



A journey of two therapists: a little bit of spit never hurt

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Sometimes work takes us to places we could never have imagined, and changes us profoundly as therapists and individuals. Over the course of a career we change jobs and we pursue different areas of interest, and every so often one of those areas really captures our imaginations and we become motivated to learn as much as we possibly can. In the past year, we have had one of those periods, and a great portion of our time, energy and interest has been devoted to the area of attachment. We have attended workshops, read books and papers, learned and practised techniques and had regular supervision. Yet each time we have felt a solid grasp of concept and technique, that sense has slipped away or utterly vanished, only to be rebuilt and fall away again, and so on. Many of our beliefs about therapy have been thrown into question as we have worked with children with attachment problems, children who have hurt their parents and sometimes tried to hurt us too. Our journey through the dilemmas and challenges of assessing, understanding and treating attachment disorders is the subject of this paper.

What is attachment theory?

The concept of attachment as a universal human drive and need is now so widely recognised that it is easy for us to forget that it is a relatively new concept which initially met with scepticism. This paper will not attempt to fully canvas the relevant literature, the interested reader is referred instead to one of many excellent summary texts available, such as Cassidy and Shaver's 1999 *Handbook of Attachment*. 'Attachment' describes the enduring affective relationships between people. It is characterised by a tendency to seek and maintain proximity to a specific person, especially when sick, afraid or otherwise under stress (Bowlby¹). Bowlby¹ saw attachment as a lifelong drive, operating most powerfully in infancy but continuing to be present to the grave. He saw it as bi-directional, not something the parent "does" to the child, but something that is created by the relationship between them.

Bowlby¹ notes that many researchers in the 1930s and 1940s had begun to study the impact of prolonged periods of institutional care and multiple changes of primary caregiver on personality development. They published their findings, but with little impact. In 1951, Bowlby himself published a monograph for the World Health Organisation, *Maternal Care and Mental Health*, in which he canvassed the evidence on the impact of inadequate early maternal care and separation from primary caregivers. The professional communities remained sceptical, claiming a deficiency of evidence and "the lack of an adequate explanation of how the types of experiences implicated could have the effects on personality development claimed". (Bowlby¹)

Acceptance came finally, through the persistent efforts of researchers such as Harlow, Ainsworth, Spitz and Robertson. Bowlby set himself the task of assimilating the research findings into an explanatory theoretical framework. Attachment theory was born. Prior to this, most human behaviour was assumed to result from the drives for food and sex. By contrast, attachment theory emphasises a child's need to feel safe and secure as a primary motivational drive. Bowlby suggested that this security is obtained and maintained through relationship with a primary caregiver, who notices and responds to the child's needs and emotional state and who provides a secure base for exploration. The development of attachment theory utterly changed our thinking about children's relationships with their caregivers.

The child with secure attachment

Our early attachments profoundly affect our development in all spheres. Ordinary "good enough" (Winnicott²) parents provide for the infant's needs in a caring and timely manner. They provide food, change nappies and anticipate a range of needs. Singing and gentle rocking is used to soothe a fretting baby. The child is smiled at, talked to, and gazed at lovingly over and over every day. This child learns that the world is a safe place where adults can be trusted to care for them. In the second year, the parents gradually increase the child's opportunities for independence and decision making. The

securely attached child uses their parents as a secure base (Ainsworth) from which to explore the world. This child learns that adults are stronger and wiser and will look after them. The child learns that when they get angry or upset or scared, there is someone strong enough to look after them and help them feel better. This child learns that there are rules to be followed, and that these rules apply to them. These experiences are the foundations of trust and conscience development.

What happens when something goes wrong?

There are many things that can compromise attachment formation, such as lack of physical or emotional access to the primary caregiver/s, or inadequate protection or care. Children at risk of attachment problems are those whose basic needs for nurturing and safe exploration are not adequately met in their first 3 years. The child who does not receive food when they are hungry, or warmth when they are cold, who lies in a dirty nappy, is screamed at, hurt or ignored will form in their pre-verbal memory a belief that the world is not a safe place and that adults cannot be relied upon to care for them. Some children experience prolonged periods of painful separation from their caregivers for a range of reasons, sometimes no-one's "fault" and this too can negatively impact the child's development of trust in the world as a safe place. When it is time to learn about rules, some children experience a world that is confusing or frightening or dismissive. The child who is subject to harsh or inconsistent or little discipline learns that rules are frightening, that adults cannot be relied upon to keep them safe, and that rules do not apply to them. Their early development of empathy, conscience and trust is likely to be compromised, especially in the absence of corrective experiences.

Our work with children who have attachment disorders

As mental health professionals, it is part of our brief to assess and treat children and young people with attachment difficulties. We find it most useful to think about attachment styles as falling on a continuum, with totally secure at one end and severely disturbed at the other. Most styles are not pathological, but severe unresolved attachment problems cause all manner of difficulties for children and their caregivers. It is this end of the continuum that has been our recent focus.

It is through our work with these children that we have come to learn about identifying and treating Reactive Attachment Disorder (RAD). RAD manifests in markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age five years. It is associated with grossly pathological care such as neglect, abuse, mistreatment, abandonment or periods of separation from the primary caregiver. (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, 2000³). Children with RAD typically present with characteristics such as being controlling, defiant, superficially charming, manipulating, oppositional and indiscriminately sociable. They have problems in relationships with others especially their primary caregivers. Assessment and diagnosis of RAD rests on three major pillars, early history, historical and current symptoms, and direct observation of relationship patterns. (Levy and Orlans⁴) In our experience these assessments are best carried out over a period of time, taking information from a range of sources and using the expertise of a multi-disciplinary team. RAD is a serious condition and for this reason we recommend the inclusion of a Psychiatrist in the assessment team. Some children diagnosed with psychiatric conditions are eligible for additional resources through other service systems and we have found the early involvement of a Psychiatrist has substantially facilitated applications for those resources.

Responding to attachment disorders

Reactive Attachment Disorder is both preventable and treatable. We have found, however, that treatment approaches are the subject of considerable controversy and this has confused, unnerved and troubled us. For example, a simple internet search for "attachment therapy" will bring up results that are disquieting indeed. One will find stories of children who have been subjected to punishment, screamed at, sat on, humiliated, coerced, or hurt during interventions reportedly designed to treat attachment problems. We have therefore concluded that the term "attachment therapy" is not a very useful one, at least not at this point in time, as it has no agreed definition and holds negative meanings



for many professionals. We have, however, identified a number of research-based therapies that are well regarded, grounded in attachment theory and are not considered controversial.

Circle of Security

Developed by Cooper, Hoffman, Marvin and Powell⁵, *Circle of Security* is a group program designed for use with high-risk pre-school children and their carers to support the development of secure attachment. Prior to entering the program the attachment style of each dyad is assessed. An individualised 'parenting road map' is designed as a clear pathway to establishing a secure relationship. A core component is the video recording of interactions between parent and child. After each recording, parents are encouraged to reflect on their child's behaviour and their own responses, thoughts and feelings. The main objectives of the program are:

- increasing parent skills in observing parent/child interactions
- increasing capacity of the caregiver to recognise and sensitively respond to children's needs
- supporting a process of reflective dialogue between clinician and parent to explore both strengths and under developed capacities
- introducing parents to a user-friendly way to explore defensive processes.

Theraplay

Theraplay was founded by Ann Jernberg⁶ in 1967. Theraplay encourages the replication of normal parent-child interactions, and includes regressive activities which attempt to evoke early feelings and memories. One of the features of *Theraplay* is the adult and child learning to connect with each other in a basic intimate and accepting way. As therapy progresses there is less emphasis on regression and an increase in age-appropriate activities. Jernberg categorises the scenarios of normal parent-child interaction into four groups:

- structure – relieving the child of the burden of maintaining control of interaction. The adults set limits, define body boundaries, keep the child safe and help to complete sequences of activities
- challenge – helping the child feel more competent and confident by encouraging them to take a slight risk and to accomplish an activity with adult help
- engagement – establishing and maintaining a connection with the child and to surprise and entice the child into enjoying new experiences
- nurturing – reinforcing the message that the child is worthy of care and that adults will provide care without the child having to ask.

Dyadic Developmental Psychotherapy

Developed by Daniel Hughes⁷ *Dyadic Developmental Psychotherapy* is a cornerstone of our approach. A central feature is creation of a therapeutic PACE for children: Playfulness, Acceptance, Curiosity and Empathy. Opportunities for enjoyment and laughter, play and fun are provided unconditionally throughout each session. This safe setting enables the child to begin to explore, resolve, and integrate a wide range of memories, emotions, and current experiences, which are frightening, stressful, avoided or denied. This safe setting is created with nonverbal attunement, reflective and non-judgmental dialogue, empathy and reassurance. As the process unfolds, the child is creating a coherent life story that is crucial for attachment security and is a strong protective factor against psychopathology. Therapists recreate early attachment experiences by using eye contact, voice, tone, touch, movement and gestures which actively communicate safety, acceptance, curiosity, playfulness and empathy.

Treatment plan

Therapy is just one part of a treatment plan, and we need to work with all those involved in the child's life for the best outcomes to be achieved. Attachment difficulties are created in relationships, and need to be addressed in relationships, and the child's relationships outside the therapy room provide their greatest source of support. Treatment plans must also take account of a range of variables. We see children of different ages and abilities, living in various family situations, with differing needs. Their parents/caregivers in turn have their own needs and abilities. Some parents are insightful, reflective, strong and capable. They are usually fastest to take on board both content and technique. Other parents are themselves traumatised and may struggle with the material, with the emotional content and with their own demons. The youngest children are always seen with their caregivers, with the aim of enhancing the attachment between them. Teenagers, at the developmental stage of individuation, are seen both individually and with their family. A life-skills approach can be more useful for them.

Our journey begins

Theory comes to life for us in our work with children who have attachment disorders. We would like now to introduce you to Callum, the bringer of spit. Callum was our first client with Reactive Attachment Disorder. There have been others since, and each of them has provided us with many opportunities to develop, question, challenge, reflect upon and agonise over our practice in this area.

Our journey started when we were contacted by a local Social Worker seeking urgent advice about a five year old. His behaviour was so uncontrollable his family was at great risk of being hurt by him. Callum had been a very difficult child for some time, and he was getting worse. Callum was admitted to hospital for medical assessment, and following this admission he was assessed at CAMHS. His parents told a sad story of separations, illness and trauma. Callum had a history of harming and threatening his brothers, sister and parents. He was so charming to others that his family had an almost impossible task to get anyone to understand how hard it was to live with him. His mum had been trying to get help from a number of different services for some years, but most of Callum's behaviours were just getting worse. After a thorough assessment of early history, past and current behaviours and observation of relationships by a multi-disciplinary team an assessment of Reactive Attachment Disorder was made.

Despite our collective experience, we both knew we needed to learn much more to be able to effectively work with children whose attachment is severely disturbed. A locally held workshop introduced us to a range of ideas, approaches and resources and we were inspired and eager to commence this work. We were lucky enough to be able to arrange regular supervision with an experienced practitioner and this has provided a solid foundation on which to build our practice. Use of technology such as telephone and email mean we can receive high-quality supervision no matter where in the world our supervisor is working at the time.

A journey which challenges our thinking and beliefs

In most of our clinical work, the therapeutic starting point is engagement and developing rapport. But how do you develop rapport with a child who does not trust? With Callum, we learned that the first step is establishing physical and emotional safety by explicitly conveying acceptance and setting clear ground rules. We have been able to watch our supervisor do this, and we have used modelling as a key learning technique. Initially, her words would come out of our mouths too. Gradually over time we have found our own words as we develop our own style, beliefs, self awareness and value system for this work.

We continued to attend workshops, buy books and read articles and to talk to people about how to best respond to children like Callum and their families. We listened to audio books as we drove to and from work. We can do therapy in all the different accents of our favourite speakers, so often have we listened to those tapes. We have learned ways to respond to situations we had never imagined we would face. We have had to think really hard, for example, about how to respond when a child tries to hurt us or



their caregivers. Prior to working with children like Callum, we both had firmly held beliefs that children should not be touched by a therapist. When faced with the reality of extreme distancing behaviours such as attempts to hit, kick and bite, we found we needed to learn about safe containment. This has been done with much soul searching, exploration of self and professional ethical responsibilities. One of our solutions to this is to never work alone with a child who has these behaviours in their repertoire. Two adults provide much greater safety in all respects. This particular part of the journey has led us to look long and hard at the issue of “holding therapy” – a term that seems to have as many different meanings in the literature as there are authors commenting on it. Of course, there are so many practices we can dismiss with ease for being clearly harmful, but we remain overall somewhat confused and conflicted about this debate, and continue to read and talk and think about it.

We have also learned how to cope with being spat on, something that had never happened to either of us prior to commencing this work. The first time Janice was spat on, she went back to the office and cried many tears and felt terribly sorry for herself for some time. Through supervision, we learned to be able to understand and respond to this behaviour and we are now pretty good at anticipating and dodging it. We have learned how to avoid being bitten, and what sort of clothing makes being bitten less risky. We have learned ways to manage each of these behaviours in a way that conveys deep understanding while increasing accountability. Nevertheless, such confronting behaviours throw us again and again into ethical and moral debates. What are we doing? Is it working? Is there any better way to do this than we already know? Sometimes we think it is just too hard. We debate, we change our minds, we go full circle over and over again. This cyclical process is praxis, practising a theory and skill, reviewing, altering as required, then trying again, and so on.

“Playversation”

Working in the area of attachment has resulted in us working with much younger children than usual, with our youngest client aged just two years. This has taken us out of our comfort zone as we cannot rely on the ‘talking therapies’ with which we are most familiar. We have found we need lots of self-prompts to remember that we communicate better with younger children through play, and we have coined the term “playversation” to remind us of this. It describes for us the process by which we have very meaningful and rich exchanges with children via play, dance, story and fun, and is something about which we will write some more at a later date.

The importance of good relationships

We live and work in a small rural community. Some services available to those in larger centres are not available to us, and we rely instead on close co-operation and flexibility to meet client needs. This close contact means that strong and enduring working relationships can readily be formed. Service systems are small enough that we can get to know most key people and agencies quite well. Our work with children who have attachment disorders has involved very close contact with many other service systems, and this has worked well for several reasons. Firstly, both of us had prior experience working in other services. We knew the local staff with whom we had a mutual respect. We knew their service systems, and therefore knew what might be requested, and the timing necessary for any requests that had a financial component. We have been really intentional about communicating well, and this has enabled us to avoid duplication and enhance efficiency. Our local child protection services had a long-standing interest in and commitment to attachment theory and its clinical applications, and its implications were structured into much of their service planning. Like all relationships, there has been the occasional minor dummy spit or period of tension. Our focus on supporting one another and lubricating the wheels of goodwill with humour and tolerance has enabled us all to ride through any tense moments with ease.

Conclusion

Our work with children like Callum has opened our eyes to a world of theory, of debate, of new techniques, and of highly traumatised and troubled children and their families. We have struggled with many ethical, personal and professional issues to be able to do this work, and we continue to struggle still. We recommend that others embarking on work in this area use a multi-disciplinary team including a psychiatrist, use co-working of complex cases, read extensively and secure appropriate supervision. Of course, prevention is better than cure, and we wholeheartedly support community and government programs which nurture young children and their parents. We hope we continue to eschew complacency and simple answers, and to continue the journey of working hard for better outcomes, working well with other services, and finding new and better ways to dodge spit.

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Presenters

Janice Trezise left her home town of Melbourne at age 22 years to move to rural Tasmania. She graduated from the University of Tasmania with a Bachelor of Social Work with First Class Honours. She has worked in the human services field for 16 years in a diverse range of areas including family violence, drugs and alcohol and child protection. She has worked for the Child and Adolescent Mental Health Service in north-west Tasmania for 12 months, and is pursuing a specialisation in attachment difficulties. She is currently studying family therapy at a postgraduate level.

Belinda Sims is a mum, wife, daughter and social worker. She grew up in Burnie, Tasmania. She graduated from the University of Launceston in 1991 with a Bachelor of Social Work and began working in Child and Family Services as a case manager. She spent a year in Queensland as a family services officer with a primary role of investigating abuse of children. She returned to Tasmania and went to the remote west coast for five years as the sole education social worker. She has been with the Child and Adolescent Mental Health Service for six years and is specialising in attachment therapy.

Just pretend for a little while longer. Hidden out of your line of sight, his knuckles tightened. SESSION TWO. "Any hobbies?" "Painting." Scaramouche had never found reigning himself in to be more challenging. Irrationally, he bit out, "I've never actually done it." "But you want to." He was deathly silent. Poised like a cobra, furiously angry, ready to strike. You tried again, less antagonistically, but firm. "Scaramouche. Do you want to hurt me?" After a long, hard moment, Scaramouche hissed through his teeth, "Yes." "Do it." [Post-Chorus] A little bit of love, a little bit of love Love for you and love for me A little bit of love. [Verse 2] We're here to dim the light and And just chill with me tonight I feel it within your eyes I ricochet back into mine. [Pre-Chorus] Tomorrow, will you be the one I know? Tomorrow, will you be the hand I hold? So hold me now. [Chorus] A little bit of love, little bit of love never hurt nobody Little bit of love, little bit of love never hurt nobody I could be the one in it for the fun Little bit of love for you and love for me A little bit of love. [Post-Chorus] A little bit of love Perlin, never shy of hyperbole, declares that this is nothing less than the modern-day resurrection of the class divide between the bourgeoisie and proletariat. "The rich get richer or stay rich thanks in part to prized internships," writes Perlin, "while the poor get poorer because they are barred from the world of white-collar work." Unfortunately, rather than challenging the system, such complaints merely encourage interns to think of themselves as victims of the system. This inhibits any "get up and go" on the part of students or school leavers determined to get on. Why fight tooth-and-nail