Many adopted and looked after children with histories of physical and sexual abuse, and severe loss and neglect, develop highly disturbed and distinctive problem behaviours. Those diagnosed suffering such ‘disorders of attachment’ put great stress on the resources and skills of their post-placement carers. Children with these behaviours have proved very difficult to treat. However, as David Howe and Sheila Fearnley discuss in their paper below, attachment therapies based on ‘cognitive restructuring’ and ‘therapeutic holding’, appear to be having some success with children who have failed to respond to other treatments employed by the child mental health services. The authors describe different patterns of attachment and the behaviours associated with children classified as disorganised and disordered in their attachment behaviours. They outline therapeutic interventions based on developmental attachment theory using a case example.

The number of children with histories of severe abuse and neglect being looked after and placed for adoption has increased markedly over the last 20 years. The level of disturbed behaviour shown by some of these children, both before and after placement, is often high. This has required parents, guardians ad litem, placement workers and support specialists to develop an understanding of the nature of the developmental disturbances that can affect maltreated children and the kinds of supports and treatments that might benefit both children and parents.

Within this field have arisen two interesting, sometimes controversial phenomena. One involves the diagnosis of a ‘disorder of attachment’ for some children who are being looked after or adopted. The other concerns the use of developmentally-oriented therapies to treat ‘attachment disordered’ children, including therapeutic holding. Using the therapeutic practice of one of the authors (SF), based at the Keys Attachment Centre, to illustrate diagnosis and treatment in this field, we hope to cast further light and generate discussion on an intervention technique based on attachment theory.

The Keys Attachment Centre is a small independent agency which provides a specialist service for children and families. It recognises that early traumatic life experiences suffered by some children seriously impair their ability to form positive reciprocal relationships. Attachment therapy is used to treat children living with adoptive families and foster carers who are displaying major relationship and behavioural problems. Residential treatment programmes are also offered. At any one time, Keys typically is working with 40 children and young people placed with adoptive families and foster carers. A further 14 children, unable to live with their families, live residentially. The residential treatment programme aims to place these children into ‘long-time’ families who are recruited, trained and supported post placement by Keys. A fourth creative residential house aims to reunite children with their adoptive parents and foster carers.

The number of placed children suffering an attachment disorder is not known. However, research on the developmental pathways taken by late-placed adopted children suggests that many of those who have experienced significant abuse and adversity prior to placement show considerable psychosocial impairment post placement (Thoburn, 1991; Rushton et al., 1995; Howe, 1997, 1998; Quinton et al., 1998). Much of this impairment is expressed as restless and antisocial behaviours. Over the last ten years or more, mental health clinicians, therapists and post-placement support groups have been reporting...
increasing rates of referral from foster carers and adopters who have been experiencing major behavioural difficulties with older-placed children (for example, PPIAS, 1997). Attachment theory and research has helped us to understand why many maltreated children show such troubling and disturbed behaviours, even when placed with new families.

**Attachment theory**

Evolution has ensured that when infants experience feelings of distress, anxiety and fear they seek proximity with an adult who provides protection, care and comfort (Bowlby, 1979). Protest, or *attachment* behaviours, such as crying, clinging and following, signal the baby’s distress. These behaviours generally provoke a protective caregiving response by those adults involved with the child. In most cases, these caregivers will be the infant’s parents who, over the first six or seven months of life, become the preferred or selected attachment figures for the baby.

Experiences that trigger attachment behaviour in babies include physical discomfort (hunger, illness, pain), feeling frightened or in danger, and loss of or separation from the attachment figure, either physically or *psychologically*. Attachment behaviour is that behaviour which propels the infant into a relationship with the caregiver. If the caregiver is able to comfort, soothe, gratify and relax the baby, the child ceases his or her attachment behaviour, resumes normal exploratory behaviour, and develops trust and confidence in the caring and protective capacities of adults. However, if the quality of caregiving repeatedly fails to offer comfort, protection and understanding, the child experiences prolonged periods of unregulated emotional distress.

It is within close attachment relationships that children learn to make sense of themselves, other people and social interaction. They begin to develop mental representations of how to view the self and others. These ‘internal working models’ therefore contain expectations and beliefs about: (i) one’s own and other people’s behaviour; (ii) the loveability, acceptability and social effectiveness of the self; and (iii) the emotional interest, concern and availability of others, particularly one’s caregivers (Bowlby, 1979). If the quality of parenting or caregiving is ‘good enough’, then children develop a broadly positive view about the likeability of the self and the psychological availability of other people (Winnicott, 1964). Children who are classified as *securely* attached develop such positive mental representations.

Children who experience less sensitive, consistent and responsive caregiving are less able to mentally represent themselves as loveable, effective and worthy, or other people as emotionally available, caring and protective. This lack of sensitivity or apparent concern means that at times of distress the caregiver is not experienced as emotionally available. This ‘psychological’ loss of the caregiver further raises the infant’s level of distress and emotional arousal. Within such relationships, babies experience the self as insufficiently worthy to warrant attention, love, comfort, understanding or protection. These children are classified as *insecurely* attached (Ainsworth *et al.*, 1978).

A particular pattern of insecure attachment behaviours is observed in cases where the caregiver is the actual source of the child’s distress. Two kinds of parent-triggered distress can be identified. Children will be *afraid of* parents who physically or sexually abuse them. Children will be *afraid for* parents who are psychologically unavailable and deeply unresponsive because of depression, unresolved traumas in their own childhoods, or heavy misuse of alcohol or drugs (Main, 1995; Lyons-Ruth, 1996).

In both cases, children’s distress is triggered by the ‘loss’ of the caregiver’s emotional, caring and protective availability. Such a loss triggers attachment behaviour which normally acts to propel the child towards the caregiver. But the relationship with the caregiver is the source of the fear and distress. As infants, these children are
unable to organise their attachment behaviour in any way that has the effect of increasing the caregiver’s emotional availability. These infants are said to show a disorganised insecure attachment style (Main, 1995). Their feelings of distress and emotional arousal remain high and unregulated. Fears and traumas stay unresolved. In many severely abused and rejected children, the overwhelming feelings are ones of helpless rage and hopelessness, and fears of being unprotected, abandoned, and left to die. Severe maltreatment in the first years of life is highly correlated with developmental disturbances and problem behaviours in later childhood and adolescence (Lyons-Ruth, 1996). It is within close, attachment-based relationships that we learn to love, reciprocate, and understand ourselves and others. If children’s early close attachment relationships are ‘disordered’, their ability to develop these social understandings and interpersonal competences will be compromised. (For an introduction to attachment theory and child maltreatment, see Howe et al., 1999.)

The disorganised pattern of attachment is displayed by the majority of children who have suffered severe maltreatment (Carlson et al., 1989). However, by no means all children classified as ‘disorganised’ go on to present as clinical cases, nor have they necessarily been abused. In this paper, we are only considering a small group of children: (i) who have histories of abuse, neglect and/or rejection; (ii) whose attachment behaviour and style is consistent with the disorganised-controlling and aggressive pattern described below; and (iii) whose new carers feel that they can neither understand or control their child’s behaviour. Typically, adopters and foster carers of these children feel in need of urgent help and support.

**Disorganised and controlling patterns of attachment**

Children who show disorganised attachment behaviours fear that carers might not only be psychologically unavailable but also rejecting and dangerous. The self is therefore cognitively represented as unlovable, unworthy and yet capable of causing other people (caregivers) to behave with great anger, violence or deep psychological withdrawal. As a consequence, the self can also be experienced as powerful and bad. This is a strange, disturbing mixture of mental representations of the self and others. Other people are viewed as frightening, frightened and dangerous. The self is experienced as unloved, rejected and yet strong, bad and even evil. Initially, at least in infancy, these children are unable to use any organised strategy to handle their extreme attachment-related anxieties (Main, 1995). They feel vulnerable. ‘Flooded by pain, anger, fear, and distress, their representational models become dysregulated; they are left feeling helpless and out of control’ (George, 1996, p 416). The fear of feeling out of control is a constant theme in the experiences, behaviours and mental models displayed by children classified as disorganised.

These attachment/distress related behaviours leave little time for exploration or social learning. Maltreated children show less novelty seeking and pretend play. They are less cognitively competent (Cicchetti et al., 1989). They also exhibit reading problems and ‘verbal deficits’, especially children with conduct disorders (Lyons-Ruth, 1996, p 69). Children who are not provided with the words and concepts to recognise and understand their feelings (emotional scaffolding) are those who find it most difficult to regulate their effect. The poverty of interpersonal exchanges, particularly in the case of children whose mothers are maltreating and/or depressed, means that children are exposed to fewer words to help them identify, conceptualise and discriminate feelings and other mental states. Beeghly and Cicchetti (1994) found that children who had experienced severe neglect and abuse used relatively few ‘mental state’ words. Maltreated toddlers talk less about their own thoughts, feelings and actions than non-maltreated toddlers. They are also
less able to differentiate between different feelings (e.g. they become confused between feelings of sadness, anger and fear).

A lack of ‘emotional scaffolding’ means that many maltreated children find it difficult to distinguish, understand and control emotions both in the self and others. The result is social confusion and incompetence that results in aggression, withdrawal or both. Thus, children who have experienced the greatest traumas are those least emotionally equipped to deal with them. This paper hopes to demonstrate that these basic deficits in maltreated children’s ability to recognise, name, understand and handle strong emotions form an important focus of attachment-based therapies.

The behaviour of attachment disturbed and disordered children

Clinicians recognise a group of problem behaviours associated with profound disturbances in children’s attachment relationships that are diagnosed as ‘attachment disorders’:

- **Clinically disordered attachment** represents an extreme and impaired subgroup of children with insecure attachments. Thus, disordered attachments are all insecure attachments, but most insecure attachments are not disordered. (Zeanah, 1996, p 42)

- The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and The International Classification of Diseases (ICD-10) describe the criteria for attachment disorders. Both recognise two types of disorder: inhibited and disinhibited.

- The disturbed and problem behaviours shown by many looked after and adopted children with histories of severe trauma, abuse and neglect meet the criteria for a diagnosis of attachment disorder (Cline, 1992; Archer, 1996). The Keys Attachment Centre has developed an Attachment Disorder checklist based on DSM-IV and ICD-10 and adapted from Reber (1996). Symptoms of an attachment-disorder include:

  **Social**
  - Superficial and charming behaviour with strangers, grandiosity;
  - Little eye contact;
  - Poor peer relations;
  - Fights for control over everything.

  **Emotional**
  - Indiscriminately affectionate with strangers, grandiosity;
  - Inappropriately demanding or clingy;
  - Lack of affection with carers;
  - Resentment.

  **Behavioural**
  - High levels of anger, rage and even violence towards carers, particularly mothers (adopters, foster carers); oppositional behaviours; constant blaming of others; poor impulse control;
  - Restlessness; constant need for stimulation and activity that often leads to antisocial behaviours;
  - Children act as if their new carers (particularly adoptive and foster mothers) were responsible for their past abuse and hurt, which is puzzling and hurtful for carers.
  - Coercive, demanding behaviour;
  - ‘Crazy’, obvious lying; manipulative lying to get what they want;
  - Early sexual activity;
  - Stealing (e.g. from mother’s purse);
  - Preoccupation with fire, blood, gore, and weapons, often expressed in violent drawings;
  - Cruelty to animals;
  - High breakage rate of toys and objects, and a tendency to trash rooms when in a temper.

  **Developmental**
  - Lacks cause and effect thinking;
  - Abnormal eating patterns (gorging, stealing food, hoarding, refusing to eat, particularly in presence of other family members) – these eating problems reflect
early failures of nurturing and repeated experiences of hunger and physical neglect;

- Lack of conscience and moral sensibilities;
- Self-neglect; very poor personal hygiene; urinating in inappropriate places.

No one child will present with all of these behaviours. Attachment disordered children show both an avoidance of intimacy and extreme attempts to control close relationships coercively (using mixtures of threatening/angry/menacing behaviours and seductive/charming/paranoid behaviours (for example see Crittenden, 1995). As some of these behaviours are also said to be typical of children with Attention Deficit Hyperactivity Disorder (ADHD), there is active debate about the relationship, overlap and diagnostic distinctions between problem-behaviour children with adverse caregiving histories and those with ADHD (eg Crittenden, 1995). The Keys Attachment Centre acknowledges these overlaps and recognises multiple diagnoses such as Attachment Disorder/ADHD/dyslexia.

Certain experiences, particularly if met before the age of two, act as risk factors in the development of an attachment disorder. These include:

- Pre-birth and birth traumas;
- Sudden separations from primary caregiver;
- Frequent moves between different carers and/or placements;
- Undiagnosed and/or painful illness;
- Chronic maternal depression/substance abuse;
- Primary caregiver has experienced serious childhood traumas which remain unresolved;
- Severe neglect;
- Severe physical, sexual and emotional abuse.

### Explanation of disordered attachment behaviours

In terms of attachment theory these behaviours are explained in terms of children trying to exert some early control over a world that is experienced as threatening and dangerous, frightening and unpredictable. If infants’ attempts to organise their attachment behaviour around strategies designed to increase the availability of the caregiver fail, abused and frightened children are left in heightened states of distress, fear and rage with no prospect of being soothed, relaxed and comforted. Sustained interactions with frightening or frightened caregivers, who are both the source of the alarm and emotionally unavailable as attachment figures, leave young children traumatised. If traumas are also mixed up with sexual abuse, children’s understanding of love, need, arousal, intimacy, hurt, fear and guilt become even more confused.

This frightening and uncontrollable state of affairs is psychologically unsustainable. Young children have to try and introduce some predictability, understanding and control into their dangerous, painful world. The solutions to their problem begin to define the way they cognitively represent themselves and other people in their emerging internal working models. The only predictable element in the parent–child relationship is the child himself or herself. Therefore children begin to feel that the only route to feeling remotely safe, physically and psychologically, is to take control of the self, other people and the environment. Adults who try to provide care cannot be trusted. Physical and psychological survival appears to depend on being vigilant and wary. In the past, close relationships and being dependent and trusting have always led to abuse, and feelings of fear, distress and hurt. Closeness to others spells danger. Intimacy therefore has to be resisted.

It also appears to many ‘controlling’ children that in their relationships with their carers, it is they, as children, who seem to ‘cause’ (by their very presence) other people to be angry, violent or very frightened and in need of care (for
example, in the case of parents who are depressed or drunk). The self is therefore seen as strong and powerful, but also dangerous and bad in terms of how it affects others. Indeed, as children’s behaviour grows worse, it is not unusual to hear parents describe their difficult children as ‘mental’, evil monsters and beyond control. Children, too, will often depict themselves as some kind of dangerous, invincible, bad force that cannot be defeated no matter what frightening and threatening things take place.

In such ways, young children achieve a perverse predictability that to the outsider might seem bizarre and self-destructive. However, from the child’s point of view such behaviours introduce some kind of desperate ‘self-control’. Rhythmic rocking, head-banging, hair pulling and self-mutilation are typical examples of such behaviours in young childhood.

As the children grow older, this anxious need to be in control leads to increasing interpersonal and behavioural problems. And because close relationships have been associated with experiences of severe trauma, children remain wary of and reluctant to commit themselves to caregiving relationships. They continue to cut themselves off from experiences of reciprocity and shared attunement. They therefore fail to develop much in the way of emotional scaffolding. Feelings of anger and need become confused, so that to experience one might be to display the other. Fear, distress and sadness also become muddled and undifferentiated. Disorganised-controlling children therefore tend to misunderstand and mis-play many social situations, further adding to their distress, mistrust and displays of intense rage and anger. All attachment-related issues seem to lead to arousal and aggression, none of which appears to make sense to well-meaning others, especially new, loving carers. Indeed, to the child the close relationship offered by new carers implies closeness and dependence, which in past abusive relationships have always led to pain and fear. Perversely, the more ‘love’ offered by the new carer, the more distressed, controlling and aggressive becomes the ‘disordered’ child. In many situations, adoptive parents and foster carers can soon feel desperate and de-skilled (Keck and Kupecky, 1995; PPIAS, 1997). Exhausted parents can be mistaken for incompetent, critical parents.

**Therapeutic interventions**

The philosophy, character and rationale for attachment-based interventions with controlling children are firmly based on the research evidence that recognises that close caregiving relationships are where things tend to go wrong for these children, and therefore close caregiving relationships are where things are likely to be put right (for example, George and Solomon, 1996). However, close relationships are the one thing that these children avoid. Their developmental agenda is to control and not engage people. This denies them exposure to the very experience that they need. So long as they remain unable to relinquish control and relate fully and accurately with their carers and therapists, the children make little emotional or developmental progress. Their early traumatic experiences mean that they remain ‘stuck’ at an early stage of their development.

The relationship between the maltreating parent and the child, although damaging, was nevertheless experienced as intense. An equally intense therapeutic relationship is therefore necessary to overcome and counteract the child’s commitment to that first attachment relationship. Therapy with children with an attachment disorder has to be close, intense, intrusive, nurturing and highly alert. Positive therapeutic and relationship experiences have to match the intensity of the negative emotional conditions that the child experienced in relationship with the abusive parent if the child is to become ‘unstuck’. ‘One goal of therapy, then, is to approximate to the healthy bonding cycle, thus reworking the process that was so traumatically interrupted early in the child’s life.’ (Keck and Kupecky, 1995, p 152).
Educating the child about his or her early attachment experiences and the resultant psychosocial difficulties gives the message, ‘We understand how you got to be this way and can help you.’ Further, this positive reframing gives the message, ‘It was not your fault that you were maltreated, but you are responsible for your behaviour and choices now and in the future. We also understand that in the past you needed to use your defences and be in control in order to protect yourself and survive, but those defences are now preventing you from learning to love and trust’ (Keck and Kupecky, 1995; Orlans and Levy, 1995; Fearnley, 1997, 1998).

A thorough and comprehensive assessment is first carried out. Risk factors in the child’s early developmental history are noted. An extensive behaviour checklist is used to establish areas of disturbance. The perceptions of the current carer are obtained. The checklist gives a maximum score of problem and disturbed behaviours of 108. Children scoring below 60 are not considered suitable for attachment therapy treatment. The mean score for a study group of children treated at Keys was 77 (n = 24; compare a matched control of 24 non-clinical children whose mean score was 33). Scores for the treated group ranged between 60 and 99 (compared to 27 to 42 for the control group). Treatment normally comprises a number of elements, but two in particular might be teased out:

1. Cognitive restructuring of emotional experiences and ‘disconfirmation’ of negative, insecure working models of the self and others, by
2. Experiencing an intense, close, caring, firm, containing physical and emotional relationship (known as therapeutic holding).

Most of the initial work takes place in a two-week ‘intensive’ treatment programme (three hours a day over ten working days), followed by long-term, less intensive treatments that build on the initial breakthroughs.

**Therapeutic holding**

Therapeutic holding (but not restraint) seeks to develop a meaningful, intense, fully-open relationship with the angry but hurt child (Welch, 1988; also see Fahlberg, 1990). Therapeutic goals include (Orlans and Levy, 1995; Fearnley, 1998):

- To contain and reduce acting-out behaviour;
- To identify and express emotions verbally;
- To experience a safe, caring, nurturing, interested relationship with significant adults;
- To facilitate descriptions of past traumas and the expressions associated with them;
- To help the child explore and recognise that the perpetrators of the original abuse and traumas were the born-to parents (and not the current carers) and that anger and sadness is appropriately directed at them (and not the current carers).

Holding seeks to recreate feelings of infant security. It allows children to release control, develop trust and express strong feelings in a safe environment. Therapy with attachment disordered children needs to create a corrective emotional experience. As deficient and traumatic experiences often occurred in the first years of development, many techniques involve the child experiencing intense, positive interventions based on physical proximity, touch, nurturing, care, constant eye contact, verbal exchanges, and the successful experience and negotiation of confrontation. Therapy aims to approximate, through experience, what should have occurred in the child’s formative years. The intense introduction of safe, healthy, unabused bonding behaviours help initiate more secure attachment behaviours. The child is helped to reframe the process that was traumatically interrupted in the initial abusive experiences. Close proximity heightens the therapeutic process. The growing attachment relationship is
systematically transferred to the carers.

Before treatment begins, the method of working is explained to the children and their current carers. They are shown what is involved and all aspects of the intervention are described. Prior to beginning treatment, all parties have to agree to participate. Furthermore, once treatment is underway, the child or young person contracts at the end of each session to return to the next session. Although there is often verbal resistance to being ‘held’, Keys has not yet had a child who has refused. If they did, the first response would be to negotiate a way forward.

The child is asked to lie across the laps of the two therapists and/or the parents with a cushion placed under the head. The right arm of the child is placed around the back of the lead therapist. Without the agreement of the child, ‘holding’ is not attempted. Children’s carers are involved and informed at all stages of the therapeutic process. Children are prone to self-stimulate under these conditions (to avoid emotionally engaging with the parent or therapist, while maintaining self-control and arousal). They have to be discouraged from either fidgeting or scratching. Eye contact is extremely important and the therapist ensures that it is maintained. These are children who avoid the intimacy of eye contact, unless they are feeling very aggressive and hostile. Eye contact aids communication and bonding. It is integral to the formation of close, trusting relationships in which socio-emotional learning takes place.

Holding is a situation of dependence in which attachment-related experiences rise rapidly to the surface. These are disturbed children who, under such conditions, will react with confused anger and feelings of distress linked to their earlier experiences of abandonment and abuse, separation and trauma, care and love. Such feelings of distress activate their controlling behaviour.

The held child typically goes through four stages: (i) resistance and anger; (ii) acceptance of the other’s control; (iii) sadness and pain; and (iv) increased trust and secure attachment behaviour. Holding therefore increases emotions and provokes responses that are unlikely to occur in less demanding treatments in which children simply avoid or deflect attempts at psychological connection, and thus remain stuck and locked behind their defences.

Holding provides a ‘corrective emotional experience’. It also helps children sense that their emotions, including anger, can be contained; that they do not always lead to destruction and abandonment. In short, therapeutic holding seeks to generate an experience that replicates the qualities of good-enough early care, nurturing, trust, safety and security. Once children begin to experience these, they can then allow themselves to be understood, influenced and controlled by a trusted, loving parent – the starting point for sound socio-emotional development. Relinquishing control allows children to enjoy, trust and learn from others.

Cognitive restructuring of the self and others by rebuilding positive and accurate ‘emotional scaffolding’

The physical proximity provided by ‘holding’ allows both child and therapist to access feelings that are not always verbally expressed. More generally, the treatment helps children not only to release and demonstrate feelings, it aims to help them recognise, label and understand them. Not until children can distinguish between despair, anger, guilt, happiness, shame, rage and fear (‘sad, mad, glad and scared’) can they begin to regulate their own affect and understand the nature and origin of other people’s feelings and behaviour. Indeed, many children even find it difficult to differentiate feelings associated with their basic senses, including touch, smell, taste, sound and sight. Bodily signals, such as pain or hunger or needing to urinate, are easily misread and lead to inappropriate behaviours (putting a winter coat on for a hot summer’s day; wanting to eat when they are already full). Experience and recognition of feelings are the first important steps to help children get in touch with themselves; to help them access and deal
with their early experiences of loss and abuse; to recognise their true origins and make sense of how they continue to affect current feelings and behaviour in close relationships.

The deep anxiety felt by ‘controlling’ children is that by ‘letting go’, danger, abandonment and feelings of fear and rage will overwhelm them and destroy their psychological integrity and survival. By identifying, labelling and differentiating strong feelings and understanding some of their origins in abusive, rejecting and neglecting early caregiving relationships, children can begin to ‘disconfirm’ their current insecure internal working models. The self can be experienced as worthy and loveable rather than as unloveable, bad and deserving of abuse. Other people can be represented as available and caring, and not as unavailable, unpredictable and hostile. Children need to be able to say such things as: ‘My father sexually abused me. I hate him for that. I am upset and very angry that my mother was unable to protect me.’

These children have ‘lost’ a great deal. It is not until they have connected with their experiences and grieved their losses that they can begin to resolve early traumas. The case of Mel illustrates both the characteristics of a child with an attachment disorder and aspects of attachment therapy.

**Case example: Mel**

Mel was 11 years old when she was referred to the Keys Attachment Centre after three foster care breakdowns. She has three siblings, all of whom are being looked after by foster carers. When she first started school, her teachers expressed worries about her lack of care and her aggressive behaviour towards other children. Mel and her siblings witnessed a lot of violence at home between their mother and her many male partners. Mel had experienced a large number of short-term, temporary ‘care’ arrangements in which she would be looked after by one or more of her mother’s friends. Various concerns eventually led to Mel being placed with foster carers at the age of five.

Over the next five years, Mel reacted with great distress in any situation that she perceived to be threatening. If someone unexpectedly knocked on her bedroom door, she would yell, scream and run out into the street shouting ‘They’re going to kill me’ while literally pulling chunks out of her hair. Each of her several foster carers said that Mel was ‘unresponsive’ and ‘switched off’ for much of the time, except when there were violent outbursts of anger and aggression, directed mainly at the foster mother or female carer. She never laughed or smiled. She had no sense of humour. Foster carers found her very difficult to handle and each placement would end with an urgent request to have her removed. Carers felt that the more they tried to get close to Mel, the more frightened and determined she was to push them away. From knowledge of Mel’s pre-placement care it seems that she would only get a cuddle from her mother after there had been violence. Mel began to associate blood and violence with comfort and care; that you could not have love until there had been hurt and aggression. It also seemed that at times of distress, Mel took on the role of carer for her mother, suppressing her own attachment needs to meet those of her parent.

In foster care, Mel constantly threatened to self-harm and run away, particularly when she felt that she could not be in control. Other children rejected and taunted her. She would hoard food, take other children’s audio-tapes, watches and earrings, both in her foster homes and at school. She would regularly wet herself but not wash so that there was a constant smell of urine around her. Her knickers would be soiled but she either put them back on or would hide them in her bedroom. At school, she would tell fantastic stories about how she had recently been raped, and that boys were always having sex with her, but investigations suggested that these incidents had not really happened. Rather, it was felt that Mel had seen, and even possibly experienced, a lot of sexual activity in the home of her birth mother.

An important therapeutic aim in
working with Mel was to help her to recognise that in her dealings with caring adults, she was operating on the assumption that first you had to experience pain and violence before you could get love and attention. Through holding and role play, Mel was helped to recognise this association. By relinquishing control, she could then experience care that was not conditional on the prior expression of hurt and aggression. She was also helped to distinguish between her needs and wants.

It also seemed to Mel that the only way to gain proximity to her birth mother was to reverse roles and ‘parent her parent’. In her play, Mel repeatedly enacted adults being violent towards each other followed by her, the child, providing them, the adults, with comfort. The developmental price paid for this strategy was that Mel had to deny her own attachment needs; she could not admit or acknowledge her own strong feelings; she had to be in control; she could not afford to be dependent on adults; she was the emotional provider and not the receiver. Although Mel felt on familiar ground with her mother and therefore believed that was where she was best placed, so long as she continued to believe this to be true she could not acknowledge that her mother had failed to provide her with care and protection, and that this failure had caused her much neglect, distress and considerable anger. It was necessary for Mel to begin to recognise and understand both her own needs and her mother’s unwillingness and inability to care for her. Mel was eventually able to articulate that her mother ‘hadn’t done her job properly’ and that for a vulnerable child that was hurtful as well as sad. Her anger and sadness at the realisation that her birth mother would never be capable of looking after her safely began to be redirected away from her female foster carer towards her own mother.

In the past, Mel was unable to let her fear show. She could only keep profound feelings of distress at bay by being in control and not letting anyone close to her. The holding and cognitive restructuring allowed Mel to accept contact and comfort from her carers without first causing hurt. She learned to say that she would like a cuddle without first having to attack her carer. It was as if she was beginning to see herself in her own right, with her own needs. Mel began to talk about feeling anxious when a preferred carer was not immediately available and how this sometimes made her feel cross and angry. Connections began to be made between her feelings and behaviour. She also allowed herself to feel dependent and explore the emotions that go with that. ‘I get butterflies in my tummy when I’m looking forward to someone coming,’ she said, ‘and that’s exciting and it also makes me feel glad.’ Previously, Mel refused to allow other people to have that kind of emotional effect on her.

Mel began to say that she was jealous when adults, including her birth mother, gave other children attention. ‘I just want to hit out and have them all for myself.’ A lot of work was also carried out to help Mel make chronological sense of her many care experiences. She grew excited at these exercises, saying ‘Yes, I was there. Yes, and then I went there’, as if all the comings and goings were beginning to fall into place and with it the scattered fragments of her life.

As the child and carers work through each stage of treatment, there is a growing understanding of how early upsets, traumas and maltreatments adversely affect perceptual, emotional and cognitive functioning. The child’s outlook and understandings have to change if they are to learn to trust others and allow themselves to be cared for so that their needs can be met. Within a close, intense, focused relationship, children begin to make sense of themselves and others; they allow others to care for them.

Conclusion

Many children entering the care system with backgrounds of severe abuse and neglect show very disturbed behaviours. Children who feel great distress and fear in close relationships find it difficult to enjoy the two-way benefits of open and accurate communication of thoughts and feelings. They deny their attachment
needs with the result that their relationships are disordered. They make little progress in developing emotional literacy and social competence, two prized resiliences. They fear letting the world inside their defences lest they are overwhelmed and psychologically annihilated. Control of the self, others and the physical environment therefore remains paramount. This makes children with disordered and controlling attachments extremely difficult to parent. Foster mothers and adoptive mothers in particular are the targets of these children’s anger and aggression, though family, friends and school are soon drawn into the tense, conflictual world generated whenever these children experience close, social, attachment-evoking environments.

On first meeting, children typically present as fleetingly charming. In contrast, parents appear distraught. Diagnosing parents as ‘low on warmth’ and ‘high on criticism’ in many cases may be mistaking the consequences of parenting a disturbed child for the cause. Attachment-based treatments are not panaceas, but they hold out therapeutic promise. They allow children to make close relationships with their carers. It is only within warm, consistent, accepting, reciprocal relationships that children learn to be empathic and socially competent. Holding therapies and the development of emotional understanding and empathy help children to relinquish control and begin, often for the first time, the serious business of learning how to relate directly with other human beings without fear or the distress of psychological disorganisation. The clinical and anecdotal evidence of the value of specialist attachment-based treatments is strong. However, rigorous controlled studies are lacking. Evaluative research is now underway in the USA (eg Myeroff and Randolph, 1997) and at the Keys Attachment Centre in the UK, the results of which should further develop our understanding of both the ‘disordered’ child and the importance of specialist support and therapeutic services for these children and their parents.

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