Attachment Theory and Art Therapy: Indications of Attachment in the Art Therapy of Two Children with Disruptive Behavior Disorders

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Abstract

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Linking art therapy to attachment theory, this paper hypothesizes that children re-enact, and have the opportunity to repair, their attachment styles in art therapy through the art materials and their artistic process. Children's art in art therapy provides tangible indicators of their attachment styles. The focus is on two insecure ways of attaching, which are the avoidant and resistant/ambivalent attachment styles. Establishing a secure base in art therapy is explored; the therapist does this through the art materials and how he/she responds to the client. Providing a secure base enables the art therapist to help children repair insecure attachment styles. Certain art materials and/or activities are described as indicating attachment because they have qualities that symbolically relate to attaching and detaching, which are attachment behaviors. These behaviors are explored through the acts of taping, gluing,tying, stapling, and cutting. The paper finishes by drawing conclusions regarding which art activities seem to relate to the children's hypothesized attachment styles.

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Introduction

In this paper, I explore attachment theory and the implications of using this theory in art therapy. The purpose of this paper is to begin to make links between art therapy processes and products, and the basic tenents of attachment theory. Several questions have guided me in my research. Most importantly, how do attachment theory and art therapy inform one another? Does art therapy have any particular value from an attachment perspective? What does attachment theory have to offer to art therapists? I believe that connecting art therapy and attachment theory will expand the current modes of viewing both the art and therapeutic relationship in art therapy. In my opinion, a major strength of this association is that art therapy provides tangible and clear examples of the concepts in attachment theory.

In this research paper, I hypothesize that art therapy can be valuable in assessing attachment styles. From my experience, children use art materials, particularly materials that symbolically relate to the acts of attaching and detaching, to express their issues of attachment. I further postulate that art therapy is an effective means of treating children who use insecure attachment styles. Through the art making process and the therapeutic relationship, children have the opportunity to re-enact their attachment styles and repair their insecure attachments.

I will specifically explore how art therapy informs attachment theory with children who have Disruptive Behavior Disorders and a history of physical and/or psychological maltreatment. My underlying premise in this paper is that attachment problems, in the form of insecure attachment styles, are linked to the later development of Attention-Deficit and Disruptive Behavior Disorders.

Attention-Deficit Hyperactivity Disorder (AD/HD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), are all classified as Disruptive Behavior Disorders and seem to have some relationship to problems of attachment. The history of people with

Disruptive Behavior Disorders often suggests inconsistent upbringing. Inconsistency in upbringing may take the form of neglect, abuse, or interrupted parenting (Reid & Wise, 1995). Forms of maltreatment and inconsistent parenting suggest that the attachment relationships of children who have these disorders has not been optimal, and that these children may be insecurely attached. Thus, using attachment theory seems to be an excellent way for clinicians to orient themselves to children who have been diagnosed with Disruptive Behavior Disorders.

For this research paper, I follow two children whom have each been diagnosed with AD/HD; the girl has been additionally diagnosed with ODD and the boy additionally with CD. Both children come from families where inconsistent parenting and interrupted parenting have been issues. Throughout my paper, I use vignettes from their individual therapy to illustrate my points, which means that I select specific instances in therapy. This approach is different than a case study where the child's progress is followed throughout the course of therapy. The reason for choosing this methodology is to isolate and then explore the most pertinent examples of the *resistant/ambivalent* and *avoidant* attachment styles[1]. This allows for a more in-depth examination of attachment issues, which is one of many issues in therapy with children, and therefore, I use case vignettes out of a necessity to stay within the parametres of this paper. From these case vignettes, I demonstrate how each style can be assessed through the art, examine how these children re-enacted their early attachment styles in art therapy, and discuss their individual reparative experiences through art making and the therapeutic relationship.

Looking at how attachment evidences itself in the artwork of the two children I discuss, enables the art therapist to gain an awareness of the theory. Although I am not proposing a model of attachment based art therapy per se, I do believe that the way in which these children manifested their attachment styles through art materials could be generalized to some extent to other work with children. Therefore, although the examples I

am using are specific to these children, they can be thought of as a beginning stage of inquiry into how art therapy informs attachment theory and vice versa.

My research paper consists of four chapters. The first chapter gives an overview of attachment theory; the main theoreticians that I discuss are John Bowlby (1969, 1977, 1988), who is the originator of attachment theory, and Mary Salter Ainsworth (1978), who worked with Bowlby and was instrumental in developing assessment procedures for attachment. I also refer to the contemporary authors Beverly James (1989, 1994) and John Pearce and Terry Pezzot-Pearce (1997) who have linked attachment theory to neglect, abuse and trauma. I then discuss the Disruptive Behavior Disorders and link attachment theory to these disorders. My second chapter gives a case outline of the two children, and hypothesizes their respective attachment styles. The third chapter outlines Bowlby's conception of the *secure base* and then applies this to art therapy through the use of Judith Rubin's *Framework for Freedom* (1978). I elucidate the idea of a secure base in art therapy through case vignettes. The fourth chapter looks at indicators of attachment in the process and products of art therapy. Here I expand upon the proposed attachment style of each child through a discussion of their artwork, using the theories of Bowlby. I use some of Donald Winnicott's concepts to expand on the understanding of attachment theory. The fourth chapter also discusses attachment theory and termination in art therapy, drawing primarily upon the concepts of Jeremy Holmes (1997).

Chapter One

Overview of Attachment Theory and Disruptive Behavior Disorders

1.1 Brief History of Origins of Attachment Theory

Attachment theory has its beginnings and development in the work and writings of a British psychoanalyst named John Bowlby. Bowlby began writing in the 1940's. His articles contained the central thoughts about the importance of early family interaction that later developed into attachment theory (Bretherton in Parkes, Stevenson-Hinde, & Marris, 1991). Bowlby trained in psychiatry and psychoanalysis and had Joan Riviere, a friend and follower of Melanie Klein, as his analyst. Despite his training with analysts and psychiatrists at the British Psychoanalytic Society, Bowlby developed his own ideas and was more influenced by two social workers he met while he was employed at the London Child Guidance Clinic upon finishing his training (Bretherton in Parkes, Stevenson-Hinde, & Marris, 1991).

During the 1940's, around the time that Bowlby began his career as a psychiatrist, the British Psychoanalytic Society was divided into three major groups that had different ideas about psychoanalytic theory and technique (Mitchell & Black, 1995). One group followed Melanie Klein's ideas about psychoanalysis. Anna Freud headed another group that kept with Freud's views. The third group fashioned new concepts that came to be known as object relations theories. This group believed that babies were born with the instinct for "harmonious interaction and nontraumatic development" that could be thrown off track when parenting was not adequate (Mitchell & Black, 1995, p. 114). John Bowlby was a major figure in this last group. Other key clinician/theorists in what later became known as the Object Relations school of thought were D.W. Winnicott, W.R.D. Fairbairn, Michael Balint, and Harry Guntrip (Mitchell & Black, 1995). Their individual approaches, that grew out of the common belief stated above, were distinct from one another.

Bowlby's unique approach included his criticism of the Kleinian and Freudian emphasis on the child's fantasy world and the indifference paid to the child's actual life and experience of lived events. He felt the child's early family experience was paramount to later healthy or disturbed development. His ideas contrasted with many of his Kleinien and Freudian contemporaries in the field, who placed much more emphasis on the child's internal world. This was the case when he worked with Kleinians at the Tavistock Clinic. Bowlby wished to study family interaction, which Kleinians saw as irrelevant to child development (Bretherton in Parkes, Stevenson-Hinde, & Marris, 1991). His ideas were controversial for his time, but he persevered and supported the concepts he developed through his continued inquiry.

Natural observation played an important part in researching attachment; ethology, empirical data, and scientific study also became important buttresses of attachment theory. Bowlby (1969) compared the work of Konrad Lorenz and imprinting in animals to attachment in humans as achieved through learning the characteristics of the object. Because he could not do his research at Tavistock Clinic, Bowlby began a clinic of his own and invited other professionals to join him to do observational work (Bretherton in Parkes, Stevenson-Hinde, & Marris, 1991). Mary Salter Ainsworth was a part of this staff and was instrumental in developing the *Strange Situation*, along with B.A. Wittig in 1969, which is a scientific study that assesses attachment styles (Bretherton in Parkes, Stevenson-Hinde, & Marris, 1991). The *Strange Situation* is discussed in section 1.3. Bowlby and other professionals attached human psychology to the study of animals, and showed attachment theory's basis in biology and ethology; they also studied human behavior through scientific means. As Bowlby and clinicians around him continued to ground attachment theory through observation, attachment theory became more respected.

Many theorists have continued to expand upon the ideas of attachment theory. For the purposes of this chapter, I will primarily be using the texts of Bowlby and Ainsworth, who are the originators of attachment theory. I will also use the work of contemporary

attachment researchers who have written on attachment theory, the most crucial to my discussion are Beverly James, Jeremy Holmes, and John Pearce and Terry Pezzot-Pearce.

1.2 Definition of Attachment

According to Bowlby, attachment theory is a model of infant-mother interaction that functions in a primarily harmonious fashion, unless external difficulties and conflict disturb the interaction (Holmes in Goldberg, Muir, & Kerr, 1995). In this respect, attachment theory emphasizes the interpersonal over the intrapersonal; Bowlby saw the relationship, or interaction, between the dyad as paramount to development of the infant. Bowlby felt the unconscious held portrayals of the interpersonal world, rather than "a cauldron of fantasy" (Holmes in Goldberg, Muir, & Kerr, 1995, p. 26), emphasizing that our internal world was organized around the external reality. In Bowlby's view, children experience pleasure from proximity to their primary caregivers, play, and nurturance. This ties in with Holmes' (in Goldberg, Muir, & Kerr, 1995) postulation that the key issue in attachment theory is space, rather than power. The child varies the amount of space between him/herself and the parent according to the amount of security needed. Space and proximity are expressions of the relationship. Therefore, attachment can be seen as a spatial/relational theory where the child is in relation to his/her loved one, rather than one where the child thinks only of power in terms of what the child can do or have done to him/her. Bowlby (1979) downplayed the sexuality that Freud felt was instrumental in childhood fantasy life, and instead spoke in terms of the ambivalence children feel between love and hate inherent in their relationships with their primary attachment figure.

Bowlby (1979) describes attachment theory as "a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional detachment, to which unwilling separation and loss give rise" (p. 127). Therefore, attachment relationships are both a source of love or nurturance, and of conflict. Children engage in attachment behaviors in order to have needs

met and to avoid separation and loss, which are naturally not desired as separation can endanger the child. Loss and separation are very traumatizing experiences for the child because the infant totally depends on parents for care and security. Children feel longing and wish to restore contact when their attachment figure is absent. Infants also feel rage when their desire for love and care is frustrated, and anxious and fearful about losing their attachment figures. Children experience ambivalence about simultaneously loving and hating parents. Bowlby emphasizes that attachment behaviors are natural behaviors in humans.

James (1994) further refines the definition of attachment; she explains that "an attachment is a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver. The child receives what she needs to live and grow through this relationship, and the caregiver meets her need to provide sustenance and growth" (p. 2). Attachment relationships are ways of having our needs met, particularly in the sense of achieving felt security. More succinctly, attachment bonds provide children with security, and this is what differentiates them from friendships or other social relationships (Lieberman & Pawl in Belsky & Nezworski, 1988).

Infants and very young children usually have a preferred or primary attachment, who is often their mother (James, 1994). The primary attachment figure may enlist others in caring for the child, but usually the child gets comfort and security mainly through this primary attachment in the first few years of life. Children form other attachments as they mature, which may include grandparents, other relatives, close family friends, and teachers. As children grow older, their attachment behaviors decrease and become more internalized (Cicchetti & Toth in Goldberg, Muir, & Kerr, 1995). During the process of growing up children develop internal working models, which are their psychological representations of how they relate to others based on their early experiences with primary attachment figures (for a further discussion see section 1.4).

1.2.1 Role of the primary attachment figure.

James (1994) states that the primary attachment figure acts as a protector, provider and guide. The following quote (James, 1994, p. 2) gives an excellent description of how parents take on these three roles in their everyday interactions with their children:

- As *protector*: "Everything will be OK. I'll take care of you, set limits, and keep you safe."
- As *provider*: "I'm the source of food, love, shelter, excitement, soothing, and play."
- As *guide*: "This is who you are and who I am. This is how the world works."

Belsky and Nezworski (1988, p. 9) argue that principle caregivers who can provide a "sensitive regimen of care" should be able to negotiate a secure attachment relationship with a child, irrespective of the child's temperament. This is a controversial issue, since it places prime responsibility on the parents for the quality of the relationship and child's attachment style. The parent's attunement and sensitivity to the child's temperament and what that child needs to securely attach become paramount. The parents need to recognize if their child is more or less vulnerable to distress and adjust their parenting styles accordingly (Belsky and Nezworski, 1988).

The primary caregivers' attunement and sensitivity influences their ability to manage and tolerate their own feelings in relationship to their child. I have described the ambivalence inherent in attachment relationships mostly from the child's perspective (section 1.2), but this ambivalence is also apparent in parents (Bowlby, 1979). Parents have had their own attachment relationships and may re-enact those patterns with their own children. Often the problems that parents have with their children result from their difficulty in regulating their own ambivalence. Along with intense love and devotion, parents experience a mixture of resentment, and even hostility and hatred towards their children. These feelings can be horrifying to parents, and difficult to confront and understand. Trouble in the relationship between caregiver and infant does not arise because the parent

has these feelings, but instead difficulties manifest when parents cannot tolerate or regulate these feelings (Bowlby, 1979). Therefore, an important part of the role of primary attachment figures is to consciously deal with their own feelings and experiences that arise from being a parent.

The role of the primary attachment figure is relevant to therapy with children because if the parent cannot adequately fulfill his/her roles, difficulties may arise that lead the family to seek help for the child. The role of primary attachment figure acts as a model for how the therapist who uses attachment theory orients him/herself to the child, since the child's representation of the attachment relationship characterizes how the child relates to the therapist. (See section 3.1 and 3.2 for a further discussion.)

1.3 The Attachment Styles

The *Strange Situation* developed by Ainsworth and Wittig in 1969 is a laboratory observation procedure that allows researchers to study the "interplay of attachment and exploratory behavioral conditions under conditions of low and high stress" (Bretherton in Parkes, Stevenson-Hinde, & Marris, 1991, p. 23). The interesting aspect of the experiment was the children's behavior on being reunited with their mothers. Ainsworth (1978) found that the children's separation behavior did not act as a good indicator of attachment style, since many securely attached infants acted in similar ways to insecurely attached infants during separation. Their behavior upon being reunited however, was markedly different, and indicated the securely attached children's "competence in expressing their needs directly, and their unambivalent acceptance of maternal ministrations" (Goldberg in Goldberg, Muir, & Kerr, 1995, p. 4), which was not the case with insecurely attached children . Ainsworth and her colleagues (1978) validated the research by connecting the children's laboratory behavior to their behavior at home. From that, she identified and explained three main attachment styles. In the original classification research, Ainsworth described the following as the main attachment styles that children use: *secure*, *avoidant*,

and *resistant or ambivalent*[2]. The *avoidant* and *resistant or ambivalent* styles were both identified as being insecure styles, as opposed to the *secure* attachment style.

The *secure* type (Type B) was the most common of the attachment styles and Ainsworth saw this as the ideal style (Ainsworth et al., 1978). Secure infants were able to use their mothers as secure bases for their exploration and would check to see where their mothers were from time to time. When their mothers left the room, the secure infants limited their exploration and varied in their level of upset from individual to individual. Secure infants were alike in that all the children responded by actively seeking their mothers upon being reunited. Children who were more upset upon reunification tended to need more physical reassurance.

Securely attached children usually ask for their parent's help; they accept comfort and nurturance from their parents when they need it (James, 1989). These children have loving and close relationships with their parents that provide them with security so that they can explore the environment and master developmental tasks. Bowlby (1979) states that a child whose parents have established a secure base, and thus are securely attached have "built up a representational model of himself as being both able to help himself and as worthy of being helped should difficulties arise" (p. 136).

The *avoidant* type (Type A) of attachment was found by Ainsworth to be the next most common (Goldberg in Goldberg, Muir, & Kerr, 1995). Infants who were classified as avoidant explored the environment without showing concern about their mothers; they did not use their mothers as a secure base (Ainsworth et al., 1978). They did not check to see where their mothers were and did not seem distressed when their mothers left the room. Upon being reunited with their mothers, these children seemed to ignore and rebuff their mothers.

Ainsworth described *resistant/ambivalent*[3] children (Type C) as not exploring, or having difficulty exploring, on account of problems with separating from their mothers (Ainsworth et al., 1978). These children often had poor and underdeveloped play styles.

When their mothers departed, they became extremely upset, and when their mothers returned the children sought contact but did not calm or settle easily. Often they did not settle enough to return to exploration.

Although these three types sufficed to describe most infants, later research in the 1980's and 90's with maltreated children led to the additions of Type A/C and Type D attachments (Cicchetti & Toth in Goldberg, Muir, & Kerr, 1995). Researchers saw behavior by maltreated children that did not fall into the existing categories. Maltreated infants and toddlers at some point used all three strategies, sometimes avoiding their mothers and at other times resisting or acting securely with her (Type A/C). Type D referred to disorganized or disoriented behavior also found in maltreated children: in these cases children reacted to caregivers by freezing, using stereotypies, or responded to attachment figures in a generally fearful manner.

Following Ainsworth's original *Strange Situation*, many researchers continued to do research on attachment styles, most of which has focused on infancy (Goldberg, Muir & Kerr, 1995). However, as Bowlby clearly stressed that attachment theory spans across the life cycle, more researchers thought other age groups needed to be studied and began to develop ways of assessing people's attachment styles at different ages. As a result of this, researchers developed additional classification schemes for pre-schoolers, 5-7 year olds, adolescents and adults. Of note, no classification scheme is available for 7-11 year olds (Goldberg in Goldberg, Muir & Kerr, 1995), which is unfortunate for therapists working with this age group. Despite this, clinicians can view children's attachment histories through the "manner in which a person forms (or fails to form) a therapeutic alliance and the nature of transference, resistance, and dependency within treatment" (Goldberg in Goldberg, Muir & Kerr, 1995, p. 8).

In looking at the secure and insecure attachment styles, we may fall into the misperception that only securely attached children behave in an adaptive style. This is not the case. Whatever attachment styles children use, secure or insecure, their attachment

styles are considered to be functional. Insecurely attached infants have adapted to the way they are cared for, irrespective of the fact that these ways of relating may later be problematic in school and society. Seen from this perspective, "insecure relationships are considered to be functional in that they serve to protect the child against anxiety, which arises in the face of a caregiver who may be less than optimally available" (Belsky and Nezworski, 1988, p. 8).

1.4 How Attachments Effect Relationships in Later Life

A basic belief of attachment theory is that early relationships influence later ones (Bowlby, 1969). Bowlby (1979) describes attachment behavior as "any form of behavior that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser" (p. 129). This behavior is particularly noticeable in children. Attachment behavior includes "crying and calling, which elicit care, following and clinging, and also strong protest should a child be left alone or with strangers" (Bowlby, 1979, p. 129). Although attachment behavior is most evident until the age of three, people continue to use attachment behaviors in latency, adolescent and adult life (Bowlby, 1969). For example, a six year old may grasp at her parent's hand while out walking and be angry if the parent refuses to hold hands. A ten year old may seek a parent or surrogate-parent when something goes wrong on the playground, or he if becomes scared. The main difference in these attachment behaviors over the life span is that the frequency and intensity decreases as people grow older.

It is important to note that attachment behavior serves many adaptive functions and that these ways of relating are important parts of human's "behavioral equipment" as Bowlby (1979, p. 129) calls it. As they grow older, people may draw upon their attachment styles as coping mechanisms when they are "distressed, ill, or afraid" (Bowlby, 1979, p. 129). Attachment also includes other intense emotions such as falling in love, and maintaining close *affectional bonds*[4] with others. Therefore, our emotions reflect the state

of our affectional bonds (Bowlby, 1979). Bowlby conceptualized attachment behavior throughout life as a valuable and necessary part of human functioning and relating.

Internal working models are an important concept related to attachment behavior across the life span. Children develop cognitive models of themselves, others, and how relationships work between self and others, from their interactions with their early caregivers (Bowlby, 1982). These cognitive models, that Bowlby termed internal working models, influence the quality of their later relationships as people then impose these models on other figures in their lives (Pearce & Pezzot-Pearce, 1997). For example, a school aged child imposes her internal working model onto teachers, baby-sitters, and other children. She would also use this internal working model to understand and react to her therapist, using an attachment pattern such as avoidant, resistant/ambivalent, or secure, in that relationship.

Bowlby (1979) felt that the models children develop of self and others during childhood may endure into adult life almost unchanged. Carson and Goodfield (1988) have done research that shows that internal working models can be changed, but that it is extremely slow difficult work. Children begin developing internal working models very early in life along with their attachment to parents. Children's internal working models determine secure or insecure attachment style and play a crucial role in later development.

1.5 Discussion of Attention-Deficit and Disruptive Behavior Disorders

In order to understand how insecure attachments can be linked to the later development of one or more of the disorders that is described under the heading of Attention-Deficit and Disruptive Behavior Disorders in DSM-IV, I first describe the main features of Attention-Deficit/ Hyperactivity Disorder (AD/HD). Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are described mainly in how they relate to AD/HD. I will concentrate mostly on AD/HD since this is the most commonly diagnosed disorder of childhood (Weiss in Lewis, 1996), and in children with AD/HD symptoms of

ODD and CD are often seen. I then discuss psychosocial[5] influences of AD/HD and link attachment theory to these interactional determinants.

The main feature of AD/HD is the child's "developmentally inappropriate inattention, impulsiveness, and hyperactivity" which shows up in various settings and significantly affects school, home, and social activities (Reid & Wise, 1995, p. 50). Children with AD/HD are often intelligent, but not successful in school (Weiss in Lewis, 1996). Their hyperactivity is off task and highly disturbing to others; often restlessness moves from not being able to sit without talking to fidgeting constantly as the child grows older. Poor sustained attention seems to apply particularly to areas that these children do not like or have difficulty in. Often a child with AD/HD can sit for hours attentively when he/she is working on something he/she enjoys. Low internal motivation is possibly involved with inattention to boring and repetitive tasks. Barkley (1990) feels that AD/HD is more a problem of motivation than solely an attention deficit (in Henley, 1998).

Difficulties with inhibiting impulses seems to be one of the most pervasive and disabling of AD/HD's symptoms. Often children have problems with talking without being asked, not being able to wait for things, and doing things which are dangerous without thinking of consequences (Weiss in Lewis, 1996). Although most children exhibit varying degrees of inattention, impulsiveness and hyperactivity as they grow up, children with AD/HD engage in these behaviors to an extent that they are extremely disruptive and aggravating to people around them, including other children.

Low motivation and difficulty inhibiting impulses indicate a lack of internal control. As they grow older, children move from being controlled externally by adults to internalizing control. This does not happen with children diagnosed with AD/HD and implies the effects of an environment where parents do not provide consistency and support when their children test limits.

Associated features of AD/HD may include "poor self-esteem, lability of mood, poor frustration tolerance, and temper outbursts" (Reid & Wise, 1995, p. 50). Low self esteem

threatens to become a depressive disorder as children with AD/HD often enter a vicious cycle of failure and negative feedback (Weiss in Lewis, 1996). Lability of mood means that the child is unpredictable from moment to moment (Barkley, 1981). The child goes from being calm and content to hyper, excited or aggressive, and negative. Parents often complain that the child is emotionally immature and unable to control him/herself (Barkley, 1981). Perhaps these mood shifts are the child's attempts to get attention or gratify him/herself. Poor frustration tolerance can be seen in the inability to attend to tasks that require seemingly minimal patience. Poor frustration tolerance can lead to temper tantrums. These associated features seem related to poor internal control, lack of modeling by caregivers, and the difficulty that caregivers have in providing boundaries, limits, and giving their children positive feedback and constructive criticism.

In terms of behavioral problems, AD/HD has a relationship with other psychiatric illnesses; symptoms of ODD, CD, and specific developmental disorders often present in these children (Reid & Wise, 1995). Both CD and ODD have predisposing factors of parental rejection and inconsistent parenting (Reid & Wise, 1995). CD and ODD seem closely linked to AD/HD, as they share some of the same features as AD/HD. These include low self-esteem, poor frustration tolerance, and temper outbursts. CD describes a pattern of behavior where the child consistently does not respect the rights of others and violates rules and age-appropriate norms. Both AD/HD and ODD have been associated to the possible later development of CD. ODD describes "a pattern of negativistic, hostile, and defiant behavior toward authority figures but without the serious aggression or violations of others' rights seen in Conduct Disorder" (Reid & Wise, 1995, p. 55). Children with ODD often have AD/HD as well. With the essential features of AD/HD now described, and a brief discussion of the other Disruptive Behavior Disorders (ODD and CD) I now turn to possible causes of AD/HD.

Psychosocial influences have recently been the most emphasized areas of study on AD/HD; this has been due to the relatively weak evidence supporting biological

determinants of the disorder (Weiss in Lewis, 1996). Children with AD/HD often share a common history that suggests being physically abused, neglected, or going through multiple foster placements (Reid & Wise, 1995). This is also true for the other Disruptive Behavior Disorders, ODD and CD. Family factors seem to contribute to both the severity and duration of the disorder: children whose families are in turmoil, experiencing financial difficulties and/or emotional distress are more likely to develop symptoms of AD/HD (Weiss in Lewis, 1996). Children with AD/HD can exacerbate "disruptive and aversive family situations" because the family becomes stressed in attempts to parent 'difficult' children (Barkley, 1981, p. 55). It seems that the patterns in the family are cyclical and both parents and children contribute to conflict. Some studies have reported a higher incidence of psychiatric problems in family members of children with AD/HD (Weiss in Lewis, 1996). The child's biological predisposition also determines how well the child will cope with things like family stress and low socioeconomic status. Clearly, assessment and treatment of children with AD/HD needs to consider the family context (Barkley, 1981).

As can be seen from the influence that the environment plays in developing AD/HD, ODD, and CD, a child's family history seems related to receiving one or more of these diagnoses. Although there are no causal links between AD/HD and attachment problems in the literature, children's history seems to imply that, along with other factors such as biological predisposition and family stress, inconsistent parenting and child maltreatment resulting in insecure attachment styles could predispose a child to develop AD/HD and other Disruptive Behavior Disorders. The diagnoses discussed provide a background in order to see children's behavior as problematic to their current and future functioning. I believe these behaviors have a connection to inconsistency in upbringing, which is an important factor in considering attachment theory as a way of orienting to children with disruptive behavior disorders.

Children's internal working models have interesting links to Disruptive Behavior Disorders (DBD's), since these disorders are defined by their behaviors which may be

more troublesome to others than the child (Reid & Wise, 1995), implying that children have a pattern of interaction or way of relating that is disturbed. I believe this maladaptive relationship style that children with DBD's use points to distorted internal working models. Supporting this view, research suggests that these troublesome behaviors are associated to early and current family difficulties. Neglect, abuse, and inconsistent parenting often suggest attachment insecurity. The children's lack of concern about their behavior suggests that this behavior has been adaptive in the past and that they currently do not understand why others are distressed by their behavior. This also points to attachment issues of insecure styles being adaptive in early years and later causing the child problems in school and other social situations.

1.6 Clinical Application of Attachment Theory

1.6.1 Orientation and principles.

When using an attachment perspective in working with children, clinicians need to orient themselves to multi-generational issues, current family dynamics, and individual styles of relating. In the literature, most therapy conducted from an attachment perspective aims at intervention before the age of five or six and is family oriented. There have been many parent-infant programs designed from an attachment perspective (Lieberman & Pawl; Nezworski, Tolan & Belsky in Belsky & Nezworski, 1988). The reason for intervening at this age is related to the family system being relatively open as it attempts to adjust to having a new child in the system (Nezworksi, Tolan & Belsky in Belsky & Nezworski, 1988). These clinicians believe that intervening at a young age decreases the likelihood of psychopathology in adulthood. Therapists have a main goal of targeting the mother to increase her sensitivity and responsiveness; the focus on the primary attachment figure is supported by the belief that the mother has a "disproportionately powerful influence on the development of the mother-child relationship" (Nezworksi, Tolan & Belsky in Belsky & Nezworski, 1988, p. 356). Intervention focused on the mother enables the mother to look

at multi-generational issues, such as her own childhood, and hopefully to change family dynamics by examining her style of relating to her child in the parent-infant dyad.

Although therapists seem to primarily orient to the family with younger children, other types of therapy with older children with attachment disturbances exist. The age group considered for this paper (6-11) has not been well studied from an attachment perspective. However, literature does exist on treating latency age children who have been traumatized (James, 1989, 1994) and children who have been abused and neglected (Pearce & Pezzot-Pearce, 1997) with a focus on attachment issues. The age of these children, combined with the programs that they are often involved in (i.e. after school programs, day treatment, or care through government agencies), allows clinicians to focus on many areas of the children's lives including the family, the school, and individual concerns. In this paper, I focus on an individual orientation, and discuss principles, assessment, and goals in terms of individual art therapy.

In looking at the basic principles of working with children who have attachment problems, I draw mainly from the writings of Pearce and Pezzot-Pearce (1997) who work with children who have been abused or neglected, and James (1989, 1994) who works with a similar group of children who have experienced what she refers to as attachment-related traumas. James (1989) defines trauma as "overwhelming, uncontrollable experiences that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety, and loss of control" (p. 1). This description would include instances of abuse and neglect, making the two groups similar in terms of how therapy is conducted.

There are several points that both James (1989, 1994) and Pearce and Pezzot-Pearce (1997) agree are basic principles of treatment. The two most important principles are involving the child's caregivers and immediate environment in treatment, and ensuring that treatment is developmental in focus. Having a developmental focus means assessing and treating any developmental issues that stem from maltreatment (Pearce & Pezzot-Pearce,

1997). Abuse or neglect can interfere with children's capacity to achieve stage-appropriate developmental tasks, and this further hampers their performance at later stages in development. The developmental focus also includes sequencing treatment over the life span, treating children as they progress through stages of development, since different issues related to their traumatizing experience or maltreatment will be more relevant at each stage (James, 1989; Pearce & Pezzot-Pearce, 1997).

Several other principles are relevant. The authors agree on the use of nondirective therapy combined with directed approaches when required. Pearce and Pezzot-Pearce (1997) stress the issue of being culturally sensitive, which seems important no matter what population a clinician works with. James (1989) feels that it is important to help children return to and accept the pain of the events, and to interact with children in an intense, playful and positive manner to counterbalance children's intense, negative self beliefs. James (1989) stresses that the therapist must be aware of and confront her emotional responses and work through those responses in order to continue working with children effectively.

Children with attachment related traumas often have difficulty being in close relationships with others, and trusting in others and the environment (James, 1989). It is with this in mind that these principles were designed.

1.6.2 Assessment.

The child's attachment style can be assessed in order to determine what specific goals the therapist wishes to work towards with the child. Often when working with infants, toddlers and pre-school children, assessment procedures based on the *Strange Situation*, such as watching how parents and children reunite, can be used. Also available to the clinician is the *Children's Garden Attachment Model* (Carson & Goodfield in James, 1989) which is a questionnaire that helps the therapist consider children's attachment through reciprocity, separation response, and ability to explore. Greenspan (in Belsky & Nezworski, 1988) outlines a classification of pathological attachment in infancy to four

years of age based on developmental tasks. As there are no psychological assessment procedures of attachment to my knowledge for latency age children, clinicians working with this age group must be innovative and use the relationship they develop with the child as an indicator of attachment styles and issues. Attachment indicators developed from early childhood may also point to places where older children seem to still be having trouble mastering earlier developmental tasks.

I have mentioned various inventories and procedures to assess the child, but as James (1994) and Pearce and Pezzot-Pearce (1997) discuss, assessing a child as having attachment disturbances takes time and involves knowing the family history, including multi-generational issues, and how the child perceives that history. This would suggest, as Bowlby states (1979), that family interviews at intake are very important to get a history and also see how parent and child interact. The child's perceptions can be explored through various art media, and directed art activities such as kinetic family drawings,[6] which may have interesting information in terms of the spatial quality between the child and other family members that relates to attachment relationships. One assessment drawing available in the art therapy literature is a projective drawing technique of drawing a bird's nest to indicate secure or insecure attachment style in women (Kaiser, 1996); this *Bird's Nest Drawing* could be applied to assessment with children. Equally important in assessing attachment style is the clinician's on-going involvement during treatment with both the family and child, as current family interactions play a significant role in attachment style as well. The most important questions for the therapist to consider seem to be "What type of attachment behaviors does the child use?" and "Are these behaviors adaptive at this point?"

When assessing the family history from an attachment perspective, James (1989) discussion of the causative factors of attachment insecurity can be effective in identifying possible attachment traumas. Often the attachment disturbances are rooted in "loss, threat of loss, disruption, and reunification" (James, 1989, p. 117). James groups the causative factors of attachment disturbances into three main areas: *loss and disruption, reunification,*

and *impairment*. *Loss and disruption* occur when a child undergoes experiences like being abandoned, having a parent who is terminally ill, a parent threatening suicide, or the child suddenly loses contact with the parent. James (1989) describes *reunification* as "the actual or suggested renewal of contact with a parent after extended separation [which] can be traumatizing to a child for a number of reasons" (p. 117). *Impairment* refers to parent's attachment behaviors that significantly and persistently get in the way of their children's capacity to engage in satisfying relationships with others (James, 1989). Children can experience attachment disturbances as traumatic even when the attachment relationship has been relatively secure (James, 1989); this seems particularly relevant with disturbances caused by *loss and disruption*, and *reunification*. (This is discussed further in section 2.5.)

1.6.3 Goals.

The primary goal in therapy with children with insecure attachments is to establish a *secure base*[7]. This involves building a relationship based on trust and felt security. After this is achieved, the therapist can begin helping the child to recognize behaviors that are related to insecure attachment style, and questioning those behaviors. The focus on relationship building and the child achieving felt security with the therapist underlines the importance of the therapeutic relationship as an instrument of change from an attachment perspective. James (1994) describes the treatment process with children who have attachment-related and trauma-related problems as having to address five main areas: education, developing self-identity, affect tolerance and modulation, relationship building, and mastering behavior. Working on these five main areas may be a very long and difficult process. It is only after the child feels safe with both the therapist and with his/her present caregivers that the clinician can begin to work on issues of exploring trauma and mourning losses without being overwhelmed (James, 1994).

In working with children with attachment disturbances, the therapist has two main goals. The first objective is to help the child achieve a secure base: this involves building a relationship based on trust and felt security. Given the ingrained quality of children's

insecure attachments, this first goal requires time and investment in the therapeutic relationship, and may be the main purpose throughout therapy. The second intent in therapy involves exploring trauma and mourning losses, which can only occur after the secure base has been established. In this area, the therapist helps the child return to and accept the pain of events in his life.

In this chapter I have given an overview of attachment theory. In giving an overview of its history, I have discussed the work of John Bowlby. A definition of attachment theory was given and the different attachment styles were illustrated through the work of Mary Ainsworth and her laboratory experiment, the *Strange Situation*. The primary caregiver is usually the key attachment figure for a child; this role was defined as being a *protector*, *provider*, and *guide* by Beverly James (1994). A key belief of the theory is that attachment relationships affect people throughout the life span. The Attention-Deficit and Disruptive Behavior Disorders were examined and linked to attachment theory. The clinical application of attachment theory was discussed by examining orientation, assessment, and goals in therapy from an attachment perspective. The overall orientation in therapy was explained by theorists working with children who have been abused, neglected or traumatized.

Chapter Two

Case Outline

For this research paper, I have chosen to look at the individual therapy of two children who were in art therapy with me this year. Frank and Karen (pseudonyms) participated in a special day treatment program that offers a variety of interventions to children aged 6-13 who have behavior problems, including psychiatric evaluation and follow-up (including medication if required), a behavior modification and social skills program, special school services, family therapy, and creative arts therapies. Creative arts therapies were offered in group and individual sessions. Individual psychotherapy took the form of art therapy or play therapy and was psychodynamic in orientation. Although both children were involved in numerous interventions that were important to their progress over the year, they will not be discussed in this paper. I will focus on their individual art therapy experience.

In this chapter, I provide my impressions of each child and a family history. I discuss the events I believe Frank and Karen experienced as traumatic in terms of their attachment relationships. From the family history, my observations, and psychosocial development of Frank and Karen, I hypothesize the attachment style of each child. Frank experienced maltreatment and Karen was neglected. Each child has been in a family where inconsistent parenting was evident. These factors put them at risk for insecure attachments. Frank and Karen used insecure attachment styles in therapy: Frank seemed to use the avoidant style of attaching to me, whereas Karen used an resistant/ambivalent approach to relate to me. It is my belief that Frank and Karen re-enacted their early attachment styles with me in art therapy.

2.1 Patient Identification

2.1.1 Frank.

Frank is ten years old, of European ancestry and is color blind. He currently works at an age appropriate level in school; Frank has been described as intelligent, but his teachers feel could apply himself more. He had a reputation for considering himself before other children, and being pushy and bossy, always looking out for 'number one'. This reflected his use of identification with the aggressor as a defense where he identified with his abusive parents and acted this out on peers (Mishne, 1983). Over the course of therapy, Frank went from acting in an intelligent and pleasant manner to adopting a resistant stance where he distanced me. In keeping with a growing resistance to therapy, he would come late, act impatiently with me, and had an attitude of putting in time during the sessions. Despite this resistance, Frank seemed intensely involved in art therapy. This was evidenced by his involvement in the art making process and his desire to engage me in the process. As we grew closer, he had more difficulty expressing himself verbally. In an effort to remain detached and impersonal, Frank responded to emotional situations in therapy by using intellectualization, and repressing unacceptable feelings of sadness from consciousness. He seemed to have ego strength, which was evidenced by his ability to trust and express negative feelings without feeling he would destroy me. During termination, Frank seemed able to tolerate more closeness and voiced positive feelings about our relationship and his time in art therapy.

2.1.2 Karen.

Karen is seven years old and of mixed race. She is big for her age, looking more like a nine year old child. Karen is in good health and presents herself in a somewhat coy and guarded manner that can switch easily to defiant and hostile behavior. Karen employed splitting as a defense mechanism throughout her therapy. She seemed to swing between openly rejecting me and idealizing our time together. Cognitively, she seemed aware, but sometimes she seemed confused about events, people and objects. This may be age

appropriate and related to the changes in school and getting to know new schedules, new ways of doing things, and new people. Her confusion also seemed related to the many changes she has gone through with multiple caregivers. Often I felt Karen interpreted my actions as hostile and dangerous, such as when I showed concern for her or helped her structure something so she could succeed. This implied that Karen found it too frightening to like me, as she felt I would reject her. Trust was a major issue for her. I found Karen froze or became unable to move when she was extremely upset. This freezing enabled her to shut down when things were too stressful, and seemed indicative of a child who has been previously traumatized.

2.2 Reasons for Referral

Both Karen and Frank were referred to the program because of aggressive behavior towards other children and acting oppositionally towards teachers in regular school. Their violent and aggressive behaviors at home were also becoming extremely hard to handle.

Frank was referred to art therapy because of his poor self esteem and low frustration tolerance. He went to an art therapist last year, and enjoyed this therapy modality; thus art therapy was seen as an excellent way to continue working with Frank. From his previous therapist's termination report, working on hearing, tolerating, and acknowledging feelings seemed to also be an area where Frank needed help.

For Karen, the referral to art therapy stated that Karen had behavioral difficulties at home with authority and listening to directives. She expressed herself through aggression and temper tantrums. Karen had been seen previously in art therapy. The team felt that a new art therapist could encourage Karen to work at developmentally appropriate levels and support and solidify her ego growth by helping her control herself through the art and enjoy the creative process.

2.3 Beginning Diagnosis

Both children have been diagnosed with Attention Deficit/Hyperactivity Disorder (AD/HD) and were placed on ritalin when they entered the program. Karen was

additionally diagnosed with Oppositional Defiant Disorder (ODD). Frank was additionally diagnosed with Conduct Disorder (CD) and enuresis, which is the "repeated voiding of urine into bed or clothes (whether involuntary or intentional)" (Reid & Wise, 1995, p. 65). AD/HD, ODD, and CD, which were discussed in section 1.5, all belong to the DSM-IV section titled Attention Deficit and Disruptive Behavior Disorder (Reid & Wise, 1995). They are grouped together due to their commonality in describing socially disruptive behaviors.

2.4 Pertinent Background Information

2.4.1 Frank.

Frank is a ten year old boy whose parent's divorced when he was five years old. He lived with his mother, Cindy, until recently. During the time he lived with his mother, she remarried and had another son. Cindy often did not let Frank see his father, James. She often canceled the visits with James if she felt that Frank did not deserve them. She used threats to cancel the visits and Cindy and Frank's relationship seemed characterized by conflict, abuse, anger and hostility. James's became alerted to Cindy's verbal and physical abuse of Frank; Frank was nightly wetting the bed when he did visit his father and he was aggressive. James decided to report his ex-wife to local child protection, who stepped in and attempted to help Cindy learn new strategies of disciplining and relating to her eldest son. This met with limited success and soon after, James received custody of Frank. Because James had challenged Cindy as a mother, the relationship between mother and father went from strained to hostile with Frank caught in the middle not knowing which parent to trust. During this time, Frank probably witnessed many battles between his parents.

When Frank moved in with his dad, James had difficulties managing Frank's behavior. He was still wetting the bed and visiting his mother on weekends. On one occasion, Cindy returned Frank from a visit early because Frank had soiled his pants as a way of expressing his anger at her. This suggests the primitive nature of Frank's anger and

his ability to express it. Cindy returned him without cleaning him. This suggests Cindy's level of anger and disregard towards James and Frank. Frank began to act violently at school. James lost his job as a result of having to attend so many meetings about Frank's behavior. At this time, James asked for his parent's support, which meant that he and Frank moved in with them temporarily. One day, Frank's behavior was so out of control that James took him to a local hospital's emergency room.

Since moving into his father's home, Frank and his father have been working to rebuild their relationship and establish trust. In this process James has been struggling to set limits for Frank, who continually tests him. James seems involved and committed to Frank's well-being; however, James has had difficulty throughout the year setting limits and keeping his temper with Frank. James had stopped Frank's visits to his mother before Christmas, but in the spring he resumed sending Frank to Cindy on the weekends. James sent Frank to the mother's for respite when he could no longer tolerate Frank's difficult behavior. It seems James was exhausted and unable to handle Frank. James sometimes got angry and declared that if Frank's behavior continued, he was going to send him back to his mother. In this way, James repeated the style in which Cindy parented Frank. It seems that James pressures Frank to get better and "fix his problem", which undoubtedly contributes to Frank's stressed out, aggressive and bossy behavior as he tries to control himself and others.

Frank has had difficulty with the visits to his mother's family. His brother gets Frank's toys, which mom will not let Frank take home. Frank's feelings for his half brother involve intense love, need to protect, and extreme jealousy. Cindy continues to be harsh in her treatment of Frank. James explained that Frank comes home in an emotional upheaval and it takes three days for him to calm down after visiting his mother. The relationship between Cindy and James continues to be poor, and Cindy does not cooperate regarding any issues at the day treatment program. Frank's attachment to his mother, however, seems to be quite strong and he idealizes her. Unit staff have informed me of his

fantasy of reuniting his parents. He seems to be caught between two parents who both have habits of threatening him and using physical force.

2.4.2 Karen.

Karen was born when her mother was young, and is the oldest of several children, each who have different biological fathers. Her mother, Alice, used illegal drugs during her pregnancy with Karen. Karen's father, who also had substance abuse problems, has not been involved with Karen's upbringing.

Alice was unable to care for Karen properly and often left her unattended for extended periods of time. Karen was often sick during the time she was with Alice. As a baby, Karen was placed under the care of her mother's sister Cecilia and her husband, where she remained for several years. Cecilia had difficulty with Karen beginning at about 9-10 months of age when Karen became violent. At a later age, Karen also became aggressive towards Cecilia's child. When Karen was four, Alice felt she was now ready to parent Karen, but again had difficulty caring for her. Neglect and an unstructured environment became a problem and Karen was returned to Cecilia after nine months, where she remains presently. Recently Cecilia and her husband divorced and Cecilia has returned to work. Karen kept in contact with her mother by visiting her on the weekends, until after Christmas when her mother disappeared for several weeks. Karen's behavior began to deteriorate and Cecilia has decided she can no longer parent Karen. Cecilia began the process of separating herself from Karen and Karen will be placed with another relative over the summer.

Karen exhibited a great deal of anger about the repeated separations and disruptions she has experienced from her mother and aunt. It seems that she is highly confused by who is her primary caregiver, as it has switched several times in her brief life. Now at seven, she is experiencing another separation and will be placed with another relative. The relationship between the women in this family seems highly enmeshed, with the sisters often taking on each other's children when they are already overburdened by their own.

Another major component of her history is the lack of male figures she has had for role models.

2.5 Hypothesized Attachment Styles

2.5.1 Frank.

From what I know of Frank's family history and how he currently relates to me, it would seem that Frank has had some difficulties forming secure attachments. Frank's mother has emotionally and physically mistreated Frank; children who have been mistreated may have difficulty being in intimate reciprocal relationships (James, 1994). This seems to suggest an impairment in attachment, although it is unclear at what age the maltreatment began. Intimacy in relationships may be difficult for Frank because closeness leads to feelings of vulnerability and danger of being hurt either physically or psychologically. This is characteristic of a child who has adopted an avoidant style of attachment in order to adapt to his earlier life situation (Pearce & Pezzot-Pearce, 1997).

Frank's family history sheds light on his attachment style. Frank went through his parent's divorce at age 5; given the animosity between his parents, this was probably a traumatic event for him. At seven, he was also 'replaced' when his mother had another son. Frank seems to have gone through a number of separations or disruptions with his family in terms of divorce and switching from mother to father. Although I am unsure how he viewed moving in with his father, he seemed to miss his mother a great deal. I sensed that he was jealous towards his half-brother who got his mother's attention, and perhaps he felt punished when he was taken away from her. Even though Cindy's treatment of Frank has not been optimal, he idealized her. Avoidant children may "portray the rejecting, hostile parent as a wonderful caregiver, thereby attenuating the trouble-some feelings of anger, sadness, and anxiety associated with an accurate perception of the relationship" (Pearce & Pezzot-Pearce, 1997, p. 15). Perhaps he also fantasized about being reunited with her.

Beverly James' (1989) description of attachment trauma caused by *reunification* is helpful in considering Frank's family history. He seemed to experience the reunification

with his father after separation of several years as traumatizing. He was overwhelmed by conflicted loyalty between his two parents. *Loss and disruption* are also inherent in the reunification trauma since he lost his mother to go to his father. James later experienced difficulties when going back to his mother after several months of his father protecting him and then giving in and sending him back to Cindy. Traveling between the two homes seemed traumatizing for him, like he relived the trauma each time he visited his mother.

Several indicators over the course of the year lead me to conclude that Frank used an avoidant style with me. Frank was able to hold impersonal conversations, but was extremely uncomfortable with any conversations of importance. Upon reunion after Christmas, he avoided contact with me and acted in a distancing manner. Frank wished to terminate our sessions, displaying a way of avoiding contact with me upon reunion. He often greeted me by yelling "Boo!" which seemed like a way to distance me at the beginning of each session. Frank seemed to particularly have trouble relating to older females on the unit, but did not seem to act avoidantly with his father. He was able to relate to females when there was a male around, perhaps because this ensured that the level of interaction would not be as intimate. Maybe this intimacy with women, like myself, was frightening because Frank frequently let me know that boys were not supposed to be affectionate or emotional. Intimacy may also have been frightening because in the past, being intimate would in a sense make Frank vulnerable to later criticism or psychological abuse.

Difficulty with tolerating intimacy seemed apparent in the therapeutic relationship, where in the transference, Frank at times experienced me as his mother. Frank's identification of me with his mother seemed to begin in our third session when Frank talked about his mom and commented that I looked like her. When I asked how I looked like her, he said, "You look like her, except you have short hair and dark eyes and you're taller." It seemed that even though he knew rationally that I did not look like his mother, he saw me like her in the transference. I wondered if this meant he would replay a similar relationship

style with me as he had with his mother. Through comparing me to his mother, he seemed to ask, "Is this someone I can attach to? What will she be like?" Later in that session, Frank said I did not act like his mother. He seemed to express confusion about how to view me. Like any child who seeks pleasure from proximity in relationships (attach), Frank wanted to trust me, yet his unconscious internal working model wanted to fit me into the representation he had of his relationship with his mother. His level of comfort and trust seemed to increase when he experienced me more as a buddy, which occurred during termination. This confusion in how to view me seemed to be his primary struggle in art therapy.

Since developmental issues are important in treating children with attachment disturbances, as discussed in section 1.6 (James, 1989), I very briefly consider where Frank seemed to experience difficulties from a psychosocial developmental view (Erikson, 1950)[8]. Developmentally, Frank seemed to struggle with issues of shame versus being 'number one'. Being able to take care of himself, and not needing anyone seems important to him. This places him in Erikson's second stage of psychosocial development, which is *autonomy versus shame and doubt*. The two primarily social ways of being at this stage are "holding on and letting go" (Erikson, 1950, p. 251). Evidenced by his enuresis and episodes of soiling his pants to express anger, Frank seems to experience letting go as a "letting loose of destructive forces" (Erikson, 1950, p. 251). In relationships, therefore, Frank has difficulty letting loose, being himself, and expressing himself fully. He feels that when he does this, it is shameful or destructive. An element of not being safe enough to let go seems to link to the relationship with his mother. With an avoidant attachment style, the child avoids expressing the intimate part of himself because he anticipates being "rebuffed, rejected, or subjected to anger and hostility if he or she makes demands" (Pearce & Pezzot-Pearce, 1997, p. 14). Perhaps his issues of autonomy versus shame also give an indication of where Frank first experienced an impingement in his development.

2.5.2 Karen.

Both Karen's family history and current relational style in art therapy indicate that she employs an insecure attachment style. Karen's early experiences of a rejecting mother and inconsistency in caregivers have put her at risk for developing an resistant/ambivalent attachment style. Karen seems to have undergone multiple attachment disturbances and maltreatment when in her mother's care. Ambivalent/resistant children are uncertain whether their mother will be "available, responsive, or helpful" (Pearce & Pezzot-Pearce, 1997, p. 15), which fits with Karen's early life with a rejecting and neglecting mother. Ambivalent/resistant children attempt to provoke attachment figures in order to be cared for. This is done by becoming angry, aggressive, or coercive (Pearce & Pezzot-Pearce, 1997). This fits Karen's behavior when she was a young child and during art therapy.

Karen's family history reveals attachment disturbances in more than one of the three areas outlined by James (1989). Karen seemed to experience *loss and disruption*. Karen has an early history of neglect and of being rejected by her mother. She underwent multiple disruptions in her primary attachment relationships. She seemed to suffer loss and disruption when she was moved from her mother to her aunt. During this time she became extremely difficult to care for, and as an infant sought constant attention, but was rarely comforted by it, and often became violent. This seems to fit with a resistant/ambivalent attachment style in that she attempted to be cared for through aggressive action. The fact that she was not comforted may relate to research that shows that parents of resistant/ambivalent children only try to regulate distress after the child has become intensely upset (Pearce & Pezzot-Pearce, 1997). Karen probably felt multiple abandonments. She was abandoned by her mother again when she was three; later by her uncle left the family, and now she feels rejected by her aunt. Karen also experienced *impairment*, which is a "persistent pattern of anxious or distorted parental attachment behaviors that interferes with the youngster's ability to form satisfactory relationships with

others" (James, 1989, p. 117). This seems to have occurred with a mother who neglected and verbally abused her.

My belief that Karen uses an resistant/ambivalent attachment style seems supported by her behaviors with me. Karen seemed to replay the attachment style she used with her mother and other caregivers. In the transference, Karen often experienced me as her mother. For example, she often brought in current events, like her mother's incarceration where she played at putting me in jail for being bad. Karen both sought and resisted me at the beginning and end of most sessions. When proximity was achieved or when I offered her attention, Karen usually resisted and became suspicious of me. A mixture of reunion behaviors is characteristic of resistant/ambivalent children (Goldberg in Goldberg, Muir, & Kerr, 1995). Karen displayed anger when I comforted her; she rarely could accept care. These behaviors all seemed related to what I knew of her family history. Karen seemed able to attach to others very quickly; in our first sessions she always held my hand when we walked together. I witnessed her do this with several new people (i.e. strangers) outside of our sessions. This seems to relate to the clingy, dependent behavior that younger children with the resistant/ambivalent style use. In this sense, Karen's behavior seemed to be a desperate attempt to meet her needs for care and protection, which she has not received enough of in her primary attachment relationships.

Issues that Karen worked through concerning anger and trust also indicate an resistant/ambivalent attachment style. Karen primarily expressed anger in art therapy, which usually connected with her difficulties with an open structure and need for firm boundaries where she would not become overstimulated. This seems related to the resistant/ambivalent child's need to be kept emotionally stable and have a secure base that contains her. Not being able to trust me, which was reflected with her difficulty in leaving her art in the room because she felt it wasn't safe, seemed related to the early experience of not trusting that a caregiver could be reliable. The issue at play here was the distrust and

uncertainty Karen felt that I could be reliable enough to keep her artwork safe and continue to see her.

It is important to consider Karen's experience of being neglected and rejected in terms of her psychosocial development. Erikson's stages of psychosocial development illuminate Karen's basic issue of mistrust, placing her in the first stage of development which is *trust versus mistrust* (Erikson, 1950). This points to where Karen seems to have experienced an attachment impairment since Karen was neglected/rejected at a very young age. At this stage when an infant is totally dependent on the mother, her struggle is about life and death. When a healthy attachment is not formed, the mother may not care for the baby, so the infant is at risk of not being fed; this means death. This suggests a very early impairment in attachment, and alludes to the severity of Karen's attachment insecurity.

2.6 Goals in Art Therapy

Goals were set after three initial assessment sessions. Although the goals I established for the children do not directly involve focusing on AD/HD, they connect to the disorder. These goals relate to the social problems and low self esteem that both Frank and Karen evidence. They also connect to attachment theory in their focus on questioning the children's beliefs and assumptions about themselves and how they relate to others, which is about recognizing, questioning, and hopefully reformulating their internal working models through the therapeutic relationship. I wish to note that my focus on attachment style was not how I initially interacted with the children, as I discovered this approach over the course of working with them.

2.6.1 Frank.

1. To understand the effect of his actions on others.
2. To create a safe place to express his conflicts and their affective responses.
3. To develop a degree of comfort following rules and to internalize control.

2.6.2 Karen.

1. To develop a sense of trust within the therapeutic relationship.

2. To work through and make sense of losses of significant people in her life.

We worked towards accomplishing goals through art and play and the therapeutic relationship we established.

The purpose of this chapter has been to give information about Frank and Karen that leads me to hypothesize their attachment styles. I have discussed their family histories, presenting problems, and my clinical impressions of their overall behavior in therapy. I have given a case outline and related it to attachment theory, proposing that Frank used an avoidant style and that Karen used a predominantly resistant/ambivalent style. I have outlined the goals for each child in light of this information. In the next chapters, I will be discussing specific parts of the children's art therapy and linking that to attachment theory.

Chapter Three

A Secure Base in Art Therapy

This chapter looks at the concept of the secure base in attachment theory and how the child and the therapist form a relationship. I explore how the therapist provides a *secure base* in art therapy. The therapist uses different approaches depending on the attachment style of the child. I discuss Judith Rubin's concept of a *Framework for Freedom* in relation to establishing a secure base in art therapy. Finally, I look at how Frank and Karen evidenced their need for a secure base through various events during their therapy. Here I primarily use attachment theory to describe events in therapy, and I incorporate some of Winnicott's concepts, like the transitional object, that help to further elucidate some of the children's attachment issues.

3.1 Attachment Theory: A Secure Base

Bowlby (1988) describes the *secure base* as "the provision by both parents of a secure base from which a child or an adolescent can make sorties into the outside world and to which he can return knowing for sure that he will be welcomed when he gets there, nourished physically and emotionally, comforted if distressed, reassured if frightened" (p. 11). In providing a secure base, the parents make themselves available to their child and are ready to respond, encourage, and aid their child when the child needs comforting and protection. Predominantly "the role of the base is a waiting one but it is none the less vital for that" (Bowlby 1988, p. 11). Bowlby characterizes the secure base as a parent's ability to monitor and be attentive to the child. Even though they are attentive, this often means that parents intervene only when necessary, thus allowing their child to explore and take risks, and seek comfort and security when needed.

Bowlby (1979) says that the psychotherapist acts as a secure attachment figure for the child in therapy. Much like the primary caregiver provides a secure base for the young child to explore the external world, the therapist provides a secure base for any age child to

explore their internal world. This therapeutic secure base allows the child to "explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance" (Bowlby, 1988, p. 138). The internal world that the child explores includes their distorted internal working models of self and others, which he begins to question with the help of the therapist. As the relationship develops over the course of therapy, the child begins to feel safe, secure, and protected by the therapist. Providing a secure base enables the child to become self-reliant, cooperative and trusting (Bowlby, 1979). Within the therapeutic process, where he feels safe and able to seek comfort and reassurance, the child begins to confront issues which he/she finds distressing. Pearce and Pezzot-Pearce (1997) compare the establishment of a secure base in therapy to the notion of establishing a therapeutic alliance.

James (1994) lists five essential treatment conditions that describe the work of providing a secure base, where the therapist acts as a *protector*, *provider* and *guide*. They are "safety, a protecting environment, therapeutic parenting, appropriate clinical skills, and a therapeutic relationship" (p. 58). These conditions must be established in order for any work to be done with children who have experienced attachment traumas.

Of particular interest is James' discussion of therapeutic parenting, where she discusses the fact that individual therapy is often not enough to help children reformulate their attachment styles, but that treatment must encompass the children's whole environment. Therapeutic parenting, whether done by biological parents, foster parents, teachers,[9] or special staff in day treatment programs, requires ongoing care of children and better than average parenting skills; this must be supported and encouraged by the therapist (James, 1994). This expands the therapist's role in providing a secure base to the children's everyday environment of parents and school. The therapist has a responsibility to exchange with parents and school and offer support or guidance regarding other

resources in order to help the child. This requires the therapist to mediate between keeping confidentiality and trust in the therapy hour, and providing helpful and relevant information to others about what the child is working on. Thus, the secure base extends outside of the actual therapy hour with the child. This seems to be a more complete description of what it means for the therapist to establish a secure base with her client, as the "child's disturbed behavior, emotional distress, and fear that adults will not protect and care for her may not emerge during weekly therapy sessions" (James, 1994, p. 59). Keeping ties with parents and school can sometimes be difficult logistically and emotionally for the therapist, who must deal with her counter-transference reactions. However, through this involvement, the therapist ultimately shows the child and his/her caregivers that the therapist is trustworthy, open, and committed to the child's well-being.

When a secure base has been established for the child by the primary attachment figure, the child stops his/her attachment behaviors and begins to explore the environment (Bowlby, 1979). Likened to the therapeutic situation, when a secure base has been established in therapy, the child feels safe enough to stop attachment behaviors with the therapist. In art therapy this would mean that the child now begins to explore her internal environment through the exploration of art materials, talking about art and other important things in her life, and through the use of symbolic play.

3.2 The Therapist's Style with Insecurely Attached Children

Taking into consideration the previous discussion of a secure base in therapy, and the importance of the mother's sensitivity to her child, the therapist must be sensitive and adjust her methods to each child. From my experience, I found that resistant/ambivalent and avoidant children (respectively Karen and Frank) needed different things from the therapist. This meant adjusting my style to best suit them and their needs.

Holmes (1997) postulates that people with different attachment styles need different approaches in therapy. This leads to deliberating the different styles that children need in their therapist. Ambivalent/resistant people need a firm and consistent therapeutic frame to

feel safe and express anger. The therapist needs to use more "consistency, firm structure and well-marked boundaries" (Holmes, 1997, p. 167) with resistant/ambivalent clients; with avoidant children, an attuned follower style in the therapist works better.

With the resistant/ambivalent client, the therapist mainly needs to be a *protector* (James, 1994) in order to establish a secure base for the child to operate from. When this is established, the child can "express the anger and protest that can lead to a sense of autonomy" (Holmes, 1997, p. 167). Achieving autonomy for the resistant/ambivalent child is a crucial step in therapy, since autonomy allows the child to tolerate separation.

Avoidant children, on the other hand, need a more attuned, empathic and following type of therapist (Holmes, 1997). The therapist's holding, or ability to make the client feel secure, is the most important aspect of therapy with avoidant clients. Thus, the therapist acts primarily as a *provider* (James, 1994) for the avoidant child. In achieving felt security, the child now can begin to explore his inner world and voice his feelings (Holmes, 1997).

There seems to be a delicate balance between the role of the attuned follower or provider and the role of the protector who gives structure. Children need both provided for and protected, as seems evident from James (1994) statement that the attachment figure has multiple roles. However, individual differences play a part in what children need more. Thus, the therapist needs to sensitize herself to her clients in order to adapt her style. This is not always an easy job, as all therapists have stylistic preferences that probably relate to their own attachment styles. For example, I found over the year that I had more difficulty taking the role of the protector. This alerted me to question my counter-transference responses, and be sensitive to myself. I also took more time preparing for sessions where I knew I had to be the protector in order to be fully ready to act in that role when needed.

Although both providing structure and following the client are necessary and crucial to the role of therapist, I feel therapists must guard from becoming too extreme in either direction. In taking on the role of protector, the therapist must moderate from becoming didactic; here the therapist may interpret structure as allowing the child no choices of his

own. As the provider, the therapist can also be too extreme in following. This can happen when following happens at the expense of boundaries and rules, and the child rules the therapy room without limits on her behavior. Thus, balancing of the role of protector and provider means the therapist must constantly stay flexible and attuned to the child. The therapist must also monitor her counter-transference and style.

3.3 Providing a Framework for Freedom in Art Therapy

To further illustrate the concept of providing a secure base in art therapy, I turn to the idea's of Judith Rubin (1978), who describes the art therapist's job as that of providing a *Framework for Freedom* for children. I will also outline relevant examples of the secure base or *Framework for Freedom* in the therapy of Frank and Karen.

In providing a *Framework for Freedom*, the art therapist's primary task is to establish the conditions for a child to be free in a safe and supportive environment (Rubin, 1978). Here, freedom is meant to be the state in which a child can delve into art making and creative process. Rubin explains that creative activity requires both freedom and control; that neither absolute chaos or rigidity are conducive to creative work. The therapist needs to help the child find the right level of both freedom and control, and negotiate a "productive and integrated relationship between the two" (Rubin, 1978, p. 22). Because letting go (being more free) is naturally frightening and clients may not know how to play or be free on their own, the therapist needs to both model what freedom can look like and provide a structure to ensure that letting go does not become overwhelming or unsafe.

To provide a *Framework for Freedom*, the art therapist both structures and limits the child's experience. However, it is important to note that art therapists can become too extreme in their role, leaving the child little room to express their individuality when structure is imposed without considering what the child needs. The opposite danger is that art therapists can become too lax and allow the child to rule the art therapy room without structuring or guiding the experience, so that the child does not experience any limits on her behavior. This applies to the previous discussion of mediating between the protector and

provider role. In order to guard against this, the art therapist needs to both trust the child's capacity to self actualize (Rubin, 1978), as well as be aware of her own reasons for needing to impose order or allow excessive freedom. The way the therapist reacts to the child may also be examined to see what dynamic the child may set up in the therapy, and by extension at home or in school, and how that relates to her attachment style.

The art therapist provides an environment in the art therapy room where the child wrestles with both the physical and psychological aspects of order and control (Rubin, 1978). The therapist helps the child to structure himself through the art materials and activities that he engages in. An aspect of enabling the child to structure himself is giving the child choices, and allowing for and respecting the child's decision making. Unless the structure comes from within, the child will not learn how to control and organize the self (Rubin, 1978). This means often that the therapist helps the child with a process of moving from external to internal structure, the goal being that gradually the child takes more control of the situation.

3.4 Issues Particular to Frank and Karen

3.4.1 Set up of the room and access to materials.

The art therapist sets up the room in a way that the child has access to essential materials, but not necessarily to everything. The therapist does not want to overwhelm the child with materials. The art therapist also has to think how much she allows the child to use. There has to be enough materials out that child feels she can do whatever she wants to, or she can find new media to work with and try new things. This may particularly be an issue with children, like Karen, who feel deprived.

How the room is set up when the child enters gives her a certain message. My art materials were in cupboards, so I ensured when Karen came that materials were set out on the table for her and were ready to use. When materials were not placed out (like at the beginning of therapy when I wasn't as knowledgeable about what she needed), or when Karen had a particularly difficult week at home, she would overload the table with

materials. Although overloading was her way of asking to be provided for, overloading made it very difficult for her to make her projects and was frustrating for her.

In order to make the art experience more gratifying and less overwhelming for her, I needed to take the role of the *protector*. I began to help her structure the materials by giving her choices of what to put on the table and helping her question if the materials were going to get in her way, thus showing her how to plan in advance. I also structured the room for Karen by putting away certain materials that she particularly had trouble with before she came for her session. For example, we went through a period where Karen became extremely aggressive and began to act out physically. This involved smearing paint on walls and damaging art materials. Because she did not seem able to handle the messy paints (i.e. regressive materials), I put them away and explained to her why I had done so. Surprising to me at the time, she accepted this limit. In retrospect, I see that she probably felt contained by my limit setting, as she knew her anger could be more directed and thus less frightening to her.

A securely attached child experiences the therapist's concern for materials and ability to supply art supplies as positive. However, in the transference, an insecurely attached child may not be able to accept the therapist as a *provider*. When a child has distorted internal working models of primary attachment figures, the child can feel that the therapist is withholding, dangerous, or hostile. For example, Karen felt that I could never provide her with enough materials and she believed that I was not willing to provide for her. She experienced me as withholding the love or materials she wanted, and therefore she saw me as mean and hostile. This seemed related to her attachment relationship in infancy where she sometimes was not fed and was emotionally and physically neglected. It was necessary for me to realize early in her therapy that, in Karen's eyes, I would not be able to provide enough for her psychologically/emotionally, even though 'objectively' I had an abundance of supplies for her. This distorted internal model has parallel's to Winnicott's concept of the *not-good-enough mother* who cannot provide her child with the "kind of good-enough

environment necessary for the consolidation of a healthy sense of self" (Mitchell & Black, 1995, p. 129). Karen's attachment distortion around seeing me as a *not-good-enough* provider of materials related to her experience of not having a secure base where she was adequately provided for emotionally or physically.

Respect for materials is part of building a secure base in art therapy. Materials need to be well taken care of by the therapist; this models appropriate use and care for children (Rubin, 1978). Providing good quality materials facilitates a child's creative process and final product, thus enhancing his/her feelings of self worth. This creative play with art materials can be likened to the first steps that a child takes away from the secure base to explore the world and expand his view. Like a loving parent, the therapist cares enough to supply materials worthy of the child. The child has a better chance at success when he has good quality materials that do what they are supposed to do.

3.4.2 Storage of child's art.

Storing the child's art is an aspect of art therapy where the therapist acts as a *protector* and shows the child that she will take care of and value the child's creations. The therapist provides the child with his own space that is safe and confidential. Because the therapist and child usually discuss storing the child's artwork at the beginning of therapy, storage acts as a metaphor for security and containment that is established at the beginning and continues throughout therapy, much like the secure base.

Storing art takes a variety of forms and/or activities. For example, the art therapist may ask the child to make a folder for his artwork. The child can decorate it, making it his own. Storing art can facilitate conversations about confidentiality if a child has fears about other children seeing his artwork, or wishes to peek at other children's art. Putting art away at the end of each session reinforces that the folder is the child's special container. Later, when the child takes his art home, the folder continues to be a container or safe place where everything is kept together. Taking art home can be talked about with the child, to help him plan how to keep his art safe outside of therapy. This also is part of the role of being a

guide, since the therapist models how to take care of self possessions and carries that skill into the future for the child, when the therapist is no longer available.

Sometimes art therapists have storage cabinets for three dimensional work. At my setting, the children and I placed paper over storage shelves in order to make the shelves private. This is different than how art at school is stored in shelves, since confidentiality is not an issue that teachers address in art classes. Placing the paper on the shelf brought Frank's desire for containment to the forefront. He talked about his desire to keep things in the cupboard and his worry that his art may fall out. Storing the artwork in a confidential way also gives children the message that the art in art therapy is private, versus the public art they make in school. This encourages children to feel safe and express themselves in ways that may not be condoned in school art classes. The therapist sends the message to the child that all emotional expressions through art are accepted in art therapy.

Both Frank and Karen had difficulty putting their art away to varying degrees. Frank sometimes had difficulty because he wanted to leave his artwork out, especially since he was the last child in the room at the end of the day. He liked the idea of being able to leave his art out; perhaps in this way he continued to be in the room with me even after he left to catch the bus. Frank often tried to run out of the room to escape putting his art away and ending the session abruptly, which seemed to fit with an avoidant strategy. He evaded having conversations with me about his art in this way, thus avoiding an intimate connection that he found difficult. Despite his attempts to evade, Frank was able to stay in the room and finish the session. Karen had more trouble with the storage of her artwork, which seemed related to how difficult endings were for her, and she frequently became hostile and aggressive about putting her art away. This was directly related to her refusal to leave the therapy room, and I opened the door and left to end our sessions while I reassured her that I would see her next week. Her difficulty with storing her art and ending connected to the lack of consistency she received from caregivers; I hypothesized that she expected me to reject her and abandon her before our next session and therefore, she was

resistant to storing her art. Both Frank and Karen had difficulty in accepting that their artwork could be protected and guarded by me, but the severity and style of this distortion varied considerably between the two of them.

3.4.3 Destroying and repairing art.

Children may destroy their art for several reasons, such as being frustrated either about the art, or at the therapist, or about a related issue in the art therapy. The meaning of destroyed artwork is totally contextual, and must be handled according to the individual. It seems clear however, that as a protector, the art therapist needs to move in such a way to help the child deal with the powerful emotions associated with destruction. This may involve several different actions such as helping the child stop destructive behavior, examining the destruction after it has happened, repairing artwork, saving the remains of the destruction and talking about what took place.

In the last five minutes of our seventh session, Karen declared she was going to take her things home even though we had agreed several times that she left her art in the room and could take it home at the end of session 11. Because we had such a short period of time to talk, I asked her if we could talk about it next time. She displayed her anger by cutting and flattening her art (see figure 1). She wanted me to throw it in the garbage. I explained why I didn't feel very good about doing that and she replied "I hate my art". This statement seemed to say she wasn't *good-enough*. I said, "I wonder if we could work together so that you can start to like your art." I was holding her damaged art at the time. At this point she touched her nose to my nose in a gentle manner and wanted me to walk her to the bus. She asked for a bag for a plant which she was taking home from school. She was pleased when I had a bag and she wrapped her plant to take it outside. I connected the bag with a type of skin, protecting the plant. It also seemed to serve as a *transitional object*,[10] something Karen could take home other than her artwork that I had given her from the art therapy room.

Figure 1
Karen's cut and flattened art

Sometimes the art therapist accidentally damages something; the therapist may also act in a way that does not adequately protect the child and leads to some sort of damage. The later happened early in Karen's art therapy when I was still adjusting to the level of protection and firm structure that Karen needed. Incidents such as this provide both the therapist and child with valuable learning experience where the therapist learns to adjust her role to the child, and helps the child to have a corrective experience regarding her internal working model because the therapist addresses the incident with the child.

In Karen's case, Karen wanted to make a Christmas tree and wanted me to make the shape. She gave me a green sheet of paper and I drew the shape which she exclaimed was perfect (see figure 2, taken with cut out pieces). She decided to paint it pink, and also mixed the various color paints together in a tray for another color. She asked me what colour it would make. I reflected the question back to her and she said, "Black" and she painted the top of the Christmas tree this colour. Perhaps her choice of colors had something to do with her mixed race and her sense of being both pink and black. She wanted to cut the tree out and said, "Most people wouldn't let me cut this out while it's still wet: will you?" I responded that she could cut it out if she wanted to, which was my lack of attunement to her need for limits.

With my help holding the paper, she was cutting it out very well until she got the top and final parts of the tree, at which point the tree ripped a tiny bit. She became furious exclaiming that it was my fault the tree had ripped. Since I had told her she could cut it out, I had not responded to her need for limits. She ripped the tree more and cut off the top left branch. She said that I was bad and would have to go to prison now for hurting her feelings. She put her hands together in the form of a gun and aimed it at me. She then put her hands on me to push me. I took her hands and removed them from my stomach saying that she was not allowed to hurt me and there were other ways she could tell me she was angry by talking or making art. She took the black paint and poured it on the table.

Figure 2
Karen's Christmas Tree

Karen's emotions were high at this point, and I needed to calm her in order to help her regulate her distress. My reflection to her diffused the situation. I was able to accept her anger and then mirror it back to her in a more digestible form; I turned her angry statement into a song, which she joined me in singing. It seems I had successfully mirrored her feelings. Peter Fonagy[11] explains that mirroring is most effective if it combines accurate reflection with incompatible affect. Karen cooled down after this interaction, but she refused to help me clean up.

This example shows the extent to which the therapist must be sensitive to the needs of resistant/ambivalent children for firm structure. Karen's response to not having strong limits was extreme; she was unable to tolerate it. In this case, she went from seeing me as perfect to a criminal.

3.4.4 Art in the garbage.

Throwing art in the garbage is closely related to destroying artwork. When children throw their art in the garbage, they can be sending strong messages to the art therapist. The context of the situation can tell the art therapist what the child is trying to convey. Throwing art in the garbage may mean that the child has failed in some way, that the art is *not-good-enough*, or that something took place between the child and therapist that the child is displeased about. The therapist's response to the child can further the development of a secure base in art therapy and allow the child to work through difficult emotions and examine their internal working models.

In the middle of therapy, Frank and I had a session where he made two submarines that he submerged in the sink (see figure 3). They did not sink properly and, as a result, Frank ripped them open under the water and sank them. This also resulted in their destruction. After I tried to help him rescue the submarines, Frank decided it was time to leave. I called him back into the room, as we still had time left, and asked him what he wished to do with the submarines. He threw them in the garbage. Frank left the session

Figure 3
Frank's rescued submarine

before I could talk to him about throwing the submarines in the garbage. This left things unresolved for him, as he avoided dealing with his emotions.

This interaction forced me to determine my stance, as an art therapist, on clients throwing artwork out. As art therapists, do we always or never rescue? It seems that this depends on what statement the child is making by throwing the art in the garbage. For Frank, it seemed he threw his art in the garbage because he had failed. Although the therapist must respect the client's decisions, it is also the therapist's responsibility to provide a safe environment. As the art therapist, I needed to ensure that Frank knew that I did not view anything he made or felt as garbage even when he felt that way. In art therapy, the art is very important. Art can be likened to the words in verbal therapy. The client can not throw words or feelings away; rather the therapist contains the words/art and brings the words/art back to the client's attention to be explored. When Frank ran from the room, none of these things had been explored.

Was Frank throwing himself out symbolically? Was he destroying both of us, as he destroyed both submarines, and perhaps neither one of us survived? Perhaps this was a metaphor for Frank's sense of relationships with his parents or therapist which he feels that he has destroyed. He put the submarine in the water, which was like the nurturing mother placing the baby in the bath water; this nurturance ended up destroying the submarine, so he put it in the garbage after. This seemed to be a re-enactment of his attachment relationship with his mother where nurturance was intermingled with feelings of being hurt or destroyed. As this situation seemed to be a reflection of him and his feelings about being cared for, this was an instance where I needed to rescue Frank's art to show that we could deal with destruction and his accompanying feelings of anger, fear, and sadness.

There seems to be a difference between the therapist's rescue fantasy and seeing when the child really needs to be taken care of and rescued. The job of the therapist is to know when the child needs to be protected and guide the child through that experience. At the time of the session, I rescued one of the two submarines. If the two submarines

symbolically represented Frank and I, then I only rescued one of us. In a sense, maybe I felt I had not survived the session or lived up to what I was 'supposed' to be able to do as the therapist; therefore, I saved Frank and not myself. However, I saw why pulling Frank's submarine out of the garbage was a very important act, and Frank and I discussed it next session. Even though I saved only one of the two submarines, I showed Frank I could deal with what had happened by bringing the issue into the next session.

The result of this session for Frank was a period of working through issues of throwing parts of himself in the garbage and looking at being able to accept his emotions. During this time, Frank built two more submarines that did survive their underwater journey (see figure 4). This seemed to be a reparative experience through the art. He also decided to go through all of his art and sort the 'garbage' from the 'good stuff'. I suggested that we place his 'garbage' in a bag he could keep, in case he ever needed to look at his garbage (see figure 5). This process allowed Frank and I to talk about his feelings through the metaphor of throwing art in the garbage.

3.4.5 Transitional objects: does the art go with them?

The concept of transitional objects comes from Object Relations theory. *Transitional objects*, as described by Winnicott, are objects that represent the mother (or attachment figure) and allow the child to "maintain a fantasied tie with the mother as she gradually separates for increasingly longer periods of time" (Mitchell & Black, 1995, p. 128). Most importantly, transitional objects help the child move from the world of subjective omnipotence, where her desires make objects come to her, to a world that is more realistic. In the more realistic world, the child's desires require her to work with others and accommodate in order to get what she wants (Mitchell & Black, 1995).

The transitional object is an important part of attachment and separation process because it shows how the child gradually becomes more able to tolerate separateness, which is an indicator of a more healthy style of relationship where the child feels secure enough with the parent to tolerate separateness. The transitional object helps the child feel

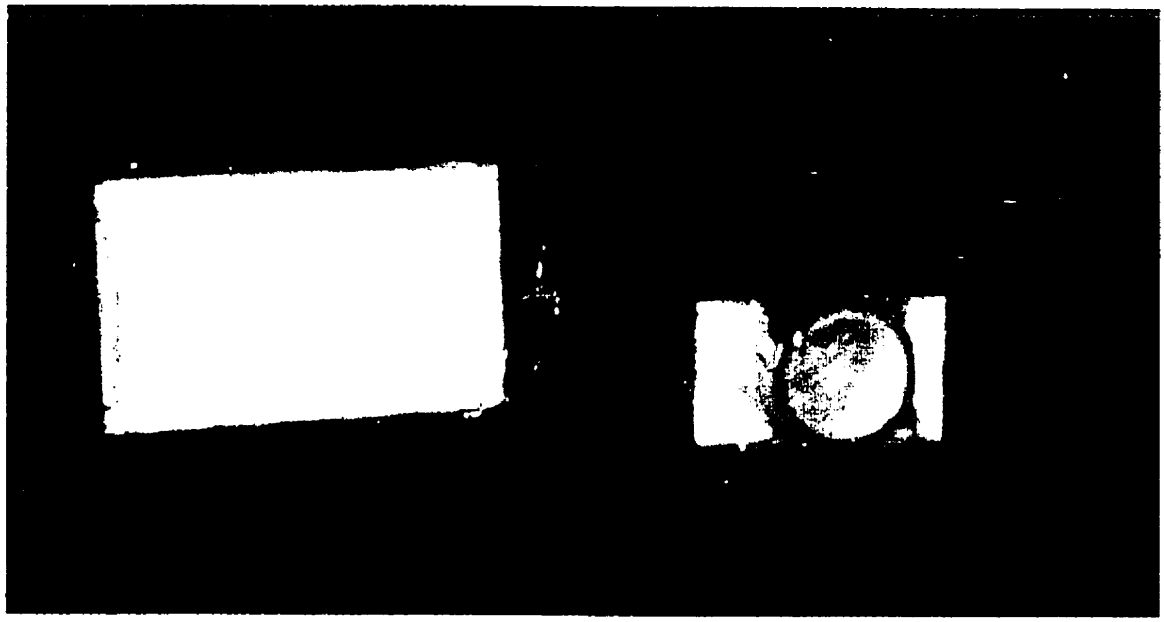

Figure 4
Frank's two following submarines

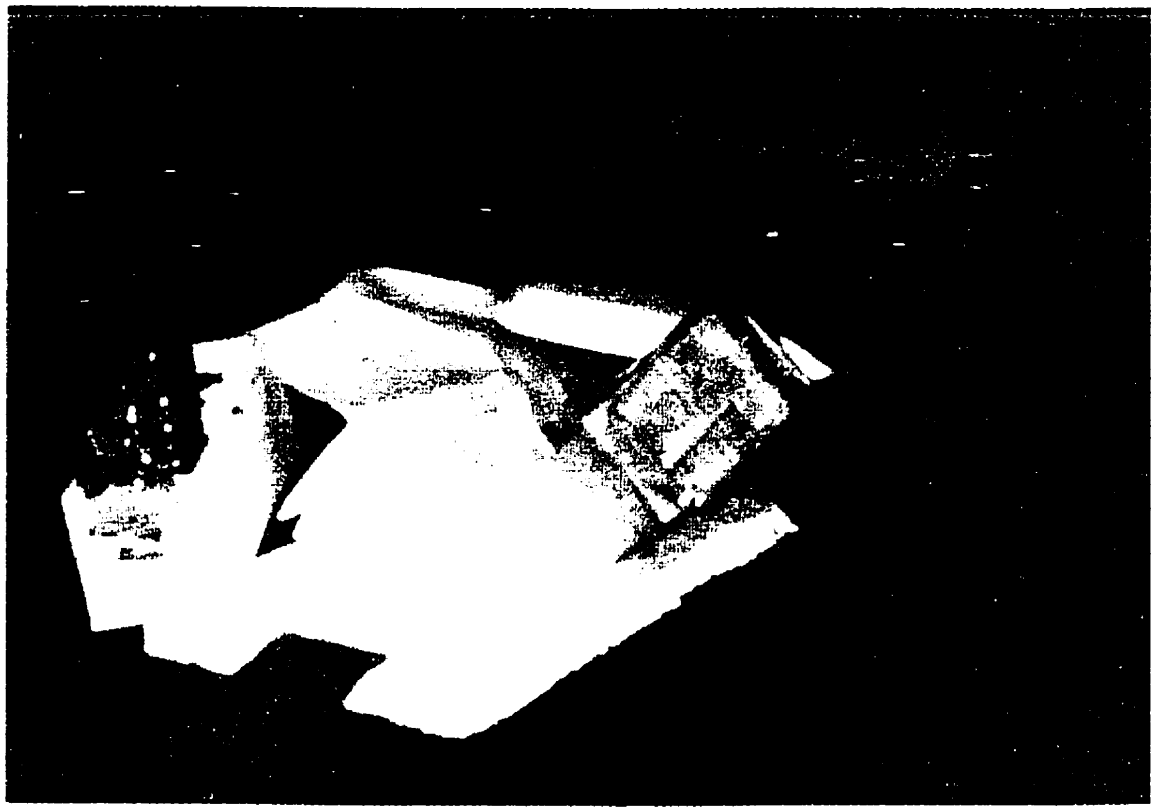

Figure 5
Frank's garbage bag

attached to the mother; it also encourages a dependence on the mother. A weaning process seems to take place as the child grows and gradually needs the transitional object less.

Because of the art product that the child produces with the therapist, transitional objects have a special significance in art therapy. Often in child psychotherapy books, authors talk about making artwork with children and then they send it home with the children that same session. It seems that in child psychotherapy, art is not afforded the same significance as in art therapy, where art therapists consider the reasons for and against the child taking their art home at the end of each session. For example, it seems to make sense to send home art with the pre-school children, who don't yet have the sense of time to grasp the idea their art will be in the room next week. However, with school aged children (7 years and older), it is my experience that most therapists encourage children to leave their art in the therapy room. This is not a hard and fast rule, but it brings up the question of negotiating with the child, and deciding as a therapist what is best for the child ñ to take the artwork home or have it stay in the art therapy room.

What are the issues at play in deciding whether art should go home or not? Developmental considerations, such as the object permanence, should be examined. The child must be able to cognitively understand the idea of object permanence to not be afraid that the art will disappear once she leaves the room. From an attachment perspective, the therapist needs to decide if the child can tolerate separateness, or if she still needs the transitional object that may help in establishing a secure base.

The art therapist has different reasons for either keeping the art in the therapy room or sending the art home with the child. The purpose of keeping the art in the room is to provide an environment that is safe and protective for the child and his thoughts and emotions. This enhances the child's attachment with the therapist, as he experiences the art therapist as protecting and caring for his art. The purpose and benefits of allowing the child to take art home seem to focus around the child having a completed artwork she can feel good about taking home, thus enhancing self esteem and supporting ego development. The

art that the child takes home becomes an extension of the relationship the art therapist has with the child, much like a transitional object.

Issues about transitional objects were relevant to Karen's therapy. Around our sixth session, Karen began to demand that she take her art home. Karen felt that I was withholding if I did not allow her to take things home. I began to evaluate different ways of handling Karen's repeated requests. There seemed to be benefits to letting her take art home, yet at the same time, I had set a ground rule from the first day and maintaining consistency seemed very important with her since she tested limits. Part of her reason for wanting to take her art home seemed connected to taking home a transitional object that was a part of her time with me; this would, in a sense, allow her to take me home.

One of my main concerns in allowing Karen to take her art home was the destructive behaviors she engaged in at home. She had recently been shredding her clothes and destroying her toys. The family reported that they felt upset about getting her new things because she destroyed them right away. I felt that if she took her art home, she would not be able to keep it safe. This may have negative effects on her already weak ego.

I debated the merits of making an object with her that would be something for her to take home and also be an experience of making something together, which may strengthen our relationship. The negatives of doing this, however, were equally strong. Making artwork together may also encourage a stronger dependency on me, which I wasn't sure was appropriate since I would only be working with Karen for seven months. I felt this would make the termination process even more difficult for her. Perhaps in a more long term therapy, I would have chosen to make an object with her to take home. I was also concerned that when Karen took her art home, I would no longer be able to act as a *protector* for her. She had a history of destroying her clothes and toys. If she took her art home, she may destroy it. Keeping the art in the art therapy room kept the therapy contained to the session, rather than expanding the therapy to her home, where I could not protect her art and help her deal with how she treated the art at home. I decided to restate

my original stance, but to allow her to take her art home at Christmas, rather than waiting until April. This way I was being more flexible, and not frustrating her as much. I could also continue the work of providing a secure base, as I was acting as a protector, and also as a guide, since I would help her prepare for taking her art home and making a safe place for it.

It is difficult to say what decision is best regarding transitional objects and whether children should take their art home or not. The question seems to be highly contextual. However, in looking at the idea of a secure base in therapy, it seems that transitional objects could act as a way to build feelings of trust and security between the child and therapist. Perhaps this is particularly true for resistant/ambivalent children who tend to cling to attachment figures and need constant reassurance that the attachment figure is available. Through such means as transitional objects, the therapist could help the child first establish a secure base in therapy and then replay the gradual weaning process that is needed for autonomy.

In this chapter, I explored attachment theory's concept of a *secure base*. I have shown how a secure base can be established in art therapy through Judith Rubin's *Framework for Freedom*. I then illustrated various issues that relate to the secure base with case material from Frank and Karen's art therapy. The main points that I covered were setting up the room and the child's access to materials, storing the child's artwork, destroying and repairing art, what it means when children throw art in the garbage, and how transitional objects relate to attachment issues. In these areas, I demonstrated how Frank and Karen enacted their insecure attachment styles and explained that providing a secure base is essential to helping children examine and later rework their internal working models.

Chapter Four

Indicators of attachment in the process and products of art therapy

In the following chapter, I explain and demonstrate what I define as attachment theory indicators in art and the artistic process in the context of art therapy. I examine the various media qualities and first look at normative art making processes for children. I then explore how the concepts of *attaching* and *detaching*, as well as attachment styles related to those activities, are inherent in the processes that Frank and Karen engaged in while making art. This exploration shows how children attach and detach through art, and how adhesive materials that children choose have qualities that relate to the actions of uniting and separating, which are central acts in people's attachment behaviors and interactions. An important aspect of the attachment process in art therapy is termination, since this involves the letting go of attachment figures. In termination, children re-enact their earlier patterns of separation. I consider termination in the last part of this chapter.

4.1 Attaching Through Art: Taping, Gluing, Tying, Stapling and Cutting

The use of tape, string, staples, glue, and scissors to put things together and take things apart is a rich metaphor for attachment. It is my belief that these materials are likely to show a child's attachment style. My hypothesis in this research paper is that children show their attachment styles through how they use these types of media in art therapy.

The major theme I wish to explore is *attaching* and *detaching* in art through the actions of taping, gluing, tying, stapling, and cutting. What makes these activities indicative of attachment? Taping, gluing, tying, stapling, and cutting are activities that virtually all children utilize when they make art, and that most children do in art therapy as well. Children's artistic actions, also referred to as the artistic process, are symbolic communications of their ways of interacting with others, of how they perceive themselves, and of their emotional states. In art therapy, children's symbolic communications are directed at the art therapist, and often the child and therapist interact through the art making

and the whole therapeutic process. Therefore, the materials children use and the way they use them give the art therapist a wealth of information about the state of the child and the therapeutic relationship.

Transference is a part of the therapeutic relationship. Transference develops once the child has formed an attachment to the therapist. In attaching to the therapist, a therapeutic alliance becomes possible when the child recognizes the benefits of change and works together with the therapist towards a common goal (Copolillo, 1987). Once an alliance exists, the child begins to replay, through the transference, her attachment relationships with parental figures. The child's art process and products reflect aspects of their transference to the therapist, which is based on their internal working models (Bowlby, 1977).

In summary, children use materials symbolically in art therapy as an expression of themselves, in a manner that is uniquely characteristic of their individual styles. Why does one child do something one way and yet another child would never do that? In considering children's individual expressions, the art therapist can become aware of attachment styles for example, through how children act and interact in therapy.

4.1.1 Normative artistic processes at various ages.

In order to understand what processes are attachment related, it is important to know what processes are developmentally appropriate for children at different ages. In this way, the therapist can distinguish what activities are developmentally appropriate and what activities that the child engages in seem related to an insecure attachment. Knowing the normative processes aids the therapist in determining what actions the child uses are not age appropriate. I now describe the normative artistic processes for preschool (3-5 years), and early elementary (grades 1-3) (Chapman, 1978). I focus mainly on the early elementary group, since this is the group that both Frank and Karen are in.

At the preschool age, children should be able to cut basic shapes (Chapman, 1978, p. 149). They begin to anticipate the amount of glue they need to paste pieces of paper

together. Children at this age enjoy discovering media and usually are not that concentrated on the finished product. They enjoy the tactile and kinesthetic activity more than the visual nature of art.

In the elementary years, children can anticipate how much glue they will need ahead of time and can plan how to efficiently glue parts together in a sequence. When doing three-dimensional work, children at this age may still be limited by their body size and strength (Chapman, 1978, p. 170). Younger children may still lack the strength to use staplers, hole-punches, or handle big materials. Finer muscle control is usually developed by age six; poor coordination in manipulating materials is usually due to lack of practice (Chapman, 1978); this implies that children need proper instruction and help to use tools like scissors. Third graders often display uncertainty in using media because they are beginning to become more aware of the 'right' way to make things, and are more focused on the final product (Chapman, 1978, p. 171).

4.1.2 Media Qualities.

Like the children who use them, all media have individual qualities that allow people to do some things and not others. Each media encourages children to express themselves according to the properties of the media. This means that some materials, because their properties relate symbolically to attachment, will be more likely to bring out attachment insecurity. To better understand the metaphor of the various materials for attachment, I briefly describe the material's qualities and suggest how they relate to attachment theory.

Tape and glue both are both adhesives, but they have different attachment qualities. Glue (liquid type) is the most permanent of the materials to be discussed and also can be a messy way of attaching. Because glue is messy and sticky, the child may require a fair amount of containment or structure in its use. The child may use the glue sparingly or excessively, which may suggest her varying need to attach. Overuse of glue in attaching can damage the two objects the child attempts to glue together. Paper may buckle and warp, suggesting a 'destructive aspect' in this 'messy' way of attaching. The child's need to

empty the bottle and difficulty accepting limits in using glue may allude to a lack of limit setting from the attachment figure, and a need for the therapist to take on a *protector* role. Glue has similar qualities as liquid paints, that children enjoy pouring, smearing, and squeezing out of the bottle. This can be extremely gratifying, but also overwhelming to both the child and the art, which gets destroyed or damaged in the process. In using glue, the child may need the therapist to be a *guide* who models appropriate usage and helps the child control the glue until she is able to handle it herself.

Also an adhesive, tape tends to be more immediate and less permanent than glue. Taping involves cutting or tearing the tape off the main roll in order to attach two other materials, and seems to be the least permanent of the attachment methods discussed. A solid, ribbon-like material, tape is not messy like viscous glue. Although tape can be quite sticky, it often is not a permanent adhesive, as it dries out and falls off many materials, especially wood, foam and plastic. The child may have to reapply the tape to ensure attachment. Repeated use of tape, even after seeing that it does not attach well, may be indicative of an insecure attachment style. Several types of tape are available. For instance, children in my therapy room had clear scotch tape, masking tape, and clear, wide packing tape. The packing tape is much more adhesive than the other types of tape, but it often sticks to itself, rips, and is difficult to get off the roll. The therapist often needs to be attuned to the process of getting the tape off the roll, and follows the child, ready to help when needed. This is akin to the therapist who is an attuned follower in working with avoidant children (Holmes, 1997). In terms of process, tape is a more immediate way of attaching and requires less patience to use because the child does not have to wait for it to dry. Repeated preference for tape and impatience with glue may suggest a child's difficulty with delaying gratification and need for instant results.

Tape can be used for other purposes, besides fastening two objects together. For instance, tape can be used to bind an object shut. Tape can also be applied over a surface as a protective covering. In both of these instances, the tape is being used to guard or defend

the object. Rather than attaching two objects together, the tape becomes an integral part of the object which it protects, much like a skin. This use of tape may indicate the child's need to protect himself or the object he has constructed. In attachment terms, the relationship between child and attachment figure may be such that the child feels he needs this protective skin. This may be a healthy defense in the attachment relationship. However, this same action may be construed as not being as adaptive in other settings, where the child does not need to protect so much, but does so because that is the way of relating that he has learned is effective.

How much tape children use may indicate certain attachment issues. Here the therapist needs to consider what she feels is excessive taping or not enough tape to secure the two objects together. It may be normal for children to use more tape than an adult, as they are still coming to terms with understanding the properties of this adhesive. Being aware of the child's process over time will help the art therapist to judge this.

String as a means of joining objects usually involves piercing or cutting the objects, and then putting the string in these holes and tying knots and bows. Younger children who are learning to tie their shoes may find string exciting, since it is an excellent way of mastering their new skill. String can be used in a complicated and intricate manner, as in the case of weaving and braiding. This may imply the complexity of the attachment between the two objects. It may also allude to the 'esthetic' quality of the attachment, as something which is beautiful and is being exhibited by the child. Bows and elaborate knots call attention to the place where things have been tied together. Knots ensure that the two objects will not come apart, giving a security to the attachment. Bows can be seen as a decorative proliferation at the end of the joining process. Bows seem to say, "look at me!" This may be conveying a sense of pride, or perhaps be a compensation for what the child feels is lacking. The child may weave and tie the string herself, or she may enlist the therapist's help. Tying it herself may suggest independence. Asking the therapist to tie, when she knows how to tie the knots and bows, may be more indicative of the relationship

or of the attachment style of the child, as she wants the therapist's involvement, may feel insecure, or feels that the other person needs the child's acceptance.

Stapling seems to be the most aggressive of the artistic ways of attaching, involving a sharp pushing motion and a piercing of the paper (or other material) to affix the staple in place. A stapler has a metaphorical connection to a gun, and may imply violence depending on how the child uses it. The child or therapist loads the stapler with staples, much like loading a gun. A child may need help using the stapler, since he may not yet have the strength to push it down. He may also enjoy pressing the stapler with the therapist, thus enlisting the therapist in the attachment process.

Cutting is a process related to attachment, since it is a way of detaching. Separation, or detaching, is a healthy part of the attachment process. Cutting is a means of separating, in that the child makes one object become two (or more). Cutting involves using other materials, like cutting the tape and string previously discussed. Suffice to say, children cut almost all art materials to some degree. The child can cut in a variety of different ways: involving scissors it can be clean or rough, depending on the child's skill and what material he cuts. Sawing is another type of cutting that can be done with scissors; it requires more physical exertion and seems more aggressive than cutting. Breaking, such as snapping something in half, and tearing seem to be less resolved forms of cutting. Breaking and tearing are also more destructive, and may relate to the child's violent desire or need to break away. In attachment terms, this may mean breaking away from attachment relationships, in the sense that the child breaks or tears something in order to become separate. The child may also be re-enacting a messy break that he experienced with an attachment figure. Cutting symbolically relates to termination in the child's everyday life and also in the therapeutic relationship, since the alliance is being 'cut off'. Children's cutting actions may change in quality or quantity during termination of therapy, since they are working through strong emotions like anger, sadness, that may be mixed with

happiness and relief that therapy is ending. This is explored further in the termination section of this chapter.

4.1.3 Avoidant attachment: Frank.

Children seem to have more difficulty using materials that move them out of their comfort zone. Thus, if Frank avoided expressing himself emotionally because he feared how I would react to him, and had a need to control unacceptable feelings by shutting them off, perhaps he would have trouble using more regressive materials, such as glue, and prefer materials he could control. In expressing his attachment style and needs, he probably would also prefer materials which symbolically allowed him to protect himself.

Fitting with this hypothesis, Frank tended to stay away from more regressive materials. For example, he did not use glue[12]. He tried it once but became frustrated when it took too long to dry. He said that he didn't like glue. It didn't seem to work with his constructions. He seemed to find the mess of the glue distasteful; it went all over the place and was difficult to control when gluing complex little pieces together. He preferred a quicker solution to holding the pieces together.

Frank regularly used tape, and in taping, he expressed his strong ambivalence between attaching and avoiding. When building a large semi-truck, he would attach objects using tape and then take them apart again. He liked the different parts of the truck to come apart. He preferred the large masking tape. One of the results of using tape to build complex objects (such as a forklift and a semi-truck) was that the finished products were not as stable as they could be. This seemed to apply to his feelings about attachment figures, as the trucks were about his father (who was a truck driver). Perhaps it indicated the instability of the relationship, or Frank's feelings that his father could not hold things together for the family. Frank often would come in the next session and need to re-attach parts of the truck that were drooping or falling off.

Later, Frank switched to using wide packing tape to waterproof his boats. This required large amounts of tape, and Frank was worried that I would run out of tape for him

to use, which was a real concern since he used tape extensively. Frank's anxiety seemed to speak of how much he needed to have that tape surrounding his boats, and this implied to me his need to protect himself which seemed like his defense mechanism that had served him well in the past. This waterproofing, which involved taping things shut, was a major part of building. Frank regularly used what I considered to be excessive amounts of tape. This excess use of tape seemed to have a protective quality that had a dual nature. It seemed to symbolize both his need to keep people distanced from him, but also to make sure objects inside the boat would not escape or leave. The protective tape also symbolized his need to keep his undesirable emotions inside of himself.

Much of Frank's taping activities required cutting and he often enlisted my help in this process. Roughly in the middle of therapy (session 14 of 27 which was previously discussed in chapter 3) Frank's process revealed how he used the taping and cutting in an avoidant style. Frank walked into the room without greeting me. He picked out a box from the recycled materials and began to tape it shut, asking me for help with tape and scissors. He did not look up at me. Although we worked together, I felt like Frank treated me as a tool to get his work done. He ordered me around, telling me to "cut" the tape and "flip" the box as he worked. I felt like a nurse helping the doctor operate. We were playing out a type of operation where Frank fixed something and I helped, but I couldn't get over my feeling of being treated like an appendage or part-object, as if I was being used like a doctor used a tool. Fitting in with the doctor metaphor, at one point Frank sliced the tissue box open in order to add some heavy plasticine, like he was doing surgery. Frank then wanted me to guess what he was making. In this interaction, Frank wanted me to know what he was making without talking to me, but by getting me to guess, he was attempting to engage me and asking for attunement. Thus, he was asking for what he needed, which was a therapist who could be an attuned follower. This fits with the style of therapist that avoidant people need in therapy, according to Holmes (1997). Frank both wanted my attention and help, but simultaneously distanced me and cut me off when I attempted to talk to him. This

shows Frank's avoidant way of wanting intimacy, but simultaneously shows his struggle against intimacy. Frank's ways of interacting, which were supposed to bring me closer to him, were having the opposite effect of frustrating and distancing me.

4.1.4 Resistant/ambivalent attachment: Karen.

Children seem especially attracted to materials that help them express where they are currently having problems, or have experienced impingement in the past. A child like Karen, who seems to have problems with internally structuring experiences and controlling her impulses, expresses her difficulties through her trouble with using materials like glue, and through her cutting and stapling, which at times became destructive. She seemed to do this to call attention to her attachment figure, in an effort to be nurtured. Karen's attachment figures seemed to struggle with structuring her experiences and they changed often (i.e. who would be there next?); therefore, Karen has major difficulties structuring her experiences. In art therapy, Karen seemed to re-enact her ambivalent relationship with attachment figures: she sought nurturance and love, but simultaneously acted in a hostile and aggressive manner. It is the therapist's task to help her experience a structure and limits in order to help her tolerate both love and hate in relationships. Previously, Karen did not experience effective guidance, so it was difficult for her to accept help from the art therapist without acting oppositionally.

A major theme in Karen's art has been tying, gluing, and stapling things together. This seems to be a metaphorical way for her to bring things together in her life, which for most of her existence has been in upheaval. As someone who has been rejected, it seems very important that she hold onto people and keep them stuck to her. This relates to attachment and the importance of having a strong bond with her caregiver, who she is dependent upon emotionally and physically.

Karen's tying activities focused around punching holes in the corners of her drawings and then tying elaborate knots and bows from them. The string came off the artwork like kite tails, and she did not attach any objects to her drawings with the string. This suggested

to me a intense focus on joining, but not knowing what object to join onto, which related to her family history where she had multiple caregivers and seemed at times unsure who to view as her primary attachment figure.

Karen used glue in a messy and excessive manner. Sometimes when she was angry with me, she would look up at me as she poured the glue out onto her artwork or the table. Once she said, "You won't be able to get that off." This suggested that she wanted her gluing the table to be permanent, leaving her mark in the therapy room, which was her way of ensuring her attachment to me. Karen had a hard time judging how much glue she would need, and often had difficulty accepting guidance from me in using the glue. Her drawings sometimes buckled because of the amount of glue she used.

Karen enjoyed stapling, and was quite aggressive with the stapler. She especially liked loading the stapler, which she wanted to overload in the same way she loaded the table with supplies. She once attempted to staple me at the end of a session when it was time to leave. This demonstrates her ambivalence towards attachment, in that she wasn't sure whether to love or hate. It also conveyed her somewhat angry and destructive attempts to stay attached.

Karen has also focused on cutting and cutting things out. Cutting was sometimes used in a destructive way, such as when she cut her art. This seemed related to her 'ritualistic' cutting of her clothes and toys that she engaged in at home. Her cutting could symbolically relate to the Winnicott's idea of the *whole object*. The *whole object* is the provider of both goodness and frustration (Mitchell & Black, 1995), and usually is the mother or attachment figure. Karen cannot seem to imagine that good and bad can come together to form a whole, therefore she attempts to damage the relationship, either at home or in therapy, by cutting or destroying her art, clothes or toys. Karen often destroyed her art. This usually happened when she had experienced me in the session as being both good and bad. In those moments, she experienced me as the whole object, but this seemed too difficult and frightening for her to comprehend, in that it challenged her internal working model. She

seemed to attempt integrating the idea that I could be good and bad at the same time. When she came close to integrating the object (me, the therapist), I believe that she could not handle the union, and so she invalidated it symbolically by destroying her art. In this respect, cutting things up had connotations of undoing some of the work Karen did in holding things together.

Karen was able to use cutting as a way to express negative feelings, instead of taking them out on me. This happened one session after she had attempted to hit and kick me. I set limits to help her contain her anger and she did very well. As she went about the session, she had a pair of scissors and a cardboard box, which she cut up into pieces during our session. In this way, she directed her negative emotions into the art materials.

By cutting things out, I mean that Karen would make a drawing and then cut around the edges of it, like when she drew a heart or a popsicle and then cut it out of the paper. This seems a way of giving her drawing more importance: the heart and popsicle she made were no longer just drawings; they became objects. Her cutting out mostly happened in the middle sessions, which I feel reflects the added strain she was under trying to deal with discovering she was being 'rejected' by her aunt. She needed to show that these objects, which seem to symbolize being fed and being loved, are her urgent needs; therefore, she gave them added importance by cutting them out and making them into objects.

4.2 Attachment Theory and Termination

From the work of Mary Ainsworth previously discussed, children's patterns of separating can indicate the state of their attachment relationships. Most children have trouble with transitions and endings, but this is especially true of children who have not had caregivers who have guided them through transitions and helped them acknowledge and make sense of the feelings associated with endings. The type of ending I refer to can be ending one activity to change to another, ending a session on time each week, or the final ending in therapy where, as in the case with both Frank and Karen, child and therapist will most likely not see each other again. Termination in therapy with children who have

disturbed attachment styles is an important part of the working through process in therapy because children are re-enacting previous ways of separating, and the therapist can look at these different issues with them. It is in termination that children may learn a more adaptive way than they have previously used to say good-bye to people who are important to them.

The way that children deal with termination in therapy relates to their attachment style. Children who are insecurely attached are probably going to have difficulty with saying good-bye. They may not deal with the feelings of sadness and loss inherent in saying good-bye. Expanding on the ideas of Holmes (1997), who talks about how adult clients or therapists may terminate either too early or too late from an attachment perspective, it seems that avoidantly attached children may wish to terminate too early. Children who are ambivalently attached similarly have trouble saying good-bye, but in a different way than the avoidant child. The ambivalent child may have trouble terminating and, if not given the structure needed, will terminate too late. Holmes (1997) stresses that for clients to experience a good ending, they must have achieved a secure base in therapy that the therapist promotes by adopting the style, either structuring or attuned following, which is concordant with the child's attachment style.

4.2.1 Termination issues with Frank: avoidant attachment.

Frank began the termination process on his own quite early, suggesting his use of an avoidant attachment style. Perhaps he began saying good-bye early in an effort to avoid getting any closer to me and thus feeling hurt. I think of avoidant children as having a type of self talk that involves saying, "Better to say good-bye now and not get to close, rather than to get close and risk feeling hurt." These types of statements are often common in adults, speaking to the pervasiveness of internal working models in determining interactions in relationships.

Frank's termination process began in session 16 (out of 27) when he asked me if I would be around next year to be his therapist. During this session, he had built two submarines that went on an underwater voyage together (see figure 4). We enacted the

voyage together in the sink full of water. In session 17, Frank decided to sort all of his work and filled a bag with his 'garbage' work. This seemed to be his sorting and taking stock of what he had done in art therapy, and in this sense, had a quality of ending to it because he was reviewing each piece of art.

I formally began to address our ending in session 22, which gave us six sessions for termination. After talking about when we would finish, Frank decided that it was time to stop making art. Perhaps stopping making art, which was so focused on taping, symbolized stopping the attachment and beginning the detachment process. Frank instead wanted to focus on playing with me. In this way, the transference seemed become more buddy-like, as we played games he played with peers and began referring to me as his friend. This 'buddy' relationship was more interactive and Frank focused on engaging me. Perhaps his more active role allowed Frank to deal with his relative powerlessness over when we were ending, as termination was imposed on him.

During this playing, session 22 and 23 focused on battle. Frank took the large semi-truck he had built over a number of sessions and instructed me to use a much smaller forklift that he had constructed. What followed was a face to face battle that involved direct confrontation, death, anger, and secret weapons. Parts of Frank's semi-truck could detach, and he used these as extra defenses against me. We often stopped to make repairs, but Frank played in such a way that nothing got destroyed. This seemed to speak of the care that was behind the battle; he could, in a sense, be angry without destroying the 'other'. Despite previous problems with objects staying taped together, the trucks were surprisingly resilient. The construction was good, even if Frank did not always use taping methods that held things together optimally.

Frank needed to metaphorically kill me during these battles, and as we progressed, Frank said, "The battle is not as easy anymore." This seemed to reflect his growing difficulty in saying good-bye. It was also a paradoxical statement because the battle was much easier for him, as he played the large dominating semi-truck, compared to my little

forklift that had relatively few weapons or defenses. Although he took on the role of the aggressor, I felt Frank took that role out of identification, and also felt much like the forklift I played. As we played, I reflected to him how hard it was for the forklift because it had to be much a faster and more crafty opponent. I had to think a lot and always anticipate what the big semi-truck was going to do; it was hard work. I felt that I enacted Frank in relation to his parents during this play. What I said related to how Frank felt when battled his parents.

Frank seemed more able to disclose how he was feeling today; he said that he would miss me and the time that we had spent together. This was an extraordinary statement compared to his usual avoidant style with me. Perhaps his ability to express his feelings related to our more open battle, in that he could be more open about how he felt. His willingness to be open also may have made the battle more difficult for him. I wondered if now that we were ending, Frank felt more at ease revealing himself. Perhaps knowing that I would be leaving allowed him more distance, and therefore, more ability to be open with me. At the end Frank wanted to run out and get me to put the trucks away. I called him back in and we put them away together, thus not allowing him to leave in an avoidant mode.

During termination, Frank had one session where he made a hockey puck for us to play with. This was during our fourth last session, and was the only time during termination that Frank made anything; otherwise Frank focused on playing. He had difficulty with the tape that day, and it was the only day that I ever saw him attempt to rip the tape. He tore at it with his hands, and was frustrated. We talked about different ways of separating through the metaphor of cutting the tape that day in order to work through our upcoming ending. He was making rough breaks, perhaps displaying his displeasure at seeing me leave. The break was more messy, not a clean break, as when we used the scissors to cut the tape. His ripping suggested that he had feelings of being ripped away, and perhaps related to the lack of choice he had in our termination. He had previously been

upset when I told him I would not be his therapist next year. Perhaps, in the ripping, he anticipated that the break would be difficult. When I suggested that there were ways of taking things apart without destroying them, Frank decided to get the scissors.

Fitting with the friendship transference that seemed to develop in termination, Frank told me during our play with the hockey puck that we had built a special friendship. The theme of our conversation focused on friendship and our relationship. The game he introduced was one that he plays with friends. I commented on how a couple weeks ago he had been very lonely, and that it seemed he had made some friends in the program. He said that was true, and that now he had some friends and was less lonely. Later, when I asked if Frank would like to do anything special or build something together for our last sessions. Frank said he felt we had already built something special, which was our friendship. I was touched by his openness in saying this. I also felt that our closeness over the year was distanced and difficult for him. Often I got the sense that he was very lonely and did not know how to connect with me; at times, perhaps because of the tension in our relationship, I had difficulty measuring how connected we were. His statement about our special friendship seemed to show a change in our relationship over the course of therapy.

At one point in our play, we were no longer scoring goals on each other, but just passing the puck back and forth. Frank said that this sound was like music. This seemed a nice metaphor for our conversation today in which I felt we had reached a good level of attunement, and the relationship we built over the year.

During our last session, in packing up Frank's art into boxes I supplied, he decided he needed several boxes. He wanted everything in separate boxes and asked me to help him close them, explaining that each box had to fit the art. This showed the care he felt for the art he had made, and by extension his time in art therapy, in that he took special precautions to guard against damage. He then sealed each box with tape, which seemed to be a symbolic way of closing his time with me. He decided to recycle the bag with the garbage. In putting it in the recycling bin that I brought in for the session, Frank stomped on his

'garbage' art. This seemed to be his way of holding onto the good parts of art therapy, and concentrate on his accomplishments, rather than on the 'garbage' art that he felt had not turned out.

4.2.2 Termination issues with Karen - resistant/ambivalent attachment.

Although Karen and I formally began termination five weeks before our final session, I found that I needed to view each session's ending as a mini-termination that would prepare her for our final ending. I suspected that Karen would not wish to terminate, and thus be 'too late' in ending, unless I helped her structure the experience. I felt this way because Karen's reactions to ending the sessions were so strong. Much like an resistant/ambivalent infant, Karen seemed to both seek and resist contact when ending our sessions.

In treating each session as a mini-termination, my goal was first to help her act in an age appropriate manner, and work on her ego strengths rather than allowing her to regress, which is what she tended to do. My concern was that she would regress more in our final termination if she was not prepared in this way. In order to accomplish this, I engaged her in clean up and asked her to take responsibility for ending the session. I felt this was developmentally appropriate for a seven year old child. These were both tasks, that even with my help, Karen had great difficulty doing. Often she slowed down at the end of the sessions, working on her art more slowly and finding "just one more thing" to do. When I set limits, she became oppositional. Slowly, however, she became more used to ending. We had several sessions in a row after Christmas break where Karen was able to either clean something or put her art away. In a way, I was asking her to develop the strength to do these tasks and pushing her to make some developmental leaps, and she began responding slowly. She also grew comfortable in allowing her art to be stored in the room. Thus, the room had finally become a safe enough place. She could leave her art in the room and exit the session knowing she would see me again.

Karen's progress around ending the sessions seemed interrupted by a family crisis where her mother disappeared and a final date was also set for Karen to move out of her aunt's house: Karen was extremely affected by these events. As her family situation became more precarious, she had shut down in class and sat immobile and mute, unable to come to art therapy. Although she entered the session the next week in a relatively good state, she quickly decompensated. She brought her rage (that was being more controlled in class) to art therapy in the form of physical and verbal aggression. Despite my attempts to set limits and structure her in the session, it took several sessions and a meeting with Karen and her teacher to get her behavior under control.

Our last session before spring break, two weeks after her family problems, is an example of how breaks affected Karen and how she reacted to breaks. Her difficulty at home seemed to be another trauma for her already weak ego to handle and she played out the 'breaking' of her family with me. This breaking was simultaneously taking place in our session, since we were also having a break, making her reaction that much stronger. These 'mini-breaks' within therapy must be treated much like mini-terminations, since the child is loosing that special support for a week that she has come to enjoy and rely on. The following is my account and discussion of the session before spring break.

Karen came in happy and excited about a camp she was going to in the summer. We talked about her anger last day at the end of the session and she felt bad about it. She explained that she was upset because she didn't know she was going to camp last week. She seemed upset that she had gotten so angry, but her reasoning seemed to indicate her feelings of hopelessness for her future, particularly that she didn't deserve anything good (like camp) to happen to her. We developed some ways to help her manage the end of the session by keeping track of the time and telling me she was getting angry before acting out, so that I could give her some space. This way she would not need to act out.

Karen's artwork also displayed her resistant/ambivalent style of dealing with termination. Karen began a drawing where she wrote my name as "BRAKTI", saying she

didn't want to spell my name right (see figure 6). The word seemed close to 'break' and 'brake'. This play on words seemed to imply her conflicted need/desire to break me, since it is supposed to be my name. "BRAKTI" also seemed related to taking a break and our upcoming break, as well as the breaks in her family. She described the drawing as being on a "big red wall". The saying 'the writing is on the wall' appropriately describes Karen's impending sense of endings and breaks in her life as being a fate she cannot escape.

An important aspect of this drawing was the way she attached it to another piece of paper. She took the glue and smeared it all over the back of the drawing. The glue became thick and heavy. She asked me to attach the two pieces of paper. I suggested we do it together, which went well. The paper buckled and became warped from the amount of glue she used, suggesting the damaging connotations that attachment had for her. She seemed to need to hold on at all costs, showing how much she needed to receive the love and attention she got from our relationship.

Karen became verbally and physically aggressive towards me when I began to clean up and end the session. She attacked me in a way that I almost restrained or held her. As someone who has been rejected, it seemed very important that she hold onto me and keep me attached to her. It was as if she had to reassure herself that she was attached. Her need to be held or attached seemed to relate to her need to be restrained, like she was attaching to me in the ending in a resistant or ambivalent manner. The resistant/ambivalent person clings to attachment figures, afraid she will be abandoned forever (Holmes, 1997). This seems to describe Karen's behavior in the session; much like an resistant/ambivalent infant, Karen both sought and resisted contact.

I developed more structure for Karen after this session to help her contain her anger and end the sessions in a positive manner. This involved putting away many of the materials she used destructively to attach or detach (as well as other regressive materials). I put away such materials as sharp scissors, and limited the amount of glue in the bottle. I

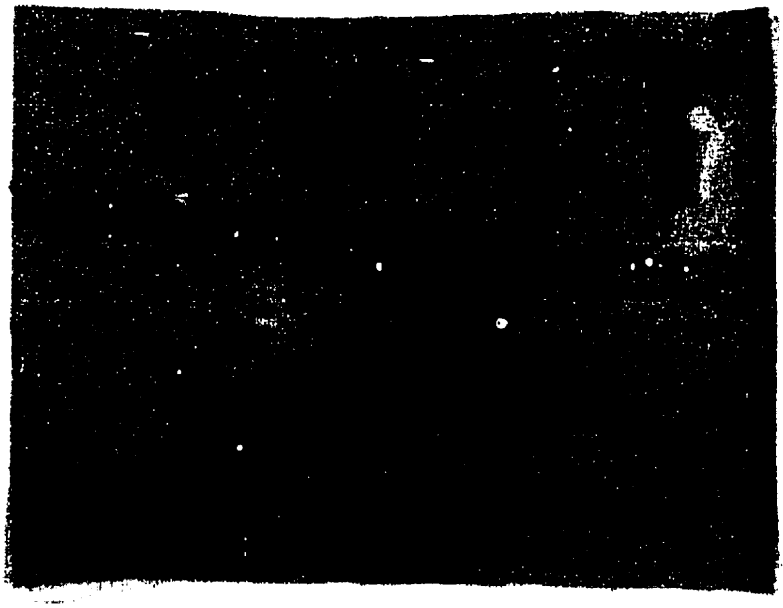

Figure 6
Karen's BRAKTI image

also devised some concrete and immediately available art activities for her to use when she felt overwhelmed.

Even with the structure, she had an increasingly hard time leaving in the last three sessions. I could assume that for the last session we would have problems and began to strategize what we could do to help her have a good ending with me. I saw the final goal as Karen being able to say good-bye without becoming physically or verbally abusive towards me. This was very important so that she would feel she was capable of saying good-bye without feeling she was being abandoned forever. Instead I hoped that she could feel that an ending could be an experience that did not psychically destroy her and tear her apart, which I felt was her experience in her family.

My biggest concern was that I did not think she would be able to say good-bye on her own with my help. This was partly due to the large amount of anger that she displayed about leaving and her simultaneous denial of this anger. This anger and denial was evident in the way she ended sessions by becoming violent. One strategy I used for her to use when she felt overwhelmed was a plasticine cone for her to pound. As she pounded it and smeared it all over the paper, she would say, "I'm not mad." She seemed to be regressing a fair bit also in the final sessions. Although regression is to be expected in termination, in her final drawings, she drew people in a developmentally much lower fashion than she was capable of and they were disorganized and angry looking. Regression can be a way that the child tries to hang onto the therapist, saying that she is not ready for the therapist to leave because she is still not doing well enough to be alone (Holmes, 1997).

At the end of therapy, making books together became a way of helping Karen separate easier. It seems that my earlier stance on making an object together was not as strongly negative for Karen as I originally thought. During our last three sessions together, we made books that depicted our times together that Karen took home in at the end of each session. In this way, she took her art home slowly over the last three sessions, helping in the process of saying good-bye. The first book we made had a drawing of the two of us on

the front of it. First Karen drew me and then I drew her. By the last book, Karen had decided that only she should be on the cover. Her last book seemed to express Karen's knowledge that she could continue her own, and she understood that I was leaving.

An interesting process in making the books was our work together of punching the holes, tying the ribbons together, and making the bows. This process of binding the book had an attachment quality that suggested to me that Karen had begun some more positive methods of attachment. She and I worked co-operatively; she asked for my help in punching the holes, and she chose the ribbon, then we cut the pieces of ribbon together. Karen tied the bows herself and did so competently. There seemed to be an increased maturity in the way she conducted herself during making the books, and she expressed her pride about how they turned out. Through making the books, Karen was able to see the gains she had made in how she conducted herself. Karen also saw that she could make a beautiful final art product, which I felt was an excellent achievement for her in art therapy, since she had initially stated that she hated her art and felt things did not turn out how she wanted.

For Karen's final session, I invited Karen's new therapist to join us for the last fifteen minutes. I did this to give Karen the security of having a new person to attach to, and this way she would not feel totally abandoned. The downside to this was that Karen would not experience total closure with me, but it seemed that she was not capable of handling the loss. Mourning the loss seemed unlikely for Karen, considering all the trauma she experienced related to abandonment. The following is my account of our last session.

Karen arrived in a good mood and enjoyed the special tea party that we had arranged together for our last session. We ate together and she helped me make hot chocolate to drink. I introduced inviting Michael (her next therapist) to join us as a special surprise I had for her. She was very excited about the idea that I was giving her a gift, and initially thought I was giving her something concrete I had hidden in the room; she accepted my inviting Michael as a special gift. She hugged me and told me she was very happy about it.

I encouraged her to make a folder to take her artwork home in, as she had been unwilling to do this at any other time. She agreed and got out the paper which we stapled together. Karen asked me to staple, as she felt she could not do it (even though she was capable). This suggested her desire to stay away from the more aggressive materials, but to see me use it was enjoyable for her, almost like I was acting out for her. In this way, she seemed to ask me to take control, which contained her ambivalent emotions. She wrote "Karen's special folder" on the front and then drew a big heart which she asked me to color red. Then she asked me to draw a small heart beside it, which she colored pink.

We discussed what she would do with her art when she took it home, and if she could find a safe place to keep it at home and take care of it. She decided to leave several things for Michael; these were all art that I had saved that she had not liked or wanted to destroy, or had destroyed and I had saved it. This spoke of her need for containment.

Michael came in and we sat together and talked. I let Michael take a more active role, and I began to sit back more, to allow Karen to begin to form a relationship with him. We ended by taking Karen's art to Michael's office and then we walked together to the bus. Karen held Michael's hand on the way, mostly ignoring me. Michael stepped back as I said good-bye to Karen, and handed her the folder with her art. She gave me a bus she had made earlier in the year and told me to give it to Michael to keep. This seemed to act as a transitional object. I felt that introducing Michael and beginning her transition in therapy greatly eased Karen's anxiety and anger about leaving me and allowed her to experience a more positive ending.

4.3 Discussion of Attachment Style and Art Therapy Indicators

In writing about Frank and Karen's art therapy, I put forth two main hypotheses. The first was that children re-enact their attachment styles in art therapy, and may begin to rework their internal working models in their relationship with the art therapy. The second was that certain art materials seem to indicate attachment issues through their symbolic connection to the acts of attaching and detaching. Through this exploration, I discovered

that Frank and Karen used materials and behaved in art therapy in ways that fit respectively with their hypothesized styles of attaching.

4.3.1 Frank.

Frank seemed to re-enact a situation in therapy where he needed to protect himself and sometimes did not want help, which fits with my hypothesis of his avoidant attachment style. He seemed to simultaneously want to have a relationship with me, but had difficulty tolerating intimacy with me. Frank expressed this through his art process and materials, such as in his use of tape as a protection for his submarines. Through the taping process, he seemed to express his ambivalence about wanting to engage me and also needing to distance and protect himself. This seemed to be his way of re-enacting his previous relationships, in that he protected himself because he expected to be rejected or have his parents act in a hostile manner towards him. The way that Frank used materials suggested to me that avoidant children may use materials in protective ways.

In the taping process, Frank also seemed to look for the therapist to use an attuned and following style. My involvement as a follower perhaps allowed him to be closer to me because I was not as threatening to Frank when I was in the follower role. In his need for a therapist who used a following style, Frank seemed to be able to keep the distance between us comfortable for him. In this way I sometimes felt he wanted to protect himself from asking himself the scary questions about his life, and experiencing a deeper intimacy with me. From these conclusions, it seems that children with an avoidant style may choose and utilize attachment materials that encourage the therapist to act as a follower who is active and involved in the process. However, this same use of materials can act as a way of distancing the therapist, which seems to be the way the child protects himself and keeps his feelings inside so that he avoids intimacy, thus re-enacting the avoidant attachment style.

In looking at the avoidant attachment style, and what seems to have caused the insecure attachment, I gained further insights into Frank's use of materials in re-enacting his style. As previously discussed (section 2.5), Frank seemed to experience attachment

difficulties based on Beverly James' (1989) idea of *reunification*. This is particularly relevant to Frank's use of tape, which I described as a less permanent attachment material, since it often lost its adhesiveness. Perhaps in using this material, he was asking "Will this be a permanent attachment?" In his attaching activities where objects sometimes fell apart, he may have been expressing his real life concern about reuniting with his father, and his fear that this would not be permanent. This lack of adhesion seems to relate to the avoidant style in that the child who is afraid of intimacy may pull away from attachment figures, in a similar way that the tape separates from objects it is attached to.

Frank's cutting activities about detaching seemed related to the *loss and disruption* of his relationship with his mother (James, 1989). Detaching had some healthy aspects for Frank, since he seemed to need to re-experience cutting where he was in control, such as when he ordered me to cut. He also began to trust that I could tolerate his anger about detaching, which seemed important in terms of deepening intimacy because he could open up to me. Frank expressed loss and anger through the tape and detaching in the termination process when he tore the tape. Using a less resolved of cutting suggested the unresolved nature of that loss for him.

In terms of repairing internal working models, Frank seemed able to establish a secure base with me, which is the first goal of working with children who have insecure attachments. Over the course of therapy, Frank was increasingly able to accept me as a *provider* of art materials. Frank also worked through issues of destroying and throwing out his art, which partially had to do with re-experiencing an attachment figure as a *protector*. This allowed him to begin to trust and feel secure within our therapeutic relationship.

Frank worked through issues about loss in termination. This was accomplished primarily through battles we played out, and later through playing games. During termination, Frank stopped or 'avoided' making art; perhaps this was his unconscious way of hanging on to his avoidant strategy, while he simultaneously practiced a new and more secure style of relating to me through the games. This may suggest that children with

avoidant attachment styles need to avoid art materials in order to lessen intimacy upon ending. It seems that this could be either adaptive or less than optimal depending on how the child behaves during this time. In Frank's case, it seems to have been a way to hold onto the old style while he tried out the new, which I felt was a healthy way of adjusting. Decreasing intimacy and thus, beginning the process of letting go, is a normal part of the termination process. However, Frank's avoidance of art materials suggests that avoidant children need guidance during termination to express feelings and effectively say good-bye, rather than ignoring the importance of the relationship.

4.3.2 Karen.

Karen seemed to re-enact, through the art, a situation where she sought nurturance and protection in an aggressive fashion, which fits with a resistant/ambivalent attachment style. Karen tended to use some of the attachment materials in an aggressive fashion, such as the stapler, scissors, and the glue. Perhaps resistant/ambivalent children use art materials in an aggressive manner in an attempt to call for nurturance and protection. It may be that Karen was mostly attracted to the more aggressive materials, perhaps because they allowed her to be intensely involved in the art making process. Stapling and cutting seemed to allow her to express her distress and pain in an instantaneous and concrete way that sometimes could be difficult for the art therapist to control or modulate immediately. In this way I felt that Karen re-enacted her experience of not having her emotions modulated effectively.

Karen predominantly focused on gluing, which I described as the most permanent of the 'attachment' methods in art. This suggested to me her desire for permanent attachment, and for things to be stable and secure. Karen seemed to operate at a lower developmental level in her use of glue and her need for firm structure when she used it. To me, this suggested attachment issues. The need for structure spoke to me of her need for a *protector*, which related to the needs of children who have a resistant/ambivalent attachment style. Her focus on glue suggests to me that resistant/ambivalent children may express their need for stable attachment through choosing attachment materials that are permanent.

Looking at what caused her attachment trauma is relevant to how Karen expressed herself in art therapy. Examining her art therapy process with Beverly James' (1989) description of *loss and disruption* and *impairment* sheds light on how she used the art materials. From the *loss and disruption* Karen experienced, she may look for stable attachment figures. Thus, perhaps she was attracted to the permanence of glue. Combining this with her resistant/ambivalent style seems to explain her ambivalence towards the materials. The glue is good for attaching, but it also may hurt or even 'destroy' the art because symbolically the attachment is both sought and resisted through the act of gluing. Karen's *impaired* attachment relationships is suggested through the sometimes 'destructive' aspects of the way she used glue.

Karen's intense focus on joining through tying also seemed related to her attachment style, the loss that she seemed to experience from childhood, and her desire to be loved and taken care of. For example, she would tie elaborate knots, but what did they join onto? This seems to relate to her feeling of loss and not knowing who to join onto in her life. Simultaneously, this tying was also a way to keep things together. Her tying, in its duality of not knowing what to attach to and trying to keep things together, seemed to metaphorically speak of her ambivalence towards her desire for attachment.

Karen seemed to make some steps towards repairing her internal working models. Most of our work together focused on establishing a secure base. This involved a focus on our alliance and building trust and felt security for Karen. My main task was to act as a *protector* to Karen through both the art materials and our relationship. With resistant/ambivalent children like Karen, it seems that accepting protection from the art therapist in the form of storing the art is a major issue. Karen also worked at allowing me to protect her from over-stimulation by modulating her use of materials, and thus her emotional state. This seems particularly relevant with resistant/ambivalent children, and a further goal in my opinion is helping them internalize the ability to modulate their moods.

As the art therapist, being the *protector* involved helping Karen contain her aggressive impulses and allowing her appropriate expression of her feelings through art materials.

Establishing the secure base also meant that Karen began to accept guidance in her use of materials, and how she acted with me, without extreme anger or resistance. Finally, being able to let the therapist provide materials for her, and accepting them, was a major step. Karen's gradual acceptance of me as a *guide* and *provider* seemed to show her progression towards changing her internal working models.

The termination process also gave Karen a chance to re-experience an ending as something she could manage and survive. She displayed problems with termination through her actions and her regressive use of art materials. With structure, she was able to use materials to express negative emotions, rather than physically or verbally acting out. Structuring art materials greatly improved her ability to end art therapy. This suggested to me that resistant/ambivalent children are distraught by the thought of termination because they re-experience previous losses. Structuring art materials, and the art process or activity if necessary, during this time seems to greatly reduce this anxiety and any accompanying acting out. This allows resistant/ambivalent children to say good-bye in a more healthy way, thus challenging their internal working models.

In this chapter, I have looked at indicators of attachment theory in art therapy. I postulated that children re-enact their attachment styles in art therapy, and may begin to rework their internal working models through their relationship with the art therapist. Looking at indicators of attachment theory involved examining the symbolic meaning of various art materials, the normative processes in art making for children, and Frank and Karen's art and artistic process. In the second part of this chapter, I continued looking at indicators of attachment theory in the termination process. Here I looked at how Frank and Karen dealt with termination in ways that fit with their attachment styles. This was done by analyzing their art and process. In the final part of this chapter, I discussed my conclusions regarding indicators of attachment style in art therapy.

Conclusion

My main purpose in writing this research paper has been to begin making links between art therapy and attachment theory. The subject of attachment theory and art therapy evolved directly out of my work with children with Attention-Deficit and Disruptive Behavior Disorders. During my internship as an art therapist, I struggled with finding a theoretical model that best informed the art therapy process with these children. I saw my search for a theoretical model as indicative of my strivings to position myself as a clinician who is both flexible to the needs of her clients, and who has a framework to conceptualize what happens in therapy and to guide my interventions. By exploring my personal orientation as a therapist, I could begin to glean the children's needs and establish goals.

My entry into choosing attachment theory involved studying the children's art, and exploring the intense emotions between myself and the children during the process of making art. As I looked at the children's art and process, I began to see themes around taping, tying, gluing, stapling, and cutting. These themes seemed to relate to replaying attachment style in that the activities indicated a need to attach and detach. Often the interchanges during art making were intense, and left me feeling confused as to whether the children were relating to me, or to an internalized idea of what an adult or caregiver is. This transference relationship brought me to the idea of internal working models, which is central to attachment theory. As I watched and participated in the children's art making process in therapy, I intuitively felt attachment issues were pertinent in their therapy. I decided to pair my intuition with research to further explore these issues.

Linking art therapy and attachment theory in this paper, I have attempted to expand the view of the therapeutic process and the art in art therapy, as well as inform attachment theory from the specialized field of art therapy. My assumption in this paper was that art therapy can make a valuable contribution to attachment theory through the unique art making process that children engage in during therapy. The central hypothesis in this paper is that art therapy enables children to re-enact their attachment styles both in the art making

and the therapeutic relationship; through these methods, children also have the chance to repair insecure attachment styles. The materials in art therapy provide a special opportunity for the therapist to observe in a concrete way the child's attachment style, suggesting that assessment of attachment insecurity through art is possible.

In order to join attachment theory and art therapy, my first step in Chapter One was to explain the central concepts of attachment theory, such as the *primary attachment figure* and his/her role, the attachment styles with a focus on the *avoidant* and *resistant/ambivalent* styles, *internal working models*, and the *secure base*. I examined the major goals of therapy with children from an attachment perspective. Then I showed how the art therapist takes on the role of the primary attachment figure and works with the child. I explained my underlying assumption that insecure attachment styles seem to put a child at risk for the later development of Disruptive Behavior Disorders.

In my second chapter, I presented Frank and Karen, talked about their lives, and hypothesized on their respective attachment styles, using my observations from art therapy, their family histories, and my assessment of their psychosocial development.

In chapter three, I explained how Bowlby's concept of the *secure base* comes into play in art therapy, and compared this to Rubin's *Framework for Freedom*. I illustrated this through examples of Frank and Karen's therapy, and spoke of the art therapist's role from an attachment perspective. This allowed me to show how, in establishing a secure base, the art therapist acts as *protector*, *provider*, and/or *guide*, according to the needs and attachment style of the child.

In chapter four, I provided the framework for considering certain art materials from an attachment perspective. The underlying assumption behind this postulate is that certain art materials, due to their innate qualities, and the accompanying processes involved in using them, may indicate children's attachment issues. I specifically focused on the acts of taping, gluing, tying, stapling and cutting. These actions that the child engages in all deal with *attaching* and *detaching*, which metaphorically relate to the major activities of

attachment theory. I then discussed termination from an attachment perspective, focusing on the child's use of art materials to deal with detaching.

At the end of chapter four, I drew conclusions regarding the ability of art materials to indicate attachment style. From my exploration of the art materials and processes Frank used, it seemed to me that he used the 'attachment' materials in a protective way. He used a process where he seemed to need me to follow, and be active at times in order to be attuned to his actions. Frank tended to use tape, which was less adhesive than other attachment materials, and this seemed to relate to the avoidant style where the child has difficulties staying attached and expressing intimacy. In termination, Frank 'avoided' making art, which seemed to be his continuation of using an avoidant style in the art. Karen seemed to express her resistant/ambivalent style through the 'attachment' materials in an aggressive fashion, which seemed to be her way of asking for protection and nurturance. She had an intense involvement with materials, and used a variety of the 'attachment' materials, becoming absorbed in cutting, gluing, stapling, and tying. Karen tended to focus mostly on permanent attachment methods like glue, which I felt suggested her desire for stable, secure attachment relationships. She used the materials in a way that they often had both 'good' and 'bad' qualities, such as the permanent glue that also can buckle the paper. In this she seemed to symbolically both seek and resist attachment, thus fitting with the resistant/ambivalent style. In termination, Karen had trouble using attachment materials appropriately and needed structure. This speaks to the difficulty resistant/ambivalent children have in terminating relationships, as they feel abandoned and re-experience previous losses. It seemed to me that Karen needed additional structure in order to say good-bye and feel she had not been destroyed by the ending. My findings regarding art materials and attachment suggest that Frank and Karen used materials in unique ways that fit with their hypothesized attachment styles. These conclusions, although specific to Frank and Karen, perhaps could be generalized to other children through future research.

Further exploration in the area of attachment theory and art therapy hopefully will emerge out of this paper. Assessment of attachment insecurity through art therapy is an area that definitely needs research. What kinds of assessment tools could be developed from the observations I have made around material choice? What types of interventions work around these materials? It would also be interesting to look at other ways of assessing attachment style, such as applying the the Bird's Nest Drawing proposed by Kaiser (1996) to children. Developing art therapy programs for children with attachment insecurity may be a great project for research and development.

I believe that looking at how attachment issues evidence themselves in Frank and Karen's art enables art therapists to gain an awareness of attachment theory. This knowledge gives art therapists a powerful and insightful way of viewing how children relate to others, which is a crucial social and relational skill. Using art therapy with attachment theory also relates to therapy with children with Disruptive Behavior Disorders, since the disorders are about social difficulties. As I stated previously, although the examples of attachment I used are specific to Frank and Karen, my exploration can be thought of as a beginning stage of inquiry into how art therapy informs attachment theory and vice versa. Hopefully, the investigation I have begun which focuses on two children with specific problems can be expanded into other areas, and perhaps even generalized to larger populations of children.

Endnotes

[1] See section 1.3 for a definition and discussion of attachment styles.

[2] Each of the three major patterns included two or more sub-types, which are not within the focus of this paper for discusion.

[3] Although Ainsworth et al. primarily use the term *resistant*, I am using *resistant/ambivalent* to encorporate their idea that the child both seeks and resists contact on reunion.

[4] An affectional bond is a "relatively long-enduring tie in which the partner is important as a unique individual, interchangeable with none other" (Ainsworth in Parkes, Steveson-Hinde & Marris, 1991).

[5] Although biological predisposition has been discussed in the literature, I will focus on psychosocial influences, since I see these as being the most relevant to my discussion.

[6] Various art therapy books discuss kinetic family drawings. See in particular Gregg Furth's The Secret World of Drawings, which discusses spatial relationships and other formal qualities of this assessment drawing.

[7] See Chapter 3 for a more detailed discussion of a secure base.

[8] Although I am not using an Eriksonian view in this paper, I wish to bring his developmental model in to highlight the importance of developmental issues in assessing attachment style.

[9] For a further discussion of the role of teachers in children's lives see Pianta, R.C. (Ed). (1992). Beyond the parent: The role of other adults in children's lives. San Francisco: Jossey-Bass Publishers.

[10] See section 3.4.5 for a definition of transitional objects.

[11] Peter Fonagy, conference lecture, Attachments over the life cycle: implications for clinical practice. Nov. 13/1998, Jewish General Hospital

[12] Frank also avoided other regressive materials, such as paint and clay, which are outside of the scope of my paper to include in discussion.

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Appendix #1

Consent Form

Art Therapy Paper
Brandie Cormier, Student
Master's in Creative Arts Therapies Programme
Concordia University

I, _____, the undersigned, as legal Parent and/or Guardian of _____, give permission to Brandie Cormier, Art Therapy Intern, to photograph the art work produced by _____, in his/her art therapy sessions. I understand and give permission for these photographs to be used for inclusion in Brandie Cormier's paper written for her Master's degree.

I understand that both my child's identity and the setting where the art therapy sessions took place will be kept anonymous and that confidentiality will be respected in every way possible. I understand that agreement to this request is voluntary and that I may withdraw my consent at any time before the paper is completed, simply by contacting Brandie Cormier or her supervisor (Leland Peterson 848-4643). This decision will have no effect on the child's involvement in art therapy with Brandie.

I have had an opportunity to ask any questions about the implications of this consent, and I am satisfied with the answers I received.

I have read and understood the contents of this form and I give my consent as described above.

Child Signature: _____

Parent/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____