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Proximity, Defence and Boundaries with Children and Care-Givers: A Sensorimotor Psychotherapy Perspective

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Traumatised children can be easily dysregulated by relational dynamics. These children often experience the sequential or simultaneous stimulation of attachment and defence characteristic of disorganised/disoriented attachment patterns. Expressing their relational needs for proximity and distance can be fraught with conflict, confusion, frustration and fear. Parents/care-givers are often baffled about how to balance boundaries and limit setting with closeness and proximity in a way that is effective for themselves and their children. Additionally, parents/care-givers themselves may have histories of trauma and attachment failure that impair their own ability to balance closeness and distance. Both proximity seeking or closeness and defense or boundary setting actions are organized by innate, psychobiological systems of attachment and defense, and for parents/caregivers, the caregiving system as well. Each action system has to meet particular goals to achieve proximity to and security with a trusted other (attachment system); to defend and protect when needed (defence systems) and to protect and care for offspring (care-giving system). The legacy of trauma and attachment failure, with their consequential neuropsychological deficits, can constrain and disrupt adaptive responses to the arousal of these three systems. This paper clarifies the inborn systems that drive actions of proximity and distance. A case study will explore the interactions of these systems in child/care-giver therapy. Sensorimotor Psychotherapy will be described and somatic relational techniques will be illustrated to address proximity and defence/boundaries in the context of child therapy and care-giver/child therapy.

■ **Keywords:** trauma, children, attachment, Sensorimotor Psychotherapy, boundaries, family therapy

Introduction

All human beings have innate relational needs for proximity, contact and intimacy, as well as for protection, distance and boundaries. Many parents/care-givers naturally respond to their own and their child's needs for proximity and for distance in a way that, in the long run, establishes a foundation of safe connection. When the inevitable mis-attunements occur, they are able to provide interactive repair to re-establish closeness. However, relational trauma can disrupt this dyadic dance of intimacy and boundaries between children and care-givers. In such situations, expressing these needs and getting them met can be fraught with conflict, confusion, frustration and fear. Many of the difficulties that bring these care-givers and children to therapy reflect problems navigating these fundamental human needs. Parents and children who are traumatised or have insecure attachment patterns may communicate their needs for proximity or distance in an unclear, confusing or dysregulated fashion. The recipient may withdraw or submissively comply, or may respond aggressively, critically or fail to respond at all, when the other person attempts to express these needs.

A variety of relational troubles can arise when children are traumatised, especially when parents/care-givers themselves have a history of trauma or attachment failures. care-givers may be baffled about how to balance boundaries, limit setting and intimacy in a way that is appropriate for themselves and their child's developmental stage. Some may demand obedience to strict, inflexible boundaries, but others may be too permissive and fail to set limits that the

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child needs. care-givers and children alike may be unaccustomed or unable to reach out effectively to the other for comfort, support or contact. care-givers may seek excessive contact with their child to meet their own relational needs, or they may respond inappropriately to their child's proximity seeking. Some care-givers may require that the child not be so 'clingy' or 'babyish', while others may require that the child be physically close in ways that are not right for the child, such as demanding physical closeness when the child does not want to be close. Most care-givers complain that their child disrespects the boundaries they try to set; some complain that their child is passive or overly compliant. Others report that their child is unpredictable, vacillating between compliance and rebellion. Traumatised children are often easily dysregulated by relational dynamics, and experience the sequential or simultaneous stimulation of defensive and proximity-seeking impulses toward their care-givers, a pattern characteristic of the disorganised/disoriented attachment pattern (Lyons-Ruth, Bronfman, & Parsons, 1999). This pattern can leave care-givers scratching their heads in confusion or, worse, blaming the child or themselves as being inadequate or flawed.

This paper examines proximity seeking and defence/boundary-setting actions, clarifies the inborn psychobiological systems that drive these actions and explores the influence of parents' histories as well as that of the child. Approaches and interventions from Sensorimotor Psychotherapy are illustrated through a case study to describe specific techniques that address these needs in the context of child therapy and care-giver/child therapy.

Action Systems

Both proximity seeking and defence/boundary-setting actions are organised by evolutionarily prepared, psychobiological systems that are epigenetically hard-wired, open to classical conditioning, self-organising, self-stabilising and adaptive in nature (Cassidy & Shaver, 2010; Nijenhuis, Van der Hart, & Steele, 2002; Ogden, Minton & Pain, 2006; Panksepp, 1998; Van der Hart, Nijenhuis, & Steele, 2006). The defence system organises distancing actions, such as avoidance, fight, flight, freeze and feign death/shut-down responses. The defence system is also involved to some degree in boundary setting, especially when boundary setting is protective in nature.

The 'social engagement system', mediated by the ventral parasympathetic branch of the vagus nerve, fosters interaction with the environment (Porges, 1995, 2001, 2004, 2005, 2008, 2009, 2011). This system, available to the full-term infant, underpins the attachment and care-giving systems, both of which organise proximity-seeking actions. Other terms have been used to describe such systems, including *behavioural* (Bowlby, 1969/1982; Cassidy & Shaver, 2010), *motivational* (Gould, 1982; Lichtenberg, 1990), *functional* (Fanselow & Lester, 1988) and *emotional operating systems* (Panksepp, 1998). In Sensorimotor Psychotherapy, the phrase *action system* is preferred because the arousal of a particular system stimulates particular actions relevant to that system (Ogden et al., 2006; Van der Hart et al., 2006). Each action system is programmed into the brain and represented by neural circuits that, when activated, dictate somewhat predictable actions geared to achieve the particular goals of the activated system (Nijenhuis et al., 2002; Ogden et al., 2006). The clinician assesses the interrelationship between the attachment, defence and care-giving systems, and targets particular actions related to these systems for therapeutic intervention.

Attachment Action System

All human beings, from infants to adults, depend upon the social engagement system in order to build attachment and affiliative relationships (Porges, 2004, 2005). This system facilitates the neural regulation of facial muscles and vocalisation that serves to increase proximity with care-givers, securing the survival and wellbeing of the infant. This behaviour is the cornerstone of attachment.

Bowlby (1969/1982) observed that the attachment system organises proximity-seeking behaviours in two primary ways: *signalling behaviour*, which is designed to bring the attachment figure closer, and, as the infant matures, *approach behaviour*, which is designed to bring the individual closer to the attachment figure. Fortunately for infants, establishing attachment bonds depends on crying, facial expressions and other forms of signalling, rather than on coordinated movements of the body. As motor skills develop, the periphery of the body – arms and legs – become effective in approaching others to achieve proximity. Crawling toward the parents, following them around, climbing up on their laps, holding on, clinging and resisting being put down are normal proximity-seeking behaviours that maintain closeness to care-givers. Other proximity-seeking and inducing behaviours include facial expressions such as smiling, responding to the mother's expressions and eye contact, infant participation in mother–child game playing, shaping (Stern, 1985) or automatically conforming to the mother's body (Ainsworth, 1963; Bowlby, 1988; Lyons-Ruth & Jacobvitz, 1999; Schore, 1994, 2003a).

This early learning in the context of attachment facilitates relational capacities and their action sequences, such as reaching out for help or contact with others. With sufficient care, children acquire generally positive expectations of interactions with others and become increasingly effective at non-verbal signalling, approach behaviours, engaging and responding to others (Brazelton, 1989; Schore, 1994; Siegel, 1999; Stern, 1985; Tronick, 2007).

Defence Action System

An infant's first survival instinct is mediated by the sympathetic nervous system to galvanise the attachment system in search of help. Infants cry out, called the 'separation

cry' (Panksepp, 1998; Van der Kolk, 1987), 'attachment cry' (Steele, Van der Hart, & Nijenhuis, 2005) or simply 'cry-for-help' (Ogden & Fisher, 2015), and frantically utilise some of the proximity-seeking actions described above in an urgent attempt to secure the nearness of attachment figures for help and protection.

Other animal defensive subsystems, also mediated by the sympathetic nervous system, are also instinctively catalysed under dangerous or life-threatening conditions. Those that involve the arms and legs to mobilise the body to flee or fight become available as the infant's motor capacities mature. A freeze defence, described as 'alert immobility' (Misslin, 2003, p. 58) is characterised by high arousal coupled with a cessation of movement except for respiration and movement of the eyes. People often report feeling tense but paralysed. When no one else is available to help, when fighting back or running away is impossible or would only make the trauma worse, the body becomes numb, collapsed and immobilised, enabled by the dorsal vagal branch of the parasympathetic nervous system that supports the defence of feigning death/shut down. No one defence is 'better' than another, but is used because it is instinctively assessed to be the best possible option to assure survival.

When the attachment figure is also a threat to the child, two systems with conflicting objectives are activated simultaneously or sequentially. The attachment system, the goal of which is to seek proximity, and the defence systems, the goal of which is to protect, are both stimulated. In these contexts, the social engagement system is profoundly compromised and its development interrupted by threatening conditions. This intolerable conflict between the need for attachment and the need for defence with the same care-giver results in the formation of a disorganised–disoriented attachment pattern (Main & Solomon, 1986). A contradictory set of behaviours ensues that supports the different goals of the animal defence systems and of the attachment system (Lyons-Ruth & Jacobvitz, 1999; Main & Morgan, 1996; Steele, Van der Hart, & Nijenhuis, 2001; Van der Hart et al., 2006). When the attachment system is stimulated by hunger, discomfort or threat, the child instinctively seeks proximity to attachment figures. But during proximity with a person who is threatening, the defensive subsystems of flight, fight, freeze, hypoarousal/feigned death/shut-down behaviours are mobilised. The cry-for-help is truncated because the attachment figure is the threat.

Care-giving Action System

care-giving is intimately intertwined with both attachment and defence. Variations of basic proximity-seeking actions are used throughout life to meet the goals of the care-giving system. 'Good-enough' (Winnicott, 1960) parents respond sensitively and affectionately to the proximity-seeking actions of their child with those of their own. They pick her up, hold her close, stroke her, coo and use the voice, along with rocking and comforting movements, to soothe her. care-givers also seek proximity when the child is not distressed, too, by cuddling, holding, snuggling and playing with the child. Even when the child is not seeking contact, a parent may watch him with a loving expression, smile or gaze fondly at him, or reach out to pat the child's cheek or tousle his hair. These proximity-seeking actions all convey an implicit message to children that close relationships are rewarding, that others want to be near to them, and that their own proximity-seeking actions are welcomed and will be responded to lovingly most of the time.

The care-giving system becomes activated when the child is stressed, threatened or in danger (Bowlby, 1988, 1969/1982; Cassidy & Shaver, 2010). Schore (2003b) has described this reciprocal relationship between the attachment and care-giving systems, noting that the care-giver becomes dysregulated by the infant's distressed cries and responds with care-giving. Modulating the child's distress allows the care-giver to re-regulate. This is the mechanism underlying the pleasurable emotions parents feel when they can protect and care for their children, and the fear, anger and anxiety when they cannot.

Goals of Action Systems

Each action system has particular goals to meet when it is aroused that remain relatively constant throughout childhood, but the behaviour required to accomplish these goals is modified and elaborated as a child matures and as the environment changes. The goals of the attachment system are to achieve proximity to, and security with, a trusted other. The goal of the care-giving is the protection, care and survival of offspring, which can involve proximity-seeking actions as well as defence and boundaries (think of the limits needed for the child who wants to play in the street or get in a stranger's car). The defence action system serves the goal of survival under threat and is activated whenever a stimulus is assessed to be dangerous.

Several action systems are evoked simultaneously in care-giver/child interactions and work together to achieve a variety of interrelated goals. For example, interactions might simultaneously elicit systems of attachment, care-giving and defence. Balance in parenting to meet the goals of all these systems simultaneously requires flexibility, cooperation and coordination among action systems (Van der Hart et al., 2006). When several action systems are aroused in the same context, a higher-order integrative capacity is required, which is often difficult for traumatised or stressed individuals to achieve. The specific care-giver actions are determined by the nature of the relationship, and by assessment of the signal of the child and evaluation of threat or need. When a system is aroused, the care-giver must decide whether and how to respond (Cassidy & Shaver, 2010) – with proximity-seeking behaviours that comfort the child; with care-giving actions that tend to a child's physical needs, like providing food or warmth; with boundary actions (those

that admonish the child or set limits, and thus often combine with defence, such as jerking a child's hand away from a hot fire); or with a defensive actions towards a threat to the child, like stepping between the child and a vicious dog. Therapists often need to help care-givers, and sometimes children, to tend to the tasks and goals of various action systems simultaneously, and to execute the complex actions to achieve success.

Faulty Neuroception

When a child's caregivers are 'good enough' (Winnicott, 1960), action sequences 'remain to some extent fluid and flexible throughout life; the nature of the consequences that are anticipated for a given action will change as the context of interaction changes and with development of the individual's powers' (Bucci, 2011, p. 6). As brains compare current information with past data, there is the possibility of an 'upgrading' (Llinas, 2001, p. 38) of meaning and whether the expectation of the immediate future is of danger or safety. However, schemas become more and more rigid in increasingly less functional environments, impeding new learning (Bucci, 2011). The legacy of trauma and attachment failure, with their consequential neuropsychological deficits and skewed expectations, constrains adaptive responses to the arousal of defence, attachment and care-giving systems.

Porges (2004, 2011) coined the term *neuroception* (distinguished from *perception*, which requires cognitive awareness of input from sensory systems) to describe a neural process, outside the realm of awareness, that is neurobiologically programmed to detect features in the environment, including behavioural cues from others, that indicate degrees of safety, danger and threat. When safety is neurocepted, the social engagement system is strengthened along with prosocial behaviours. Proximity-seeking actions require the inhibition of the areas of the brain that organise defensive strategies, and such inhibition is appropriate only in contexts that are safe (Porges, 2011).

Traumatised children typically have a compromised social engagement system and thus have difficulty accurately neurocepting safety even in non-threatening contexts (Sahar, Shalev, & Porges, 2001). Many traumatised children have developed 'faulty' neuroception – 'an inability to detect accurately whether the environment is safe or another person is trustworthy' (Porges, 2011, p. 17).

Molly's faulty neuroception disrupted her interactions with her family and peers. A 9-year-old girl abandoned at birth, adopted at age two from a middle Eastern orphanage, Molly suffered neglect, fetal alcohol syndrome, minimal stimulation, had multiple transient care-givers and multiple surgeries to correct a physical deformity before and after her adoption at age two. Her mother, the main care-giver, brought her to therapy for a variety of problems, most notably extreme verbal and physical aggression toward her parents, brother and peers. She also injured herself by banging her head, biting herself and poking herself with sharp objects. Molly's symptoms were brought about by a number of triggers: misattunement, sibling jealousy, boundary and limit setting, when she was tired and/or hungry, when her desires were thwarted, or anytime she was dysregulated.

We can speculate that at those times she neurocepted danger of some sort that aroused her defences. Porges (2011) asserts that, 'playing nice' comes naturally when neuroception detects safety and promotes physiological states that support social behaviour. However, proximity-seeking behaviour will not occur when our neuroception misreads the environmental cues as unsafe and triggers physiological states that support defensive strategies. Faulty neuroception is especially obvious in children like Molly with a tendency to overactive 'fight' responses, i.e., those who are overly aggressive and categorised as 'oppositional-defiant'.

Psychoeducation about the Fight Defence

Previous therapy had focused on trying to change Molly's behaviour through insight and understanding the effect of it on others, which was ineffective. From a different perspective, Molly's aggression toward herself and others can be understood as a dysregulated 'fight'animal defence, a subsystem of the defence action system designed for survival. Molly's therapist helped her and her mother understand that these actions were 'instincts' and that Molly did not purposely desire to hurt others. Understanding the negative influence of implicit memories of a past that a child does not explicitly remember on present-day behaviours can be reassuring to caregivers. Molly's therapist explained to her parents that implicit memories are often 'situationally accessible', activated in present time by both internal and external stimuli reminiscent of the past (Brewin, 2001). They were helped to understand that neurocepting innocuous stimuli as threatening set off Molly's defensive subsystems again and again.

Her therapist found non-provocative language to describe Molly's aggression. She called her angry outbursts her 'reflexes' and her curious, non-judgmental attitude about Molly's reflexes decreased the shame and increased the child's self-esteem and willingness to explore modifying her impulses. Prior to this psychoeducation and finding non-triggering language, Molly routinely denied that she had been aggressive, but afterwards, she readily admitted it. She was even able to non-defensively tell her therapist "I socked Brandy. It was my reflexes again", when reporting how her week had been. Reframing her dysregulated fight defence as a reflex rather than as a personal deficit was the first step in eliciting Molly's willingness to address this issue.

Dominance of Defensive Actions

Over time, children and care-givers build up habitual responses to the arousal of each action system and fulfil its goals with varying degrees of breadth, richness, success, adaptability and personal satisfaction. Traumatised children like Molly often experience overactive defensive subsystems

with accompanying rapid, dramatic, exhausting and confusing shifts of intense emotional states, from dysregulated fear, anger or even elation, to despair, helplessness, shame or flat affect. They may continue to feel frozen, numb or tense and constantly ready to fight or flee. They may frantically seek someone to rescue and protect them at the slightest provocation. They may be hyperalert, overly sensitive to sounds or movements, and easily startled by unfamiliar stimuli. Or they may underreact to stimuli, feel distant from their experience and their bodies, and even have a sense of deadness. Eventually, these defensive action tendencies become default behaviours that take precedence over actions that could meet goals of action systems unrelated to threat, such as seeking proximity.

Awareness of Physical Patterns

In Sensorimotor Psychotherapy, physical actions belonging to defensive subsystems that interfere with effective proximity-seeking actions are brought to awareness. For example, one child exhibited little affect or movement in social interaction, causing others to say they felt 'disconnected' from her. Another had the habit of crossing his arms in front of his chest and leaning back when talking with others, a physical tendency that others implicitly interpreted as a superior attitude. Yet another froze and had difficulty speaking if more than one person was present. Sometimes parents actively thwart or block proximity-seeking behaviours, responding with negative emotions, withdrawal, pushing the child away, or even abusing or punishing the child. Sometimes these responses are intentionally malicious, but often they are the result of a parent's own blind spots or past experience with proximity seeking with their own care-givers. Some parents may dislike physical contact, except on their own terms, and may respond to their child's overtures with an avoidance of eye contact, a disapproving facial expression or a rejecting tone of voice. These behaviours from children and caregivers alike can reflect childhood histories and the simultaneous activation of defensive and proximity-seeking actions. Therapists observe physical tendencies that emerge when the proximity-seeking actions are aroused, and work to help children and care-givers challenge the tendencies that interfere with meeting the goals of proximity-seeking actions.

Proximity-seeking behaviour changes 'based on that person's forecasts of how accessible and responsive his attachment figures are likely to be should he turn to them for support' (Bowlby, 1973, p. 203). Molly needed to rely on the expectation that her parents would be receptive when she sought them out. George, Molly's father, had suffered physical abuse and neglect by his alcoholic mother. He remained vulnerable to traumatic activation in the context of his relationship with Molly. This caused the mobilisation of his defence system, with its accompanying actions, when Molly's attempts at closeness activated his attachment system. Instead of being able to welcome Molly's desire to cuddle, George unconsciously tightened up and pulled away, which provoked Molly's aggression. Molly's therapist drew George's attention to his propensity to tighten and pull away when Molly sought proximity. Once George became aware of this himself and realised its source, he made a conscious decision to relax his body and reach back to Molly when she wanted to cuddle. Making this new action took mindful awareness and inhibition of his action tendency, along with practise of his own proximity-seeking action of reaching back to Molly. Over time, Molly's father was able to respond to Molly's proximity-seeking actions with reciprocal actions of his care-giving and attachment systems instead of his defensive system.

The dominance of the defence action system in people with trauma-related disorders is a central theme in the treatment of children and care-givers. The therapist must be aware of the intrusion of defensive actions, which then override the functioning of other action systems. care-givers and children can learn to recognise the physical signs of the arousal of the defensive system, such as hyper- or hypoarousal and muscular tension or flaccidity, as George did. care-givers and older children can learn to evaluate whether these responses are appropriate to their current situation, and learn to inhibit or calm this arousal and change their actions so that they can respond effectively to action systems related to non-threatening daily life.

Defence and Boundaries

Facilitating adaptive relational boundaries is an essential focus in treatment (Boon, Steele, & Van der Hart, 2011; Kepner, 1987, 1995; Levine, 2004; Levine & Frederick, 1997; Ogden et al., 2006; Rosenberg, Rand, & Asay, 1989; Rothschild, 2000; Scaer, 2001/2011), and is especially critical in care-giver/child therapy. Faulty neuroception interferes with adaptive boundaries, and since it is automatic and often unconscious, attempts to change it via top-down insight or understanding often fails. However, identifying the signs of faulty neuroception can give care-givers and children the information that they need to help them learn how to bring their arousal into the window of tolerance and regulate dysregulated behaviours. New actions can be executed and practised in a variety of ways.

Molly's therapist utilised the game of playing catch to introduce new, regulated defensive actions to integrate her out-of-control aggressive movements on a physical level. The complexity of a simple game of catch helped Molly make controlled aggressive motions as she threw the ball, and receptive ones as she caught it. However, the game was challenging for Molly, and at times, she impulsively threw the ball too hard, hitting and hurting her therapist with its force. Gradually she and her therapist uncovered Molly's triggers – misattunement, 'teasing', misunderstanding what Molly was trying to say, and her father or therapist not paying attention to her when she wanted them to. Molly was able to discuss her actions as her reflexes, saying things like,

"I didn't even think about it. It just popped out. I didn't mean to do it." As her parents and her therapist acknowledged Molly's triggers, including their own misattunements, to which Molly was extremely sensitive, Molly visibly relaxed and spontaneously sought proximity by moving in close for physical contact.

In therapy, Molly was taught to mark her own space by placing a rope around her at a distance of her choosing while she sat on the floor. This was 'Molly's space', and no one could come inside her rope circle unless she made a proximity-seeking action. Molly's therapist first rolled a large ball toward her as she sat in her rope circle, and she and Molly talked about how Molly felt in her body when the ball started to come into her space. The therapist suggested that Molly push the ball out as it crossed her rope circle. Over several sessions, Molly and her parents took different roles with this exercise, sharing their experience. Eventually, her therapist, and then one of her parents, took a pillow and began to move it into Molly's circle asking Molly to slowly push it out of her space when it felt too close. At first Molly had difficulty doing the pushing in 'slow motion' and instead pushed impulsively and aggressively. This exercise was also demonstrated with Molly's parents while Molly observed. Over time, Molly was gradually able to slow down her actions, and 'think' as she pushed. Being able to think and execute the action that is normally executed in a dysregulated fashion is thought to integrate the functioning of the cortex with subcortical regions of the brain, increasing regulatory capacity. With repeated iterations, Molly's physical patterns visibly changed: her spine lengthened, her head came up, her eyes softened as she made eye contact, and her body relaxed. These physical actions supported engagement with her parents and connection while physically setting a boundary. Previously, Molly's tense shoulders, squinting eyes, downward turned head and compressed spine supported disconnection and aggression. Molly learned to set a boundary while staying in contact with her parents, and often they reversed the exercise, which helped Molly begin to accept their limits as they pushed the pillow away. Sometimes the family decided that the pillow would represent a boundary problem for them, such as Molly asking to stay up late, and her parents saying 'no'. Gradually her aggressive outbursts gradually began to decrease and she began to accept reasonable limits more readily.

Congruence between Words and Body Language

Molly's parents benefited from psychoeducation about the functions of boundaries and about the crucial role of the body in setting boundaries. They both confused non-verbal boundary setting with verbal boundary setting, and needed the therapist's help to learn that boundaries are primarily communicated non-verbally. Her mother especially set verbal limits only to have them ignored or tested, often because her body told a different story – an experience both confusing and often triggering for Molly. The therapist asked Molly's mother to notice what happens in her body when she thought about saying 'no' to Molly. She reported a slump in her spine and tightening in the throat, and the word was uttered tentatively, with averted gaze. Her attachment and care-giving systems were stimulated in the sense that she wanted to seek proximity and comfort Molly, not set a definitive boundary. As she explored this tentativeness, she realised that she had learned as a child that she did not have a right to set boundaries. This, combined with her own guilt about Molly's early life, which she had no control over, rendered her unable to set congruent boundaries with her body language and her words. Her words said one thing, but her body said something else.

Molly's father, on the other hand, said the word 'no' definitively and even aggressively, often accompanied by a forward movement and tension in the jaw, arms or shoulders, which stimulated Molly's aggression in return. Her father realised his own trigger of interpreting Molly's disobedience as meaning that she did not love him or want him as a father. He benefited from understanding the effects of Molly's early life as setting up a propensity for an overactive arousal and dysregulated nervous system, which had nothing to do with his daughter's love for him. Both parents explored saying 'no' firmly, with congruent body language, and maintaining proximity-seeking actions, such as eye contact, with their daughter. In this way, they were able to integrate actions related to care-giving, attachment and defence systems effectively, and Molly began to respect limit setting better.

Conclusions

Setting boundaries is intimately entwined with attachment, caregiving and defensive action systems. Attachment trauma is inherently a relational boundary violation, as it was with Molly, leaving her with the felt sense of having no protection and an overactive 'fight' defence that conflicted with her need for proximity and care from her parents. Her parents had their own histories that influenced their distancing and proximity-seeking actions. Even in the absence of relational trauma, both children and care-givers will have developed implicit patterns of setting boundaries that reflect difficulties in responding effectively to the arousal of the attachment, care-giving (for parents) and defence action systems. Healthy relationships require both connection and distance. 'Too much' or 'too little' distance between people can be equally negative (Hall, Harrigan, & Rosenthal, 1995, p. 21). Reading the body's actions for unsymbolised meaning that had been adaptive in previous contexts, and exploring these actions in therapy, can be fruitful avenues of insight and growth for care-givers and their children, and can influence more adaptive responses to the complex arousal of attachment, care-giving and defence systems. care-givers and children can learn together that proximity-seeking actions and relational boundaries go hand in hand, and that

using both contributes to increased connection, intimacy and harmony.

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