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The Emotional Tasks of Moving from Fostering to Adoption: Transitions, Attachment, Separation and Loss

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ABSTRACT

The paradoxical emotional tasks involved for a child moving from fostering to adoption are discussed from two linked perspectives. Attachment theory highlights the fact that the child is being expected to form a new attachment to the adoptive family whilst often being in the grips of mourning the loss of the foster family. The author suggests that a significant amount of the anger and violence expressed by children such as these is the result of their suffering from 'multiple traumatic loss'. Winnicott's ideas about the potential of transitional experiences, phenomena and objects to offer a way of working with the painful paradox of simultaneous attachment and loss in as creative a way as possible, are illustrated. The three-year-old patient was referred for psychoanalytic psychotherapy to help him to cope as well as possible with his move from his loved foster home to his unknown adoptive home. The importance of facilitating a growing ability to play out in the therapy the intense feelings inevitably engendered, as opposed to acting them out in everyday life, is emphasized. It is argued that therapy offered during such difficult life transitions, if it can be thoughtfully contained by the professional network around the child can hold a significant therapeutic potential. The psychodynamics of the professional network surrounding the child are discussed in this context.

KEYWORDS

fostering and adoption, life transitions, multiple traumatic loss, psychodynamics of the professional network, simultaneous attachment and loss, transitional objects and phenomena

THE PROCESS OF moving a child from long-term fostering to adoption is essentially paradoxical and inevitably fraught. There is often a tremendous, almost fairytale-like, sense of excitement and potential, but simultaneously there is the sense of painful loss of the foster family, and the risk that this loss will trigger traumatic memories and feelings from the past, as well as severely disturbed behaviour. This cocktail of emotions may at times feel overwhelming for the child, as well as for the adults who are trying to help the

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child. The whole experience can feel alarmingly similar to the surgical removal of the child from the security of the foster family, followed by his or her artificial transplantation into the adoptive family. There is always the worrying risk that the transplant will not 'take'.

The clinician working directly with the child may hold a key position in the transition process, by engaging with and knowing in depth the child's internal world, as well as playing an active part in the decision-making processes taking place in the adult network that surrounds the child. This is a difficult position for the clinician to hold, but by working imaginatively in this intermediate area, which faces Janus-like both inwards and outwards, it is possible to harness the potential for positive change that is available during any transition. It can also be argued that part of the therapist's role in the network, is to try to prevent as far as possible any further traumatization or repetition of destructive processes being acted out within the network. The persistence of these unconscious destructive processes needs to be held in great respect, as do the defences against anxiety and pain that creep into the network surrounding children who are 'looked after'.

It can be difficult to judge what is the right time for psychotherapy for a child who is in care. This article illustrates the value of working therapeutically with the child who is moving from foster home to adoptive home, *during the transition itself*. Psychotherapeutic work during this transition can enable the child to cope creatively with the extraordinary changes in his or her internal and external life, by remaining as in touch as is possible with the intense, conflicting feelings that are inevitably experienced. This can mean trying to help the child to be no more defensive than is absolutely necessary in order to survive from day to day. The theoretical and technical issues raised in working with children who are in transition could be helpful in thinking more generally about life transitions and their potential for positive change.

There has been a dramatic increase in the number of looked after children being offered psychoanalytic psychotherapy over the last 15 years. Psychotherapy with looked after children currently takes up a very high proportion of child and adolescent psychotherapists' clinical time. For example, a recent audit in one inner city NHS trust found that 37.5% of child and adolescent psychotherapy sessions were taken by looked after children (Fleming, personal communication). A high proportion of PhD research carried out by experienced clinicians within the profession, relates to these children and provides valuable findings regarding their treatment (e.g. Hindle, 2001; Ironside, 2002). Hunter (2001) has recently provided a valuable view of psychotherapy with children in care.

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Psychotherapeutic treatment has to address both the impact of neglect and the impact of trauma. Different practitioners will approach this in different ways. Over the years I have come to believe that too much direct reference to traumatic events, too early in treatment may only serve to reinforce defences against emotional pain. Additionally, there is always the real risk of opening up wounds that are beginning to heal, if traumatic memories are triggered by ill-timed or insensitive probing of the past (Lanyado, 1999a). The availability to think about traumatic events will vary greatly from one child to another and it is a matter of clinical sensitivity to judge when the time is right to think about the terrible past (Lanyado, 1985). It is therefore important for the clinician to be mindful of the constant risk of re-traumatizing the child – both within therapy and in the day-to-day management of the child's life.

Therapy should be acutely attuned to any tiny signs that a child starts to show of developmental progress, and should aim to further this growth through providing the type of therapeutically facilitating environment discussed below. In addition, I would like to suggest that progress is most clearly indicated by improvements in the child's ability to play and the development of new transitional experiences (Winnicott, 1971/1974). The child's carers need to know that these are positive signs that require careful attention and nurturing. These new shoots of growth are signs that the child is starting to recover from some of the impact of neglect and trauma, thus indicating that a healthier emotional and intellectual climate and structure of mind are developing within the child. As a result of this growth, the child gradually becomes more robust and more able to cope with thinking, feeling and remembering the painful and traumatic past, as it surfaces spontaneously in the present (Lanyado, 1999a).

The clinical material that follows describes 'Sammy's' therapy during the transition from his foster parents to his adoptive parents. (For further clinical material and discussion from different perspectives, on the psychotherapeutic treatment of Sammy and other children like him see Lanyado, 1997, 1999b, 2001, 2002.) In the discussion of the clinical material, two main theoretical concepts are utilized: the importance of recognizing the value of 'transitional phenomena' as described by Winnicott (1971/1974), and the concepts of attachment, separation and loss in relation to children in care.

Alongside these themes, the need to try to create a sense of continuity and transition in these children's very disrupted lives is highlighted. This may seem like a contradiction in terms but having these ideas in mind when working with children like Sammy, whom I have described elsewhere as suffering from 'multiple traumatic loss', can help to conceptualize what psychotherapy in these very complex circumstances is trying to achieve (Lanyado, 2001, 2002). In the broadest of terms, this could be described as trying to help the child to become more able to contain some of his or her anxiety about all the changes, so that they can be navigated with creativity rather than despair.

To protect the confidentiality of 'Sammy', and his foster and adoptive families, some details of what follows have been changed and much information necessarily omitted.

Clinical example – 'Sammy'

Sammy had a history of neglect and had been in and out of care throughout the first years of his life. He was placed in a foster home with a view to adoption when he was two years old and referred for therapy when he was three. The social worker who referred Sammy was very concerned that, because he was so attached to his foster family, he would find it very difficult to form new attachments in any adoptive placement. There were also concerns that the foster family would find it so distressing to part with Sammy that they might not be able to face fostering another child, despite having done so well with Sammy.

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Although he had severe temper tantrums and could become suddenly very aggressive, Sammy was also able to be loving and sorry for being 'bad' as he put it, and an affectionate relationship had built up between him and his foster carers. He often expressed his aggression and distress by deliberately wetting and soiling in his foster home, and was a child who aroused strong and conflicting feelings in the adults who tried to help and care for him.

A treatment plan was set up in which each session started with Sammy and his foster mother seeing me together, so that I could help them with their turbulent and rather passionate relationship. At some point, depending on what felt right in the session, I would then see Sammy on his own. This very fluid arrangement (which was unusual for me) was well suited to the purpose of trying to help them to face their impending separation with as little defensiveness as possible. I met regularly with the fostering social worker who had referred Sammy, and she continued to meet the foster parents regularly to support the therapy. It was agreed that I would be involved with any major decisions about Sammy, and that I would be part of the network planning meetings about the move from the foster home to the adoptive home.

Whilst Sammy was struggling to contain his growing desperation that a 'new mummy and daddy' would never be found for him, the fostering and adoption team had in fact found a suitable family who were passed by the adoption panel. Sammy's foster parents and I knew about this, but there were several of weeks when Sammy could not be told because all of the arrangements for the transition were not yet properly in place. During this time, Sammy would plaintively say to me that he wanted his new mummy and daddy 'now', and that he had been waiting a very long time for them. However, it also became clear that he was frightened of meeting his new mummy and daddy, whoever they were, in case he didn't like them. He harboured fantasies that he would be handed over to complete strangers who would abduct him from the safety and care of his foster home in the same way that he felt he'd been abducted from his birth mother's home.

During this time, it was important to acknowledge these fears and talk to him repeatedly about the way in which he would move to his new family when the time was right. It would be gradual and that he would have time to get used to the idea and to say goodbye to his foster family, in contrast to the abruptness of previous separations and losses. It is hard to know how well he could really understand these rational accounts of what were momentous life events for such a young and understandably confused child. He expressed his sense of being at an in-between place in his life by insisting on spending a fair amount of time on the stairs between his foster mother in the waiting area and the therapy room itself. This helped us to talk about how he felt in limbo and torn in two directions in his life, not knowing where to 'put' himself emotionally and physically.

During this period, at the end of a particularly painful session, Sammy was desperate to take a green ball from his box of toys home with him. As we had often battled about his usually quite arbitrary wish to take therapy toys home, this was very much against my better judgement. However, on this occasion there was such an imperative expressed in his wish to take the ball that I let him do this, as long as he bought it back to the next session – which he agreed to do. It was the imperative nature of his wish to take the ball that changed my mind about letting him do so – and this was after only a brief disagreement. I then said to him that although he knew I did not normally allow therapy toys to go home, on this occasion I would, because I could see it was so important to him, and we would see together what came of this. In other words, I was giving his acquisition of the ball my blessing, rather than letting it feel to him like a theft or a triumph over me.

I agreed to Sammy taking the green ball home because I was intrigued by the way in which this ball, which he had barely noticed before, had, suddenly and genuinely, become special to him. He seemed to be claiming rights over it, in the same way that a baby will naturally discover and claim his or her own special blanket or soft toy, that becomes the

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classical transitional object as described by Winnicott (1971/1974). This felt potentially healthy to me and was quite unexpected in the midst of his generally disturbed behaviour at this time. I wanted to see what happened to this fragile beginning of what might have been his first transitional object. This may have helped the ball to become significant for us.

Throughout the weeks that followed, during which time he was introduced to his adoptive family and left his foster family, the ball came and went from the sessions with Sammy. It was played with and carefully looked after as well as at times aggressively knocked about, both in the therapy session and at his foster home. His foster mother intuitively understood that the ball was important to him. Even when he forgot to bring it to the session he always referred to it. It was very clearly neither his nor mine, but it was also both his and mine. This paradoxical state of affairs was very much in keeping with his feeling that he belonged to both his foster and his adoptive family, as well as at times that he belonged to neither of them. Winnicott describes how transitional phenomena serve the function of holding this type of anxiety. It was therefore fascinating to recognize that Sammy had created a new transitional object just when it was most appropriate and most needed – at the height of his anxiety about the transition between his foster parents and his adoptive parents. I think that Sammy's use of the green ball may have been important in helping him to cope with the anxiety of the paradoxes of moving from foster to adoptive home, in what became a manageable transition, as opposed to a traumatic discontinuity and loss in his life.

I knew a few weeks in advance when Sammy was going to be told that his new mummy and daddy had been found. Unconsciously, I think that Sammy also picked up the anticipation, excitement and anxiety that was in the air and coped with it remarkably philosophically, expressing his feelings very movingly (and somewhat unusually at this point in therapy) through play (see Lanyado, 1997, 1999a).

When I went to fetch Sammy and his foster mother from the waiting room, the day after he had met his new mummy and daddy, his head was down in a very doleful and ashamed way. This was rarely his style. He avoided my gaze and was wordless and reluctant to come to the therapy room. His foster mother was exasperated with him, saying that he had been 'as high as a kite' since he'd met his new mummy and daddy. Sammy continued to stand with his head down in a desolate and lonely way when he came into the therapy room with his foster mother. She said that she didn't know what had come over him just as he came to the clinic. I asked Sammy if he could say anything about this, but he just stood rooted to the spot and started to cry – which had never happened before in the sessions. I wondered if he needed some time on his own with me, so I suggested that his foster mother go back to the waiting room for a while. No sooner had she done this than Sammy wanted her back in the room, so we went to fetch her, but she had just gone to the toilet.

As we waited I took the opportunity to say to Sammy that I knew that he had had some very important days since our last session, and I wondered if it was this that had led to his upset. He immediately and urgently blurted out 'I don't like my new mummy and daddy'. As I wasn't quite sure that I had heard him correctly, I asked him if he could say this again, but he then in his urgency said something quite different. 'I'm going to miss Sara and Jim' (his foster parents). There was no time for him to say anything else as Sara had just returned from the toilet and to her surprise he flung himself into her arms. She carried him back to the therapy room, tearfully overcome by his show of emotion. Sammy continued to cry and cling to Sara, and this was one of the many occasions in which her anger melted and she was able to see how upset he was at leaving her, behind all the bravado and rejecting defences he had shown her so far. She comforted him and told him that she and Jim would really miss him and that they also felt very sad that he was leaving them.

The three weeks that followed, during which Sammy bought out his full repertoire of awful confrontational and aggressive behaviour towards his adoptive parents, as well as

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being very volatile with his foster parents, were like an emotional roller coaster. The green ball was with him a great deal of the time, and it came and went from the therapy sessions as before. Gradually, Sammy was able to see that his adoptive parents really wanted him and tried very hard to understand his distress, and he gradually became more able to accept them, and the inevitability of saying goodbye to Sara and Jim. As the day approached that he was leaving Sara and Jim, he often asked them whether they would cry when he went. They told him truthfully that they probably would – and in fact did. It was very significant for Sammy to know that he mattered enough to them for them also to be very upset at their parting. This was very different to the separations and losses of the past in which he had felt that the grown-ups were glad to get rid of him.

Sammy is still with his adoptive family although it has been very difficult for them all at times. His foster family after a break, were able to foster other children.

The creation of transitional phenomena in therapy – The green ball

The idea of transitions, and the manner in which they are not 'either/or', but are paradoxically 'both', is extremely pertinent when thinking about children in Sammy's position. Sammy's use of the green ball as a transitional object helped him to cope with the paradoxes of his life during the transition to his adoptive home. By managing to hold so many paradoxical feelings within him, rather than becoming torn apart by the internal conflicts they represented, he managed to stay remarkably together during a period in his life when he might have literally felt that his mind was 'blown'. Transitional phenomena (objects and experiences) help to contain and transform anxiety within what might be experienced as a terrifying void or chaotic gap, into experiencing that same psychic or external space as being potentially bearable and creative. Harnessing the creative potential that is present within a transition, can be seen as a significant aim of the psychotherapy of looked after children.

Where there has been severe early emotional deprivation, many children will not have reached the point in their emotional development at which they are able to create their own special transitional phenomena. If they have been able to reach this point, this might in some measure help them to cope with ordinary, as well as more extreme, anxiety. Tragically, where there might have been a special blanket or other transitional object, it has often been lost as children in care move from one placement to another. With this in mind, the emergence of new transitional phenomena is an important sign that despite all the difficulties these children are presenting, some significant emotional recovery and development is taking place within the child. These are signs that foster and adoptive parents, as well as clinicians, should watch out for.

Therapy, as well as restorative experiences in foster placements, can provide the kind of environment in which new transitional phenomena can emerge. I find it helpful to draw parallels between the psychotherapeutic process and ordinary developmental processes. In thinking about how play and transitional phenomena develop in ordinary childhood, I find Winnicott's concept of the parent creating a facilitating environment within which the child can naturally mature, helpful (Winnicott, 1960/1965a). Children who are in care have rarely had this experience for enough of their early childhood and need to experience this in foster homes, residential settings – and in therapy. One of the qualities of this facilitating environment is providing the quiet and often repeated experience of what Winnicott evocatively describes as being 'alone in the presence of someone' (Winnicott, 1958/1965b). This experience is very relevant to the child's developing

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capacity to play, which in turn relates to the ordinary developmental creation of transitional phenomena.

The experience I am trying to capture can be described in a classical scenario from early childhood. The baby might be sitting or crawling and able to manipulate, explore and play with rattles, soft toys, spoons and so on. This ability develops gradually and the concentration with which it takes place can be impressive. There can be periods of five or ten minutes when the baby is totally engrossed. This is fine as long as mother or another trusted person is present – the baby can be alone in this absorption. However, if this trusted person tries to go off and do something else, or their thoughts stray too far from an awareness of the baby, after a few minutes the baby is likely to start complaining and effectively call the adult back. This is because now the baby is aware of being truly alone and cannot continue to play because of this aloneness. The baby at this stage in development can only be alone with his or her play *because* of the quiet presence of someone else. This is an experience that is likely to have been too scarce for many children in care and it can be argued that this is one way of trying to understand why these children have such difficulty in playing.

Through this concept of being 'alone in the presence of someone' Winnicott describes the states of mind that are likely to be present in the 'secure base' image of a child being able to playfully explore the environment, as long as an attachment figure is present (Ainsworth, 1967; Bowlby, 1988). These ideas are discussed in more detailed elsewhere (Lanyado, 2003).

I want to draw attention to how therapeutic the kind of play that Sammy was sometimes able to achieve can be to a child who is trying so hard to make sense of his or her life. The content of his play was entirely unprompted by me, because psychoanalytic psychotherapy is non-directive. However, the strength of offering therapy to Sammy at this time in his life was that by providing a facilitating environment, Sammy gradually became more and more able to play out instead of act out these very painful and complex thoughts and feelings. I think that this was because he felt increasingly held in my mind and his foster carers' minds as described earlier. Watching the highly relevant play themes that emerged at times in Sammy's therapy seemed to confirm that despite all the pressures he was under, he was able to grow and develop, emotionally (see Lanyado, 1997, 1999a). The ability to play during such a crucial time in Sammy's life enabled him to some extent to keep his conflicting feelings *in his mind*, rather than finding that the whole experience *blew his mind*.

If children experience an environment in which they can safely play out their anxieties and fears they are more likely to creatively use play to express and work through their feelings. This was also true for another little boy 'Harry' whom I have discussed elsewhere (Lanyado, 2002). Without this opportunity to play, children are likely to become 'over the top' (as Sammy was after his first meeting his adoptive parents) or highly defended and out of touch with their emotions – particularly in this instance, feelings of sadness and loss. They may also seem detached or bewildered.

Another point to keep in mind is that it may be that when it has been possible to stay with the 'here and now' experience of massive change, in this instance moving from fostering to adoption, with all its paradoxes, it may be more possible to process the memories which contribute so importantly to a sense of continuity in life. The narrative of these events is likely to be more coherent as a result and therefore better integrated into the child's internal world. It is also possible that where painful events have been processed in this way, they are less likely to become pathogenic in the future as a part of a cumulatively traumatic process.

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Attachment, separation, loss and emotional defences

The consequences of separation from and loss of important primary attachment figures in early life are particularly evident for children in the care system. Their plight highlights what we all know that, for whatever reason, loss of contact with someone whom we love and depend on is a devastating experience.

Bowlby first wrote about the psychiatric consequences that resulted from broken relationships at critical periods in childhood, in 1944. At this time he was very clear that children who had had these experiences were likely to grow up to be psychopathic, delinquent and antisocial, and he described them as having an 'affectionless' personality. Initially, Bowlby felt that this was an irreversible condition and that it was pointless or an unacceptably intense use of scarce clinical resources, to attempt treatment (Bowlby, 1944, 1953). At this stage of his thinking, he might well have questioned the wisdom of my work with Sammy.

Bowlby's views developed over time. He moved from placing too rigorous and simplistic an emphasis on maternal deprivation and separation, *per se*, as the major causes of antisocial and psychopathic personalities to a much more complex theory of attachment, separation and loss (Bowlby, 1969, 1973, 1980). It is also now recognized that whilst the attachments to mother and father are likely in childhood to be the strongest, we all form many new attachments as we go through life (Holmes, 1993; Parkes, Stevenson-Hinde, & Maris, 1991). The quality of each early attachment can be quite independent – that is, for example, a child may be insecurely attached to his mother but securely attached to his grandmother. Attachments to siblings are also often of great importance. It is probably more realistic to think in terms of a hierarchy of attachments, and this in turn implies that it might be possible to be securely attached to a caregiver to a greater or lesser intensity. The question for children like Sammy is, following their disastrous early attachment experiences, what kind of attachment are they capable of forming?

There is a great deal of evidence which suggests that the strength of the template formed by the earliest experiences of attachment can determine all future types of attachments (Holmes, 1993). This is what we are seeing when a child mistakenly perceives kindly, patient foster carers and adoptive parents as if they are cruel to and /or neglectful of him or her in ways that his or her birth parents have been in the past. It can be very difficult to shift this perception, and this can be an important function of therapy – to free the child from the ghosts of past attachment relationships clouding his or her vision of new relationships (Hopkins, 2000).

In addition, when a young child has experienced neglect and abuse from his or her parents followed by abandonment, there is a fearfulness about allowing anyone else – possibly particularly an adult – close to him. In the child's mind, this risks a repeat of the painful rejection, attack, abandonment or uncertainty of past relationships. The child may by now be convinced that 'daring to try again' to allow a new relationship to grow, is a highly dangerous proposition (Lanyado, 2001). Therapy can play its part by trying to help the child to disentangle their expectations from the past – that they would be mistreated and rejected – from the actual experience of the present (Hopkins, 2000).

Sammy's relationships with his foster parents were always much affected by this fear of getting too close to them. At times he could be very loving but at others he became deliberately rejecting of them and very angry with them. The session described above, which followed his first meeting with his adoptive parents, illustrates all these processes of attachment, separation and loss very clearly – and they all seemed to be happening at once to this very overwhelmed little boy. One minute he was rejecting and denigrating of his foster mother and idealizing of his adoptive family, the next he was clinging to his

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foster mother, never wanting to leave her and giving his adoptive family hell. He was trying to face the loss of the family he had known for half of his life whilst coping with the fear and excitement of the opportunity of 'trying again' with what he had been told was his 'forever' family.

The wise response and understanding of the adults around him, allowed him to express all of these very confused feelings, whilst not responding by rejecting him in turn. Above all, his ability to remain for enough of the time in touch with the painfulness of his loss of the foster family, together with their sensitivity about this loss and openness about their own sadness, helped him to mourn the impending loss in a way that he had been unable to mourn other losses in the past. This mourning process in which he gradually accepted the need to let go of his foster family, freed him to start to attach to his forever family.

It is the work in the transference relationship that frees the child to see the good that is there for them in the present, because it is no longer overshadowed by traumatic and neglectful experience of the past. (For clinical examples of the difficulty of 'daring to try again', see Hopkins, 2000; Hunter, 2001; Lanyado, 2001.) It is because these powerful experiences in the past are so deeply ingrained in the child's mind and heart that their therapy needs to be lengthy, and to penetrate to deep levels of the personality. This is labour-intensive work which frustrates service providers because of the expense involved. But this must be counterbalanced by the costs to society of the same children who if untreated perpetuate the cycle of deprivation and abuse when they become parents, and become very needy of mental and general health services as well as social services, or indeed become seriously antisocial resulting in imprisonment.

The phrase 'broken attachments' is a euphemism for describing separation and loss. This use of language might be thought of as a professional defence against seeing in all its awfulness the number and nature of the losses some of the children we work with have suffered. It is well recognized that loss and the process of mourning are as much a part of human experience as forming relationships with others. With some small variations in emphasis, the key components of the ordinary mourning process (in no particular chronological order or order of importance) are still viewed as being sadness, depression, numbing, searching for the lost loved one, yearning, anger, disorganization, despair and eventually with gradual recovery, reorganization (Parkes, 1972). When this process has followed its natural path, the individual can also, paradoxically be seen to have grown emotionally as a result of what they have been through.

By contrast, when mourning has not been able to follow its natural path, or has been compounded and complicated by external or internal circumstances, there are likely to be many developmental repercussions. For example, it is now generally recognized that mourning following a death may take at least a year, with anniversaries of important past events playing a significant part in the process. The age of the mourner also determines his or her ability to fully engage in the process. In addition adults, and children in particular, fare better or worse in managing to engage with the mourning process, depending on how well they are supported by other established attachment figures during the mourning period.

With this in mind, it is not surprising to discover that many children who have lost contact with key attachment figures not through death, but through neglect, abuse or abandonment, are unable to mourn this loss. Not only are their emotional structures naturally less developed than adults' in similar circumstances, but they are also frequently unsupported by the presence of other established attachment figures. It is also now recognized that in some ways it is less complicated to mourn the death of a loved one, than to cope with the ambivalence of knowing that a missed parent is alive and well

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and living a few miles away, but not wanting to see their child. And finally, for most children in care, the ordinary process of time that is needed in order to go through the usual process of mourning, has often also been filled with an accumulation of further losses and changes which it becomes almost impossible for the child to metabolize. A great deal of the anger and violence of children like Sammy can be understood as being rooted in undigested experiences of loss.

Problems of how to regulate emotional proximity and distance can arise from defences against the pain of loss. The individual may long for emotional and physical closeness (including touching) but also be frightened that if this is offered, there is then the terrible risk that this precious experience could be lost again, as it was in the past. This is based on real experiences such as being physically uncared for and at times harshly pushed away and attacked by those from whom the child also seeks security and proximity at times of physical and emotional need. Children who move on to adoption have often been completely abandoned by their parents. Contrast this with an ordinary secure attachment in which an infant, child or adult seeks closeness with their attachment figure (parent, sibling, friend, partner) when he or she feels in danger or distress, and receives the welcome and care that is needed. It is therefore not surprising to find that emotional and physical closeness and distance are central anxieties when children like Sammy dare to try to form new attachments. Their defence is to reject the other person before being rejected themselves. This is very hard for foster families, adoptive families and therapeutic carers to live and work with.

At a conference about looked after children, it was noted that despite the clear observational profile of children who are 'beyond the family', it is surprising there is no clear clinical category for children like Sammy (Kasinski & Rollinson, 2000). I have suggested elsewhere (Lanyado, 2001, 2002) that children such as Sammy who are in the care system, could be described as suffering from 'multiple traumatic loss' for the following reasons. First, many of these children's terrible experiences of loss become too readily 'lost' when one is in direct contact with their disturbed and disturbing behaviour. It is important to emphasize the idea of loss in any attempt to suggest a clinical category. Second, the losses they have suffered are not the more ordinary and unavoidable losses that we all have to face in life. They are truly traumatic losses of the most important relationships in their vulnerable young lives. These children are terribly alone and unprotected in the world. Hence the emphasis on trauma. And finally, they have usually suffered these traumatic losses repeatedly without any real chance to recover from one loss before another loss takes place. Whilst it is often possible to retain an empathic response to young children like Sammy despite their aggressive and hostile behaviour, it is much more difficult to feel this when these children become physically larger and more dangerous. It then becomes easy to forget what has led to this level of apparent detachment, hostility and violence. The idea that these frightening adolescents are suffering from 'multiple traumatic loss', reminds us of what has led to their severe disturbance.

Psychodynamics of the network surrounding the looked after child

With regard to the professional/caring system surrounding the child, it is important to always bear in mind that the impact on the foster carers, adoptive parents, social workers, teachers, guardian ad litems, solicitors and so on – in fact anyone who comes into contact with children like Sammy – is often profound. It is terrible as an adult, to appreciate the fear, distress and extreme vulnerability of a child who is essentially unprotected and

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alone in the world. In part, there is a rescuer side to all of us who want to help these children. However, it is also all too easy to become 'accommodated' to the level of pain, aggression and trauma that they have experienced, so that the case notes and contact with the child, start to lose their full meaning.

These are defences that in some measure may be necessary in order to protect the professional from becoming overwhelmed and thus enable him or her to keep working with these children. However, these professional defences can too readily fit in with the awful, violent and rejecting behaviour of the children, successfully encouraging adults to leave them alone, just when this is least desirable. When the defences of the professional and/or carer reinforce the defences of the child in this way, there is a greater risk that actions and decisions that are traumatic for the child will be carried out (Menzies Lyth, 1988, 1989). In my experience the active presence of the therapist within the professional network is very helpful in monitoring this risk of acting out in the network. The therapist's intimate knowledge of the child's inner world enables him or her to spot the potential for destructive repetition within the network and thus reduce its possible impact. The difficulties of preserving the child's privacy whilst being in contact with so many people in his or her external world are in my opinion outweighed by the advantages of the improved level of containment of anxiety that results from the contact between all adults working with the child.

It is important to note that it is painful in a *different* way for everyone involved when a child is moving on from a positive and good placement, such as Sammy's foster placement, to an adoptive placement, as this involves the loss of good relationships in the child's life, which needs to be mourned in a very different way to the loss of neglectful or traumatic relationships experienced in the past. There is great sadness, poignancy, hopefulness and anticipation inherent in situations such as these.

At times there can be poor practice as a result of the pressure of work or inadequate training or supervision. But at other times even the most competent of inter-professional systems can unwittingly be spurred into action, the consequences of which are not sufficiently thought through for the child. Splits develop in which professionals blame each other when things go wrong – mirroring the ways in which society likes to point the finger of blame and avoid responsibility for the poor care of its weakest members. There are ways in which these difficulties can be worked at, although I think that by the very nature of the work, this will need to be an ongoing process as the anxieties projected into the system by the children are unremitting (Menzies Lyth, 1988, 1989).

A number of child psychotherapists consult to social work teams and fostering and adoption agencies to help them to retain an overall perspective on the work. This can enable professionals to keep thinking and feeling as much as possible, about the painful issues they are trying to work with daily (Sprince, 2002). The child psychotherapist is able to apply experience from the therapy room about the ways in which these children function, and make links with the way in which this in turn impacts on the system around the children. This can be done without the therapist having actually met the child face to face, but having 'met' the child in another way – that is, through the way he is presented through the network. Consultation meetings such as these can be very productive, facilitating communication between professionals and helping them to pull in the same direction rather than spending fruitless time in conflict.

Recovery from childhood trauma and neglect is a long and tortuous *lifelong* progress. It cannot be rushed. All adults who have experienced such difficult starts in life will bear the scars and will need to learn to live as creatively as possible despite all that has happened to them. It is important to hold onto this perspective on the treatment of the child in care. We cannot make it 'all better'. However, we can do our best not to

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contribute to further traumatization and to positively facilitate the recovery of ordinary developmental processes – emotionally, intellectually and physically.

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