Practitioner Perspective

Child-Centred Attachment Therapy (CcAT) Programme

When personal and professional quests for healing intersect

By Alexandra Maeja Raicar

The article describes a brief (10-session) family attachment therapy programme, CcAT, developed by the author and three adoption colleagues in Essex, England, in the mid-1990s. The framework was later used to carry out therapeutic assessments for local adoption agencies, and to support birth and step-families – latterly by Maeja in Ireland too.

Introduction

Developing and offering Child-Centred Attachment Therapy (the CcAT Programme) to families in Essex and, more recently, in Ireland became part of my own healing journey. In the past, I mistakenly assumed that my choices of work and training were adult-led. I now know they were driven by my Child Self who needed to heal relationships within my family of origin.

It seemed just chance that my job opportunities - both as a social worker and a therapist - were mainly in the field of adoption and fostering. Decades later, I realised I was unconsciously seeking throughout to compensate for my own family losses.

In the early 1990s, I felt impelled to join a pioneering course in Parent-Infant Psychotherapy at The School of Infant Mental Health in Hampstead, even though I was halfway through my training as an Adult Psychotherapist at what is now The Bowlby Centre in London. I can still recall the tutor's surprise (and mine) at the pre-clinical training interview when – in response to his standard question as to why I wished to proceed with that adult therapy course - I heard my Child Self reply: "to be a resource for mothers and babies." That could well have been the end of my adult training, but, as the good therapist he was, he reflected back my seemingly irrelevant answer. I somehow explained my reasoning, he accepted it, and I duly began the clinical work.

Shortly after qualifying as an adult therapist, I was invited in February 1995 to lead one of the many attachment-themed mini-workshops at the annual John Bowlby Memorial conference. Mine was to be on my social work specialism: adoption and fostering. This meant I had to emotionally understand and explain "attachment" as a working concept to myself first. As a Kenyan Goan in Britain, coming from a traumatised migrant family with a range of "insecure" attachment styles (Bowlby, 1969) amongst our members, I understand now much better why it took me so long to recognise at "heart" level what a "secure" attachment feels like and how it can be carefully fostered in a new family.

Both my parents came from Catholic families in Goa which had been culturally colonised by the Portuguese for generations there; they then emigrated to Kenya, an apartheid-style British colony – where my siblings and I grew up. Not surprisingly, our parents' "sense of self" was severely impacted, and they could not model secure attachments for us. However, my training therapist and supervisors happened to be white migrants from South Africa. "Homeless at heart" like me, they had escaped its harsh apartheid regime when young and then had the shared experience of being "othered" in the "mother country," England, as I was.

Through therapy and supervision support, and play in the Winnicottian sense, I gradually reconnected with my hidden "Child Self" and slowly learned about "secure" attachments - which I could then model better for the clients and families I worked with. Winnicott explored the relationship between play, creativity, self-discovery, and the ability to engage authentically with others (Winnicott, 1985).

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Development of the CcAT Programme (1995)

In order to prepare for my mini-workshop presentation at the Bowlby Conference, I turned to the writings of Dr. Vera Fahlberg, an American attachment therapist. She had presented her work at BAAF (British Agencies for Adoption and Fostering) training events in London, as well as in her many "how to" manuals. Although I heard Fahlberg speak in previous years, and even read her books, it was only now that her very simple "bonding cycle" diagram – which I had seen before and in different guises by other writers too on attachment – suddenly made complete emotional sense to me, as did her "Positive Interaction Cycle" (Fahlberg, 1991). It is no coincidence that I had by then over four years of training therapy with a wise and committed therapist who nurtured my avoidant, almost runaway Child Self.

This became my "aha" moment, since I finally understood at heart level both how attachment works_and ways in which it can be fostered in new families. I remember my childlike excitement as I copied and expanded on Fahlberg's diagrams one weekend at home. Later that week I took them into work to photocopy and share with any one in our always busy adoption and fostering team who might be interested. My colleagues knew of Fahlberg's work, but only three - Maggie, Margaret and Pauline - seemed to see the potential of applying her specific model to work with newly formed families.

They shared my excitement at its possibilities and discussed how we could use it systematically to support new adoptive families. It felt like synchronicity with the Universe as a series of fortuitous events occurred to offer new opportunities for exploring and clarifying our ideas in a more disciplined way.

Our then director of Social Services was already interested in Attachment Theory, and in Fahlberg's work in particular. He was looking for new initiatives that might help to maintain child placements, and so it was a good time to approach the County Adoption Manager with a formal proposal. A senior colleague and friend happened to meet with me that same week, and her questions helped to further crystallise my ideas. Within a few weeks our proposal for a six-month pilot project was accepted. A county focus group of senior adoption practitioners was set up to meet bi-monthly and reflect on our findings. Even more helpfully, a senior researcher in the county agreed to evaluate our pilot project.

Understandably, our local manager had doubts about the unit being able to afford the extra staff time we four workers would need to trial such intensive placement support. However, we negotiated working one day a week in pairs, with a family each, for specific attachment therapy over a six-month period.

The manager wisely insisted that our service be time-limited, in order to focus the work for both the parents and therapists. We agreed to a ten-session programme, incorporating assessment and review. This time boundary has proved to be very effective, both for containing the work and keeping everyone motivated over an agreed period of time.

Coincidentally, Pauline and Margaret were already doing play-work with one or more children at our unit, so it was agreed that Maggie and I would be Parent Therapists and co-work with them as Play Workers in separate pairs. Through further synchrony, one of Pauline's child clients was suddenly labelled as "attachment disordered" by his social worker. She had already asked for the family to be referred to a specialist post-adoption service in London for a week's experimental attachment therapy that was to be trialled there shortly, based partly on a controversial model in America of "holding therapy."

Not long afterwards, Pauline and I were able to accompany and observe some of the therapy interventions with the family on their first and final day of the week's trial in London. This was very useful as we had to provide follow-up support locally; we could thus be more discerning as to how we ourselves might work with the family in the future. Neither of us agreed with "holding therapy" for children, especially if they had previously been abused physically, sexually, and/ or emotionally. We agreed that we needed to be child-centred ourselves in any therapeutic interventions, and our own project was named accordingly.

It was again synchrony for us that a self-help group of adoptive parents in Britain, PPIAS (Parent to Parent Information on Adoption Services, and later known as Adoption UK) had already been disseminating among its members new information from America about various attachment therapies, including "holding therapy," to treat what were now described as attachment-disordered children, many with Reactive Attachment Disorder. The mother of Pauline's child client happened to be a member of PPIAS and so had heard, not only of American adoptive parents' experiences, but of the new attachment therapy to be trialled in London. Her family was one of only two included in the pilot project there.

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The CcAT Pilot Project (1996) - key strands of work

1. The importance of grief work

Conceiving and co-developing the CcAT Programme in one year from theoretical framework to therapeutic practice had been facilitated by synchronistic events. Sadly, however, over a six-month period, our unit also experienced a series of devastating personal and family losses – through serious illnesses, deaths or accidents. These inevitably delayed the start of the pilot project as seven of the eleven staff were affected and needed time off for mourning. They included our manager and three of the four CcAT team members – almost aborting the project at its very inception.

Furthermore, both our pilot families also experienced a sudden parental loss so that they too were forced to do griefwork before we could even begin attachment work with them and the identified child client. Since (following Fahlberg) griefwork is one of the three main strands of CcAT attachment work with child and carers, the timing of all these losses felt like more than just coincidence. It was as if we, as CcAT therapists, had to be reminded of the incapacitating effects of loss, and the need to acknowledge and mourn it, before we could move on to work with our chosen families.

As I have written elsewhere:

> *"Loss is the bedrock on which the social and legal edifices of adoption are built. And on which they can crumble when this stark reality is not acknowledged and honoured by all those involved in their construction..."* (Raicar, 2010)

In the context of adoption, both child and carer losses need to be acknowledged and mourned before either can be expected to form new attachments. The child will need sensitive Life Story Work, perhaps in gradated versions to accommodate her growing understanding of why she is not living with birth parents, who may have been idealised by her. She may have to give up the fantasy of perfect birth parents in order to grieve, and accept the reality of her losses, while slowly beginning to attach to her new carer.

Similarly, the adopter will need to relinquish the fantasy child

she may have dreamed of having herself or adopting. She has to walk an emotional tightrope of attaching enough to the child to claim him as hers, and so protect him from harm, while remembering he has a birth family whom he may later wish to seek out and reclaim as a member. If adopters are too empathic with the birth family, they may feel guilty or not entitled to parent the child, and so may not claim her to keep her safe.

2. Matching cues and responses

For any relationship to work, both partners have to give the right "cues," so as to elicit the desired "responses." This is such a fundamental truth that even newborn babies instinctively cry in order to have their basic needs met. Their carers have to learn to correctly identify the baby's cue and need (to be fed, held, comforted, kept warm or cool, played with, etc.) in order to give the right response, so meeting the need appropriately.

As in the Basic Bonding Cycle – which is one of bodily arousal, crying to express discomfort, satisfaction of need, and relaxation – both baby and carer will need countless repetitions of such interactions in order to reassure the baby that her needs will be safely met (responded to) and appropriately. The baby's relaxed state, after the need has been met, will likely invite playful interactions with the carer who feels reassured he has met the baby's need, i.e. he is a good-enough carer. Such daily repetitions of cue, response, and playful interaction slowly build up trust in the baby, who learns: "It's okay to have and express my needs. This carer will meet them and enjoys being with me."

The carer develops confidence:

They spend less and less fun time with each other; instead, they become increasingly critical, rejecting and hostile, magnifying each other's negative traits and seeing no positive ones

"I know how to care for this baby. She trusts me. I am a good carer."

In this way, mutual attachment and trust between child and carer grow, as well as their self-esteem. They develop a sense of belonging, and claim each other – crucial for keeping the child safe.

Attachment and protection are two sides of the same coin. If the carer feels claimed by the child, s/he will feel entitled to look after and protect her. Equally, if a carer feels rejected by the child, s/he will not feel entitled to claim him as hers to keep him safe. And if a child does not feel claimed by the carer and kept safe, she may run away or put herself in danger to provoke safe care. This will likely confirm for the carer his feelings of inadequacy and may even lead to his ending a placement – so confirming to the child she is so bad and dangerous, no one cares enough to keep her safe, since she is worthless.

3. Having fun time together

This third, but equally important strand of the CcAT Programme builds on the success of the second: matching cues and responses to improve the carer/child relationship. We all know that, if we get on well with someone, we are more likely to spend fun time together. The converse is also true. When we don't get on with someone, we have no wish to spend any time with them.

This is exactly what happens when carer and child (or couples) get caught up in "Negative Interaction Cycles." They spend less and less fun time with each other; instead, they become increasingly critical, rejecting and hostile, magnifying each other's negative traits and seeing no positive ones.

Even in seemingly hopeless situations, just starting by having brief fun time together every day can help to salvage the relationship, if both are committed to making positive changes.
In a carer/child situation, we suggest that the child be allowed to choose a fun activity that the carer can tolerate, if not actually enjoy, and gradually increase time spent together in fun or neutral activities.

The carer, as adult, will be expected to model positive communication, or at least desist from saying anything negative. Carers may need individual work to ensure that their hurt Child Self is heard, and not pulled out inappropriately for slanging contests with the actual child in their care.

Learning from CcAT work

We realised over the following decade that we had indeed been inspired when putting together CcAT as a brief and coherent programme of simple child and family interventions to help both child and parent grieve their losses and learn to attach or reattach. It is based on very simple attachment principles that can be easily taught to families and professionals who are committed and open. It is a cost-effective, brief family intervention (four to six months usually) that

can make a positive difference to a lot of unhappy children and parents.

We have also used the CcAT framework for therapeutic assessments of struggling families to salvage failing placements, including in long term foster homes. And to assess sibling and family attachments, and complex contact arrangements, in order to make recommendations to placing agencies and the Courts.

Since moving to Ireland in recent years, I have been able to trial CcAT in a different culture and with birth families on self-referral to a family centre, usually for help with a child. Over a period of twenty months, I received thirteen referrals, and generally positive feedback on our work together from most of the parents who engaged with my service. They were all single parents, after the father had left or been coercive towards them and/or the children, or had found another partner. These mothers were resourceful and resilient, and most were willing to learn and work on themselves in order to move on.

Bereavement was a major issue for the families, since the loss of the father had to be talked about and grieved, even if it was the mother who had asked him to leave. Protection was also a recurring issue.

The mothers chose whether to bring their children to any of the sessions or not. I saw a separated father occasionally, often because the still grieving child wanted him included in family work.

I added a new tool, EFT (Emotional Freedom Technique) tapping on specific acupressure points, while stating negative self-beliefs and gradually changing them to positive affirmations. Humorous self-statements can be included, which add a touch of lightness to what can otherwise be quite heavy sessions. I noticed that the women who were willing to use this energy therapy to work on their own issues were most likely to experience positive changes in their home situation. One or two felt able to continue work on their own after only a few sessions, mainly because of using EFT.

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Increasingly over the years in my work as a therapist, I have encouraged interested clients to learn to use EFT for self-care. It can be very effective in interrupting the cycle of negative self-beliefs and actions, which can otherwise feel hopeless when reinforced by constant repetition of trauma stories.

Conclusion

It has been very encouraging to find that CcAT principles and ways of working are also easily transferrable to contexts outside adoption. And that they can be adapted to couples or sibling relationships too. Hopefully, a new generation of therapists will take this work forward.

Alexandra Maeja Raicar

Alexandra Maeja Raicar is a UK-trained Parent-Infant Psychotherapist, an Attachment-based psychoanalytic psychotherapist, an NLP (NeuroLinguistic Programming) Master Practitioner, and EFT (Emotional Freedom Technique) Advanced Practitioner.

Maeja and her CcAT Programme social work colleagues in Essex wrote about their learning in Child-Centred Attachment Therapy, published by Karnac Books in London in 2009.

She is a Kenyan Goan migrant, who lived and worked and studied in England for over five decades, before moving to the west of Ireland in 2019. She has been a regular book reviewer for *Attachment Journal*, The Bowlby Centre, where she trained, and has recently begun to write fiction.

She can be emailed at catnamaste@aol.com

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