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Attachment Theory and Wellbeing for the Young Person in Residential Care: the Provision of a Second Chance Secure Base for the Child in Crisis

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Attachment Theory and Wellbeing for the Young Person in Residential Care: The provision of a second chance secure base for the child in crisis.

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Aristotle argued that happiness for humans is not possible in the absence of reciprocal, affective relationships or friendships (Sherman 1991). Such relationships for children are only possible in the context of satisfactory attachments which provide for them a secure base from which to explore their environment (Bowlby 1988). Young people placed in the child welfare system, particularly those in residential care, often experience a system that is problem focused, intent on physical protection and control, where warm reciprocal relationships are not prioritised. This paper states that young people in residential care, whose primary attachments, whatever their quality, have been disrupted; require care that prioritises reciprocal, affective relationships. Those children who have experienced satisfactory attachments, these need to be maintained. Those who have not had satisfactory attachments in their primary relationships, and consequently did not experience a secure base, require a “second chance secure base” that yields a sense of wellbeing and happiness in order to reduce for them the risk of developing pathology in the future. A secure base is a relationship within which a child or youth feels safe, nourished both physically and emotionally, where s/he is comforted when distressed, reassured when frightened. Where children who are placed in the child welfare system have not experienced a secure base with their primary carers it is essential that social care practitioners aim to form this quality of relationship with them which is what is meant by the provision of a ‘second chance secure base’. Such practice requires, inter alia, that the social care practitioners have a sound understanding of attachment theory, in particular attachment strategies, combined with highly developed observation and communication skills (Fulcher 2002). This paper presents attachment theory and strategies in a user friendly format for social care practitioners and uses practice examples to illustrate the

use of this perspective in residential care with children across the various attachment strategies

Attachment Theory

Attachment theory attempts to explain both attachment and attachment behaviour. Attachment is a biologically pre-determined tendency for human beings to form affectional bonds with others in order to ensure protection, comfort and ultimately survival. Attachment relationships endure through time and distance. Attachment behaviour is any behaviour which results in a person attaining or retaining proximity to an identified individual who is considered better able to cope with the world and to provide the necessary protection and comfort. (Bowlby 1988). Human infants require protection for survival, they are pre-programmed to develop in a socially co-operative way; whether they do or not depends essentially on how they are treated by their primary carer/parent. Vera Fahlberg describes how attachment is formed through the Arousal/Relaxation Cycle. This cycle demonstrates how, when an infant experiences a feeling of fear or discomfort, behaviours are triggered (most likely crying in the young infant) which attract the attention of the mother whose response to the infant will determine the quality of the attachment the child subsequently develops (Fahlberg 1991). When the mother's response is predictable and meets the needs of the infant it results in the baby achieving a state of quiescence that facilitates the development of security, trust and positive attachment. Behaviour designed to elicit protection is not 'eliminated' by the development of such secure, positive attachments but is also obvious when a person is fatigued, frightened (because of perceived threat or danger), sick (which can be psychologically threatening). Such behaviour is assuaged by comforting and care-giving. (Bowlby 1988).

Attachment theory is a theory of interpersonal relationships. (Bretherton 1991). It is only by being in social relationships that we can actually form a sense of self and become human.

(Howe 1995). Relationships underpin psychological development, social competence and personal wellbeing. Psychological development occurs as we make sense of social experience and recognise it as meaningful. The brain makes sense of new experiences as a result the particular social worlds the person has already experienced and therefore all new social situations are possessed of social meaning based on history. The more limited, incomplete or distorted the social experience the less adequate or coherent will be the models for making sense of future social experiences. If models are weak or unpredictable the individual's ability to make sense of the experience and cope with it will be impaired (Howe 1995).

Attachment Strategies.

An attachment strategy reflects the way the child organises his/her behaviour with regard to his/her primary attachment person, usually during infancy (Ainsworth et al 1978). The strategy that develops is valid and adaptive to the particular relationship with the primary attachment person but is transferred to all other relationships as a pattern of behaviours. The purpose of attachment is twofold: the provision of safety and the provision of comfort. The child's attachment behaviour pattern is a strategy that has as a purpose getting the attachment person to remain close by and to provide safety and comfort. Maternal sensitivity is the primary determinant of the quality of attachment at the age of one year. The quality of attachment reflects learned patterns of mentally managing cognitive and affective information so as to predict and adapt to dangerous circumstances (Crittenden 1999). Crittenden presents a chart of patterns of attachment in childhood (Crittenden 1994), where she discusses three levels in the three attachment strategies: A (Insecure Avoidant), B (Balanced) and C (Insecure Ambivalent). All three levels of the B strategy emerge from relationships which provide a secure base and are recognised by normative behaviour. The first level in both strategies A and C emerge from relationships where safety is provided but comfort is often not experienced. These relationships, while inducing certain levels of anxiety for the attached person, provide a secure base and are also typified by normative behaviour. The remaining

levels of both strategies A and C emerge from relationships wherein neither safety nor comfort are experienced sufficiently to facilitate the development of a secure base. Behaviour in these strategies is typified by levels of compulsion (A strategy) or obsession (C strategy). These are the children most at risk of developing pathological behaviour. The aim of social care intervention with children in residential settings whose strategies are A or C is to maintain these children's behaviour in the normative range. This is achieved by ensuring that each child reliably experiences a reciprocal affective relationship which results in a feeling of safety in his/her living environment and the provision of a secure base.

Implications of Attachment Theory and Strategies for the Creation of a Secure Base in Social Care Practice

Attachment theory emphasises that continuity and sensitive responses to youth in care are key features of the environment of care-giving (Rutter & O' Connor 1999). Social care practice is about the creation of an environment in which individualised care-giving of troubled clients occurs. In his discussion of the reciprocal, care-giving relationship, Bowlby suggests that the most influential factor in the development of such a relationship with a troubled young person is how the carer treats the young person, by how available the carer is to the young person and not the young person's history. (Bowlby 1988). The social care worker must always be aware of what she contributes to the relationship. The focus needs to be kept on interactions in the here-and-now. The social care intervention has two important aims:

1. To keep the child's attachment strategy in the normative range
2. To offer, (when necessary), a second chance to form a positive attachment which becomes a secure base for the young person.

The secure base for the individual child is formed through the here-and-now of interactions, building up a memory of positive shared experiences and a predictable future for on-going, meaningful, time with the social care worker. The insecurely attached child often inhibits exploratory behaviour, and the capacity for play, trust and learning can be lost (Barrett &

Trevitt 1991). The social care worker aims to create a safe life space for the child in which these skills can be recovered. Negative and ambivalent feelings must be allowed and the behaviours related to these feelings managed in a safe and respectful manner. The life space is carefully managed to communicate a belief in each child's potential for growth through a process of tuning in to the young person to exploit interactions in which a sense of attachment and caring is felt. This is one of the essential features of child care work (Maier 1987).

To provide such focused care in a residential setting requires teams of practitioners who collaborate in the provision of a secure base for each troubled young person. The aim is to validate each child's self-worth. Sensitive care-giving requires an ability to evaluate the child's behavioural cues appropriately and to respond quickly and pro-actively to attachment behaviours (George & Solomon, 1999). Admission to residential care is a crisis in the young person's life. Crises by their nature are threatening and threatening events activate attachment behaviour. During the admission period feelings of fear and insecurity are to the fore for the young person. These will be communicated through the child's behaviours and provide on-going opportunities to evaluate the young person's behavioural cues and to respond in a manner that expresses caring and elicits feelings in the child of safety and comfort.

Importance of Communication

Clear, open, communication is fundamental to the development of the reciprocal relationship which is to become the secure base for the child. Communication is a two-way process; the worker firstly receives messages from the child and secondly, communicates to the child. The social care worker needs to be acutely aware of both elements of the process. Children tell us many things about themselves on a daily basis, mostly through their behaviour. The practitioner is required to decode the messages of the presenting behaviour. Examples of decoding from an attachment theory perspective are to be seen in the practice examples in this paper given in the various attachment strategies. Accurate decoding will require the on-going

recording of behaviours in a systematic way (Whittaker 1979). Analysis of these recordings will eventually build an accurate picture of the child as he interacts with key people in his living environment. Attachment theory informs us of the primacy of protection and of the importance of comfort for the achievement of inner safety. The worker uses all available data to pro-actively work on the young person's life space to minimise the events that trigger expressive, negative behaviour and maximise opportunities for positive, responsive interactions. Repeated experience of individualised responses to behaviour will enable the young person to eventually feel protected and enable him to be more open to positive suggestions from the trusted worker.

Social care workers must also constantly reflect on the communicative quality of their own behaviour by regularly reviewing their use of life space events and shared experiences with their young clients. It is through the effective exploitation of these opportunities that they can begin to connect with the young people in their care in a way that is healing of itself and can lead to young people being able to avail of adult support in the resolution of other issues that may be causing difficulties for them. Attachment theory informs such work by explaining how individuals, from early childhood onwards, actively process their experiences. Attachment theory also demonstrates that attachments are highly selective but several selective attachments are usual and they serve the same purpose to differing degrees (Howes 1999). An appropriately individualised response by the SCW will require her to be able to discern the presenting attachment strategy and to offer effective care-giving in the different strategies. Strategies A through D are now presented and care-giving in each strategy will be discussed using practice examples for clarification.

The A Strategy. (Insecure Avoidant)

If the child's attachment behaviour or signals for *protection* and/or *comfort* predictably result in an interfering or rejecting response from the primary attachment person the child will not

achieve the feeling of *safety* or *comfort* desired. This results in feelings of confusion and anxiety. The child is biologically driven to seek *safety* and *comfort* from the primary attachment person and so will continue to signal feelings of fear and discomfort. All attachment behaviour is accompanied by strong emotion (Bowlby 1988) which is communicated through the use of affect. If the child repeatedly experiences from his primary attachment person a rejecting response to his affective signals, s/he will interpret this as a punishment for the behaviour, and so will learn to inhibit the punished behaviour. This can result in the child inhibiting affective signals in order to reduce maternal rejection or interference. It teaches the child that expression of affect is counterproductive in this relationship. This child's adaptive attachment strategy is classified as *Strategy A* or *Insecure Avoidant Attachment*.

Distinguishing Characteristics of the *A Strategy*

- Predictable environment: The predictable rejection of affective signals or disruptive emotional displays will result in the child organising a self protective strategy around the expression of affect.
- Suppression of Affect: These children try to cope with distress by turning inwards, they expect rejection and tend to generate internal working models of others as being emotionally unavailable, untrustworthy, and rejecting, and of the self as being unlovable and of low value.
- Strong on Cognition: *A Strategy* children rely on cognition, temporal order and causal statements guide mental functioning. They recognise if/then contingencies but can distort information to protect the self or the attachment person. Negative feelings can be nominalised to create the impression of belonging to somebody else. Idealisation can occur where the parent is all good and the self all bad or vice versa.¹

¹ For a more detailed account of the A and other Strategies see Graham, G. (Forthcoming) '*Attachment Strategies and Care-Giving in Troubled Families*' Children and Youth Services Review.

Care-giving in Residential Care for the *A Strategy* Child.

This strategy for self-protection was adaptive with a caregiver whose care-giving was characterised by cognitive deactivation (George & Solomon 1999). The child using an insecure avoidant strategy may withdraw in times of major distress or fear, the flight reaction. While his behaviour was adaptive within his primary attachment relationship it may not result in the provision of the necessary protection or comfort in the residential care environment. The social care worker needs to recognise this child's strategy and to devise a response that will not push the child further into his strategy but, instead, ensure that the child experiences safety in his new environment. *A Strategy* children are particularly vulnerable in residential settings as they are less likely to be continuously demanding and can easily be overlooked. If *A Strategy* children feel continuously threatened because their need for safety is reliably unmet they are at risk of further avoiding the development of relationships. This is likely to result in the development of behaviours characterised by levels of compulsion: compulsive care-giving where neglect is the threat, compulsive compliance where violence is the threat or compulsive self-reliance where protection from dangerous caregivers is the threat (Crittenden 1999). The SCW must be cognisant of all children, recognising and respecting their attachment strategies and devising tailored responses to their behavioural cues aimed at ensuring their experience of safety and comfort and the provision of a secure base. The aim is to modify the strategy rather than reinforce it. For the *A Strategy* child the practitioner can use language to communicate concern and the provision of safety. Encourage discussion about relationships/experiences, aim to clarify misunderstandings and ensure the provision of care that enhances feelings of safety. The provision of comfort may be more challenging. This will require the recognition of the situational cues that cause discomfort and a response that aims to provide comfort in a way that is acceptable and recognisable to the child. The experience of both safety and comfort over time will have the effect of enabling the young person to use the placement as a secure base for exploration of solutions for other issues in his life.

Take for example, Sean, a thirteen year old boy who has been in his present residential placement for fifteen months following the breakdown of his adoption. On admission to care he was very much a loner who just wanted to go back home. He made few demands of the staff but was regularly in trouble for fighting with peers. He had been a good student in school prior to admission but now seemed to be interested only in reading anything he could lay his hands on and in playing his guitar. He was always being commended by the care staff because of how neatly he kept his own room, a factor which did not add to his popularity with his fellow residents. He began having very disturbing dreams which caused him to wake up shouting and very frightened at night. Only one of the care staff, whom he had selected as his key worker, could pacify him and he just refused to engage with anyone else at these difficult times. At a staff meeting called to discuss Sean it became clear that he had been having difficulties at night as he prepared for bed. This was always a bad time for Sean, a time he regularly fought with his peers. He could not tolerate anyone touching any of his things and got in a frightful state if he discovered that any of his clothes or belongings were not in their proper place. He could be very frightening when in one of his rages. His key worker was asked to discuss her relationship with Sean. She had regularly found him in an agitated state in his room when he should have been preparing for bed. She always made time to talk to him at these times. He found night times reminded him of home. If he got into bed quickly at home and read his book his mother would come up to his room and read him a story. He loved these stories and missed them very much. He hadn't seen his mother for several weeks at this stage and desperately wanted to know what was going on at home. His key worker started reading to him at night which had a soothing effect on him. Sean's mother has recently had a nervous breakdown and is in no fit state to visit him. His adoptive father did not explain to Sean the extent of her illness. The staff recognised that Sean's competent exterior shielded a fragile, worried, young boy. His key worker managed to make him feel protected without ever invading his space. Sean expressed feeling responsible for his mother's illness as he

could not help her when his parents had their regular fights. Knowing these factors about Sean made it possible for this staff team to ensure time and support for Sean at bed times and to arrange for him to visit his mum in hospital.

B Strategy (Balanced)

The child, who experiences parenting which predictably offers protection and comfort, where attachment behaviour is recognised for its communicative properties and is responded to in a way which facilitates the achievement of emotional quiescence, develops trust in the attachment figure, a feeling of security in his environment and a balanced attachment strategy. This child feels safe in the knowledge that the primary attachment person can be relied on to always protect his safety and comfort. Through the consistent experience of responses to his affective signals (attachment behaviours) that restore comfort and security the child develops a representational model of himself as being of value. This child uses both cognitive and affective transformations of sensory stimulation to information that are predictive of danger. Repeated use of both can be truly predictive of danger and safety. This eventually results in the correct identification of danger and in the undertaking of appropriate self-protective action. This child gains accurate understanding which eventually facilitates him in the control of his environment.

Distinguishing Characteristics of the *B Strategy*.

- Predictable Environment: This child learns the predictive, communicative power of behaviour where the anticipated, positive, response to his affective behaviours facilitates the development of trust, security and attachment (Fahlberg 1991).
- Presence of Safety and Comfort: The attachment relationship results in the child reliably experiencing emotional quiescence. The balance and organisation these children display is the natural outcome of developing in a safe, comfortable, environment where things are as they appear to be.

- Ability to use Cognition and Affect accurately: *B Strategy* children develop an ability to describe complex causal relationships and to assign personal responsibility. They reflect an understanding that people are motivated both by anticipated consequences and also by feeling states (Crittenden 1999), which facilitates the development of high levels of social empathy and results in them becoming more co-operative, considerate, and compassionate in their dealings with others.
- Use of Support: The effectiveness of communication between these children and their primary attachment persons and the accuracy of their internal working models facilitate them in seeking advice/support from adults. They expect people to be positively disposed to them, which facilitates relationship development and enhancement of psychological support.
- Control over Personal Environment: The ultimate aim of attachment is independence (Bowlby 1977). The regular experience of emotional quiescence helps the *B Strategy* child to more accurately organise his/her behaviour which in turn positively affects adaptive functioning. The child's internal working models of the world, of attachment persons, of himself, and relations between them, reflect a stable environment and become templates for future relationships. These internal working models (Bowlby 1988:) contain a sketch of the environment which can be manipulated to undertake future action and to learn how to satisfactorily manage one's social environment.

Care-giving and the *B Strategy* child.

This child will be less challenging for the social care practitioner as he is less likely to misinterpret the responses of the caregiver. He integrates affect and cognition but this ability may be compromised in the new residential environment which he is likely to perceive as threatening. Again, through the observation and recording of behaviours, it will become clear how this child expresses his fears and anxieties. The aim here is to maintain the child's balanced strategy by minimising his feelings of fear and aiming to respond quickly and

specifically to his attachment behaviours. Intervention strategies need to be tailored to individual needs and fears which are likely to be idiosyncratic. This will require a response of the care team based on the accurate understanding of the child's behaviour cues. Every opportunity must be exploited to dispel misunderstandings and to increase feelings of safety and comfort. *B Strategy* children are vulnerable at times of crisis and can be pushed into either a *C* or *A Strategy* if their fears and feelings are not appropriately responded to during these challenging periods.

David, a nine year old boy, who has been in care for six months, is an example of best practice with a *B Strategy* child. David's mum, Irene, is a single parent who is currently involved in a custody battle over her second child, James, who is five years old. James's father is a non-national who expressed little interest in James until this year when Irene was issued with court proceedings which signalled the father's intention to seek custody of James. Irene's legal advice was to fight this case but it necessitated her taking up residence in another jurisdiction prior to and during the court case. It was arranged that David and James would come into care during this difficult period. David was fully informed about the court case and agreed to come into care with his brother. James has settled well in care where he is the youngest resident and very much liked by staff and residents alike. David misses his mother terribly. He is expected to look out for his young brother and is also concerned about his mother who phones regularly and sends him regular emails. David still attends the same school but his friends hadn't been told why David is now staying in a local children's home. They have started to make fun of David and to exclude him from their school activities. Some older boys from the school have noticed this and have started to taunt David on his way to and from school. While David had reasonably open relationships with the care staff at the unit he did not tell anyone of his difficulties at school. He really missed his mum who always asked him about his day at school. He became withdrawn in school and in the care home. He began to refuse to go to school, claiming to be sick. David did eventually get sick and was

confined to bed when, to his horror, he began to wet the bed at night. The bed wetting continued after the infection had cleared. While the care staff had been satisfied about their relationships with David they now began to reconsider the situation and to observe and record his behaviour regularly. They soon detected his anxiety in relation to school. It was agreed to provide a lift to school for David and to discuss his class room behaviour with his teacher. David was encouraged by his key worker to discuss his feelings in relation to school and any other issues. He responded positively to his key worker's attention and found the extra support and advice helped him to cope with school issues and with his loneliness for his mum. He is gradually winning his friends back and they are being invited to visit him in the care home. David knows his mum will be back soon and is coping better with life in the care home.

C Strategy (Insecure Ambivalent).

The *C Strategy* child experiences an unpredictable environment. When feelings of discomfort trigger attachment behaviours the child cannot rely on being predictably responded to by his primary attachment figure in a manner that achieves safety and/or comfort. On some occasions the primary attachment figure is fully available to the child and facilitates the achievement of emotional quiescence but on other occasions the attachment figure's response does not result in feelings of comfort and in more severe situations the child fails to experience safety or comfort. The child cannot predict the outcome of his attachment behaviours. The result is that he becomes anxious about his safety and comfort which causes him to maintain states of high affect. This child expresses his high levels of anxiety or fear by frequently engaging in increasingly extreme behaviours. The one reliable experience is that consistent demanding behaviour usually elicits some response from the primary attachment person. The level of anxiety or discomfort that his unpredictable social environment causes results in a decreased ability to organise social experience. This interferes with the child's ability to predict danger. He becomes pre-occupied with feelings.

Distinguishing Characteristics of the C Strategy

- Unpredictable Care: This child's experience is that a particular behaviour can have totally different outcomes at different times. This makes it impossible for him to draw conclusions about his behaviour; he does not gain an understanding of cause and effect and fails to learn the connections that would enable him to predict likely outcomes of his behaviour. He does not develop trust in others as he cannot rely on them to provide safety and comfort. He experiences his parents as indecisively loving which exacerbates his feelings of frustration, dependence, anger and/or fearfulness.
- Pre-occupation with Relationships: The attachment relationship is the medium through which the child learns to organise and model experience, form a core concept of self, cope with anxiety, develop social understanding, make sense of other people and cope with social relationships (Howe 1995). The *C Strategy* child is continuously trying to make his insecure attachment relationship more effective. External inconsistencies and contradictions become internalised which can result in feelings of confusion, anger, despair, often expressed as difficult behaviour. He is uncertain of his worth and unsure of the availability of others which results in an inability to trust others. He suffers separation anxiety which affects his willingness to explore his world and causes him to be clingy to his attachment person. This results in the development of a sense of low self esteem, low self confidence and relationships racked by self doubt, uncertainty and ambivalence.
- High on Affect: The primary attachment person (PAP) in the *C Strategy* relationship is often inconsistent, insensitive and may lack empathy which can cause the child to intensify attachment behaviour to attract the PAP's interest or maintain her presence. Because the child cannot rely on the mother's availability he becomes vigilant, looking for any indications of unavailability. This causes the child to be in an almost

constant state of affective arousal which can be displayed through a tendency to laugh, cry, shout, when such responses might not be reasonably expected. This state of high arousal causes difficulty for the child in the control of his/her emotional boundaries, there is often evidence of the blurring of boundaries of time and a blurring of people. There is a tendency to mood swings and a tendency to waver. These children, who can crave affection, can be indiscriminate in their displays of affection.

- Low on Cognition: The unpredictable environment of the *C Strategy* child causes him to not recognise the temporal order or timing of events which causes confusion about causation and a tendency to omit or falsify cognitive information. This tendency to omit cognitive information from processing permits him to avoid acceptance of responsibility for his own behaviour or his contributions to relationships. He displays a greater tendency to respond to affective signals than to cognitive communications, to blame others, to not listen to alternative perspectives, to not negotiate or to accept responsibility.

Care-giving and the C Strategy child.

This child has experienced unpredictability in his primary care-giving relationship. The principle attachment person in this relationship failed to integrate positive and negative, good and bad, her care-giving could appear heightened but ineffective. There is evidence of cognitive disconnection (George & Solomon 1999). These factors cause confusion and ambivalence in the child. His attachment behaviour cues may have been responded to but not in a way that predictably achieved feelings of safety and comfort. During times of crisis this child is likely to present as affectively expressive. His behaviour could be demanding and may require interventions aimed at modifying it. However if this child has not been able to gain understanding of cause-and-effect due to his unpredictable attachment relationship he will not benefit from a strict regime based on behaviour modification principles. The *C Strategy* child accesses his episodic memory but may not accurately interpret semantic

messages. He/she is affectively expressive and will respond to affective cues. His/her attachment behaviour is readily activated and will be heightened at a time of major insecurity such as admission to a residential setting. He will communicate readily through his behaviour which again must be observed systematically and accurately recorded to note all patterns and situational cues. The provision of care that results in the *C Strategy* child predictably experiencing safety and comfort will help with his organisation of behaviour. Failure to respond effectively to such a child could result in him becoming more seriously embedded in a *C Strategy* where behaviour can become obsessive. This places the *C Strategy* child in danger of developing pathological behaviour. The individualised response of the practitioner based on accurate interpretation of situational cues of behaviour will minimise this likelihood and help maintain the child's behaviour in the normative range. The *C Strategy* child needs a calm environment which aims to keep anxiety provoking events to a minimum. Aim to help this child to manage affect by reliably responding to behavioural cues as quickly as possible and ensuring the provision of a secure base for on-going exploration and learning.

An example of a *C Strategy* in a care placement is Daniel, a five year old whose admission to care eight months ago was triggered by, Anne, his mother's, hospitalisation due to the use of bad heroin. Anne's addiction to heroin has been escalating in recent years. Three of her older children are also in residential care but she tried to parent Daniel and is distraught at his admission to care. Despite substantial community support with Daniel, Anne spent most of her days getting sufficient money to feed her habit and really only managed to be available to Daniel in the evenings. While evenings were her best time of the day, Anne's availability to Daniel varied according to how successful she was during the day in getting sufficient heroin. These evenings were Daniel's favourite time of the day. Sometimes his mother was most attentive to him while on other occasions she had friends in the house and paid little attention to him. On admission to care Daniel was distraught. During his waking hours he kept an almost constant vigil by the door hoping his mother would visit. He was prone to severe

temper tantrums. His developmental stage was more typical of a two year old. Systematic observation and recording of his behaviour indicated Daniel's inability to understand even the most basic requests or house rules. While he craved affection he shunned the staffs' attempts at comforting him. He became most disruptive in the unit. By working hard at the provision of a more predictable environment for Daniel where his behaviours resulted in responses that were designed to provide security and safety and every effort was taken to initiate positive interactions with him he became more amenable during the day-time. Evening-time remains most challenging. It is clear that Daniel misses his mum most at this time. Daniel's mum is now regularly brought to visit him in the evenings and efforts are made to involve her in his care as he prepares for bed. While there is a long way to go with Daniel the care staff are intent on providing a more predictable environment for him with adequate controls and use of positive affect.

The D Strategy (Disorganised)

There is some dispute among attachment theorists about the reliability of the D or Disorganised Strategy. A number of the D Strategies in the Main, Solomon, classification (1990) are re-classified by Crittenden in the Dynamic Maturational model as A/C or AC (Crittenden 1999). While Crittenden maintains that the D strategy is a modifier and only used in conjunction with one or more primary classifications, Main and Solomon see it as a discrete strategy with discernable characteristics. A distinguishing characteristic of the *D Strategy* is attachment behaviour which is contradictory. The following patterns, among others, are observable in *D Strategy* children:

- Sequential display of contradictory behaviour patterns (strong proximity seeking behaviour followed immediately by a freeze or a dazed expression).
- Simultaneous display of contradictory behaviour pattern (child sitting comfortably on primary attachment figure's lap while simultaneously ignoring the attachment figure's repeated overtures).
- Indicators of fear of parent (fearful expression, dashing away from parent).

For further development of these and other patterns which suggest a *D Strategy* see Main and Solomon (1990). Researchers have established links between the *D Strategy* and disturbed and disrupted patterns of care giving, relationship violence, and signs of psychopathology in children and adults (George and Solomon 1999). There is also evidence to suggest that the *D Strategy* is associated with parents' own unresolved experience of loss, separation, trauma (Schuengel, C. et al. 1999). *D Strategy* children demonstrate an absence of a coherent attachment strategy with respect to the attachment person. Infant's display of disorganised attachment behaviours is thought to occur because the infant is faced with an unresolvable paradox. When fear is aroused the infant experiences unresolvable conflict with respect to seeking comfort from a frightened or frightening caregiver who is the only haven of safety. They display 'fright without solution' (Main 1995). Attachment disorganisation in infancy forecasts controlling behaviours with caregivers, aggressive and fearful peer relations, internalising and externalising problems in preschool and elevated psychopathology in adolescence (Lyons-Ruth, K. and Jacobvitz, D. 1999).

Care-giving and the *D Strategy* child.

This strategy presents in care-giving relationships characterised by abdicated care-giving. (George and Solomon 1999). The care-giving system is disabled by a sense of helplessness on the part of the primary attachment person. Mothers of *D Strategy* children struggle to maintain control. There is evidence of the mother experiencing fear (George & Solomon 1999). If the child's history on admission to residential care suggests evidence of the mother's fear it will be important to establish the source of this fear as an essential factor in any aim to reunite the child with his/her primary carer. The relationship of mother and child needs to be observed during times of stress to isolate the particular features that lead to attachment disorganisation. The mother's fears need to be understood in the context of the stressful events that deregulate her and leave her feeling vulnerable, unprotected and helpless. The mother's helplessness results in her inability to respond to her child's needs for a particular

time period. She expresses an inability to manage affect. When the mother is in a frightened state she exhibits fear behaviour which can in turn frighten the child. The child's attachment system becomes closed and the ability to seek protection becomes blocked (George & Solomon 1999). This is clearly a dangerous condition for the child and needs urgent intervention. The most ideal intervention here is one that involves mother and child in the care-giving relationship. It should be organised around the care-giving system, around the mother's evaluation of herself as effective in providing protection for the child. The social care practitioner could work with the mother in her home. Observation and recording of interactions between mother and child are critical to establish patterns and situational cues that trigger the mother's fear. Armed with this knowledge the practitioner aims to reduce fear triggering events and to keep the attachment and care-giving systems open for reciprocal interaction. In the context of a trusting relationship with the principle attachment person the social care worker could model responses to the child's attachment behaviours aimed at achieving safety and comfort for the child. Key to this intervention is the reduction or management of the situational cues that cause the mother to be frightened. A reduction of such incidents will increase the mother's ability to predictably respond in an appropriate manner to the child's attachment behaviours.

With a young person in a residential setting whose observed situational cues and background history suggest the presence of a *D Strategy* the major focus on intervention needs to be the provision of an environment that aims to reduce the occurrence of fear inducing events. This requires careful planning based on all information available on the child and most particularly on on-going analysis of systematic recordings of observed behaviour of the child which will elicit fear inducing situations and situations of apparent contentment. A child with this strategy is in danger of becoming seriously disturbed so it is critical that his environment be managed effectively by caregivers who aim to keep the child's attachment system open in order to increase the incidence of feeling safe and comforted, thereby providing a secure base

for the child. Caregivers of *Strategy D* children may benefit from additional expert guidance in the modification of this strategy.

An example is Anne, a three year old child, recently admitted to a residential home due to the breakdown of her foster care placement. Anne was placed in foster care at age two following grave concern for her safety while in the care of her mother. Margaret, Anne's mother, a twenty three year old single mum, presented as a devoted mum who was most concerned about her daughter's care. Margaret's mother was tragically killed on Margaret's fourth birthday. She missed having a mother and was determined to be good mother herself to her daughter. Anne presented as a contented, balanced, child in her day care nursery up to approximately eighteen months of age. At this age Anne began to get acutely upset when being prepared for her day time nap. Staff noticed bruising on both her upper and lower limbs. These bruises became sufficiently severe for the nursery staff to tell Margaret that they felt obliged to report Anne to the child protection services. The child protection assessment that followed found there were grounds for concern about Anne's safety and suggested a foster care placement for Anne while Margaret was referred for counselling around parenting related issues. It was also felt that Margaret might benefit from some respite and that the foster care placement would facilitate observation of the mother/daughter relationship. Despite the careful management of Anne's foster care placement and on-going support to Margaret, Anne's behaviour proved too difficult and strange for the foster mother to manage. This resulted in Anne being admitted to a high-support residential unit. Margaret remained concerned about her daughter's welfare and was a regular visitor to the residential unit. The care staff undertook to observe the mother/daughter interaction. While Anne seemed to look forward to Margaret's visits it became clear to the care staff that Anne was also frightened of her mother. Following expert psychological advice it was decided to invite Margaret to spend more time in the unit to undertake a more active role in Anne's care in the supported environment of the care home. As Anne's 3rd birthday approached Margaret's behaviour

became more noticeably strange and she was observed shaking Anne aggressively, an activity that had to be stopped by the care staff. Margaret was noticeably upset following these incidents and tried extra hard to make it up to Anne but Anne's behaviour began to deteriorate and she showed signs of being very frightened of her mother. It was agreed that Margaret needed help with anger management and the care staff, in consultation with the psychologist, suggested the need to explore with Margaret issues around parenting that triggered behaviour in Margaret that she herself found to be most upsetting and frightening. After some time in therapy a source of Margaret's difficulty seemed to be tied to the sudden loss of her own mother at a young age. Margaret may need ongoing help with this issue but the care staff can now help Margaret to recognise the feelings and events that trigger her aggressive behaviour with Anne. Her parenting has become less problematic and Anne is beginning to seek her mother out now in times of stress or discomfort. It is hoped to eventually discharge Anne to Margaret's care with the on-going support of a community based social care worker.

Conclusion

This paper discusses how a social care worker's knowledge of attachment strategies and skill in decoding the communicative quality of young people's behaviour, from an attachment perspective, provide an opportunity to offer, for some youth, a second chance, but for all youth a secure base in residential care. Attachment theory is briefly discussed with more emphasis on attachment strategies and their impact on relationships. In times of crisis children's attachment behaviours are readily in evidence. By systematically recording children's observed behaviour, paying particular attention to situational cues that trigger specific responses, social care workers note patterns and see evidence of particular attachment strategies. This understanding facilitates individualised care of young people in residential units. The aim is to enhance these children's levels of happiness through their experience of

reciprocal, warm relationships which provide for them a secure base from which to explore their world.

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