Emotional ties that bind: weaving a healing tapestry for an attachment disordered child

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Abstract

The paper presents therapeutic work with a child, directed towards repairing his capacity to form secure attachments, and demonstrating the use of symbolism woven into play therapy sessions. Attachment theory is used as the framework for analysing the process of therapy, the interface between the therapy and the day-to-day care of the child, and the overall decision-making context when the child is in the care of the state (Department of Child, Youth and Family). The weaving together of these strands aims to create a healing tapestry for the child to attain secure attachments to the emotionally significant adults in his life and to reach his potential in other aspects of his development.

Introduction

Daniel, aged eight and a half years old, was referred to me for therapy one year after he had been removed from the care of his family of origin and placed in a residential school. During this time, Daniel's progress had been intermittent, unpredictable and unstable, especially regarding his capacity to form and sustain relationships with the caregiving staff at the school and the children he lived with. As a child in long term care, with little likelihood of returning to his family of origin or kinship care, the Department of Child, Youth and Family had a responsibility to provide substitute care where Daniel "should be given an opportunity to develop a significant psychological attachment to the person in whose care the child .... was placed" (Clause 13h, Children, Young Persons and their Families Act, 1989). Attachment theory was therefore seen as particularly relevant, and was used as the framework for undertaking Daniel's therapy.

The theme of the narcissus represents one of many strands in Daniel's therapeutic process. Communication through the imagery of the narcissus was a natural extension of the use of metaphor in my therapeutic work (Babits:2001), and the recurrence of the symbol marks important stages in his pathway to healing. The image is used in different ways to explore a mutual understanding

of Daniel's sense of self and his relationships with significant adults, and of the therapeutic process itself. The case material examines the many layers of therapy: Daniel's representation of his inner world; his work during the therapy sessions and his developing relationship with myself as social worker-therapist; and the interface of his sessional work with his experiences and relationships in the outside world. This paper illustrates the complexity of weaving a healing tapestry so that the many layers come together to create a coherent fabric for the therapeutic treatment of an attachment disordered child.

Initial presentation

When Daniel came into care aged seven and a half years old, he was admitted to a residential school. He presented as a very disturbed child, with extremes of behaviour from total withdrawal - curling up in foetal position and continual nonsensical fantasising, so out of touch with reality that it verged on the bizarre - to other times when he flung himself into ferocious temper outbursts, kicking, fighting, screaming, a danger to himself and others. Occasionally, he ended up running away from the unit, later claiming that he was searching for his mother.

On the residential unit, Daniel's behaviour was not particularly unusual compared with the other emotionally disturbed children he lived with, although he was one of the more difficult to manage. He tended to resist being cared for, believing that he was capable of being independent, telling staff when he was in a bad mood "I can look after myself", "leave me alone", "stop bossing me around". His social skills with other children were minimal, and he had difficulties joining in their activities and games. He could not bear to lose, and he was very poor at sharing, be it toys or taking turns with equipment or during games. He wanted to control everything, even when he was not capable of doing the activity or did not know the rules, yelling and screaming if he was not allowed to get his own way. Nor was he able to play alone or occupy himself constructively. He was unable to look after his belongings, continually breaking his toys and even losing his favourite bear. Daniel had difficulty getting himself to sleep, making strange animal noises, and he was often troubled by nightmares.

It was at school, where he was expected to conform in a carefully structured classroom, that the extreme oddness and unpredictability of his behaviour showed up. From the moment that he entered the classroom, it was evident whether it was going to be a good day or not. His hair standing up on end was always a bad sign. Other aspects of his physical appearance also changed when he was in a bad space, his eyes looking more sunken and partly closed, his face long, thin

and pointed, and his body crumpled and hunched up. Even his clothes looked dishevelled and untidy. On a bad day, Daniel would not start to work and was unable to co-operate with any instructions from the teacher. He was generally fidgety and could not sit still, continually annoying the other children. He often complained of aches and pains. One day when he was wailing and moaning about a sore leg and was told there was nothing to be seen, he got out a blue crayon and drew marks on his legs for bruises and sores.

At one stage, Daniel became obsessed with being a cat. He crawled around the classroom on all fours. When no-one was watching, he jumped up onto the kitchen bench and ate a piece of cake, lapping the food from the plate, just like a cat, looking up periodically to hiss and miaow. He would only accept his medication by taking it with his mouth from the teacher's open hand. In the teacher's opinion, it was more than a child pretending. This behaviour persisted for long periods of time, increasing in duration each day, and the quality of Daniel's involvement was total absorption.

Generally in the classroom, even on good days, Daniel found it hard to remain on task, and despite working with him on a one-to-one basis, his behaviour remained very difficult. His threshold for frustration was low and he threw major tantrums at perceived injustices or requests to comply with instructions. He seemed to have problems retaining what he had learned from one day to the next. There were gross discrepancies in his academic performance. He could barely read and yet, in science, in art and creative construction work, he had remarkable knowledge and skills, capabilities way beyond his years.

When Daniel was referred to me, a year after his admission to the residential school, he was still a complete enigma to the staff. Apart from his rage, he shared little of his thoughts or feelings. On the other hand, there had been periods of improvement and stable behaviour, and also signs that Daniel was making relationships with a particular child or staff member. Then suddenly, and for no apparent reason, Daniel would revert to his original bizarre behaviour patterns, and withdraw from these relationships. Some time later, and equally unpredictably, his behaviour would become more settled again and he would start making relationships but often with a different child or staff member.

At this stage Daniel was given a dual diagnosis of Asperger's syndrome and ADHD, for which medication was prescribed. There was also a possible differential diagnosis of reactive attachment disorder, and given Daniel's history of abuse and dysfunctional parenting, there was, in my opinion, a reasonable likelihood of some success in undertaking therapy with Daniel based on attach-

ment theory. At the same time psychological and psychiatric overview was maintained to review diagnosis and progress.

Attachment theory and the therapeutic process

Historically, Bowlby developed attachment theory out of the roots of object relations theory (Karen:1994), which he also integrated with concepts from ethology (animal behaviour), cognitive psychology, and control theory. Like object relations theorists such as Winnicott and Fairburn, Bowlby believed that real events in the child's life, such as separation or trauma, as well as the actual quality of the infant-parent relationship, were the most important influences shaping the child's personality development. Bowlby rejected some aspects of traditional psychoanalytic theory, including the concept of libidinal drives (Bowlby:1969). Instead, he considered that the propensity to make affectional bonds is a prime motivating need in its own right. Attachment behaviour is seen as one of several behaviour systems with its own specific function. Other systems include sexual behaviour, eating and exploration. The function of attachment behaviour is to ensure that children remain in close proximity to an attachment figure for protection and a sense of felt security. A natural consequence of disruption to the child's attachment to its caregivers, through unwilling separation or loss, is emotional distress, including anxiety, anger, depression and emotional detachment, and possible personality disturbance (Bowlby:1984). Furthermore, there is a reciprocal relationship between the attachment and exploration systems, such that it is only when attachment needs are assuaged that the child is free to engage in creative or playful exploration (Holmes:1997).

During the first years of life, children build up internal working models or representations of themselves and their primary caregivers in interaction with them. These models, based on real experiences, incorporate generalised beliefs and expectations founded on the child's attempts to gain comfort and security, and the success or otherwise of doing so. They are "working" models because they can be updated. However, over time, they tend to persist, are taken for granted and end up operating unconsciously, guiding interactions not only with the primary caregivers but also with other new attachment figures, such as with a teacher, foster mother or therapist (Bowlby:1988).

The internal working models are outwardly manifested in patterns of attachment behaviour. Three principal patterns were identified by Ainsworth and her colleagues (1978), based on observations of young children and their caregivers both in natural environments and in a highly structured laboratory situation often referred to as the "strange situation procedure". These patterns

were found to be related to the quality of early mothering experienced by the infant.

In the first pattern of *secure* attachment (about 65 per cent of a normative population (Holmes:1993; Karen:1994)), the child is confident that the mother (or other attachment figure) will be available, responsive and helpful when adverse or frightening situations are encountered. With this assurance, the child feels bold in exploring the world, and internalises a representation of self as loveable and worthy of care. This pattern is promoted by the parent being readily available physically and emotionally, sensitive to the child's signals and empathically responsive when protection and/or comfort is sought. In the strange situation procedure, the infant is often, but not necessarily, distressed by the mother's absence. On reunion, the infant seeks and obtains comfort, and readily returns to play.

A second pattern (about 12 per cent of a normative population) is that of *insecure ambivalent* attachment, in which the child is uncertain whether the parent will be available or responsive or helpful when called upon. Because of uncertainty caused by the parent's inconsistency, the child is always prone to anxiety, tends to be clinging, and is anxious about exploring the world. The core anxiety of the insecure ambivalent child is the fear of abandonment. In the strange situation procedure, the infant is often distressed by the mother's absence. However, on her return the infant is difficult to comfort, angry and resistant while at the same time seeking contact. Such infants often become clinging towards the mother and are reluctant to return to play.

In the third pattern of *insecure avoidant* attachment (about 22 per cent of a normative population), the child has no confidence that there will be help when care is sought. On the contrary, the child expects to be rebuffed. In the extreme situation of repeated rejections, the child tries to become emotionally self-sufficient and avoids emotional contact with others. The core anxiety of the insecure avoidant child becomes a fear of impingement. In the strange situation procedure, the infant rarely shows distress at the mother's departure. However, they are often watchful and their play is inhibited.

A fourth pattern, that of *insecure disorganised* attachment, has been identified since Ainsworth's original research. These infants showed no coherent pattern of responses, suggesting the infant views the parent as frightening, and thus making it uncertain which behaviour will be appropriate in the presence of the parent (Main and Hesse:1990). This category represents only a small percentage of a normative population (less than 5 per cent), but the proportion goes

up dramatically in vulnerable groups, such as socio-economically disadvantaged families and those with mothers who have themselves been abused as children (Crittenden:1988).

These patterns of attachment behaviour tend to be maintained not only because caregivers tend to parent consistently across time, but because the process is inherently self-perpetuating (Bowlby:1988). The internal working models of insecurely attached individuals may become habitual and not respondent to the world. They may persist even when other adults treat them in ways that are totally unlike how they were treated by their primary caregivers. The circularity then continues because individuals with unchanged internal working models of self and others will elicit behaviour which confirms their working models.

Bowlby's model of clinical intervention is therefore based on clients' reappraising and re-structuring their internal working models. This is accomplished by the therapist providing conditions in which clients can gain new understandings, both by exploring and gaining insight into the various aspects of their internal working models through therapy, as well as from the actual experience of a therapeutic attachment relationship. Bowlby (1988:138-9) outlines five tasks for the therapist using attachment theory, as follows:

1. To provide clients with a secure base from which to explore the various aspects of their lives - past and present - many of which the client may find difficult to think about without a trusted companion providing support, encouragement and empathy.
2. To encourage clients to consider how they engage in relationships with significant figures in their current lives, what their expectations (often unconscious) are for their own feelings and behaviour and for those of other people.
3. To encourage clients to examine the client-therapist relationship, recognising that clients will import perceptions and expectations about attachment figures into this relationship.
4. To encourage clients to consider how current perceptions and expectations may be the product of childhood events and interactions with attachment figures.
5. To enable clients to recognise that their models of self and other may or may not be appropriate to their present situation, and to reflect on the adequacy of earlier models, and whether these are accurate in the light of current experiences with others, especially the therapist.

The application of Bowlby's concepts to clinical work has been slow, and indeed this was a source of disappointment to him (Bowlby:1988). There has recently been a gradually growing literature relating his ideas to counselling and psychotherapy with adults (for example, Pistole:1989, 1999; Sable:1994; Krause and Haverkamp:1996; Holmes:1997). There has also been a systematic application of attachment theory to family therapy (for example, Byng-Hall:1991) and to therapeutic interventions in early infant-mother relationships (for example, Fraiberg:1980). In contrast, there has been little literature about applying attachment theory to therapy and counselling for children, although Bowlby and subsequent researchers such as the Robertsons (Robertson and Robertson:1989) have had a profound influence on the quality of substitute care for children. These include: acknowledgement of the importance of parents' visits to children in hospital; the preference for foster care and the resultant closure of large residential nurseries and children's homes; and the recognition of children's need for permanent family placement or adoption when they cannot return to their family of origin.

In considering Bowlby's five tasks for the therapist, I would suggest that the application of attachment theory to the field of therapeutic work with children has been hindered by developmental issues that necessarily change the ways that these tasks can be undertaken. This is partly related to children's cognitive development, where the stages of egocentric and concrete thinking (Piaget and Inhelde:1957) preclude a child's capacity to participate in abstract reflection about relationships, past and present, as outlined by Bowlby. Furthermore, children's natural medium of communication is through play and symbols in addition to talking, although for some emotionally disturbed children, like Daniel, part of the task of therapy is to bring the child to a state of being able to play (Sanville:1999). Because of this, the provision of the actual experience of a therapeutic attachment relationship becomes the primary vehicle for helping the child revise his internal working models of self and attachment figures. However, unless the quality of day-to-day care of the child is good enough and work is undertaken to facilitate attachment to the primary caregivers, the overall effectiveness of therapy can be compromised (Morris:1997, 2000).

Thus, whether working with adults or with children, the primary initial task of the therapist is to encourage the client to form a therapeutic attachment. Unless there is a measure of felt security therapy cannot even begin (Holmes:1993). The therapist emulates, in many ways, the conditions under which the infant develops secure attachment to its primary caregiver. The function of attachment is to provide comfort, security and safety, to serve as a secure base from

which the individual can explore the world. To actively promote attachment, the therapist needs to be consistent and reliable in his or her presence, emotional available and focused on the client's needs (Pistole:1989). This is provided partly through empathic acceptance and understanding. The therapist modulates the client's affect and becomes a source of comfort or a soothing agent for the client (Pistole:1989). Safety and security is also provided by the structure and regularity of the therapy sessions, and boundaries related to professional role and ethics. The therapist's office may literally become a secure base to which the client can return (Pistole:1999). For children it is essential that the playroom is experienced as unchanging with a consistently laid out set of toys in order to provide a sense of safe haven and security (Axline:1949).

Work with Daniel: a shared understanding of the therapeutic process

As outlined above, the initial work with Daniel focussed on developing a therapeutic attachment relationship. Communication with Daniel was at first limited solely to reflecting what he volunteered to discuss. I quickly learnt that any questions I asked went unanswered, and furthermore they stopped the flow of conversation from Daniel. Besides, in this initial stage, even simple reflection can lead to a sense of empathic acceptance and understanding. The next stage would be to find an activity and a venue that would provide the opportunity for Daniel to express needs that could be interpreted as cues for attachment, and to which I could respond appropriately. The search itself would become part of the strategy for forming a therapeutic attachment.

We started our sessions in a play therapy room at a local clinic. Daniel occupied himself building a scene in the sandtray, then constructing a working model with gears, and taking a photograph of me which he stuck to a large piece of cardboard headed with his name printed in glitter. A good start, it seemed. But after two sessions, Daniel declined to return to the playroom.

On the first occasion that Daniel refused to come to the playroom, he clearly mistrusted whether or not he would be forced to go. He half-heartedly ran away, and took refuge in a small patch of woodland adjoining the residential unit. I followed, but not too closely. I commented to Daniel that he could choose what we did and where we went, and whether or not he involved me. What he did not get a choice about was whether I would visit him. I would come each week, at the same time, and I would stay with him for an hour.

Daniel was watchful and wary. I assured him that I would not chase him or make him come with me. Suddenly, Daniel issued a warning not to follow him: "It is not safe here for you." I crouched at the edge of the wood, wonder-

ing how this session would evolve. I waited and I watched. I then realised that Daniel was right. It was not safe. I was being attacked by mosquitos, to which I am very allergic. I explained to Daniel that I needed to get myself protection, that I would be back soon and I went to find some insect repellent.

When I returned, Daniel had retreated deeper into the wood. He was hiding. He remained anxious that I would come too close. I moved slowly and cautiously towards him. He ventured behind a large tree. I stopped. I commented again that I would not chase him and I assured him that I would come no nearer.

Daniel started to dig. "I'm searching for bulbs," he said. I expressed serious doubt that he would find anything - but it seemed that Daniel knew better. He suddenly found a narcissus bulb, dormant. He tore it out of the soil and brutally ripped off its roots. He started to collect the bulbs in a pouch formed by pulling up his jersey. Eventually, I was invited to join in. "You will need to get your hands dirty, too." I started to dig in the soil searching for bulbs.

Daniel came across a sprouting bulb. Immediately his actions changed tenor. Great care was taken to remove the bulb from the soil without damaging its roots. It was handed to me for safekeeping. Daniel continued. The dormant bulbs were added to his pouch, their roots ruthlessly removed. The sprouting bulbs were all given to me, until there were half a dozen. Daniel then indicated that he had finished. He wanted to plant the growing bulbs in a pot. I was then given the pot to take away. "You will look after them every day, otherwise they will not grow."

I was stunned by the power of Daniel's allegory, and his evident astuteness about the process of therapy: the visit to the wood, territory of the unconscious; the instructions to me, as therapist, to nurture the tender growing shoots of the narcissus, while he took charge of the dead-looking, dormant bulbs; the fact that I, too, needed to get my hands dirty if we were going to work together.

I wondered whether to share with Daniel a demonstration of "loving and caring water"[1] (Batty and Bayley:1984), which would explain symbolically to Daniel about his need for therapy. It was with some hesitance that I decided to do so, because anything that I had previously initiated in the sessions had led to com-

1 The demonstration of "loving and caring water" is a way of providing a child and caregivers with a narrative for their experience of attachment difficulties (Batty and Bayley, 1984; Morris, 1997). The adults are represented by jugs, the children by cups, and nearby there is a "well" where the adults can replenish their supply of loving and caring water. The children are born, full cups emerging from the mother jug after she has been filled by the father jug. In everyday life, all

plete closure by Daniel. It felt a big risk after the depth of his revelation, and we had already had one false start in the playroom.

Daniel attentively watched the demonstration of "loving and caring water". As I finished, Daniel took over the dialogue. He showed me that he allowed his cup to be filled through the hole in the "suffering skin", but only partially. He then spent considerable time closing over the hole in the "suffering skin". He talked about opening the hole from time to time, to fill up a bit more, and then carefully closed the hole again. In this way he showed how much he needed to control his relationships with the adults around him, only risking brief interludes of closeness. His explanation reflected the pattern of intermittent attachment that had been observed. He also described the way he withdrew from close relationships, for no apparent reason, except that it would seem that Daniel made conscious decisions about when and with whom to allow relationships to develop. Again, I was struck by Daniel's profound astuteness.

Work with Daniel: the first steps towards attachment

The next sessions were problematic. While he trusted me enough to risk going in the car, he continually checked that I would not make him return to the playroom. However, it also became apparent that he was unsure how to use the time, what to do, where to go - a coffee shop, a playground, a shopping expedition. As a social worker trained in the use of direct work techniques, handing over the decision to Daniel about these things (activity and venue) was acceptable, whereas as a therapist these aspects of treatment may not have been negotiable.

There were several outings that felt aimless and unsatisfying. However, he seemed keen to go out with me, and for several sessions we visited playgrounds, a coffee shop and he browsed seemingly aimlessly in toy shops. The search was for an object or a potential space that would create the opportunity to engage in the

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children spill their loving and caring water. They are hungry, they get hurt. In an ordinary family, "good enough" parenting (Winnicott, 1965) can refill the children's cups. But, when parents are unable to meet their children's needs, for whatever reason, their cups become increasing depleted. Eventually, children need to protect themselves and put on a "suffering skin" (cling film over a nearly empty cup). This stops any more "loving and caring" getting spilt. However, when such children are placed in a nurturing environment, the "suffering skin" now prevents the children's cups being replenished. Whatever loving and caring is poured forth by the new caregivers, it spills over the impervious "suffering skin". The result is a mess, "loving and caring" spilt everywhere. The caregivers feel drained and they experience the children as unresponsive. At the same time, the children, with their underlying needs unmet, often present escalating behaviour problems. The aim of therapy is to help children make "holes" in the "suffering skin", to risk opening themselves to relationship without dismantling all their defences, and to learn gradually the experience of having their cups refilled with "loving and caring".

attachment process. In the meantime, this was particularly difficult to negotiate because any questions I asked immediately resulted in Daniel's withdrawal into silence. Nevertheless, Daniel eventually arrived at a session with a sense of purpose and direction. He talked of a motorway nearby, and seemed surprised that I did not know its whereabouts. In contrast, he seemed to know exactly where he was and where he wanted me to go. He wanted us to find "the man with a boat".

This was the first occasion that Daniel had so clearly expressed a need. It was important that I did whatever I could to meet this need, and indeed, if possible, find the "man with a boat". At the very least, Daniel needed to understand that I took his request seriously, and that I would undertake a genuine search for the man with a boat, even if in the end we were not successful. I asked him questions about the identity of the man with a boat, and for the first time Daniel responded, albeit with tentative, monosyllabic answers. The faltering conversation was a breakthrough in terms of a beginning step towards attachment. However, attempting to meet Daniel's expressed need with any immediacy posed practical difficulties. Daniel was unable to give me any sense of where the destination might be, what distance or time might be involved, and the session was only one hour long. Apart from honouring the usual structure of the sessions, my time that day was also constrained by other commitments.

Naively, I talked with Daniel about the limitations of this session. I explained that we would go as far as we could in half the time, and then we would have to return to the unit. I showed Daniel on the car clock when we would have to turn around. I promised that if we did not reach the man with a boat, I would try to find out more and we would try to find him another day. Daniel seemed to understand and accept. However, at the half-way point, no sooner had I turned the car around, than Daniel started to kick and scream. He tried to grab my glasses to break them. He tried to destroy his own glasses. His little boots hammered the dash board with the fury of his rage. I eventually ended up holding Daniel by his arms and pinning him back into the car seat. I had to hold him so strongly that I worried that my firm grip would leave finger marks on his arms.

The violence of his anger subsided as suddenly as the initial explosion had erupted. Daniel flopped down off the seat into foetal position, curled up on the floor of the car. He jammed his legs under the car seat, and wailed and moaned for the rest of the journey about the pain he was suffering. However, he resisted any attempt I made to help him to free himself, crying out in pain if I simply touched him.

It was an unfortunate, and an unforgettable, experience. I confessed my fears of bruising Daniel to the staff, and learned that I had unwittingly re-enacted a scene that was commonplace on the unit. Sadly, it took another parallel experience before I understood the sheer terror that could be unleashed and expressed by him - the high arousal state, firstly manifest in his "fight" and then his sudden retreat or "flight" into withdrawal (Perry, Pollard, Blakley, Baker and Vigilante:1995).

The following session, I talked with Daniel about what had happened. He immediately commented that he had been "a little bit angry" last week. I said that I thought he had been "a big bit angry" because he thought I had broken a promise by not finding the man with a boat. I talked with him about promises, saying that I would only use the word "promise" for something that I was absolutely certain I could do. Thus, I could promise to search for the man, but I could not promise that I would find him. I gave Daniel a card that I had made especially for him. It was the shape of an egg and the front of the card was made with wrapping paper decorated with narcissus blossoms. Both symbols had been carefully chosen, though nothing was said by way of interpretation. The message in the card reiterated what I had already told Daniel about promises.

Daniel was very quiet. Eventually he commented that he would "have to decide whether I was one of the liars". I responded that indeed he would have to decide whether I was one of the liars; it was something that only he could decide. For a child who had so far mainly communicated through metaphor, this statement was truly profound. The hope now was that he would find in me, as a therapist, someone who was consistently trustworthy so that he would risk giving me his trust, and thus consolidate this initial stage in the formation of a therapeutic attachment.

We didn't ever manage to find the man with a boat. The staff and teachers were sceptical about the reality of his existence and it was not until a year later that I established his identity. In the meantime, the reality or otherwise of his existence was not relevant to me. My immediate response to Daniel's request was intended to validate the genuineness of his expressed need. Furthermore, Daniel's interest in the boat led to my suggestion that we might make a boat together.

We bought a balsa wood model boat that became the focus of our work for many weeks to come. Working together was a painstaking process. Daniel's need for immediate gratification meant that he was often impatient with the long-winded task of building the model boat. In addition, he was continually

irritated with me as a helper, while I grappled with finding an appropriate emotional distance in our relationship. His tolerance for frustration in relation to the task of boat-building was low, but his tolerance for allowing help was even lower. As the therapist, I struggled to find an appropriate balance between imposing help at the critical moment to avoid failure, or standing by and allowing Daniel to grapple with the task and perhaps have some sense of success, while at the same resisting his need for total independence by retaining a continuously supportive role.

For the practical task of boat-building to be therapeutic, it was essential to consider our complementary activities as a re-enactment of the process of attachment formation. This experience could then create the basis for Daniel to revise his internal working models of self and attachment figures. Because the concept of internal working models is described in terms of cognitive representations, it is easy, as Bowlby (1988:156) points out, for the "unwary reader to suppose that these terms belong within a psychology concerned only with cognition and one bereft of feeling and action". Rather, attachment theory is essentially a spatial theory (Holmes:1993) in which the care-seeker (child or client) is constantly monitoring his or her emotional and physical distance from the caregiver (attachment figure or therapist) depending on the level of perceived anxiety and the strength of the drive to explore. Balint's (1986) description of the importance of the therapist getting the right emotional distance from the client encapsulates the dilemma that these boat-building sessions posed for Daniel and myself. The therapist must be

> felt to be present but must be all the time at the right distance - neither so far that the patient feels lost or abandoned, nor so close that the patient might feel encumbered and unfree - in fact at a distance that corresponds to the patient's actual need. (quoted in Holmes: 1993: 155)

The sessions felt perilous and uncertain. It was difficult to know whether I was ever finding the appropriate distance. There was no evidence that I satisfied Daniel's needs, not even fleeting moments with any sense of synchrony. Daniel only ever indicated through his irritation when the balance was wrong. My experience in the counter-transference was a sense of dissatisfaction, and an atmosphere that felt somehow prickly, yet Daniel was often reluctant to leave, with the ending of sessions occasionally becoming a prolonged battle. Although I was left wondering, week by week, whether he would want to continue his sessions, he did keep coming. Gradually he incorporated other activities into his sessions: the two armies of fighting men; the doll's house peopled with monsters and aliens; floor games with farm animals, monsters and the train set;

scenes created in the sandtray; and eventually, a series of creations made with cardboard boxes and tape.

Work with Daniel: signs of progress

Building a secure attachment to the therapist is an important beginning of the therapeutic process, but it brings a further dilemma for the client. Pain and anguish about separation need to be re-experienced if a client is to feel safe enough to form new attachments, secure in the knowledge that, should things go wrong, the loss can be mourned and the client will not be left feeling permanently bereft (Holmes:1993). The real experience of the client-therapist attachment necessarily involves separations, the endings of each session and also enforced breaks in therapy during holidays or illness (Bowlby:1988). These may resonate with previous experiences of separation and loss of attachment figures, which the client will need to work through (Ruderman:1999). Otherwise, if the pain becomes overwhelming, the tendency will be for the client to revert to older defences that reflect previous internal working models corresponding to insecure attachment.

In his sessions, Daniel was gradually changing from being almost silent, shutting down completely if I commented or asked a simple question, to talking freely about his play in the session and allowing me to ask some questions, but only rarely mentioning anything about events outside the sessions (past, present or future). Eventually he talked about day-to-day incidents, allowing some questions, but also able to state quite clearly what he felt unsafe talking about. If I occasionally persisted in asking questions, he "reminded" me that he did not wish to discuss the topic.

The change in Daniel's capacity to express himself and to interact in ways that enabled the formation of a secure attachment is epitomised in the sequence of incidents, outlined below in sections (a) to (d). Each incident occurs during the last session of the term for four consecutive terms, when Daniel is anticipating the changes in caregivers and routine with the closure of the residential school and a break in therapy for the duration of the school holiday. A sense of loss and abandonment is triggered. This sequence demonstrates Daniel moving in stages from symbolic communication during the therapy sessions to sharing his needs and feelings explicitly and eventually experiencing his social worker's responsiveness. This sequence also illustrates the critical link between the therapy sessions and the interface with day-to-day caregivers so that the attachment process is facilitated and eventually repaired.

(a) Daniel was difficult and unco-operative in school all morning. During the therapy session, he was somewhat withdrawn, but for no explicitly stated

reason. Just before the end of the session, he wanted to show me "something magic", asking to use a wax candle, a piece of paper and food colouring from the loving and caring demonstration (see footnote 1). He drew with the wax on a white sheet of paper, and used the food colouring to reveal the picture of an aeroplane. I was going overseas during the school holidays, which he had known about for some time. However, until this picture, there had been no indication from Daniel that he had feelings about this. I surmised aloud about the meaning of Daniel's picture, but there was no response from him to confirm or deny my interpretation. Despite this, staff were made aware of his probably heightened anxiety and asked to be sensitive to his possible feelings of loss and abandonment, not just related to my absence but also to the holiday arrangements of camp and a week in a family group home. For the rest of the week Daniel's behaviour greatly improved.

(b) Daniel had complained continually at school about his injured foot. He did the same during the beginning of the therapy session. I offered comfort and special cream for the injury. He persisted in his complaints. In response to the continuation of this behaviour, I suggested to Daniel that maybe more than his foot was hurting, that maybe he was upset about the start of the holidays and the ending of his sessions. This seemed to meet his needs, in that the complaints about his sore foot stopped. He allowed me to talk about the holidays and what would happen before our sessions resumed.

(c) There were no presenting behaviour difficulties prior to the session. However, when we talked about the session being the last one for the term, Daniel suddenly developed a terrible headache, looking white and pinched. He said that he did not feel well enough to go back to school. He talked about how he hated the school holidays, and said that he did not like what had been arranged for him. I promised to share his concerns with staff. However, I also intimated that it was unlikely that things could change for this holiday, although I suggested that something different might be possible for the next holidays. I returned Daniel to the residential unit, and not to school. On our arrival, the staff member started to coax Daniel back to school. I relayed Daniel's upset about the holiday arrangements, and confirmed that they could not be changed at this late stage. I encouraged the staff member to comfort Daniel, including putting him to bed to nurse his headache, and gained agreement that he should stay at home for the remainder of the day. I suggested to Daniel that he needed to talk to his social worker before the next holidays so that he might get arrangements

more to his liking. In addition, I primed the social worker to facilitate a constructive response to Daniel's request.

(d) There was no disturbed behaviour prior to the therapy session. During the session, Daniel talked positively of his holiday arrangements. He was pleased that some of what he had wanted was now happening, and he seemed more tolerant towards the things he did not like. He talked confidently of the continuation of sessions the following term.

The changes shown in the above sequence reflected Daniel's growing capacity to express his needs and feelings. In addition, he gradually learnt that some adults were responsive to his needs, which resulted in his developing attachments to several significant adults involved in his day-to-day care, such as his favourite staff member on the residential unit and one of his teachers in his new class at school. Moreover, Daniel increasingly showed a capacity to understand himself and to make sense of his situation. An example of this was shown when he recounted an incident during which he was excluded from class for swearing, eventually being sent to the head teacher. "I told her that I decided not to store up my feelings, that I decided to let them out with bad words. She said I was just making excuses for bad behaviour." We talked about swearing not being allowed at school. I asked what happened on the residential unit when he had strong feelings. "You are allowed to say bad words, but you have to go to your bedroom and say them there." I commented that he was growing up, that using bad words was better than storing up the feelings, but that he needed to choose where he could say them. I reminded him that when he was younger his stored up feelings came out as bad behaviour, kicking and screaming, and that the grown-ups had no way of knowing what was troubling him, commenting that things worked better now that he could use words. Daniel observed, "You are the only one who listens and understands." I replied, my reflection not entirely accurate, "You think that I listen and understand", to which he responded, "You haven't listened. You are the *only one* who listens *and* understands". We talked about the importance of sharing feelings and I suggested that part of growing older was finding people who understand. He then commented, "The only trouble is that as you get older, you know more bad words!" Daniel's final remark, with its wry humour, reflected another crucial development which was his increasing capacity to bring enjoyment and fun into his relationships.

Work with Daniel: weaving the threads together

In the next stage of therapy, Daniel started to integrate themes from previous sessions with accounts of incidents in his day-to-day life. He then synthesised

his experiences in both the inner and outer worlds in order to come to new understandings. This is exemplified in a session where the symbol of the narcissus re-emerged.

Earlier in the week, Daniel had been one of three children who had a special party to celebrate their progress at school. Daniel had now successfully completed a term in a mainstream primary school. He was proud of his achievement, and he showed great pleasure in each of the gifts he received to mark the occasion. Amongst the gifts was a "poster" made by his social worker. It was made from a sheet of cardboard covered in wrapping paper, decorated on one side with a poem and stickers, so that it could hang on his bedroom wall.

In the therapy session, Daniel created seven "posters", modelled on the gift from his social worker. He indicated that these were to be gifts for all the people on his unit. The most beautiful and carefully produced of the posters was allocated to his favourite residential staff member. The other six were for each of the children on the unit.

One of the posters he made was decorated with pictures of narcissus. "My favourite flowers," he said. He recollected the card that I had made him, some eighteen months previously. He commented that the card was about my broken promise. He then remembered another time I had disappointed him, another broken promise as it were, because I had forgotten to bring his birthday present on time. He remembered that he had been angry with me. He commented that he had "now forgotten". I suggested that he still remembered about it, so I wondered if he meant "forgiven" rather than forgotten. Daniel then recollected an incident in the previous week's session where I had accidentally knocked him on the head with my elbow and hurt him, saying that he had now forgiven me. He went on. "Sometimes you make mistakes, but I forgive you. You don't mean to make mistakes, but sometimes you do, and then I forgive you." He went back to discuss the original card I gave him that had been decorated with the narcissus flower. We talked about the broken promise and how he had needed to decide whether or not I was one of the liars.

This session marked further steps in Daniel's capacity to form a secure attachment. It was the first time that Daniel had used his creative energy to make gifts for those he cared about. Moreover, the idea for these gifts was modelled on a gift he had been given. This incident is a clear demonstration of Daniel's capacity to give and receive gratification. In addition, my failure to provide his birthday present in a timely fashion reminded him of other occasions when he had been disappointed and angry with me. However, unlike the catastrophic

experience on the occasion leading to the narcissus card, Daniel was able to weather the disappointment without any serious impact in terms of the stability of his internal working models, which now represented his self as worthy of love and his expectation that attachment figures would generally meet his emotional needs. Winnicott (1965:37) argues that healing occurs when the trauma is re-experienced in the therapeutic relationship in such a way that it "comes within the area of omnipotence".

> The patient is not helped if the analyst says 'your mother was not good enough ....' Changes come in an analysis when the traumatic factors enter the psychoanalytic material in the patient's own way, and within the patient's omnipotence.

Ironically, it was not only the provision of good enough "mothering" from myself as therapist that has been the source of healing, so much as also understanding the times when I had failed to meets his needs. Somehow these failures had been held within a therapeutic context that was basically secure. Winnicott states this paradox, as follows:

> The patient used the analyst's failures, often quite small ones, perhaps manoeuvred by the patient ...The patient now hates the analyst for the failure that originally came as an environmental factor, outside the area of omnipotent control, but that is now staged in the transference. So in the end we succeed by failing - failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. (1965: 258)

The healing tapestry: interweaving the roles of therapist and social worker

Therapy is always a joint journey in which both participants, the client and the therapist, are challenged and each has opportunities for growth. It is humbling when a child shares something of his or her innermost self. Daniel was remarkable in his willingness to give me glimpses of his profound vulnerability, the sheer terror that he experienced if I misjudged the narrow band of emotional safety where his feelings were close enough to the surface to engage but not so heightened that he became unreachable. As his therapist, he gave me a profound insight into the way he could oscillate between two extremes, his fear of impingement versus his fear of abandonment. Even when I made mistakes, however, he was prepared to forgive me and to risk again whether I would be worthy of his trust. Once a secure therapeutic attachment had been established, the co-operative venture of working together became a satisfying experience for both of us. Daniel learned to express a full range of emotion, from

painful anguish to exuberant joy. It was a privilege to observe the subsequent release of energy, which was channelled into creative and imaginative production during his sessions: a cardboard model of a hockey field; a secret hideout and garden for dinosaurs; a puppet theatre; a cardboard lorry; and a cage for transporting cats.[2]

In the world outside his therapy sessions, Daniel also made significant progress. He was able to occupy himself constructively through play. He began to make and sustain relationships with the children at school and on the residential unit. His capacity to form secure and discriminatory attachments to a chosen few amongst the residential staff and teachers showed that he could transfer his experience of attachment from therapy to the relationships in his real life. Increasingly he shared his feelings and thoughts with these attachment figures rather than spiralling into difficult and unmanageable behaviour. There was a striking contrast between this and the now isolated incidents of "bad behaviour", when he was mishandled by unfamiliar adults who did not understand and therefore could not be sensitive to his emotional needs.

As a social worker-therapist, I had undertaken tasks that would not traditionally be associated with a therapist role to create a bridge between therapy and his experience of day-to-day care. For instance, in transporting Daniel between his sessions and school or the residential unit, there were informal opportunities to share insights into Daniel's emotional state with his caregivers. In addition, I could translate the caregiver's experiences of his difficult behaviour so that these could be interpreted differently and understood as distorted cues for attachment. This was particularly important at the beginning stages of Daniel's revising his internal working models so that his attachment experiences were not limited to his therapy sessions but were also generalised to his everyday life. In addition, I also gave advice about a bedtime comfort programme to create a special time of nurture and comfort that would help him move from high arousal to a more relaxed state for going to sleep, as well as enhancing his growing attachment to a specific residential staff member.

Over time, my role in facilitating attachment became decreasingly necessary as Daniel became more able to express his needs and feelings appropriately and to negotiate events and relationships satisfactorily for himself. This was demonstrated in his increasing capacity to cope with the changes at holiday time. He was now ready for placement in a permanent substitute family. Therapy would

2 Further case material relating to Daniel is recounted in "Heroes' journeys: children's expression of spirituality through play therapy" (Morris: 2002).

then change focus. Introduction to a new family usually causes issues of separation and loss to re-emerge, as well as triggering a need to understand the reason for being in care and the experience of abuse and rejection from the family of origin (Jewett:1980; Fahlberg:1991). In addition, work would need to be undertaken with Daniel and the new family to facilitate the transfer of attachment to the new caregivers (Fahlberg:1991; Morris:1997, 2000). Unfortunately, in Aotearoa New Zealand it seems that there are not the resources, training and knowledge nor the mandate to facilitate the placement of an older child like Daniel in permanent out-of-family foster care, in contrast to social work practice in the United States and Britain.

In the meantime, as a social worker-therapist, I also became aware of a vast discrepancy between Daniel's evident intelligence and capacity for total absorption in constructive activity and learning experiences in his therapy sessions compared with his intermittent progress at school. Daniel's immature emotional needs could not be contained in a school system where the imperative was to move him from his small special class into a mainstream classroom and where cognitive-behavioural strategies were the only treatment offered for his subsequent behaviour difficulties. Indeed, the proposed behaviour modification techniques were directly antithetical to treatment strategies based on attachment theory. Furthermore, although specialist psychological testing confirmed Daniel's superior intelligence, it was also evident that he had a serious specific learning disability, but there were no resources to involve a specialist psychologist because they were outside the remit of Special Education Services. It was decided that Daniel's needs would best be met by placement in a long term residential school. The change of school and the termination of therapy were undertaken without any reference to attachment theory and the need to "bridge" attachments (Fahlberg:1991) to a different therapist and to new caregivers.

Conclusion

The process of therapy using attachment theory as a framework has as its overall aim the restoration of a child's capacity to form secure attachments. One of the consequences of such therapy is that it enables children to get back in touch with their feelings with an expectation that particular adults will be available to respond empathically and reliably to their emotional needs. Through the presentation of one strand of Daniel's case material focussing on the symbol of the narcissus, it can be seen that attachment theory provides not only a means of analysing the process of therapy itself, but it also shows the need for addressing issues about the day-to-day caregiving for children in care and the decisions

about where and with whom they live. If the context of caregiving and the overall decision-making framework does not protect the attachment needs of the children, then there is a very real danger that children are re-traumatised by their experiences in the care system (Hayward:1992; Morris:2000). As a social worker-therapist I was aware of the many threads of treatment that needed to be drawn together to create healing that would encompass all aspects of Daniel's well-being. However, the definition of my role by the funding agency as therapist only, and not as social worker or social worker-therapist (Nathan:1993; Meyer:2000; Phillips:2000), meant that involvement in the overall management of Daniel's care was outside my remit. In the final analysis, there were gaps in the weaving of the fabric of Daniel's healing tapestry, and it is too early to know whether the safety net created will be adequate to hold him.

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