Repairing attachments

Assuming basic knowledge of both attachment theory and professional interventions in general, **Colby Pearce** describes the rationale behind his work with children who have experienced family trauma

Children who have experienced gross deficiencies in care during their early formative years (preschool) are increasingly spoken about as having suffered from *complex developmental trauma*. Gross deficiencies in care incorporate physical, emotional and/or sexual abuse of the child and/or a persistent failure or inability of the child's main caregiver or caregivers to consistently offer physical and emotional comfort in times of distress, such that the child is frequently left in a state of prolonged and severe physical and emotional distress. The *developmental* aspect incorporates the impact that complex trauma has on developmental processes and outcomes for the child, which is increasingly being tied to impacts on the developing brain. However, the very nature of the aetiology of complex developmental trauma allocates a central role to the child's primary attachment relationships and their impact on attachment security.

Children who have experienced complex developmental trauma frequently exhibit attachment insecurity. Many are diagnosed with Reactive Attachment Disorder (RAD). Children diagnosed with RAD typically exhibit gross disturbances in social and emotional relatedness and behaviour. These disturbances are considered to stem from maladaptive beliefs about self, other and the world (attachment representations), hyperarousal (and associated arousal dysregulation), and a pervasive and enduring preoccupation with access to core needs provision (including the need to feel safe, accepted and to be physically nourished)[1].

Psychological interventions for complex developmental trauma, and its common associate RAD, are often referred to as attachment therapy. As the name suggests, attachment therapy is grounded in attachment theory and typically seeks to repair the traumatised child's attachment relationships and/or promote attachment security. There is an apparent consensus among attachment therapists that attachment security is the foundation for healthy development and adjustment though the lifespan. However, given the plethora of approaches in the literature for which the promotion of attachment security is the goal, it can be argued that attachment therapy is an umbrella term for a *range* of therapy approaches that share a common goal, rather than the name of a unitary therapy approach. What follows is a description of my own approach to attachment therapy.

Promoting attachment security

Consistent with other documented approaches to attachment therapy, the overarching aim of my approach is the promotion of attachment security. Wherever possible, this involves the repair of the primary attachment relationships, as these are the most common source of family trauma. More commonly, there is a focus on promoting attachment security in foster, adoptive and kinship care arrangements. However, the chronicity and extremity of family trauma and its associated emotional and behavioural effects leaves many traumatised children without stable care arrangements or access to stable attachment figures. In such

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instances, I become the main attachment figure. Many professionals and agencies are uncomfortable with the scenario where the therapist becomes the main attachment figure and will refuse to treat such children. But to do so can have the unintended effect of compounding the child's trauma by denying them access to a reparative attachment relationship.

With the exception of those children who have no stable attachment figure, my approach to attachment therapy incorporates two key elements: therapy with the child, and psychoeducation and skills development with the child's main caregivers. Children who have no stable attachment figure receive only the former.

Therapy with the child

In my work with children who have experienced family trauma, there is a focus on *process*, as opposed to *skills development*. Central to the *process* of my work is the provision of reparative attachment experiences in therapy. Therapy is experiential, just as early attachment relationships are formed through experiences. My intention is to create an environment and experiences where the child feels safe, validated, emotionally connected with, looked after and capable. Children feel safe when adults are in control of their own emotions and behaviour, and of the interaction with the child. I calmly acknowledge the traumatised child's resistance to relinquishing control and attempts to punish and distance me in association with transferential processes. I acknowledge the intent of their behaviour and affective displays. I verbalise understanding of the disordered attachment representations that subconsciously exert a powerful influence over the child's interactions with themself, others and their world. I *make statements* where others ask. I *direct* where others request cooperation and compliance. I offer *choices* where others argue. I am in control of myself, the interaction with the child and the therapeutic environment. I am successful because the child feels understood and validated. My consistent observation over many years treating traumatised, attachment-disordered children is that they respond to me taking charge with profound relief.

No questions, only statements

Central to my approach to attachment therapy is elevating maladaptive ideas and core beliefs (ie attachment representations) to conscious experience through a sustained process of interpretation of the child's thoughts, feelings and intentions. Again, there are no questions; only statements. This process facilitates self-awareness and the development of inner-state language for the traumatised child. The development of inner-state language is fundamental to encouraging these children to express themselves with words, as opposed to actions – the latter often bringing them into conflict with others and further compounding their trauma. Elevating maladaptive ideas and core beliefs also facilitates opportunities for me to challenge them and promote adaptive alternatives, though not in more traditional

ways by using praise and brainstorming. Merely praising the child who has experienced family trauma only contributes to their experience of being misunderstood, and these children rarely engage successfully in cognitive skills-based therapeutic approaches. Rather, it becomes increasingly difficult for the traumatised, attachment-disordered child to maintain beliefs that they are unsafe and unloved, and that others are harsh and uncaring, when they are safe, understood, cared for and delighted in through the medium of the therapeutic relationship. That is, the child's experience of the therapeutic relationship attains a central role in challenging maladaptive attachment representations and promoting adaptive alternatives.

Attending to core needs

Children who have experienced family trauma are inordinately preoccupied with their needs[2]. This arises in the context of inconsistent parental accessibility, sensitivity and responsiveness. The degree of obsession many of these children have with core needs, such as the need for physical nourishment, can represent an impediment to the child fully engaging in the therapy process. Successful management of this issue is not only critical to engagement in therapy – it represents another opportunity to challenge maladaptive attachment representations and promote adaptive alternatives. In addition to providing a safe and emotionally nurturing environment, I feed children when they attend for therapy. I make a snack and a drink available to the child at the outset of every session. This alleviates their obsession with their needs, thus promoting their engagement in therapy. In addition, by addressing this need in a proactive way, I am offering the child the experience that their dependency needs are understood and important before the child has the thought that they have to go to great lengths to make me understand their needs and secure a caregiving response.

Facilitating attunement experiences

As to what else the child and I do during therapy, well, we play games and engage in therapeutic activities. I favour therapeutic activities drawn from Theraplay[3], as these support and deepen the child's engagement with me and are a source of positive attachment experiences. Incorporating play into therapy facilitates the child's willingness to attend and, thereby, their engagement in the therapy process. Play also facilitates opportunities for attunement experiences, where the child and I are experiencing the same or very similar emotions. This is important for providing the child with the experience of emotional connectedness with others that is often absent in their life. Experiences of emotional connectedness are implicated in the development of secure attachment relationships, as well as in the development of emotional (and arousal) self-regulation[4,5]. As such, I utilise play as a means of facilitating a range of affective experience and a return to calm contentment. Moreover, I utilise play as a means of providing the child with affirmative experiences, such that they experience themselves as likeable and capable, others as fun and 'nice', and their world as safe and a source of happy experiences. In doing so, I am again seeking to challenge maladaptive attachment representations and promote adaptive alternatives.

Working with caregivers

Successful outcomes for traumatised, attachment-disordered children rest in no small way on the promotion of a supportive care environment outside of the therapy setting. Where the child has a stable caregiver or caregivers, their engagement is an important aspect of the intervention process. You might have noticed that I used the word *intervention*, instead of *therapy*. I did this, in part, to convey that I view caregiver psychoeducation and skills development as a parallel, complementary process. Unlike other therapists in this area, I do not routinely include the child's caregiver or caregivers in therapy sessions with the child. In the past, I found that this interferes with the depth and quality of therapeutic relationship that can be achieved with the child because the child orients primarily towards their caregiver instead of me. This is a problem, as the child's caregiver does not yet have the knowledge of how to achieve the depth of relationship with the child that is required to resolve their attachment difficulties. It also presents opportunities for the traumatised, attachment-disordered child to engage in splitting. Rather, parallel to therapy with the child, I seek to engage their caregiver in psychoeducation that facilitates greater understanding of the inner world of the traumatised child and their parenting requirements, as well as encouraging and nurturing parenting practices (skills) that support and extend my therapeutic endeavours with the child. Caregivers are only included in therapy sessions with the child where I consider that they need to see what I am recommending in action.

Three key elements of caregiving

Caregiver psychoeducation focuses on promoting understanding of the three key elements of the psychological profile of children who have experienced family trauma: disordered attachment representations, hyperarousal (and

arousal dysregulation) and a preoccupation with accessibility to needs provision. I rarely refer to concepts like *the neurobiology of trauma* and *the effects of trauma on the developing brain*. My opinion is that these concepts misrepresent the focus of therapeutic endeavour and do not readily lend themselves to developing an understanding of the rationale for prescribed approaches to therapeutic care. They are also used by some practitioners to elevate the esteem of their work in the eyes of their clients by grounding it in realms usually occupied by medical doctors. This has more to do with social processes than therapy processes. Rather, as the source of the child's trauma is the attachment relationship, psychoeducation should focus primarily on the promotion of secure attachment relationships, not the remediation of purported deficits in brain development.

Successful development of caregiver skills rests on my ability to achieve understanding and acceptance of required approaches to the care and management of the traumatised, attachment-disordered child. Wholesale changes in care and management approach are rarely accepted and implemented by the caregiver in a consistent and sustained manner – if at all. Even if they were implemented, the potential effectiveness of wholesale changes is likely to be quickly dismissed, because these children are highly reactive to changes in caregiving practices. More subtle changes to care and management practices are more likely to be accepted – by the child and his or her caregivers alike. My practice is to identify those aspects of common caregiving that facilitate the child's experience of their caregiver as being accessible, understanding and emotionally connected, such as is the infant's experience when he or she is forming their first (secure) attachment relationships. As caregivers can rightfully assert 'I do that anyway', they feel validated for the positive contribution they are making to the remediation of the child's trauma and attachment difficulties and, having been made aware of what caregiving practices help, might be expected to do them more often.

Encouraging caregiver cooperation

So what key aspects of caregiving do I refer to as promoting attachment security? Firstly, I draw the caregiver's attention to the fact that each time they anticipate the child's needs and provide a caregiving response before the child does anything to call attention to their needs, the child has the experience that their caregiver understands their needs and will respond to them without the child having to be inordinately controlling, demanding or deceitful in order to reassure themselves that their needs will be met. Caregivers can burn themselves out trying to respond to the dependency needs of these children, but so long as they are always *responding*, as opposed to *anticipating and attending to*, then the child will always have the experience that they need to control and regulate the behaviour of their caregiver to reassure themselves that they can access a caregiving response.

Secondly, I draw the caregiver's attention to the fact that every time they take the opportunity to observe the child's presentation, behaviour and the setting in which it is occurring and say what they think is in the child's head and in their heart, as opposed to asking, the child has a powerful experience that their thoughts, feelings and intentions are understood and important. In turn, they feel validated by their caregiver, which is critical to challenging maladaptive attachment representations and promoting adaptive alternatives. This contrasts with the usual practice of *asking* children how they feel, what were they thinking and why did they do it. When a caregiver asks, the message they are conveying to the child is that they do not know. The effect is that the child continues to be denied access to the experience that their thoughts, feelings and intentions are understood and important. Finally, I draw the caregiver's attention to the importance of engaging in mutually enjoyable activities with the child, and how routines, predictability and proactive care promote lower arousal levels and improved self-regulation of emotion.

How long does this therapy take? The answer is as long as it takes for the child to be interacting with their caregiver(s), their teachers and their world in a secure manner. It is rarely a short-term endeavour. Where the child has no stable caregivers, therapy might be expected to span years. Nevertheless, through this process of exposing the traumatised, attachment-disordered child in a systematic and sustained manner to the very source of their trauma, the dependency relationship, cognitive change and anxiety reduction through habituation to the trauma stimulus are likely to be lifelong benefits. ●

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