Chapter 2 - Literature Review

> Klaus smiled because the books on the rules of V.D.F were very thick and full of difficult words – just the sort of challenging reading he enjoyed.
>
> (Snicket, 2001c, p. 133)

2.1 - Introduction

In this Chapter, the elements of the study are considered in the light of relevant knowledge and research in related fields. The elements considered are:

- Mental Health Needs of the Looked After Child
- Developmental Needs and Deficits of the Looked After Child
- Attachment
- Trauma
- Therapeutic Intervention
- Theraplay
- Play Therapy
- Clinical Decision Making
- Treatment Outcomes and Existing Clinical Measures

2.2 - Mental Health Needs of the Looked After Child

2.2.1 – Complexity of the Needs of the Looked After Child

Removal of a child from their home and birth family by the State can not be lightly undertaken. In English law this is solely permissible on the basis of the likelihood that the child would otherwise have suffered *significant* harm. Courts and indeed professionals will thus only intervene to beak up families in the most serious and extreme circumstances, where the burden of proof is on the local authority and the standard of proof is that the child will more likely than not be significantly harmed if they remain in situ (Children Act 1989). The implication of this rigorous threshold for Looked After Children, is that for this standard to have been met, they will most certainly have endured or been exposed to highly dangerous, damaging or traumatic events or circumstances. It is not enough that they may have experienced harmful or distressing circumstances, the situation or experience must be obviously and gravely harmful (Department of Health, 1995).

The grounds for statutory intervention and admission to care may have built up over a considerable period of time before the threshold for removal has been met, adding to the stress of the child. The removal of a child may have been precipitated by a sudden catastrophic event or experience or one following on from a long period of unsatisfactory care (Howe, 1999). Looked After Children will have more significant mental health needs compared to the general child population (Ford *et al.*, 2007). This may be attributable to the significantly harmful circumstances from which they have come, as well as their experiences in entering and moving through the care system.

A further reason for the level of trauma present in these children may be that some will have remained in damaging and harmful circumstances for an unacceptably lengthy period of time, because of the very high legal threshold to be met to secure a court order or to precipitate emergency measures to remove a child from their family. Additionally, evidence from all the serious case reviews undertaken in England over the past six years suggests that the lessons of inadequate assessments of risk, poor planning and monitoring of children in high risk situations and ineffectual interagency working have not always been properly learned across the country, and that each year it is reported that around one hundred children or more suffer preventable significant harm through inadequate social care intervention (Leslie, 2009). This figure relates simply to children who have been subject to serious case review; the actual number is likely to be significantly higher.

A small number of younger children and considerably more teenagers will be accommodated voluntarily under Section.20 often with long histories of complex difficulties, primarily abuse, neglect and anti-social behaviour accounting for 32% of the LAC population in 2001 (Department for Children, Schools and Families, 2009). Given the resource implications of accommodating children under Section.20, it is unlikely to be agreed without significant concerns regarding the child’s well being within the family home or, increasingly, in the case of unaccompanied minors who are likely to have experienced extreme adversity in their country of origin (McAuley, 2006). No referrals have been received by the project for children accommodated under Section.20 requiring Play Therapy or Theraplay and as such all the children in this study were subject to Section.31 care orders.

> Typically, the majority of these children (children placed at older ages) are placed either for adoption or with long-term foster carers after a history of adversity. The quality of their pre-placement care is usually characterised by severe neglect, physical abuse, sexual abuse, rejection, emotional maltreatment or some combination of these. (Howe & Fearnley, 2003, p. 370).

The implication of this is that the vast majority of Looked After Children are likely to have experienced some form of neglect, abuse or trauma within their families/countries of origin, severe enough for a court order to be granted, with limited mitigating factors such as a non-abusing parent who can protect them, a strong attachment figure or member of the extended family who can provide care. All of these factors in their own right are likely to have widespread and long-term implications for the child (Jewett, 1984; Stanley, 2005).

Looked After Children comprise a very small proportion of the general child population and a small proportion of children who receive services from local authorities.

2.2.2 – Statistics for LAC Children

Statistics for the LAC Population in England on 31st March 2009

Children in Public Care: 69,000 children were in the care of local authorities on 31st March 2009 in England. There were estimated to be 11 million children in England at this time. 0.63% of the general child population was looked after on 31st March 2009.

Gender: 57% (34,600) of children looked after on 31st March 2009 were boys and 43% (26,300) were girls

Age:

- 5% (3,200) of children looked after on 31st March 2009 were under 1 year old
- 16% 9,500) were aged between 1 and 4 years old
- 17% (10,500) were aged between 5 and 9 years old
- 41% (24,800) were aged between 10 and 15 years old
- 21% (12,900) were aged 16 and over

Placements:

- 73% (44,200) of children looked after on 31st March 2009 were living with foster carers
- 10% (6,200) were living in children's homes (includes secure units, children's homes and hostels)
- 7% (4,100) were living with their parents
- 4% (2,500) were placed for adoption
- 3% (1,720) were placed in residential schools or other residential settings

Unaccompanied Asylum Seeking Children: 3,700 unaccompanied asylum seeking children were looked after on 31st March 2009; 87% (3,200) were boys and 13% (490) were girls

Private Fostering:

- 1,530 children were known to be living under private fostering arrangements at 31st March 2009
- 1,980 new private fostering arrangements began and 1,520 ended during the year ending 31st March 2009
- 2,180 new notifications were received during the year ending 31st March 2009

Adoption Orders by date of entry in Adopted Children Register:

- 5,680 adoption orders were made in England and Wales during 2002
- 4,818 adoption orders were made in England and Wales during 2003
- 5,562 adoption orders were made in England and Wales during 2004
- 5,558 adoption orders were made in England and Wales during 2005
- 4,979 adoption orders were made in England and Wales during 2006
- 4,637 adoption orders were made in England and Wales during 2007

N.B. Figures on adoption orders apply to adoptions by relatives and step–parents, as well as to adoptions from care.

Adoption from Care: 3,300 children were adopted from care during the year ending 31st March 2009

Gender: 51% (1,600) of children adopted during the year ending 31st March 2009 were boys and 49% (1,600) were girls

Age: The average age at adoption was 3 years 9 months

- 2% (80) of children adopted during the year ending 31st March 2009 were under 1 year old
- 72% (2,300) were aged between 1 and 4 years old
- 23% (760) were aged between 5 and 9 years old
- 3% (80) were aged between 10 and 15 years old

Adopters: 92% (3,000) children were adopted by couples and 8% (270) by single adopters during the year ending 31st March 2009

Waiting times: 75.8% children were placed for adoption within 12 months of best interest decision during the year ending 31st March 2009.

(BAAF, 2009).

Mental Health Needs of Looked After Children in England (2001/2002)

- Among 5 to 10 year-olds, the overall rates of mental health disorder were at least five times higher than for children in the general population (42 per cent versus 8 percent), and contrasts were only slightly less marked for 11- to 15-year-olds (49 per cent versus 11 per cent)

- Overall risks of psychiatric disorder varied with the length of a child's current placement: rates were highest (at 49 per cent) for those in their current placement

for less than one year and lowest (at 31 per cent) for those in the most stable placement group (five years or longer)

- 44 per cent of Looked After Children with psychiatric disorders had been in touch with specialist child mental health services
- One third had used specialist educational services
- 19 per cent of all looked after 11 to 15 year-olds, and 25 per cent of 16 to 17 year-olds, had been in trouble with the police over the same period.

(Meltzer *et al.*, 2003)

Statistics for the Looked After Children's Team 01/04/08 – 05/12/08

Number of referrals: 49 (with the greatest number 11 being received in June and the least 1 being received in September and December).

Gender: 32 (65%) Girls; 17 (35%) Boys

Ethnicity: 22 White (45%); 16 Black (33%); White/Asian 5 (10%); White/Black 3 (6%); Iran/Kurdish 2 (4%); Chinese 1 (2%)

Age: 18 % were aged between 0-4 years; 29% were aged between 5-9 years; 37% were aged between 10-15 years; 16% were aged between 16-18 years.

The LAC Team statistics reflect the nature of the work undertaken and the areas most prevalent for mental health referral in this population. They reflect an elevation in children referred to the service between the ages of 5 and 9 years of age (29%) in comparison with the statistics for this age group in the general LAC population (17%).

This may reflect the nature of the work undertaken and, in particular, the intervention offered by the Attachment Project in supporting difficult to place older children in

adoptive families or long-term foster placements through the use of Theraplay and Play Therapy intervention. Therefore, five of the six children within this present study were aged between 5 and 9 years of age at the outset of intervention. It is also worth noting that different clinical modalities within the LAC Team offer different types of therapeutic input and as such the statistics reflect the work of the team as a whole.

The elevated statistic for girls referred to the LAC Team (65%) in relation to the general LAC population (43%) is reflective of the work undertaken with teenagers who present at Accident and Emergency. During adolescence, girls (particularly LAC children who have experienced neglect and abuse) are more likely to present with emergent personality disorder, suicidal or self harm ideation and be referred to mental health services within the LAC Team. Boys are more likely to be referred with anti-social or criminal justice involvement and other specialist agencies or in extreme cases mental health forensic services would be accessed for this child population.

Referrals received by the LAC Team for children aged between 5 and 9 years of age are more reflective of the national statistics for England and those of this present study, where 50% of the children where girls and 50% were boys. However, the statistics for black/minority ethnic children referred to the LAC Team (55%) are not reflective of the children in this present study, where only 1 child (17%) was minority ethnic. This is, however, reflective of the ethnicity of children receiving support through the Attachment Project and reflects a number of things.

Firstly, the uptake of services by black/minority ethnic families is often poor within mental health provision. This is the topic of much exploration within the Trust and consideration is presently being given to making mental health services more accessible to this child population. Secondly, with these concerns in mind, a black/minority ethnic worker is in post within the LAC Team. Her remit is to develop and expand services to black/minority ethic families and is reflective of the number of referrals received by the LAC Team. Therefore, much of this work is undertaken within this specialist post and the statistics for the rest of the LAC Team are fairly reflective of those within this present study. Thirdly, one other minority ethnic family and three white families declined the offer to be part of this present study.

Fourthly, there is a significant shortage of black and minority ethnic adoptive placements within England. Black children often wait longer for adoptive families, are placed in long- term foster care earlier than white children as adoptive placements cannot be found, and are more likely to be placed out of borough where adopters/carers are found to match their cultural needs. Thus the number of black children referred to the Attachment Project for support in long-term families is significantly less that those referred for other interventions within the LAC Team. Finally, much work has now been done within the borough to recruit black/minority ethnic families and these statistics are now slowly beginning to change. There is an increase in black/ minority ethnic families being referred to the Attachment Project and this would be an interesting, insightful and important topic for future research.

2.2.3 – Implications for this Study

The LAC population is diverse and complex in nature, their attachment relationships are likely to be poor; uncertain at best, dangerous or even life threatening at worst (Penzerro & Lein, 1995; McWey, 2000). The threshold for services offered by tier 3 and 4 mental health provision in the project is that children are at significant risk of placement breakdown. Thus, the children on the therapist's caseload are likely to be the most disadvantaged and traumatised of an already significantly challenging LAC population. In common with the general LAC population, the constituency of the Attachment Project will often continue to have contact with birth families in one form or another, which in itself can be very emotionally laden (Quinton, Rushton, Dance & Mayes 1998; Farmer, Moyers, & Lipscombe, 2004; Sinclair, 2005) although much research also advocates the importance of this ongoing relationship (Cleaver, 2000; Shaw, 1998).

All too often the child's experience within the care system serves to further disadvantage them; the impact of placement (often multiple) with total strangers, changing name, status, identity and role with each new family, compounding their feelings of low self worth and confused identity.

> 'Despite some cases of extremely happy results, most children who spend lengthy periods in public care experience significant difficulties as adults'
>
> (Thoburn, 1990 as cited in Munro, 2002, p.111)

It is little wonder then that (Care and Health Editorial, 2003, p. 3) reported that one in ten adoptive placements break down before the child is legally adopted, and recent statistics reveal an even bleaker picture. Ford, Vostanis, Meltzer, and Goodman (2007) showed that Looked After Children had significantly poorer mental health outcomes than most disadvantaged children outside the care system. Richardson and Lelliott (2003) highlight the poor educational attainment of LAC children, the importance of stable placements and the need for specialist LAC mental health provision.

The children in this study had particularly complex and often unsatisfactory experiences of entering and journeying through the care system which significantly exacerbated their trauma and severally compromised their ability to form relationships including those that could be the basis for therapeutic engagement (Wilkinson, 2010). With the study population, given the tenuous nature of their capacity to form relationships, it was imperative that contacts even of a therapeutic nature were carefully planned and the introduction of extraneous adults minimised. This was one of the reasons why the therapist adopted the dual role of therapist and researcher to safeguard the integrity of the emergent therapeutic alliance.

In summary, being a Looked After Child means that by virtue of being in and moving through the care system, children have and develop what professionals perceive and categorise as deep-rooted psychological needs which impact upon their ability to form stable relationships. To the child, however, the matter is less complicated; they just

experience overwhelming emotional pain and do not know what to do with it (Fahlberg, 1991).

Given the complexity and severity of their needs, there has been insufficient attention given to LAC children. The process of meeting the Looked After Child's mental health needs is often lengthy, as reflected in the National Institute for Clinical Excellence (NICE) Guidelines 2006, and often conflicts with government initiatives for short-term interventions. Often, the pain within is manifest in outward emotional and behavioural problems, alienating the child from the world around and limiting their ability to develop. The developmental needs and emotional deficits of Looked After Children are discussed in greater detail below.

2.3 – Developmental Needs and Deficits of the Looked After Child

The developmental needs and deficits of Looked After Children are now considered in terms of the neural development, social constructs, and the developmental narrative of significantly harmed children and the defence strategies they develop to survive in their emotionally and physically hazardous environments.

2.3.1 – Neural Development

LAC children, by virtue of surviving empty, confusing or frightening home environments, have proved themselves to be adaptive and resilient. However, these adaptations are not always helpful, and as new research unfolds in child development so does our understanding of the impact of 'adaptation' on the development of the LAC

child. The crucial role of relationship and in particular that of early caregiver, is recognised in relation to child development (Carter, 2006). This research is now extending into branches of medical science previously unconnected and, very recently, into the field of neural development.

Masson (1998) describes how research on the 'emotional' development of the brain is now moving beyond the arena of speculation, and very firmly onto the map of medical sciences. These advances are based on new techniques of brain imaging and physiological research. It is an indication of the degree of public interest in the potential impact of neuroscience that recent television documentaries, such as 'My Brilliant Brain' screened by Channel 5, have proved extremely popular, and they are highlighting the importance of early relationships in the 'hard wiring' of the brain and attempting to take these ideas to broader audiences.

The brain's synaptic connections are being formed at their greatest rate in the first eight months of life, and by one year old redundant connections are being re-absorbed at a greater rate than new connections are being made. The significance of these early interactions can clearly be seen (Balbernie, 2001).

> Because childhood abuse occurs during the critical formative time when the brain is being physically sculpted by experience, the impact of severe stress can leave an indelible imprint on its structure and function. Such abuse it seems induces a

> cascade of molecular and neurobiological effects that irreversibly alter neural development (Teicher, 2002, p. 68).

Positron Emission Tomography (PET) Scans are used to show electrical activity in the brain, revealing areas of dense synaptic connections, and there is now clear medical evidence that the temporal lobes of the brain (dealing with hearing, learning, memory skills, emotions…) of children who experience significant neglect, as seen in large Romanian orphanages, do not develop in the same way as their healthy counterparts (Rutter, 1998).

> Without touch, stimulation and nurturing, children can literally lose the capacity to form any meaningful relationships for the rest of their lives. In general, the severity of the problem is related to how early in life, how prolonged and how severe the emotional neglect has been (Perry, 2007; lesson 2, p. 2).

Archer and Burnell (2003) use the analogy of a well trampled, interweaving set of paths within the developing brain of the securely attached child, a phenomenon previously described as ‘Hebb’s Hypothesis’ – ‘neurons which fire together, wire together’ or ‘neural net profile’ (Siegel, 2003, p. 5, p. 12). The child is allowed a repertoire of new experiences and safe relationships, through which healthy neural pathways are thought to develop.

However, pathways developed within the brain of the traumatised or neglected child are limited, and are preoccupied with survival strategies for eliciting close contact with their primary carer. These children often experience limited stimulation or new experiences that would allow the development of new or expanded neural pathways.

> Ideally, 'remodelling' of internal 'road maps' through developmentally-appropriate, somatosensory and emotional input should occur as early as possible whilst the child's neural networks are most plastic and before states become fixed traits (Archer & Burnell, 2003, p. 96).

2.3.2 – Developing Defence Strategies

Looked After Children will almost always experience some form of insecure attachment due to the nature of separation they have experienced (Howe, 2005). Because of this insecure attachment, the LAC child is potentially 'programmed' to scan their environment for danger, to protect and care for themselves and others, to live with uncertainty and unpredictability, with an inbuilt sense of low self worth, shame and guilt. As such, the mechanisms this child learns for eliciting the attention of their caregiver, are very different from those learnt by a securely attached child. It is these responses that are often called 'defence strategies' as they are designed not only to elicit closeness, but also to protect and survive potentially dangerous situations. As is the case in disorganised attachment, a form of insecure attachment discussed below, the child quickly learns "I draw my caregiver to meet my needs then I must protect myself against possible attack by them".

Even when the LAC child is placed in the care of safe, secure foster parents, although their external environment changes and their need to protect themselves is reduced as trusting relationships are built, ongoing challenging behaviour is often reported (Cairns, 2009). However, when these situations are explored, it is at times of stress, direct questioning or conflict that this behaviour is most commonly seen (Balbernie, 2001).

Foster and adoptive parents are often recruited and assessed having themselves experienced good-enough parenting or showing an ability to address issues of adversity in their own childhood experience where these have arisen. This may make it hard for them to identify with the experiences of the children they care for. This in itself may create additional pressure in the care giving role and set up additional stresses in the Looked After Child who will deal with this by returning to their established coping or defence strategies with resultant scared, angry, challenging or overly compliant behaviour and may present as either 'the compliant or defiant child' (Leslie, 2009).

Therefore, in order to respond to the LAC child effectively, those working with them must understand the environment within which the child is socialised, not only their attachment relationships, but also the narrative which informs their understanding of the world around them.

2.3.3 – Developing Narrative in the World of The Looked After Child

Daniels (2005) explores the basis of Vygotsky 'social construction theory' which is further explored and expanded by Vivian Burr (1973). Social constructionism argues that

the world does not exist in definitive fact but that this is a perceived entity revealed through narrative and influenced by variables such as community, religion, history, dominance, power and control, existing within the context of time and culture. One example of this would be the experience of children over the past one hundred years and how childhood is still very much defined by geographical area and other socially constructed variables.

The child growing up in the securely attached home is likely to acquire a clear sense of the predictability which defines their experience of the world around them, as their primary carers respond to them with consistency, i.e. the securely attached child who asks the colour of the walls in his room will receive the same answer every time. The child of a mother who is depressed or emotionally unavailable may receive no answer at all to his question, leaving him without any knowledge or depth of understanding pertaining to the world around him. The child of a substance misusing parent may receive a different answer each day, depending upon the drug induced state or lack of drug induced state a parent is in. The abused child may be terrorised for asking the question in the fist place (Archer & Gordon, 2006).

Therefore, the child starts to relate to the world around them as it is presented to them in a phenomenon Siegel (2003) described as ‘the co-construction of each other’s minds’ (p. 18). Thus it becomes clear that the narrative surrounding the LAC child is unlikely to be consistent or reliable, and their perception of the world limited, confusing or frightening. This, coupled with the profound impact of early childhood attachment and trauma

experiences, leaves the child programmed to respond in a chaotic and unpredictable way, described by Siegel (2003) as ‘neurons and narratives’.

> ‘The infant’s brain is programmed to make sense of experience. But it needs exposure to experiences of which it needs to make sense. True of learning to see and speak but also true of learning to recognise, understand and make sense of the mind and the psychological nature of both self and others’
> (Fonagy, Gergely, Jurist & Target, 2002 as cited by Howe, 2005, p. 4).

When a child is removed from their birth family with its perceptions, construct and definition of the world around them which, empty, confusing or terrifying as it may be, is still ‘their world’ where they fit and they make sense (Verrier, 1993). Such disadvantaged children are particularly compromised in their capacity to understand and adapt to an alternative construct, characterised by consistency, in a new environment as alien to them as if they had been uprooted and sent to rural China (Archer & Gordon, 2006).
In the light of this disorientation and alienation that the Looked After Child experiences because of a lack of clear and consistent narrative, the approach of professionals has to be adapted to take account of the child’s struggles and their unfamiliarity with their new world and their limited capacity to adjust accordingly. Professionals often need support to change the way they phrase questions, to look beyond what the child is saying, and respond to the emotions that lie beneath, thus reducing the need for counterproductive conflict (Golding, 2008) which would further serve to disorient and alienate the child. In responding to the LAC child, the professional must challenge their personal view of the

world and the social constructs which surround them, (Farmer, 2009). Without an ability to offer creative, unconventional ways of thinking and communicating, the professional will inevitably induce stress within the child. When stress is induced the child's defences are triggered, the professional retreats further into their own defences, creating greater stress for the already confused child and so the situation potentially spirals out of control (De Haan & Gunnar, 2009).

The goal of professionals working with Looked After Children is to help them to feel contained, through the use of clear, consistent boundaries and begin to give the child an emotional language to express their distress, thus reducing the need for these entrenched defence strategies (Jernberg & Booth, 1999). By understanding the child's experiences, the sting can often be removed from their vicious attacks and by avoiding emotional responses, the professional can help calm the child and then think and reflect with them, rather than become enmeshed in the child's defences which are fighting to keep the professional safely at arm's length (Fahlberg, 1991; Guishard-Pine *et al.*, 2007).

In thinking about social constructionism and the neural development of the LAC child, reference has also been made to early attachment relationships and trauma. The impact of early relationships is increasingly at the interface between child development studies and conventional medicine, which has lead to a proliferation in new thinking around attachment theory; this is discussed in more detail below.

2.4 - Attachment

Klaus and Kennell (1976) as cited within (Archer & Burnell, 2003 p. 64), describe the pervasive nature of early attachment as 'a bond between two individuals, that endures through time and space, and serves to join them emotionally' even when this relationship may have been a negative one for the developing child.

2.4.1 – Introduction

Attachment theory is fundamentally a way of thinking about how children grow and learn and the role which 'relationship' plays in their early development. Attachment Theory was first conceived in the early papers of John Bowlby (Bowlby, 1940, 1944) but with time has evolved through a process of academic critique and intense research to become a complex and robust theoretical model, the potential and limitations of which, remain yet to be fully explored (Bretherton, 1991).

One of the earliest breakthroughs in Bowlby's work came when he noted the similarities in presentation between a group of orphans and a group of 'juvenile delinquents', many of whom still had birth parents living. 'A significant minority of the children turned out to have affectionless characters, a phenomenon Bowlby linked to their histories of maternal deprivation and separation' (Bretherton, 1991, p. 11).

The new born infant is 'programmed' with one highly evolved and effective strategy for attracting attention – 'the infant cry', without which they would die. Bowlby's observations led not only to his belief that the relationship with mother is of crucial

immediate importance to the child, but also to a belief that this relationship is important for *later* functioning (Bowlby *et al.,* 1952). It is the pattern and emotionality by which the child is responded to which is thought to bear direct relevance to a child's later development (Bowlby, 1973; Main & Hesse, 1990). This is important for Looked After Children because of their lack or disruption of these early unconditional relationships.

However early separation takes place, the child will carry within them a yearning for what is lost, be it real or perceived, however abusive or traumatic their early experience may have been (Kubler-Ross, 1970). Both Verrier (1993) and Cairns (2002) describe the Looked After Child's need for validation and acknowledgement, their search for a sense of belonging and identity. Research undertaken by Chisholm, Carter, Ames and Morison, (1995), Marcovitch, Goldberg, Gold, Washington, Wasson, Krekewich and Handley-Derry (1997) and Howe and Hinings (1987) concur with Humphrey and Ounsted's (1963) findings that even children placed as babies are likely to suffer the long-term effects of separation, and are roughly twice as likely to be referred to child psychiatry and psychological services as children within the general population. 'With one hand the past pushes us forward and with the other it holds us back' ('Frasier' episode 265, NBC, 2003 paraphrasing Anzaldua, G. translated by Acosta-Belén, E. and Santiago, C. Borderlands/ La Frontera - The New Mestiza, 1987, p.37 Aunt Lute Books).

In the following sections, the features of secure and insecure attachment will be explored with particular reference to the development of Looked After Children and their capacity to form meaningful relationships with their caregivers.

Secure Attachment

2.4.2 - Physical Needs

Of immediate importance to the child is the issue of survival. The infant is utterly dependant upon a primary care giver to meet her basic physical needs and protect her from danger. As the newborn is alerted to discomfort they become aroused and cry. Neuro-imaging studies have revealed that when a baby cries the amygdala, the centre in the mother's brain responsible for reacting to danger, becomes activated and she responds to her baby. The problem solving areas of the brain (pre-frontal cortex) then become activated within the securely attached mother, allowing her to consider and meet the needs of her child. However, the insecurely attached mother is not able to access the pre-frontal cortex in the same way, and she becomes frozen in her response to the child (Fonagy, 1999). It is through the consistent and repeated pattern of safe care giving that a child internalises a sense of safety, security and predictability.

Human babies are born able to react to a perceived threat in their environment through an innate release of stress hormone (cortisol) in response to danger. Those newborns who experience their caregiver as safe and consistent have their equilibrium maintained through touch, stroking, feeding and rocking, thus leading to lower levels of cortisol (Hofer, 1995; Levine, 2001).

Securely attached children produce lower levels of cortisol under stress than insecurely attached children do, suggesting the level of production of cortisol is related to the availability of a secure adult to help manage stress (Gunnar & Donzella, 2002; Nachmias, Gunnar, Mangelsdorf, Parritz, & Buss, 1996; Gunnar, Broderson, Nachmais, Buss &

Rigatuso, 1996; Essex, Klein, Cho, & Kalin, 2002). This finding highlights a crucial component in the development of Looked After Children; it explains why their responses to external stressors are often so extreme, unpredictable and often unconscious. Further, it defines the role of therapeutic professionals and the skills required of caregivers and the importance of these being developed and sustained and supported through the work of the project and team.

2.4.3 - Emotional Needs

As described above, Bowlby's observations led to his belief that the relationship with primary caregiver is also important for *later* functioning. The securely attached child is likely to experience their caregiver as available, interested, safe, nurturing, reciprocal as well as offering stimulation and praise (Bowlby, 1988).

The process of bonding begins long before birth and a synchronised dance develops between the emotionally attuned parent and their newborn. Before and after birth, very powerful instincts of love, protection and nurture begin to surface. These often manifest themselves not only in a desire to meet the child's physical needs, but also in a yearning for closeness and connection (Iwaniec, Herbert, & Sluckin, 2002; Klaus & Kennell, 1982; Mercer, 1990; Goulet *et al.*, 1998).

This can be seen in the way the parent looks at the child, talks to the child, holds and cuddles the child. It can also be seen in how the child responds to the parent, snuggling, babbling, smiling, sucking and clinging. These interactions develop into a 'reciprocal

positive feedback loop' (Perry, 2007, lesson 2, p. 2) and are now thought to be where attachment begins, a very natural process for many parents who have themselves received 'good-enough' parenting (Winnicott, 1965).

2.4.4 - Cognitive and Developmental Needs

These early interactions with primary caregivers provide stimulus and the bedrock of cognitive development. It is in mirroring the actions of others that the child begins to learn, e.g. speech emerges as the child mirrors the cooing, gurgling sounds that attentive parents make to their new born; the child learns to smile through positive responses gained from those around them. These interactions lead to the release of chemical stimuli in the brain which in turn lead the brain to organise in such a way as the child learns through experience. (Cicchetti & Tucker, 1994; Winnicott, 1971; Perry, 2007).

Through physical interactions between parent and child, e.g. holding, rocking, touch, the child begins to get a sense of themselves in relation to the physical world around them. As the child grows, so these tasks become more complex in nature, e.g. holding and rocking give rise to rolling and crawling, which in turn provide the building blocks for walking and swimming. Without the early stimulus of touch, safe environment, praise and encouragement of appropriate risk taking, the child is likely to struggle with later more complex motor skills (Fahlberg, 1991; Schore, 1996; Mesulam, 1998).

Engaging with sensory stimuli is another very early precursor to play and learning. The tiny baby explores his/her world through his/her mouth, then through colours, textures,

sounds and touch. The available mindful parent provides a variety of sensory experiences for the child, e.g. play material, food, water, bubbles, and sounds. The child learns names for things experienced through their senses as these are reflected back to them in an ongoing and consistent way.

> It is the quality of the daily interactions between parent and child that helps children develop physically and mentally. These interchanges aid in organising the child's nervous system and in setting the stage for learning how to learn. (Fahlberg, 1991, p. 63).

2.4.5 - Secure Base

As described above, within close relationships, young children acquire *mental representations* or internal working models of their own worthiness based on other people's availability and willingness to provide care and protection (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth visualised this relationship with the primary care giver as providing an internalised 'secure base', similar to the more recent idea of established neural pathways. For the securely attached child they have an inherent sense of self worth and security, they rely upon when in new or uncertain situations. Stress is more easily managed and they are quickly/easily calmed, (Gunnar & Donzella, 2002).

Initially, this secure object of attachment takes the form of a primary caregiver and the child will seek reassurance in the physical form of a parent or carer. However, with time, as the child starts to separate from their carer at nursery and later school, learned patterns

of behaviour are held internally, and the physical representation of the caregiver is no longer needed. 'Each age and developmental stage has its own rhythms and needs that demand a caregiver's attention' (Perry, 2007, lesson 2, p. 3). Winicott (1971) developed the concept of 'transitional objects' which can support the child in the early stages of separation, allowing them to hold their primary care giver in mind through the use of an object.

Secure Attachment and Dyadic Child Development

2.4.6 - Relationship

Bowlby was heavily criticised within the psychoanalytical arena for his early papers on attachment, as they were felt by many at the time to be too concrete in nature, rejecting the inner world and 'drive' theories of Freud. However, in turn; 'Bowlby felt very strongly that psychoanalysis was putting far too much emphasis on the child's fantasy world and far too little on actual events' (Bretherton, 1991, p. 10). Psychoanalytical theory focuses on the psychic functioning of the child, including their dreams and fantasies and possible relationships between these and behaviour.

Over the past fifty years much research has been done in the psychoanalytic, attachment and neurodevelopment fields, and it is at the interface between these three that much new and innovative thinking has arisen. There is no question that both theories hold early relationships as central in the developing world of the child. However, what remains unclear is the role that 'relationship' and 'the unconscious' play. At the interface between the two is the concept of reciprocity in which the parent responds to the child, and

through the process of relationship a number of complex developmental tasks are facilitated within the child (Douglas, 2007).

2.4.7 - Dyadic Interaction

Beebe and Lachmann (1988) and Field and Fogel (1982) each carried out a series of experiments looking at the parent child dyad, giving rise to the concept of affect synchrony. Affect synchrony is the process by which a mother (or other) watches and internalises her infant's facial expression and reflects this back to the child, mirroring their emotional state and adding their own warm loving experience of the infant, thus allowing the infant an experience of self and other regard.

Affect synchrony would appear to suggest an 'infant-leads-mother-follows' sequence of dyadic interaction (Greenberg, Speltz, & De Kleyn, 1993). The care giver becomes interested and engaged with baby watching, looking and reacting to their cues. The dyad then starts to align as the baby responds to the care giver in a reciprocal and resonating process. Each partner's affect (or emotional state) is matched by the other as they interact together, in a process described as attunement or 'moment to moment state sharing' (Schore, 2003, p. 32).

Through this process of Affect Synchrony, the child begins to get a sense of themselves as reflected through the parent in a process Trevarthen (1993) describes as 'primary inter-subjectivity' (p. 121). He goes on to consider the more complex process of 'secondary inter-subjectivity' by which the parent internalises their experience of the child and

reflects back their own feelings towards the child. In the secure relationship, the child internalises the sense of warmth and love which is felt towards them, building their self-esteem and self worth. The insecurely attached child, however, is likely to experience themselves as empty, disgusting or overwhelming, thus clearly limiting their ability to internalise a strong sense of self worth.

At the heart of Affect Synchrony is also the concept of re-connection. As the child engages with the parent they each become stimulated, holding each other's gaze and following their rhythmic responses. However, with time the child will become overwhelmed and will look away. Much research now suggests that it is in the re-connection, as the baby looks back to the parent and the parent moderates their responses in response to the infant, that much of the emotional connectedness and well-being of the child grows (Beebe and Lachmann, 1988; Hughes, 2009)

Fosha (2003) and Hughes (2006) further expand upon the concept of re-connection and explore this in the more complex developmental tasks of 'shame and guilt'. A child who has had these early experiences of affect synchrony and reconnection begins to gain a sense of themselves as worthy of automatic love and affection and the desire of 'the other' for closeness with them. When a boundary becomes necessary and a young child is told no in a loving secure home, the desire for re-connectedness brings child and parent quickly back together after an outburst or tantrum.

When calm, the child feels shame that they have misbehaved and a consequence is often imposed, thus the child learns that certain behaviour is unacceptable but that this in no way alters their parent's love or desire for closeness with them and does not affect their underlying sense of self worth. With time the child moves beyond the sense of being a bad or naughty child, as they fundamentally know that they are both loved and loveable but instead feel an age-appropriate sense of guilt for their actions (Fahlberg, 1983).

LAC children who have not received the messages of unconditional love or internalised a sense of self worth when they are chastised are unlikely to experience a parent as desiring reconnection with them, and are therefore left isolated in their sense of shame and belief that they are fundamentally bad, naughty, worthless and undeserving of unconditional love. Equally, when they are hurt or abused, they are likely to believe they are responsible for this and left in isolated shame. Thus LAC children are less likely to develop an age appropriate sense of guilt for their action but instead immediately respond in shame often producing violent, unexpected outbursts of rage due to the level of self disgust and isolation they feel in that moment (Golding *et al.*, 2006).

This is a key point for all those sharing the care of the LAC child and goes some way to explaining their often disproportionate responses to relatively minor stimuli, their inability to accept any responsibility for their action, show age appropriate guilt or to answer when questioned about their actions. It is essential to understand their levels of self disgust and isolation not only in the moment, but as connected back through every

like moment they have experienced in environments where they were taught to experience themselves as bad, naughty and unlovable (Fahlberg, 1988b).

In contrast, the emotionally attuned parent actively shows an interest in the child's emotional state and thus reflects back to the child an amplified version (rhythmic matching) – 'the same but not the same'. Thus, the child effectively has a mirror of his own emotional state, learning self through the mirroring of 'the other'. With time the child not only learns to recognise and name their own emotional states, they also become aware of the emotional states of others and how to respond to these, in other words the child develops empathy (Schore, 2001a).

This phenomenon of affect synchrony, when further explored by Trevarthen (1993,) was thought to be connected to neural development through the stimulus of sight, sound, touch and gesture. Several researchers have now undertaken neural imaging studies of mother and child as they interact together. Strong patterns of electrical activity in the right hemisphere of the brain of both mother and child have been noted within the secure dyad (Fonagy, 1999; Perry, 2007; Schore, 2003). This underlines the importance of repeated experience, stimulating and establishing significant neural pathways in the right hemisphere (or emotional brain) thought to develop largely through relationship with 'the other'. The child, therefore, has learnt experience of the empathy and emotional states of others as reflected in their earliest caregiving dyad in a process termed mind-mindedness by Elizabeth Meins:

> Such sensitive responsivity goes beyond the ability to respond promptly to the infant's behaviour, and involves a degree of interpretation on the caregiver's part in order to calculate what a given behaviour means (Meins, 1997, p. 329).

Schore (2001a) explores how negative states and arousal within the child are managed by parental re-establishment of calm, which Bowlby (1958) would describe in terms of maternal sensitivity and Bion (1962) in terms of 'metabolising':

2.4.8 - Mentalisation & Reflective Functioning

> It is now thought that the process of re-experiencing positive affect following negative experience, is crucial to the child's learning that negativity can be tolerated and endured, and that infant's resilience is best characterised as the capacity of the child and the parent for transition from positive to negative and back to positive affect – resilience in the face of stress is an ultimate indicator of attachment capacity (Schore, 2001a, p. 33).

It is through such interaction as Schore describes that the child will eventually learn to recognise not only their own emotional state as it has been mirrored back to them, but also the emotional states of others as experienced in their early dyadic relationships, a process Fonagy (2001) describes as Mentalisation. 'Mentalisation – to assume thoughts and feelings in others and in oneself, and to recognise these connected to outer reality' (Fonagy, 2001, p. 171).

Through a process of ‘reflective functioning’, the child can relate to ‘the other’ as distinct and different from ‘the self’ with a distinct capacity for thought, emotion and relationship separate from their own. They learn a process of ‘reading’ those around them and in doing so have the capacity to relate in a meaningful, attuned and empathetic way which forms the basis for all relationships (Fosha, 2003).

However, lack of attunement can lead to emotional toxicity for the infant, as their emotional states are not effectively mirrored back to them and they are left isolated (Schore, 2001b). The child who does not experience a secure and attuned early relationship is likely to present as confused or uncertain of their own emotional states, as well as unable to effectively relate to those around them. This is particularly significant for the multiplicity of relationships that Looked After Children experience. Even in a closely controlled and protective therapeutic environment, the six children in the study were exposed to significant numbers of key caregivers and professionals as described in the case studies below.

> ‘What goes on in other people’s minds in terms of thoughts, feelings, desires and beliefs is the key to understanding their actions and behaviour, and the character of their relationship with us and other people’ (Howe, 2005, p. 19).

2.4.9 - Containment

Through the early experiences of affect regulation and physical containment, coupled with the consistent and safe responses of a secure primary attachment figure, the child

learns the process of 'emotional regulation'. In a securely attached child, their early construct is 'The world is safe, I am loved and cared for, my primary care giver will calm and soothe'. With time, as the child grows, learns and starts to differentiate from 'the other', the child begins to establish more firmly their own desires and wills as their personality begins to emerge. Freud (1928) described this in terms of development of the ego and superego and later Bowlby (1973) identified this as the process of separation. Through this time, about twenty four to thirty six months of age, the child will attempt to enforce their will on 'the other' or act out their sense of frustration and fear at separation, thus entering what is commonly know as the 'terrible twos'.

Because the child has first learnt the safe emotional and physical containment of 'the other' through this process of affect regulation, they can now be supported to experience this in more concrete and physical terms. The safe consistent parent will react in a predictable and containing way to the overwhelming outbursts of the child as they struggle with a battle of wills, which at this stage of development they do not have the ability to fully understand or reason (Jernberg & Booth, 1999). With time the child learns a sense of internal containment as they inevitably learn that such outbursts do not often lead to a desirable outcome. As the child's cognitions become more complex and their understanding of the world around them more advanced, so they move onto the next stage of development – that of negotiation (Fahlberg, 1991).

Through such developmental processes, the child not only learns internal containment and the more complex skills of negotiation, they also learn that the parent is safe and

consistent through the use of predictable, appropriate boundaries. They learn how to be safe in the world and when they cannot keep themselves safe there are others who can. A lack of consistent, safe boundaries, however, leaves the child with an age inappropriate sense of omnipotence which is terrifying. Inconsistent responses create boundaries which leave the child confused and uncertain of unpredictable responses.

> One of the major problems with neglected poorly attached children is [their] aggression and cruelty. This is related to two major primary problems in neglected children: lack of empathy and poor impulse control (Perry, 2007, lesson 3, p. 6).

Bion (1962) first explored the concept of ‘emotional containment’. He found that as the child projects their fears into ‘the other’ a sensitive responsive parent can manage this fear, be affected by it but not overwhelmed, and reflect back a manageable perception of the fear experienced. The rigid parent does not respond to the projected feelings of the child, and the child receives no information from the parent about how to process their fear. The fearful parent becomes so overwhelmed by the child’s fear that they respond in panic or by breaking down.

> An understanding mother is able to experience the feeling of dread that this baby was striving to deal with by projective identification, and yet retain a balanced outlook (Bion, 1962, p. 103).

Bion's (1962) ideas foreshadowed much of the recent thinking around inter-subjectivity, reflective functioning and affect synchrony. The securely attached child learns how to manage their strong emotions and to negotiate increasing emotional containment. However, the insecurely attached child, left without any understanding of these emotions, becomes shut down and unresponsive, or alternatively overwhelmed, pushing their fear and chaos into all around them. This is particularly evident in Looked After Children (Greenwood, 2005).

2.4.10 - Inter and Intra-personal factors

In essence, it would appear that the fields of attachment and psychoanalysis share much common ground. Through their relationship with their parents or carers, the child gains a learned understanding of the world around them as safe, secure and consistent, and through the interaction with their primary caregiver a sense of security, self-worth and containment. However, within that there is scope to consider the psychoanalytical view that the child also uses the relationship as an anchor to explore 'the other' and that secure attachment brings with it the safe exploration of the psycho-social world.

> This may be one of the reasons why many of the characteristics of children who have experienced maltreatment may also be found in those whose childhoods may apparently have been relatively benign. The parent may have been emotionally inaccessible to the child. This would prevent the child from forming the images of his internal world in the parent's mind that he needs to in order to form the core sense of himself (Fonagy, 2001, p. 179).

Attachment Theory and Psychoanalytical thinking also concern themselves with the longer term impact of adverse early experience. Attachment theory suggests strong links between the attachment patterns of the insecurely attached child and their adult counterparts, whereas Psychoanalytical theory looks at the psychic functioning of the child and the resultant psychopathology exhibited in adulthood. Thus, both theories show a strong correlation between early childhood experiences and later adult functioning.

> Children of abusive carers internalise a hostile, persecutory self. Those of severely neglecting parents internalise hollow, empty abandoned self. These fractured, disorganised states are difficult to live with. Children (and adults) try to cope by projecting many of their distressed feelings on to others and then try to control the other, often in an aggressive way (Howe, 2005, p. 23).

2.4.11 - Attachment Across the Life Cycle

Early attachment research noted that classic, external signs of ‘separation anxiety’ were not seen in the first six months of development. However, more recent research (Murray Parkes, 1997; Perry, 1999; Schore 2001a; Drell, Seigel, & Gaensbauer, 1993; Schwartz & Perry, 1994) would suggest a much earlier global response to distress. Among others, Spangler and Grossman (1999) observed neurobiological disregulation in neonates, which they suggest may be the result of uterine exposure to maternal distress. Mesulam (1998) demonstrated that this ‘dialogue’ takes place through the exchange of neurohormonal messages *in utero* and showed the amygdala of the brain’s limbic system (emotion/learning) to be affected by pre-natal stressors.

Many researchers have now gone on to consider attachment patterns across the life cycle as being potentially 'emotionally embedded' (Gerhardt, 2004, p. 64) and the Internal Working Model laid down in childhood is thought to act as a template for later development such as separation in early childhood, the formation of meaningful peer and romantic relationships, separation in adolescence, the move into adulthood and ultimately parenthood.

Colin Murray Parkes (1997), through his work with bereaved adults, also noted similarities in the grief process of adults, and the despair felt by children on separation from a primary care giver. The resultant findings led to a paper with Bowlby, in which the phases of separation delineated by Bowlby *et al*. (1952) for young children, were elaborated into four phases of grief during adult life (Bowlby & Parkes, 1970).
Mary Main, in her early work in Africa, undertook a detailed study of attachment patterns, and through this developed the Adult Attachment Interview (AAI) (Main & Goldwyn, 1998). This tool is now widely used to assess adult attachment relationships for diagnostic, parenting and therapeutic purposes. More recently, Bifulco, Lillie, Ball and Moran, (1998) developed the Attachment Style Interview (ASI) designed to assess parental attachment patterns in situations of stress, thus providing useful insight into the impact upon parent/child relationships under stress and trauma for the purposes of assessment, treatment and support.

It has long been assumed that the style of attachment most likely to lead to advantageous long-term outcomes would be that of the securely attached child. However, recent research by Pat Crittenden (2000) has begun to cast doubt upon this assumption, and in

her most recent, as yet unpublished work, she explores the idea of changing attachment styles in later development. David Shemmings at his seminar ‘Advanced Reflections on Attachment and its Impact on Practice’ in April 2006 presented some of this thinking, also described as ‘earned secure attachment’ by Roisman, Padron, Sroufe, and Egeland, (2002) and Phelps, Belsky, and Crnic (1998).

Shemmings (2006) suggests that children who experience insecure attachment patterns in earlychildhood, but go on to receive therapeutic support in later childhood, adolescence or adulthood, may ultimately be provided with a new more secure attachment pattern. The work of Crittenden (as described by Shemmings) suggests that the securely attached child is likely to have experienced little direct adversity or trauma. So when adverse life events do occur, despite an inherent sense of well-being and security, they have few direct tools for managing this. Conversely, the insecurely attached child who has received therapeutic support to explore their attachment experiences, trauma and re-new attachment relationships, develops a greater degree of resilience to adverse life events. Thus therapeutic support can help prevent established defence strategies dominating the child’s relationships and enable the child to develop new or ‘earned’ secure attachments.

Insecure Attachment

2.4.12 – Introduction

Mary Ainsworth (1978) developed The Strange Situation Test, which measures the infant’s response to separation from the primary care giver, and initially led to two early classifications of attachment related behaviours, namely secure, as outlined above, and insecure attachment.

However, it was clear from the infant's response on separation, that insecurely attached infants related to the care giver in two quite specific ways, namely avoidant and ambivalent. Since this time research by Main and Solomon (1986) has led to the recognition of a further category of insecure attachment, namely disorganised. These classifications are now largely used for assessment and diagnostic purposes, to enable insight into presenting behaviour and appropriate therapeutic support.

2.4.13 - Insecure - Avoidant Attachment

The child who shows avoidant attachment is likely to have experienced emotional distance from their primary care giver. Instead of experiencing a mutually satisfying close nurturing experience, the child is likely to have experienced emotional separation or even rejection. It is likely that their primary caregiver will have met their basic physical needs in a perfunctory or mechanical way, thus limiting meaningful loving interactions which shape the child's perception of self, relationships and the world around them. Therefore, their internal working model is one of emotional distance: the world is not safe, my primary care giver will meet my needs, but I am not worthy of close meaningful relationships. Howe, Brandon, Hinings and Schofield (1999) describe these children as 'cut off from the world of feeling and close relationships' (p. 64). Their behaviour is often manifest as emotionally shut down, invisible, hyper-good, taking a care giving role from an early age and emotionally detached, with few internal resources to form later meaningful relationships.

2.4.14 - Insecure – Ambivalent Attachment

The child who shows ambivalent attachment is likely to experience their caregiver as inconsistent, at times capable of offering love and nurture, but at others rejecting or hostile. The child remains constantly alert and aroused in an attempt to elicit positive interactions with their caregiver. These children are likely to seek close proximity to their carer, and show heightened levels of anxiety on separation. Their internal working model is one of emotional uncertainty: the world is not safe or consistent, sometimes my basic physical and emotional needs are met, at other times my carer is hostile or frightening. I must keep my caregiver close at all times using a variety of behaviours, positive or negative. Sometimes I am worthy of love and affection, but at others I am disgusting or abhorrent. Howe describes these children as feeling unworthy of automatic care or love, anxious that the self is neither valued nor liked (Howe *et al.,* 1999, p. 90).

2.4.15 - Insecure – Disorganised Attachment

The child who shows disorganised attachment is likely to have suffered unresolved loss or trauma. They are likely to experience their caregiver not only as the person who meets their physical needs, but also as the person who is dangerous to them or who is unresponsive or unavailable due to their own fear or alarm. Therefore, the child will run to the carer for comfort, then push them away in a classic push-me, pull-me dilemma, safe and dangerous contained within the same person, the very person who is fundamental and essential to the child's initial survival and later development. The child's internal working model is one of emotional chaos and incoherence: the world is

not safe; I feel terrified and confused; I have no consistent or safe way to ensure my needs are met; I have no consistent sense of myself or my emotional being.

> Infants are classified as disorganised–disorientated if, in the presence of their parents, their behaviour seems to lack an effective proximity seeking strategy. These behaviours broadly divide into apprehension, confusion (contradictory approach and avoidance behaviours) and trances (freezing), only appear to make sense if they are seen as reflecting fear and disorientation in the relationship with their carer (Howe *et al.*, 1999, p. 123).

2.4.16 - Reactive Attachment Disorder

Some children who experience extremes of inconsistent parenting, separation or loss may go on to develop symptoms of Reactive Attachment Disorder (RAD) as classified within The Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (1994) - (DSM-IV) (where it is categorised as DSM-IV, 313.89) or The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnosis Guidelines (1992) – (ICD-10) (where it appears as ICD-10, F94.1). Two distinct subtypes of RAD exist, namely ‘inhibited’, where the child fails to respond to most social interactions in a developmentally appropriate way, and ‘disinhibited’, where the child shows a lack of selectivity in their attachment figures. These definitions are clearly documented and, of necessity, narrow and precise to aid diagnostic differentiation. Additionally, they pertain to a relatively small group of children from quite extreme backgrounds, with much

research originating in Eastern European orphanage provision, and children severely emotionally deprived.

The Journal of Attachment and Human Development devoted an entire edition in September 2003 to the topic of Assessment and Treatment of Attachment Disorders. O'Connor and Zeanah (2003a) reviewed present assessment criteria for attachment disorder as represented in DSM-IV or ICD-10. There is presently some dispute as to the definition of reactive attachment disorder, with some clinicians feeling the above criteria too prescriptive, with many presentations failing to fall into the categories of 'disinhibited' or 'inhibited' attachment disorder. Some clinicians prefer instead the use of terminology such as attachment problem or difficulty. Many felt that the clinical definition should be reviewed to allow a more holistic definition, or incorporate the idea of a spectrum of related behaviours as described by Hughes (2003). In the same issue Howe (2003) writes:

> As someone who has met, and tried to support and advise many of the parents of the adoptive children, restricting the definition of attachment disorder to the behaviours shown by a relatively rare group of severely deprived and institutionally reared children who have selective attachment problems, might, once more, benight the majority of adopters and their children who are just beginning to feel recognised and understood by the professional community, if not specifically, then at least generically as carers of children who find great difficulty in directing, organising and regulating their attachment behaviour (p. 269).

In their summary, O'Connor and Zeanah (2003b) acknowledge the growing disparity between the formal definition of attachment disorders, and those used within research and practice arenas. They conclude there is a need for a more generic term and the inclusion of more characteristic behaviours, but mark the need for clear definition and distinction from other disorders such as conduct disorder.

Byrne (2003) reports some children referred to Child and Adolescent Mental Health Services (CAMHS), although not classified as having attachment disorder, often show symptoms of disturbances in attention and concentration, stealing, aggressive behaviour or marked problems with peer and family relationships. This highlights another dilemma facing many professionals that attachment disorder is rarely seen or referred for what it is. Winnicott (1984) describes children being viewed as naughty or rebellious, when in fact nobody within their environment could recognise their distress signals.

The child whose energy has been taken up with the task of survival may have limited tools for learning and play. Often children entering the care system will be assessed as having what is described as 'global delay'; this tends to be quite an ambiguous phrase as the extent and nature of the delay can be quite difficult to determine (Cairns & Stanway, 2004). Often children placed within secure homes will show marked global improvement and, as described by Gerhardt (2004), it is the residual effects of early programming on the brain which are addressed through therapy. Some have argued that the effects of neglect and trauma may be too prolific for therapeutic input to stimulate change (Perry, 2007). However, in a paper exploring the capacity of change in Romanian orphans,

Rutter (1998) agues against this, but emphasises the long-term nature of work necessary, a principle, it could be argued, which is also pertinent to the LAC child, given the level of complexity of their mental health needs, as previously discussed.

Within the LAC population, attachment difficulties rarely exist without the presence of trauma, and the two are so inextricably linked that their resultant effects cannot easily be separated. Therefore, the concepts, definitions and implications of trauma must also be considered for this population of children (Benamer & White, 2008).

2.5 - Trauma

2.5.1 - Towards a definition

Perry (2007) in his work for the 'Child Trauma Academy' describes trauma as:
'A psychologically distressing event that is outside the range of usual human experience. Trauma often involves a sense of intense fear, terror and helplessness. An experience which induces an abnormally intense and prolonged stress response' (Lesson 1, p. 2). Cynthia Monahon (1993) in her book Children and Trauma describes sources of childhood trauma as: accidental injury or severe illness, catastrophes or disasters, physical and sexual abuse, interpersonal and community violence. She also considers the impact on children of the criminal justice system, media and witnessing violence.

The term 'trauma' is a broad one and encompasses a wide range of cause and effect. For instance, the adult experience of trauma may be different from the child's, because the effects of a one-off life threatening event may differ from the pervasive nature of long-

term chronic trauma, mitigating factors which build resilience alter an individuals response to trauma. As such, no two individuals will react in the same way to the same trauma, and any one person may react differently to different episodes of trauma (Greenwald, 2005).

This has historically led to trauma being defined more by its effects and presentation than its inherent features. The standard DSM-IV (1994) diagnostic criteria for trauma response, at present, is that of Post Traumatic Stress Disorder (PTSD):

- Post-traumatic stress response lasting longer than one month
- Recurring intrusive recollection of the traumatic event
- Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness
- Persistent symptoms of increased arousal – physiological hyper-reactivity

Trauma responses which do not fall within these criteria are often associated with other diagnoses such as conduct disorder, anxiety disorder or oppositional defiant disorder. However, there is increasing disquiet within the field of child trauma with many who feel the pervasive nature of chronic childhood trauma does not fit easily into the above diagnostic criteria, and children are often being labelled inappropriately.

> The traumatic stress field has adopted the term 'complex trauma' to describe the experience of multiple, chronic and prolonged developmentally adverse traumatic events, most often of an interpersonal nature (e.g. sexual or physical abuse, war,

community violence) and early life onset. Isolated traumatic incidents tend to produce discrete conditioned behavioural and biological responses to the reminders of the trauma, such as those captured in the post traumatic stress disorder (PTSD) diagnosis (Van der Kolk, 2005, p. 1).

In acknowledging the differing impact of one-off highly traumatic events and the impact of 'complex trauma', The National Child Traumatic Stress Network set up a working party called The Complex Trauma Taskforce. They set out to consider the impact of complex trauma on the developing child, and move towards a more coherent, integrated diagnosis for presenting behavioural patterns. The result was 'Developmental Trauma Disorder'. The proposed diagnosis has four main assessing criteria, which are presently being piloted by the Taskforce with a view to moving towards more official diagnostic criteria within the next revised DSM handbook. The diagnostic criteria of DTD postulated were:

a. Exposure, e.g. physical/sexual abuse, domestic violence, rape, betrayal

b. Triggered pattern of repeated disregulation in response to trauma cues, e.g. self harm, dissociation, oppositional, blame

c. Persistently altered attributions and expectancies, e.g.. lack of trust, negative self attribution

d. Functional impairment, e.g. educational, familial, peer, vocational, legal

(Van der Kolk, 2005, p. 8-9).

This was not accepted as an additional diagnostic category in the revised DSM handbook, but many practitioners, including the therapist in this study, continue to use Van de Kolk's principles as an aid to assessment and treatment for Looked After Children. The search goes on for a set of criteria which aim to be more global in their consideration of the impact of complex trauma, and encompass the similarities as well as the diversity found within child development. Such criteria must have at their root an understanding of the prolific impact trauma has on the cognitive, emotional and behavioural development of the child (James, 1994).

These advances potentially mark a milestone in recognising and responding to the specific presentation of children affected by chronic long-term trauma. Children entering the care system are likely to come with an extensive history of neglect and abuse, with little likelihood of a secure attachment experience. Some of the children entering the care system may have experienced one-off life threatening events. However, it is unlikely that such an event alone (unless of significant magnitude with few mitigating factors) would lead to the permanent removal of a child from their family of origin. It is more likely that such an event would act as a catalyst to the child's removal from a birth family which has long been of concern to social services (Cooper & Ball, 1987; Glaser & Frosh, 1988; Howe, 1995). Thus, some children entering the care system may present with symptoms of PTSD from significant and extreme trauma. However, the majority of LAC children entering the care system are likely to have experienced complex trauma and therefore symptoms consistent with Developmental Trauma Disorder.

2.5.2- Physical Responses to Trauma in the Looked After Child

In order to understand better the prolific and lasting implications of trauma for the LAC child, it is important to first pause and consider the complex responses to danger within the human brain and body. As a risk is recognised through the senses, it arrives initially in the brain stem or lower brain, causing a cascade of neurotransmitters to be released, and where necessary an immediate response is evoked. For example, the child moves back from the stimulus of pain in a reflex response. Messages are then sent to the more complex areas of the brain allowing thought and recognition of risk or pain, and then the brain prepares the body for action to get away from the risk (Solomon, 2003).

The upper part of the brain effectively tells the lower part to make changes to the body's physical state, such as increased heart rate, increased blood flow to vital organs, and a shut down of non-essential activity. This is commonly known as the "fight, flight or freeze" response, and is designed as an emergency reaction to the release of cortisol in the brain. This is a highly adapted, evolved and genetically selected response which also activates proximity seeking attachment behaviours within the child (Perry, 2007; Siegal, 2003; Schore, 2001a; Howe *et al.,* 1999).

The brain is an anticipatory machine which makes sense of what has gone previously to create a 'template' of experience. It is impossible for the brain to store all experiences, so when neural pathways are consistently fired, it is the 'similarities' in experience that provide the template for recognition, or memory (Van Der Kolk, 2003; Perry, 2007). It is through these 'templates' that any new experience is compared to anticipate the level of

threat, new faces or situations present in a highly evolved system of survival (Perry, 2007; Panksepp, 1998; Damasio, 1989).

The securely attached child who is not exposed to traumatic events will experience increased cortisol levels when perceived threat is present, but this stress is managed by a caregiver and the child returns to a baseline state of calm (Gunnar & Donzella, 2002). However, when children live under the constant threat of danger, assault or attack they start producing greater levels of cortisol (Nachmias *et al.,* 1996; Essex *et al.,* 2002; Gunnar *et al.,* 1996). This results in 'cortisol dysfunction' through which their survival systems are constantly switched on, and over time their base line arousal is re-set (Gerhardt, 2004).

Therefore, it becomes clear that the traumatised LAC child will react far more quickly and more acutely to minor events, as their base line arousal rate is already elevated. Thus, even relatively small stressors can induce a state of fear or terror commonly known as hyper-arousal. The child may present as hyper-vigilant, scanning for danger or may misinterpret innocent cues from those around them as attacking, dangerous or seductive. It is also clear to see that these physiological changes are likely to be pervasive in nature and outlive their usefulness as children move onto safe, secure foster/adoptive homes (Perry, 2007). Therapeutic intervention must therefore be particularly sensitive and geared to calm the child and dismantle the cycle of fear and reaction with its resultant stress for the child (Gil, 2006).

2.5.3 – Trauma and Learning

If a child's arousal level is reset then it will have a pervasive and long-term impact upon the physical, emotional and cognitive development of the child. It is well documented that children learn best at a base level of calm (Perry, 2007; Cairns & Stanway, 2004) and, as we have seen, the traumatised child becomes 'reprogrammed' not to reach this baseline. Under threat, different parts of the brain become activated and the parts of the brain most used become most established (Balbernie, 2001; Archer, 2003). Therefore, the LAC child's ability to learn is compromised, as they are pre-occupied with danger and survival and they are often termed 'globally delayed' (Jackson, 2007).

Much of the child's early learning takes place within a 'relationship' and where there is little encouragement, stimulation, praise, affirmation or available learning experiences, the precursors to later more complex learning tasks are compromised. In school, for example, LAC children can present as silent or invisible in class, copying those around them and flaring up when singled out, thus masking their sense of empty worthlessness. Some will struggle to remain contained during unstructured periods such as circle and golden time; fidgeting, distracting others or eager to answer questions they do not comprehend. Others will become attacking to those around them as they perceive a slight in apparently innocuous interactions with peers, due to elevated stress responses. For optimal learning, children also require an inherent sense of self worth, rarely seen in children who have been abused, degraded or scapegoated in early experiences, instead the child becomes overwhelmed by shame, guilt and self loathing. (Geddes, 2006; Hughes, 2006; Cairns & Stanway, 2004).

2.5.4 - The effects of trauma

Due to the re-setting of baseline arousal within the traumatised child, their responses to trauma do not automatically subside when they are removed from a stimulus of fear. With time, their arousal levels will begin to reduce, dampening immediate trauma responses, but they will be left with a raft of presenting difficulties related to the impact trauma has had upon their cognitive and emotional development. They will take this compromised ability to respond into each encounter with a new placement and new caregivers (Sunderland, 2007).

Young children quickly learn that they have little capacity to fight and that running is often futile, so the most common form of response to trauma in children is reported to be the freeze response. In extreme cases the child may withdraw so deeply within themselves that they 'dissociate' from the traumatic event, they may view the trauma as happening to someone else or escape into a complex world of fantasy. For some children the trauma may be so intense or chronic they may have a disrupted memory of the events (Teicher, 2002). Siegel (2003) describes the hippocampus (responsible for memory) as particularly susceptible to the 'neurotoxic effects of excessive and prolonged cortisol secretion', and goes on to that suggest parental behaviour which produces disorganisation may be 'at the heart of dissociation'.

In such traumatised children, where the fight and flight responses are also activated, they will also often show heightened signs of aggressive or anxious behaviours. Persistent anxiety may show no relevance to the trauma experienced and exists only in a pervasive

fear. If dissociation has been great enough to disrupt memory formation, the child may have no direct memory of the trauma, whilst remaining in a highly anxious fearful state. Feelings of being out of control, threatened, fear and pain are often re-lived, either consciously in play, semiconsciously in flashbacks, or in distorted memories and subconsciously in sleep disturbance, such as nightmare or night terrors. The child may suffer panic attacks, increased separation anxiety, behavioural regression, denial, personality changes, and inappropriate responses. The child may be behaviourally impulsive, show increased risk taking, become more accident prone, hyper vigilant and hyperactive and appear withdrawn or depressed. The child may experience a distorted sense of self, involving blame, shame, self-disgust, low self worth. They may show signs of inappropriate sexual activity or struggle to gain appropriate physical closeness. The child may present as unpredictable, sadistic or dangerous, as verbal and non-verbal cues have not matched up in the child's early templates, so the child learns a distorted, often destructive pattern of interaction and communication (Monahon, 1993; Landreth, 2001; Cairns, 2002; Perry, 2007; Van der Kolk, 2005; Carroll, 2001).

The child who is unable to explore their sense of self and trauma through 'the safe other', may in some cases experience splitting the idealisation of the good object and the rejection of the bad. Siegel (2003) describes the child who projects the imperfect parts of themselves outwards then views these parts as threatening; commenting that this fragmentation of reality and inability to create a coherent world can eventually emerge as psychosis.

Some children may attempt to harm themselves or others. When their feelings of shame and disgust escalate and the intensity of emotional distress becomes unbearable, physical pain becomes preferable and can act as a welcome distraction from this pain. Children will often project their feelings into 'the other' and in some instances this is a useful therapeutic tool. However, in extreme cases this can lead a child to attack the recipient as they cannot bear the rejected aspects of themselves or, if unresolved into adulthood, it can lead to paranoia (Copley & Forryan, 1987).

As described above, some extreme cases of trauma lead to disruption in later psychic development as 'the other' is not experienced in a safe way leading to a disruption in the child's internal development of 'the self'. When 'the self' is not appropriately assimilated through development, the resultant fragmentation of 'self' leads to significant risk of psychiatric disturbances and accompanying risk to self and others (Bannister, 2003). Bannister (2003) goes on to describe the 'unspoken abuse' as visible in personal difficulties, the recurring cycle of abuse or in the mental illness of adults.

> Each child will then cope in different ways, by dissociation or denial, by regression and so on, and this will lead to distortion of cognition or perception (Bannister, 1992, p. 16).

By considering new research, developments in the field of attachment and trauma, greater understanding has been gained into the complex presentation of the LAC child. This study devotes itself to the consideration of decision making in relation to therapeutic

intervention within this child population, and consideration can now be given to what is presently known in relation to Therapeutic intervention, and in particular Theraplay and Play Therapy.

2.6 - Therapeutic Intervention

There are presently a number of therapeutic interventions available to the LAC population, and many have been shown to be very effective when working with children affected by attachment and trauma related difficulties. These include systemic approaches such as family therapy (Campbell, D. *et al.,* 2003) and individual approaches such as psychotherapy (Fonagy, 2001; Holmes, 2001). 'This process may be a component of the emotionally attuned communication and co-construction of narratives that are the foundation of numerous forms of therapy' (Siegel, 2003, p. 48).

O'Connor and Zeanah (2003a) specifically reviewed interventions available to children suffering from reactive attachment disorder, and raised some concern regarding many of the new treatment modalities being offered, especially in the light of a number of fatalities documented in the United States following the use of so- called 'Holding Therapies'. Several clinicians, such as Dan Hughes, responded to this review, documenting much of the pioneering work in the field of attachment therapy.

> When there is a lack of consensus regarding the definition of attachment disorder as well as the means of assessing it, there most certainly will be considerable difficulty in attempting to provide treatment for this 'undefined disorder' and

> extreme difficulty in determining if such treatment for 'attachment disorder' is effective (Hughes, 2003, p. 272).

O'Connor and Zeanah (2003b) conclude that further research is required into the definition, assessment and treatment of attachment disorders, whilst acknowledging the skill and expertise of many working within this field, as described by Howe and Fearnley (2003):

> The number of therapists and support organisations involved with these children (adopted and fostered children with pre-placement histories of severe abuse and neglect), remains relatively small and the clinicians' practice and understanding of those people is still running ahead of the research evidence. But so far research and theory appear to be supporting much of what these pioneering clinicians and lobbyists have been claiming about the traumatic nature of these children's early history, the huge problems they have in handling normal family life, and the need for early intensive interventions based on helping children engage with, and trust their new caregivers using a variety of emotional and relationship based developmental techniques (p.386).

This study is not designed to consider the appropriateness of other modalities in the cases of the children considered or address the comparability of various therapies e.g.

- Family therapy (A reflective, systemic team approach with child and family together. The team observes and provides input to the therapist who offers the

family a space to think and reflect encouraging access their own restorative, problem solving capacities)

- Filial therapy (Therapist works with and observes child and family both separately and together. The therapist uses and models therapeutic play to support families in building closer attachment relationships whilst also addressing issues of trauma)
- Psychotherapy (Therapist works with child individually whilst a second therapist supports the family/ professional network. Through the exploration of conscious and unconscious thought the child and family are supported to integrate trauma in a more useful way and adapt thought processes to encourage closer attachment relationships),

Since this study is embedded in the practice of one specific practitioner who is trained and employed to offer two specific forms of therapy, Theraplay and Play Therapy, these exclusively have been discussed below.

2.7 – Theraplay

2.7.1 - History

In 1967 Ann Jernberg, in her role as the director of psychological services for Head Start (similar to Sure Start) in Chicago, found striking similarities in the presenting behaviours of many of the children referred, and later demonstrated a strong correlation between this behaviour and insecure attachment patterns. Jernberg and Booth (1999) describe factors affecting the presenting behaviour of the insecurely attached child as falling within four

broad categories or domains, namely: Nurture, Structure, Challenge and Engagement, which form the basis of Theraplay intervention.

Nurture. The abused child who has inconsistently experienced close, loving or safe contact with a parent may shrink from this or deny their own emotional needs, having been self reliant from an early age. This child may well struggle with appropriate intimacy, either becoming over familiar or indiscriminately affectionate, especially with strangers. Others present as unable to engage in any close nurturing activity unless on their own terms. The child may often attempt self soothing, may shrug off pain or may undertake activities to make them less attractive to those around them e.g. poor hygiene, soiling, wetting, spitting. This child may hoard food or steal (often bizarre things they have no use for or food they don't even like), an instinctive response for the neglected child responsible for their own nurture and possibly that of younger siblings (Howe *et al.*, 1999; Bowlby, 1973).

Structure. Those children who experience their parent as frightening or inconsistent often present with a need to remain in control (Main & Hesse, 1990), a defence strategy which keeps them alert to any presenting danger. The child may argue even to the smallest detail, they may oppose instruction or request, even if this leads to some favourable outcome for them, they may sabotage activities, even ones they take pleasure in, they may struggle to remain contained throughout even simple activities, they may become volatile for no immediate apparent reason. Levy and Orlans (1998) note problems with impulse control and aggression. The child may seek constant closeness and reassurance

from their carer, either physical or verbal, taking whatever measures (often negative) necessary to elicit this close contact or ‘regulate the care giving pattern’ (Greenberg *et al.*, 1993). They may have little or no internalised concept or belief of their needs being met, their own self worth or identity (Heller & Berndt, 1981).

Challenge. The child who has received little praise or encouragement, for whom failure, be it slight or even perceived, is likely to have been ridiculed or unduly chastised, is likely to grow up with chronic low self esteem, an inherent lack of belief in their own abilities or fear to attempt activities (Perry, 2007; Main & Cassidy,1988). This child may present as quite withdrawn and uncertain, or by contrast may present as quite confrontational. Attack is their greatest form of defence, and if they can distract your attention from the task in hand which they fear they cannot accomplish, then you will chastise their behaviour rather than belittle their inabilities (Hughes, 2006).

Engagement. The child who does not experience their parent as consistent is unlikely to feel safe enough to take risks or to engage emotionally with them. Their emotions are unlikely to be read, managed and reflected back to them in a way which helps them to become self regulating. These children often struggle to allow emotional closeness or warmth, becoming quite expert at distracting those who would attempt it; they may avoid eye contact or engage in activities which will keep a carer at an emotional distance (Hughes, 2006; Carlson & Sroufe, 1995).

2.7.2 – Research

It is in the context of this history and against the backdrop of uncertainty that Theraplay is emerging within the United Kingdom. Essentially Theraplay intervention models the natural, playful patterns of healthy interaction between parent and child. It helps troubled families to develop the responsiveness and structure vital to a child's development. Theraplay shows parents how to use play to communicate love and authority and to engage their children in interactions that develop competence, self-esteem and trust. The therapist is responsible for mirroring playful, engaging activities which parent and child then undertake together firstly in session and later within the home (Munns, 2009).

Little formal research has been undertaken to investigate Theraplay, and that which does exist is largely unpublished or anecdotal in nature. However, two studies in particular are worth noting. Makela and Vierikko (2004) undertook a study of twenty six children receiving Theraplay at a therapeutic village for children in Finland. Marked changes in attachment presentation were reported by parents/carers at the end of intervention and even more marked changes seen in the six months following treatment. Cain Snipp (2004) undertook an unpublished study entitled 'How effective is Theraplay in improving the effects of attachment difficulties in children who are, or have been, in public care?' Ten children received twelve sessions of Theraplay, and Snipp found a universal improvement in the children's presentation when comparing the initial Marschak Interaction Method video assessment (1960) to those undertaken following twelve sessions. He also noted an improvement in mean scores in all categories of the Strengths and Difficulties Questionnaire (Goodman, 1997), except emotionality and peer

relationships, and an improvement in mean scores in all categories of the parental stress index (Abidin, 1990) except Parental Distress. These results would suggest positive outcomes through the use of Theraplay intervention. The small clinical population bears direct relevance to this study, and in particular the rich qualitative insight which can be gained through research of its kind.

2.7.3. – Attachment based therapy

> Given the potential long-term effects that lack of attachment can have on a child, it is crucial that the foster care system respond in ways that help the child develop attachments with their primary caregivers whomever they may be (…) the development of an attachment to foster carers should be encouraged (Fahlberg, 1991, p. 17).

Many Theraplay practitioners have been drawn to this rapidly developing form of therapeutic intervention by virtue of the fact that parent/carer remains in sessions. The therapist facilitates interaction between carer and child, thus directly working upon the developing attachment relationships. Many attachment based therapies are evolving to nurture relationships within the family unit (Archer & Burnell, 2003; Keck & Kupecky, 2002) and Bowlby himself noted the importance of working with mother and child to restore attachment relationships:

> Having once been helped to recognise and recapture the feelings which she herself had as a child, and to find that they are accepted tolerantly and

> understandingly, a mother will become increasingly sympathetic and tolerant toward the same things in her child (Bowlby, 1940, p. 23).

2.7.4 - Process

Through playful activities, the child is given new experiences which they may have missed in infancy and early childhood. Jernberg and Booth (1999) describe this in the following terms:

> Perhaps the most innovative aspect of Theraplay treatment is the nature of the play itself. It is the kind of play which belongs to the earliest stages of development. It is the joyful play of the parent with an infant, play that entices the child into a relationship (p. 35).

Play activities mirror healthy early attachment interactions such as touch, soothing, eye contact, safe boundaries, encouragement, nurture, sensory stimulation and singing (Perry, 2007). Through playful, engaging and attuned interaction the child learns to compensate for deficits in his or her early experiences, specifically:

- *Structuring*, Parents are trustworthy and predictable, they help define and clarify the child's experience
- *Engaging*, Parents provide excitement, surprise and stimulation in order to maintain a maximum level of alertness and engagement
- *Nurture*, Parents are warm, tender, soothing, calming and comforting

- *Challenging*, Parents encourage the child to move ahead, to strive a bit, and to become more independent.

(Jernberg & Booth, 1999, p. 17)

2.7.5 - Theraplay and the Looked After Child

One of the difficulties often experienced with the LAC child is trust:

> The primary task of parents who foster or adopt children is to help them form new and positive attachments (…) This makes it hard for children to trust or relinquish control. They bring with them patterns of behaviour which may have been adaptive enabling them to survive in the past, but which are inappropriate in the context of caring families (Archer & Burnell, 2003, p. 148).

The intention behind Theraplay, is that activities which could lead to conflict, rejection or some kind of stand off, if introduced to the child directly, should be so subtly experienced that the child's defence strategies are not triggered. In this way, the child is so engaged that there is little opportunity to return to earlier patterns of behaviour, and thus the child learns to interact differently within new families. Through this playful engaging approach, new healthier attachment patterns are facilitated (Rubin, 1989).

With time, the Theraplay process has been revised and greater emphasis has been placed upon regulation and attunement. Parents/carers are taught to react in an emotionally attuned manner to the child, to interpret and read the child's emotions for them. Often,

insecurely attached children will have a skewed sense of their own emotions due to a lack of early attunement. In a recently published best practice document Booth (2007) updates her original text in the light of new research emerging and comments:

> The emphasis on attunement to the child's feelings and emotional needs has shifted our focus from the playful activities themselves to a focus on reading the child's responses.. It is this dance of attunement that we initiate with the child and invite the parent into that makes it possible for the child to change (p. 3).

Jernberg and Booth (1999) explore the use of Theraplay when working with traumatised/abused children commenting 'Theraplay's emphasis on building relationships makes it an ideal treatment for children who have been traumatized' (p. 266). They describe the importance of understanding the impact of trauma and the need to 'customize' treatment to meet the child's needs on a 'case by case basis'. In her later best practice document Booth (2005) sounds a more cautionary note: 'If a child has been physically or sexually abused, we reduce our physical contact and proceed slowly' (p.5).

Lindaman (1999) explores the use of Theraplay with adopted or fostered children arguing 'Theraplay, with its emphasis on building relationships through playful interactions, can act as a healthy antidote to a painful past' (p. 291). She describes the need for in-depth assessment encompassing: the child's early relationships, care and history; the present parent-child relationship; an in-depth knowledge of the adoptive/foster parents' own attachment experiences and history. She describes the need to work closely with the

parents ‘because of the special challenge that these children present, these parents need much more support, understanding, reassurance and guidance than almost any other group of parents’ (p. 308). She also emphasises the need for case by case decision making when using Theraplay.

2.7.6 - Attachment based therapy

Jernberg and Booth (1999) reflect that Theraplay is not a trauma based therapy, and that many children will also need more conventional therapeutic support to allow them to explore the trauma they may have experienced, especially those within the looked after population.

> All treatment of traumatised children must be customized to meet the child’s needs… One child’s strong need to talk about a traumatic event would best be met by primary trauma treatment. Another child, fearful and withdrawn, following placement in a temporary foster home, would benefit from Theraplay, with the trauma treatment coming later when life is more secure (Jernberg & Booth, 1999, p. 267).

However, more recently the Theraplay Institute has sought closer links with Dan Hughes (2006) an American Psychologist who has pioneered the therapeutic technique Dyadic Developmental Psychotherapy (DDP). DDP works with child and carer together, addressing issues of shame and guilt, and has had some significant success in the United States and increasingly within the United Kingdom. When coupled with Theraplay, the

attachment relationship is addressed through playful, attuned interaction and the trauma through work with the carer and subsequently with the child. Other more conventional forms of therapeutic input are also used when addressing trauma, and increasingly in building attachment relationships. Play Therapy is one such therapeutic modality, fairly widely available within the United Kingdom and offered by the project in addressing issues of trauma as described below (Gillotta & Blau, 2008).

2. 8 - Play Therapy

> The dynamic process between child and play therapist, in which the child explores, at his or her own pace and with his or her own agenda, those issues past and current, conscious and unconscious that are affecting the child's life in the present. The child's inner resources are enabled by the therapeutic alliance to bring about growth and change. Play Therapy is child centred, in which play is the primary medium, and speech the secondary medium (Association of Play Therapists Newsletter, Issue 1, 1995, p. 1).

2.8.1 - History

Play Therapy has grown and developed over the past fifty years, training considerably more practitioners and providing a greater body of literature than that for Theraplay, which is a newer therapeutic intervention. This is reflected in the more extensive discussion in this Chapter of the literature of Play Therapy. Practitioners such as Virginia Axline led the way in her work with Dibs (1964)

‘I wanted him to lead the way, I would follow… He needed to develop strength to cope with his world, but the strength had to come from within him and he had to experience personally his ability to cope with his world as it was’ (Axline, 1964, p. 39).
Although still small in comparison with some of its more established individual therapy counterparts, Play Therapy is nevertheless gaining in recognition and reputation. The term ‘Play Therapy’ in the United Kingdom has historically often been misused as a form of ‘direct work’ requiring no formal qualification and The British Association of Play Therapy is now moving to a more formalised registration of their professional identity. In doing so, training courses are becoming more rigorously defined and maintained, with increased expectations upon teaching, experience and personal therapy.

However, there is still much ignorance which exists regarding the role and application of Play Therapy. Perhaps much of this ignorance and mistrust stems from the fact that this field remains largely unresearched. Research which does exist is often anecdotal in nature and relies heavily upon the reputation of those undertaking the work. More often than not, there is a lack of opportunity for skilled, competent practitioners to bring their work to the academic arena, or tools to accurately reflect the process, mechanisms and outcomes of their work (Schaefer & Kaduson, 2006).

2.8.2 - The Importance of Play

> Children’s play is not mere sport. It’s full of meaning and import (Froebel, 1903, cited by Landreth, 2002, p. 9).

Few researchers would disagree with the overwhelming body of evidence as to the significance of play in early learning, and also the formation of meaningful social interactions (O'Connor & Braverman, 1997). Landreth (2002) cites several schools of thought and theoretical diversity, including psychodynamic and attachment theories when considering the concept of the importance of play. He describes how play unites them all, regardless of their differing perceptions of child development.

> 'Through the manipulation of toys, the child can show more adequately than through words how he feels about himself, and the significant persons and events in his life' (Ginott, 1994, p. 51).

Thus play therapists come from a variety of theoretical backgrounds, including psychodynamic, attachment, person centred, social constructionist, Jungian, Gestalt and ecosystemic, differing in their theoretical model of child development but united in their use of play in the child's therapeutic journey.

> Interestingly, in spite of the enormous diversity of theories they represented, none of the practitioners (authors) said that they would be unable to address this case from their theoretical orientation (O'Connor & Braverman, 1997, p. 2).

Play Therapy, despite coming from a variety of different theoretical orientations, is largely non-directive in nature, although some work has been done with a more directive, crisis intervention focus (e.g. Oaklander, 1978). Often a child's experience and

perception of trauma is very different from the adult making a referral for Play Therapy. Play Therapy allows the child to explore trauma through their primary medium of communication, namely play. ‘Language in which emotional experience is encoded is nonlinear and not linguistically mediated, but, instead, body focused and experiential’ (Fosha, 2003, p. 225).

2.8.3 - Cognitive development and play

As a child brings play to the therapist, they will do so not only in the context of the stage of development at which the trauma occurred, but also their present stage of development adding confusion as the child moves between the two. In understanding these developmental stages of thought and cognition, the therapist gains insight into how trauma is likely to be presented within the child’s internal world:

> Children tend to rely on magical thinking and readily believe that events result from something they have done, thought or wished. The younger the child is, the more comfortable she will be with accepting irrational or impossible explanations for events. It is only around the age of seven that children gradually develop the ability to consider the role of forces outside themselves as primary influences on reality. Even eleven and twelve year olds can lose their grip on reality-based cause-and-effect thinking in the face of trauma (Monahon, 1993, p. 41).

In understanding how a child may be conceptualising their experience in play,

greater strength can be gained in more effectively responding to this play and resultant emotional presentation (Kelly-Zion, 2008).

2.8.4 - Developmental Play

Anne Bannister (2003) describes Moreno's (1944) three developmental stages of play as embodiment (which entails finding identity), projection (which entails recognising the self) and role (with entails recognising the other). These stages of play would appear to bear some similarities to recent attachment research, with healthy development achieved through mind-mindedness, affect synchrony and reflective functioning. Suggesting that healthy play development is also achieved through healthy attuned attachment relationships. Jennings (1999) explores the use of developmental play in therapy, which may go some way to providing a framework for restorative healthy attachment relationships through play.

2.8.5 - Embodiment play and touch

Through the embodiment stage of play, the child learns the concepts of 'identity' growing towards an increasingly autonomous sense of being. As described earlier, where a healthy attachment relationship is fostered, the child is supported in this process through early stimulus of touch, mirroring and early games such as peek-a-boo. A safe environment is created in which to explore movement, to take risks such as their first steps, and rough and tumble play (Jernberg & Booth, 1999).

However, where this is not the case, the child can be supported in the Play Therapy

process with the use of embodiment play, which encompasses techniques such as sensory play, i.e. touch and texture, smell, sounds, taste, colours and visual stimuli. Examples of this play include sensory boxes, music, messy play, hand and foot painting. Through this, the child is given an experience of themselves in relation to their environment and encouraged to explore through sensory experience, one of the earliest stages of development (Daniel, Wassell & Gilligan, 1999).

Many play therapists warn against the use of touch in sessions, and Jennings (1999) advises caution and sensitivity saying 'Most children's play and games involves varying degrees of touch, and I regard it as artificial not to allow this as part of the therapeutic value of the play' (p. 84). One way of managing this is to agree safe boundaries with the child when compiling rules prior to the start of intervention (Cattanach, 1994). This allows a medium for safe touch, containing play, affirming of the child's need for close physical contact; whilst also minimising the likelihood of re-traumatisation, keeping child and worker safe.

Jennings (1999) goes on to explore the use of some physical games such as rolling, crawling and climbing, which the majority of children will gravitate towards at some point during therapy. Embodied stories similar to a guided narrative can also be used, which will involve the child exploring their environment through their sensory and physical play (Cattanach, 1997).

2.8.6 - Projective play

As children move into subsequent stages of development, so their play develops and they begin to use imaginary play (Fahlberg, 1991). A brick can become a car or a house, whilst toys can be attributed human characteristics such as hunger, anger or sadness. It is this stage of play that Jennings (1999) calls projection, encompassing the use of imaginary and symbolic play. It is in the realm of symbolic play that much of the therapeutic process takes place. A child can project their feelings, their thoughts, worries and perceptions into the imaginary play process, toys and materials available to them (O'Connor, 1991). It is through this process that the therapist gains the greatest insight into the internal world of the child, and can most adeptly respond to the trauma, confusion, blame, guilt or shame incorrectly assimilated within the child's developing psyche (West, 1996; McMahon, 1992).

Children will often enter into repetitive play in healthy development, and this can also be seen in the Play Therapy process as the child repeatedly brings their 'encoded' trauma to the therapist to decipher. Landreth (2002) makes reference to the fact that themes will often become apparent in a child's play, despite the fact that the play itself may vary greatly. This is also often seen in a child's response to trauma as resultant pathology and anxiety is often not reflective of the trauma experienced (Solomon & Siegel, 2003).

2.8.7 - Role Play

The final stage of developmental play as described by Jennings (1999) is role play. This has been well documented in child development literature; as the child's play becomes

more sophisticated, so they start to reflect the world around them in play (Fahlberg, 1991). The child now uses their capacity to attribute characteristics, thoughts and feelings to innate objects. The child plays these out either in increasingly complex fantasy play or through their mirroring of day to day activities within the home. Role play can take the form of a dramatised story (Cattanach, 1997) or smaller interactions such as the preparation of food or nurture activities and, like projection, can be quite repetitive in nature.

Through the process of role play, the child can externalise their experience and often role play and symbolic projective play are combined. Thus, the child acts out some of their fears or worries, whilst symbolically exploring their experiences through play materials (Wilson, Kendrick & Ryan, 1992). Once again, this play often shows little or no direct resemblance to the original trauma, but does give insight to the meaning ascribed to this trauma by the child. 'If the child chooses an imagined scene or character, then we call this 'distanced' from the child's actual experience' (Jennings, 1999, p. 120).

2.8.8 – Narrative Therapy

Another important feature of Play Therapy which runs through all the developmental stages of play is narrative therapy. The child's 'narrative' is steeped within their early experience and the world they are directly socialised within (Burr, 1973). Siegel (2003) described the therapeutic process as moving towards 'integration' and the development of 'coherent narratives'. Often within the therapeutic process, a child is encouraged to tell their story in whatever form this may take. Freeman, Epston and Lobovits (1997) explore

the relationship between therapist and child as they co-construct the child's story. They describe this as a way in which the child can distance themselves from a trauma or a presenting difficulty, and as the story progresses the child and therapist think together about helpful resolutions to difficult thoughts, feelings and presenting behaviours.

> In Play Therapy children tell stories as containers for their experiences, constructed into the fictional narration of a story. There is a special quality to a relationship based on story telling. There is the story teller and the listener, and the story acts in the middle as a way to negotiate a shared meaning between the two (Cattanach, 1997, p. 3).

Both Cattanach (1997) and Jennings (1999) share a joint interest in using stories within the Play Therapy process to convey deeper meaning and share the child's themes of play. They use stories from a variety of sources, including mythical and fairy stories from around the world, which have at their heart some concept of adversity or challenge, common to that of the child's own narrative or experience. Stories have long been recognised for their therapeutic value and are often refined for use within the healing process with children.

2.8.9 - Play Therapy and Attachment

As described above, there has been a proliferation of research over the past fifty years into the impact of attachment on child development, and recently more psychoanalytic thinking has been brought to bear on the concepts of affect synchrony, mind mindedness,

containment, reflective functioning and attunement. This proliferation has led to much speculation regarding the role of psychotherapy in addressing attachment disruption and, in particular, the impact of the therapist (Fonagy, 2001; Holmes, 2001).

> Psychotherapy is a form of attachment relationship in which the patient seeks proximity to the therapist, has a safe haven (is soothed when upset), and achieves an internal working model of security, based on the patterns of communication between therapist and patient (Schore, 2003, p. 44).

The role of therapeutic alliance has long been recognised in many therapeutic fields, including psychotherapy and Play Therapy, for its healing potential in the exploration of trauma. However, more recent applications consider the role of therapeutic alliance in facilitating closer attachment relationships through the use of the empathy, responsiveness and separateness of the therapist in having 'a mind of his own' (Caper, 1999). It is in this separateness that much of the restorative work is thought to take place, as the child begins to conceptualise themselves internalised by the therapist (in the way the securely attached child experiences a safe, consistent caregiver) and through the relationship, many of the early attachment tasks are achieved. 'The patient experiences containment of the affect through the interpersonal presence of the therapist' (Neborsky, 2003, p. 318).

2.8.10 - Play Therapy and Trauma

The past fifty years have not only been prolific in the exploration of attachment, but also

of trauma. Much work on trauma was undertaken around the turn of the century and following the First World War, but then lulled until the Vietnam War. Interestingly, much of the original work of Freud (1893) and Janet (sited by Carroy & Plas, 2000) has been borne out in more recent research on the development of the brain. 'The memory of the trauma acts like a foreign body which long after its entry, must be regarded as an agent that is still at work' (Freud, 1893, p. 7).

Chronic overproduction of cortisol in stressful, abusive situations can impact upon a child's memory and functioning. This, coupled with the age of the child, their immature reasoning capacities and the rapid development of brain function in early childhood, has lasting implications for the emotional well being of the child. In considering recent neuro-imaging studies of PTSD Van Der Kolk (2003) considers the impact of trauma in fragmenting memory and reflects: 'This would imply that it is difficult for the traumatised individuals to verbalise precisely, what they are experiencing, particularly when they become emotionally aroused' (p. 187).

Play Therapy provides safe, non-directive play opportunities for the child to explore the trauma as they perceive it. Play Therapy has historically been viewed as less intense or in-depth than other therapeutic modalities (Lees & Freshwater, 2008). Play materials are used to facilitate communication (McCarthy, 2007), but the work which is undertaken exists primarily through the relationship (Giordano, 2005). The therapeutic alliance established between therapist and child builds trust (Wilson & Ryan, 2005). Trust allows the child to bring out their conscious fears and worries, to test things out with their

therapist, to explore their self loathing in a non-judgemental environment, and to start feeling safe enough to let go of their defences, which in turn allows them to access the unconscious. Landreth (2002) makes reference to the fact that, despite the different therapeutic orientations of play therapists, they consistently agree on the significance of the relationship between the child and the therapist. 'It is the emotional communication between a patient and therapist which plays a crucial part' (Bowlby, 1988, p. 158).

Wilson, Kendrick and Ryan (1992) describe the core skill of reflection in Play Therapy as 'recognising what the child is experiencing and reflecting this in a non-threatening manner' (p. 189) and the underlying principle of the process as 'accurate empathy' (p. 205). Barnes (2007) draws on the work of Rogers (1980), Axline (1976) and Wilson and Ryan (2005) to describe the creation of the therapist as 'safe base', providing the child with a 'therapeutic space' and the process of reflection.

> The therapist uses her own genuine feelings in relationship with an individual child to help her determine appropriate boundaries for each child, and to feed back important congruent messages about the issues and concerns represented in the child's play. This is usually done sensitively within the play metaphor (…) This helps the child to gain a new understanding of the world. Reflections are always tentative so that the child can contradict if the therapist is wrong, or if something has been brought to awareness that challenges the need for protective defences; sensitivity to what is tolerable for the child is paramount and defences are respected (Barnes, 2007, p. 43).

The process of reflection relies on the use of self and relationship. As the therapist gently reflects back the emotionality behind the play, he/she does so having undertaken their own personal therapy, aware of how the child impacts upon the self and able to differentiate the child from self. In doing so, the child receives the mirroring from the therapist they may have missed in early childhood (Winnicott, 1971), and experiences their trauma and emotion (as presented in play) as 'the same but not the same' through this gentle process of reflection. Thus, the child experiences the therapist as containing, experiencing the trauma as bearable, experiencing the emotionality as appropriate and experiencing 'the self' as worthy and accepted (Gammage, 2007).

> This was a very different process when she talked to herself through the medium of another person…. It was only when another self looked upon her behaviour without shame or emotion that she could look upon it in the same way (Rogers, 1965, p. 38, 40).

This process of reflection is one which is recognisable in a variety of different forms through a variety of different theoretical modalities, with a varying degree of interpretation. Carl Rogers (1965), in his person-centred approach, argues that we are born with an innate sense of self as it should be: 'the ideal self' and over time, as we are affected by experience, an alternative self or 'perceived self' develops. For many whose life experience is managed and contained by 'good-enough' parenting (Winnicott, 1965), these two selves will develop along a fairly similar trajectory. However, for those who experience adversity or trauma, the two selves grow increasingly disparate and

fragmented with time. Through a process of non-directive reflection, the individual is encouraged to explore this fragmentation of self, ultimately leading to the acceptance of a more integrated self:

> The individual has a sufficient capacity to deal constructively with all those aspects of his life which can potentially come into conscious awareness. This means the creation of an interpersonal situation in which material may come into the client's awareness (Rogers, 1965, p. 24).

Klein (1949) in her 'object relations theory' considers the development of 'self' as related to 'the other' and along with Anna Freud (1965) developed the use of play in psychotherapy with children. Klein explores the child's fragmented sense of self in relation to the need for the available 'other' as explored earlier in the context of inter-personal relationships. This requires the therapist to take the role of 'the other' to interpret and translate the child's unconscious world and explore, through a process of appropriate mirroring, the assimilation of 'good and bad object' in 'the separate self'. 'Above all she was frightened and therefore distrustful of her mother, and now she might feel the same way about me' (Klein, 1949, p. 7).

Psychoanalytic response places the relationship at its core in order to interpret the child's fragmented sense of self, through the use of the unconscious. Person-centred counselling uses the 'space between', whereas Play Therapy uses play to facilitate the relationship in which trauma and unconscious responses are reflected back to the individual. 'Play

Therapy has the advantage of allowing children to work through their own issues in their own time and to access their own unconscious, creative resources' (Barnes, 2007, p. 48).

Play Therapy aims to support the child through the process of exploring their trauma and resultant distortion of self (as they perceive it); re-framing the trauma, and reflecting a more realistic sense of self; finally integrating the re-framed view of the traumatic event and a more integrated sense of self into the child's conscious memory in a process Bannister (2003) likens to Piaget's model of assimilation, accommodation and equilibrium. Thus, Play Therapy does not set out to remove the trauma from conscious thinking, to minimise or deny the child's experience, but instead to facilitate the child's understanding of the traumatic event in a way which supports them to manage thoughts of blame, guilt and shame, so often associated in a child's consciousness with the trauma they have experienced (Hughes 2006). Where memory is fragmented or distorted, trauma is suppressed or held within the unconscious world of the child, Play Therapy very gently seeks to facilitate the progression of trauma into conscious thought, where it can be explored and assimilated as above (McMahon, 2009).

As described earlier, there is little direct research presently available in the field of Play Therapy, but that which does exist suggests that it is a useful therapeutic intervention for the treatment of trauma (Landreth, 2002). However, its impact upon the attachment relationships of the child remains largely, although not completely, unresearched. Given what is already known of the restorative role of therapeutic alliance and reflection, this would suggest that Play Therapy would impact upon a child's attachment presentation

and trauma as described above. The work of Schaefer and Kaduson (2006) and Baggerly, Ray and Bratton (2010) would appear to correspond with that of Landreth (2002,) who claims that Play Therapy has been demonstrated to be effective for children in almost all diagnostic categories, the only contraindications being in some cases of autism and schizophrenia.

Having considered research presently available in the fields of Theraplay and Play Therapy, this study now concerns itself with the process of decision making by which Looked After Children receive appropriate therapeutic provision, and the available research, to support practitioners in making these often complex decisions.

2.9 -Clinical Decision Making

Many practitioners in the field of attachment are now questioning the conventional DSM-IV definition of attachment disorder, as described by Howe and Fearnley (2003) and intervention is often moving beyond what is presently known or established in existing research. This can also be seen within the field of decision making, as practitioners are regularly called upon to make skilled clinical decisions regarding therapeutic input for children, but without the benefit of research evidence on which to draw.

As this study attempts to consider the therapeutic decision making process in offering children Theraplay, Play Therapy and other therapeutic interventions, it must be borne in mind that it does so in the absence of a strong research base. Therefore, this section will focus primarily upon the peripheral research available in related clinical fields, in an

attempt to consider what is known and what can be transferred to enhance our understanding of therapeutic decision making.

2.9.1 - Effective decision making

Blower, Addo, Hodgson, Lamington and Towlson (2004) when undertaking a study of the mental health provision for Looked After Children in the Scottish Health Board of Lomond and Argyll, found that problems in outcome did not arise from poor assessment but rather from ineffective interventions. 'The need we identified was not for improved recognition of mental health problems, but rather for more effective interventions' (Blower *et al.,* 2004, p. 117). As previously discussed, many conventional forms of therapeutic intervention have been shown to be highly effective when working with children within the LAC population, which would suggest that the above findings are in fact at odds with the established research.

If as, Blower *et al.,* (2004) suggest, the problem does not lie in assessment, there is perhaps an argument to suggest that it may lie in screening for outcomes, or that not all forms of therapeutic intervention are appropriate for all children. Therefore, the dilemma is actually one of clinical decision making and the appropriateness of therapeutic intervention corresponding to the specific needs of the child. In considering this point further, there are three main areas of interest to consider, namely the clinical presentation of the child, the interdisciplinary therapeutic response to the presenting needs of the child and broader systemic issues including the ability of child/adult to engage in therapy.

2.9.2 - Theory

The field of human decision making has been quite widely researched and ranges extensively from the highly mathematical to the more social.

- Heuristics and Bias - Chapman and Elstein (2000) explore short cuts in thought process, specifically relating to decision making.
- Social Judgement Theory - Brunswick (1952), Hammond (1955) and Baron (2000) ‘A judgement is the evaluation of one or more possibilities with respect to a set of evidence and goals’ p. 87.
- Social Cognitive Theory - Bandura (1986) looks at self within the decision making process.
- Naturalistic Decision Making - Klein, 1993, Beach, 1990 and Falzer, 2004 study decision making in real life or clinical situations.

Galanter and Patel (2005) suggest the idea of a ‘decision making tree’ incorporating ideas such as: identifying the decision, considering options, information gathering, consequences, pros and cons. These ideas appear to fit comfortably within the therapeutic model of review and reflection presently operated within the Attachment Project which is the focus of this present study. In identifying the decision to be made, practitioners will acknowledge the power dynamic of child and professionals. They will often weigh up pros and cons and use their experience to recognise patterns of presentation especially when time is limited. Information gathered and professional intuition will be used to consider therapeutic modalities available and the possible outcomes/suitability of each modality.

2.9.3 – Research

Research on the subject of clinical decision making in the area of therapy for traumatised children is limited, and appears to be largely in the field of pharmacology and other medical models. However, the research that does exist in the field of clinical decision making within child therapeutic services largely reflects two areas: firstly, clinical decision making in an interdisciplinary setting; and, secondly, the importance of the therapeutic alliance to a positive outcome for children in therapy.

Using questionnaires sent out to five child clinics, a sample of 64 cases were reviewed by Weissman (sited by Beck 1991). He found that there was greatest consistency between disciplines in rejecting a child for a service, and the greatest disparity in whether a child should receive individual or group therapy. However, a later study by Falvey (2001) suggested greater correspondence between disciplines when considering treatment planning tasks. She concludes that orientation and work setting did not significantly influence judgement but experience had a greater impact. This highlights the importance of training and discipline style in the decision making process. It is essential to acknowledge difference in the multi-disciplinary team, to allow rigorous discussion and thorough exploration of material available and the richness of experience and training in this setting.

Watts (1980) suggests that decision making is influenced by clinical listening skills, modes of inference, relative weights given to stereotypical and individual information. He concludes that more attention should be given to ‘low risk’ and more intuitive styles

of clinical judgement. This would appear to compliment the work of Munro (2002) and Galanter and Patel (2005) suggesting the importance of experience, informing intuition in clinical decision making.

The ability to establish a strong therapeutic alliance between child and therapist was found to be of significant importance to outcome measures for the child in many studies of the subject of clinical decision making. For example, Truscott, Evans and Knish (1999) consider this to be significant for children at risk of suicide, Cloitre, Chase, Miranda and Chemtob (2004) for recovery from PTSD, Chethik (2001) for more enduring and successful adaptations of trauma, Falvey (2001) for the treatment of anxiety and affective disorders within the adult mental health population and Rasmussen (2001) for the treatment of sexual abuse and trauma.

Thus it becomes clear that clinical decision making differs according to therapeutic disciplines, but that there is scope for creative and intuitive decision making when informed by recognised training and appropriate experience (Patel, Arocha, Diermeier, How & Mottur-Pilson, 2001; Leprohon & Patel, 1995; Falzer, 2004). Also, that the therapeutic alliance is central to the therapeutic process and a child's (or in some cases adult's) ability to engage with the therapist could be used to inform decisions regarding appropriate therapeutic intervention. Therapeutic decision making, in the specific context of this present study is the sole responsibility of the therapist, but does not exist in isolation for the LAC child, who is surrounded by a network of professionals who must also be considered in this process.

2.9.4 – Intra-agency and Inter-agency Considerations

This study is not concerned with intra-agency or inter-agency decision making; it is concerned with single practitioner therapeutic decision making processes. Notwithstanding this very narrow focus, of necessity, the practitioner will seek to incorporate the views of professionals involved in the care of the child, thus attempting to limit reporting bias and gain additional perspectives on this process.

Further the practitioner will receive input from and contribute to interagency and intra-agency reviews of the child. This is separate from the process of therapeutic decision making which is the focus of this study, although material arising from such fora may be considered by the practitioner when reaching therapeutic conclusions. In determining the appropriate weight to be given to contributions from such fora, it is important for the therapist to have some understanding of the factors which may have affected assessments and decisions taken by other agencies or professionals singly or jointly (Broadhurst *et al.*, 2010). This information gathering process is distinct from the therapeutic decision making process, which is unilaterally determined by the therapist and scrutinised through normal channels of clinical and managerial supervision.

Additionally, it is important for the therapist to consider the form in which her feedback and recommendations will be conveyed to decision making forums in order to maximise its potential usefulness to other professionals (Cleaver *et al.*, 2008).

For all these reasons, an awareness and an understanding of the features of the multi-disciplinary context and factors which may affirm or detract from the validity of information to be used in the therapeutic process are important to the therapist (Department of Health, 1995).

The issue of inter-agency working, decision making and accountability is one which is extensively explored, predominantly due to failures in the system, which have caused injury or death to vulnerable children. Resultant enquiries have found communication between child and adult services and in particular drugs agencies, notoriously fraught, as both have such divergent value bases and requirements placed upon them (Leslie, 2007). For over a decade in England, all agencies working with children or those responsible for children have had to adhere to the statutory guidance published as Working Together (Department of Health, 2006) which is updated on a regular basis, and places an emphasis on all agencies to work in a collaborative manner. Despite this, interagency communication, planning and decision making is a recurring failure, as noted in aftermath enquiries and reviews throughout the country (Leslie, (2009); Laming (2003); Munro (2002); Ofstead (2009); Thoburn, (2007); Brandon, (2008).

There is a wealth of research available exploring interagency working and communication; undertaken independently (Tomlinson, 2003), commissioned by local authorities (Hambleton, Essex, Mills & Razzaque, 1996) and presented by well respected organisations such as the Rowntree and Coram Foundations. It predominantly advocates open communication and regular liaison between agencies. Tomlinson (2003) found

considerable examples of good inter-agency working, but concluded that this was often developed in a 'local context' and focused more on outcome rather than the process, providing few transferable working models. In a recent study Hambleton *et al.,* (2008) comment on barriers to collaborative working including vested interests, short-term thinking, complexity of cases, divergent professional/organisational cultures, and highlight the need for clear accountability in inter-agency decision making.

Those coming together in the professional network of the child do so with their own personal and professional agendas, interests and values. When these are mixed (the level of risk held within the team/network and some of the difficulties presented above) these agendas can begin to threaten effective multi-agency working and practices. It is the therapist's responsibility during therapy reviews to manage these differences in an effective and, where possible, useful way. 'The professional boundaries and culture sometimes inhibit such relationships' (Payne, 2000, p.235)

Payne (2000) considers team working and draws some useful comparisons to interagency and professional networking. He introduces the concepts of 'expert and legitimate power' (p.142) and suggests that the most effective way of managing these power dynamics is through open communication in a safe forum and respectful working practices. He considers that within the idea of a generic team working approach. However, within the LAC child's network, it is essential that expert and legal power exist side-by-side to safeguard the global needs of the child and that 'clarity about role, accountability, responsibility, effective relationships, collaborative commissioning, strategy development

and training' (p.238) become important factors in negotiating different professional perspectives.

Payne also considers the least powerful partner in the inter-agency arena to be the service user (in this case child and family), suggesting that their views are rarely sought or heard. This has been a key component in the design of this study, the rigorous consideration given to the ethical implications of user feedback and the methodological challenges of so doing.

The plethora of research in this area and the biennial reviews of serious case reviews and Part 8 reviews (held in England following the death of a child) suggest that there should be little doubt that agencies know what they need to do to improve inter-agency working and decision making, but that they have, in many cases little idea of how to go about it. In other words, agencies know what the lessons to be learned are but not how to implement them. Some of the reasons for this are suggested in work undertaken by the Social Care Institute for Excellence (SCIE) (Bostock, 2004) which suggest that interagency working can be compromised by the political context which is driven by performance targets and indicators, limited resources and recruitment problems. This has lead to the development of 'a tick box mentality' (Bostock, 2004), which has lead in turn to impoverished assessment and has failed to adequately understand the social context and developmental history of children who are presenting with behavioural difficulties or are living in unsatisfactory circumstances.

In this present study these factors must be understood in the context of where the therapist interfaces with the multi-agency process. The therapist does not attend child protection case conferences where she would be a contributor to the decision making process. The therapist may, however, provide advice or recommendations to Looked After Child Reviews. The therapist is also at times approached as a consultant without authority for her views regarding the longer term care plan for the child. In such instances her contribution will be informed by her own assessment, which may include elements of information provided by other professionals whose reliability and accuracy will have been tested by the therapist, a process which will take into account what is known of the rigour, quality and effectiveness of the assessment and decision making process from which it has emerged (Van de Luitgaarden *et al*., 2008).

Where the therapist is aware of difficulties inherent in single or multi-agency operations, or inadequate practice, systems or intervention by other professionals or agencies, which may impact on the quality of care received by the child, this becomes an important consideration of the therapeutic assessment and decision making process. Alternatively, where the therapist is aware of exceptional quality of assessment and working practices, she can place considerable weight on the observations and contributions of practitioners and agencies and rely more closely on their capacity to recognise the value and fulfil recommendations re-emerging from the therapeutic process as a history of reliability is established. Conversely where the practitioner is aware of constraints and limitations which impact on the effectiveness of single or multi-agency contributions, these will become considerations in possible treatment plans (Gilgun, 2005).

This applies also to the therapeutic assessment process, where at times information provided by carers or families may be contradicted in more formal assessment tools such as video and questionnaire assessment. Where such disparity arises, it is the responsibility of the therapist to gently challenge the parent and carer, thus eliciting additional information which can help to inform the most appropriate treatment plan for child and family (Booth & Jernburg, 2010).

Therefore, it becomes clear that there is an additional responsibility upon therapists not only to make responsible therapeutic decisions in line with the limited research available, but also to ensure close communication with the other professionals working with the child, tailored to what is known about the operating practices and quality of systems which support children within and amongst agencies. This does not mean that therapeutic decisions should be compromised as the available research evidence clearly recognises the skill, experience, knowledge and training of therapists in this process, but instead suggests a role for the therapist as interpreter and an onus to ensure understanding of these decisions. The task for the therapist in the inter-agency setting becomes one of sensitive, responsible, informed implementation of the therapeutic decision made by the therapist in relation to a solid understanding of the needs of the child and the professional network, as ascertained through consultation within the review setting (Golding *et al.*, 2006; Wilkinson, 2010).

In conclusion, Munro (2002) dedicates an entire Chapter to the principles of decision making, reflecting much of this present thinking. She describes the two main areas of

decision making in child protection as naturalistic (Klein, 1993) and those modelling the more theoretical approaches. These principles fit comfortably with those described above and indeed Munro conceives of decision making within therapy as following a more intuitive, naturalistic pattern. She outlines the limitations of this approach in terms of 'tunnel vision' as time restraints allow for restricted consideration of options, relying heavily on the practitioners' experience and a good working knowledge of the child's system.

Munro (2002) advocates a more combined approach to decision making using naturalistic principles as well as some of the more theoretical 'decision tree' ideas (Galanter and Patel, 2005), effectively dovetailing the research findings as presented in this Chapter. She advocates the use of intuitive, experienced, creative thinking whilst also recognising the need to take time and to have a more structured format for considering options. She does, however, sound a cautionary note as theoretical decision making principles can generate large quantities of data which, if not carefully managed, can distract workers from their primary task of protecting the child.

Munro (2002) also touches on the principles of multi-agency decision making, describing experienced practitioners making decisions in the child protection arena and then relying on relatively inexperienced members of staff to make emergency decisions in the field. This mirrors some of the therapist's earlier thinking around the implications and potential limitations of assimilating data from the multi-agency arena without first filtering this

through her therapeutic knowledge and experience of child, family, system, network and individual workers.

2.10 - Treatment Outcomes and Existing Clinical Measures

Given the desirability of evidence based practice and definable outcomes, it becomes clear that ways of measuring the effectiveness of intervention must be developed. Conventionally this has taken the form of measuring a child's presentation at the outset, during therapy and at a given end point. There is much discussion regarding measurement of child presentation and potential change (O'Connor and Zeanah, 2003a) but currently many health authorities use standard questionnaire instruments. Most commonly the Strengths and Difficulties Questionnaire (SDQ) is used to measure a child's presentation and possible diagnostic criteria. Parents, carers, school and in some cases the child themselves are asked to complete these questionnaires at the outset of intervention as a screening measure, routinely throughout intervention as a monitoring measure (where later scores are compared with earlier ones) and at the end of therapy as an outcome measure (where initial and final scores are compared).

In considering definable therapeutic outcomes, we enter a contentious and much explored area of research. Unlike other scientific counterparts, therapeutic intervention is very subjective in nature, carrying a number of variables including the experience, temperament and resilience of the child, which makes quantifying change a daunting task. This has led to the exploration of less quantitative and more qualitative ways of measuring change, such as the Six Part Story method (Kelly, 2006) and Story Stem

assessment (Hodges & Steele, 2000). Fonagy (2003) explores the pressure upon psychoanalysis to become more evidence based, moving from ‘anecdotal clinical accounts’ to the use of (as yet unspecified) ‘specific constructs’ within the therapeutic process that allow for cumulative data-generating. In addition to the search for ‘specific therapeutic constructs’, LAC children do not start from a baseline of calm, thus making any standard comparison with the ‘average child’ potentially unrealistic, and further compounding the difficulties in effectively monitoring change within this child population (Perry, 2007; Hughes & Archer, 2003).

2.10.1 - Limitations

O’Connor and Zeanah (2003b), in their review of reactive attachment disorder, address the issue of assessing attachment disorder and raise a number of discrepancies in many of the traditional assessment methodologies. They conclude that no one diagnostic instrument can be complete in assessing the existence of attachment disorders and that a combination of tools and sources should be considered, e.g. interview, observation, questionnaires.

O’Connor and Zeanah (2003a) cite as a limitation of questionnaires, their reliance on the reporting by parent or carer and the subjective nature of their responses. However, they also acknowledge that questionnaires have a ‘long history’ in research, and information gleaned from questionnaires corresponds reasonably well to data collected through other methods. Several questionnaires exist to help assess a variety of clinical presentations, and many have a solid grounding in theory, with questions specifically designed to

measure presenting behaviour suggestive of trauma, and attachment or clinical diagnosis such as ADHD and autism. Research evidence regarding the three screening tools used in the present study is now examined.

2.10.2 - The Strengths and Difficulties Questionnaire (SDQ)

The SDQ is designed to measure emotional difficulties, hyperactivity, peer problems and prosocial behaviours with a combined total score reflective of the overall mental health presentation of the child. Higher scores may indicate the presence of emotional difficulties commonly associated with depressive/anxiety disorders; conduct disorder associated with behavioural difficulties; hyperactivity disorder; relationship difficulties, including separation anxiety. The SDQ has been reliability tested and norms established.

The SDQ has been extensively researched, and was used in surveys by Meltzer, Gatward, Goodman & Ford (2000) and Meltzer, Corbin, Gatward, Goodman & Ford (2002) looking at the mental health of children and adolescents in the United Kingdom, then subsequently, in a further survey of the mental health needs of Looked After Children. Mathai, Anderson & Bourne (2003, 2004) have undertaken a number of studies, which conclude that the SDQ is a useful screening and outcome measure for use within the Child and Adolescent Mental Health Service (CAMHS) setting. Muris and Maas (2004) compared institutionalised and non-institutionalised children using the SDQ and found greater difficulties and lower strengths in institutionalised children. Emerson (2005) concludes. ‘The SDQ appears to provide a simple, robust measure of the mental health needs of children and adolescents’ (p. 14).

However, despite there being a good deal of research into the use of SDQ, there seem to be few studies of the effectiveness of the SDQ specifically with the LAC population, and that which does exist centres largely around its use as a screening measure (Meltzer *et al.,* 2000). Whyte and Campbell (2008) identify the SDQ as a useful screening measure to identify the mental health strengths and needs of Looked After Children, and for use in informing care plans at LAC reviews. Ford *et al.* (2007) used the information generated in the surveys conducted by Meltzer *et al.* (2000, 2003) in a comparative study looking at psychiatric disorder in Looked After Children, and children living in private households, concluding, 'Fewer than one in ten children looked after by local authorities demonstrated particularly good psychological adjustment, compared with around one in two children living in private households' (Ford *et al.,* 2007, p. 7).

2.10.3 - The Parental Stress Index (PSI)

The Parent Stress Index (PSI) is designed to identify potentially dysfunctional parent-child systems through five dimensions; defensive responding, parental distress, parent-child dysfunctional interaction, difficult child and total stress. The PSI has been reliability tested and norms established, allowing for a more in-depth view into parental perceptions of 'affectional bond' (people for whom we feel affection and whose company we like to be in), as distinct from attachment bond (a special kind of affectional bond that forms when one person experiences security and comfort from another) (Golding, 2008, p. 36). The PSI short form consists of 36 items (excluding defensive responding), which were devised by a multi-disciplinary team based at the University of Virginia and drawn from

well researched theoretical bases (Abidin, 1990). Items were discarded, changed and reliability tested throughout the process, refining the diagnostic instrument.

Several studies using the PSI in adoptive families exist, but these largely pertain to Romanian orphans (Chisholm, 1998; Mainemer, Gilman, & Ames, 1998). Some studies exist using parent child dysfunction in birth families as a longer-term indicator as to the outcomes for LAC children, (Jacobsen and Miller, 1998; Kelley, 1992) and in relationship to grandparents as kinship carers (Harrison, Richman & Vittimberga, 2000; Whitley, White, Kelley, & Yorke, 1999; Heywood, 2002). Although studies would suggest that the PSI can act as a reliable screening tool within the LAC population, its use as an outcome measure to explore the level of relational dysfunction following intervention is largely unexplored.

2.10.4 - Randolph Attachment Disorder Questionnaire (RADQ)

Randolph (1997) in her work at the Evergreen Attachment Centre, Colorado, devised a 30 item attachment disorder questionnaire. It is designed to distinguish presentation most indicative of attachment disorder from that of attachment difficulties. She distinguishes attachment disorder from reactive attachment disorder, as classified in DSM-IV and ICD 10. In the present climate of debate around classification and assessment of reactive attachment disorder (O'Connor & Zeanah, 2003a), Randolph attempts to provide an assessment measure more in tune with current theory, research and practice.

The RADQ has been reliability tested and norms established. The questionnaire took several years to develop and was refined through lengthy pilot projects. The RADQ is

routinely used as a screening tool to identify whether or not behaviour problems are consistent with the presence of attachment disorder. However, little research presently exists as to its use as an outcome measure, and in particular within the LAC population.

2.10.5 – Implications for the Study of the use of Questionnaires

Despite the limitations of questionnaires, it is clear that there is a good deal of research to support the use of these tools in assessing a child's emotional and behavioural presentation. The tools are rooted in theoretical thinking and have undergone extensive reliability and validity testing to become the refined instruments now available. Although they should not be used as sole diagnostic instruments, a number of factors combine to increase their validity as clinical measures and outcome indicators; 1) when completed by a number of respondents such as: school, parent, sibling, young person, 2) when patterns emerge in the information gathered between questionnaires and 3) when additional information is also provided, as such interviews, showing high levels of correlation between information provided (O'Connor & Zeanah, 2003a).

All these screening measures have been devised within the general child population. Questions designed to elicit information regarding specific disorders or presentations have been 'controlled' against the presentation of the 'normal' child population. Each has been widely researched, and in particular the SDQ. However, to date, little specific research exists into the use of these measures as effective outcome measures specifically for the LAC population. The limitations of the screening tools and the implications of this for this study are discussed in more detail in Chapter 3.

2.11 – Summary

This study is designed to investigate therapeutic decision making with respect to children with attachment related difficulties in a project working with Looked After Children. Therefore, any consideration must begin with an overview of this child population and their needs. Present research highlights the high level of presenting difficulties experienced by these children, and the complexity of meeting their resultant mental health needs. New research draws into sharp focus the impact upon child development of adversity and adaptation within the LAC population. Neuroscience begins to interface with child development through the use of brain imaging and through the application of what is already known of the endocrine system within the body.

There has been a proliferation of new research into attachment theory which further explores the fine detail of early dyadic interactions. Principles such as affect synchrony, inter-subjectivity and mind-mindedness have emerged. Recent years have also seen psychoanalytic researchers move towards attachment theory to augment principles such as containment and reflective functioning. The very powerful role played by early dyadic relationships is still emerging in cognitive and emotional development as new research unfolds. Researchers such as Perry and Van Der Kolk are forging ahead in their thinking around complex trauma and the impact upon child development. There is also a growing evidence base surrounding the prolific impact of trauma on the developing mind which begins to support a more robust framework of recognition, acknowledgement and integration into work with the Looked After Child.

At a time when so much research is being generated in the fields of attachment and trauma and new thinking is evolving so rapidly, therapeutic input is also moving and adapting to incorporate these findings at a similar pace. While the result of this is a degree of mistrust from some, there is a move to facilitate this thinking in conventional therapeutic intervention and the development of new ways of working. The resultant experiential professional learning is, at times, leaving research behind. However, the limited literature that does exist supports the use of Theraplay and Play Therapy when working with attachment. Research in this field is further hampered by the thrust towards evidenced based practice at a time of uncertainty surrounding screening and assessment tools within the LAC population.

This review of literature has collated a wide range of theoretical perspectives and published research evidence, all of which has informed both the practice of the therapist and the design of the present study. This study does not exist in isolation, and despite being one of the first to systematically and longitudinally explore Play Therapy, Theraplay and single practitioner therapeutic decision making; it does so in the context of this significant body of related knowledge, which can now be used to ascribe potential meaning to any emergent findings. In Chapter 3 the methodology of the study and the challenges of its design and implementation are discussed.