THERAPEUTIC CHILDCARE IN A FAMILY SETTING

Introduction

ISP (Integrated Services Programme) was one of the first, if not the first Independent Fostering Provider (IFP) in the UK when it started in 1987. It was created by experienced foster carers who had been part of Kent County Council's pioneering fostering scheme, for the most troubled and troublesome young people, which started in the 1970s. [Nancy Hazel, "A Bridge to Independence: The Kent Family Placement Project" Blackwells 1981]

Having been specially trained and provided with intensive support to work with young people with highly complex needs, who had previously been thought of as "unfosterable", the carers who started ISP knew what was needed to make fostering work as an alternative to residential care.

It was an instant success. Foster carers were keen to join this new organisation. They were attracted by being treated as a professional, by the training and 24 hour support on offer and, of course, by the fact that they were paid well for this most difficult work. ISP also provided education for those children who couldn't cope in mainstream schools. This was a big plus for carers because nothing puts a family placement under more strain than a child constantly at home without a school place. Children were provided with therapy within weeks rather than years of being placed. Transport to and from school or contact with the birth family; facilities for enabling contact with family members, all reduced the frustrations that many carers and children faced when dealing with a large bureaucracy.

When I joined ISP 5½ years ago, as the Chief Executive, I brought with me a model of work learnt in a therapeutic community setting for severely traumatised children.

[John Whitwell, "The Cotswold Community, a Healing Culture" International Journal of Therapeutic Communities, Vol 10, no. 1, 1989]

I began to see that much of what good foster carers do routinely on a day-to-day basis could be described as therapeutic childcare but was not realised. I saw instances when children and young people, who had been expelled from group care in a residential context, started to thrive in a family setting with more individualised care, without the pressures of group living with similarly disturbed children. This was turning the received wisdom, that children needed specialist residential care after failing in families, on its head.

The model of therapeutic care that I had seen work at the Cotswold Community put the residential social worker at the heart of the therapeutic process. The reason being that these children, who had severe attachment disorders, were not suddenly going to start trusting a whole range of professionals, but would first make an attachment to their focal carer. It would be to this person that the child would "open up". Therefore, the residential workers needed to be specially trained and provided with on-going, expert consultant advice "to do the therapy". Of course some children would need a skilled therapist in addition to this but this would be built on the bedrock of the main therapeutic relationship with the focal carer.

I felt that not only was therapeutic work already taking place in some foster families, but that by making it more explicit it could become a more conscious part of the treatment plan for each child. There are some children who are not ready to see a therapist for therapy. The foster carers though would benefit from a regular

consultation with a therapist to help make sense of the chaos they were encountering. We have seen this develop within ISP during the last two years.

I joined forces with Jayne Westcott, who is Head of Operations, to run a training course in Therapeutic Childcare. Jayne had worked in a residential treatment programme in the USA for several years, so we had common experience to draw upon.

Jayne and I are very clear about the need for and merits of therapeutic care for young people whose past experiences and relationships with adults have created a legacy of pain or torture - emotional, physical and intellectual. We wished to present training for people in the ISP which could provide an overview of Attachment Theory, acknowledge some commonly experienced behavioural presentations, think about the importance of looking beyond the behaviour and, most importantly of all validate the many ways in which foster carers care therapeutically for children in the minutiae of every day living. We also wished to encourage and enable a "real" debate about the nature of the fostering task within ISP, the viability of transferring some "tools" or interventions from the "therapeutic community" setting to family life and to grapple with what is reasonable to ask of expect from a family. Although we have numerous carers with no children of their own, or older children who have "flown their nest", most have birth children of various ages still living at home and we must be mindful that all family members are involved in and touched by the experience of fostering.

A key premise is that for children with attachment disorders, it is the relationship between the child and the foster carer which will provide the arena for the work at hand. It will be essential to provide opportunities for the child to develop this primary

attachment. This will provide the secure base for all of the "work" with the child and allow for that youngster's progress and development.

In this sense, the rest of the "care team" - therapists, eductionalists, social workers, psychiatrists, are really there to assist the carer, to help underpin the relationship between the child and the carer. This concept can be challenging for other professionals, as they may perceive a threat to their own status and "professional" worth. However, there is no disputing the fact that all children need a secure attachment in order to thrive.

Theories are important - they can help us know what we can ordinarily expect, can help shape our thinking and understanding, give some meaning for the seemingly inexplicable and provide frames of reference and guidance. However, theories cannot provide all the answers, cannot alone give ideas for concrete interventions or prescribe what to do in difficult or challenging situations. Nor can they replace the need for every child to experience a safe, secure and nurturing environment and the knowledge that they are cared for, cared about and cherished. At the same time, many exceedingly kind hearted foster carers have, when looking after children, discovered that love just isn't enough. Somehow the theory and the care need to meet and complement each other in concrete ways. Our training rests on the basis that many foster carers are providing therapeutic care everyday. In the workshop we wish to share experiences, exchange information, stories, "tips" and ideas.

To achieve this we intersperse the workshop with practical exercises, which the carers do in groups of 3 - 5, and then feedback into the whole group. The exercises follow a child's day: waking and preparing for the day; going to and returning from school; activity and leisure time; preparing for bed. We also pepper the workshop

with examples taken from ISP's own foster carers' accounts of their work with children placed in their homes. To become a senior carer in ISP requires a written account, usually 1500 words of their work with a particular child, demonstrating a certain level of experience and understanding. These accounts provide a rich source of material from which to find suitable examples for the workshop.

Dictionary definition of THERAPEUTIC

"Contributing towards or performed to improve health or general wellbeing"

Psychodynamic Approach to Childcare

"The psychodynamic approach sees all children's behaviour as a communication to their parents [carers]. When looked at in this way, all behaviour has meaning. Instead of seeing behaviour as a problem, parents [carers] can ask themselves: "Why this behaviour, now?" Behaviour is a reflection of the child's development and emotional integration. Parents [carers] then have a key for helping children with their emotional lives."

Ruth Schmidt Neven

Aim of today's training

To look at why and how everyday caring experiences can be used

therapeutically, especially for children who have not received good

enough parenting during infancy and early childhood.

What are the causes of severe emotional deprivation?
(emotional unintegration)

- Quality of care during babyhood and toddlerhood was not good enough.

- Lack of bonding and attachment between mother (or primary carer) and baby.

- Lack of support for mother (or primary carer) to be preoccupied with her baby. This would normally come form her partner and/or extended family.

- Cycle of deprivation. The child's parents themselves suffered severe emotional deprivation, during their childhoods, which affected their ability to parent.

- The mother (or primary carer) unable to contain the baby's fears, distress, anxieties. Instead, feelings become amplified.

- Poor social conditions (housing, unemployment, deprived neighbourhoods). Not a causal factor on its own but can exacerbate any of the above conditions.

The purpose of spending time examining the underlying causes of emotional deprivation is to convey to carers that during the first two years of life emotional foundations are being laid. If these are not solid the child will be like a house without foundations, ok on the surface, but vulnerable to any stress, tension and frustration. It is during these first two years that basic trust is established. Basic mistrust is crippling throughout life unless "corrected", "treated" - hence the need for therapeutic childcare.

Waking and preparing for the day

- Think about your family morning routines and rituals.

- Consider how your foster child wakes up/gets up - is there a pattern to any upsets or difficult behaviour.

- Do they respond best to sound, (mechanical/human/tuneful) light, smell?

- Who usually wakes the child?

- Are there any feelings of dread or reluctance about these first interactions or are there feelings of joy or playfulness. Or - just feelings of being rushed?

- What might our feeling tell us about how the child is feeling?

- What sort of response or rituals are most successful in getting the child up as calmly and happily as possible?

- How does the child mange self care, dressing and breakfast - what helps?

What is it like to live with an emotionally deprived child?

- Panic rages when frustrated.

  This is closer to a toddler's tantrum than the wilful use of aggression to intimidate others. It can be a relatively small thing (or so it seems to the adults) that ignites the rage.

- Disrupts functioning groups.

  Unable to function him/herself, it is felt to be a tremendous threat to see functioning in others, so it is spoilt.

  The presence of these two symptoms in a child is a fairly reliable indicator that emotional integration has not been achieved. This would normally have happened by the time a child is 18 months old. It is very difficult for emotionally integrated and unintegrated children to live alongside each other.

  This is a major challenge in group living. In a residential setting there is the ever present problem of "contagion". In the family, the challenge lies in ensuring that birth children are protected from some of the "sabotaging" whilst recognising and dealing with the temptation to label children as selfish, self-centred, and intent on always spoiling the pleasure of others.

- Merges with other children in wild, anti-social groups.

- Shows little or no concern for others - expert in pressing buttons.

- Little or no sense of guilt or the ability to make reparation.

- Hyperactive - a general sense of restlessness, an inability to concentrate or settle into any activity.

- Poor sense of time and space.

- An inability to play.

- An inability to communicate feelings. Feelings are bottled up and explode into acting out behaviour.

- Verbally and physically aggressive.

- Splits between good and bad - good parent/bad parent, nothing in between.

- Poor self-preservation - from poor personal hygiene to suicidal feelings. Conversely there are children who have had to parent themselves.

  "Jamie, aged 4 years, 9 months, first appeared to be a happy little boy with a constant "smile" on his face. We noticed that this smile was ore of a grinning grimace, more like a smile through gritted teeth. Jamie was a very lively little boy who always seemed to want to be busy. Jamie was also very independent in a lot of ways, he could bath himself, dress himself, clean his teeth, put his shoes and coat on without help. This seemed to show us that he always had to look after himself as nobody was really there for him. We had to gradually take over his care and let him know that we were here to look after him, he didn't need to be "grown up" as he was only a little boy. He had a need to be looked after as he allowed us to help him with things like cleaning his teeth, washing his face and hands, cutting up his food . . . "

  Sadly, before the age of 5, Jamie had already experienced approximately 17 episodes of being "in care" - about a dozen during a prolonged period of unsuccessful rehabilitation attempts. Recently a "care leaver" reminded me that for young people, being in care may only compound and reinforce their difficulties and negative experiences. Certainly Jamie's previous carers had pushed him to be more independent. He would become rigid when it was time to cut his nails or clean his ears, as he had been used to quite rough, peremptory treatment. It was new for him to set on his carer's knee while she spoke softly with him or sang songs, requiring much reassurance that he would not be hurt.

  Even in such small acts, we see the opportunity for the therapeutic re-parenting of children.

Going to and returning from school

Transitions = moving between two different spaces, leaving behind what was and moving onto what becomes the new present. For our children, every transition may feel like a frightening separation: the daily transition between home and school may be especially difficult – they may not feel that the people and place they leave behind at the beginning of the day will continue to exist and be there when they return.

Put yourself into the shoes of the child you foster:

- Visualise the different transitions they make, during the day and at school the particular behaviours they display at these times and imagine what feelings they are expressing.

- Does the child/young person have a favourite toy or object that helps the child feel less anxious – is this recognised, encouraged and respected?

- Can you change or do anything that would make the child's feelings more conscious (i.e. recognisable to the child) and slowly help them develop new ways of handling separations and returns?

- Think about how they present on their return from school: what are they communicating: what do they need from you?

What helps them rejoin the home / family?

What sort of conditions does this emotionally damaged child need to live in, in order to start to get better?

- Carers/parents who are committed, interested, involved and genuinely care.

- A nurturing environment. Carers who can respond to needs which are associated with younger children. Emotional warmth. Physical care. Emotional holding.

- Regular only-child time with main carer.

- Grown-ups who can be firm as well as nurturing. Clear boundaries and limits.

- Carers who can make the child feel safe and protected from harm and trauma.

  One of our carers found that two sisters placed with her, aged 3 and 5, suffered with extreme night terrors and fought against sleep. She thought carefully about what they needed and decided to have a bedtime routine whereby she sat between the two beds, holding their hands, until they fell asleep. She did this seven nights a week for several months before they started to feel secure enough to gradually wean off this intensive care at bedtime.

[In "normal" childhood, being looked after and being managed/controlled is internalised. This later forms the basis for the young adult to look after him/herself and to have sufficient self-control.]

Activity and leisure time

- Think about the leisure and play resources you provide.
- Think of your foster child and reflect on how and when they play and also join in leisure activities.
- Do they tend to be solitary in these activities?
- Is there time for adults to involve themselves in the play?
- Do you draw on interests the child already has and also draw on your own enthusiasms to initiate play activity/hobbies?
- Identify anything that seems to stop creative activity taking place, and what could be changed to allow for more possibilities.
- Are there opportunities for children to talk about aspects of their day / their relationships / what they did at school or on a visit home?
- How can children be helped to find words for affect and feelings?
- Describe the child's ability to choose and share – how can you help develop this?

How will he/she start to get better?

- Begins to trust a reliable grown-up (Erikson's "basic trust"). Makes an attachment.

  "I went through several changes in my relationship with Tom. I had to be strong and consistent with him and always carry out my promises. I felt I needed to gain trust and a little respect. We decided to call me the "boss" in the family unit to show Tom that women can be respected. I felt that he had seen his mother being very poorly treated and having no control. I gave a lot of nurturing to Tom and we shared books and did lots of fun activities.

  Tom's relationship with me became very positive. I felt that he had eventually learnt to trust me. He stopped the aggression towards me and his sexualised behaviour at home almost ceased.

  Tom became more affectionate and could express himself more verbally.

- Allows him/herself to be dependent. (The opposite of, "I don't need anyone else. I can look after myself. No one else can be trusted. Adults always let me down".)

- Begins to be able to feel sad and face up to the painful feelings that have been avoided. (The opposite of, "I don't give a damn. I want excitement. I want trouble. No one can hurt me".)

- Signs of regression - being younger than his/her years, eg, having a teddy bear, playing as a young child, being read to, wanting a cuddle, curling up in a sleeping bag or under a duvet etc.

- Genuine interest in food - maybe some special food from his focal carer/attachment figure.

- Starts to play - fantasy play with, for example, sand and toys. Symbolic communication.

- Is given and able to receive complete experiences - ie, with a beginning, middle and end. Emotionally deprived children have a memory bank full of interrupted, unfinished experiences. This needs to be rectified.

- A growing ability to communicate feelings.

- Alongside this will be a reduction in acting out behaviour.

Preparing for bed

- Think about your foster – child's presentation in the evening – are they restless, anxious, active, tired?

- How do you provide a "wind – down" period: what is specifically helpful for the child?

- How do you manage the child's personal care: how are "everyday product" e.g. toothpaste, shampoo, sanitary towels acquired and kept?

- Describe any anxieties you feel in relation to the child's intimate care. Have you taken your concerns / anxieties / conflicts to supervision?

- If you supervise others, is this an area of work that is discussed……. why might you feel reluctant to ask questions in this area?

- How do you establish a bedtime routine which safely provides for the needs of your children?

CONCLUDING REMARKS

1. Remember to use ISP's team of therapists as a resource. They may help to make sense of the chaos. They may help you to view a problem in a different way. They may be able to confirm that what you are doing is as good as it can be for the child.

2. A crucial time is when the child is pushing to be scapegoated and rejected. Surviving this could be the breakthrough with the child and lead to growing trust and attachment.

3. How your family (including your children) work as a team is a crucial part of enabling the fostered child to feel secure.

4. It is important to value children showing a younger, softer side of themselves. This may mean their defences are dropping and showing some vulnerability and accessibility. Treasure these moments.

Recommended reading:

"Attachment, Trauma and Resilience
Therapeutic caring for children"
By Kate Cairns
(published by BAAF)

I am well aware that one day's training will not turn well-meaning foster carers into residential therapists. However, it is an important strand in the development of a therapeutic culture within ISP. The fact that the training is delivered by the two most senior managers is of symbolic importance, even though there may be others who could do it better.

John Whitwell
Managing Director
ISP