Attachment Issues Between a Caribbean Mother and Daughter

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I begin from the position of attachment theory being a very good framework for understanding human behaviour, in particular how feelings of trust, confidence and belonging are nurtured in the human infant.

Dr Bowlby said that his observations of animals and how they behaved with their young were invaluable in his studies of children and their mothers. He formed a great collaboration with James and Joyce Robertson who conducted valuable studies supported by film. These films which I studied as an undergraduate Social Worker were painful to watch. They show children who experience separation from their mothers in particular, who are their primary caregivers. Their separations were because of hospitalisation or mothers' confinement at the end of a pregnancy; although short, they brought in their wake anger and protest, despair and detachment in the children. The Robertsons reported on the difficulties that existed on reunification and how with sensitive caring, rebonding and trust could be negotiated.

It was the work of John Bowlby, James and Joyce Robertson and Donald Woods Winnicott, which helped to shape my professional career. I began my observation study of a mother and infant which was a requirement of my training as a Clinical Social Worker. My practice developed over the years in the area of children and families; being concerned to work with parents as allies in raising their children.

The past 16 years have witnessed a new accent in my work. The Intercultural Therapy Centre was founded by Jafar Kareen, an Indian Psychotherapist who began his career in Austria, nurturing the orphans and misplaced children of the concentration camps, after the second world war. He worked with these children for almost eleven years.

I first met Jafar in 1980, when he was a senior member of the institute where I did my psychoanalytic training.

At the Intercultural Therapy Centre an interdisciplinary group began to treat and consult in the treatment of problem parenting and other difficulties which arose with children and parents, or children in institutions and foster care. Whilst the referrals were made to a specialist agency with a service geared to clients and patients from minority ethnic groups, there was little difference in the cause for referral. We were approached because family doctors, social workers, psychologists and others, were beginning to feel less confident about working outside of their culture which was often White and British. The only real difference between us - refer and referral agency - was our keen interest to work with this group.

We were: the Founder, an Indian Psychologist and Psychotherapist from Child Guidance Clinics, a Greek Family Social Worker training in Child Psychotherapy, a Caribbean Psychiatric Social Worker and academic specialist in attachment, a White British Psychiatrist and Social Anthropologist, a Caribbean Clinical Social Worker, Family Therapist and Individual Psychotherapist, a White British Psychotherapist / Researcher, a Greek Psychiatrist, a Jewish Family Physician, other professional supporters, and lots of eager interns from all of those professions. The Centre has since grown to employ some 17 staff and has access to 22 languages and backgrounds. The Centre is contacted to provide Community Mental Health and Child and Family Consultation.

We were interested to develop theory and research in all of areas of interest. We were keen to investigate all of the psychological ideas, which we employed in our practice to ensure that they were indeed useful. Attachment theory was not based on the standard of a White European module but on that 'stuff' that goes on with caregiver and young. We were concerned that only singular ideas and patterns were being used and appropriated. When this happens it sometimes upholds European based ideas as the right and only ones. We were interested in moving away from that tyranny of the universal mother and child. We were interested in the following:

- Which particular child, which particular mother, which neighbourhood or cultural background are we faced with?

- Having done that we have to ask ourselves, how do attachment patterns get transmitted from one generation to another and does it work well or might it be problematic?

- We need to think about how children achieve their developmental milestones, and the factors which might affect this. For example, Sudhir Kakre on Indian Child Development points out that the autonomy and independence that is privileged in the West and fostered in their young is not part of Indian culture in the same way: Because interdependence is part of the cultural form, children are indulged and expected to be dependent and unstructured for longer.

- Our values - for example social class, ethnicity and gender biases - are reflected in our work and whilst this cannot be eliminated, we have to be aware that

professional judgements do not transmit too much of our personal values and biases.

- The Nigerian style of attachment might differ from the Turkish style of attachment, and we need to be aware of the fact that they have done it their way for many years with little evidence of ill effect. Nigerians and Indians have talked about multiple attachments and of being suckled at more than one set of breasts.

- The Victorian preference of wet nursing is an example of the connection with these practices, which we see in non-Western cultures.

- I have been interested in the effect that urbanisation has had on attachment and child development. Is what we see in other cultures more of a reflection of pre-industrialisation and before the urban shift to nuclear structures?

- A question presents itself...does a different form of attachment to multiple caregivers make for attachment problems in later life? Could attachment to family and clan be a better survival insurance for a small child and have greater meaning?

- Might the urban western attachment style to a single caregiving figure be in some way maladaptive and insufficient to sustain the needs of a growing infant with a variety of needs?

In the following clinical example, I discuss some therapeutic work with a family - mother and two daughters. This case illustrates some of the issues around faulty attachment and the impact this has on family life over three generations. Particularly important is the abuse of the older child and the rift that this created in the family. There was an opportunity to work with this family in a way to help restore and strengthen attachment bonds and to do this within their own cultural idiom.

I received a referral from a Mental Health Social Worker explaining that Ms Benoit was attending a Day Centre run by a voluntary organisation, and that she had done so for eight months, but now needed one-to-one psychotherapy. It was a helpful referral, explaining that Ms Benoit had been diagnosed as clinically depressed but that she had done very well.

The following day I received another referral of the Benoit family, this time from a Child and Family Social Worker. The referral ran into six pages. It informed me that the referral was made at the family's request. From the social worker's omission I had the impression that she would not have considered the family suitable for referral.

Ms Benoit, it was said, had mental health problems and had a difficult relationship with her eldest daughter Lisa 12. Lisa had made allegations of abuse against her father but before the court hearing he had absconded. Lisa received support from a Girls' Group and Ms Benoit from a Mothers' Group. The eight-year-old, Valerie, had denied that she had been abused at the investigation stage but later told her mother about being fondled. Both of these referrals seemed something of a puzzle since they seemed to be about such separate issues.

To further complicate matters the organisation's receptionist put through a call about "the Benoit case". I expected to be speaking with a Social Worker either from Mental Health or Children and families. I decided to play it by ear because I did not want to be the one to break a confidence. I enquired where the person on the phone was calling from. The caller replied that she was Ms Benoit and that her social worker had referred her with her daughters. She said that she wanted to check that the organisation would be able to help her. She said that she had seen so many people, mostly white, and she did not want to go to somewhere else where she would not be understood.

The subtext to the conversation was "tell me why I should come to your organisation, what can you do for me?" Her urgency was that her daughter was getting out of hand and if things continued she felt that the girl would have to go into care.

The Benoit family was seen two weeks later by a senior assessor who worked in a Child Guidance Centre and is both a Psychoanalytic Therapist and a White British Family Therapist. Her report to the Clinical Team created such a stir, splitting opinion in the team.

One strongly held view originating in the assessment was that Ms Benoit needed two years of individual psychotherapy. She was considered to be on the borderline of psychosis and moreover her current resentment towards her eldest daughter was such that the child might at some stage have to be placed in a residential school or with an uncle and his family. The other opinion held mainly by a Middle Eastern adult therapist, Child Psychologist and Psychotherapist, was that Ms Benoit had some insight into the deteriorating quality of her relationship with her daughter and wanted to be able to change this. A combination of family and individual sessions were considered the only way to get the family talking about how the abuse had left them. Ms Benoit refused to talk about her partner - the abuser of their daughter - about her own history and at that stage her mental health diagnosis.

The Benoits began therapy with Dr A, the therapist from the Middle Eastern background. The reports back to the team were that they attended regularly but that family meetings were awkward and Ms Benoit was rebuking Lisa for staying out late at nights, not coming home for several days and not phoning home. Ms Benoit was worried sick, but also angry with Lisa. She said that the Police were dealing with two accusations of rape by Lisa against boys in the neighbourhood.

Dr A. said that Ms Benoit was really cut off from feelings in joint sessions, but alone was able to talk with greater ease. She was worried about her daughter but could not reach out to her. Her worst fear was that she became involved with a crack cocaine crowd. Lisa was silent in individual sessions. After six weeks Dr A. was told that she would need an emergency operation and she needed to be in hospital the following week with two months recovery after surgery.

I was asked to see the family and with reservations I agreed. I was introduced to Ms Benoit, Lisa and Valerie by Dr A.

I was interested to find out what exactly the family wanted from sessions with me. Ms Benoit thought this a silly question and became annoyed. Lisa was silent, looking at her shoes and Valerie, as bright us a button, said that she wanted things to get better at home because Lisa was making mummy unhappy. Lisa did not respond to my question but shrugged her shoulders. Ms Benoit said that she wanted Lisa to settle down because matters are now worse because she has been expelled form school for arguing and shouting at teachers. This was hard to believe because Lisa seemed timid and coy in sessions. Her younger sister was confident and able to engage with adults. Dr A. suspected that Ms Benoit wanted to be rid of her daughter and I was beginning to agree with this view. They appeared to be using Valerie as a sort of go between and their body language with each other indicated that they could not face each other.

I brought attention to this inability to talk and that Valerie seemed to be too busy trying to hold the family together. I set Ms Benoit and Lisa some joint tasks, for mother and daughter to sit on the sofa and hold hands, to hold hands when crossing the road and to brush and braid each other's hair. Valerie would report that this had gone well. After a few weeks Ms Benoit requested that only she and Lisa attended and both agreed that there was an improvement. I agreed to have phone contact with Valerie to find out how things were at home.

Lisa had ceased her staying out at nights and the relationship between mother and daughter was restored. They had a good loving relationship brushing and braiding each other's hair. Whilst at the beginning Ms Benoit found these tasks to be a bit silly, they were able to position them so that intimacy and closeness could be achieved in a way that words had failed...or could not help.

I received a call from Ms Benoit who wanted to speak to me about something and asked for a session alone. She said on arrival that she thought I would have got Lisa to talk about the abuse. I told her that I thought it more important that she had a good relationship with her daughter so that in time Lisa would be able to get her support by talking about the matter. She said that this was not what she had come to talk about. She asked if I had noticed how much she was close to tears. I said that I had. She said that she wanted to wait in order to see if I was the person that she could talk to. She said that Lisa's abuse had seemed like a punishment from the past for her.

She told me that something similar had happened to her when she was around 12 with a 14 year old brother. She said that they always got on well and still do. The abusive relationship between them stopped when at 17 she left home to train as a nurse. She said that her brother was never unkind and she thought that if they forgot it, no harm would be done. She said that carrying around the secret was her problem and feeling that what happened to Lisa was a punishment for her sin with her brother.

Ms Benoit agreed to have another one off session with me. She said that she did not want me to mention her secret to anyone. I agreed that we would continue our discussions with her and Lisa as usual, and when she came again for her individual session, we would talk again. I said that I would not mention it to anyone.

On her return to her individual session, Ms Benoit said she felt better without the secret, which she felt had come back to haunt her, on learning of her daughter's abuse. She said that she was sorry for not being forthcoming earlier on in the therapy, but she did not want to say too much. She was afraid that the social workers would think that she was not a good mother, who failed to notice her child's abuse. Tearfully she said that she loved her daughter but could not bring herself to show it before. She added that she had wanted to raise her girls with love so that they did not have a childhood like her own. Until this point I had known nothing of Ms Benoit's past. For some weeks she had hinted the sort of... not quite saying it. This was a vast improvement because at the beginning she said that she was here for Lisa and did not see what her background had to do with it.

It transpired from this session that Ms Benoit was the second of four children, half born in the Caribbean and the other two - several years younger - born in the United Kingdom. The older two joined their parents after a separation of four years, coming to the UK at 7 and almost 10. They were well cared for by grandparents in the Caribbean and settled obediently, but not lovingly into their new family. She said that they were left to bring themselves up and to look after the younger children. Her father worked extremely long hours and her mother also worked full time. For all the cooking and cleaning, and looking after her spoilt younger sister and brother she got no thanks, only threats to send her back to the West Indies when she was moody. She said that she wished her mother did send her back.

Ms Benoit did not have a close loving relationship with her mother. She said that she never felt loved by her parents although she knew she must have been, in their own way. Ms Benoit said that it became clear to her that she and her own mother needed to do what she is doing with Lisa. She described Lisa as going back to being the girl she used to be. She added that Lisa is so connected to her now that she can scarcely go to the loo without her daughter calling out "mum...", but not quite saying where are you.

My choice of method for working with this family was in part dictated by Dr A's assessment of what was needed. I know that if the mother and daughter did not get back on talking terms they would never get back to loving each other. It seemed like the last chance, yet I could see Ms Benoit's fearfulness and her rejection of her daughter, but I could also see the longing of a good mother who wanted to do the best for her child. She was frozen emotionally but I knew that there was a time when she was not. I also knew that I had before me a mother who, not satisfied with a hospital referral and a social services referral, rang up our clinic and spoke to the person in charge. I admired her courage.

Getting Lisa and mother re-connected was my objective and I knew that words had failed them both. I suspected that there might be an attachment issue at the back of it all, and I called on my experience as a family therapist to put each member of the family in position to play a part to find a solution to this impasse. I had to bear in mind that:

- I was more interested in problem solution than problem exploration.

- Ms Benoit was the best resource available to her daughter and that I needed her as my ally in the treatment.

- Lisa was failed by a father who in her earlier childhood she adored and was close to.

- Lisa feels like a bad blameworthy person and in order for change to happen she needs to value and love herself until mother's love kicked in.

- Valerie needed to be recruited as part of the treatment team to reflect on the change, if indeed change were to take place.

- I am a man helping a woman and her daughter to re-connect after a man had played the part of destroying the bond with mother and daughter. I needed to keep my antennae positioned to pick up how this would affect the treatment.

I was much more accustomed to working with parents and much younger children where problematic attachment was the reason for referral. Of course play with toys, dolls, dolls' houses, drawing and plastercine are my tools. In part, I chose methods appropriate for an almost teenager. For this I substituted hair care, brushing, washing, styling and braiding. In addition, shopping, and in the early days hand holding and sitting together on the sofa.

In the face of some resistance, not much I must add, comments from Ms Benoit, like "why do you want us to do this? I don't have to hold her hand to cross the road. I don't need to do her hair, she does it herself or goes to the hair dresser." I thought this resistance genuine enough because Ms Benoit could not see this minor detail as connected to the big picture, which was her problem.

Conclusion

To conclude, I have presented some different ways to think about and use attachment theory. I have pointed out some of the issues around culture, social context and ethnicity as variables in the study and understanding of attachment behaviours.

The case of Ms Benoit and Lisa contextualises the effect of trauma and its effects on good attachment parenting. The work of Elaine Arnold exemplifies the need for good practice with Migrants and Refugees who have experienced broken attachments.

Attachment theory lives beyond early years into the whole life cycle and has much to offer us in practice as carers, educationalists and mental health professionals. In therapeutic process work, attachment theory works to provide the conditions for natural healing to take place. Many therapists have had difficulty understanding this piece of work, which is unfamiliar. The transference was of no great import in the work, yet it could be argued that tactically my presence was important in a variety of ways in the work. Having said that, is it then psychoanalytic therapy or psychoanalytic family therapy, a type of family therapy that is particularly English

practised by Dr John Bying-Hall, Gorrell-Barnes, and the early British family therapists, or is it just attachment orientated family therapy?

Another critical position could be that I was not particularly concerned to hear Lisa's story and failing to do so did not deal with catharsis and the healing of the emotional wounds. I felt strongly that the job for me was to position mother and daughter for this listening and joining to take place. I had a belief that the loving bonds were strong enough to support and sustain Lisa if I could get the two of them back to loving each other and talking to each other.

For me, this piece of work was to be the greatest test of my belief in the effectiveness of good attachment work, which I already knew worked well with younger children and parents.

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