

FINDING AND NURTURING THE GOLD

AN INTEGRATIVE APPROACH TO WORKING WITH AN ADOPTED ADOLESCENT AND HER PARENT

ROZ READ

Introduction

Over the years I have developed archetypes for giving meaning to the different roles that I bring in my work as a therapist when working with adopted children and their parents. Here in this chapter, I attempt to illustrate some of the ways in which a trainee might approach their work with adopted children and their parents using a clinical example of therapeutic work with a fifteen-year-old adopted adolescent.

I am employed part-time as a therapist within a small multidisciplinary team working exclusively with adopted and other permanently placed children and their parents. The model of therapy places a strong emphasis on using the arts, developmental play, body-based interventions, and narrative techniques underpinned by a research-based and neuroscientific understanding of developmental trauma and attachment. While I integrate these tools in my method, the main treatment model I use is Dyadic Developmental Psychotherapy (DDP); this is a specialist therapy created by Dan Hughes in the 1980s (Hughes et al.,2019) for children and their families who have experienced neglect and

abuse in their birth families and suffered from significant developmental trauma. I have also had additional trainings in dissociation and EMDR (Eye Movement Desensitisation and Reprocessing). Occasionally the work will include individual sessions with children, but usually it takes the form of family work with children and parents together. Adopted children and their parents have unique challenges and working integratively in this context means that I can develop a framework that is flexible enough to meet the needs of the individual children and families that I'm serving.

Every therapist has a story

In my interview for my first post as a child psychotherapist in adoption, I was asked what it was that drew me to working in the field of adoption. It was a good question. Rarely are we drawn to working with complex trauma for purely altruistic reasons. I reached for different answers. I knew I had a preference for working within a team and that I was drawn to helping children and adolescents within their families, but I couldn't really answer the question. It wasn't until my mother was dying some twenty years later that I finally found the answer. My mother, while she hadn't been adopted, had suffered multiple separations from her own parents and was raised in her early years by extended family. Of course, the story was hazily familiar to me growing up but the significance of this developmental trauma didn't really "click" until the moment I was about to lose her. By then I had helped many adopted children process their losses, and now faced with the reality of losing my own mother, I began to take on a fresh perspective. I realised then that these "ghosts in the nursery ... from the unremembered past of the parents" (Fraiberg et al., 1975, p. 387), felt during my own childhood and attachment relationship with her, had left their imprint.

This has gone some way to explain the resonances I have felt within the field of adoption and why I have found a home here in my therapeutic work. Like most therapists, I am seeking to understand something about my own history. The *wounded healer* is the first archetype relevant to this work.

The midwife

The second archetype is the *midwife*. The midwife facilitates the giving birth of something new. In this case, it's the helping to forge new attachment bonds between parent and child.

As an integrative child psychotherapist, I have been trained to think about *transference*, the usually unconscious process by which we transfer significant attachment relationships from the past onto others in the present. When working with adoption, there are multiple, complex transferences to take into account: the child's transference onto the adoptive mother which might carry abuse and neglect. This is an important one to understand and work with; both to encourage the parent to understand and so bear it, as well as to help the child drop the filter that hinders their trust in their adoptive parent. There are also the parents' transferences onto me of their own parents and the child's transference onto me as a strange, new person. Perhaps I could, in fantasy, adopt them or have the power to move them to a new family. Traditionally in psychotherapy, transference would be interpreted to help deepen understanding and can strengthen attachment. But here my ultimate aim is to be a trusted facilitator who can provide enough safety so that truthful encounters between parent and child can happen. This is where the real work is done. Not with the therapist, but with the relationship between parent and child. So instead, I mainly make a "silent interpretation", sometimes voiced as recognising the child's anxiety about whether I will like them, whether I will understand their worries and muddles, and help them feel happier in their adoptive family. This then informs how I work with the parent-child interaction.

In this way the midwife is a good image for one of the roles I take on in this kind of work. A midwife accompanies a mother and baby as they meet one another in the real world. Their task is complete once the new pairing is safely made. In adoption, the attachment relationship may begin when older but the journey is similar; it is not without risk and can potentially be dangerous and even life threatening. Here, the midwife provides containment, experience, knowledge, and is there as a guide as they meet one another in moment-by-moment connective experiences.

The alchemist

The third archetype is that of an *alchemist*. Developing a parent and child's attachment relationship is like alchemy: finding the base elements and working with them in such a way that these raw ingredients can be re-formed into the gold of a deepening attachment. "The alchemy of the transformational process turns emotional suffering into resilience and wellbeing: first, through accessing and processing emotional experience to completion, and then, through *metaprocessing* the emergent transformational experience" (Fosha, 2013). During a session, I take something that has happened in the week which is broken and not working very well, and together we take it apart, sift through the details, and look at it together, including the full emotional impact, before putting it back into a story with new meanings that becomes something valuable. I'm aiming to help a child make links and to start to be interested in and curious in the motivations of others, and so to shift assumptions of how the world works. This can be in very small ways, but over time as the iron turns into gold, reflective capacity or mentalizing begins to develop along with a more secure attachment (Fonagy et al., 2016). The process is creative, experimental, emotional, and spontaneous: working in the moment, and drawing past and present together to co-create new meanings and make sense of experiences. Hughes describes this process of conversation as "affective-reflective dialogue" (Hughes et al., 2019). These conversations happen within an overarching relational stance of PACE (an acronym that stands for playfulness, acceptance, curiosity, and empathy) shared by both therapist and parent, which forms the basis of DDP (Hughes et al., 2019).

The archivist

The final archetype is that of an *archivist*. When working with adopted children, it is unfortunately far too common to have insufficient details about their early life. Sometimes we are lucky enough to have access to local authority records that give a flavour of what life might have been like, but with increasing pressure to protect personal data and information, this is becoming less common. It seems incredibly unfair to the children who were there at the time (and to their adoptive parents

who are caring for them now) that they don't have all the information available. Even so, we can hypothesise: sorting through the facts and meanings, preserving key information, and imagining into how those experiences might have felt. Children help by remembering small fragments and these details are pulled together to draw a picture of what life may have been like. Developing a coherent narrative, a story around what happened and leads to where one is now, helps to develop an integrated sense of self as in, "I know who I am, where I came from, and how I came to be here." Trauma has a way of creating rigidity in thinking (Perry, 2002), and the stories that children may have told themselves at the time frequently need to be addressed and revised. DDP is at heart a way of co-creating new stories (Hughes et al., 2019, p. 240) to aid healing through providing new meanings to past experiences. "From these jagged stories of shame and terror that arose from relational trauma, DDP is creating stories of connection, strength and resilience" (Hughes et al., 2019, p. 7).

The following shows how these archetypes of *midwife*, *alchemist*, and *archivist* fit together in a long-term piece of clinical work with a fifteen-year-old young woman and her adoptive mother.

A case: Aisling

Aisling, aged fifteen, was the youngest of a group of siblings all adopted together. Aisling's history was typical of the many children today who are adopted through the care system. She suffered neglect, physical, sexual, and emotional abuse, and had had multiple moves before her adoption at five years old. Aisling and her adoptive mother were not close and a mental health crisis eventually led to her referral for therapy.

Early on in the work, I experimented with keeping Aisling's mother in the room. Usually with adolescents they like to have a more independent space, but in adoption I'm still building the attachment while paradoxically also conscious that an adolescent in brain and body is pressing for individuation. We developed a pattern of beginning with a sharing of the week and highlighting an interaction between them which we would explore together.

In this dialogue taken from a session, Aisling and her mother had had an argument on their way to therapy and nearly didn't make it.

The argument had started over changes happening at home that meant her mother's attention had needed to shift towards her siblings. As we thought about this together, and meanings were made about how painful it was to have felt the loss, we got to the stage of making repair. For many adopted children, if they don't yet have a coherent narrative about their own past traumatic experiences, it can be difficult to know where to start. But it is crucial to do so if they are to build a more secure attachment relationship with their adoptive parents. Here, I use a technique developed by Hughes (2011, p. 63) as "speaking for the child"—a way of leading the child into an exploration of their internal world. This isn't about putting words into children's mouths so much as making a bridge for the child to speak to the parent themselves. Permission from both the child and the parent is important, as is safety, trust, and my own thorough understanding of the history. I speak about what I know. It arises out of the therapeutic relationship, and knowing how to pitch it and when to go in is one of the most risky things I can do. Cues are taken from the child and I step out in a titrated way. Sometimes the step is too great and the child is not yet ready, so tiny steps need to be taken backwards and forwards. It's important that both the child and the parent are comfortable. At the beginning of this vignette, Aisling and I speak together to try to draw out the complexity of what she is thinking and feeling. The mother is listening to us before I draw her in and speak for Aisling.

Speaking for the child

Therapist: How are you doing? You look quite sad actually. But I think you might still be angry. Maybe a little bit less? Your Mum is looking at you. [*Aisling nods*] But you can't quite bring yourself to look at her yet. This is the bit that isn't so easy for you. How do you reconnect? How do you do it? It's a tough one. Would you like to be the first to speak? [*silence*] Would you like some help? [*silence*] Shall I have a go? [*silence*]

Aisling: Well ... yeah.

Therapist: I take that as a yes—thank you. Okay, I'll have a go. [*pause*]
*Mum, help me.**

*I have used italic font to delineate where I speak for Aisling.

Aisling: For what?

Therapist: *I'm stuck over here.*

Aisling: I'm not ready to let it go. I'm still pissed off.

Therapist: *I'm still pissed off with you.*

Aisling: Yeah.

Therapist: *Not ready to let go of my anger just yet. So I might need you to hold on just a bit longer. Don't give up on me. I love you really.*

Aisling: Never said I hate you.

Therapist: *Never said I hate you so I must love you really. Wait for me.*

Aisling: Just don't touch me.

Therapist: *Otherwise I might punch you.*

Aisling: In the face.

Therapist: Yup.

Aisling: I don't want Costa with you either Mum.

Therapist: *Because I'm that cross with you.*

Aisling: Don't want to sit down and have chit chat.

Therapist: *So don't be offended if I'm still cross. Or rather, do be offended because I want you to feel something. But we will move on from this. [pause] Okay, it's your turn, Mum.*

Mum: Aisling, I know you're angry with me. I can really see that. And actually, I'm really pleased that you've been able to tell me and show me how angry you are. And I am really sorry that I caused you hurt and pain.

Aisling: Again!

Mum: Again. I'm really sorry. And I'll be here when you're ready. Because I love you and I will always love you. And I know you well enough not to try to touch you. You'll be able to show me when you're ready.

Therapist: *Yup, don't think I want that Costa yet Mum just because you said that.*

Mum: Oh I got that loud and clear.

Aisling: [silence]

Therapist: *Just wait for me.*

Mum: I'll always wait for you. Whatever happens, today, next week, throughout your life Aisling. I'll always be waiting. Because now we've fallen in love as mother and daughter, nothing will ever shatter that ... we will always get back to normal and I will always wait. [pause] You look so sad.

Therapist: Mmm.

Mum: I have a scooping sense.

Therapist: *Don't touch me, Mum.*

Mum: I'm not going to touch you. I just want to let you know that I see. I see how sad you are. I feel how sad you are.

Aisling: [*silence*]

The mother's words were beautiful. Working in this way highlights how crucial it is to work with the parents, to help them be part of the therapeutic process. I can only go as far as I can with the safety of the parent, and building this requires much work. My relationship is not just with the child, but with the dyad. Aisling was punishing her mother, giving her the "silent treatment" before she could be nice to her again. My role here was to work out some way to help them connect and find one another, even while still full of feeling. Sometimes this means reminding the child of what they have.

For adopted children, who have suffered so many losses, love can feel transitory. My words offered a scaffolding to Aisling's own words—either more or less. Reflecting on this piece now, perhaps I might have added a summary at the end, that when her mother has said those words about falling in love and that she was really sorry, there was nothing more to add. It's important that there shouldn't be an expectation of saying, "... and I love you too." Aisling had a lot to be angry about, and her mother was letting her know that she knew that.

As therapists we're in charge of the ending, and sometimes, especially when working with these delicate pieces of affective-reflective dialogue, there can be an urgency in the therapist to make it right. The healer within the therapist pushes for something before the child is ready. All the same, having a way of ending this process contains it. When working with trauma, there needs to be a balance of acknowledging reality while also keeping a hope burning for something different. A summary would have helped, such as, "Sometimes when you don't say very much, so much is happening. Your Mum has said things that deep down you need to know. It's believing it that is hard. You might need to hear these words many times."

Therapy sessions are small times in a child's life. Ultimately, I'm looking for the work to happen when I'm not there, when the connections

are happening outside and the therapy begins to shrink to a small part of a child's life so it's become integrated inside them. Aisling and her mother would often go for a coffee following our sessions, and that combined with the travelling back and forth provided space to reflect together. Many times, cycles begun in therapy would be completed just after and the mother would text me to say a further insight had been made, or they had found a way of connecting again. In this way, the process is about helping children learn how to safely reach out themselves; to know what to do and manage the accompanying fear. We start as a therapist getting something going with the parent's help, then the parent takes over and then finally, the child starts something off that isn't based so much on anger but on curiosity; they're now trying to work something out for themselves.

Just over a year later, I began to see such a shift with Aisling as in the following session, where she started making links herself.

Aisling and her mother arrived sitting at opposite ends of the sofa. A text before the session told me that they had not seen one another all week. The atmosphere was tense. Usually when this happens, I invite the parent to let me know the story in a matter-of-fact way in front of the child. The aim is to have a shared understanding so that we could then work with it. Her mother said that Aisling had been out every night.

As her mother explained to me what happened, she said that she had gone into her bedroom in the evening to say goodnight and plan that the next morning they would be alone in the house so they could spend some time together. In the morning, the mother went to wake her, and Aisling grunted irritably from under the covers and the mother took that as a message that she wanted to be left alone. In the evening Aisling got angry with her mother saying, "You said you were going to wake me and we were going to spend some time together!" The evening ended in a row. Unpicking this became the content of the next session.

"We missed each other"

Therapist: So does that make sense with your Mum as well, why you were angry with her?

Aisling: Mmm?

Therapist: I'm trying to piece it together in terms of when you then saw your Mum. You had an argument with her. You shouted at her last night.

Aisling: Oh, last night.

Therapist: I was thinking that—

Mum: Aisling came home Tuesday night and I put her to bed and I said, "I'll wake you in the morning and we'll spend some time together." And when I went into her room the next morning, she grunted and turned over and I took it as a message to leave her be. It was just Aisling and me in the house yesterday. She was in her dressing gown for the rest of the day and I took that as a message to "*leave me alone*".

Aisling: No!! [*starts coughing loudly and trying to interrupt*]

Therapist: Just hear your Mum out.

Mum: I took that as a message from Aisling: "*Leave me alone*." I was there, I was available. But then last night Aisling was really angry with me because she said, "You said you would wake me! And we were going to spend some time together!"

Therapist: Ahh! So you realised!

Aisling: But at the same time she said I didn't wake up when she came in my room! But I heard her outside talking!

Mum: I didn't go back in until later.

Therapist: Aisling—your Mum is in the middle of a story and she's about to say something about herself. [*to the mother*] Go on.

Mum: I realised that we had just missed each other and I was angry with myself because it was like—I should have done more to try and get through that "Go away"—

Aisling: You say "Go away!" You're being rude and horrible!

Mum: No, no, no, no! Aisling I didn't say any of that!

Therapist: Aisling, listen to your Mum. You're not listening to what she is saying.

Mum: It was what I was feeling. Not what you were doing. I was feeling that you were saying, "Go away! I don't want to spend time with you." And I was angry with myself because I didn't recognise the real message.

Therapist: Which was?

Mum: Which was, “*Mum, I need you.*” And I needed to just get past that “Go away” message to get through to what Aisling really needed.

Therapist: *And I’m feeling miserable ...*

Mum: “*And I need you to hang on to me.*” I think the reason why I was angry with myself was because yesterday morning for whatever reason I was feeling too—whatever—to see past that. I wasn’t feeling robust enough. Does that make sense?

Therapist: Ahh. So what was going on for you, Mum? Help Aisling understand that. Because she isn’t likely to know what you were feeling.

Aisling: I was like ... I woke up and you didn’t try waking me up cos you didn’t want us to spend the morning together.

Therapist: Right.

Aisling: And I was ready to come downstairs and if you were to make the slightest comment about it, I was ready to say, “Well, you didn’t wake me up!”

Therapist: Ohh!

Aisling: The last thing you said to me was, “I’ll wake you up in the morning so we can spend some time together.”

Therapist: Aww. You missed each other!

Mum: We just missed each other! But you know what the great thing is, Roz?

Therapist: You’re talking about it now.

Mum: She let me know last night!

Therapist: Oh, did she?

Mum: But she let me know last night. So I was able to buy the Doritos and the salsa and leave them on the pillow and say, “Aisling, we missed each other yesterday.”

Therapist: Ahh. Lovely, lovely.

Mum: But I’ve got it now.

Therapist: And when you missed her, help Aisling understand what you were feeling cos she obviously didn’t get you right either. So tell Aisling what you were feeling.

Aisling: So when she came in, I didn’t register it.

Therapist: No, I'm not talking about that. I'm talking about—you need to know what was going on for Mum. We know what was happening for you because you explained it, but you need to know what was going on for Mum. So what was going on for you, Mum?

Mum: I just ... we hadn't really spoken since we finished here last Friday. Aisling was very angry with me, wouldn't come to Costa. And at one point she said, "I'm going to wait here!" [*Mum folds her arms grumpily with a frown*] And I thought, do I go to Costa? Or wait? But we decided to go home and she stormed off and we travelled separately.

Aisling: She started yelling at me on the escalator ...

Mum: I wasn't!

Aisling: People were looking at me on the escalator, in the eye. And I thought I'm not going to be publicly humiliated by you and so I said goodbye!

Mum: Aisling—I'm still explaining Wednesday to you ...

Aisling: [*tries to interrupt*]

Therapist: Mum—just a little bracket here. When you explain it, Aisling might be reacting a bit to the "grrr". [*folding arms and frowning*]

Mum: Oh, Okay.

Therapist: It's a little bit touching into her shame. You might need to just temper that.

Mum: Oh, was I?

Therapist: That's what she's reacting to. She's very sensitive about how you might do that.

Mum: Oh, I'm sorry. I didn't mean to do that. Did I do that?

Therapist: I'm not saying it to shame you either! I'm just saying it because she will make more of it than you intend her to. So it distracts from the story which she needs to hear.

Mum: [*turning softly to Aisling*] We had all of that going on. And I know when you left on Monday, we weren't connected in the way that we had experienced before. And then something happened on Monday. And I thought what is going on? And I was so worried about you and worried about upsetting you. And sometimes it feels like I don't know what to do. I don't

know what to do! [*Mum becomes tearful*] It was my “I don’t know what to do” that stopped me on Wednesday.

Aisling: No—I feel bad now. Because when I was with my ex, I didn’t know what to do and when he was acting all psycho I felt useless. And it makes you feel bad. And you haven’t even done anything. Can’t do much. And they’re just angry with you. I know it doesn’t feel very nice.

Therapist: That’s lovely Aisling. You’ve made that connection with what Mum is saying.

Aisling: No—Mum—all the time I sit there and I’m like, I don’t know how she does it when I’m being like—horrible—when I know I can be. Must feel like you’re always on the edge.

Mum: No. It doesn’t always feel like that. But I’m fighting the urge to rescue you. To scoop you up. To wrap you up. To keep you safe. And I know I can’t.

Therapist: And I think that’s lovely. And I think Aisling did need to know that. You said it so beautifully, Mum. And I think it’s lovely for you Aisling—I’ve not heard you do that before, which is immediately make an association with what Mum is talking about with something from your own experience. And now you’re both talking very intimately. It’s really beautiful to listen to and watch. Very intimate. This is love.

Reading this through, it would be easy to see that somehow I had controlled the trajectory of the session. There are many, many threads that could be taken up but it’s important in this case to keep everyone to one simple track so that a process can be completed. When completed, this is integrated and other links made; the sense can be felt in the body. Some interruptions are important but sometimes an animated boundary, as shown above, is a way of pushing through the many deflections. Control issues are a familiar behavioural pattern in adopted children who understandably struggle to feel the good intent in those entrusted to look after them. Not recognising this and not dealing with it head-on by maintaining one’s authority as a therapist can mean the therapy never gets anywhere. Of course, this can only be done after understanding how to build “cues of safety” (Porges, 2017, p. 50) that can be returned to when the autonomic nervous system threatens to move into overwhelm.

By this stage, Aisling did trust me so I could risk halting the deflections more directly.

At a deeper level, which we returned to many times in our work together, the dialogue reveals the painful expectation in Aisling that her mother would have understood her communication when she grunted from under the covers. The longing she felt inside to be understood and welcomed in that moment of waking had its origins in her neglectful history. Underneath Aisling's rejecting behaviours of "go away" was the opposite longing to have her mother push past these defences. What is also revealed is how incredibly difficult it is for adoptive parents without help and support to recognise the meanings behind these rejections and to be persistent. These daily interactions are rich with potential to strengthen attachments and find meaning and this is why it becomes so important to use the therapy to unpack them in this way for both parents and children.

Working with dissociation: the "five-hour brain"

Alongside working with the attachment relationship between Aisling and her mother, we were also working with the developmental trauma and the resultant dissociation in a multilayered treatment. In the context of Aisling's developing attachment to her adoptive mother, it would then become safer to look at the trauma, and as the trauma was processed, it in turn would become safer to draw closer to her adoptive mother. The two processes are worked with in tandem. As Herman states, "There is no single, efficacious 'magic bullet' for the traumatic syndromes" (1997, p. 156).

Dissociation in adopted children has often been overlooked but more has been understood about its significance in recent years (Silberg, 2013; Wieland, 2011). It makes sense with very young children, when faced with extreme trauma that they cannot run away from or fight, and often at the hands of people close to them, that they would dissociate. Dissociation acts like a buffer; an involuntary way for a baby or young child to protect themselves by creating a distance from unbearable, overwhelming circumstances around them that threaten their very survival. We all have the capacity to daydream from birth, but trauma takes this to a

whole new realm. Faced with terrifying violence and shouting around them, a young child might focus on a favourite toy—something that helps them to escape from their present reality. This toy becomes a helpful “part”, taking on a life of its own in the child’s imagination, becoming a hero and saving the day. Aisling focused on pictures in a catalogue of happy families and would imagine jumping into this ideal world to escape from where she was. She also developed other “parts” which gradually became known during our work together.

Right from our first session together, Aisling was clear that she didn’t want to use any art materials; but she did agree to draw her brain. I showed Aisling an iPad app of the human brain, pointing out the different regions. Psycho-education and explaining some of the neurobiology around the brain in a very simple and basic way helps children recognise that it’s not their fault that they find life a struggle. Instead, there are “muddles” in their brain (Marks, 2011, p. 92) and therapy can help make their brains “*stronger*”. This idea helps motivate children without pathologising them; after all, it must be a clever brain that can work out how to dissociate in order to manage extreme trauma.

Having explored the brain a little, I suggested that Aisling draw what she thought was her own brain. I’m often amazed at how children know that there is something “not quite working” with their brain and how accurately they draw it. The first drawing Aisling did was drawn so faintly in yellow that the writing could hardly be seen, bringing to mind a dissociative quality (Figure 15.1). She described her brain as being like a computer that could only store information for five hours, so that whatever happened during the day at school she would later completely forget. A large part of her brain was “memory that I can’t remember”, and the remainder “mixed feelings—angry but sad underneath everywhere”. She had a tiny corner that was happiness, but even then, it was about reassuring everyone else that she was happy when she wasn’t really.

From here, I drew her awareness to her body, where she noticed comfortable spots and ranges of temperature. Her body tended to shift states very quickly, common in developmental trauma (Levine, 1997), but she found walking around the room and moving her legs and arms opened her up to talk more.

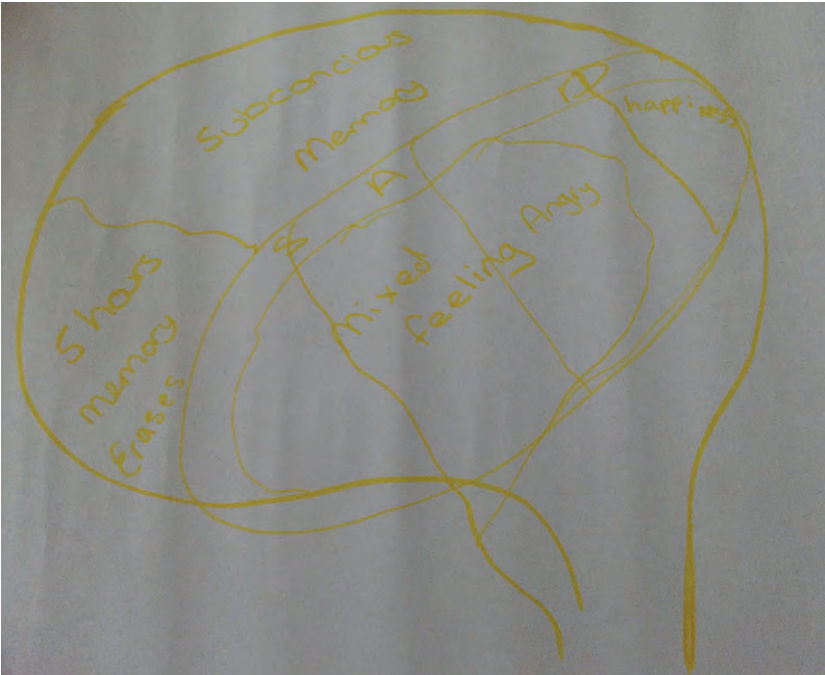


Figure 15.1 Aisling's first drawing of her brain

I soon got to experience for myself how Aisling's "five-hour brain" worked. The early sessions were marked by a thick, heavy dissociation that felt like a pea-souper in the room. Aisling herself would arrive looking different for every session, with different hair, make-up, style of clothes, voice, and way of holding her body that suggested different ages. These were the multiple "parts" of her that helped her survive various traumatic events. I would find myself constantly moving to try to stay awake—the tiredness being a common countertransference when there is dissociation. Movement helped shift the energy in my body but I still found it hard to think. Sometimes the fog would lift but sometimes it would remain there throughout. Sometimes when it lifted, a hostile, potentially violent "part" of Aisling would be exposed and I did have sessions which finished suddenly with shouting and angry slamming of doors while walking out. At least once, I did a session over the phone while the mother put the loudspeaker on in the car so that my voice could be heard. Aisling was silent but her mother's descriptions helped me track what was happening and whether my interventions were being

helpful. Sometimes I sent emails to Aisling, particularly in the breaks, and many times I emailed and texted the mother out of hours to support the transitions around the work. However, throughout all of this, Aisling showed her own resilience and very rarely missed a session, returning the following week supported by her willing mother. Her engagement, even if it was difficult, told me that she was getting something even if I was not always sure at the time what it was.

Towards the end of our first year of work together, I asked Aisling to draw her brain again. This second drawing was a great deal richer than the first and noticeably, the “five-hour brain” had become smaller (Figure 15.2). Some of the dissociative “parts” had begun to make themselves known in our work together as we began to understand how they had developed at various stages in Aisling’s early life to help her survive unbearable experiences. We were at the beginning of understanding their stories and why they had come to live within Aisling. A level of “co-consciousness” between the parts was also developing so that the dissociation was lessening. Different parts were becoming aware that there were others within a system.



Figure 15.2 Aisling’s second drawing of her brain

In one session, Aisling recounted a dream she had had in the week of how a man had pushed her into a car boot and driven her to a garden centre where they met a woman and two children aged three and six. The woman disappeared and the man put magnets into the hands of all three children and wrapped them around a pole. The three-year-old managed to get out and went to call for help. People came from a cake shop and the man was scared off. The dream ends with Aisling in tears and praising what the three-year-old did. Through the dream two important “parts” who had helped Aisling survive had been identified. As we explored the dream together, how young she was, and what a responsibility she had taken upon herself while so young, Aisling began to realise the inappropriateness of the three-year-old part’s role and said that she needed to be “relieved of her duties”. Furthermore, Aisling began to realise that neither the three-year-old nor the six-year-old parts were aware that they had been adopted. This is relatively common in adopted children with dissociation, where younger parts may be “frozen in time by the trauma and may be unaware of the existence of the adoptive parents” (Marks, 2011, p. 102).

Together we devised a drama to work with these parts. We found cushions and a teddy bear to represent the three-year-old part and buried it under some cushions with Aisling saying she was “trapped because of fear”. Aisling felt she would like to be her sixteen-year-old self who would help bring the three-year-old part to her adoptive mother. Together we planned how the drama would unfold: Aisling would take the bear, wrapped in a soft blanket, and present it to her mother. The mother was asked to sit on the sofa and it was explained that, “Three-year-old Aisling was trapped and needed rescuing.” Aisling collected the bear and carried it in the blanket and then questioned her mother: “Will you look after her and keep her safe? Will you love her? Adopt her?” The mother took the bear into her arms, and movingly reassured the three-year-old part that she was wanted and loved. It’s important to note here that I didn’t work directly with the younger parts myself; my role was to support Aisling in caring for her own parts—this ultimately is what helps support integration.

After two years, Aisling drew another more colourful brain (Figure 15.3). The dissociation was becoming better understood, a complex system was being revealed, and a level of co-consciousness was

happening with the parts of Aisling becoming more aware of the others with different ages and functions. After she had completed the new drawing, we would look at the older ones and these served to encourage her that more was becoming known. Over time, Aisling developed her own strategies for managing her different parts when they were clamouring for attention by saying, “Hey, guys” as a way of calling them all together.

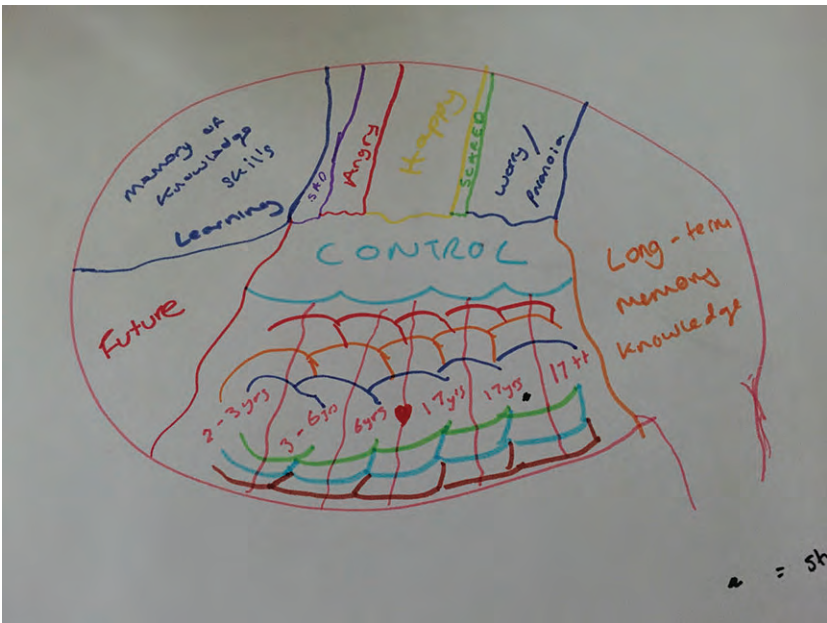


Figure 15.3 Aisling’s third drawing of her brain

Aisling had always been aware of various bodily symptoms that over time we realised were connected to her different “parts”. For instance, with one “part”, she would have more painful hips and pelvic area and this helped us have an understanding of who was particularly active. Aisling would often want to take her shoes off and curl up on the sofa in the therapy room under a soft blanket, allowing her body which held so much trauma to relax.

In one session, Aisling described herself as struggling all week because she had been hearing “all the parts inside talking all at once and making a lot of noise and I can’t shut them up”.

She drew a picture of herself as having layers, drawing another image inside and then further images on the outside (Figure 15.4). Around her was “electricity”. She described how the bodily sensation was in her bowel and drew rings around that area, but when she had finished the drawing, we realised that she had drawn the centre on the bowel of the one that was her, but around the genitals of the little “part” inside her. This drawing became significant in her understanding of how the trauma of her sexual abuse had been somatised in her body. Here her “drawing hand” had been able to give clues from the non-declarative memory system in her brain. We had discovered that not all the “parts” knew, but some did,

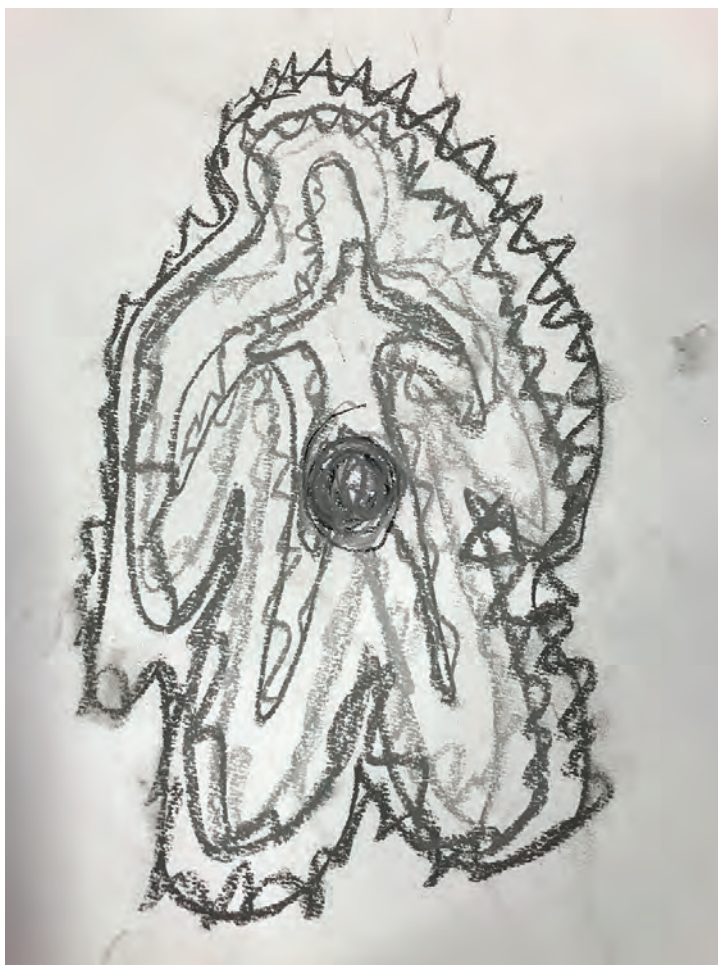


Figure 15.4 Aisling's drawing of the activation in her body

and the drawing hand that had not been forbidden to speak revealed more (Magagna, 2012, p. 130).

Adoptive families need more than just the therapist; they need a team around them and so the work included other important elements which I've not included here. The "team around the family" (TAF) is something of a cliché, but when it really works, it has potential to be the transformative space that Bion (1962) had in mind with "the container-contained". Part of the system includes supervision in the different models, bringing them together in a way that ensures quality and coherence, so that it doesn't become a mess. In concentric circles with Aisling at the heart, then her parents, then me, my colleagues, and then finally the enveloping of the wider professional system around everyone, it offered an arousal to soothing cycle of a thinking and understanding space.

The work with Aisling ended a few years ago. But when preparing this chapter, I asked Aisling if there was anything she wanted to say, reflecting back on her therapy. Using a metaphor, she said, "My brain was a jigsaw all jumbled up in a box, and therapy with Roz was like putting it out on a table looking at every piece individually and putting it back together in the right order. I put the puzzle together because in that room she gave me the courage and safety to look at every piece from every angle. That really helped me."

Conclusion

The "parts" of Aisling stepped forward to lead at various points depending on the presence and the nature of the trauma. In a similar way, the various "parts" of me as archetypes step forward therapeutically depending upon which therapeutic challenges and goals are present in the moment. Over many years in therapy, I have learnt about the various parts of me so that I have become aware of their qualities, roles, and usefulness. Likewise, successful therapy brings awareness and eventual integration to the client's various parts.

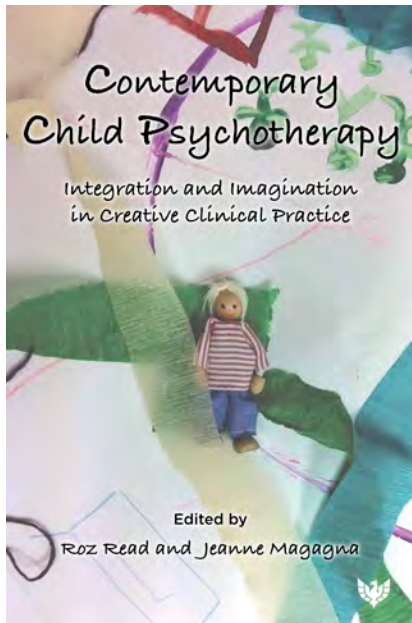
Working integratively means that the therapist is not confined by one particular theory or a given framework through which to see their client, but instead works in a uniquely creative way to bring different theories together into a congruent whole. This means that the therapist can address the individual needs of a client and at the same time draw upon the range of theories and tools that are most relevant to them. All

of this has a context within the history and experiences of the therapist, their strengths and passions, that can contribute meaning to the work. In this chapter I have attempted to show how I have integrated using the arts, DDP, and the body with an understanding of attachment, trauma, and dissociation to help a developmentally traumatised adolescent. The archetypes of “wounded healer”, “midwife”, “alchemist”, and “archivist” are just some of the images that reflect the approach of an integrative child psychotherapist when they work with children and families. Of course, one is not limited to just these; the beauty of this work is that other therapists may develop their own.

References

- Bion, W. R. (1962). *Learning from Experience*. London: Heinemann.
- Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2016). Reconciling psychoanalytic ideas with attachment theory. In: J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment*, 3rd edn. (pp. 780–804). New York: Guilford.
- Fosha, D. (2013). A heaven in a wild flower: Self, dissociation, and treatment in the context of the neurobiological core self. *Psychoanalytic Enquiry: A Topical Journal for Mental Health Professionals*, 33: 496–523.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant–mother relationships. *Journal of the American Academy of Child Psychiatry*, 14(1): 387–421.
- Herman, J. (1997). *Trauma and Recovery*. New York: Basic Books.
- Hughes, D. A. (2011). *Attachment-Focused Family Therapy Workbook*. New York: W. W. Norton.
- Hughes, D. A., Golding, K. S., & Hudson, J. (2019). *Healing Relational Trauma with Attachment-Focused Interventions: Dyadic Developmental Psychotherapy with Children and Families*. New York: W. W. Norton.
- Levine, P. (1997). *Waking the Tiger—Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences*. Berkeley, CA: North Atlantic.
- Magagna, J. (Ed.) (2012). *The Silent Child: Communication Without Words*. London: Karnac.
- Marks, R. (2011). Jason (7 years old)—expressing past neglect and abuse: Two-week intensive therapy for an adopted child with dissociation. In: S. Wieland (Ed.), *Dissociation in Traumatized Children and Adolescents*, 2nd edn. (pp. 89–134). New York: Routledge.

- Perry, B. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind*, 3: 79–100.
- Porges, S. W. (2017). *The Pocket Guide to The Polyvagal Theory: The Transforming Power of Feeling Safe*. New York: W. W. Norton.
- Silberg, J. L. (2013). *The Child Survivor: Healing Developmental Trauma and Dissociation*. New York: Routledge.
- Wieland, S. (Ed.) (2011). *Dissociation in Traumatized Children and Adolescents: Theory and Clinical Interventions*, 2nd edn. New York: Routledge, 2015.



**FULL EDITION AVAILABLE FROM
WWW.FIRINGTHEMIND.COM**

