Adapting Non-directive Play Therapy for Children with Attachment Disorders
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Adapting Non-directive Play Therapy for Children with Attachment Disorders

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ABSTRACT

Brief, intensive, non-directive play therapy with a looked after child in transition who had serious attachment problems is discussed in this article. As a background to deriving practice suggestions from this difficult and largely unsuccessful intervention, the play therapy literature on maltreated children is presented. Heard and Lake’s extension of attachment theory, ‘the dynamics of attachment and interest-sharing’, is then used to analyse and understand the complexities of the intra- and interpersonal relationships within this intervention from the child’s, carers’, social worker’s and therapist’s viewpoints. Finally, practice suggestions are made, namely, that: (i) in complex cases for shorter term work, consultations based on Heard and Lake’s theory, rather than direct work by the therapist, should be considered; and (ii) a combination of filial therapy and the use of Heard and Lake’s theory can provide both the depth of understanding needed by professionals and the development of appropriate adult–child attachment relationships in longer term work.

KEYWORDS

attachment disorder, child maltreatment, child therapy, dynamics of attachment and interest-sharing, non-directive play therapy

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This article examines brief, unsuccessful, play therapy with a looked after child, ‘Delroy’ who had serious physical and emotional problems. These problems included severe epilepsy, deep-seated attachment difficulties, developmental delays, and a history of abuse and neglect. My main reason for undertaking the detailed analysis of Delroy’s case presented later is to derive practice implications for professionals and carers who become involved in complex therapeutic partnerships when trying to meet the needs of looked after children with significant problems. Before presenting the case discussion itself, which is followed by a discussion and suggestions for practice, the play therapy literature with maltreated children is summarized and a theoretical framework for understanding complex attachment issues is outlined.

Non-directive play therapy with maltreated children

Very few unsuccessful play therapy cases have been discussed to date in the play therapy literature (Carroll, 2001), yet breakdowns in treatment are a problem for play therapists, as they are for child therapists generally (Campbell, Baker, & Bratton, 2000; Kazdin, 1996). Children in the local authority care system are often challenging for clinicians. These children usually have life histories characterized by abuse, neglect and trauma, in addition to instability of their attachment figures. For maltreated children, issues of control and compliance are major concerns in their families of origin. Within maltreating families children are not safe and do not trust their primary attachment figures to meet their need for physical and emotional protection. Children’s exploratory needs, based on developmentally appropriate experiences, which includes play experiences, are often distorted and delayed by unsafe and unresponsive environments. Maltreated children develop external and internal strategies for feeling safe within their difficult environments, usually either trying to organize their behaviour to elicit increased parental attention coercively or to appear self-sufficient and detached (Crittenden, 2000; Crittenden & Ainsworth, 1989). These strategies then are brought into children’s new attachment relationships in foster and adoptive families after removal from their birth families into local authority care.

Therapeutic work with maltreated children and their substitute families is increasingly recognized as a priority in clinical practice. This is because new environments alone can be insufficient for changing these children’s internal models of attachment relationships and their behavioural strategies for maintaining and engaging attachment figures. Long-standing maladaptive strategies often are difficult for substitute families to help children rework and also may be maintained by children’s contacts with their families of origin (Courtney, 2000; Pearce & Pezzot-Pearce, 1997). However, relatively few intensive child therapy outcome studies for maltreated children exist in the psychological literature. Similarly, little empirical research has been conducted on the relative values of individual, family and group therapy approaches with maltreated children. Therefore, play therapy and other forms of therapy with maltreated children and carers largely continue to be based on clinical rather than research evidence (Pearce & Pezzot-Pearce, 1997; Ray, Bratton, Rhine, & Jones, 2001; Ryan, 1999).

Delroy’s therapy, presented later, was based on the method of non-directive play therapy. This method of play therapy is a well-established therapeutic approach for working individually with children based on Rogerian counselling principles; with the core conditions practised by the therapist of empathy, unconditional acceptance and congruent use of the therapist’s own feelings (Axline, 1949/1976; Dorfman, 1976). This method’s theoretical underpinnings in child development principles is now more thoroughly specified, and a systemic approach to children’s environments and the
inclusion of significant adults in therapeutic interventions are advocated more frequently. Non-directive play therapy has recently been updated for working with maltreated children in statutory settings. Its characteristics of being able to address multiple problems simultaneously, of using non-verbal communication, and its inherent flexibility in adjusting to children’s changing, and perhaps atypical, developmental needs, point to its suitability for maltreated children (Ryan, 2002; Ryan & Wilson, 2000; Wilson, Kendrick, & Ryan, 1992).

The theoretical framework

The complexity of cases with looked after children such as Delroy seems to require a corresponding complexity in theoretical understanding and treatment strategies. Heard and Lake’s theory, ‘the dynamics of attachment and interest sharing’ (Heard & Lake, 1997, 2001), is a theoretical extension of the well-established attachment work of Bowlby (1980) and Ainsworth, Blehar, Waters, and Wall (1978). Their extension is used in the case discussion to provide a theoretical framework for understanding the emotional needs of children with serious attachment difficulties and their relationships with those who care for and work with them.

Attachment theory and research have expanded rapidly from Bowlby’s and Ainsworth et al.’s original work to encompass adult attachment styles, the more complex organization of attachment responses in older children, intergenerational transmission of attachment styles, and newer models for treatment of maltreated children with attachment difficulties (Crittenden, 2000; Fonagy, Steele, & Steele, 1991; Hughes, 1997; Main & Hesse, 1990). However, attachment theory also has been criticized as incomplete and one-dimensional for its lack of integration of interrelating intrapersonal systems, such as autonomy, psychosexuality and creativity. Nor has the interrelationship of interpersonal systems, particularly children’s social systems, including familial and peer relationships, been worked into a cohesive developmental approach as yet (Lewis, 1997).

Heard and Lake (1997, 2001) attempt to bridge these gaps in theory by using Bowlby’s seminal theory of the attachment system as a base. They formulated five interrelated behavioural systems. All of these systems are instinctive, interpersonal, goal corrected and intrinsically motivated. A goal-corrected system that is instinctive, as Bowlby explained, becomes activated when specific signals are perceived (e.g. danger) and becomes quiescent when the goal of the system is reached (e.g. safety).

The following five goal-corrected systems are outlined by Heard and Lake:

- the parenting system, which includes Bowlby’s original theory of caregiving. Heard and Lake extended it to include a subsystem that enables caregivers to sustain and develop their children’s capacity to be autonomous and exploratory, named the ‘growth and development’ component (formerly referred to as the educative aspect of caregiving);
- Bowlby’s care-seeking system;
- the exploratory system, extended from Bowlby’s original formulation to include shared interest with peers during development and adulthood;
- the affectional, sexual system, developed with peers; and
- the personal self-defence system, activated either when fear of abandonment, shaming and/or dismissive and angry care is experienced, or when caregiving is perceived as insufficiently nurturing and protective (Heard & Lake, 1997, 1999, 2001).

Heard and Lake discuss in detail the ways in which these systems become active and quiescent in relation to one another within interpersonal experiences. Part of their
contribution to attachment theory is their emphasis on caregiving in relation to care-seeking, thus rectifying Bowlby’s and Ainsworth’s greater emphasis on care-seeking. They have also begun to formulate the developmental progression from primary attachment and exploratory systems to adult attachment and interest-sharing systems. Heard and Lake’s extension, therefore, provides a more complete theoretical integration of systems of caring for others, of self-care within intimate relationships, and of exploration and interest-sharing with peers.

Psychotherapy, as Bowlby explained, can be viewed as a relationship in which clients’ internal models of experiences based on past and current attachment relationships are influenced by their newly developing relationship with their therapists. Psychotherapy then can be conceptualized as aiming to restore the smooth, interrelated functioning of all the five systems posited by Heard and Lake in adults. When all the systems’ goals are met, a sense of well-being, the ability to care for self and others, and the ability to enjoy creative and intimate relationships with others occurs. Research on the ways in which the five goal-corrected systems of individuals interrelate within therapeutic encounters has begun. Affect attunement and empathy, key components of the dynamics of attachment and interest-sharing, have been operationalized and tracked empirically within therapeutic encounters (Heard & Lake, 2001; McCluskey, Hooper, & Miller, 1999).

The roles and activity levels of each of the five systems in relation to one another continue to be mapped out. It is assumed that adults’ caregiving system is central to the harmonious functioning of the interpersonal components of their other self systems (e.g. caregiving/care-seeking, interest-sharing with peers and affectional sexuality). When an adult’s self-defence system infiltrates his or her interpersonal partnerships, different types of insecure attachment patterns may develop. These can be mapped out for partners in both dyadic and triadic relationships.

It is possible to view more complicated family relationships and children’s developmental progress from this perspective, although neither phenomenon is as yet well developed within this new model. In parent–child dyads, for example, children’s self-defence systems become more highly activated when a threat to their well-being is perceived. Their care-seeking activity is also more highly activated, and exploration and interest-sharing lowered. Insecure caregivers with high levels of self-defence, and low exploration and interest-sharing with peers, are prone to care-seeking themselves. If insecure carers perceive their children’s care-seeking as a threat, their caregiving lowers as their self-defence system becomes more highly activated (Heard & Lake, 1999). This model also posits that these carers’ and their children’s caregiving, care-seeking and exploratory systems revert to their original, pre-threat levels when either fatigue or children’s defences take over. A repeated cycle of such responses leads to the establishment and maintenance of different patterns of insecure attachment relationships. This, in turn, has detrimental consequences within the other interpersonal, interconnected partnerships within the self-systems of parent–child dyads.

When caregivers cannot meet children’s needs repeatedly, high levels of frustration and anxiety are engendered in both parties. Three common behavioural outcomes of such scenarios are: (i) conflicts in which each partner attempts to influence the other to meet his or her demands, (ii) one partner seeming to submit to the other’s demands, and (iii) negotiation to achieve a compromise in which both partners’ potential losses are minimized or avoided. The third outcome is dependent upon one person not being drawn into either a complaint or a controlling pattern of interacting. With carers and young children, it is the parent who needs to suggest a way to compromise or to state clearly what the real situation consists of (Heard & Lake, 1997, 1999).
Non-directive play therapy with Delroy

These theoretical formulations are now employed to discuss my therapy with Delroy, a maltreated child in foster care who displayed serious attachment problems and developmental delays. I employed attachment concepts throughout to understand and work with Delroy, his social worker and carers during his play therapy, including Bowlby’s (1980) formulation of separation protest, Main and Solomon’s (1990) category of disorganized attachment, and Main and Hesse’s (1990) adult attachment classifications. However, my intervention was conducted before the development of Heard and Lake’s theory. In retrospect, their framework provides important supplementary understanding of Delroy’s case.

Delroy

Eight-year-old Delroy was referred for shorter term play therapy prior to attending a residential centre for children with severe epilepsy. Delroy was mixed race, with an Afro-Caribbean father and white mother, and was the younger of two children. His father had left the family in Delroy’s infancy; the mother and children remained in their council house on a crime-ridden, inner-city housing estate. The local authority had ongoing concerns about the mother’s parenting of Delroy; these concerns included neglect of his medical condition, a failure to control his wanderings from home and a punitive and aggressive style when conflicts arose between them. These difficulties resulted in a court supervision order earlier in Delroy’s life. Delroy, therefore, was from birth onwards at great risk for abuse and neglect, given his disability and the stresses of his family’s economic and ethnic status.

Six months prior to play therapy beginning, Delroy was taken into local authority care following his allegation of sexual abuse by his mother’s current partner, when his mother failed to protect him from close contact with her partner. After Delroy was removed from her care, his mother sold all his belongings, as a gesture of defiance towards the local authority, but continued to visit him in his various foster placements and continued to profess deep affection for him. Prior to therapy beginning, there had already been several breakdowns of temporary foster placements due to Delroy’s aggressiveness, his continued wanderings from home, and the added care he needed due to his seizures. His latest foster home was stretched to the limit, with two other young foster children and three teenagers in the family. Delroy’s carers seemed unable to provide him with the high level of individual attention he needed, particularly as he did not attend school at the time of referral for therapy because his special school had recently closed down.

Delroy’s severe attachment difficulties seemed to have developed during his earlier care by his mother. His mother appeared to have a highly insecure attachment pattern herself, with an internal representational model of caregiving as one of helplessness, with Delroy perceived as either in control of her or out of her control. His mother’s caretaking pattern appeared very ambivalent and defensive, with a lack of concern for Delroy’s needs when she herself was threatened emotionally (e.g. selling his belongings when angry). Other incidents of physical neglect and failure to meet Delroy’s emotional needs for security and age-appropriate exploration also were contained in his local authority records. In terms of the dynamics of attachment and interest-sharing, his mother’s self-defence system was often highly activated in their relationship. It is likely that her care-seeking and affectional, sexual systems were often activated to reach their goals with her partner, given her own intrapersonal needs. With these systems activated, his mother seemed unable to adequately activate her caregiving system to meet Delroy’s continuously high level of needs.
Twice-weekly play therapy sessions were agreed to, with the aim of helping Delroy manage some of his current feelings around loss of his mother and carers before leaving for the residential centre to treat his epilepsy. Another aim was to give support and understanding of Delroy’s needs to his carers and social worker, who felt overwhelmed by his emotional and physical needs. My decision to work directly with Delroy was not taken easily. There is continuing discussion in the play therapy literature on whether therapy can help children with their anxieties while in transition, given that their physical and safety needs are being met well, or whether therapy should wait until permanence is established (Carroll, 2001; West, 1990; Wolff, 1986). The former position argues that children’s anxieties during transition may be ameliorated, while accepting that deeper changes may not be possible. This was the main basis for my acceptance of Delroy’s referral; I was hoping to help him and his carers with some of his immediate problems before his move.

During an initial meeting more information on the work overload of his social worker and carers emerged. His carers declined to bring Delroy to his therapy sessions due to their busy schedules, but agreed to come to his first one. The social worker assured me she would transport Delroy and remain with him herself during every session. This assurance was given in response to my strong reservations about her availability due to her workload. In the event it was Delroy’s social worker who brought him to his first play therapy session on her own, after his carers, without notice, were unable to attend. She remained in the waiting room during this first session, but explained that she had to return to her office nearby during our remaining sessions.

Once therapy had begun, the social worker and carers also stated they were unable to attend our scheduled progress meetings, due to their other commitments. I had telephone contact thereafter with Delroy’s carers and social worker. These limited contacts inevitably hampered any close work in partnership to meet his therapeutic needs.

**Themes in Delroy’s sessions**

Delroy sometimes enacted important emotional issues in his symbolic play, including play that seemed related to feelings of vulnerability and care-seeking due to his epilepsy. In his symbolic play during an early therapy session, he showed distress when the small animals he was setting up continually wobbled. As our relationship developed, Delroy eventually allowed me to help him stabilize the animals using my hand, while he played. He began to place big animals with the smaller ones, and seemed able to play out these apparent attachment concerns and resolutions when his social worker brought him to sessions. Delroy also enacted an emotionally powerful, sexualized scene during this period; this seemed related to the allegations of sexually abusive experiences he had made earlier. When he returned home after this session, he made further allegations of sexual abuse by another adult to his carers. These allegations were investigated quickly, but not taken further on the grounds that he would make an unreliable witness. (Because the investigation was conducted quickly, his play therapy continued without interruption.)

While some of Delroy’s time was spent playing symbolically, much of his play therapy seemed to consist of direct, behavioural enactments of previous and current difficult experiences, rather than Delroy processing these experiences symbolically or verbally. There were many instances of Delroy requiring me to set firm limits (e.g. not taking toys from the playroom, not running away from me on the stairs); he also became overly affectionate and attempted to please me in order to be rewarded with toys. These behavioural strategies appeared to be deep-seated; they seemed to have begun when he had been cared for by his mother, then distorted further, perhaps by the sexual abuse he had alleged, and continued within his inadequate local authority foster placements.
Delroy's behaviour with me dovetailed with other information I had received on his disturbed attachment pattern and overwhelming emotional needs. His pattern with his mother seemed highly insecure and disorganized, with a mixture of extreme avoidance and ambivalence (e.g. D or A/C, Crittenden & Ainsworth, 1989). Using DSM-IV's broader classification system, Delroy displayed a reactive attachment disorder of the disinhibited type characterized by indiscriminate sociability, a classification associated with children receiving pathological and disjointed care in their early lives, often resulting in developmental delays (American Psychiatric Association, 1994).

It was Delroy's relationship with his social worker that seemed to be his primary attachment relationship in his current life. When she brought him for the first time, Delroy hugged her, then began to hug me excessively after his worker went to the waiting room, but he also asked me his social worker's whereabouts several times during the hour. Delroy continued to hug me frequently during later sessions in a manner that appeared ritualized and unsatisfying for him. Before our seventh session, his social worker stated that she was going on holiday and a voluntary driver would bring Delroy to his next session. Delroy protested loudly after she left, saying he loved his social worker, refused to enter the playroom and was angrily defiant. While waiting for her to return – I had telephoned her office nearby to report that Delroy was unable to make use of his therapy that day due to his distress – he disregarded me and my attempts to calm him. I needed to place my hand firmly on his arm when he abruptly ran out of the building and attempted to run into the road.

During this incident it seemed clear from his responses of loud distress and flight that Delroy was protesting at his abandonment by his attachment figure; these responses were very reminiscent of the behaviour of much younger children. These and other behaviours implied that due to his inadequate and damaging attachment experiences and to his continued need for constant adult care, Delroy's internal working models of self and attachment relationships were seriously delayed and distorted. They seemed unable to provide him with any sustenance and hope during periods of separation.

Delroy's desire to take toys from the playroom also seemed to reflect his attachment patterns and needs, including patterns of pathological relationships that he may have learned during the sexually abusive experiences he had alleged. During another session at a midway point in his therapy, when his social worker had been called to court and a voluntary driver stepped in, Delroy tried to extend his time with me, pleading to take some marbles home, and becoming very angry with me when I refused. Stating my limit first, I also acknowledged his feelings of need and of anger clearly, and then my own feelings (in keeping with non-directive practice on limit setting): ‘I’m going to have them. It’s a rule . . . I’m not trying to be mean and I’m not angry with you.’ I then agreed to allow him to show the driver the marbles before he left, making clear that I would return them to the playroom afterwards.

According to Heard and Lake’s formulation of the nature of caregiving relationships, my non-confrontational and non-defensive stance with Delroy was essential to promote his healthy emotional development within our therapeutic relationship. By compromising with him through negotiation, in addition to making the reality of the situation clear, Delroy was experiencing secure caregiving responses, unlike the responses that seemed to dominate his attachment relationship with his mother. However, our relationship was not a long-standing one and would be unlikely to result in permanent change, because Delroy's habitual means of relating to adults caring for him and to his mother during their visits was a very disturbed pattern of vacillating control and compliance. This pattern, as Heard and Lake discuss, is developed within parent–child dyads when adults repeatedly do not meet their children's caretaking needs.
As therapy progressed, Delroy continued to have difficulty leaving the playroom and toys, but began to internalize the consistent rule of leaving the toys in the playroom. As we have discussed elsewhere, this consistency of rules is important for troubled children and non-directive play therapy practice overall has a high level of in-built stability and structure (Ryan & Wilson, 1995). Delroy responded well to this consistency and began to say as we finished that he would leave everything and play next time. As his sessions were nearing the end, however, Delroy surreptitiously took away a toy from the playroom. He managed to return it, with help from his social worker and carers, after I acknowledged his feelings and explained my limit again. Delroy did not seem to have developed sufficient internal control over his desires, or to feel guilty for his actions, when his emotional needs reached higher levels, even given the consistency of the playroom environment. He then required more intensive caregiving from significant adults to regulate his emotions and his behaviour, similarly to a very young child.

During his last two sessions Delroy became more emotionally detached and more highly controlling of me; he very readily finished each of these sessions and returned quickly to his social worker. Analysing this behaviour within an attachment framework, Delroy's ending seemed to activate his previous adaptation to losing significant adults in his life; he moved beyond protest to despair and seeming indifference (Bowlby, 1980). He also seemed to react to feelings of extreme helplessness by increasing his control over me within his last two sessions.

**Discussion**

Although Delroy's attachment pattern was highly disorganized, delayed and distorted, he appeared not yet despairing altogether of finding an attachment figure. But Delroy's environment was unable to respond sufficiently. His carers at times seemed to contain Delroy's anxiety, and they managed his physical care, including his medical condition, but Delroy's emergency placement necessarily limited their commitment and their physical and emotional resources. They remained more available to Delroy following each of his therapy sessions, as I had recommended initially, and indeed it was after therapy that Delroy made his further allegation of sexual abuse to them. But his carers remained unavailable in many situations Delroy found emotionally threatening, including entering and leaving the play therapy room.

The carers' professional relationships in turn did not provide enough support for them; instead they, similarly to Delroy, seemed to feel 'abandoned' to deal with Delroy on their own. The carers, as well as Delroy himself, often seemed to have their self-defence systems, rather than their caregiving systems, activated in attempting to care for him. This was because of their continual anxiety and frustration in not meeting Delroy's strong need for nurturing. As Heard and Lake explain, the growth and development component of the foster carers' parenting system was not realized, nor was Delroy's exploratory system activated easily with them; he appeared to not receive enough nurturing for this to occur reliably.

Because his social worker was the one continuous figure in his life after removal from his family, and because of the unavailability of his carers, Delroy frequently turned to her to meet his attachment needs. Indeed, Delroy seemed desperate to find an attachment figure during his therapy, judging from his relationship with his social worker, including his forceful protest over her holiday. However, Delroy's attempts at forming an attachment relationship with his social worker were fraught with obvious difficulties for them both.

Using the dynamics of attachment and interest-sharing as an explanatory framework, either Delroy's care-seeking system or his self-defence system were activated at high
levels in his relationship with his social worker, mirroring his earlier attachment relationship with his mother. Delroy’s epilepsy and history of maltreatment contributed to his high level of fear and need for close protection. Yet his social worker’s professional relationship with him, along with her long list of other clients, resulted in frequent emotional and physical unavailability. On his social worker’s part, in addition to her job demands she had strong internal conflicts about viewing herself as Delroy’s primary attachment figure. Her frustration over his inadequate care and her limited role in his life often activated her self-defence system, and vacillated with her need to place herself in a parenting role with Delroy.

After several sessions I initiated a conversation with Delroy’s social worker, outlining my view of his attachment patterns, including his wish for her to care for him. My non-critical perspective seemed to enable the social worker to discuss her role conflicts, feelingly stating that her importance to Delroy was contrary to good social work practice, where professional rather than carer relationships were meant to develop (Ryan, Wilson, & Fisher, 1995). She expressed feelings of incompetence and then of inadequacy, knowing that she was unable to meet his attachment needs. During our conversation the social worker began to accept that she inevitably was placed in the position of Delroy’s most stable substitute attachment figure for the present and near future, while he was in transition to his residential placement.

Viewing our conversation in retrospect using the dynamics of attachment and interest-sharing, my acknowledgement of Delroy’s attachment issues and his social worker’s personal conflicts (in effect, my being in a caregiving relationship with her) allowed her to lower her self-defence and accept her own troubled feelings towards Delroy. She was then energized to become less defensive towards him and his carers. His carers, in turn, were enabled by the social worker to share their feelings of inadequacy with her. The social worker decided to organize her workload to spend more time with Delroy, and consciously coordinated her availability with his foster carers’ schedule in order to share his care more fully where his care-seeking needs were highly activated. Both the social worker and his carers, therefore, were able to develop a new, shared and non-defensive interest in meeting Delroy’s needs together.

My own anxieties and frustrations during therapy were similar to those of his social worker, his carers and Delroy himself. I also felt incompetent and inadequate for not meeting Delroy’s parenting needs, with added doubts about whether my own involvement had been a mistake, given the limitations of Delroy’s foster care. This contagion of emotional responses is well-recognized in the psychodynamic literature, and a particular hazard for professionals working in complex systems containing elements of pathological relationships (e.g. Furniss, 1991; Sprince, 2000). The dynamics of attachment and interest-sharing show how these skewed emotional responses occur within the five posited, interrelated systems. These responses are less difficult to unravel with a conscious understanding of these systems, as the systems themselves are posited to be fundamentally instinctive, complex, and operating at both intrapsychic and interrelational levels for each member of the system.

In my therapeutic role I had the benefit of professional supervision on my internal conflicts, in contrast to Delroy’s foster carers and social worker. I realized that my inadequate and out-of-control feelings were becoming magnified by working closely with him. This realization enabled me to control my tendency to over-identify with his strong feelings. For example, I was able to accept and understand Delroy’s anxiety in our initial session and his later resentment of me when I seemed to be his primary – yet dilute and unsatisfactory – carer when he was left with me following his worker’s announcement of her holiday.
Applying the dynamics of attachment and interest-sharing in retrospect to my own responses, I was able to maintain an accepting and non-defensive relationship with Delroy and helped him explore some of his emotional issues briefly. And I did enable him to feel safe some of the time in the playroom with me. I also helped his carers and social worker understand and meet some of Delroy’s attachment needs non-defensively, especially during the later stage of the intervention. Because I felt able to explore my own conflicts in this case within supervision, I was able, in turn, to lower my own self-defence system and engage the social worker’s exploratory/interest-sharing system along with my own. This interest-sharing was made possible because I succeeded in becoming empathically attuned to her care-seeking needs regarding her professional role. Crucially, I was attuned to her without activating her self-defence system. The social worker, in turn, was then able to engage Delroy’s foster carers in sharing their parenting difficulties with her, after she, in turn, became more empathically attuned to their emotional needs. These interest-sharing responses from key adults engendered more effective relationships for Delroy himself, within the limitations of his placement. (I strongly advocated for a longer term placement that would meet Delroy’s attachment needs, but sadly, later reports were very discouraging. And Delroy himself appeared too damaged emotionally to sustain significant benefits from his play therapy in his next, unsatisfactory placement.)

Practice implications

Delroy’s case illustrates the importance and usefulness of using the dynamics of attachment and interest-sharing both with children having serious attachment difficulties and complex needs and with the key adults who are attempting to help them. This theoretical framework seems particularly useful clinically because of its internal coherence and breadth in assessing the complex internal and interpersonal functioning of these children and their carers (including other key professionals, such as therapists, teachers and social workers). Delroy’s relationships with his social worker, carers and therapist, and each adult’s relationships with the other key people in Delroy’s attachment network were discussed earlier. For complex cases it seems important to use all five systems to analyse each person’s intra- and interpersonal relationships at the outset to inform hypotheses and guide initial decisions, and then continue to use them on an ongoing basis to assess changes, progress, and setbacks.

An added difficulty in Delroy’s case, and a difficulty likely to occur in similar cases, was his unplanned attachment relationship with his social worker. This relationship resulted in frustration and confusion within himself, within his carers and within the professionals working with him, particularly the social worker herself. This attachment relationship was much more difficult to identify and work with by virtue of its being unwanted. Therefore, in complex cases children’s professional relationships, in addition to those with their assigned carers and former carers/parents, are important to analyse also using this theoretical framework.

Delroy’s case highlights the ways in which the instinctive nature of these five systems adds to the difficulty professionals and carers experience in becoming consciously aware of their own and others’ dynamics of attachment and interest-sharing during interactions with one another, in addition to the interpersonal dynamics within their relationships with the children themselves. Child therapists have a key role, enhanced by their specialist training and clinical supervision, in helping carers and professionals who are working closely with these children to understand and respond appropriately to children’s difficult and distorted attachment patterns and interactions.
In cases in which children who have highly complex needs are placed in short-term, overloaded placements, the option of consultations by child therapists rather than therapy should be considered in the first instance. It seems more helpful overall than direct work with the children themselves. By employing the framework of the dynamics of attachment and interest-sharing with key professionals and carers, therapists can make a substantial contribution to helping children in short-term placements. Consultations have the advantage of not stretching these children’s very limited coping resources further and not extending their fragile and fraught attachment relationships even more by including therapists.

One strong disadvantage of consultations, however, is that child therapists then do not have direct experience themselves of children’s relationships with adults, nor do they have direct input in helping the children change their emotional and behavioural responses. In cases in which there is more time and commitment, and more emotional and practical resources available than in Delroy’s case, carers or childcare professionals and children can be assessed for their suitability to undertake direct work using Heard and Lake’s framework. All the adults who already have established attachment relationships with these children should be considered, depending on children’s care circumstances, as direct work will be more helpful than consultations alone. Filial therapy, which has a well-established research and practice base in North America, should be considered seriously in these cases.

The method of filial therapy has the advantage of both building on children’s existing attachment relationships and directly involving child therapists in promoting change. It is a modification of non-directive play therapy in which the parents, carers or professionals (e.g. teachers) themselves are trained as therapeutic agents and learn to practise non-directive play therapy at a basic level with supervision by qualified, experienced filial play therapists. From its inception, filial therapy has emphasized relationship-building goals and now uses attachment concepts (Guerney, 2000). Combining Heard and Lake’s more complex theoretical model of the dynamics of attachment and interest-sharing with the practice of filial therapy for viable cases will give added understanding of intrapersonal and interpersonal dynamics to the robust and direct treatment strategy of filial therapy. This is a topic to explore in a future article.

### Conclusion

Although the effect on children, their families and professionals of unsuccessful interventions is demoralizing, as it was with Delroy, unsuccessful cases also can serve a useful function for professionals. Such cases may be instrumental in spurring clinicians to acquire deeper understanding and to implement productive modifications of practice in order to prevent future failures.

Delroy’s play therapy did not seem to address his attachment and interest-sharing needs sufficiently, or the underlying attachment and interest-sharing needs of professionals and carers at the outset, thus lowering its therapeutic benefit overall. Lessons were learnt for tailoring future interventions to meet children’s attachment and interest-sharing needs more fully. By employing the formulation of the dynamics of attachment and interest-sharing in initial assessments and in ongoing analyses of cases, clearer and more effective interventions in complex cases are possible. A filial therapy approach that enhances and promotes change in carer–child relationships directly is advocated in longer term work with children who have attachment disorders; consultation methods seem more suited to short-term work.
Notes

1. For a fuller case discussion see Ryan and Wilson (2000), Chapter 5. All identifying details have been changed for Delroy’s case; verbal consent was given by the social worker involved, and written consent was given by the local authority for the use of all case material contained in this article.

2. ‘The dynamics of attachment and interest sharing’ is Heard and Lake’s most recent title for their theoretical extension of attachment theory (Heard, personal communication). It was formerly known as the ‘attachment dynamic’.

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