about what has worked for them, and our own “continuing professional development”. For instance, Angela Reynolds’ enthusiasm about NLP encouraged me to learn about it for myself and so to overcome a long-held prejudice about its use by unscrupulous salesmen to manipulate buyers!

Coming from a multi-cultural background, I am naturally eclectic, and have always valued diversity. Increasingly, in my own work with adult therapy clients, I have been struck by the powerful healing some experience through a sudden release of repressed feelings, whether through “inner child work”, visualization techniques, or EFT. This is much more than “insight”, which we can all develop and still not use to make positive changes. While continuing to work with unconscious processes and communication within a psychoanalytic framework, my practice has gradually broadened over the years to include such new “body–mind” therapies with thought-provoking results.

I am reminded of Neville Symington’s approach to writing about The Analytic Experience (1986):

I am talking of a single reality but coming at it from different perspectives. This is the Hebrew rather than the Greek way of explaining a human phenomenon. The Hebrew way is to go round and round a subject, each time using different images to illuminate what is most profound. [p. 11]

In Symington’s view,

truth can be seen or glimpsed. When I see the truth some change occurs in me. I can never be the same again. Something in my personality has altered; a previous preconception gives way to truth, but it is in the very nature of truth that each glimpse only emphasizes the degree to which truth still lies outside or beyond. [ibid., p. 17]

Hopefully, this is what we have done in our writing about the CAT Programme, using family stories and different perspectives to illustrate what we sought to achieve so that other attachment therapists can continue to build on our learning and help a greater number of children and families than we could ever hope to reach.
Note

1. Paragraphs 1–20 of “Initial learning” were co-authored with me by Maggie Gall and Pauline Sear
Epilogue

Rose’s healing

Forty years on, Rose was still alone and without a family to call her own. She had briefly married a foreigner and emigrated with him to his country. But they literally spoke different languages, and so could not communicate with ease. This was a very disabling experience for Rose, who unconsciously reverted to Hurt Child mode. She found herself, as at six years old, in a strange country and culture, among people she did not understand and who did not seek to understand her.

Rose retreated into herself and would not go out of her husband’s flat, so starting a self-imposed imprisonment that lasted for a very long time. Her physical and mental health deteriorated, and her husband decided to end their marriage. He took Rose back to India and arranged for her, still very young, to live in a home for the aged since she had no relatives or friends to take care of her.

Rose spent ten years in what felt to her like solitary confinement among very elderly and dying women. Nevertheless, most of the “inmates” had families who came to visit or took them out briefly. Only Rose had no one to care about her. Her family still lived abroad and, apart from occasional visits to India when they visited her briefly, she had no contact with them.
Rose felt just like an orphan, repeatedly abandoned and rejected by all those she had ever trusted. Her mother, Marie, had died without any reconciliation taking place between them, and her brothers and sisters were busy with their own lives and families. Rose grew very bitter and decided to sever all contact with her birth family.

Then, suddenly, while on a holiday in India, her older brother, Peter, fell very ill and died. Letting go of her old hurts, Rose stayed with him in the hospital, helping to care for him there. It was the beginning of a new life for Rose as Peter then left her a generous legacy. For the first time in her life, she could choose where to live and to even travel abroad on her own.

Peter’s death unlocked secrets of the past for Rose and her family. Jenny and Emily at last felt free to talk to each other about the family’s total abandonment of their younger sister. They decided to visit Rose in India together, and gradually shared with her their different perspectives of their family story. They made no excuses for theirs or the family’s abandonment of Rose since a baby, and so they finally validated her experiences.

Rose decided to forgive her sisters and bury the past with Peter. During her long and lonely sojourn at the home for the aged, she had found healing resources for herself. These included her great love of reading and a continuing interest in the world and people outside. Rose also found spiritual practices, including meditation, of great help. And she observed how other women in the home dealt with their own adverse situations.

Slowly, Rose began to let go of her long-held childhood hurts and to take charge of her life as an adult. It was not too late to start living at sixty, instead of merely existing and waiting to be rescued by her family or others. Rose had grown up at last and reclaimed her innate ability to choose to be in charge of her own life.
APPENDIX A1

CAT: child’s attachment behaviours

© CAT Team, 1996

The scales listed below are from 1–4; please circle the appropriate number for each item:
1—a very low attachment; 2—fairly low attachment; 3—average;
4—a good level of attachment

Child’s interactions with parents

1. Interacts positively with parents 4 3 2 1
2. Looks at parents when communicating 4 3 2 1
3. Seeks a response from parents 4 3 2 1
4. Seeks affection from parents 4 3 2 1
5. Seeks comfort from parents 4 3 2 1
6. Seeks care from parents 4 3 2 1
7. Seeks attention from parents 4 3 2 1
8. Accepts affection from parents 4 3 2 1
9. Accepts comfort from parents 4 3 2 1
10. Accepts care from parents 4 3 2 1
11. Accepts attention from parents 4 3 2 1
12. Expresses need appropriately to parents 4 3 2 1
13. Expresses feelings appropriately to parents 4 3 2 1
14. Shows awareness of parent’s feelings 4 3 2 1
15. Accepts limit setting by parents 4 3 2 1
16. Protests at separation from parents 4 3 2 1
17. Seems indifferent to separation from parents 4 3 2 1
18. Seeks comfort from parents on reunion 4 3 2 1
19. Accepts comfort from parents on reunion 4 3 2 1
20. Gives appropriate cues/signals to parents 4 3 2 1
21. Recognizes cues from parents 4 3 2 1
22. Claims parents as hers/his 4 3 2 1
23. Shows signs of pride in parents 4 3 2 1
24. Shows signs of joy in parents 4 3 2 1
25. Responds appropriately to cues from parents 4 3 2 1
26. Explores new surroundings with interest 4 3 2 1
27. Shows anxiety in new surroundings 4 3 2 1
28. Shows normal anxiety about physical dangers 4 3 2 1
29. Plays well on his/her own 4 3 2 1
30. Shows imagination in playing 4 3 2 1
31. Is able to concentrate 4 3 2 1
32. Seems generally relaxed and content 4 3 2 1
33. Eats well 4 3 2 1
34. Sleeps well 4 3 2 1
35. Reacts appropriately to pleasure 4 3 2 1
36. Reacts appropriately to pain 4 3 2 1
37. Reacts appropriately to losses 4 3 2 1
38. Shows appropriate awareness of bodily needs 4 3 2 1
39. Shows appropriate awareness of sensations 4 3 2 1
40. Shows a range of feelings 4 3 2 1
41. Shows appropriate attachment to toys 4 3 2 1
42. Shows appropriate feelings of joy 4 3 2 1
43. Shows appropriate feelings of anger 4 3 2 1
44. Shows appropriate feelings of sadness 4 3 2 1
45. Shows appropriate feelings of hurt 4 3 2 1
46. Engages in age-appropriate activities 4 3 2 1
47. Uses speech age-appropriately 4 3 2 1
48. Expresses likes 4 3 2 1
49. Expresses dislikes 4 3 2 1
50. Seems spontaneous when smiling 4 3 2 1
51. Seems spontaneous when interacting 4 3 2 1
52. Seems spontaneous when reacting to situations 4 3 2 1
53. Shows signs of pride in self 4 3 2 1
54. Shows signs of joy in self 4 3 2 1
55. Shows signs of embarrassment 4 3 2 1
56. Shows signs of shame 4 3 2 1
57. Shows signs of guilt 4 3 2 1
58. Takes time when playing 4 3 2 1
59. Interacts positively with adults 4 3 2 1
60. Shows normal anxiety about strangers 4 3 2 1
61. Initiates positive interactions 4 3 2 1
62. Accepts limit-setting by adults 4 3 2 1
APPENDIX A2

CAT parent’s attachment questionnaire

The scales listed below are 1—4; please circle the appropriate number for each item:
1—a poor level of attachment; 2—quite low; 3—satisfactory; 4—a good level of attachment.

Parent’s interactions with the child 4 3 2 1

Does the mother:

1. Encourage appropriate exploration by the child 4 3 2 1
2. Encourage appropriate independence by the child 4 3 2 1
3. Respond supportively when the child shows fear 4 3 2 1
4. Respond supportively when the child shows anxiety 4 3 2 1
5. Initiate positive interaction with the child 4 3 2 1
6. Respond positively to interaction with the child 4 3 2 1
7. Recognize cues from child for care 4 3 2 1
8. Recognize cues from child for comfort 4 3 2 1
9. Recognize cues from child for attention 4 3 2 1
10. Help child to recognize and meet bodily needs 4 3 2 1
11. Help child to recognize and express range of feelings 4 3 2 1
12. Help child to verbalize likes 4 3 2 1
13. Help child to verbalize dislikes  
14. Help child to make choices  
15. Help child to recognize parent’s **cues**  
16. Help child to respond to parent’s **cues**  
17. Prepare child for changes/new situations through play  
18. Talk to the child to prepare for changes  
19. Explain to the child about separations, however brief  
20. Reassure the child about separations, however brief  
21. Encourage the child to learn new skills  
22. Through play, encourage the child to learn new skills  
23. Encourage the child to carry out age-appropriate tasks  
24. Set appropriate limits for the child’s behaviour  
25. Act consistently, when setting limits for child  
26. Explain sensitively to child about family origins  
27. Show affection towards the child  
28. Show liking for the child  
29. Show pride in the child  

**Mother’s behaviour/attitudes towards the child:**
30. Seems to enjoy parenting the child  
31. Seems to feel overwhelmed parenting the child  
32. Has a positive view of self as a parent  
33. Has a positive view of the world  
34. Sees positive family resemblances in the child.  
35. Sees negative family resemblances in the child  
36. Helps the child to learn positively about her cultural heritage  
37. Helps the child to develop a positive self view  
38. Helps child to develop a positive ethnic identity  
39. Shows empathy with the child’s situation  
40. Shows empathy with the child’s birth family  
41. Feels entitled to parent this child  
42. Shows claiming of child as own  

**Does the father:**  
1. Encourage appropriate exploration by the child  
2. Encourage appropriate independence by the child  
3. Respond supportively when the child shows fear
4. Respond supportively when the child shows anxiety 4 3 2 1
5. Initiate positive interaction with the child 4 3 2 1
6. Respond positively to interaction with the child 4 3 2 1
7. Recognize cues from child for care 4 3 2 1
8. Recognize cues from child for comfort 4 3 2 1
9. Recognize cues from child for attention 4 3 2 1
10. Help child to recognize and meet bodily needs 4 3 2 1
11. Help child to recognize and express range of feelings 4 3 2 1
12. Help child to verbalize likes 4 3 2 1
13. Help child to verbalize dislikes 4 3 2 1
14. Help child to make choices 4 3 2 1
15. Help child to recognize parent’s cues 4 3 2 1
16. Help child to respond to parent’s cues 4 3 2 1
17. Prepare child for changes/new situations through play 4 3 2 1
18. Talk to the child to prepare for changes 4 3 2 1
19. Explain to the child about separations, however brief 4 3 2 1
20. Reassure the child about separations, however brief 4 3 2 1
21. Encourage the child to learn new skills 4 3 2 1
22. Through play, encourage the child to learn new skills 4 3 2 1
23. Encourage the child to carry out age-appropriate tasks 4 3 2 1
24. Set appropriate limits for the child’s behaviour 4 3 2 1
25. Act consistently, when setting limits for child 4 3 2 1
26. Explain sensitively to child about family origins 4 3 2 1
27. Show affection towards the child 4 3 2 1
28. Show liking for the child 4 3 2 1
29. Show pride in the child 4 3 2 1

Father’s behaviour/attitudes towards the child:

30. Seems to enjoy parenting the child 4 3 2 1
31. Seems to feel overwhelmed parenting the child 4 3 2 1
32. Has a positive view of self as a parent 4 3 2 1
33. Has a positive view of the world 4 3 2 1
34. Sees positive family resemblances in the child 4 3 2 1
35. Sees negative family resemblances in the child 4 3 2 1
36. Helps the child to learn positively about her cultural heritage 4 3 2 1
37. Helps the child to develop a positive self view 4 3 2 1
38. Helps child to develop a positive ethnic identity 4 3 2 1
39. Shows empathy with the child’s situation 4 3 2 1
40. Shows empathy with the child’s birth family 4 3 2 1
41. Feels entitled to parent this child 4 3 2 1
42. Shows claiming of child as own 4 3 2 1
APPENDIX B

Life story work and life story books

Health warning: this can be very painful work for the child and adults involved, leading to regressive behaviours.

Compiling a life story book without involving the child and/or family and foster carers and other significant persons in the child’s life, as appropriate, is not life story work, which is both griefwork and celebration. Arrange a “life celebration day” for the child.

Life story work is a collaborative process, which can take weeks, months, even years, to help a child or young person to understand who they are, where they have come from, why they are where they are now, and who have been the important people in their lives.

Compiling a life story book is a means to that end: it is both a tool and an outcome. Depending on the child’s age and understanding, she may require more than one book—even perhaps a series of simple “graded” books/photograph albums with pictures and simple captions—to help her understand why she is where she is at a particular time.

There may be simpler or more informative books for her to look at on her own, or in the company of trusted carers or others important to her. At least one simple version should be always accessible to her, for when she needs to read or hear her own story, perhaps
even as a favourite bedtime story when young. The child needs to be aware that the book belongs to her, and does not have to be shared with anyone (adult or child) who might misunderstand or misuse it. Looking at it together allows her to express her feelings.

More detailed or painful information about the child’s past, gleaned from Social Services files, etc., can be kept in a separate book, perhaps a ring binder with plastic pockets to preserve precious documents, which she will be able to understand or need to access only when she is much older. *Do keep all original certificates, photographs, letters from parents, etc. in a safe place. Make colour copies, if appropriate, for a simpler version of the book for the child to look at on a regular basis.*

Sometimes a child might find the book a very painful reminder of his past, and wish to destroy all evidence, and later regret it. Some of the letters or photographs or videos may be irreplaceable. As the material is so valuable (a treasure trove of memories and information about the child’s life and history), it is important to ensure that the originals are not lost at the child’s whim or during a succession of placement moves.

So, what should the life story book consist of? If you were compiling one for yourself as a child, at different ages, what would you like to have included in it? A good way to prepare for such sensitive and emotionally-laden work with children is to first compile a book for yourself. This will help you to empathize with the child’s feelings and wishes, and what she might like to preserve of herself, her past and present, for the future, when no one might be around to give her very precious information or share family memories.

Birthday and Christmas cards can be included; letters, a family tree, an ecomap; a simple flowchart to show her different moves (with dates and reasons for the move); photographs of homes, schools, her own writing and drawings and pictures cut out, and so on.


APPENDIX C

Structure of CAT Programme

(1) Publicity to social workers
-----------------------
Information and training as needed

(2) Initial referral

(3) Assessment of/by family

(4) Co-planning a draft Programme: preparation by CAT workers and family

(5) Build in support and consultation for CAT team

(6) Implementation of negotiated programme

(7) Evaluation of programme by workers and family

(8) Programme modification if needed: perhaps re-run on smaller scale

(9) Reviews at 1 month, 4, 7, and 12 months

(10) Monitoring and support of child and family

Structure of CAT Programme.
CAT work with carers.

APPENDIX D

CAT work with carers

Griefwork
– for carer
– for child

Life story work
– by carer
– with child

“Ghosts in the nursery” reworking of childhood scripts for carer

Inner child work
– healing carer’s hurt child self
– reclaiming positives of past
– reclaiming joyful child self

Identifying with carer(s) issues of concern re self, couple, child, other family members

Individual/couples work on loss of fantasy/dream child: grieving/letting go

Work on couple’s issues

Work with other children in family

Work with family/child: play/scripts

Parenting issues
– reworking unhelpful family scripts
– taking charge as parent
Developing new skills and strategies to manage child’s challenging behaviours

Attachment work
– basic bonding cycle: identifying and meeting needs of child
– positive interaction
Practising “claiming” play with child; fun time
APPENDIX E

Child-centred attachment work

Life story work supported by carers: on birth family, moves, losses, and current placement. Birth family could be involved in this

Individual play-work with child (as part of family work)

Attachment work with child and carers: learning/matching cues and responses for care-seeking and care-giving

Identifying with child issues of concern

WORK WITH CHILD

“Positive interaction cycle for child and carers: Play (Theraplay™ ideal)

Griefwork: mourning losses and reclaiming positives of past

WORK WITH CHILD

Behaviour modification with child and carers, rehearsing new positive roles

Work with child and family: correcting old negative scripts

Work with siblings

Child-centred attachment work
APPENDIX F

Ascertaining the wishes and feelings of children

New learning can be painful. It may undermine our confidence in what we thought we knew, took for granted, and leave us deskilled. We may have feelings of loss, insecurity, and feel overwhelmed by the demands made on us, before we slowly integrate new learning with the old.

We have all been a child once and so have the innate capacity to communicate with other children now. The more we are aware of our own inner child, the easier it is for us to empathize with other children.

To understand what a child is communicating to us, we need:

1. **Humility**: the willingness to suspend adult beliefs and preconceptions about a child and her situation; to really learn from the child what it is like for her.
2. **Observation skills**: practise observing children of all ages in interaction with each other and their families, but discreetly! In trains, buses, supermarkets, doctors’ surgeries, playgrounds, adult environments, etc.
3. **Be aware of your own feelings (countertransference)** when observing interactions between a child and an adult. Sometimes very
painful feelings from our own childhood can be stirred up in us when we see a child being treated without respect or affection. We may defend against such feelings, which trigger hurtful memories from our past, by “identifying with the aggressor” (adult)—rather than with the “victim” (the child we are observing in the present, or the child we were once).

We may find ourselves making excuses for an adult’s rejecting or even abusive behaviour, or justifying it, as we might have had to in a similar situation when we were young, because it was too unsafe then for us to be critical of an adult, especially if he was our parent. We may find ourselves blaming the child for provoking negative interactions from the adult, because the child’s behaviour reminds us too painfully of our own neediness and vulnerability when we were children.

On the other hand, observing a child in play or loving interaction with a parent might stir up feelings of resentment and envy in our child selves, who might not have had such positive experiences when young.

4. *Listen to what a child is really communicating* through his words, gestures, body posture, play, stories, drawings, etc. Do not assume too quickly that you have the full message. The child may well have very ambivalent feelings about his situation, just as we might have felt ambivalent about our parents when we were young. **TAKE TIME TO GET TO KNOW THE CHILD, SO HE CAN GET TO KNOW AND TRUST YOU.**

5. *Unconscious communication:* one important clue may be the feelings evoked in ourselves when we observe a child. Do they relate to memories of our own childhood, or belong to the child in the present?

6. *Monitoring your own body sensations* during an assessment, together with good supervision and support, can help you separate what belongs to you and your past from what is being communicated to you by the child in the present, especially if there are child protection issues.

7. *Be aware of your own hurt inner child:* talk to her, be an advocate for her in a replay of all those hurtful childhood incidents you can recall when you were small, and perhaps on your own and unsupported, and totally powerless.
8. *Keeping a journal, recording dreams* and your own interpretations of them, peer counselling, can all be helpful in developing awareness of your adult and child selves, unconscious communications from one to the other, and so dealing with your past hurts and detoxifying them.

9. *Nurture your playful and creative child selves*: relaxing, having fun, being out in nature, doing creative things, are all ways of healing your inner child and nurturing healthy aspects.

10. *Be aware of child development stages* as a context for the behaviour and communications of the child you are working with. Even an infant can express her wishes and feelings through her gaze, or averted looks, clinginess to, or avoidance of, an adult, as well as to you, as a complete stranger to herself. Knowing how a normally developing child should react to carers and strangers can help you assess the interactions you are observing, and give you an indication of the quality of the child’s attachment.

    DON’T JUST GUESS. BACK UP YOUR HUNCHES WITH FACTS. Vera Fahlberg (1982) and Mary Sheridan, among others, have written detailed guides to children’s development.

11. *Be aware of class, religious, race, cultural and other biases in assessment.*

12. *Commitment*: once you have ascertained the child’s wishes and feelings, you have to be an *advocate* for him, representing his views and best interests, even in the face of adult opposition, whether from carers or professionals.

Children are the largest minority in the world, totally dependent on adults for their welfare and security. If they are also black, or disabled, or poor, or are members of other oppressed groups, they are even more likely to be disadvantaged. Being an advocate for an oppressed person is not easy or comfortable; you may find yourself also being oppressed. Seek appropriate support, personal and professional, for yourself when doing such challenging work with children, who are our hope for the future.


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