Therapeutic Care in Family Settings

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Introduction

I became the Chief Executive of ISP (Integrated Services Programme) in 1999 following a 14 year period as the Principal of the Cotswold Community, a pioneering residential therapeutic community for emotionally unintegrated boys (Tomlinson 2004, Whitwell 1989). ISP was started by foster carers in 1987 and was the first independent fostering provider in the UK. A core part of the ISP ethos is that carers are the colleagues of fellow professionals not clients. It's vitally important that a community is created among the carers, providing an essential source of mutual support.

My ambition, on joining ISP, was to develop the therapeutic understanding of the staff and carers and to apply the therapeutic child care principles (Dockar-Drysdale 1990, Winnicott 1984) which we practiced at the Cotswold Community. The professionalism of the foster carers, referred to above, was a good starting point for this work.

The Meaning of Therapeutic

For a lot of people the word therapeutic is wrongly, in my view, associated with therapy and therapists. A dictionary definition of therapeutic is, "contributing towards or performed to improve health or general wellbeing". Foster carers realise that a lot of what they already do fits with this definition. Once carers start to talk together about their care practice some amazing examples emerge. For example, one carer described how she provided a box of food that the child could go to whenever she felt hungry, rather than steal and hoard food.

It was important to introduce psychodynamic concepts to enable carers to see children's behaviour as a means of communication. In society in general behaviour is quickly labelled as good or bad, rather like the weather. I wanted carers to think about the meaning of behaviour instead of seeing it as a problem and to ask themselves, "Why this behaviour and why is it happening now?" This is easier said than done. Under pressure we may all resort to the need to control behaviour rather than understand it. I also think it is harder sometimes to achieve this reflective space in families than in a residential setting with a staff team. At the Cotswold Community we spent time together each week with consultants thinking about how best to meet the needs of the different children and how as a team we would work together, drawing on our different strengths. Families don't usually have the same time and space to do this reflective work. However, the centre based multi-disciplinary teams in ISP do have the capacity for reflection in their support of carers.

This is an example from a carer which illustrates my point about the meaning of behaviour. "Michael appeared not to know how to use the toilet and said that he'd never used toilet paper. He was fascinated by where the water went and became obsessed with the drainage system. This was to be the first of many of Michael's obsessions." The temptation for the carer was to think that this was a simple educational task of helping Michael to understand the household's plumbing. A bit more reflection might enable the carer to make a connection between Michael's lack of toilet training as an infant and this obsession and this in turn might inform a more empathic approach to his need for toilet training as an older child.

Another aspect of psychodynamic thinking is to help carers to monitor their own feelings. How a child makes you feel may be a clue as to how she is feeling. This puts the onus on the grownup to know themselves sufficiently well, to know which feelings belong to themselves and which might be picked up from the child. This next example also illustrates the benefit of reflecting with others.

"A very experienced and highly regarded foster carer was asked to look after a 6 year old boy. She soon found that she was struggling in a way she hadn't with other foster children. The boy made her feel inadequate and humiliated. He seemed to save his worst behaviour for public places, e.g., pulling down his trousers in public. She felt he was deliberately 'showing her up'.

At a network meeting called by the Social Worker it emerged that the carer wasn't the only one the boy had made feel like this. In fact, several people recognised a similar reaction. His class teacher, for instance, described how the boy had managed to undermine him publicly with defiant behaviour in front of the other children.

The meeting went on to discuss how this might reflect how the boy was feeling now, very humiliated by his present situation and feelings of dependence, and how this linked up to the abusive behaviour of his birth family. The discussion helped the carer to understand how some situations might make the boy feel especially vulnerable and how he then 'turned the tables' by making her the one with the problem, not him. Things didn't change overnight but they did improve and she no longer felt unable to cope with him."

I was trying to achieve in ISP a therapeutic culture, a recognition of how everyday caring experiences can be used therapeutically, which is especially relevant for children who have not received good enough parenting during infancy and early childhood. I want carers to realise that by looking after a child 24 hours a day they are in a strong position to meet her emotional needs. A lot of therapeutic care is opportunistic, being ready to respond whenever the child feels less defensive, e.g., a child might start to communicate at a deeper level during a car journey or at bedtime or while helping in the kitchen. Therapists would "give their right arm" for moments like this.

Developing Empathy in Foster Carers

I think it is important for carers to understand how an emotionally disturbed child is damaged during infancy. This is not an intellectual exercise but a need for the carer to retain a sense of empathy in the face of challenging and rejecting behaviour.

"How you are cared for in the first few weeks and months of life affects the way you come to care about yourself for the rest of your life. It's not the only factor that influences how each and everyone one of us develops, but it is always significant.

A baby cries for his mother, for food and warmth. At first the baby isn't sure if mum will come, but she does, and when this is repeated an endless number of times, the baby builds up a picture in his mind of a mother who feeds him, looks after him, tries to understand him and keep him warm both physically and emotionally. The baby gradually builds up a resilient picture in his mind that if mum isn't here, she is just over there.

When mother can be confidently expected to come back soon, waiting isn't too difficult and the baby has a reassuring experience that mum can be depended upon and that painful feelings can be managed without becoming absolutely overwhelming. But what happens if the baby's experience is not like this but is full of adverse experiences, with need and vulnerabilities remaining unmet? Instead of a helpful and soothing mum, the baby encounters somebody out of touch with her infant's state of mind or even worse, responds to the baby in a way that is abusive or neglectful. The answer then to "who cares? is "no one" or "my mum but only some of

the time" -and the children struggle to have a consistent and reliable view of their place in the family - and in the wider world." (Fagan)

Most of the children who are placed with ISP foster families have suffered this early emotional deprivation and neglect. They have usually suffered further abusive and traumatic experiences, quite often in the care system itself, by being moved many times when their behaviour leads to yet another rejection. I liken children who have been through these awful experiences to houses without foundations. They may look alright on the surface but under stress will crack and crumble. Rectifying a house without foundations is difficult and expensive work. Children without emotional foundations to their personality will need long-term therapeutic care and it is expensive. However, if this therapeutic work isn't undertaken the long-term cost to society is enormous.

Symptomatic Behaviour

The kind of behaviour to be expected from children whose early emotional needs have not been met is:-

Withdrawing and not caring - the child switches off her desire for contact and tries to avoid all feelings of disappointment, loss, anger or frustration by a facade of not caring.

Pushing boundaries - children feel compelled to test the boundaries, as if driven by a conviction that all good things come to an end and it's better to get it over with sooner rather than later.

Demanding total attention and possession - to feel uncared for is a devastating experience of loss and for many children one way of avoiding these feelings is to imagine that one can have everything.

Pushing away intimacy - when a child receives attention this can provoke terrible feelings of resentment arising from the earlier neglect. The experience of being close to another person, which she may really want, feels too much and she pushes the adult away. This is double deprivation, rejecting intimacy in the here and now as a result of the previous neglect.

Becoming aggressive - feelings may build up and erupt in a volcanic like explosion. Terrible feelings can't be put into words and their source often pre-dates the use of language. The explosion may occur over some minor frustration because the volcanic pressure has been building for some time.

Any one of these behaviours would be difficult to live alongside but usually they all come bundled up together and carers will feel like they are being tested to destruction. The reward of surviving this is that the child may gradually start to believe that the carers really do care. She has thrown everything at them and they have survived. The testing behaviour will start to subside although could return if something happens to disturb the child's equilibrium.

Other behaviours that emotionally unintegrated children display are: disruption in groups; merging with other children in a state of delinquent excitement; showing little or no concern for others; finding people's "buttons" to press and exploiting this mercilessly; hypervigilance, an inability to concentrate on an activity; a poor sense of time and space; an inability to play; splitting between “good” and “bad” people; poor self-preservation which can include poor personal hygiene at one end of the spectrum through to self-harming behaviour.

For a carer to retain a sense of empathy in the face of this is extraordinarily difficult. It's no wonder that the children have had so many placements as they put themselves forward as candidates for being the scapegoat. However, if they are to recover someone somewhere will need to stick with them through this most testing behaviour. A starting point is for the carer to

realise that the child is not just being bloody minded and misbehaving deliberately. The carer needs to understand this behaviour is symptomatic of the underlying emotional disturbance and then it becomes more possible to continue to feel empathy for her.

Key Elements in a Therapeutic Culture

Providing therapeutic care is rather like gardening. If all the elements of a garden are in place, fertile soil, enough sunlight, enough water, continuous weeding, maybe some time in a greenhouse, possibly needing a stake for additional support etc, then the plants will grow. Foster carers are providing a garden for emotional growth in their family. It's worth unpicking some of the key elements in this garden for emotional growth.

I would start with carers who are committed, interested, emotionally involved and genuinely care. You make think this is obvious and should be taken for granted. Many children in the care system have experienced adults, both residential staff and foster carers, who are just going through the motions. Maybe they have become hardened and cynical towards children's distress or they have burnt out, having to cope for many years without support and training. I have seen children respond better to inexperienced foster carers, who are full of enthusiasm with a strong sense of commitment to the child, than very experienced carers who are tired and battle worn.

Another element in this garden is for the family to provide a nurturing environment, carers who can respond to needs which are associated with younger children. In the family there is much emotional warmth, a good standard of physical care and in general children feel emotionally held by these carers. This is an example from an ISP carer.

"During the early days of Katie's time with me I had to lie on the floor next to her bed, holding her hand until she fell asleep as she was so frightened and confused. During this time everything was done with sensitivity, not rushed, looking all the time for indicators of the effect of the trauma she'd experienced in her life so far. Gaining Katie's trust, setting in place boundaries and structure at practical levels that she could understand were fundamental at that stage."

This really shows commitment, for the carer had no idea how long she needed to help her to go to sleep in this way. In my experience these adaptations don't need to last for more than a few weeks because within the child there is the need to move forward when she feels more secure.

I strongly recommend to ISP carers that they have regular only-child time. This is building into a child's week two or three times when she can experience being an only child. She has the carer’s undivided attention. This doesn't need to be for very long, maybe 30 minutes. The rest of the family will need to support this and understand why it is needed. This is high quality time because it is given to the child and hasn't been obtained by being naughty. When that happens the grown up usually feels resentful and probably feels she doesn't deserve the attention after behaving like that! When I hear grown ups talking about attention seeking behaviour I say it should be reframed as attention needing. If we know children need individual attention why wouldn't we build it into their week?

Another element of this garden is the ability to be firm as well as nurturing. The phrase "tough love" conveys the sense that sometimes being firm is an expression of love. The opposite is being indifferent. Unintegrated children, with few inner controls, need clear boundaries in order to feel safe (Whitwell 1998). I think one of the most creative aspects of being a carer is knowing your child sufficiently well to know when she is in a good emotional state and could manage the loosening of a boundary, for example, being trusted to go the local shop by herself, or when the

boundary needs to be drawn tighter because you know she is struggling to cope with her emotions at that moment in time. This ISP carer is describing this process.

"I went through several changes in my relationship with Andrew. I had to be strong and consistent with him and always carry out my promises. I felt I needed to gain trust and some respect. We decided to call me the boss in the family to show Andrew that women can have authority and be respected. I think he had witnessed women being poorly treated with no control. I also gave a lot of nurturing to Andrew and we shared books and did lots of fun activities. I gave him lots of praise when he was good and we shared a sense of humour."

It's really important that a child gradually feels safe and secure. In a therapeutic community setting a cohesive staff team is a crucial element in creating this sense of safety. A child will test out this cohesion by "splitting", playing one person off against another. If the team are communicating well she won't succeed in splitting and may show anger about this although underneath is probably relieved. A foster family also needs to achieve this level of cohesion. This is a tough ask because a foster family has a different dynamic to a residential staff team. The carers own birth children will be part of this dynamic and may themselves be going through development stages, like an adolescent's search for their own identity, which may mean rejecting their parents at times. The chemistry within a foster family is going to be different; nevertheless, they need to work together on the cohesion of the family. A child fostered with this family will feel safe if she senses that the family has a strong community spirit and it will then be a therapeutic community in its own right.

The Beginning of Emotional Growth

Assuming the foster family has all the ingredients to facilitate emotional growth how might an emotionally unintegrated child start to change? She begins to trust a **reliable** grown-up. I have emphasised reliability because the onus is on carers to be trustworthy. A child who has been let down and rejected many times is not going to take our good intentions at face value. Our actions over a period of time will count far more than words. This is put well by an ISP carer.

"Andrew's relationship with me became very positive. It felt that he had eventually learned to trust me. He stopped the aggression towards me and his sexualised behaviour at home almost ceased except for occasional comments and actions. This, however, was a long process and I would say took up to 18 months. Andrew became more affectionate and could express himself more verbally."

Another positive change is that she is likely to allow herself to be dependent. This is a big change from the defensive attitude, "I don't need anyone else, I can look after myself". At the Cotswold Community we learnt to appreciate the dropping of this defence and welcome signs of dependency on one or two key adults in the staff team. Foster families, without the appropriate training and support, might see these signs of dependency as a backward step. This ISP carer clearly understands how this is a positive development.

"Jack (4 years 9months) appeared to be a happy little boy with a constant smile on his face. However, we noticed this was more like a smile through gritted teeth. Jack was a very lively little boy who always seemed to want to be busy.. He was also 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'd always had to look after himself as nobody was really there for him. We gradually took 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 clearly 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 for him and general things like that."

Another sign of getting better is that the young person begins to be able to feel sad and to experience the painful feelings that have previously been buried or avoided. The opposite of this is the defensive position, "I don't give a damn, no one can hurt me. Getting into trouble is much more exciting." In general in our society we are not good at dealing with sadness. There is a tendency to want to jolly people out of it. "Come on pull your socks up, let's see you smile". We need to see these small initial signs of sadness as positive, in need of support. Often, when I read about the history of an ISP child, I wonder why she is not walking around in floods of tears. Instead I see a happy-go-lucky young person seeming not to have a care in the world. She is probably defending herself from the pain of the abuse she has suffered, the sense of loss from previous rejections. If she is to develop as a person this will need to change. This will happen if she feels safe and secure and can trust the adults looking after her. It's important, therefore, that the adults are trained to recognise these initial small signs of sadness as a positive development.

Interlinked with a sense of trust in her carers, beginning to feel dependent on them and allow some real feelings to emerge, are some signs of regression, ie, showing a younger side to herself. This may take the form of playing with toys associated with younger children or seeking a transitional object, maybe in the form of a teddy bear, to help with the carer's absence or generally looking for comfort in the form of hugs and cuddles. Carers need help to see this as positive, as the young person's "true-self" emerging. This ISP carer clearly understands this.

"Bob, aged 13 years, demanded constant attention and he would get it, if not satisfied, by tapping on doors and windows, messing the dogs about, and having to be told constantly to leave them alone. He was like this from the moment he opened his eyes in the morning until he went to bed at night. He liked me to go into his room at bedtime to read to him or tell him imaginary stories. I showed him a few relaxation techniques to help him settle down and go to sleep. He liked to have his hair stroked. This in no way felt anything other than the need of a little boy who wanted a reassuring touch. He seemed like a much younger boy than his 13 years and he liked the one-to-one attention. Bob has now grown out of this need and will say goodnight to us in the sitting room before he goes to bed."

As feeding is so interlinked with the attachment process during infancy we shouldn't be surprised that many children with attachment problems also have food issues. At the Cotswold Community food was an important part of the children's treatment programmes (Hancock, Simmons & Whitwell 1990). Within a foster family an emotionally deprived child may steal and hoard food, being anxious about the supply of food in the future. Lovingly prepared meals may be rejected out of a fear of being poisoned or the child may have lost all interest in food from an early age. Mealtimes may be a battle ground as the child is not used to the family eating together and may not know how to use cutlery. These are difficult issues for families to cope with as they can seem to strike at the heart of family life. Over time, as trust and attachments develop within the foster family, food and feeding will become more positive. We advise carers to encourage children to become involved in the kitchen even if this feels like extra work. It pays off in the long run. This involvement helps children overcome their fears about the contamination of meals. Some regular one-to-one time with the carer in the kitchen creating things that the child really wants to eat can help rekindle a genuine interest in food and even to reach a state of excitement about it. This is a vignette from an ISP carer.

"Thomas came to us with big food issues. He told us that although there was always food in the freezer at home he couldn't cook it. He recalled eating frozen food and being dropped off alone in a play area for many hours without food or drink. He remembered an occasion when he was left with a weird character, in squalid conditions, who fed him rotting food that made him vomit.

The result of all this was a very skinny boy. Thomas was suspicious of any food that didn't come out of a frozen packet or tin. We'll never forget the look of sheer horror and disgust when he first saw us feed our baby organic meat and vegetables. Whenever we were out he would panic

saying, "when will we eat?", even if we'd just had a cooked breakfast and he knew we were only out for two hours.

We responded by putting small portions of new, previously untried, food on Thomas' plate and assuring him that he didn't have to eat it but that he might be missing out on something he really loved if he didn't try it. Whenever we went out we would make sure we always took a variety of snacks and drinks and always demonstrated that we had cash in case we needed anything while out. That way he was able to enjoy the outing, feeling secure and cared for."

As mentioned earlier one of the common characteristics of an emotionally deprived child is an inability to play. As the child begins to feel more secure and less anxious we would expect to see play and playfulness emerge. This doesn't require sophisticated toys. I recall a worker in a refugee camp saying that it was a positive sign when the children started to play, having previously been in a traumatised state, often using the simplest of objects, sticks and tin cans, for example, as play material. We know that young children respond well to sand and water. They also enjoy climbing in and out of large cardboard boxes. These basic materials are good for fantasy play and much symbolic communication occurs within this creative play.

"His lack of opportunities to play really showed when my son got a sandpit for his second birthday. Our two year old didn't get a look in. Brian was in there for nearly a week solid, making tunnels, castles, all sorts of amazing structures. He also had a fascination for blue tac modelling. We introduced him to different types of dough and clay. The imaginative models he made were magnificent. He most liked corn dough and was fascinated by its malleability. There were many similar examples where he regressed which was necessary to fill in the blanks of missed development and opportunity." (ISP carer)

As a child feels more secure in the foster family we would expect to see a growing ability to communicate feelings and a consequent reduction in acting out behaviour. I encourage carers to see this as a continuum. At one end of the continuum she may lash out and hurt people when frustrated and angry. Moving along this continuum, she may break things in her room when she has these feelings, which is better than hurting people. Further along the continuum she may resort to swearing at people using very offensive language when angry. This is better than hurting people or breaking things. At the other end of the continuum we may reach a point when she can say how she is feeling, at the time she is having the feeling, in a way that is socially acceptable. Carers need to see this as a long-term process of continually working with her to reach this end of the continuum, but there will be setbacks along the way. The aim of therapeutic care is to turn thoughtless acts into actless thoughts.

"We believe that each child has developed a survival instinct and a way of coping that worked for them in the past, but will need to change as they feel safer and more secure. Les, for example, was unable to play, walk for any distance, or eat at a table with a knife and fork. He challenged all adults as a result for the lack of respect for all the adults he'd previously known. Gradually we introduced him to new activities and ways of being in a family through which he has grown enormously. For example, he now holds a trophy for the most improved player in his football team." (ISP carer)

CONCLUSION

If I can distil several key points for therapeutic care to succeed in a family setting it would be these four points.

1. Foster carers need to use the network of other professionals (therapists, psychologists, social workers, teachers etc.) as a resource to regularly draw upon to help make sense of the daily chaos that confronts them. Family life is an intense experience and it can be difficult to see 'the wood for the trees'.

"We have not worked before with a child who has suffered multiple abuse. Our development has intertwined with Michael's and we have seen him grow into a loving, happy boy. Our ability as foster carers has expanded as we have sought guidance from other professionals such as therapists and psychologists. In return we have been valued for our work and ideas. We have learned the need to be very flexible in our approach to dealing with difficult situations and the fact that it is sometimes necessary to take a step back and reflect on the past to see clearly the progress that has occurred." (ISP carer)

2. A crucial time is when the child is pushing to be scapegoated and rejected. Children who have been rejected several times in their short life will fear the worst and rather than wait for this to happen will try and confirm their worst fear. Being able to survive this could be the breakthrough with the child that leads to growing trust and the formation of a genuine attachment.

3. The foster family, including their birth children, need to work together as a strong united team. This will clearly be put to the test so this needs time and attention. The splitting, projection and transference processes will test the cohesion of the foster family. The continuing cohesion of the family in the face of this will enable the foster child to feel and secure and in the long run provide role models of how people support each other and resolve conflicts in constructive ways.

4. It's important to value children showing a younger and softer side of themselves. It's a compliment to the family that the foster child feels sufficiently secure to do this because she is lowering her defences and showing some vulnerability and as a result allowing herself to be more accessible. These moments should be treasured!

I would like to end with the words of an ISP carer, who sums up better than I can, the qualities needed to be a therapeutic carer.

“I have become more tolerant and firm over the years. You need to have perseverance and a sense of humour. I have found that what works well with one child may not work for another.

What are the skills and qualities that have developed in me since I started fostering? Being non-judgemental, empathic, tolerance, listening to what is said and what isn’t, counselling, advocating, an ability to reflect, perseverance, seeing children through difficult times.

Through attentive, persistent listening and talking to Didi she has been able to voice her concerns to us. Over a long period of time she is now able to communicate much better, taking herself off rather than exploding, and reducing swearing to one word per sentence rather than every other word!

We have learned to recognise that what your heart and head say must be balanced and that children cannot be made better just by unconditional love. We have learned that this work is unpredictable, exhausting, heart breaking and incredibly rewarding. Discipline is required not to be drawn into an abused child’s world, but sensitivity is required to get close to that abuse so that a child doesn’t feel abandoned, self-blaming or alone.”

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