# Exploring Foster Carers' Experiences With Children Who Have Complex Attachment Problems

A Thesis Presented

by

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Dedicated to my father, whose life and amazing resilience demonstrated the importance of the first 24 months, and to my mother whose life demonstrated the restorative power of nurture. They began but did not end this journey with me.

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**Abstract**

The aim of this research was to understand the key elements of effective therapeutic foster care for children who have complex attachment problems in order to enhance training and support mechanisms for foster carers. The host for the research project was a national independent fostering agency to whom the researcher has provided training and therapeutic support. An interview study of fourteen sets of foster carers was conducted to understand peak experiences and effective practice in fostering. Thematic analysis of interview data yielded thirty-six robust child behaviour codes that were combined into five themes: i) *Developmental growth*, ii) *increased ability to manage emotions*, iii) *emergence of new positive behaviours*, iv) *developing confidence* and v) *the child showing that they are happy and safe*. These themes were then mapped to nine carer behaviours including *consistency and repetition, showing the child they are valued and important, caring for the child as an individual, showing kindness, inclusion in the family, maintaining hope* and *modelling good enough parenting.* These findings suggest it is important to provide early focused training for foster carers that provides a trauma-informed guide to therapeutic fostering. Given the demands of effective fostering evident in the accounts of carers it became evident that training should be followed by regular and ongoing Practice Development and Therapeutic Support (PDTS) sessions involving carers, supervising social worker and therapeutic lead. The importance of effective foster carer behaviours and practice development and therapeutic support groups was illustrated through a single case study. Overall, the research findings accord with the literature that suggests that children exposed to chronic neglect in the early years require high levels of consistent, predictable, patterned, and highly repetitive

interactions to address the harm caused. This suggests that therapeutic foster care requires relevant high quality training and regular ongoing support; and, that this type of training and service may allow for easier recruitment and retention of foster carers for these children. This document closes with a complete training and support package developed through this research that fulfills these criteria and that was enhanced through the findings of the present research.

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# Chapter I

## Introduction

Fifty-two thousand children are currently placed in foster care in the UK. The entire number of children being 'looked after' in England has continued to rise year on year from 2011, currently totalling almost 71,000 (DfE 2016). Local authorities hold responsibility for all children brought into the care system, but they source foster placements from independent fostering agencies (IFAs) due to a year-on-year lack of both foster placements and placements with sufficient skills to meet the complex needs of particular children. This is likely to mean that IFAs regularly receive children with more complex needs.

This study explored the high points or best experiences of foster carers within an independent fostering agency (IFA).

### Purpose of Research

The catalyst for undertaking the study arose from a growing recognition that, nationally and internationally, local authorities and independent fostering agencies were struggling to provide effective support to foster carers of children with complex needs (Colton *et al.,* 2008; Wooldridge 2009; Randle *et al.,* 2012; Hutchins and Bywater 2015; Wilson 2015; Octoman and McLean 2015). The purpose of the research presented herewith was to investigate foster carers' positive experiences and to see whether, and to what extent, they relate to known therapeutic and scientific research outcomes with regard to children with complex attachment problems. These experiences are potentially valuable and were then used in the development of training of and support mechanisms for foster carers of children with complex needs.

**Research Focus**

To help address the impact of early neglect / trauma, it is necessary to have "consistent, predictable, patterned, and highly repetitive interactions" with the neglected/traumatised child which could not be met by therapy alone (Gaskill and Perry 2012, pp. 38-39) The opportunity for this high level of relational contact, with children whose behavioural challenges may be relentless, rests almost solely with the substitute parent/foster carer. It is for this reason that the focus of this research centres on this group. It is recognised that foster carers have the potential to create positive change for children in a highly pressured environment, yet this kind of environment demands repetitive responses from individuals with relatively little focussed training and /or direct support.

**Personal and Professional Background**

My personal and professional interest in the developmental impact of early trauma is, in part, associated with my experiences of living with my father, who was abandoned in 1921 to a workhouse at the age of two years. He remained in residential care until he was 18, without further birth family contact from the point of his abandonment. Besides that, my interest is related to my own accident, coma, and traumatic brain injury (TBI) at the age of seven and its cognitive, affective, and behavioural consequences -including retrograde amnesia, which in my case meant no conscious memory to the point of the accident or retained memory for some years after the accident.

After working in a residential situation with high tariff male offenders, qualifying and then working as a social worker with adoptive and foster parents, obtaining a degree, MA and PGCE, and training and qualifying as a therapist, I began working independently

to fill the gap I had observed in the therapeutic support being offered to foster carers of children with complex attachment needs. The success of this support, being offered directly to foster carers, evolved into a training programme for carers and professionals, drawing on attachment-based and neurobiological research and literature. I recognised during this 32-year period of training and practice the generative power of appreciative dialogue rather than detached or consequence-based relationships, and this understanding was brought into my training and therapeutic support. It is this training and support programme that I have endeavoured to refine and develop through the investigations presented in this thesis.

**Methodology**

The research design incorporated two qualitative elements: an interview study with foster carers who had children with complex attachment needs in their care and a case study that illustrated the implementation of a multi-level training package. The interview protocol was adapted from the principles of appreciative inquiry (Cooperrider *et al.,* 2008). Appreciative inquiry aims to explore individuals within their natural environment seeking what is working well through individual and/or group dialogue. This approach was adopted to provide an initial understanding of what was working in complex foster placements. These AI inspired interviews provided data collection as jargon-free discussions between two people rather than a formal question and answer format. Reviewing these experiences facilitated the further development of an existing training and support package for foster carers. The principles and operation of this revised package are illustrated by a detailed case study presented in chapter VI.

**Research Questions**

The following research questions formed the basis for this study which sought to understand foster carers' peak experiences, 'the best of what is' (Bright et.al. 2006; Whitney 2010; Robinson *et al.,* 2012). The epistemological and ontological stance for this work is critical realist, thus acknowledging the importance of social experience in mediating the interpretation of objective reality (Yirenkyi-Boateng 2016). This thesis explored:

1. To what extent do accounts from foster carers lead to a better understanding of ways in which they can be involved in the therapeutic process with children with complex attachment problems?
2. How do accounts from foster carers highlight the challenges in the development of trust from the foster children with complex attachment problems towards their carers?
3. What type of training and support would enhance foster carers' ability to be part of the therapeutic process in helping foster children with complex needs?

The first two of these research questions are addressed during the discussion of the AI interviews. The third question is addressed from information contained in the literature review and applied during development of the training package.

**Scope of Research**

The host for this research was a national independent fostering agency (IFA) rated 'Outstanding' by Ofsted from 2011 to 2016. The researcher had provided independent training and therapeutic support to the Midland region of the IFA for about 4 years before the study began. To avoid potential for selection bias, a time-frame method of selection was employed, which in practice meant that all 16 foster carers that had received

attachment-based training and support in the previous 18 months were invited to take part in the study. For more information about the foster carers see Appendix A.

Foster carers that agreed to take part in the study were interviewed in their own homes to offer a more familiar and relaxed environment. It is important to understand that these carers gave accounts of many types of incidents which happened. These accounts were about positive moments in the lives of children who had previously experienced multiple placement moves and chronic neglect. In the final research the accounts from 14 foster carers were collected in interviews that averaged one and a half hours in length. On the basis of the interview data the existing training/support programme for foster carers was developed into a multi-level therapeutic package which is the central product of this project. The potential and principles of the new training and package is illustrated through an in-depth case study presented in this thesis.

**Potential Contribution of the Research**

This research has potential to make a contribution for four reasons:

1. It fills the previous gaps in literature and practice as relating to the role of foster care with children with complex attachment needs.
2. It identifies foster carers as part of a therapeutic package and providers of parenting that can positively impact on the emotional and behavioural development of children in their care.
3. It seeks to understand how the empirical evidence base concerning the biopsychosocial impact of neglect and trauma can inform the development and support of therapeutic fostering.
4. It seeks to enhance the provision of training and support to foster carers through a multi-level training package.

Because the children involved in these placements had experienced multiple placements beforehand, it was critical to understand the perceptions of the foster carers, and their best moments, as they saw the children make positive progress.

**Key Limitations of the Research**

The researcher was previously known to the foster carers in this sample and this may have led to four types of role conflict, depending on the participants understanding. First, although the interviews followed an appreciative inquiry approach in a few instances the researcher had to redirect the interviewee onto a positive course. For example, a few participants appeared to want to talk about difficulties after birth family contact and were discouraged from it. Second, a few foster carers might have been telling only the stories that fit what they perceived the therapist wanted to hear, such as indicators of stability in placement. Third, participant word usage may have become more therapeutic in nature due to difficulty in differentiation of the role of therapist from the role of researcher/interviewer. In effect saying what they thought was required of therapist rather than interviewer. Finally, the researcher recognised but did not address the quieter member in a couple which was always the non-primary carer. This may have missed the opportunity for catching the subtle differences between how partners viewed high points or best times.

The participants measured the best of the children's behaviour in relation to the worst they had experienced. The early episodes of when these children first came to the carers home demonstrated times of testing the carer's ability to be trusted with a relationship. These data then ended up demonstrating what had changed and cannot be seen as standing away from that context. In other words, the level of attachment problems in these children must always be taken into account when considering this research and

cannot be considered replicable to other types of children in foster care without additional study.

**Terms**

The following terms are used in this document and are listed here as a reference for the reader:

1. *Complex attachment problems*: They usually develop as a consequence of an insecure attachment. They can develop from early chronic neglect from primary carer and may result in life-long cognitive affective and behavioural issues or challenges.
2. *Foster care / foster carers*: This term is defined for this study as primary carers that provide a secure environment in which the child can learn that they are valued and important. They seek to be the child's secure base and are ipso facto substitute parents who will seek to provide parenting that challenges the early messages of chronic neglect.
3. *Independent Fostering Agency (IFA)*: It is an independent foster care agency that provides foster placements when local authorities do not have foster carers that can meet the complex needs of the child.
4. *Chronic neglect*: It can be defined as a primary caregiver's ongoing, serious pattern of deprivation of a child's basic physical, developmental, and/or emotional needs for healthy growth and development (Kaplan *et al.,* 2009). Children that have experienced chronic neglect often exhibit problems with attachment, cognitive development, emotional and behavioural self-regulation, poor self-concept, concentration and perseverance, and empathy and social conscience.

5. *Therapeutic foster care*: It seeks to provide a caring, consistent, and nurturing environment for children of all ages. It focuses on both emotional and behavioural needs of children whose abuse and trauma has caused them present complex and challenging issues that require high levels of skill and resilience. In particular, therapeutic carers are supported to reflect on and interpret what the child might be thinking, and try to make sense of why the child is behaving in the way they are (Ironside 2012). This can allow a greater tolerance in the carer and a healthier response. The aim is to promote the development of a relationship with the child in which s/he can begin to trust.

**Summary**

This chapter introduced the reader to this study and its focus on training and support for foster carers of highly traumatised children. In the next chapter, the literature on complex attachment problems and the therapies through which they are addressed will be considered. Chapter three reflects on the development of the research from the position of the researcher. Chapter four discusses the epistemological and ontological grounding for the research and explains the methods adopted for an interview inquiry with foster carers. The results of this interview study, as they pertain to each research question, emerge in chapter five, together with discussion of how findings from the interviews led to enhancement of the multi-level therapeutic training for foster carers. Chapter six provides an illustration of the impact of the training programme within a single detailed case study. Finally, chapter seven discusses the study as a whole and the new information which emerged from it, the limitations of the research and further recommendations for the field.

A full description of the evolution and details included in the therapeutic multi-level training package can be found in the appendices.

# Chapter II

## Review of Literature

This chapter reviews the literature on the impact of neglect in early childhood to provide the context for the research project and the design of the training & support package. It outlines early biobehavioural views of Attachment Theory in order to contextualise research findings and theoretical developments emerging from contemporary developmental neuroscience. This framework and evidence base provided foundational principles for training content in the earliest iteration of the multi-level support package (which preceded the research project). Biopsychosocial attachment models exist within, and resonate with, a broader range of therapeutic and psychological frameworks. In particular, person-centred therapy and positive psychology approaches adopt principles that fit well with a neurodevelopmental perspective on therapeutic foster care. The review concludes with an overview of the principles that can be drawn from the existing literature for understanding a sound basis for therapeutic fostering and identifies questions of foster care practice that could be clarified through the present research.

### Neglect

#### What Constitutes Neglect?

Neglect is defined in UK statutory guidance as:

> *The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse…It may also include neglect of, or unresponsiveness to, a child's basic emotional needs*. (HM Government 2015, p. 85)

Although persistent neglect is considered to be at least as damaging as other forms of maltreatment, neglect in the early years may be the most far reaching and difficult to overcome (Gilbert *et al*., 2009; Perry 2012). The infant brain's developmental growth spurt between 0-3 years is profoundly guided by experience, and adverse experiences interfere with normal patterns of experience-guided neurodevelopment by creating extreme and abnormal patterns of neural and neuro-hormonal activity (Perry, 2009).

In his consideration of the neurodevelopmental impact of neglect in childhood, Perry defines neglect, therefore, as an absence of critical organising experiences at key times during development (Perry, 2003). This issue of timing is central to John Bowlby's attachment theory. Bowlby argued that the critical period for children to develop a healthy and secure attachment to their primary carer is during the first 12 to 18 months, and that the prolonged deprivation of maternal care during this period would have far reaching effects on the whole of their future life (Bowlby, 1953).

There is now considerable psychobiological evidence to support Bowlby's early proposition of the impact of emotional neglect. Research in this realm is particularly interested in the impact of early neglect caused by inadequate parenting. This is because very early relationships have been shown to have a lifelong impact (Schore, 1994, 1997a, 2008; Stern 1985; Perry 2009; Gaskill and Perry, 2012). What we do now know about neglect in early childhood is that the earlier and more pervasive the neglect, the more devastating the developmental problems are for the child. Indeed, chaotic, inattentive, and ignorant caregiving can produce pervasive developmental delay in a younger child (Rutter *et al*., 1999; De Bellis 2005). It is also now understood that a child's resilience to neglect will differ dependent on age and, of course, previous experience; "the very same traumatic

experience will impact an 18-month-old child differently than a five year old" (Perry 2009, p. 242).

The impact of neglect upon the development of the brain during the early years has a direct impact upon the physical, emotional, behavioural, and social development of the child. MRI scans have helped us to see that Bowlby's observations and suppositions from 1950-80, regarding the impact of the primary carer relationship on the structure of the brain and personality development, were insightful. Bessel van der Kolk (2005) undertook a comprehensive review of the literature concerning children that have suffered early complex trauma and suggested seven primary domains of impairment in the exposed children: attachment, biology, affect regulation, dissociation (alterations in consciousness), behavioural regulation, cognition, and self-concept. Neuroscience has helped to further develop our understanding of this; for example, we now know that almost all of these domains are resident in the early developing right brain (van der Kolk 1985).

**Early Studies on Neglect**

"Child neglect is the most prevalent, but least empirically studied, form of child maltreatment" (De Bellis 2005, p. 150). Neglect remains the most common form of child maltreatment in England (Department for Education 2013; Radford *et al.,* 2011) and in USA (Sedlak *et al.,* 2010). It features in 60% of serious case reviews (Department for Education 2015). Serious case reviews are held for every case in England and Wales where abuse or neglect are known or suspected and either a child dies or is seriously harmed, and also there are concerns about how organisations or professionals have worked together. Learning from recent serious case reviews supports the need to treat neglect as seriously and urgently as any other form of maltreatment (Brandon *et al.,* 2013, 2014).

One of the difficulties for psychobiological research is that neglected children may additionally suffer from different forms or subtypes of neglect, abuse, and adversities other than neglect (Daniel *et al.,* 2011; NICE 2009; Farmer and Lutman 2014), which may also compromise neuropsychological and psychosocial outcomes. This supports a study by De Bellis (2005), who as part of the Federal Child Neglect Consortium (USA), comprehensively outlined the issues involved in the psychobiological research of child neglect. He stated, "Other adversities, such as physical or sexual abuse, prenatal exposure to substances, witnessing domestic violence, poor nutrition, poverty, and lack of educational opportunities are some of the important variables which are commonly seen in neglected children, and may confound the relationship between child neglect and outcome measures of adverse brain development" (De Bellis 2005, p. 150). Whilst there is considerable national and international consensus on what constitutes physical and sexual abuse, there is much less agreement about the definitions and thresholds for neglect (Munro 2011; Naughton *et al.,* 2013). Further confusion for researchers can arise due to some overlap between emotional abuse and neglect (Ward *et al.,* 2012; Hibbard *et al.,* 2012).

**Overview of Research on Consequences of Neglect**

The functional impact of impaired or abusive care-giving (which for an infant may be a consistent non-response to emotional and/or behavioural needs) has been well documented (Malinosky-Rummel and Hanson 1993; Margolin and Gordis 2000; Howe 2005; Sroufe *et al.,* 2005; Schore and Schore 2008; Perry and Pollard 1998; Gaskill and Perry 2012) and indicates, "The result of child onset trauma is that the brain becomes poorly developed and functionally disorganised, rendering the child less able to

intellectually, verbally, or emotionally respond to normal experience let alone traumatic ones" (Gaskill and Perry 2012, p. 36).

The impact of early parenting on the development of the child is now clearer as a consequence of neurobiological research and the use of MRI scanners and in particular functional MRI scanners, that can show which region(s) of the brain are being stimulated by a particular situation. Brain development is profoundly guided by experience and, just as the use-dependent process can create positive learning and memory (implicit and explicit), it can also create negative learning and memory due to neglect, trauma, or chaos. In the case of severe early neglect, the neural system may get little stimulation or negative hyper stimulation from which the neural systems can fail to form or can maladapt (Perry 2006; Perry and Hambrick 2008; Gaskill and Perry 2012). Because the brain is finely tuned to respond to environmental inputs, neglect is in effect shaping its emerging architecture (Shonkoff and Phillips 2000). Early neglect (0-3 years) compromises development significantly across multiple domains and has long standing consequences that can continue throughout childhood, adolescence, and well into adulthood (Stein 2009; Rees *et al.,* 2011).

There is evidence from both animal and human studies that neglect in this formative period for social, emotional, and neurobiological development is associated with alterations in the development of the hypothalamus-pituitary-adrenal (HPA) axis stress response and differences in brain structure and function (Keverne 2004; Perry 2009, 2012; Schore 2001a, 2008).

It is thought that such changes serve to biologically embed vulnerability that may only later manifest in mental health problems (McCrory *et al.,* 2010, 2012). This may

include a poor sense of self, fear of failure, lack of impulse control, poor affect regulation, and the individual may self-blame for the neglect they received (Manly *et al.,* 2001).

Trauma, by definition, is unbearable and intolerable. The implicit and explicit memories and feelings associated with neglectful experiences can be so upsetting that victims try to push them out of their minds. It appears that to avoid the disturbing memories and feelings many victims consciously seek to keep engaged in left brain, often high arousal, activities. "It takes tremendous energy to keep functioning while carrying the memory of terror, and the shame of utter weakness and vulnerability" (van der Kolk 2015).

Attachment researchers and neurobiologists have shown that our earliest caregivers don't only feed us, dress us, comfort, guide and protect us; they also shape the way our rapidly growing brain perceives reality (van der Kolk 2015, p. 129). Our early experiences become embedded and act as something of a guide from which to measure future experiences.

## Theoretical Considerations

### Attachment Theory

In the late 1920's, Bowlby began to consider why some children rather than others become delinquent. No research evidence at that time suggested the importance and psychobiological developmental impact of the relationship between mother and infant. His research ideas, drawing on interdisciplinary perspectives, culminated in attachment theory (1969, 1973, 1980). Bowlby emphasised that attachment behaviour is first of all a vital biological function indispensable for survival (Bowlby 1969). Following his work, an expanding body of research demonstrated that disturbances of childhood attachment bonds can have long term neurobiological consequences (van der Kolk *et al.,* 1995).

**A historical perspective**. Attachment theory was not an overnight creation; rather it evolved over three decades. Beginning from the late 1930's, Bowlby tried to combine different strands of thinking into one coherent scientific theory that would explain the function and nature of the bond between children and their caregivers. Bowlby's professional interest in the consequences of separation in childhood began in the late 1920's when he was working at a children's home for maladjusted children. His observations of the life experiences and behaviour of two children in particular led him to write, "thus I was alerted to a possible connection between prolonged deprivation and the development of a personality apparently incapable of making affectional bonds and, because immune to praise or blame, prone to repeated delinquency" (Bowlby 1981, p. 2).

Bowlby hypothesised that such affectionless characters were the result of separations from caregivers and he tried to validate this view through his research whilst working with juvenile delinquents at the London Child Guidance Clinic between 1936 and 1939. The aim was to determine whether there was a correlation between maternal deprivation in infancy and delinquency in adolescence.

To this end, Bowlby identified 44 children that had been referred to the clinic for delinquency (specifically stealing, which later resulted in this group being loosely called the "44 thieves') and used a matched control group of 44 children referred to the clinic for emotional problems without delinquency. Social workers interviewed the mothers for 1 hour to record the child's history and psychologists tested the children's IQ along with their social and emotional attitudes. Social workers and psychologists then provided separate reports. Following this, Bowlby interviewed mother and child together and mother alone.

The results identified that of the 44 thieves, 42 had abnormal character types. The study outlined in detail 6 character types but only group E (the affectionless type) was considered to be of interest in this current research context. From the 14 children that were identified as having affectionless characters, 12 (86%) had experienced long term maternal deprivation during their first 5 years. Bowlby thought that their experience of loss of their mother or primary care-giver during these early years had affected their character and noted "that behind the mask of indifference is bottomless misery and behind the apparent callousness despair" (Bowlby 1944, p.39). There were no affectionless characters identified in the control group. The findings that 13 of the 14 affectionless young people were thieves seemed conclusive evidence to Bowlby that affectionless psychopathy can lead to stealing and more generally and importantly, that suffering loss of mother early in life leads to antisocial behaviour and emotional problems.

Bowlby concluded that there could be little doubt that for the affectionless thief nurture not nature is to blame and that there is a very strong case indeed for believing that prolonged separation of a child from his mother or mother substitute during the first 5 years of life stands foremost amongst the causes of delinquent character development. He suggested this as "an unusually clear example of the distorting influence of a bad early environment upon the development of personality" (Bowlby 1944, p.39). This study was published as 'Forty-four juvenile thieves'.

The study eventually led to Bowlby's appointment with the World Health Organisation (WHO), where he was asked to write a report on mental health problems of homeless children. Bowlby spent 6 months in 1950 working on the monograph 'Maternal care and mental health' (Bowlby 1951), the outcome of which greatly and decisively influenced his further career and his research activities. In this research, Bowlby moved

away from the established view in psychoanalysis that the emotional relationship between mother and child was based upon the fact that the mother feeds the child - 'cupboard love' or secondary drive theory (Holmes 1993). Also in disagreement with the standard views of the time, Bowlby stated the importance of any adverse circumstances in the child's environment, retrospectively commenting that: "most of what goes on in the internal world is a more or less accurate reflection of what an individual has experienced in the external world" (Bowlby et.al. 1986, p. 43).

Bowlby's monograph 'Maternal care and mental health' (1951) raised a number of questions and drew some criticisms during this period as it did not consider in any depth how maternal care influences the child and what psychological processes play a role. Bowlby could not yet answer these questions, stating in an interview in 1977, "I didn't know, and I don't think anyone else knew" (Smuts 1977). It was in this period that his attention was first drawn to the emerging science of ethology, the study of animal behaviour, which is discussed in the next section.

John Bowlby was not the only founder of attachment theory (van der Horst *et al.,* 2007). It also evolved through the empirical work of Mary Ainsworth (1967), Mary Ainsworth *et al.,* (1974; 1978) and Bowlby *et al.,* (1952). James Robertson made some notable films, including 'A two-year-old goes to hospital' (Robertson 1952). This film intended to explore the impact on a young child when separated from her mother. Bowlby stated that it was widely understood that young children in hospital frequently fret when apart from their mother. He noted that whilst this is common place, he felt it should no longer be looked upon as an unavoidable inconvenience, but as something serious and worthy of study (Bowlby 1952, p. 425).

The research was a recording, by James Robertson on a handheld camera, of the experience, over the 8-day period, of a young child (2 years) from admission to going home. The intention was to obtain data, from which an objective examination of what actually happens could take place.

The child was a randomly selected emotionally healthy and happy child on admission to hospital but, as a consequence of being separated from her mother, she went through an emotional deterioration over the eight days. Robertson filmed similar situations in several hospitals and formed the theory of phases of response of the under threes to a stay in hospital without their mother, which he called "protest, despair, and denial/detachment" (Bowlby, 1979 p. 48).

'A two year old goes to hospital' was not well received by the medical profession or by the psychoanalytic society, who felt the child's obvious distress was due more to her unconscious destructive phantasies towards her pregnant mother's unborn baby than the separation itself (Holmes, 1993). However, over several years the messages from the film helped change how children were cared for in hospitals in the UK and many parts of the world. For example, as a consequence of this film, visiting conditions at hospitals have been changed to suit the needs of young children and parents can now sleep in hospitals to be close to their children.

After almost 4 years of collaborative work with John Bowlby and James Robertson in London, Mary Ainsworth spent two years in Uganda (1954-55) at the East African Institute for Social Research, where she completed her own naturalistic research on mother-child interactions, followed by further research in Baltimore, USA (Ainsworth et al. 1978). Her observational research had a significant impact upon the development of attachment theory and provided empirical support for Bowlby's hypothesis that attachment

security stems from the history of child-caregiver interactions. Ainsworth's contributions include the concept of 'secure-base' (Ainsworth, 1962, 1967) to denote the importance of the child's proximity to their attachment figure. She also developed the "Strange Situation" experiment, a still widely used method for assessing the quality of attachment (Ainsworth *et al.,* 1978, Ainsworth & Wittig, 1969) and from which she identified the original classification system of attachment relationships as avoidant (A), secure (B), and resistant or ambivalent (C) (Ainsworth *et al.,* 1978). A further classification (D) was later identified by Maine and Solomon (1990) and is known as disorganised attachment.

There has been some criticism of attachment theory over the years, including from Michael Rutter, who felt Bowlby's term maternal deprivation oversimplified the concept and suggested it should have been 'maternal privation' (Rutter, 1972) and also from feminist scholars who had several concerns, including its deterministic view and the biological emphasis Bowlby placed on the mother's role for infant development and, therefore by implication, responsibility for the child's long term well-being / mental health (Birns 1999; Franzblau 1999; Vicedo, 2013). Nonetheless, the influence of attachment theory has been widespread in terms of child care, child protection, and child mental health. Psychiatrist, Jeremy Holmes suggested "The impact of Bowlby's advocacy has been enormous and continues to the present day. It is now taken for granted, and enshrined in the 1989 Children Act, that individual care in foster homes is preferable to group care in nurseries" (Holmes, 1993, p.41).

To recap, the significant ideas about the relationship in early childhood between carer and infant, upon which the Integrative Relational Approach being explored within this project is based, include:

i. Attachment theory sought to understand and explain the importance of the relationship between child and primary carer particularly during the critical period from birth (Bowlby, 1969, 1973).

ii. Attachment theory proposed that patterns of caregiving behaviour shape a child's 'internal working model' of the self and others, which informs socio-emotional functioning throughout development (Ainsworth et.al. 1978; Bowlby 1973).

iii. Where a healthy attachment figure was consistently unavailable, the child was likely to develop a different attachment style: Avoidant (A), ambivalent (C) (Ainsworth *et al.,* 1978) and disorganised (D) (Maine and Solomon 1990).

iv. Consistent early neglect leading to an insecure attachment can compromise development across multiple domains; the consequences can be life-long (Bowlby 1969, 1973; Stein 2009; Rees *et al.,* 2011).

This review of literature will now move to what is known about these issues from a biological perspective.

**A biological view.** Another strand of influence on attachment theory, which was developing simultaneously, was ethology. This science developed as the new approach to animal behaviour and a set of ideas emerged in the 1930's, which had a significant influence on the development of attachment theory.

Konrad Lorenz is recognised as one of the founding fathers of the field of ethology and is best known for his discovery of the principle of imprinting. Lorenz viewed imprinting as a process underlying the formation of affectional bonds. His description of imprinting or attachment in birds, such as Greylag geese in 'Der Kumpan in der Umwelt des Vogels' (1935), became the foundational description of the phenomenon. He argued

that animals have an inner drive to carry out instinctive behaviours, and that if they do not encounter the right stimulus they will eventually engage in the behaviour with an inappropriate stimulus.

Attachment theory clearly owes some of its roots to ethology. As an example, the notion of instinct and the infant's drive to survive was fundamental to Bowlby's proposal that the infant initially seeks proximity to a primary attachment figure in order to ensure protection and survival rather than an emotional bond at that point. He believed it is in this development of safety provided by consistent protection, that the relationship between the parent and child develops. "From the very beginning of his career, Bowlby believed that emotional relationships between parents and children matter a great deal, have long-lasting serious repercussions, and are independent from other factors such as providing food" (van der Horst *et al.,* 2007, p. 324).

**Neuroscience and its effect on attachment theory and resulting treatment**. Because of considerable neurological scientific discoveries during the 1990's, it became known as the decade of the brain. Allan Schore, an academic, clinician, and neuroscientist spent 10 years from 1980 in self-directed learning to understand and integrate the interdisciplinary fields of psychoanalysis, behavioural and neuro-psychology, psychiatry, neurology, and paediatrics, ultimately, into basic biology and biological chemistry. Drawing on and integrating data from these interdisciplinary fields he wrote the first of three volumes 'Affect regulation and the origin of the self: The neurobiology of emotional development' (Schore 1994), including some 2500 references.

Schore proposed that attachment communications are critical to the development of structural right brain neurobiological systems involved in processing of emotion, modulation of stress, self-regulation, and thereby the functional origins of the bodily-based

implicit self (Schore 1994). This volume clarified with interdisciplinary scientific evidence the role and importance of the early maturing right brain, which he suggested is dominant in the first three years of life.

In 2001, Schore wrote a two-part article for the Infant Mental Health Journal. Both papers were no less scientifically based than his earlier volume (1994), but were probably accessible to an additional clinical audience rather than the mainly scientific and academic community of his earlier work.

The first part was 'The effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health'. It brought new scientific evidenced-based insight into Bowlby's attachment theory (1969-1980) as he was able to integrate the current interdisciplinary data into it. His work provided a deeper understanding of the psychoneurobiological mechanisms that underlie infant mental health as it built from attachment on dyadic affective communications, neuroscience on the early developing right brain, psychophysiology on stress systems, and psychiatry (Fonagy 1999; Schore 2001a). Schore demonstrated that the primary care giver-infant relationship was critical to the early development / maturation of the right brain.

Part two of the series was 'The effects of early relational trauma on right brain development, affect regulation and infant mental health' (Schore 2001b). In this part, Schore turned his thoughts to how very early relational trauma negatively impacted brain, mind, and body.

Later, Schore moved from identifying the neurobiological effects of a secure attachment on the right brain and affect regulation (Schore 2001a), and the effects of early relational trauma on right brain development and affect regulation (Schore 2001b) to

seeking to provide an evidence-based theory that was both relevant and useable in clinical practice and research. To this end, he produced an article in which he argued that:

> In line with Bowlby's fundamental goal of the integration of psychological and biological models of human development, the current interest in affective bodily-based processes, interactive regulation, early experience-dependent brain maturation, stress, and non-conscious relational transactions has shifted attachment theory to a regulation theory. (Schore and Schore, 2008, p. 9)

**A New Therapeutic Approach Emerges**

Emphasis on the implicit right brain systems underlying attachment and developmental change has in turn forged deeper connections with clinical models of psychotherapeutic change. Schore argued that modern attachment theory "can thus be incorporated into the core of social work theory, research, and practice" (Schore and Schore 2008, p. 9). Written for the Clinical Social Work Journal, his work in 2008 identified the importance for social work practitioners to have a clear understanding of the multidisciplinary advances brought about by interdisciplinary studies and neuroscience research. He was proposing the concept of regulation theory "as an amalgam of Bowlby's attachment theory, updated internal objects relations theories, self-psychology, and contemporary relational theory all informed by neuroscience and infant research" (Schore and Schore 2008, p. 17). Proposing this as the basis of a therapeutic approach "rooted in an awareness of the centrality of early dyadic regulation," these ideas built on "a thorough knowledge of right hemisphere emotional development, and a deep understanding of the dynamics of implicit procedural memory" (Schore 2008, p. 18). These understandings resonate with attachment-based therapeutic approaches which attempt to address the early neurological insults of children.

The work of child psychiatrist, Bruce Perry, adds to this emerging therapeutic understanding. His writings, clinical research, and practice focus on examining the long-

term effects of trauma in children, adolescents, and adults. His writings (1991, 1995, 1997, 1998, 2006, 2008, 2009, 2012, 2014) evolved from working with highly traumatised children and young people and describing psychophysiological effects of traumatic stress, to proposing a neurosequention model of therapeutics (2006) which he suggests "is not a specific technique therapeutic or intervention; it is a developmentally sensitive, and neurobiologically informed approach to clinical work" (Perry and Hambrick 2008 p. 39).

In trying to understand and meet the needs of children and young people who have suffered early abuse and neglect, policy and programs that focus on trauma alone, are insufficient. He argued "These adverse experiences interfere with normal patterns of experience-guided neurodevelopment by creating extreme and abnormal patterns of neural hormonal activity" (Perry 2009, p. 241).

**New Approaches to Treatment**

Traditional therapies, according to Perry, have promoted understanding, acceptance, emotional processing, insight and problem solving regarding what happened in the client's life to create powerful reactions, but have not given sufficient attention to post traumatic changes in body experience (Perry 2012). Treatment programs designed to address the needs of maltreated children need to understand "basic neurobiological principles regarding how the brain develops" (Gaskill and Perry 2012, p. 38) to be most effective. Perry suggested a number of issues with traditional therapies attempting to support traumatised/maltreated children. He states many approaches "ignore a significant non-cortical, illogical, nonverbal, sensory-motor component of social and emotional trauma, resulting in chronic, resistant, and persistent symptomatology" (Perry 2012, p. 38). This history of neglecting low brain contributions to trauma symptomology were the result

of a lack of understanding of the principles of neurodevelopment and neurotraumatology (van der Kolk 2006; Perry 2012).

Perry also felt a further limiting factor is the lack of availability of therapeutic services that provide sufficient repetition to reorganise long-standing disorganised low brain systems (Perry 2006). After years of trauma and maltreatment, the child's brain will have missed the important relational experiences which stimulate development and organisation of brain regions and the number of therapeutically necessary repetitions required to stimulate the growth and development of missing or deficient abilities (neural organisation of the brain) will be very high and need to continue for a long period of time.

The length of treatment, Perry suggested, "was discouraging to adults and professionals who expected much quicker results to their nurturing and supportive interventions" (2012, p. 38). Indeed, Perry makes the point that professionals, carers, and parents need to understand that the frequency of remedial repetitions required to modify low brain dysfunctional patterns will be very high and that therapies and therapists will only be able to provide a fraction of the reorganising contribution required for healing global trauma, and that the standard weekly session would not be sufficient (Perry 2012).

Whilst drawing attention to the frequent need of maltreated children for "intensified regularity and quality of relational interactions" (2012, p. 38), he also highlights that the number of repetitive healthy interactions needed by the child to transform internalised low brain neural patterns are so high that it will require many caretakers (Perry and Hambrick 2008). The crucial nature of the relational role could be fulfilled by anyone that has meaningful contact with the child such as therapist, carer, parent, teacher, activity organiser/cubs/brownies, family and all, he suggests, must be actively committed to participating in the effort.

**Neurosequential Model of Therapeutics**

The neurosequential model of therapeutics (NMT) was subsequently developed by Perry and has been utilised with promising results in a variety of clinical settings such as therapeutic pre-schools, outpatient mental health clinics, and residential treatment centres (Perry 2006; Barfield *et al.,* 2009). Sequential development's foundation is that the "brain is organized in a hierarchical fashion with four main anatomically distinct regions: brainstem, diencephalon, limbic system, and cortex….each brain area has its own timetable for development" (Perry 2009, p. 242). The brain organises from the bottom (brainstem) up – least complex to most complex (cortex).

Perry's approach acknowledges that the neurological insults associated with early childhood maltreatment require careful and specific assessment in order to provide the tailored therapeutic intervention for each child. The NMT core assessment of the neglected child involves a three-phase process: understanding developmental history, current assessment of functioning, and recommendations for intervention and enrichments that arise from the process.

Because the brain literally organises as a reflection of experiences, both good and bad, the assessment is focused on the developmental history of the child. The timing, nature, and severity of developmental challenges are scored, which result in an estimate of developmental "load" (Perry 2009, p. 249), which is partly expressed in a graphic grid format. This gives a good indication which neural networks and functions would plausibly be impacted by the child's developmental insults or history of trauma (Perry 2001, 2006, 2009).

As an example, Perry states "intrauterine insults such as alcohol use or perinatal carer disruptions (such as an impaired, inattentive primary care giver) will predictably alter

the norapinephrine, serotonin, and dopamine systems of the brain stem and diencephalon that are rapidly organising during these times in life. These early life disruptions result in a cascade of regulatory functions impacting a wide distribution of other brain areas and functions that these important neural systems innervate" (Perry 2009, p. 249).

The neurologically informed assessment is based on multidisciplinary observational and historical data from 0-5 years and later each item is rated in terms of the perceived confidence in the information (NMT Developmental Challenge Score). This provides evidence from which a functional brain map is formed and it…

> allows a useful estimate of the developmental/functional status of the child's key functions, helps establish the strengths and vulnerabilities of the child, and helps determine the starting point and nature of enrichment and therapeutic activities most likely to meet the child's specific needs. (Perry 2008b, p. 41)

In essence, the NMT allows identification of the key systems and areas in the brain, which have been impacted by adverse developmental experiences and helps target the selection, sequence, and necessary repetition of input that will promote positive neurobiological development (Perry and Gaskill 2012, p. 45). Because the NMT uses a functional brain mapping grid as part of the assessment, it requires suitably qualified persons who have participated in NMT training to lead it. Dr Eliana Gil, who was commenting on the potential roll-out and use of the grid brain assessment shown on Bruce Perry's web site, said "now I think in the next 5 to10 years, his (Perry's) hope is to standardize it enough so that anyone will be able to use it" (Sori and Schnur 2014, p. 256).

Throughout Perry's work he emphasises the importance of the relational connection for neurological development. He points out that the high level of consistent, predictable, patterned, and highly repetitive interactions needed to address the neurological insults of early trauma is such that therapists by themselves would not be enough to be successful in

reorganising destructive low brain memory templates (Gaskill and Perry 2012). The kinds of activities that can positively impact on low brain organisation are simple: play, music, singing, drumming, massage, and yoga (Perry and Szalavitz 2006). If this is the case, then suitable, trained, and supported foster carers could provide a significant, effective, and valuable therapeutic resource.

**Parent Co-Therapy**

This recognition that parents or substitute carers may be able to deliver effectively the necessary high level of consistency and repetition to meet the therapeutic needs of traumatised children was understood by Dr Angie Hart and Helen Thomas (2000) and by Marvin *et al.,* (2002). Both of their interventions featured direct work with parents / carers of traumatised children. Hart and Thomas proposed Parent Co-Therapy (PCT), which they felt addressed some of the issues of direct individual therapy with traumatised children. They refer to considerable attachment research (Ainsworth *et al.,* 1978; Stovall and Dozier 1998; Howe 1998; Howe *et al.,* 1999; Svanberg 1998) supporting the view that "secure attachments are heralded as the central cause of positive outcomes for families" (Hart and Thomas 2000, p. 307). They note, however, "that there is only sparse discussion in the literature of precisely how the role of the professional impinges on the achievement of secure attachments between these family members (2000, p. 307).

PCT attempts to offset the potential for professionals to get in the way of the formation of a healthy attachment, with all of its developmental benefits, by the use of a treatment model "that is fundamentally grounded in the notion that in cases where attachment issues are paramount, indirect work with parents may be more efficient than direct work with children in the early years of treatment" (Hart and Thomas 2000, p. 307). Avoiding direct contact between traumatised foster or adoptive children and myriad

professionals seeks to reduce confusion and / or stressors that may result from various well-intentioned involvements.

PCT promotes stability and attunement between child and carer/parent who directly receive professional and therapeutic parenting guidance on how to create and maintain the therapeutic setting. This therapeutic parenting approach is supported by the view of Chase, Stovall and Dozier who argued "Because foster children enter the dyad (carer & child) with problematic care-giving histories, we suspect that the foster parents need to be not only sensitive but 'therapeutic' as well" (1998, p. 80).

PCT proposes that a lead therapist works directly with adoptive / foster parents providing therapeutic guidance, and taking the central role in co-ordinating and supporting all issues concerned with health, education and social welfare of the child for up to three years at the beginning of placement when attachment difficulties are at their worst. In their single case study, Hart and Thomas (2000) conclude that the case study suggests that indirect work with children is highly successful where attachment difficulties are pre-eminent.

**The Circle of Security**

The Circle of Security (COS) intervention protocol is attachment-based and explicitly draws heavily on Ainsworth's Secure Base and Haven of Safety (Ainsworth *et al.,* 1978) and congruent developmental theories, for example Schore (1994). The COS project is an early intervention and "was developed specifically for high risk toddlers and their carers" (Marvin *et al.,* 2002, p. 108). The programme is set in a 20 week (1 hour and quarter each week) small group format for care givers who meet with a psychotherapist. "In the context of the group, each parent reviews edited video-vignettes of herself or himself interact with his or her child" (Marvin *et al.,* 2002, p. 108).

The recordings are used to form individualised psycho-educational discussions in which care-givers are encouraged to: a) increase their sensitivity and responsiveness to signals from their child as they move away from their carer to explore, and as the child returns to them for safety, comfort, or soothing; b) increase their ability to reflect on their own behaviour as well as the child's behaviour, thoughts, and feelings regarding their attachment-caregiving interactions, and c) reflect on experiences in their own histories that affect their present parenting style (Marvin *et al.,* 2002).

The core constructs for The Cycle of Security protocol are based on ideas of a Secure Base and a Haven of Safety that evolved from the Strange Situation experiment developed by Mary Ainsworth *et al.,* (1978). In essence, the 20-week programme teaches parents the principles of attachment. They are given a recording that demonstrates the basic ideas and have ongoing dialogue with a psychotherapist who tries to make the principles accessible and easy to understand. An important component of the protocol is for parents to understand and focus on the idea that the smooth interactions between children and their caregivers are often disrupted and need repair (Marvin *et al.,* 2002). Becoming aware of and understanding the cues, messages, or signals passing between child and carer offers the opportunity for carer to repair disruptions.

In the case study of 75 dyads conducted by Marvin *et al.,* (2002), preliminary results suggest a significant shift from Disordered to Ordered child attachment patterns (from 55% to 20%), an increase (from 32% to 40%) in the number of children classified as Secure, and a decrease in the number of caregivers classified as Disordered (from 60% to 15%). The 20-week COS protocol was repeated by Huber *et al.,* (2015) with 83 parents of children between 1 - 88 months. Findings support the earlier study and conclude the

intervention is effective in improving child behaviour and emotional functioning with families of children in this age range. “This study adds to the evidence base for the use of attachment-based interventions to address child behaviour problems” (Huber *et al.,* 2015, p. 565).

The COS design recognises the importance of the caregiver role in developing healthy attachment patterns. It identifies that the caregiver as an adult, has more “degrees of freedom” (Marvin *et al.,* 2002, p. 115) in changing his/her reactions and responses than a child. This specific focus of the intervention on the caregiver does not imply that the problematic pattern is caused by the caregiver.

> Rather, the implication is that…a most effective intervention for problematic attachment caregiving patterns may be to focus directly on the caregiver, and work towards shifting the caregivers patterns of behaviour and/or internal working models of attachment-caregiving interactions with this particular child. (Marvin *et al.,* 2002, p. 115)

**Trust-Based Relational Intervention**

This approach to working with traumatised children differs from the models described so far in that essentially its focus is working with traumatised children within a residential milieu. However, whether in a foster home or residential provision, the impact of developmental trauma is carried with the child (van der Kolk 2014) and will play a part in how they think, feel, and behave.

The Trust-Based Relational Intervention (TBRI) is intended to address the various subsystems (sensory, language, physical, attachment) and is composed of principles that are categorised under three headings: *Empowering principles*, which include ecology and physiology, *connecting principles* that include awareness and interacting, and the *correcting principles*, which include proactive and redirective strategies.

The empowering principles and accompanying strategies are intended to prepare the child for success by meeting physical and environmental needs and providing messages which help imbue feelings of safety by offering predictable, calm, and affirming environments in which children's fear and anxiety is reduced by knowing what to expect. Physiological needs are met by providing regular hydration and nutrition and regular physical and sensory activities.

Connecting principles and corresponding strategies are intended to build trusting relationships to help children feel valued, cared for and safe and connected. Part of the connecting process includes encouraging mindfulness in carers who are trying to build relationships. This is, in essence, providing training for carers to understand and consistently respond to the needs of traumatised children and young people. This understanding will require an awareness of self, others, and environment as well as the child.

The correcting principles, with both proactive and responsive strategies, focus on cognitive development and learning life skills. This calls on modelling of appropriate language, behaviours, and responses as part of the teaching/learning process. One such example is modelling "gentle and kind" (Purvis *et al.,* 2014, p.358.). Carer responses are calm and regulated and do not leave the child disengaged or without hope. "One of the most important aspects of the Correcting Principles is that only the behaviours are targeted, never the child. Once the behavioural episode has passed, there is an immediate return to engaging the child on a deep emotional level" (Purvis *et al.,* p. 358, 2014).

TBRI is an attachment-based intervention which places an emphasis on safety, connection, and emotional regulation. Children who experience early chronic trauma often suffer long term effects (van der Kolk 2005), such as impairment and/or deficits in the

brain across multiple domains such as attachment, sensory/physiological, affect/self-regulation, dissociation, behavioural regulation, cognition, and self-concept (Cook *et al.,* 2005). This resonates with the present research in that the behaviours associated with developmental trauma can be difficult for adults who are caring for the children to understand. Children often present as being extremely disturbed that, in turn, can be extremely disturbing to be around long enough to provide positive messages to offset harmful internalised messages from early life experiences (Fahlberg 1994; Schore 2001b; Ironside 2004, 2012; Kendrick *et al.,* 2006; Crittenden 2008).

These principles have been used effectively in a variety of settings including camps, homes, schools, and residential treatment facilities (Purvis *et al.,* 2007, 2009, 2014). Whilst acknowledging the considerable and growing knowledge base around the needs of children with developmental trauma, Purvis' concern is to have this used to "transform caregivers, and caregiving organisations, so they can provide trauma-informed care to the children and youth that need it" (Purvis *et al.,* 2012, p.12). This approach draws on a strong body of scientific and clinical knowledge including Ainsworth (1985), Bath (2008), Bowlby (1969, 1982), Egeland et.al. (1988), Perry (2008a), Schore (1994, 2003a, 2003b), Siegal (1999), van der Kolk (2005), regarding the impact of childhood loss and developmental trauma on children and youth (Purvis *et al.,* 2012).

The following single case study introduces the approach and the outcomes.

*Case study*. The child in the case study, Rachel, had suffered neglect and multiple abuses for the first 12 years of her life. At this point, and after living in four Bulgarian orphanages, she was adopted into a family in America comprising of a mother, father, older sister and two younger brothers. After 6 months of a "honeymoon period", Rachel's behaviours deteriorated into violence to the family and the family pet, self-harm, and

obsession with her adopted mother's time and attention. Attempts to help her included therapeutic interventions, four admissions to psychiatric hospitals, and the prescription of psychotropic medications. All of these failed to stop an escalation in her behaviours and at 14 years Rachel was placed long term in residential treatment centre (RTC) (Purvis *et al.,* 2014, p. 359).

The patterns of behaviours presented by Rachel are not untypical responses from a child/adolescent who had experienced complex developmental trauma and subsequently could be classified with disorganised attachment (Purvis *et al.,* 2014). We now understand that early brain development is profoundly experience-dependent, and that the early relational experiences impact on the developmental structuring of the brain including the child's perception of self and other (Bowlby 1973; Schore 1994; Perry *et al.,* 1995; Gaskill and Perry 2012), and upon their cognitive, affective, and relational abilities, including their ability to trust and make healthy attachments. Rachel's behaviours including her self-harming continued to escalate in frequency and intensity, and after two years, the RTC felt it was "evident that Rachel was immune and even reactive to the traditional methods of intervention practiced by the RTC" (Purvis *et al.,* 2014, p.359) and sought a consultation and an intervention using TBRI.

***Subsequent intervention protocol.*** Once agreement was reached that TBRI was a suitable intervention for Rachel, delivery and teaching of TBRI began at the residential treatment centre. The approach for Rachel was designed to have three phases. Phase one began with an intensive 5-day period in which the therapist, met and stayed in close proximity with her for most of her waking hours. This period was captured on CCTV to give staff and adoptive parent the chance to understand and learn

the techniques of the approach so that they could carry it on after the first five days of intensive interventions with the therapist had ended.

During phase one of the intervention, Rachel was assigned one specific staff member to be with her at all waking hours during the day, with approximately 36 inches or less to separate them. When Rachel's mother was present, she assumed the 36-inch role, with a staff member remaining in close proximity. This first phase with its close proximity of around 36 inches between adult and Rachel during waking hours was intended to mirror the ideal early attachment relationship between infant and caregiver in which all the child's emotional and behavioural needs are met; thereby encouraging the building of trust. "Bringing Rachel's caregiver closer allowed that person to be aware of Rachel's needs and meet them quickly so that Rachel could learn to trust the adult and build connection" (Purvis *et al.,* 2014, p. 362). It is also suggested that proximity is important in supporting learning, and that responsiveness by mothers to child is cited as supporting the infants' cognitive development (Bornstein and Tamis-LeMonda 1997). The first phase of the protocol ended after two months when Rachel began displaying pro-social behaviours and positive attachment behaviours.

Phase two continued the work of phase one to promote attachment and trust within the caring relationship and to enable Rachel to achieve small goals while demonstrating an improved self-regulation. This allowed greater autonomy and choice-making in terms of daily activities. Responsibility for delivery in this phase remained solely with the RTC staff and also lasted two months. Phase three was a return to the more traditional treatment services offered by the RTC while continuing to incorporate the principles of TBRI.

*Outcomes*. Rachel continued to live at the RTC for a further 4 months (6 months in all) and made positive developments across multiple behavioural, social, and emotional

indicators (Purvis et .al. 2014). The improvements allowed Rachel to move to a much less restrictive environment of transitional house where she began to have overnight and then extended visits home in the hope of eventually fully returning home to her adoptive parents.

**Summary of Developing Approaches to Treatment**

Much of the research and studies considered and discussed so far in this literature review has identified the importance of the early relationship between primary carer-child dyad on the child's global development (Bowlby 1969, 1973; Schore 1994, 2001a; Schore and Schore 2008; Perry and Hambrick 2008; Gaskill and Perry 2012). Neurobiological (brain) growth is experience-dependent and the early dyadic experiences impact on the developmental structuring and trajectory of the brain including the child's perception of self and other - the child's inner working models (Bowlby 1973; Schore 1994; Perry *et al.,* 1995; Gaskill and Perry 2012). Early neglect in children can have a profound and lifelong impact upon their cognitive, affective, and relational abilities, including their ability to trust and make healthy attachments. Early neglect and abuse can lead to children as being extremely disturbed and in turn can be extremely disturbing to be with or around (Fahlberg 1994; Schore 2001a; Ironside 2004, 2012; Kendrick *et al.,* 2006; Crittenden 2008).

Given this well-established research, this review next considers the lives and welfare of children who are identified as having suffered persistent neglect and/or other forms of abuse. They are likely to be removed from the abusive environment and placed in the foster care system for their immediate protection. Being a foster parent for children who have experienced early neglect/abuse is a complex and demanding task on many levels (Ironside 2012). It is important, therefore, that foster parents are equipped with the

knowledge, skills and understanding to provide the environment required for stability and growth.

Having considered various approaches to treatment, this review moves to consider the state of foster care, the needs of the carers and what is known about their possible role in providing an environment that can help develop positive attachment in children who have been neglected.

**Foster Care**

Internationally the number of children needing a foster home is increasing whilst the number of people willing to foster a child is decreasing (Colton *et al.,* 2008; Randle *et al.,* 2012; Wooldridge 2009). Along with the rising numbers entering the looked after system, there is a growing number of children with significant emotional and behavioural problems (Hutchings and Bywater 2015; Murray *et al.,* 2010; Octoman and McLean 2015; Sargent and O'Brian 2004; Wilson 2006). There will be a variety of reasons for this, but for children requiring stability, safety, and support "it is not an overstatement to say that we are in the midst of a foster care crisis" (Randle *et al.,* 2012, p. 65).

In the UK there are a number of forms of foster care which include: short term, long-term, permanence, emergency, remand fostering, and connected persons or kinship fostering. Fostering services in the UK are provided by both local authorities (LA) and independent fostering agencies (IFA). The number of children being fostered has continued to rise over the last decade with 51,315 in fostering placements during 2013/14, which was a 1% increase on the previous year. Of these children, two thirds were reported in placements with LA fostering services and one third with IFA's (Ofsted 2015). LA's seek IFA foster placements when they themselves do not have an available placement, or they

do not have foster carers that can meet the particular needs of a child. In practice, this can mean that more complex or challenging children are referred to IFA placements.

It is critically important to have a sufficient pool and range of foster carers that can meet the varied and often complex issues of looked after children. Without sufficient numbers of foster carers there is a lack of placement choice and this is associated with placement instability (Clark 2006).

The UK government agrees that a high level of placement instability and frequent placement breakdowns suggest that many children are not in the right placement for them or are not receiving sufficient support (The Green Paper 2006). In an interview for Community Care, Beverly Hughes, former Children's Minister, questioned how far the current social work degree is teaching people about attachment and resilience theory, which she suggested are crucial in working with children in care (Ahmed 2007). Others go beyond questioning the level and content of training for social workers and call for specialist training to help foster carers understand, cope with, and respond to the emotional and behavioural challenges that traumatised children can present (Octoman and MClean 2015; Ironside 2012; Robson and Briant 2009; Allan and Vostanis 2005; Sargent and O'Brien 2004; Hill-Tout *et al.,* 2003; Minnis and Devine 2001). The issue of placement breakdown is one that needs to be addressed, taking into account the outcome of several studies that have demonstrated that children who experience multiple placement breakdowns suffer from poorer psychosocial development and more emotional and behavioural problems than children with stable placements (Stovall and Dozier 1998).

There is a growing understanding that the task of foster carers is complex and emotionally demanding on many levels (Hutchins and Bywater 2015, Ironside 2012) and that the challenges of providing consistent, sensitive, and structured care for neglected and

traumatised children go well beyond normative experiences of parenting (Murray *et al.,* 2010; Robson and Briant 2009). Children that have suffered ongoing abuse and neglect, be it physical and / or emotional, carry the trauma with them (Perry 1997; van der Kolk 2015) into each and every placement. Severe early maltreatment is likely to present as a disorganised pattern of attachment (Carlson *et al.,* 1989).

Placement breakdowns happen when foster carers cannot meet the needs of the children they are caring for. This may be caused by a lack of understanding, skill and/or suitable support. The effects of internalised trauma that the children bring into placement can impact so heavily on the foster family that they cannot cope. What is becoming clear is that support in the form of weekly hour-long therapy sessions is not enough to meet the needs of many traumatised children (Perry 2008a). Rather than aiding placement stability, these sessions may at times return the child to ill-equipped foster carers, leaving them to cope with the child's residual feelings of sadness, anger, confusion, or emotional exposure engendered by the session. Feelings such as these can become intolerable to traumatised children and are likely to be projected onto their foster carers, who then become filled with the very feelings the child cannot tolerate (Ironside 2004, 2012).

Current research studies suggest that foster carers do well to cultivate a parenting ethos based on an understanding of the maladaptive impact of neglect and abuse on the development of children. With training and regular guidance they can recognise that this impact is so significant that for change to happen they must learn how to provide the consistent, repetitive, sensitive, and nurturing parenting that stimulates growth of further neural pathways and internal working models within the child (Bowlby 1988; Perry 2008b; Schore 1994, 2001b; Schore *et al.,* 2008).

When children are placed in foster care settings it is possible that they will spend months or years in relational contact with their carers; thus, with the right environment, there is an opportunity for significant attachments to develop (Odell 2008). Foster care is generally seen as providing a positive experience for children, but it is rarely conceived of as a place where the children are helped to address their emotional difficulties, which is something too often overlooked by social workers (Odell 2008; Wilson 2015) and other professionals. This is a missed opportunity. Foster carers who are willing and able to be trained and supported are valuable resources; uniquely situated to provide the therapeutic parenting necessary to address early neurobiological insults (Perry 2008b; van der Kolk 2015). Fortunately the field of psychology is changing to include strength based or positive focused ideals. The next section will discuss positive psychology as a point of view that guides this study and influences the choice of appreciative inquiry as a methodology.

High quality parenting and sensitive support can enable children and young people to cope with parental rejection, abuse, and neglect. It is argued that good parenting and emotional support are key factors in promoting the successful emotional, social, and academic development of children in public care (Cameron and Maginn 2008; Hutchins and Bywater 2015). This suggests the importance of supportive or therapeutic interventions for children or young people as soon as possible. Given that foster carers have the most relational contact / access to children in their care, well equipped and appropriately supported foster carers could have perhaps the most significant opportunity for positive 'therapeutic' development.

In discussing attachment disorders, treatment, and interventions, O'Connor and Zeanah (2003) considered available attachment-based interventions and identified 3 themes. Firstly, interventions are concerned with real life interactions between parent and

child and involve both parent and child. Secondly, established interventions involve young children, most often infants, and typically in the context of parent-infant therapy. They note attachment-based interventions for older children are not developed and thirdly, attachment-based interventions have almost exclusively focused on parent-child dyads in which the parent's insensitivity is suspected as the cause of the child's difficulties. They go on to suggest that:

> *This is very different from most instances of reported attachment disorders where the child is placed with adoptive/foster caregivers who may be typically sensitive (e.g. as perhaps demonstrated with older biological children). ...but nevertheless the child has not developed a selective attachment relationship with them.* (2003, p. 235).

One of the questions these authors posed is if existing attachment-based interventions would be able to help when the child is still not appearing to form a healthy attachment after several years of 'sensitive' adoptive/foster caring. Stovall and Dozier (1998) had already considered this and argued that:

> Because foster children enter the dyad with problematic care-giving histories we suspect that foster parents need to be not only sensitive but therapeutic as well. It seems, therefore, that all foster parents may require specialised training to overcome the unique obstacles they face in providing a therapeutic environment for the foster child. (1998, p. 80)

**Therapeutic Care and a Person-Centred Approach**

An understanding of the role of foster carers as a therapeutic resource for children with complex attachment problems is fundamental to and, therefore, a focus of this research dissertation. The person-centred approach (PCA) and client centred therapy evolved from the thinking, research, and practice of psychologist, Carl Rogers (Rogers 1942, 1951; Wickman and Campbell 2003). These approaches recognised and gave voice to the crucial role the therapeutic relationship played in therapeutic outcomes. His ideas

were revolutionary at the time, postulating six necessary and sufficient conditions for therapeutic personality change (Rogers 1957). This defied the medical model, with its requisites of diagnosis, planning, and control of the therapeutic process (Elliot and Freire 2007). Rogers and his colleagues were the first to record, transcribe, and publish complete cases of psychotherapy (Rogers 1942). According to Kirschenbaum and Jourdan (2005) and Cornelius-White *et al.,* (2015), Rogers, using these recordings, conducted and sponsored more scientific research on psychotherapy than had ever been undertaken before; for example, Rogers and Dymond (1954) and Rogers et.al. (1967).

Perhaps the most well-known and influential of Rogers' research papers is "The necessary and sufficient conditions of psychotherapeutic personality change" (Rogers 1957). In this classic 9-page paper, he "briefly and factually" (p. 99) presents what he proposes are six conditions for constructive personality change. The conditions include three therapist attitudinal conditions, which were known as the core conditions of empathy, unconditional positive regard, and congruence (Rogers 1957). However, due to the paper's lack of explanatory material and theoretical context, the integrative statement was easy to interpret as simply as a set of rules or shallow principles to be followed in a mechanistic way, and this interpretation was detrimental for the later development of the person-centred therapy. His hypothesis had a revolutionary impact on the field of psychotherapy despite controversial features, such as Rogers' suggestion that the therapist's endeavour is a way of relating/being rather than a way of doing, an idea that moves away from the medical model, its specificity paradigm, and the principle of non-directivity (Elliot and Freire 2007).

In the past 30 years there have been at least three offshoots of the client-centred approach: focusing therapy (Gendlin 1978, 1996), process-experiential (Greenberg *et al.,*

1993; Rice and Greenberg 1984, 1990), and person-centred expressive art therapy (Rogers 1993). All of them remain closely aligned with the person-centred movement. Focusing therapy is described as part of client-centred therapy and is part of the person-centred approach (Wiltschko 1994). Process-experiential therapy combines the person-centred and Gestalt approaches, but remains essentially person-centred (Kirschenbaum and Jourdan 2005). Person-centred expressive art therapy integrates the principles of the person-centred approach to facilitate therapeutic growth through art, movement, writing, and music modalities. It is an alternative to traditional verbal therapeutic approaches that can be especially helpful for people stuck in linear, rigid, and analytical ways of thinking and experiencing the world (Sommers-Flanagan 2007).

**The importance of relationship**. Carl Rogers' philosophy and the person-centred approach is based on a trust in an inherent impulse toward positive growth in every individual if not thwarted, and that the relationship between therapist and client facilitates emotional and psychological healing (Cissna and Anderson 1994; Rogers 1961; Rogers, N. 1993; Sommers-Flanagan 2007). This ethos and framework fits well with the underpinning rationale of this study, which in effect is exploring relationships and the impact and consequences of relationships.

Within the last 20 years, Antonio Damasio (2000) has suggested a theory on the role of emotions and feelings in human functioning. Although his theory is based on numerous experiments from cognitive neuroscience, it also draws on related disciplines such as anthropology, philosophy, and the social sciences and considers a phenomenological component based on personal experience. Damasio's concepts and findings appear to match and, thus confirm, the visionary theories of personality and behaviour proposed by Carl Rogers (from 1951 to 1995) (Motschnig-Pitrik & Lux 2008).

**Flourishing & Positive Psychology**

Positive Psychology (PP) was launched in 1998 by Martin Seligman during his term as president of the American Psychological Association, and has served as a balancing factor in the field of Psychology. During his presidential address, Seligman noted that psychology had been instrumental in finding effective treatments and even cures for psychological ailments but that, since World War Two, psychology had focused largely on pathology, which he argued was only a part of the role of psychology. Seligman's view was that it was also the role of psychology to make the lives of all people better, not just those that were unwell. As one of his presidential initiatives, he began the empirical study of flourishing individuals and thriving communities in order to learn how to foster such individuals and such communities (Seligman 1998).

Positive psychology (PP) is therefore still a relatively new field that scientifically studies the flourishing, optimal functioning and resilience of individuals, groups, and institutions (Gable and Haidt 2005; Linley et.al. 2006). This fact makes positive psychology significant for this study since it is investigating what is working well and what high points are in foster care placements, focusing on strengths, virtues, beneficial conditions, and processes that contribute to well-being and positive functioning (Rusk and Waters 2013). One of the primary aims of PP has been to legitimise the scientific investigation of positive functioning (Duckworth et.al. 2005). This research too places importance on positive functioning and aligns with the PP view that concepts such as optimism, strengths, engagement, virtues, resilience, and hope may suggest well-being. The intention of this research, however, was exploration rather than scientific validation. At the outcome of this exploration, elements of the Positive Psychology ethos were included in the final training.

Seligman and Csikszentmihalyi (2000) gave a description of PP that, to some extent, also identifies its value to this study, which seeks to explore and understand what is working well in foster placements:

> *The field of positive psychology at the subjective level is about valued subjective experiences: well-being contentment, and satisfaction (in past); hope and optimism (for the future); and flow and happiness (in the present). At the individual level, it is about positive individual traits: the capacity for love and vocation, courage, interpersonal skills, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent, and wisdom. At the group level it is about the civic virtues and the institutions that move individuals toward better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic*. (Seligman and Csikszentmihalyi, 2000, p. 5)

A positive psychology intervention may be understood, therefore, as any intentional activity or method (training or coaching, etc.) based on (a) the cultivation of valued subjective experiences, (b) the building of positive individual traits, or (c) the building of civic virtue and positive institutions (Meyers *et al.,* 2013).

According to Meyers *et al.,* (2013 p.627), the main findings from a literature review of 15 studies is that positive psychology interventions in the working context consistently enhance employee well-being, which they suggest is a crucial finding for organisations by reason of the diverse favourable effects of happiness. Happy employees are less likely to leave the organisation (Griffeth et.al. 2000), which for foster children would mean a more stable placement. Meyers *et al.,* (2013, p.628) also suggest that research on broaden-and-build theory of positive emotions has found that happiness enhances creativity (Fredrickson 2003) and facilitates the building of cognitive, physical, and social resources (Cohn and Fredrickson 2010). This has relevance to this study of a model of working with foster parents who are considered to be a significant therapeutic support for children with complex needs. The foster parent needs to be able to manage or

regulate anger, anxiety, happiness, and other emotions and needs to be able to model this to the children in their care, helping the children develop cognitive and affective skills to cope appropriately with the stressors of life.

**Summary**

This review of literature indicates it is only recently that a consensus and recognition of the profound impacts of early life trauma on human development has emerged, building on the earlier observational work of Bowlby and others.

As a clinician and trainer, my interest is in how to operationalise these discoveries in the field of fostering into a practical, accessible, and effective therapeutic intervention that is evidence-based and widely distributable. This review sheds light on why fostering is so very difficult – physical care and kindness are essential, but not enough – we understand now how complicated the task of foster caring is with such traumatised children. Whilst efforts are being made to provide therapeutic interventions to support foster placements, they are presently limited by a need for highly skilled neuroscience trained personnel, time limited nature of the intervention, focus on high risk toddlers or pre-school children, and limited potential for roll out/dissemination.

Therefore the attachment theory and neuroscience research reviewed in this chapter was used to identify key principles for providing therapeutic foster care with children with complex attachment histories that is trauma informed. The training package identifies and supports very specific parenting attitudes and strategies intended to support the developmental needs of children with complex issues. The evidence base provides a number of key principles for training to draw upon:

1. Primary carer relationship/s are crucial in the biopsychosocial development of the child (Bowlby 1953, 1969; van der Kolk 2015; van der Kolk et.al.1995).
2. The trauma of persistent failure to meet the child's basic physical/psychological needs are likely to result in the serious impairment of the child's health or development (Schore 1994, 2001b; HM Government 2015).
3. Infant brain development growth spurt (0-3 years) is profoundly guided by experience (Perry, 2009).
4. Adverse experiences interfere with normal patterns of experience-guided neurodevelopment by creating extreme and abnormal patterns of neural and neurohormonal activity (Perry 2009; Rees *et al.,* 2011; Stein 2009).
5. The trauma of persistent neglect in the early years may cause the most far reaching harm and be most difficult to overcome (Gilbert *et al.,* 2009; Perry 2012).
6. Ignorant, chaotic, inattentive carer-giving can produce pervasive developmental delay in a younger child (Rutter *et al.,* 1999; De Bellis 2005).
7. Impaired or abusive situations particularly in the early years result in the brain becoming poorly developed and functionally disorganised, rendering the child less able to intellectually, verbally, or emotionally respond to normal experience, let alone traumatic ones (van der Kolk 2005; Gaskill and Perry 2012).

8. After persistent early trauma/neglect, any therapeutic approach needs to understand basic neurobiological principles regarding how the brain develops (Perry 2012).
9. Therapeutic approaches also need to be able to provide the child with sufficient repetition of quality relational interactions to reorganise long-standing low brain systems (Perry 2012).
10. Traditional therapists alone would not be able to provide the amount of quality relational interactions to reorganise long standing low brain systems (Gaskill and Perry 2012).
11. Therapeutic foster carers might potentially play a major part in providing the necessary high-quality relational interactions.

This final point provides a rationale for both the research investigation within this thesis and associated developments in the training and support packages for foster carers. The rationale focussed its questions on to what extent the positive stories of the carer participants correlated with significant findings from previous research as to the ways in which therapeutic approaches help the client overcome the consequences of complex attachment problems (CAP).

This research had two main aims. Academically, it was important to fill the key gaps identified at the end of this chapter. Professionally, however, this researcher was seeking to understand, through accounts given by foster carers, whether and to what extent their parenting played in the high points / developmental progress of the children in their care and to produce a better informed training and support package for carers of children with complex attachment problems based on this knowledge.

This research is seeking to explore and develop supportive instruments for practice, informed by these strands of research, that enable fostering to be successful. This review of the literature unpacks the complexities of the task and provides the evidence base out of which my practice concerns emerge.

The literature review examined the consequences of early neglect and its relationship with attachment theory and neuroscience, treatment approaches and foster care, the person-centred approach, and positive psychology. When applied to foster care placements for children with complex attachment issues, gaps became apparent. Since the most prevalent distinction revolved around the fact that parents, rather than carers, constituted the population for previous studies, the following gaps unfolded.

**Key Gaps**

After completing the review of literature it became obvious that:

1. There was a gap in understanding if and to what extent carers in foster situations can be successful in helping a child overcome complex attachment problems.
2. There was a gap in understanding if and to what extent foster carers in a situation where there is no direct therapy for child and/or carer can be successful in providing the environment in which the child can develop the emotional capacities to form healthy attachments.
3. There was a gap in understanding about what works well in aiding non therapeutic carers (where there is no direct therapy for child and/or carer) to implement research based practices with foster children who have multiple

placement moves and behaviours associated with early neglect / complex attachment problems.

# Chapter III
# Reflective Context for this Study

## Introduction

My drive and passion to complete this research, which in essence explores the possibility of foster carers being seen as an integral and effective part of the therapeutic process, remains undiminished. My passion and tenacity for exploring ways in which children that have experienced early chronic neglect can be supported to develop and thrive has evolved over more than 30 years. This period of personal and professional development meant looking closely at contemporary methods of therapeutic support to foster placements, and trying to understand why national and international figures for placement breakdowns for children with complex needs continue to rise.

I can see that my passion to understand and address deficits in the supports required by foster carers is both a strength and a weakness in the context of my research and practice. I have to be mindful that, because I am very solution driven, this might lead to overinterpretation of data and perhaps an over-reliance of clinical intuition in that interpretation. I also recognise that I am driven by 'hope' for the wellbeing of children who have experienced chronic neglect and this leads me to seek out certainty in an uncertain context.

The research, data analysis and conformational case study included in these pages are embedded in 10 years of study. Their roots developed over a much wider and longer professional and academic career. In order for the reader to be able to understand the full discovery and development process in human terms, this chapter includes my personal reflections across the pre-research, research, post-research continuum of developing practice.

**Developing the First Iteration of the Three-Day Course for Social Workers**

National and international figures and research identified that foster placements of children that had experienced early chronic neglect had high incidents of placement disruption. After 6 years of working in adoption and foster care assessments and support (1990-96), I recognised that many placements were failing to meet the needs of children with complex emotional needs, even when various forms of therapy were being delivered to the children in placement. Direct therapy to the child did not appear to be having positive outcomes and rather than promote stability there were indications that the therapy might even hinder the all-important relationship development between foster carer and child. What seemed missing was a real understanding of the impact of trauma on how children think, feel and consequently behave; a lack of practical and theoretical understanding of how a child's early experiences impact on how he/she feels about themselves and the world around them; and crucially how to respond to the often bizarre and very challenging actions of the child.

Because of these thoughts and a developed bias about the apparent ineffectiveness of direct therapy for some traumatised children, the first iteration of the three-day training for social workers was developed. Participants at each training event were asked to fill out evaluation forms at the end of the three days. These suggested a real appreciation about some of the new trauma informed ideas, and a particular excitement about the practical parenting strategies and responses being presented for foster carers to deliver. Some of this feedback supported my earlier views and perhaps bias that social workers and carers were not being suitably equipped with accessible and practical training with which to support placements of children with complex needs, and this continues to have ongoing influence on development of my training

package. For instance a recognition of the importance of language which avoids any form of shaming, and an understanding of the importance of personal affect regulation.

**Pre-Research Reflection 1**

I did reflect back more than once on my academic and professional experiences that impacted consciously and perhaps unconsciously and upon which I would call during my doctoral research. For example, on my work with high tariff male offenders on license or parole (1984-88), including sex and seriously violent offenders who had continued to offend after their initial misdemeanor. My many discussions with them led me on occasions to conclude that whilst they appeared to know that what they did was wrong, and they could say it out loud, I often got the impression that they did not actually feel it was wrong. Had they embedded at an early age a maladaptive belief system that impacted on their developing conscience, remorse and empathy? Were there negative influences on their perception of self and other which were not addressed within a safe, caring and trusting 'relationship that matters' to them, leaving them unable to genuinely censor their bizarre and often cruel wrong doings?

A part of my role was to make sure the men remained inside the hostel between 11pm and 7am, with the threat of returning to prison if they did not. Whilst recognising my genuine interest in the men, it was also clear that there was frequently the possibility of aggression within the hostel, which was in truth quite scary, especially when the role dictated that I work alone between the hours of 5pm and 9am. Drawing upon my experiences and studies, and recognising the importance of relationship development, I obtained permission to introduce activities to the men that gave opportunity for modelling and connection. As relationships developed I began to feel less anxious and recognised this was because as the men got to know me and I them,

there was less chance of being attacked. It appeared to me that the development of this healthier relationship was important and offered a protective factor.

My later academic readings of Ainsworth (1962; 1978; 1985), Bowlby (1973; 1979), De Bellis (2005); Hart & Thomas (2000); Ironside (2004, 2012); Perry (1997; 1999; 2001; 2008b), Rogers (1951; 1961; 1980), Schore (1994; 2001b; 2008), Siegal (1999; 2001), van Der Kolk (2005; 2015), and many less well known practitioners and researchers supported my recognition of the importance of relationship for development and change. In fact, my own experiences in personal therapy demonstrated to me that not all relationships, even therapeutic ones, work effectively; that sometimes it is the caring friend or the kindness of strangers delivered at the right time and at the right level that has the most impact.

**Pre-Research Reflection 2**

I was commissioned in 2000 by a specialist therapeutic fostering agency to provide direct support to foster carers whose complex placements were struggling or on the verge of breakdown. I noted that it was the child's presenting behaviours, such as their difficulty in managing a range of emotions, their overt outbursts of anger and aggression without empathy and remorse, and their controlling behaviours that led to carers giving up. I thought that if carers recognised and understood the impact of early trauma, it might allow them to see beyond the presenting behaviours and illuminate why children think, feel and behave in a particular way in given situations.

**First Reflection: Preliminary model of three-day training.**

Although not really clear to me at the time, the gaps in therapeutic support to adopters/foster carers that I had identified, were the beginning of my thinking about what works in helping carers understand and then respond to children with complex

needs. My independent direct work from 2000 with foster carers and complex cases led to local authority managers asking me what it was that I did that helped stabilize and then promote thriving placements? This encouraged me to be more explicit about what I was doing and to write a three-day training workshop about understanding attachment and therapeutic support. The focus of the training was an understanding of language and strategies that responded to the needs of children whose development may have been impaired by the experience of chronic neglect in early years. After 3 years as Director of Psychotherapy in a therapeutic community (2003-2006), I was commissioned in 2006 by an inner city local authority to deliver this training to children's social workers and their managers. The training was eventually rolled out over the following 4 years to all children's workers in the local authority and to foster carers, leading to a shared understanding about this approach.

**Second reflection: Training alone may not provide confidence to deliver.**

The training was well-received and individual evaluations by social workers and their managers spoke of being excited and stimulated about new ideas alongside some anxieties about how to deliver in practice. However, the responses and strategies which were underpinned by attachment and trauma-informed ideas required social workers to deliver non-traditional and frequently counter-intuitive parenting responses. In practice, a lack of confidence made the delivery difficult. Remembering what they had learned was also problematic, perhaps because it did not follow traditional thinking, which tends to focus on the child being responsible and on the child being able to manage their own emotions and behaviours and being able to make the right choices, with consequences and rewards used as a way of modifying or controlling behaviours.

**Post Training Reflection 1**

Feedback post training clarified that there was a need to support the learning of new ideas. After a meeting between the Local Authority's managers and commissioners, I was approached to try and address this issue. I initiated and facilitated a monthly support group for a single team of 10 people, which was funded for four years from 2006 - 2010. Each session involved discussion of a single live case, drawing on attachment and trauma-informed understandings and the language, ethos and strategies of the initial training. I utilised this group for a small pilot study during my doctorate and used questionnaire and interviews to explore participants' experience and development 20 months after their attachment training with monthly support. Findings identified a hierarchy of themes, with 'greater knowledge and confidence' being the dominant theme. This suggested an embedding of understanding and a development of confidence to the point of being able to deliver information from the training.

**Summary**

This chapter has reflected on the developmental thinking that has drawn me to and influenced the topic and structure of this thesis and the product. There appears to be a thread running through this period which highlights relationships as a crucial part of any resolution for complex attachment problems; such as those frequently carried by chronically neglected children into each foster placement. Understanding and knowledge are seen as important and can be accessed through relevant training, but if the training is expecting movement from an embedded belief system like parenting, regular additional support is required over time to reinforce and sustain the new learning with confidence.

Indeed on reflection, the serious consequences of my own traumatic brain injury early in life, required considerable nurturing parenting skills beyond those expected of traditional parents. Understanding the importance of this consistent and affirming relationship modelled an ethos which has guided my professional and relational development. These understandings have been taken into various professional roles described in this chapter and to some extent my interpretation of the findings. Specifically, the importance of consistency, repetition and affirmation underpins my choice of research design and methodological orientation. My professional aim for the last 20 years appears to have remained the same and that is to have a better understanding of complex behaviours and to find ways of supporting change from maladaptive development to something more social.

# Chapter IV
# Methodological Orientation

## Introduction

This chapter provides an account of the way in which the research was conducted and the rationale behind design decisions during the development of the research project. The research was designed to address the gaps in understanding about the potential role of foster carers in supporting the needs of children with complex attachment problems and the methodological approach adopted aimed to address the three central research questions identified at the outset of this thesis:

1. To what extent do accounts from foster carers lead to a better understanding of ways in which they can be involved in the therapeutic process with children with complex attachment problems?
2. How do accounts from foster carers highlight the challenges in the development of trust from the foster children with complex attachment problems towards their carers?
3. What type of training and support would enhance foster carers ability to be part of the therapeutic process in helping foster children with complex needs?

An interview phase of the research, presented in chapter 5, was designed to explore foster carers' peak experiences and/or high points in foster placements of children with complex attachment issues. Using interviews drawing on appreciative inquiry protocols followed by thematic analysis of transcripts, this study sought to ascertain whether, and to what extent, those stories of relational growth and flourishing environments reveal good practice in therapeutic fostering and thereby hold implications for training and support of foster carers. This interview study was designed

to address all three of the research questions. In addition, a single, in-depth case study is presented in chapter 6 as an illustration of the implementation of the multi-level therapeutic training and support package. This case study provides a further perspective on the third research question by providing a detailed example of how carers can be facilitated in the provision of therapeutic fostering.

The research adopts a broadly critical realist frame. Initially, I had conceived the project from a social constructionist perspective, acknowledging that foster carers' would construct their reality in coordination with others rather than separately within themselves. Such a position resonated well with a desire to understand foster carers' perspective on their fostering and my relational approach as a psychotherapist. However, over time I have come to realise that my philosophical position as a researcher, psychotherapist and trainer is much closer to critical realism. Critical realism describes the interface between natural phenomena that may be considered as facts and the social context in which they are interpreted and/or utilised (Pocock, 2013). This epistemological and ontological perspective acknowledges the importance of social experience in mediating the interpretation of objective reality. Such a position emphasises the role of social context and experience in defining 'what works' in foster caring, but also allows this to be relatable to the body of scientific work in behavioural science and neuroscience (reviewed in chapter 2) that suggests empirically derived principles of effective foster care for children with complex attachment histories.

## Critical Realism

Critical realism is a philosophy of science that combines ontological realism with epistemological relativism (Bhaskarian, 1975, 1986, 2008). Thus, critical realism asserts that an objective reality operates independently of any awareness of it, but knowledge of this reality is socially and culturally situated. Knowledge is always articulated from a particular perspective, is subject to social and cultural influences, and is transformed by social activity (Yirenkyi-Boteng, 2016). Critical realism suggests norms can determine the nature of interactions between and within the groups and individuals concerned, and claims therefore that the nature of norms and belief systems, which provide the guidelines and resources for actors to act in the way they do (Yirenkyi-Boteng, 2016). Actors in this research are the foster carers, the social workers and other stakeholders in the child's life who may interact during the action, the multi-level training package..

In this research, the ontological reality is assumed to be closely reflected in the psychological science and neuroscience of disrupted attachments and childhood trauma. The epistemological relativism follows from social experiences, understandings, motivations and actions of foster carers, social workers and other stakeholders in interpreting guidance and co-creating effective practice.

Complex foster placement in this research is presented as a foster placement in which a child with complex emotional needs is presenting challenges beyond the understanding of the carers. One of the merits in CR is that it seeks to engage with all the actors, giving the researcher the opportunity to view the situation from all angles, as experienced on the ground. This information gathering is part of the educational format used in the therapeutic support package, with the information obtained reflecting a

variety of interpretations which Sayer (1992, (p.243) called 'intensive research', from which to provide support. A revised multi-level therapeutic package of training and support is the main product of this thesis and draws upon both the empirical evidence base concerning the biopsychosocial impact of trauma and neglect and carers accounts of their success.

One consequence of adopting a CR perspective was that it allowed me as the researcher to realise my role as an actor in selection of method, interpretation of evidence and co-creation of interview data. Crucially, in developing and conducting the interview study of placements, I straddled multiple roles as a researcher and therapist. During my development of the multi-level therapeutic package of training and support I was the originator, trainer and therapist, and during the case study I was the investigator. These roles and actions, no doubt, impacted on one another in the development and analysis of both the research studies and product. From a CR perspective roles and motivations will inevitably affect the way that research findings are collected and interpreted. Nevertheless, it is hoped that relating experiences that foster carers shared with the researcher to the scientific literature on attachment will ground the results presented.

**Interview Methodology**

The method for the interview study was bespoke but borrowed heavily from the principles of Appreciative Inquiry. The concept of Appreciative Inquiry (AI) has been around since mid 1980's, but it is gaining traction as its application is being recognised for fostering collaboration, affirming strengths, enhancing capacity, knowledge, skills, and confidence (Modic 2015). The term was first coined by David Cooperrider when, as a doctoral student, he listened to physicians sharing stories of amazing successes and life

lesson failures. He was most intrigued by their stories of success and the optimism and positivity with which the stories were shared (Cooperrider and Srivastva 1987). AI has been used to create positive change by thousands of change agents and leaders – in businesses, government agencies, health care systems, educational institutions, religious organisations, and communities around the world (Whitney and Trosten-Bloom 2003; Cooperrider et al. 2008).

AI is a positive philosophy and methodology and has been described as an agent for positive change (Cooperrider and Srivastava 1987; Cooperrider and Whitney 2005; Lewis *et al.,* 2008). It recognises the power of conversational learning and a belief that human systems move in the direction of their members' shared image and ideas of the future (Cummings and Worley 2008). AI suggests that human organisation and change is a relational process of inquiry that is grounded in affirmation and appreciation (Whitney and Trosten-Bloom 2003; Assudani and Kilbourne 2015). The understanding that recognition and appreciation is a key process necessary for human growth was identified by psychologists over 50 years ago. They discovered that food and water were insufficient on their own to promote healthy infant growth (Harlow 1962; Bowlby 1951). In the same way, Cooperrider demonstrates with AI "that human systems such as teams and organisations grow through the process of being appreciated" (Lewis *et al.,* 2008, p. 175). AI focuses on generating discussions in groups and/or interviews that move situations from the average to the exceptional. It is a strength-based rather than deficit or problem-solving approach to change and is intended to enhance innovation and facilitate learning (Modic 2015; Bright *et al.,* 2006), with the inquiry typically centred on questions seeking the peak experiences or the 'best of what it' (Bright *et al.,* 2006; Whitney 2010; Robinson *et al.,* 2012). The formation of AI questions, being a significant part of the research design,

influences what people attend to (Golberg 1998) and, according to Cooperrider, influences the repertoire of actions they will take (Cooperider 1990; Bright *et al.,* 2006).

Although AI is probably best known for its application in organisational settings where its use has been described as a means to effect transformational change (Cooperrider & Srivastra, 1987; Ludema et al, 2001), it has also been applied as a mode of inquiry oriented towards understanding organisations, practices and functions rather than attempting to change or transform them. It is the latter description of the methodology that best reflects its use within the present study which explores foster carers' best times or peak experiences within their foster placements (Robinson, et al., 2012).

Appreciative Inquiry (AI) is a qualitative method of inquiry based upon seeking the best of what is and identifying what is working well, rather than focussing on the negative. Therefore, for this study it was chosen as part of a hybrid methodology using thematic data analysis. This research study combined AI values (i.e. valuing the best of the current situation, and personally extrapolating from it what might be or what training could be) with a CR stance to understand what is therapeutic in foster care from the view of the carers. These understandings of what works could then be related to the scientific evidence base and positive outcomes in participant responses might be used to verify and develop further training and support methods.

When deciding upon which methodology to use in this project, the researcher considered grounded theory (GT), narrative inquiry (NI), and interpretive phenomenological analysis (IPA) as alternatives to the approach chosen. The researcher had experienced using GT in a previous study to collect and analyse data and the approach does fit with a CR stance. However, the aim of GT is 'the discovery of theory' (Glaser and

Strauss, 1967, p. 2) and, since there are already well-developed theoretical frameworks guiding the principles of therapeutic fostering, this approach did not seem warranted.

Narrative inquiry (NI), like many methodologies, can be approached from various paradigms which reflect different ontological and epistemological positions (Clandinin and Rosiek, 2007), but in all cases researchers seek to capture participants stories (Kennedy-Lewis et al., 2016). Using NI would have allowed the researcher to explore multiple narratives and discourses and would have been effective in illuminating experiences, providing rich, thick descriptions of individual stories embedded within social context, place, and time (Sheilds et al., 2015; Riessman, 2008; Sakalys, 2003). However, carer stories would not necessarily drive to the heart of the research questions which seek to identify 'what works' rather than a narrative of fostering.

Interpretive phenomenological analysis (IPA) was also considered because it is concerned with personal lived experience, what it is like for that person, how they make sense of what is happening and an analysis/interpretation of their lived experiences (Smith, Jarman, and Osborn, M. (1999). IPA would have challenged the traditional linear relationship between number of participants and value of research, with ten participants being at the higher end of recommendations for sample sizes (Sakalys, 2003). This too was rejected since it was unknown at that time, but suspected, that a population of greater than ten would be available though not necessarily for the time commitment required by phenomenology.

An important requirement of the methodology within this project, the study of complex placements and the traits that help foster carers achieve long term success, was that it purposely sought to view positive experiences and focus on what was working well. Given that the AI interview protocol involves a positive search for what is working well,

the successes and high points of lived experience, a mapping and drawing together of themes with an analysis leading to understanding of the reasons for or causes of success (Cooperrider et al., 2008), it was chosen as the most appropriate methodological approach and research method for the present study.

**Studying the Social Context with Appreciative Inquiry**

An appreciative inquiry (AI) protocol for interview design was chosen for this study because it is a positive methodology and has been described as an agent for positive change (Cooperrider and Srivastava 1987; Cooperrider and Whitney 2005; Lewis et al., 2008). It recognises the power of conversational learning and a belief that human systems move in the direction of their members' shared image and ideas of the future (Cummings and Worley, 2008). An AI approach is grounded in the idea that human organisation and change is a relational process of inquiry that can be nurtured through affirmation and appreciation (Whitney and Trosten-Bloom, 2003; Assudani and Kilbourne, 2015).

Principles and Assumptions. The AI interview protocol follows a number of principles, all of which were adopted in the methodology used in this study, believing that all inquiry should:

1. Begin with appreciation.
2. Be applicable.
3. Be provocative.
4. Be collaborative (Cooperrider and Srivastva, 1987).

Advantages. The principle advantage of AI is that it takes existing evidence of positive behaviours/processes to demonstrate the realistic path to transformation and because it does not use a 'fixing the problems' approach leads to better implementation and follow-through since it does not put people on the defensive (Cooperrider and

Srivastava, 1987; Cooperrider and Whitney, 2005; Lewis et al., 2008). Because this study investigated why the carers felt the positive changes occurred, participants were probed to answer questions such as, "Why do you think that happened?" This helped them make connection between their behaviour and their experience of the children's growth.

**Development of Multi-Level Therapeutic Package of Training and Support.**

While not strictly part of the methodology of research, the critical realist perspective demands an explanation of the actions taken by stakeholders. Specifically, it acknowledges the role of social actors in a given situation as well as the existence of independent structures that constrain and enable actors to pursue certain actions in a particular setting. This exploration of the reality of the foster carers' perspective was studied with appreciative inquiry, and the actions were included in the implementation of the development of the multi-level therapeutic package of training and support. That is included in its entirety in the appendix.

**Case Study**

An in depth case study provides an illustration of the implementation of the multi-level therapeutic package of training and support. This case study illustrates how an evidence led attachment informed approach to therapeutic fostering can be nurtured and supported through the training package.

**Research Questions**

This research asked the following questions:

1. To what extent do appreciative stories from foster carers lead to a better understanding of ways in which they can be involved in the therapeutic process?

2. To what extent do accounts from foster carers demonstrate outcomes of the child's developing ability to trust in the carer, and take positive risks?
3. What type of multi-level training is necessary in order to advance foster carers as part of the therapeutic process to help children trust in the carer and take positive risks?

**Data Collection**

Because in critical realism we can't directly access the "real" this study employed an appreciative inquiry protocol to uncover the foster carers' interpretation of their experience. Since the AI approach to interview research is a deeply relational process, it is not about one person interviewing people and getting the story and writing it up. It is about people sitting down with each other to engage in inquiry, to understand who they are at their best. AI interviews should be appreciative, applicable, provocative and collaborative (Whitney, 2010). This study employed those ideals as 14 participating couples or single foster carers were interviewed in their own homes.

Patton (cited in Moustakas 1990, pp. 197-198) identified three interview approaches for collecting data in qualitative research: the 'informal conversational interview,' the 'standardised open ended interview' and the 'general interview guide.'

Combinations of informal conversational interviews and general guided interviews were employed. Questions were used as prompts in a conversation that revolved around the carers' felt experience of high points and positive change noted by them in their relationships with children with CAP. It is important to note that the participants measured 'the best' in relation to what they had experienced when the child was first in placement or the equivalent of 'the worst'. Best, in other words, was the furthest distance that child had come. These interviews became stories of how far the children had come and showed

examples of what children could do now and also how the carers measured change in relation to their lives and behaviours. As with 'natural' discussions, there was some sharing of thoughts and ideas which created a sense of conversation rather than an interview (Ellis and Berger, 2003).

All 14 interviews were recorded and transcribed for immersion in and thematic analysis of the text (Braun & Clarke, 1990), with the permission of the interviewees. The findings derived from this thematic analysis resulted in amendments of existing training and support in order to develop a multi-level package for therapeutic fostering. As preliminary confirmation of the effectiveness of this package a small, single case study was completed post research. The story of that case is included here in Chapter VI.

## Population and Sample

### IFA Carers as Population.

As an independent psychotherapist working within fostering and adoption settings, the researcher is commissioned by local authorities and large independent fostering agencies (IFA's). During a conversation with a regional manager of one of the IFA's about foster placement stability and the importance of the foster carer's role, she agreed that I approach the directors of the organisation with a view to them hosting research with foster carers in her region; one of six regions the agency has around the country.

### Foster Carers Sample.

Children are referred to IFA's by local authorities. Referrals happen when the local authority does not have enough foster carers or does not have foster carers that can fulfil the needs of the child. In practice, this is likely to mean that children referred to IFA's have complex emotional/behavioural needs and fulfil one or more of the

criterion outlined below. Therefore, foster carers in this environment, who were trained to understand behaviours that develop as a consequence of early trauma, compose the sample for this study. All participant foster carers were responsible for care to children who had multiple instances of the following when they began care:

i. Suffered abuse/neglect in first 3 years.

ii. Presented significant behavioural issues.

iii. Lacked empathy, remorse or conscience.

iv. Been involved in multiple placement breakdowns.

**Avoiding Selection Bias.**

Rather than select particular foster carers to be interviewed, which would have increased the potential for selection bias, a time-frame selection was employed. This meant that all foster carers who had received training and therapeutic support in the attachment-based ethos of the organisation during the previous 18 months, received information about the research and an invitation to participate. Of the 16 invited to participate, fourteen accepted. The final sample resulted in 14 single or couple carers, responding with accounts of their best stories in interviews that averaged one and half hours in length.

**Ethics**

This research adhered to the Ethical Guidelines set out by the British Association for Counselling and Psychotherapy (BACP), Middlesex University, and Metanoia Institute. The research proposal was presented to the Programme Approval Panel and Ethics Committee of Middlesex University and Metanoia Institute in April, 2013.

All participants were provided with a letter from the researcher assuring them of confidentiality through anonymity. They were also given an informed consent document,

which was explained to them, including their right to withdraw from the research at any stage without giving a reason, and without it having an impact on their professional standing as foster carer. These documents, which they subsequently signed, are on file and will be kept for the requisite number of years

Approval was agreed and the research proposal was presented to and agreed by the Programme Approval Panel and Ethics Committee of Middlesex University and Metanoia Institute in April, 2014.

# Chapter V
# Thematic Analysis of Interview Data

## Introduction

Data from the appreciative inquiry style interviews were analysed using thematic analysis (TA) (Braun & Clarke, 2006). TA allows for both inductive and theory driven analysis of data, and in keeping with a critical realist approach, the analysis embraced both of these approaches.

## Data Analysis Processes and the Use of a Critical Friend

As the sole interviewer, I was aware of, and wanted to avoid, any potential for researcher bias. Miles and Huberman (1994) outlined one solution as "proactively involving a critical friend who reacts to your work as you go" (p.14), providing alternative perspectives, support, and protection from bias and self-delusion (Foulger, 2010) and validating that the incoming data were accurate (Geradi, 2007). To that end, Dr Alana James was recruited and worked with these data, providing a separate and completely neutral stream of analysis. Dr James (2008, 2012) is an expert in qualitative analysis of action research data. She is neither a psychologist nor involved in any way with foster carers so her reading of the data was not guided by theory or practice in the field. As 'the trusted friend who asks provocative questions' (Costa and Kallick, 1993) and who offers an external lens and conversation rather than be actively involved in data gathering within the research (Foulger, 2010; Ozek *et al.,* 2012), the interactions between Dr James and I aided the progression of these analyses. Frequent conversations allowed each of us to understand the other's coding rationale and come to agreement on shared coding decisions.

Analysis for this study was conducted with the aid of the software tool Dedoose, a programme that supports coding and qualitative analysis of textual data. Both the critical friend and I endeavoured to read the interviews with an open mind about what they would find. A first round of open coding of the 14 interviews suggested differences in the perspectives brought to the coding: I had coded data very much through the lens of my role as a psychotherapist and foster carer trainer, whereas Dr James had coded the data from a more neutral perspective. These differences were systematically discussed in order to understand the rationale each had used in coding and we examined coding agreements and disagreements to arrive at one of three outcomes: codes were merged when they appeared similar[1]; codes were dismissed when it appeared that they misrepresented data; or new codes were developed when we agreed they were unique and useful. This resulted in agreement on 36 behavioural codes (reduced from 40, see below) that revolved around obvious improvements in children who had previously been unable to cope with a) external stressors, b) separation, c) fear of shame/feeling of vulnerability, failure, fear of risk taking, fear of admitting being wrong or making mistake, d) kindness or empathy, and/or e) loss of control (see table 5.1). These 36 child behavioural codes were combined into 5 partially overlapping themes that captured the carers' positive experiences across interviews: i) *Developmental growth*, ii) *increased ability to manage emotions,* iii) *emergence of new positive behaviours*, iv) *developing confidence* and v) *the child showing that they are happy and safe*. The derivation of overall child behaviour themes concluded an inductive phase of the data analysis.

[1] We realised that our ideas overlapped but that we had used different codes due to our different life roles. As an example, my codes for "low or high arousal" were equivalent to those from Dr James of "pouting" or "temper tantrums."

*Table 5.1: Child Behaviour Codes*

| | | |
|---|---|---|
| 1. Coping with eye contact | 2. Accept compliment / affirmation | 3. Accept high five / hug |
| 4. Ok - Regulated at birth family contact | 5. OK – Regulated after birth family contact | 6. Ok at bed times |
| 7. Coping with separation | 8. Able to sleep | 9. Coping with silence |
| 10. Coping with low arousal / high arousal | 11. Coping with children's parties | 12. Happy to play alone |
| 13. Able to share – any age | 14. Can make and retain friendships | 15. Telling the truth |
| 16. Saying sorry | 17. Taking responsibility for actions | 18. Coping with feelings of shame/vulnerability |
| 19. Understanding humour | 20. Coping with humour | 21. Writing letters saying sorry, I love you, regret for... |
| 22. Kindness to animals, other people | 23. Kindness/ability to cope with visitors, grandchildren, carers' children | 24. Development of positive words for self |
| 25. Developing sense of belonging, importance, value | 26. Calling carer / mum / dad / auntie | 27. Coping with being told off 'consequences' |
| 28. Coping with sharing friendships | 29. Reduced anxiety about visitors | 30. Reduced anxiety about new people |
| 31. Reduced anxiety about new places | 32. Ability to take tests | 33. Able to cope with 'the end' of a good time, day out, a television programme, game |
| 34. Coping with 'control' words, such as: No, wait, stop, later | 35. Asking for help | 36. Putting hand up at school to answer questions |

In order to address the research questions directly, a second round of coding was undertaken to identify carer behaviours that were associated with positive fostering experiences and consideration for training. This analysis indicated a cluster of 13 'carer codes' (relating to activities in the stories that pinpointed foster carer behaviours) and 14 codes of experiences that hold implications for the training and support. Disagreement and divergence between Dr James and I were resolved in the same way as for the first round of open coding. At this stage consideration was given to rejecting codes with a low frequency in the data. An arbitrary cut off of less than 30 occurrences was decided upon for the rejection of codes. This cut off was recommended by Dr James on the basis of her experience in similar analyses. I was happy to follow this recommendation since none of

the rejected codes seemed to address a critical aspect of any of the research questions and 30 occurrences represents less than one half of one percent of the total interview data.

The thirty-six child behaviour codes combined into five partially overlapping child themes. These themes were then mapped to nine (retained) carer codes and the fourteen training considerations (see table 5.2). An overview of this thematic analysis is presented in figure 5.1. Both Dr James and I agreed that this final thematic scheme illustrated a clear picture of the best of the lived experience of these carers and the relationship between those stories and their ways of working with the children.

*Table 5.2: Carer Codes and Training Considerations*

| Carer Codes | Training Codes/Considerations |
|---|---|
| It is about trust. | Carer developing confidence with knowledge |
| Showing child they are valued and important. | Explicit and repetitive behaviours and attitudes |
| Honest caring for child as individual. | Non-shaming at all times |
| Showing kindness. | Complimenting and affirming the child |
| Consistency and repetition. | Minimising choices to avoid fear of failure |
| Inclusion in the family - belonging. | How to respond to child testing boundaries |
| A relationship that matters. | Importance of language words and delivery |
| Modelling 'good enough' parenting. | Showing the child they are equally important as carers' birth children |
| Maintaining hope. | The importance of repetitive low-level affirmations |
| | Increased confidence with knowledge |
| | Importance of language words and delivery |
| | Diminishing choices to child to avoid fear of failure |
| | Helping the child develop resilience and regulation to stressors |
| | How to respond to child testing boundaries |

Upon reflection of working with Dr James, many of the differences between us seemed to amount to a traditional parenting outlook vs trauma informed approach that I had learned as part of my personal and professional development. An example of this would be our discussion of the child's reduced anxiety when coping with new people, Dr James agreed with my perspective that this was an example of a developing sense of affect regulation and healthy risk taking, but encouraged me to keep the code description firmly grounded in the data. Therefore, I believe the key benefit of recruiting a critical friend who is very experienced in coding interview data was that she was able to encourage me to ensure that codes and themes were thoroughly grounded in the participants' accounts, thereby reducing the possibility of biased coding on the basis of my theoretical frame. This allowed me to consider the relationship between the theory/evidence base and the data after the analysis was completed in accordance with my aim of preserving the carers perspective.


*Figure 5.1: Thematic Map of Child Behaviour Themes, Carer Codes & Training Considerations*

**Themes Relating to Research Question One**

Research question one was formulated as follows*: To what extent do accounts from foster carers lead to a better understanding of ways in which they can be involved in the therapeutic process with children with complex attachment problems?*

The literature in this area suggests that that developing affect regulation, growing resilience, and ability to cope with stressors is experience-dependent and evolves over time through numerous repetitive relational interactions with a nurturing and regulated adult (Bowlby 1982; Perry 2009; Schore, 1994, 2001a; Stern 1985; van der Kolk 1985; van der Kolk et al., 2005). The emotional relational environment provided by the primary caregiver shapes, for better or worse, the experience-dependent maturation of the brain systems involved in the attachment functions that are accessed throughout the life span. Ideally the primary caregiver within the dyadic interaction will recognise when the child is moving into a stress state beyond the child's present level of coping and will then provide the necessary actions to regulate and bring the child back to homeostasis (Howe et al., 1999; Perry and Polland, 1998; Schore, 2001a, 2001b).

Consequently, it can be understood that the child internalises messages of safety and security which, over time, can lead to developing trust in other and positive sense of self. The literature also indicates that these dyadic relational interactions stimulate, among other things, the growth of the child's own tolerance for positive and negative effects and resilience to stressors (Ainsworth, *et al*., 1978; Howe, *et al*., 1999; Perry and Gaskill, 2012; Stovall and Dozier, 1998).

**Evidence**

The foster carers' stories about the children in their care identified two child codes that showed particular significance in demonstrating the child's developmental growth and ability to manage emotions. They were: a) child demonstrates developmental growth (66 instances) and b) Child demonstrates increased ability to manage emotions (44 instances). The ways in which they were most commonly illustrated are shown in the examples below.

**Example 1: Child demonstrates developmental growth.**

*He came to us in the March and he turned four in the May five next month. It made me start to think about some of those other things like the fact that he now really enjoys having a bath which is a really pleasant time. He was terrified initially and the first night he was there and I put some of that baby bath in because I thought he won't let me touch him to wash him, so I'll put some in and he would not get into the bath and the bubble bath stuff absolutely terrified him, till in the end I said "well let's take them out", and I scooped them out and then he got in but he sort of knelt and now of course he loves bath time, he loves the water*

Excerpt 66. Corresponding carer codes: "it is about trust", "child valued and important", "modelling 'good enough' parenting ".

**Example 2: Child demonstrates developmental growth.**

*The highlight for me with Daniel was when Daniel, although he was 10, he wasn't (emotionally) 10. I used to play stupid games with him, some games were so silly where even I looked silly when I was doing it and then once we were somewhere and we played this stupid game and he said Susan "I am 9" and I said "ok you don't want to play this game" and he said "well it is a bit babyish" and I thought that was really nice and any other time Daniel would have loved that. He was like coming towards his age and maturing.*

Excerpt 85. Corresponding carer codes: "it is about trust", "honest caring for child", "modelling 'good enough' parenting", "showing kindness."

**Example 3: Child demonstrates developmental growth.**

*And so I sat next to him in our doorway and he went away. I moved a bit closer and finally he went back into his bedroom and went under his bed because that's his safe place. When he goes under his bed, we usually let him stay there, so I left him*

*for about 5 minutes and then I went back into the room as if none of that had happened and I said "come on poppet. We'll change your nappy, make you comfy, and go and have breakfast. He came out from under the bed, on the towel, changed the nappy. It was that moment of letting him know that there is nothing to be scared of, before he clicks back into the fear. You can't do anything and, if you try, it escalates so you have to back off and give him time. I'm sure that's what happens, that somewhere in.*

Excerpt 107. Corresponding carer codes: "it is about trust", "showing child they are valued and important", "showing kindness", "a relationship that matters", "modelling 'good enough' parenting".

**Example 4: Child demonstrates increased ability to manage emotions.**

*Consistency, consistent routine, don't mean 7pm bedtime every night, but consistent message; the consistent 'you are part of the family', 'this is your home', 'these are your toys', 'you can play with them when you want to play with them'. Then, when people come in, the children want to know who they are because they are still unsure of their surroundings in the early days, and once they are comfortable and they ignore people, not being rude, but they don't have to make these great grand gestures when people come in, but just acknowledge and get back on with what they are doing, then you can see that they are comfortable and settled and relaxed*

Excerpt 17. Corresponding carer code: " consistency and repetition".

**Example 5: Child demonstrates increased ability to manage emotions.**

*The high point too is he doesn't try to run away or escape anymore when you get out of the car. It was always that he wouldn't want to go back into the house and now he happily does, "my house" he goes "I live with Peter and Jenny". What I did was I made it a game, so I put something in my bag and as we were turning into our road I would say "there might be a surprise in my handbag poppet" and he would get excited and I would say "when we get in the house you can have a look", and so then "in the house and look in the bag" he says. Because things like that are consistent, they always happen; are things that give him security. He knows it can be anything, it can be a balloon, or a chocolate star. It could be a tin of play dough; I vary it all the time, but there is always something. Something nice and he loves undoing the zip, looking through the pockets and it becomes a fun game.*

Excerpt 56. Corresponding carer codes: "showing child is valued/important", "consistency and repetition".

**Example 6: Child demonstrates increased ability to manage emotions.**

*When I first took him to nursery and they asked if he has learned to do Makaton and I said 'No', but he doesn't talk so he will act things out and point to tell you what it was he wanted whilst stamping his feet because it took a while to cotton on to what it was he wanted. So when he did that, I would always give him the word, such as "oh you want a drink", "I'll get a cup and get some water" and that was over a few things like he would never say things, like if he was cold, for example, he would just go and bury himself under the blanket and for a while I thought he's just hiding and then it suddenly hit me: maybe he's cold, and then I got him to the point when I would say "well let me just touch you hand and see if you are cold", that was such an issue, touch was such an issue. The first time I did it without his hands going into little claws I thought it was a major breakthrough. I almost tap danced out of the room because I could touch his hand, and then I could say "I'll get you a jumper to make you warm" that sort of stuff.*

Excerpt 65. Corresponding carer codes: "modelling 'good enough' parenting", "child valued and important", "honest caring", "consistency and repetition".

**Corresponding Foster Carer Codes**

Complex early trauma can have a lifelong impact on brain development and in particular on seven primary domains in exposed children: attachment, biology, affect regulation, dissociation, behavioural regulation, cognition, and self-concept (van der Kolk 1985). The chaotic, inattentive, and ignorant caregiving, which can produce pervasive developmental delay (De Bellis 2005; Rutter *et al.,* 1999), is carried as trauma within the child, impacting not just on them but also those around them (van der Kolk 2015).

There is a resonance between the stories derived from foster carers in the field and the literature discussed in chapter two. For example, the carers narrative/stories highlighted particular qualities or behaviours that appear to demonstrate the child's developing affect regulation, growing resilience, and ability to cope with stressors. These were: a) consistency and repetition, b) inclusion in the family, c) showing the child they are valued and important, d) modelling 'good enough' parenting behaviour, e) honest caring for the

child as an individual, f) showing kindness, g) a relationship that matters and h) good enough parenting behaviour.

**Themes Relating to Research Question Two**

Research question two was framed as follows: *How do accounts from foster carers highlight the challenges in the development of trust from the foster children with complex attachment problems towards their carers?*

The literature in this area suggests that, in order for children that have experienced early trauma to trust in the carer-giver and thus take positive risks which may expose them to feeling vulnerable/shame, they have to experience a relationship with someone who is consistent, affirming, and trustworthy (Ainsworth 1978; Bowlby 1973). It is based on this important trusting relationship that the child can explore and take bigger risks. As their sense of self develops positively within the relational connection, the child develops, through this secure base, a greater ability to cope with what they perceive as vulnerability and/or potentially shaming experiences -such as failure or rejection- asking for help, accepting comfort or affirmation, or saying sorry (Ainsworth *et al.,* 1978; Marvin *et al.,* 2002).

**Evidence**

Three semantic themes emerged as significant in relation to research question two: a) child begins to interact positively when they have not before (demonstrated in 11 codes), b) child developing confidence (demonstrated in 14 codes), and c) child says/ shows/ feels happy/safe (demonstrated in 6 codes). The ways in which these codes were illustrated and how they clustered to answer research question two are illustrated in the examples below.

**Example 7: Child begins to interact positively when they have not before.**

*Actually recently Richard has started to come and give us a hug goodnight. He has been here now nearly 14 months and he is now starting to come and say goodnight and give us a hug which he hasn't done before. It was off his own back that he came over and started to give us a hug goodnight and that was a real turning point and he was actually doing it to me (first)because I am obviously his main carer so it came to me first of all and probably for a month it was me and now it's both of us, so that was a real high point that puts a smile on your face to think that's good and he's open to show us a goodnight.*

Excerpt 85. Corresponding carer code: 'It is about trust", "a relationship that matters".

**Example 8: Child begins to interact positively when they have not before.**

*When he first came into the placement, he was always gravitating towards myself, being a man. He struggled with women, teachers at school, obviously made our problems at home more and it's only within a matter of time he has been able to learn that it's safe to be alone with Susan and Holly and Rose (females) if I have had to pop out for 10 minutes and he couldn't come somewhere I had to go. But at first, "where are you going", "what are you doing", "can I come with you"; so obviously it's been a process in terms of him beginning to feel safe and begin to trust and that everything is okay and I will be back in 10 minutes. He is doing well at school with female teachers, but also with my two daughters, which wasn't the way before and now we went away the other weekend and my two daughters had (to care for the children) between them and he was quite looking forward to it, so that was a high point.*

Excerpt 110. Corresponding carer codes: "relationship that matters", "it is about trust".

**Example 9: Child developing confidence.**

*Those little bits of confidence he has, like when Peter is doing work in the lounge and he would have been in there, then he will come into the kitchen. He just trots into the kitchen and say "cooking cake, bake a cake Jenny" and I will say "yes", "are you going to help", because he likes to mix my stuff and you can sit there with him. He brings his big stool over so he can sit up there and I will give him the cup of sugar and say "pour a bit in", it's just that, it's not exciting, it's not interesting, it's just being there with him and being part of your life.*

Excerpt 122. Corresponding carer codes: "showing child they are valued and important", "showing kindness", "inclusion in family", "modelling 'good enough' parent".

**Example 10: Child developing confidence.**

*She wet herself at school yesterday, but because someone was in the toilet and she was desperate, she was having fun at the club. She came home with no tights on in front of everybody else. She just didn't care because she knew what our reaction was going to be and I said, "oh you've got no tights on darling", and she said "I wet myself" really loud, and I said, "that's OK. I just wondered where your tights were" and she said, "I queued for the toilet" and I said, "That's fine. It happens to all of us and it was very like. It's not a problem. You're not going to get shouted at. It isn't an issue because people do wet themselves" and she doesn't need to be ashamed of herself and it was lovely to be, not proud of it, but not ashamed of it.*

Excerpt 17. Corresponding carer code: "modelling 'good enough' parent", "showing kindness".

**Example 11: Child developing confidence.**

*Since we've had the boys, they have constantly asked you the same question over and over again; almost because they don't believe it's happening or they are not going to get it; for example, we would say "here's your breakfast", "can I have a drink please Joe?" "Yes of course you can have a drink"; "can I have a hot chocolate please?" "yes", "really, can I have a hot chocolate?", "yes, you can have a hot chocolate, eat your breakfast and I'll do you a hot chocolate", "can I really have a hot chocolate?", "yes and I'm going to have a hot chocolate", "Mary, Joe says I can have a hot chocolate" and he will go on and on until his chocolate is in front of him and he does it with everything. Recently, that's suddenly stopped.*

Excerpt 34. Corresponding carer codes: "it is about trust", "consistency and repetition", "showing kindness".

**Example 12: Child developing confidence.**

*I think another high point is probably when he first came he had a very bad speech impediment, he couldn't talk properly, so we really struggled to understand what he was actually saying, it was that severe, so very gradually we slowed him down and bit by bit with the confidence and reassurance he was able to listen and talk to him and his speech now, he is like playing catch up now because he is so inquisitive now you don't have enough answers for him, but his speech now is brilliant, no stammer.*

Excerpt 99. Corresponding carer codes: "relationship that matters", "showing kindness", "it is about trust", "honest caring for child as individual".

**Example 13: Child says/shows/feels happy/safe**

*Gail used to need a night light and wanted the door open all the time. If you just creaked the bedroom door, she would shoot up out of bed. She doesn't do that anymore. She doesn't have a night light on and feels safe in her own bedroom.*

Excerpt 45: Corresponding carer codes: "showing kindness", "consistency and repetition", "it is about trust".

**Example 14: Child says/shows/feels happy/safe.**

*On the first holiday, he was very clingy to me; that was at Butlins and he wouldn't leave me for long. This (latest) holiday in March, he was just enjoying being on holiday and not as clingy or worried.*

Excerpt 72. Corresponding carer code: "It is about trust", "consistency and repetition".

**Example 15: Child says/shows/feels happy/safe.**

*We have always allowed close proximity because you get a lot of information about the difficulty the child is having with proximity and with showing affection. When he came and sat next to us on the settee, we put our arm around him, we ruffled his hair. If he gave us a kiss, we gave him a kiss back.*

Excerpt 60. Corresponding carer code: "showing child valued and important", "showing kindness", "modelling 'good enough' parent", "consistency and repetition".

The carer behaviours that were demonstrated in these stories were: a) it is about trust, b) showing the child they are valued/important, and c) consistency and repetition.

These examples demonstrate qualities in relationship that all foster carers desire. They all can imagine their looked after children interacting positively, developing confidence, showing and telling that they are happy and safe. These real, inspirational stories are consistent and repetitive enough to be added to the training and are useful to foster carers because they leave them with something practical to do, which may encourage

change and leaves them with hope. The corresponding training codes are represented in the fourth column of the thematic analysis, Table 1 at the beginning of this chapter.

**Results for Research Question Three**

Question three asks: *What type of training and support would enhance foster carers' ability to be part of the therapeutic process in helping foster children with complex needs?*

The literature relating to this area highlights the developmental importance of the early relationship between child and primary carer. Authors tell us that the child's brain undergoes a developmental growth spurt from 0 – 3 years, which is profoundly guided by experiences whether these are good or bad (Perry 2009; Schore 1994, 2001a). If these early months are traumatic, the structuring and functioning of the brain can be impaired and responds / adapts to its environmental circumstances. The literatures tells us that, to offset the early developmental insults which impact on domains of the brain including areas responsible for attachment, affect regulation and self-concept require caring/parenting that is consistent, predictable, patterned, repetitive, and affirming (Gaskill and Perry 2012; Shonkoff and Phillips 2000; Stein 2009; van der Kolk 2005).

Therapeutic change requires a high level of consistent and repetitive messages (Perry, 2008b; Schore, & Schore, 2008). The multi-level therapeutic package that developed as an outcome of this research is based on the evidence in this question in that these stories demonstrate children able to change the way they think and feel about themselves. When children feel negatively about themselves they frequently reject affirming messages unless they are delivered at a time and level the child can cope with. This opportunity for frequent low level affirmations delivered during a receptive moment is most opportune and effective in their foster home.

**Evidence**

The reader should bear in mind that the carer/participants had an early version of the training, one that highlighted insight and intuitive understanding of the needs of children who have experienced chronic neglect and rejection, but not as developed on how their actions related to positive child outcomes. The following example demonstrates one instance where the foster carer referenced outcomes related to consistent and repetitious messaging:

**Example 16: The importance of nurture and belonging**

*I wouldn't use respite. If I wanted a break myself, they would still stay in the family home with my son and daughter or Tim's mum. Somebody would come here and stay in their home and we might go for a few days and have a break, which I think would be more acceptable to the children if they are still in their home ...and they refer to Tim's mum they call granny. They don't say "Tim's mum"; they refer to her as granny and my sister they call auntie Maggie".*

Excerpt 133. Corresponding carer codes: "inclusion in family", "honest caring for child as individual", "showing child they are valued and important".

The carer behaviour codes that demonstrate actions that engender this are seen in the consistent and repetitious employment of the following four codes: a) showing child they are valued/important, b) showing kindness, c) inclusion in the family, and d) consistency and repetition.

The stories uncovered in the evidence discussed were incorporated into the training package for inspiration following the thematic analysis as discussed in Table 1 at the beginning of this chapter. For instance, the carer codes that developed made explicit parenting strategies and attitudes that these children had not received before. Carer codes lead to examples such as: 1) providing consistent and repetitive experiences that enable the development of trust, and, 2) expressing and demonstrating messages that model "good

enough" parenting behaviours which allow the child to feel a sense of belonging. Taken as a group, these specific strategies allow the carer to offer hope and feel hope about their own situation.

Therefore, it is seen that multiple levels of training are needed to introduce and reinforce important, and often counter-intuitive themes. The training themes which result are:

- Carer developing confidence with knowledge
- Explicit and repetitive behaviours and attitudes
- Non-shaming at all times
- Complimenting and affirming the child
- Minimising choices to avoid fear of failure
- How to respond to child testing boundaries
- Importance of language words and delivery
- Showing the child they are equally important as carers' birth children
- The importance of repetitive low-level affirmations
- Increased confidence with knowledge
- Importance of language words and delivery
- Diminishing choices to child to avoid fear of failure
- Helping the child develop resilience and regulation to stressors
- How to respond to child testing boundaries
- Carer developing confidence with knowledge

## Conclusion

Each research question was discussed in relation to the child behaviour codes and the carer codes that related to them. The messages throughout surfaced the importance of good foster care – demonstrated in the carers' ability to reduce anxiety, and increase ability to manage emotions, help children interact positively when they have not before, to develop confidence, and help them feel happy and safe.

All the codes and themes that surfaced through these data as important examples from the carers perspective, about the children's behaviours, thoughts, and feelings, are congruent with what would be expected following the literature discussed in chapter two. They are consistent also with the gaps that became apparent and were discussed earlier as well. The relationship between these codes and carer behaviours leads to the discussion in the next chapter.

The interviews impacted on the evolution of training and ongoing support mechanisms for which I was responsible in several ways. The 3-day training courses for both foster carers and social workers had already been developed on the basis of literature reviewed in Chapter 2. The carer behaviours from analysis of positive experience were already covered within several aspects of the training courses and therefore prompted no major revisions. However, I suspect that there has been a subtler impact on training presentation through an enhanced emphasis and highlighting of key therapeutic and nurturing behaviours required to work with children who have endured severe early trauma, and the herculean effort required to maintain these consistently. Furthermore, some of these themes seem 'entangled' as they came up frequently and appeared to work together (this is discussed further in the next chapter) and delivery was adjusted highlight these co-occurrent behaviours.

One area that the research findings impacted directly on carer support, was in the change from general support meetings for carers to therapeutic groups (PDTS) meeting more frequently. The rationale for this change came directly from the interview themes that highlighted the need for consistency and reliability, and maintaining hope, in the face of challenging behaviour. It was with the addition of this strand of regular and ongoing support (outlined in detail in Appendix B) that foster carer training and support truly became a multi-level package.

**Study Limitations**

It is important to note that there are several limitations that should be considered when interpreting the data and analyses from this study. I was previously known to the foster carers in this sample as their trainer and support therapist and this may have led to three types of role conflict, depending on the participants' experience of the interview situation. First, although the interviews followed an appreciative inquiry approach, in a few instances the researcher had to redirect the interviewee onto a positive course. For example, a few participants appeared to want to talk about difficulties after birth family contact and were discouraged from it. This might suggest they felt they were talking to the therapist rather than the researcher. Second, a few foster carers might have been telling only the stories that fit what they perceived the therapist wanted to hear, such as indicators of stability in placement. Third, participant word usage may have become more therapeutic in nature due to difficulty in differentiation of the role of therapist from the role of researcher/interviewer; in effect saying what they thought the therapist would want to hear rather than interviewer. In addition, I recognised but did not address the quieter member in a couple which was always the non-primary carer. This may have missed the opportunity for catching the subtle differences between how partners viewed high points or best times.

While it is possible role-conflict may have distorted the presentation of information from some participants, it does not seem likely to have resulted in any fictional presentations of positive experiences in fostering. Thus, it may still be a useful exercise in identifying "what works" for children with complex needs. Nevertheless, it would clearly be useful if future research of a similar type utilised a researcher who is not involved in training and support delivery.

# Chapter VI
# Longitudinal Case-Study

## Introduction

The thematic analysis of interview data suggested that training might be more effective if it included regular on-going support to reinforce the counterintuitive ideas and strategies emerging from attachment science. This approach to training was adopted within one region of an IFA for three years, with results held by the IFA that seemed to suggest growing stability and longevity of placements. When the IFA became the host of the research exploration began into whether there was some relationship between what carers were doing and stability in the foster placements. This chapter presents a case study that illustrates the way in which fostering supported by a multi-level training package can work. This case study particularly addresses the third research question set out in chapter 3: *What type of training would enhance foster carers' ability to be part of the therapeutic process in helping foster children with complex needs?*

The information for this case study was drawn from my monitoring of the foster placement, other participants involved in the support package and from IFA recordings. Names and other potentially identifying information has been changed.

The case study emphasises the relentless, emotional and physically draining nature of caring for a child who has experienced chronic neglect, and that with the best will and intentions it perhaps becomes clearer why placements can break down.

This case study illustrates the implementation of the multi-level therapeutic package of training and support. To outline the distinctive elements of the training package:

1. The social workers in this case had been trained at least a year prior to this placement.
2. Prior to placement of the child, both of the foster carers had received the three-day training and had been observed to show evidence of resilience to stressors, therefore identifying them as viable carers for complex placements.
3. This placement required a high-level support package inclusive of monthly meetings with therapist and team. These are the PDTS meeting strategy in the support package.
4. The PDTS sessions also model explicit elements of the training by providing safe, reflective and non-shaming learning experiences which model what is required within the foster placement. By offering concrete understandings of why children are the way they are and after hearing the stories from the carers, the therapist reframes from a trauma based perspective and suggests specific new parenting responses. Carers learn to respond not react whenever possible.
5. These support structures develop an ethos, outlook and language consistent across the team members and allows them to work through very difficult situations as will be seen in this case study.

Other themes in this research are illuminated during the following case study. First and foremost, even though the foster carers struggle with keeping the most beneficial outlook, it is clear they are an integral part of the therapeutic process for this child. Second and equally apparent here are the importance of the behaviours taught in the training in the development of the foster carers strategies and attitudes in the development of parenting that fosters trust, security and self-worth in the child.

**David's History in the Birth Home**

David was born into a troubled household where both parents had been around or suffered abuse during their childhoods. David's father had two previous families and in both cases child protection services were engaged or concerns over the violence of the parenting the children received were raised. Neighbours reported inappropriate care and by the age of three David and his sister were made subject to Child Protection Plans under the category of Neglect.

From 2008 to 2010 various incidents occurred, including family assaults among adults, visits by family members known for previous sexual abuse, inappropriate treatment and violent behaviours toward staff at the primary school attended by the children. There were multiple referrals for domestic disputes, including one where the children were reportedly shouting "help, help, help" through the letterbox.

By 2013, David and his sister were removed from the home under a Police Protection Order. By then the parents were separated but still living in the same house. Cleanliness had deteriorated to full or over flowing potties in the children's rooms, inadequate bedding, and doors tied closed at night. At one point, David slept with a knife under his pillow; although he could not say why.

Case notes conclude:

> In summary, David's development took place in an environment characterised by chronic emotional and physical neglect from the time of his birth until his removal at 7 years. Alongside this, David both witnessed and was subject to physical and sexual abuse. His emotional development would, therefore, have been maladaptive and he would have left his birth family feeling unlovable, worthless, like he was the problem, the 'naughty' child, that adults can't be trusted, and that to be vulnerable was to make yourself unsafe.

**David's History in Care**

David came into care in August 2014, when he was 7 years old, with his 2 younger sisters. He was quickly placed separately due to ongoing concerns that David and sibling 1 were behaving in a sexual way towards each other and could not be left unsupervised at any point. The reality at this point was that there were few foster care options for David, due to his presenting 'sexualised' behaviours, and therefore the matching of David with carers went ahead without it necessarily being viewed as a positive match because the new carers were considered to be emotionally reserved.

While the placement was initially positive, David was getting very angry. To try to maintain the placement, the family were supported by the Child and Adolescent Mental Health Service (CAMHS), the ADHD team (David was started on ADHD medication at this point) and David was individually supported by a play therapist. From David's perspective, this could have had echoes of home; confirming any negative thoughts about self, that he was the problem, and that this was confirmed by professionals offering medication to 'cure' him of his presenting bad behaviours.

The situation deteriorated. He became more aggressive and eventually David was placed in respite care for any family activities, including Halloween, football matches, and family holidays, as his behaviour was felt to be such that the family needed regular breaks. This destroyed any sense of belonging in David in his placement and his local authority social worker was frequently called to 'rescue' the carer, who felt unable to understand or respond to David when he was in a more aggressive mood. The clear message to David was she was emotionally 'weak' and not able to cope with David's chaotic feelings of fear and anger and remain in control, heightening David's

own need to take control and react aggressively to try and cope with the extreme fear he was feeling about this situation. The social worker stated that:

> David has been very angry since this time and has almost always directed this anger at Jan. When in a state of anger, David can be violent to Jan and nothing has been able to diffuse this when they are alone. Jan is regularly covered in cuts and bruises. Her neck has been injured from David kicking her in the head in the car and things are being broken in her home. Although Jan wants to support David through this difficult period, she can no longer tolerate being harmed and the placement will need to be ended for this reason.

As the reader will understand, David's experience in care served to continue to develop, rather than challenge, the negative internal working models he had developed with his birth family, forming no healthy attachment despite the awareness of the local authority social worker of what David had experienced. It was decided in May 2016 to seek a therapeutic foster placement. The local authority social workers notes report:

> David's history indicates that his first seven years of life were typified by chronic, significant neglect, both physical and emotional, and physical, emotional, and sexual abuse. David's physical situation was improved by coming into care; he was provided with regular meals, a clean home, clean clothes. However, despite saying he liked his first foster placement, he later alleged abuse by them and experienced a break in that caregiver relationship, before moving and being cared for by his second foster carer, Jan. Unfortunately, Jan was not able to help David feel safe, or sufficiently understand his significant emotional needs and/or respond to them in a way that was useful to David's development. For a child whose early life experiences had led him not to trust adults, his time in care with two broken placements would have confirmed his inability to trust, as well as his view that he was the problem.

**Current Long-Term Placement Begins**

David's current carers ("Sue and Paul", not their real names) were assessed and trained in 2015 and were seen by those who worked with them as warm, inclusive foster carers with a good sense of humour. Caring for foster children was a new challenge, but they were open to learning. They received their initial attachment,

regulation, and resilience training, in the format that was used prior to the research in the attached thesis and were assigned a supervising social worker.

When talking through the referral, the independent fostering agency (IFA) team were able to reflect on the previous foster carer responses which had not helped David's anxiety and fear to reduce. The care he had received had not adequately helped David think and feel differently about himself or about other people and situations (self and other). Although his behaviour appeared scary on the surface, with the information on attachment and regulation from the training, the team decided that, with different carer responses, David had the potential for emotional growth. It was felt that because of Sue and Paul's qualities as carers and given enough time and support, David could learn to feel safe with their family. Sue and Paul were considered to be calm, clear, and kind carers with a 'boringly predictable' home life and they had demonstrated resilience to difficult situations in their own lives.

The IFA agreed to offer the foster placement for David with a high level support package. This would enable them to receive monthly face to face support with the lead therapist, the supervising social worker, the fostering team, and at that stage this was known as the Professional Development Groups (PDGs). A network of services were offered including indirect support about specific issues between these sessions through email and telephone contact, plus weekly supervision with the supervising social worker to support and bolster the carers between the PDG sessions.

David arrived at his new foster placement in May 2016, nine years old, weighing just over 4 stone, with minimal preparation, having been told of the move that morning and packing straight away. He had his ninth birthday just 4 weeks later. The first PDG session with the carers took place a week after placement; although in this

first week the carers also had supervising social worker support and the training information to recall.

**Progression of What Would Come to Be Called Therapeutic Care**

What follows is a synopsis of care notes with bulleted outcome points from PDTS sessions, interspersed with explanation and direct quotations from the social workers case notes. Phrases accented with bold font emphasise key themes heretofore discussed as part of the thesis findings and training themes.

Sue and Paul attended all the monthly sessions available. Initially, it was just the carers who attended, with the team of supervising social workers and the lead psychotherapist. This was purposeful, in order to allow the carers to become confident in their own understanding of how the sessions worked before introducing new professionals to the group. Over time, David's social worker and head teacher also attended multiple sessions to address specific issues, with Sue and Paul's agreement.

The aim of the sessions was to offer a reflective space, where time was committed by a small number of professionals who had come together as men and women, brothers, sisters, sons, and daughters with their own personal histories, as well as being professionals, to think together about David's presentation in the placement, and to understand the origin of any issues through consideration of the impact of his past experiences of chronic neglect and abuse. The specific issues brought to each PDTS were considered in the wider context of a trauma / attachment informed perspective, in order to develop understanding and tolerance to presenting behaviours, but more importantly to consider strategies that Sue and Paul might take home with them and put into practice. The aims of these strategies were manifold: 1) to develop an environment in which David could thrive, 2) to build the carers' resilience to rejection

from the child, and 3) to build resilience in David to the fear he carried including that of getting too close.

While training was a vital foundation, the sessions began to develop themes and apply them to the highly complex individual, David, living in Sue and Paul's house. A flipchart was used to make visual notes about David's case, mapping a genogram and David's mum and dad's parenting style, which led to thinking about David's lived experience in the birth home and how this would have impacted his emotional and behavioural development, thinking about the preverbal messages he would have received that he would not be able to consciously recall, but would become part of his internal working model. We considered how this development occurred through a consequence of negative experiences, and how David's feelings of worthlessness and self-loathing, his inability to trust adults and to allow vulnerability, and the idea that men are scary and women can't keep you safe were internalised becoming hard wired. They became his rule of thumb or guide which would inform his thoughts about himself and the world around him and as such influence his responses to any given situation. The role of Sue and Paul, with support, was to stimulate development of new internal working models in David. This could only happen through giving consistent and highly repetitive messages of safety, security, kindness, and support at every opportunity; and importantly delivered at a level that David could cope with. To give the best chance for this to work, Sue and Paul would also need repetitive and consistent messages for themselves about the kind of care that was needed for David.

Having thought about David's background, we then focused on the behaviours that Sue and Paul had seen and shared with the group. This included David trying hard to be perfect and please everyone and make himself 'likeable'. We thought about the

aim of this behaviour and concluded it could be to hide the 'rubbish' that he feels he is, because this would lead to rejection and, therefore, this pleasing behaviour came with high anxiety and fear of being caught out. We agreed that this was an impossible situation for him and one that would inevitably slip and leave him exposed. The strategy was given to model mistakes, to help show David that it was okay to get things wrong in this family and it would not be the 'end of the world'. By modelling these small mistakes, David could see how mistakes are managed in the home without the spotlight being on him, before he made inevitable mistakes himself. This was successful, in that when David saw the birth daughter knock a nearly empty glass of juice over and then a full one as a genuine mistake, he saw that Sue and Paul remained calm and did not reject their daughter. They just helped her clean it up. He had looked panicky and worried initially, but then when he spilt something a few days later, he was anxious but coped with carers helping him to clear up, just as they had with their daughter which was another positive message, that of being treated just like their daughter.

We then talked about the kind of behaviours that had been seen in the previous placement. David was viewed as a 'bright' child, who was articulate, a good reader. He presented as cognitively around age appropriate, even advanced in some areas, and emotionally immature as this early developing brain regions are likely to have maladapted due to the chronic neglect received. David's behaviour indicated a high level of anxiety and fear, which were hidden behind manifest aggression.

Complex bio-psycho-social experiences and trauma are hard to articulate and easily mistaken for bodily / behavioural symptoms, which was what had happened to David. Both at home and in his second placement before the move to his current carers,

the adults around David looked to a 'medical' reason for his behaviour and concluded it could be Attention Deficit Hyperactivity Disorder. It was important for us as a group to focus on David's thoughts and feelings, and how to help create change in these areas of development, which in turn would lead naturally to creating change in behaviour in the future. To focus on behaviours and changing these would have led to learnt change, not felt/biological change, which is not sustainable over time and would have led – unintentionally – to greater failure for David.

In the initial PDTS sessions, the key aim was to establish stability in placement; as it would be from this that relational trust could develop, and from this a relationship that matters, and from that a sense of belonging, a growing sense of self-worth and increased tolerance to stress and capacity to regulate emotions. Therefore, the carers were asked to:

- use certain 'mantras' at home, 'because you're important to us', 'because we care about you', for example.
- respond, not react, and to not give too much information away, 'that's for adults to worry about, buddy'.
- have a 'pet' name for David, so that if they had to give a more corrective message, like "we've just corrected something, but don't worry, our relationship is still okay", rather than David re-interpreting it as wholly negative and a rejection of him, they gave 'hope'.
- explicitly model 'kindness' to each other so that David could see a male carer who was kind, not scary, and a relationship between carers that was kind, caring and safe.

The first looked after child (LAC) review was held before this PDTS and following the local authority social worker's visit, ahead of this David had broken down and sobbed in Sue's arms, as noted in supervision notes:

> *David had a 'meltdown' on Wednesday evening after social worker's visit, sobbing for a considerable time and hitting his head with his hands. Sue stayed with him and offered him a hug, which he took and clung onto for some time. Sue rocked him like a little baby, helping to regulate him and to bring his anxiety down through this motion. David told Sue that he was worried about Sue and Paul meeting his last carer, as she would tell them what a bad boy he was and they wouldn't like him and also he had been worried that the social worker was going to tell him he would have to move again.*

Following this, David became rejecting of Sue on the morning of the review, telling Sue that he hated her, hated living with her, and wanted to be moved, being unkind to the dog by pushing her away; he also said he would rather be at home being hit by his mum than live with Sue. This rejection so early on, after David had been so willing to please, was surprising and hurtful for Sue, but she responded to David saying that they all wanted David in their family and in their home, despite not understanding what had provoked this. She kept her responses short, knowing from her training that, when anxious, David would not be able to take many words and, from the training, she knew to keep her tone level, as David would tune into this, rather than her words. Her response began to build David's sense of belonging from the start, and a condition of worth regardless of his behaviour, through being kind and giving David hope; despite rejecting these messages, they were heard.

This show of vulnerability is frequently difficult for children with David's experiences and, typically, was soon to be withdrawn. Over the next week, David would project his negative view of himself, giving Sue opportunities to repeat her

messages of him being important to her and cared for, developing a relationship that matters and inclusion as part of the family, as noted from Sue's recordings:

> *Whilst in the bath, he kept repeating that he is naughty boy and not deserving of anything. My reply was well we like having you here and care about you. He said I care too much, but I said you can't care too much…. He said yes you do, as you don't let me go anywhere further than the green or the pathway so I said it's because you are important to us and that we care and want to keep you safe, and I added that until my girls were high school age it was the same for them. After a while he seemed to accept this.*

A lot happened within the first six weeks of placement, but with support from the PDTSs and weekly supervisions which reiterated the messages from the training, Sue was able to respond in a predictable way, calm, in control, and with kindness; regardless of what she was being faced with. This is an extract from anonymised supervision records during this first month, reflecting together over David's frequently, rapidly heightened arousal and mood swings:

- These episodes occur when David cannot get what he wants, or when he gets frustrated by a situation and can't achieve what he wants to there and then. They indicate a lack of emotional regulation as David switches from happy to anger / meltdown in an instant, and they indicate a lack of capacity at this stage of being able to tolerate disappointment; if it's not instant, David can't tolerate the frustration and will then turn this on himself, thinking that he is bad and turning on Sue; this will lead to him rejecting her before the anticipated rejection from her. Leading up to these times, David will become less co-operative and Sue is becoming able to use diversion strategies from training which work most of the time, although not in all situations.

- When David does have an episode, he will repeat the same phrases – I hate it here, get the social worker on the phone, I want a new family and I mean it this time. He will take himself to his room and he will place things from Sue and Paul in the bin / on the landing and will make grunting noises. When this has finished (normally 4-5 minutes total), Sue will go to his room and ask if they can talk. They talk and end with a hug and between them they put everything back in the room / out of the bin.
- If this happens on the way to school, David will often reject his lunchbox, but Sue will leave this with school reception with a note in it with a smiley face. This indicates David rejecting all care from Sue and again is a way of exerting / re-establishing control. Sue's gesture shows that she cares, and she is building a bridge to David, so that he knows that he is still accepted during the day, rather than having to wait all day with anxiety until he gets to the end of the school day.

Sue demonstrated that she was consistently 'providing a bridge' back to David after he rejected her; leaving him with hope that the relationship was on track and he was important to her. She also modelled kindness and affirmation to David in various ways to promote repetitively positive experiences, that over time challenge his negative IWM and lead to new positive connections of self and other which will, with time, hardwire and become a new rule-of-thumb/guide from which to measure each experience.

David had two significant meltdowns in quick succession. One on his birthday after his sister called the foster home, resulting in him shouting, grunting, and hiding in the wardrobe, and a second resulting in him hitting out at Sue. The supervising social

worker case notes at the time indicated an early attempt in supervision to put context to a behaviour; a skill that has improved over the months that she have been learning in the PDTS sessions. Being able to offer an increased level of contextual help allowed Sue and Paul to feel "okay" with a really difficult situation that was new to them. Although they presented as calm on the outside, they had felt out of their depth in the moment and were able to articulate that their ability to manage difficulties was supported by knowing that they would have access to the lead therapist and trainer and to the PDTS sessions. Both helped them maintain their presentation. Because of their calmness due to support, their affect remained in control and this, in turn, gave David the consistent message that they do not react, that they were not frightened by the external manifestation of his inner fear. They were predictable in their responses and they were able to build the bridge (the drink) to show David he is accepted not rejected; helping build his trust in them as carers and demonstrating that how David feels is important to them, they were available to him, which in turn helped him to feel part of the family and build on his sense of belonging.

David's head teacher, from the school that he had joined in May when he moved foster placement, and his local authority social worker were invited to the next PDTS session. This was for the consideration of how to best prepare David for his transition up to year 6, SATs in year 6 and the transition to high school.

Based on the PDTS session, the head teacher decided which year six teacher would be best for David, taking into consideration the need for the teacher to be female, kind, clear, consistent, regulated, calm in her tone and manner, not gushy, not fearful of rejection. We also talked about the introduction of this teacher in such a way that enabled David to see a 'transfer' of trust between his current teacher and new teacher.

This helped avoid future issues where possible and smoothed the way for David into the new school year. In this sense, again the PDTS session was used to pre-empt issues and in doing so divert from potential failure to success for David. This would have the effect of helping the placement to remain as stable as possible, as it did not lead to issues in the school that would by default be brought back into the foster placement and wobble it.

The fact that the head teacher was on board, willing to not only attend the session but do so in a capacity of someone willing to learn, was a credit to the school and reflected positively on the regard David is held in by the school. The head teacher was able to take away practical advice with an evidence-base for the TA to help recognise and reduce David's anxiety in the classroom, and in doing so avoid shaming him and creating negative situations.

Various incidents continued and were addressed with trauma-informed thinking, and always discussed openly during the PDTS sessions. It was necessary to reassure Sue that difficulties had been expected in the placement and, if providing care for David was thought to be less than complex, there would not have been a need for the group support.

The PDTS at the end of July gave an opportunity to reflect on the progress that had been made in placement, and came at a time when David had just been included on his first ever family holiday. Notes from the session evidence the group considering areas of progression, as well as then moving onto reflecting on the issues that had been raised, again putting these issues into the context of David's history, and strategies for Sue and Paul as referenced here:

- There was evidence of David's confidence developing by the longer time he took between checking in with Sue and Paul when he was playing out on the green – he was developing trust in their availability as carers, and this was providing measurable change.
- David continued to take risks by making himself vulnerable after his meltdowns, becoming sad, and worrying he had negatively impacted his relationship with Sue and Paul.
- He was also prepared to take a risk (vulnerability) when Sue asks him if he wants a cuddle and saying 'yes.'
- While there were still tantrums, they were becoming less frequent; indicating he was less anxious probably because of a developing relationship between himself and Sue and Paul, and he was beginning to want that connection.

This progression was indicative that the consistent messages David was getting from Sue and Paul about being important, of being valued, and that this, together with their kindness and inclusion of him within the family, has helped David to begin to develop trust in his carers and a sense of belonging.

Six months into placement, David's sense of belonging continued to develop, as seen by these extracts from Sue's recordings:

> David had a fab day, then on our way home in the car he was saying this 'like for xmas I'm going to wish for another family if I'm lucky I will get one', so I said why say that darling, and he replied because you will end up getting fed up with me and want me to leave, so I said we love having you as a part of our family buddy and you're here to stay, I could see him grin in the mirror.

> We popped into town to get a few bits and on our way home in the car he [David] said he loves living here and being part of our family so I said: aww, that's lovely. We love having you live with us and being part of our family.

At this same time, David began to fall asleep in the car on longer journeys, indicating a level of trust in his safety. He also trusted Sue with a disclosure while they were parked in the car. David sought a hug first, wishing for a physical connection with Sue before telling her. Sue had been prepared in a PDTS for disclosures, and so felt equipped to respond to this, reassuring David that nothing like that would happen in this house.

By September, the decision was made by the Paediatrician that David could stop his ADHD medication, as he trusted Sue's assessment that David no longer needed this and gave examples confidently to back up her thoughts. This recognition was a really important part of the session, as it gave Sue and Paul the boost they needed that what they were doing was creating biological change, that David was responding to the care they are offering, making the hard work feel valuable. When they were experiencing a complex, at times very rejecting and hostile child living in their home, without a break, they were vulnerable to having doubts, to feel like it is an exhausting task; so these moments of positive reflection that are recognised within the PDTS are an important element of stabilising the placement.

At eight months, the local authority social workers notes indicate David had shown a level of confusion over why she was not asking him questions. This led to him spontaneously telling her that he was happy living with Sue and Paul, and that he wanted to stay with them, not because he had been asked but because he wanted her to know. He directed the social worker to his 'string' of photos, which were hanging in the living room, low key, which had photos of him horse riding, him with his foster sisters, him with Sue and Paul. He wanted his social worker to see his sense of belonging and importance in the family home. The photos had been arranged around the house as an

explicit and constant reminder that David was an important and valued part of the family.

David's emotional development was also evident in the growing friendship that he had experienced at school, and it was notable that David's developing sense of empathy was evident within that friendship. Sue and Paul had been asked, during a PDTS, to try and give David lots of experiences of empathy though their modelling of empathy with each other and David.

- David's friendship with Jayden was continuing to grow and appears really positive for both children. Jayden had commented on how kind David was as a friend, and David felt the same way about Jayden.

Also at that time there were other indicators that David was becoming less anxious…

- David became a lot less fixated with the iPad, hardly going on it; preferring to talk and read, demonstrating that he could tolerate his mind not being quite, so busy and highly stimulated all the time, and so was not needing to play the electronic games he previously played before and after school.

The last point is worth highlighting, as it indicates a reduction in David's anxiety levels, and that he was developing the capacity to 'be' rather than 'do', as was the case previously.

None of these positive points negate that the road to recovery was not also rocky at times. What follows is an extract from Sue's recording, which is worth repeating in full to get the detail:

> So I said David you are trying to prove to me that you are grown up and mature enough to walk to school with Jayden…well this isn't grown up and mature mate, he then whispered something under his breath, talking to the cat, then

when he stopped he said well what can I do then, I replied you can come and give me a cuddle if you like, which he did. When Paul took him to bed he refused to brush his teeth, was messing about kept switching his light on, he kept grunting and shouting so I went up and said what's up buddy, he said I'm such a horrible boy and a brat, I said no you're not you're a very special boy and we care about you very much. He said go away, so I said goodnight and left, after 5 mins he shouted downstairs how am I supposed to sleep with no mattress, so I went upstairs again, and he had thrown his covers downstairs and half took his mattress off his bed, I made his bed up and sat with him, he said it's all my fault. So I said what is darling he replied everything that's happened so I said what do you mean, he said all the nasty things at home, getting hit getting moved from first carers and from second carers I replied you are not to blame for anything that's happened when you lived at home, parents are supposed to keep their children safe, it's not your fault at all my darling, he said they did…. I said Paul and I are both here if you ever want to talk about anything he said if I tell you, you will hate me and get rid of me, I said whatever you tell me it wouldn't make a difference to how we feel. He was thrashing about on his bed, and getting himself worked up and me being there wasn't helping so I said goodnight and came out of his room. I was only downstairs for 2/3mins and he had thrown his bedding down the stairs again and sat at the top of the stairs sobbing saying I want my mummy….so I went back upstairs and made his bed up, and he was sat curled in a ball on the bedroom floor sobbing so I sat on his bed and picked him up as when he is like this I know he is ready to be comforted, he sat on my lap and I rocked him whilst saying come on darling ssh….sssh I'm here for you. We cuddled for about 10mins then he laid down on his bed he was a lot calmer but still calling himself a retard and a horrible boy, I said please don't use the word retard as it's not a nice word, and you aren't a horrible boy you're a very loving and caring boy, this was repeated over and over, he calmed down enough to start saying goodnight and I came down at 8.45pm.'

What follows are the bullet points from the discussion at the next PDTS session. It was significant for different reasons: 1) everything needed to be considered in the context of David's past experiences, 2) in the context of evidence of David's progression, and 3) also in the context of needing to tweak some of the responses previously given and noted in the PDTS notes:

- The focus of this session was the meltdown last week – this represents lots of positives but there are also some tweaks to make.

- Could be multiple reasons, but likely trigger for this episode was David being 'caught out' using the tablet when he knew he wasn't meant to on Monday evening. David can be like a 2 or 3 year old, living in the moment, seeking and only thinking about the instant gratification, not the consequences or even that it is wrong. This can be forgotten by adults when we see the 9-year old child in front of us.
- It is positive that he feels remorse in response to an incident (because it shows that this is a relationship that matters – he has let someone down that he loves); it's just that he felt it beyond his coping capacity on this occasion. He then thought about the incident at bedtime the next night, when he is not able to keep active and the uncomfortable thoughts are starting to intrude into consciousness, leading to the meltdown.
- The bedding coming out of the bedroom on Tuesday evening can be seen as attachment/resolution seeking behaviour. David cannot put the situation right; he cannot get any resolution if Sue is not with him. He does not know how to put it right; he won't have the words to do this and can't cope with the feelings. His perception might be that 'it's all me, it's all my fault' – at this stage telling David that nothing was his fault will not be believable because his own belief is very strong; so best to avoid this response.
- David removing the bedding could be his way at this point of showing us he wants help and some resolution through proximity to Sue, but cannot bring this about through words yet.
- In context of the past when David had been 'naughty' at home, his bed was stripped so he did not have any bedclothes to sleep on. He may have

internalised this punishment and felt it was right. This is an opportunity to challenge that negative parenting message and provide a different response.

- When David makes a statement like 'it's all my fault' a different response from Sue and Paul could be:
    - '**whatever has happened I will love you / care for you just the same'**. When they are in the car, this could be repeated: '**remember what we said darling, whatever has happened, we will care for you / love you just the same' / 'remember darling, if you ever want to tell us anything we will love you just the same**'.
    - 'I've done all these horrible things' – '**whatever you've done I'll still love you**' – unconditional regard / love. Whatever he is done, he cannot undo and Sue and Paul cannot undo either, but this line gives David permission to risk giving more. This may lead to David risking saying in time, 'you know you said you'd love me whatever I've done….'
- David is likely to fear that the 'bad things' he has done are going to slip out, especially as he gets closer and closer to Sue and Paul, which could make him increasingly anxious/vulnerable. This is why it is important for Sue and Paul to model that it is ok not to be perfect.
- A relationship that matters is being built, because Sue and Paul are coping with David's every day struggles, day in day out; even when he makes mistakes, they are not made into a big deal and Sue and Paul continue to make explicit to David that he is an important and valued part of the family

and we can all make mistakes and still care about each other. Love does not end when we make mistakes we continue to care for each other.

- That evening he needed to bring Sue back to help him get away from the feelings of remorse/guilt (conscience development). Seeking proximity to Sue as a means of coping is important. David has developed this knowing because of the consistent and repetitive caring he is receiving and this connection/attunement helps build on his limited resilience to even the smallest of stressors, never mind something as powerful as feeling remorse.
- David has an internalised view of himself as worthless or 'bad' due to his early life experiences, and his early controlling behaviour being labelled as 'naughty' being internalised. Something that happens, like being 'found out', triggers those feelings of worthlessness and negative sense of self and this usually leads to a high arousal reaction as a means of coping.
- David may start to slip bits of information out and these may not be as troubling as the one he is hanging onto, the 'big disclosure about abuse, violence, cruelty, or something else', which is likely to be weighing heavily on his mind. The responses if possible:
    - '**that won't happen here / in this house**', giving him some physical touch/contact and being available for a hug but also moving not pushing the conversation. He will come back to you when he is ready and able to say more. It is important that he hears the message that he is safe with you.
- When children disclose information during a period of safety, they often want to take it back fearing the consequences of the exposure, but they

cannot. What can happen is they will try to silence the person they disclosed to by ridiculing or berating them in an attempt to minimise their power or credibility. This is not about the person being less cared; it is about the fear of exposure and what it might mean to the relationship between child and carer. This is why the carers responses are so important.

- **'I want my mum'** – this could be the 'idealised mum' rather than David's actual mum. This response can happen after an incident between child and carer. He will still have a survival need for someone who can love him and keep him safe, but fears because of the incident he has blown it with her. What he really wants is Sue back but fears he has lost Sue, so has to find a way for her to reassure him that she still loves him, what he should be saying is 'I want you' but this is too big a risk in case he is rejected.
- The consistent and repetitive messages of kindness, safety, and affirmations from this parenting will provide the best opportunity for the development of new internal working models of self and other for David. Whilst there is still a long way to go, there is clear evidence of some changes in how David sees himself and how he views his world.
- **Tweaking the response to David going on the tablet when he wasn't allowed**. Because David is so emotionally fragile and easily shaken, and his self-concept is so low, it is important to be mindful when delivering any form of correction to try and deliver at the level with which he can cope. With David even a mild 'come on mate, you know you're not meant to, let's try harder next time' will be perceived by David as a significant blow and a fear that he has let Sue down completely. It would be enough for him to

know that Sue knows he has done wrong – this would be powerful enough at this stage without him thinking that he has blown it completely. This 'knowing you know' tweaks his conscience enough for now. Because the relationship is becoming so important to David, anything that suggests it may be lost generates immense anxiety and fear. What we are looking for at this stage from his 'knowing that we know' is some form of clinging behaviour, where he seeks to find out if we still care about him. This can present as David asking if you want some help, or leaving a note for you somewhere saying something nice about carer. Over time as his ability to cope with greater stressors, such as being caught out, develops he will start saying and meaning he is sorry.

- There is evidence that David wants to be close to Sue and Paul, but the risk of doing this is still immense for David. Sue and Paul's emotional and physical availability is key.

Before Christmas, David decided that together with a friend he wanted to start a basketball club, teaching the younger years. To achieve this, David stood up in assembly several times to give notices, which shows a remarkable development in his self-confidence at school.

The above notes from PDTSs, foster carer supervisions, and carer recordings from David's first 10 months in placement highlight evidential change in David during this period, as a result of strategic care that has offered therapeutic repair to David in second by second, minute by minute care. The opportunities for delivering this kind of care, at this level, repetitively, numerous times a day, are essential and therefore required. Positive change could only result from highly repetitive, highly responsive

care, mimicking the process of positive interactions a much younger child or baby would receive. A relationship with a carer can develop over time, but if it is not a relationship that matters in a meaningful way, with all the benefits that brings, it would not offer long term stability and new internal working models that will help a child continue to feel valuable, lovable and secure at times of challenge.

**Outcomes in Placement**

The themes that were identified from interviews during data analysis and brought into the training package are seen being explicitly delivered throughout this case study. This suggests that this parenting style and ethos can be taught to other foster carers and their support networks. For example, the carers in this case study demonstrate understanding of several themes connected to one incident, which had repercussions over a number of days. The training themes were: the importance of touch as a means of affect regulation; the importance of language, words and delivery; recognising presenting anger could be terror or fear and the carers understanding of the importance of consistency and repetition for change to happen and consequently they look for opportunities to show the child (words and actions) he is valued and important. The carers identify within this case study the significance to the multi-level training package of the regular PDTS sessions to their on-going learning and support, and state that without this specific form of support the placement may have ended.

There have been hard outcomes for David, who stopped taking ADHD medication, put on considerable weight, grew, and progressed significantly academically. There were also soft outcomes, reflecting each of the codes: reduced anxiety, increased confidence, feeling safe (and therefore reduced angry outbursts) and happy (which David volunteered to the social worker), growing trust in his carer, and a

definite sense of belonging. These significant developmental areas were possible, as noted throughout the case study, by initially providing stability through Sue and Paul being consistent and repetitive in their responses, making their care predictable (and therefore helping David feel safe) and in doing so showing themselves to be people David can rely on and begin to trust. Sue and Paul showed David that he is valued, important and part of their family, and this was the basis for forming a relationship that matters. Sue has been open about her parenting having slips at times; she was open about this with David and has been able to build bridges when there have been slips. Both Sue and Paul have become increasingly able to recognise the need to leave David with hope, so that David does not have the opportunity for feeling the relationship is blown. Throughout all their interactions, Sue and Paul have endeavoured to be calm and kind, which has helped David recognise this as a valued trait.

**The Carers' Perspective**

This case study reflects the benefit of collective caring for an individual child, recognising that the job is too much for one person on their own to achieve successfully, over time. Therapeutic caring requires the energy given through reminders of why behaviours may be happening and where they are coming from, because without additional supports the exhausting nature of the job reduces carers' (like Sue and Paul) ability at times to stay positive. Sue frequently said that, as she is in the midst of the placement each day, these are important spaces to step outside and remind herself why David's progression is as it is and remind her and Paul of what is behind the presenting behaviours. Sue has said that without the PDTS sessions she is not sure if the placement would have continued, because David is so high energy, his needs so complex, and his behaviour at times bewildering and hurtful. She is open in saying that

day to day it is extremely draining and she needs regular and consistent reminders of existing strategies and new strategies as situations change. This honesty is an important quality in complex placements and reflects Sue's open nature, and she recognises now more than at the start of the placement how David's last placement broke down; she is able to see how, without the understanding, guidance and support she has had, the placement could have quickly deteriorated if responses were not attuned to David's specific emotional and behavioural needs.

These PDTS sessions implicitly model what is explicitly asked of a foster carer at home. They create a non-shaming environment where the carer may feel vulnerable when asked to talk about what is happening in their home, identify clearly the crucial role of foster carers in the therapeutic process, value the 'here and now' knowledge the carers brings about the child, and where we repeatedly go back to the context of birth family history to remind all participants of why any given situation could be happening, in order to create understanding and tolerance of behaviours while change is being developed; thereby, offering repetitive messages to help the carer remember why a certain behaviour is happening and how to respond. New strategies are difficult to maintain until they become embedded, which is why repetitive reminders are essential to carers, especially when they are tired through the complex needs of the role they have. This approach is demanding of carers and tiring by nature, so extra support is needed to ensure that carers continue to feel able to take this approach, be reminded of why it is important, and to feel energised enough not to resort to more traditional, consequence-led approaches by default because they give quick fixes which at times feel necessary.

Where inevitable glitches in care happen, they are accepted and thought through, rather than dwelt upon or punished. The sessions offer a sense of belonging to a collective, so that Sue and Paul do not feel isolated in the incredibly difficult role they have, not just in caring for David, but in helping to create positive change in his emotional development. The expectation in the group is one of kindness to each other, valuing difference in views and respecting each individual's right to be heard. In this environment trust is built and professional relationships that matter can be developed. Where this care helps support biological change in the foster child, this approach supports the sustainability of a placement through its repetitive nature; the carer is 'held' and contained by the group. This approach is replicated in supervisions, so that they become mini-PDTSs in between the monthly sessions.

**The Perspective of the Supervising Social Worker**

> These supervisions have become more meaningful as a source of support as the sessions go on, as I am increasingly confident in supporting Sue in a PDTS style, considering issues or behaviours in a wider context and bringing it back to David's early life experiences to give behaviours meaning, as well as looking for signs of progress, however small. Sue often speaks of pausing and asking herself 'what would Peter say now?', and that she would like Peter on her shoulder. For me as the supervising social worker, the greatest aspect of this approach is its usability; I have studied attachment theory and feel confident in thinking about why a child may be behaving in a certain way, but there has always been a missing link in terms of assessing and seeing this, to knowing how to help repair poor parenting. These sessions are based on complex theory but offer carers, who have their heads full with the job they do, simple, basic responses and suggestions that are easily put into practice. I have watched Sue's trust in the strategies develop from 'blind faith' at the start, to real belief as she has seen time and again the outcomes and this has helped her to remain positive about the sessions.

It is also good to see Sue and Paul support other carers, and take real pleasure and pride in the change in David. They are able to say that they are proud of the job

they have done and continue to do, despite the ongoing day to day challenges, which can never be underestimated.

What has been the benefit of supporting this model of care, which offers ongoing support to the carer, rather than the child? Care needs to be responsive to a child's changing needs, and the group sessions reflect this, adapting and reflecting the issues as they arise and as they develop as David changes, taking different risks, responding in new ways as he begins to form new internal working models. David needs to feel all the benefits of being cared for by people who genuinely care about him, but in a way that gives him the best opportunities to access therapy and show genuine development. This approach allows David to feel honestly cared for, rather than feeling like he is being cared for in a certain way as a result of adults doing a job. This would have the potential of blocking a relationship that matters. Sue and Paul are able to respond in a therapeutic way minute by minute, second by second, attuning to David in the way a new parent would attune to a new born baby, in order to give repetitive, helpful messages day in day out, which in turn is helping David to create a different internal working model. Although the process is by nature lengthy, it still seems to be having more effect than the previous weekly play therapy David received.

**The Local Authority Social Worker's Perspective**

The social worker has been a great supporter of this approach and has changed her practice with immediate success based on information gained in the sessions. Her real fear was that if a placement could not be found for David, or if his current placement broke down, that he would have no option but to be placed in a children's home, which she thought, given his fragile presentation would have been incredibly hard for him. She felt that he would only thrive in a family setting that focused on his

emotional needs, but worried that this would not be possible to achieve. In a permanency panel meeting recently for David, in which senior managers ratified the match between himself as well as Sue and David, David's social worker was able to highlight great progression in what is in reality only a short space of time and she was able to link this directly to the therapeutic support package. The panel themselves reflected that the paperwork for this match was the best they had received, as it showed great knowledge of David's complexities, but also reflected the significant positives, celebrating these, and bringing David to life.

**Summary & Conclusion**

The thematic analysis of interview data presented in chapter 5 identified the areas of care important to promote a child's emotional progress and catch up with their cognitive development; making them more able to function successfully throughout life. By making the link between identifying why a child presents as they do and giving easily applicable strategies to both anticipate and respond to presenting issues, it helps support the kind of relationship that can make a difference to a child's long-term emotional success. It not only aims to avoid placement breakdown but helps develop a child's capacity to be an emotionally able adult, who is able to enjoy relationships with family, friends, partners and at work, well beyond the end of the placement.

The training and support package for carers was initiated prior to the research and refined on the basis on interview data. The additional training information that surfaced during analysis of the data discussed in the previous chapter clarified explicit foster carer behaviours and attitudes that seemed to have some relationship to important positive changes in the children. Support moved from being an innovative training

workshop for social workers and foster carers into a multi-level therapeutic package of training and support that recognised from feedback the importance of regular facilitated team support to offer learning and stability. The attributes that are presumed to contribute to its success seem to be supported through this case example.

# Chapter VII
# Discussion

## Overview

The aim of this research, was first to obtain an understanding of the 'high points' or best experiences of foster carers with the 'looked after' children (LAC) in their care and then, using the data, to develop the multi-level therapeutic training package and finally to explore its effectiveness with an empirical case study. This chapter discusses the findings of the first section of that work, one that employed appreciative inquiry protocols, and presents a reflection on what they mean to the field of psychotherapy as it relates to the support of children who experienced early trauma, abuse, or neglect. Based upon those findings, the subsequent multi-level therapeutic package and the empirical case study, future policy considerations will be considered and recommendations for future research will be offered.

The following section will present data that relates to the research questions which guided and shaped this project. The questions evolved from gaps identified in the literature review (see page 50).

1. To what extent do accounts from foster carers lead to a better understanding of ways in which they can be involved in the therapeutic process with children with complex attachment problems?
2. How do accounts from foster carers highlight the challenges in the development of trust from the foster children with complex attachment problems towards their carers?
3. What type of training and support would enhance foster carers' ability to be part of the therapeutic process in helping foster children with complex needs?

**Discussion**

Research suggests that neurological growth is experience-dependent and that the consequences of early chronic neglect can cause significant and life-long harm for the developing child (Bowlby, 1969; Stein 2009; Perry, 2009; Rees *et al.,* 2011). The consequences of neglect affect the child's internal working model (a rule of thumb or internal measure from which individuals gauge situations) and impact on how the child thinks and feels about self and others and how he/she interacts with the world (Bowlby, 1969, 1973). Having suffered chronic neglect, the child internalises belief systems from the explicit and implicit messages they receive - such as they are not safe, secure, of value or important- and over time the child internalises these beliefs and adapts to their circumstances while learning to survive in their world (Bretherton and Munholland, 1999). These include: needing to feel in control of everything, not trusting others and living in a perpetual state of hyper-vigilance, anxiety and fear, yet not wishing to appear vulnerable.

This lack of a healthy primary attachment figure can lead to a child's development being impaired and/or immature in the areas of empathy, conscience, remorse, affect, and behavioural regulation. And importantly, their ability to respond to nurturing and kindness can also be impaired (Shonkoff and Phillips, 2000). In other words, the body keeps the score and the consequences of these relational experiences are carried into every situation or place the child goes to, including foster care (van der Kolk 2015).

In order to put these findings in context, it should be noted that foster parenting, which is at the front line of service delivery, is not only a complex and important role but also one that is extremely emotionally demanding on many levels (Hutchins and Bywater 2015; Ironside 2012) and difficult to do and sustain. Foster carers are faced with frequent

and often relentless challenges from their foster children; for instance, carers within this study have experiences of physical and verbal aggression toward themselves or their birth children, grandchildren, pets, and prized objects; etc. Even if physical aggression is not a day-to-day occurrence, they regularly deal with: rejection of kindness, protection, boundaries, rules, adult control, bed wetting or soiling, smearing, night terrors, self-harming, and sexualised or over familiar behaviour with themselves and others etc. They can also expect to deal with hoarding food and sanitary wear, stealing anything, nonsense lying, and reactions of rage/anger to endings (i.e. of TV programmes, games, outings) or even simple disappointments. Not infrequently, these children can push carers away by making allegations against them and can generally lack the ability to emotionally regulate in an age appropriate way, which can lead to raging or other high-arousal responses. It may be difficult for many people to imagine what it is like to care for a child with these levels of fear of: closeness, distance, eye contact, touch, men/women, shame, and/or being found out as not being worthy or loveable; alongside the additional complexity of being unable to regulate the emotional and behavioural reaction that emerges when these fears are triggered.

In their role as students, these children may not be able to cope with tests or homework as it is often associated with fear of failure or being shamed and they can react in extreme ways, exhibiting over reaction to losing or winning. These high levels of anxiety can also impact upon their ability as students; leading to impaired memory (inability to retrieve stored memory and store new knowledge), which affects their ability to learn and to focus/concentrate. The behaviours of children in foster care can present the children as being extremely disturbed and in turn they can also be extremely disturbing to

be around (Fahlberg, 1994), particularly if those behaviours are not understood by the people caring for them on a daily basis, who we expect to be equipped to respond.

Appreciative Inquiry (AI) proved to be extremely efficacious because, by focusing on the 'best of what is', these data did not specifically seek to hear about the challenges the child/children brought to the placement, but rather was asking carers to highlight good times and then, during data analysis, consider if there was any relationship between what the carers were doing and those high points. From these accounts, foster carers in this research have demonstrated that they not only cope with complex difficulties, as the examples given above show, but also can respond in ways that, over time, help address some of the harm caused by the children's early trauma.

Now, because there is a greater understanding of the impact of chronic early trauma on the cognitive, affective, and behavioural development of children, future foster carers can be trained in what is required to offset the negative messages of self and other that the neglected child internalises and leads to how they interact with the world around them. Foster carers in this research described nine behaviours (as identified by the carer codes discussed in chapter 4) as being important in bringing about significant change in how their children think, feel, and behave.

These data strongly support the argument that, given the right training and support package, foster carers can provide the environment that brings about cognitive, affective, and behavioural development in children with complex attachment issues. By analysing data from foster carers accounts of their 'high points or best experiences', significant emotional and behavioural changes in the children in their care were highlighted, illuminating explicit and implicit relationship between the children's developmental

changes and the parenting the children were receiving. Specifically, during data analysis nine foster carer codes emerged that were frequently used:

Code 1: It is about trust.

Code 2: Showing child they are valued and important.

Code 3: Honest caring for child as individual.

Code 4: Showing kindness.

Code 5: Consistency and repetition.

Code 6: Inclusion in the family - belonging.

Code 7: A relationship that matters.

Code 8: Modelling 'good enough' parenting.

Code 9: Maintaining hope.

Also of note was that these data demonstrate a relationship between these nine codes and the six child ones, and that the foster carer codes are frequently seen in combination of two or more rather than standing alone. This will form a significant part of the training course that will be the product of this study.

**The Most Prevalent Codes**

The following section considers the four most prevalent of the nine foster carer codes and then discusses them from a therapeutic view:

1. *Consistency and repetition* (65 instances in data). The literature review clarified that, to address the neurological insults of early trauma that can result in a variety of developmental issues for children, there was a need for a high level of consistent, predictable, and highly repetitive interactions. Such is the number of necessary interactions needed to be successful in reorganising destructive low brain memory templates that those provided by a therapist alone would not be sufficient. (Gaskill and Perry 2012). Research

in the literature review also posited that, where attachment issues are paramount, indirect work with parents or carers may be more efficient than direct work with children in early treatment. It was further suggested that the role of professionals could impinge on the achievement of secure attachments between child and family (Byng-Hall 1991; Hart and Thomas 2000; Marvin *et al.,* 2002)

The neglected child's lack of a healthy attachment figure, and therefore the lack of opportunity to develop a trusting relationship or the ability to trust others, exacerbates the child's anxiety of strangers and resistance to a traditional therapeutic relationship. The opportunity then for consistent and repetitive interactions becomes a significant domain of appropriately trained foster carers. In that sense, this research supports other studies which propose the view that foster parents need to be not only sensitive but therapeutic as well (Chase *et al.,* 1998). Foster carers in this research showed the importance of their consistency and repetition, both as a single carer code and as a necessary attribute in almost all of the other eight carer codes/behaviours. This supporting evidence confirms literature, highlighting the need for high levels of repetition to enable developmental change.

The following two examples demonstrate both the explicit and implicit nature of high levels of repetition:

> (After some years in her sibling group) *Holly had the role of mum to make sure Rose and William got something to eat. We repeatedly stepped in…to say "you haven't got to worry, that's not your job, that's ours". (That) she hasn't got to look out for them all the time as a mum when she is a child. She is able to do that now* (from excerpt 114).

> *Consistency… don't mean 7pm bedtime every night, but consistent messages, the consistent "you are part of the family, this is your home, these are your toys, you can play with them when you want to play with them* (from excerpt 17).

2. *Inclusion in the family – belonging* (61 instances in data). After experiencing and internalising the messages of significant losses, which may include the loss of emotional, physical, and psychological safety from primary carer, the resulting challenging behaviours, which may not be understood by foster carers, can lead to multiple placement breakdowns; further reinforcing the child's feelings of being unwanted or unworthy. Foster carers in this research highlighted the importance of belonging for the children in their care and described a number of ways that they promoted this feeling of belonging or connectedness.

For example:

> *We've got a little name for her 'Holls' and she loves that…it makes her feel important and part of the family* (from excerpt 133).

> *I wouldn't use respite (placement). If I wanted a break myself, they would stay in the family home with my (adult) son or daughter or Tim's mum would come here and stay in their home…(it) would be more acceptable to the children if they are still in their (own) home* (from excerpt 51).

3. *It is about trust* (57 instances in data). Infants' brains are neurologically connected/prepared prior to their birth to seek proximity to a primary attachment figure; this is an evolutionary process to enable survival. Ideally this attachment seeking is responded to positively by an attachment figure and through this reciprocal dyadic relationship, in which the child's emotional and behavioural needs are met consistently, the child develops, amongst other things, trust and the ability to trust. When this early relationship is one of ignorant or inconsistent care-giving, neglect, or other forms of abuse, trust and the ability to trust does not develop and can lead to a variety of associated developmental difficulties, which may be the most far reaching and difficult to overcome. These difficulties can render the child less able to intellectually, verbally, or emotionally respond to normal or traumatic experiences (Rutter 1999; De Bellis 2005; Gilberts 2009;

Gaskill and Perry 2012; Perry 2012; HM Government 2015). Data from foster carers in this research suggests it is possible to offset and ameliorate early messages of emotional and behavioural trauma. This can be done by providing the consistent and repetitive affirming messages for the child to begin believing in them and developing a level of trust.

This is illustrated by the following examples:

> *The boys have constantly asked you the same question over and over again…because they don't believe it's happening or they are not going to get it…Joe says can I have hot chocolate and he will go on and on until the chocolate is in front of him and he will do this with everything. This suddenly stopped* (from excerpt 34).

> *When he first came to placement he struggled with women. He has learned over time that it's safe to be alone with Susan, Courtenay and Rose (females at foster placement). He is doing well with female teachers and my two (adult) daughters, which wasn't the way before* (from excerpt 8).

4. *Modelling 'good enough' parenting behaviours* (47 instances in data). The literature emphasised neurological development as profoundly guided and organised by experience and just as the use-dependent process can create positive learning and memory so can abuse and neglectful experiences create negative learning and memories. The early repetitive experiences in early childhood imprint the experienced reality and form an internal working model or type of blueprint from which later experiences are measured. For example, if early experience is of alcohol or drug dependent and/or disinhibited or dysregulated parents whose own needs are put first, or of men as scary or violent and women as vulnerable and unable to provide safety, this is likely to be the internalised expectation and belief system for all men and women, with consequent emotional and physical reactions. For such belief systems to change, there will need to be considerable repetitive experiences that challenge what is already embedded. The following are examples from data of how the foster carer's parenting gave the children in their care a

very different experience of self and other and how over time this impacted on the children's presenting behaviours and their view of the world.

> (At 4 years) *..he doesn't talk so he will act things out and point to tell you what it was he wanted whilst stamping his feet because it took a while to cotton on to what it was he wanted. So when he did that, I would always give him the words such as "oh you want a drink. I'll get a cup and get some water"….he would never say things…. Like if he was cold he would just go and bury himself under the blanket and for a while I thought he was just hiding and then it suddenly hit me, maybe he's cold. I got him to the point where I could say "well let me just touch your hand and see if you are cold", that was such an issue, touch was such an issue. The first time I did it (touch) without his hands going into little claws I thought it was a major breakthrough. I could touch his hand and then I could say "I'll get you a jumper to make you warm", that sort of stuff* (from excerpt 65).

The carer in this excerpt notices that the child has a need. She works out what that need is in that moment and meets it with patience, kindness, and sensitivity; providing him with consistent, affirming messages, which include that he doesn't have to be fearful anymore.

> *She wet herself at school yesterday because someone was in the toilet and because she was having fun at the school club. She came home with no tights on, she didn't care because she knew what our reaction was going to be. I said "you have no tights on darling" and she said "I wet myself" really loud. I said "that's OK I just wondered where your tights were". It was very like, its not a problem, you're not going to get shouted at, it's not an issue because people do wet themselves and she doesn't need to be ashamed of herself. It was lovely (for her)to be…,not proud of it, but not ashamed of it* (from excerpt 17).

The carer in this example demonstrates kindness and concern and recognises the importance of a non-shaming approach. The child's response suggests clearly that this was not a one-off response and that she was comfortable and confident of receiving a good enough and positive parenting message.

**Entangled Parenting Codes**

The child that has experienced chronic neglect arrives at the foster placement with an internalised belief system about self and other, that makes the development of a trusting

relationship between carer and child problematic. The carer codes identified by these interviews as important in promoting positive development, appeared significant, each in their own way, in helping establish a level of trust.

The process of developing a relationship with a child who has already internalised messages not to trust, who believes he/she is worthless and unlovable, who is fearful/anxious of emotional closeness, who has limited resilience to stressors and who struggles with emotional or behavioural regulation, can be slow due to the nature of change necessary. Foster carers that understand the impact of trauma, and how the child may be thinking and feeling about them, recognise that, in the beginning, relationship development is likely to be one of them providing the necessary messages in which the child feels safe and secure and the carers expecting little in return.

Upon analysis and reflection, it became clear that the first four codes -consistency and repetition, it is about trust, inclusion in the family, and modelling 'good enough' parent- are primary, but all nine codes necessarily interrelate and support relational development. For example, for change in the brain to occur, 'consistency and repetition' is necessary in every instance. Once neural pathways are established and myelinate over time, belief systems begin to develop but continue to need consistency and repetition of these new ideas. This approach to parenting then reinforces these new belief systems as well. Because of this entanglement, the remaining codes are discussed in the next paragraphs, drawing on why these codes are each important individually, even though they are also co-dependent on the codes previously discussed.

Entangled is a good description of how the codes intermesh or interplay with one another (together). Excerpts show again and again how foster carers used codes together, without conscious thought of their multiple use. Kindness and valuing, guiding, affirming

and supporting, showing and telling. Carers showed how much the children belong to the family, how proud they were of any of the children's achievements, of the children simply trying, whether a success or not.

The following entangled codes demonstrate, each in their own way, the kind of parent these children should have had; the kind of parent they deserve. Giving the child a sense or view of a parent that simply cares about them because they exist and are of importance.

5. *Showing child they are valued and important* (46 instances in data).

6. *Honest caring for child as an individual* (46 instances in data).

7. *Maintaining hope* (41 instances in data).

8. *Showing kindness* (36 instances in data).

9. *A relationship that matters* (33 instances in data).

Emotional neglect affects key developmental functions, including perception of self, which should be acquired through the mirror of 'good enough' parenting. Emotional neglect distorts children's perceptions of relationships and has implications for everything that should be learned through and modelled by others. Taken as a whole, rather than separately, as discussed in the findings chapter, the reader can see the power of this entanglement in the following excerpts. The author asks the reader to remember that excerpts may appear less than extraordinary when viewed through the lens of traditional parenting. This highlights, in many ways, the skills and understanding of the foster carers who work with such traumatised and complex children.

> (Foster child 4 - After a moment of terror and flight triggered by the need to touched while having a nappy changed) -*I moved a bit closer and finally he went back into his bedroom and went under his bed because that's his safe place. When he goes under his bed, we usually let him stay there. So I left him for about 5 minutes and then I went back into the room as if nothing had happened and I said*

> *"come on poppet we'll change your nappy, make you comfy and go and have breakfast". He came out from under the bed, onto the towel, I changed the nappy. It was that moment of letting him know that there is nothing to be scared of, before he clicks back into the fear. You can't do anything (then) and if you try it escalates, so you have to back off and give him time. I'm sure that's what happens, that somewhere in his mind he thinks "it's ok these people don't hurt me, they don't yell at me so it's ok"* (from excerpt 107).

The multiple parenting codes associated with this excerpt (it is about trust, showing child they are valued/important, showing kindness, a relationship that matters, modelling 'good enough' parenting, maintaining hope, honest caring for child as individual ) point to the range of awareness and sensitivity needed in order to help address the significant emotional and physical harm the child had experienced before being placed in foster carer.

> (A high point or best time is). *Those little bits of confidence he has (developed), like when Peter is doing work in the lounge and he (child) would have been in there, then he will come into the kitchen. He just trots into the kitchen and says, "cooking cake, bake a cake Jenny" and I will say "yes, are you going to help", because he likes to mix my stuff and you can sit there with him. He brings his big stool over so he can sit up there and I will give him the cup of sugar and say "pour a bit in", it's just that, it's not exciting, it's not interesting, it's just being there with him and being part of your life* (from excerpt 122).

Multiple carer codes: showing child valued/important, showing kindness, inclusion in family, modelling 'good enough' parent, a relationship that matters, maintaining hope.

> (Referring to a child who could not be touched prior to living in this carer's household). *We have always allowed close proximity because you get a lot of information about the difficulty the child is having with proximity and with showing affection. When he came and sat next to us on the settee, we put our arm around him; we ruffled his hair. If he gave us a kiss, we gave him a kiss back. We decided this is what he needed* (from excerpt 60).

Multiple carer codes: showing child valued/important, showing kindness, modelling 'good enough' parent, consistency and repetition, a relationship that matters, honest caring for child as individual.

We can see from these examples how codes 5 – 9 begin to gently but repetitively challenge the early negative messages received by the child. These frequently used codes

identified by the carers are a collection of messages that intentionally use both 'showing and telling' to try and convey a sense of belonging, safety and importance to the child.

Other qualities also surfaced during this research, which are not directly linked to taught carer behaviours. It appeared that some carers found this parenting approach easier to put into practice than others. Carers who present with qualities such as patience, calmness, and a regulated manner appear more tolerant of and resilient to the many challenges of caring for children that have experienced early trauma and neglect. This insight should be helpful when making initial visits to people that show interest in foster caring as a career, and could form a part of the structure of foster carer assessments. This may reduce the pain of disappointment, failure, and guilt felt by some foster carers upon realising they cannot carry on with a foster placement, and the loss and rejection felt by children when another placement disrupts and they have to move on again with all the associated issues involved.

Finally, the frequency of carer codes cannot be stressed enough and seemed essential for change to occur. There is a need for multiple messages given time and again, and repeated over long periods. At the end, the evidence is clear that this multiplicity of entangled messages creates an environment where children can learn to trust; ultimately an environment from which they demonstrate cognitive, affective, and behavioural growth.

**Reflections and Recommendations**

There are several reflections that develop out of this study. First, this isn't for every foster carer, as not all are able to provide the level of nurture which the coded evidence demonstrated as required. Hence the recommendation for increased insightful assessment and recruitment of individuals before they are matched with these children.

Second, further research is required as the sample for this study was only fourteen sets of foster carers, supplied by convenience sampling, and known to the interviewer who was new to the interview skills required for scientific study. Reflection suggests that at times the inability to step back from the therapist's role may have gotten in the way of the carers telling their stories. While codes relating to instances where the researcher could have been perceived as leading were deleted from the sample, clearer definition of the role of researcher would have been helpful during the interview. These reflections lead to the recommendation that perhaps an interviewer/researcher who is not known to the subjects, and who is not a therapist would uncover different, perhaps greater insights.

The third reflection is that the role of critical friend ameliorated the potential for bias, and this leads to the recommendation that all subsequent research into these questions maintain this role. The outstanding qualities brought to this research were: clarity, greater detail and understanding of the data, unbiased perspective, and the balance offered by non-therapeutic contextual / pragmatic view. In short, the critical friend offered a pragmatic dialogue focused on data outcomes and it is recommended that any who follow on this path include this type of help.

**Conclusion**

All but one set of the foster carers that took part in this research project had received the same training, and foster placements were supported by supervising social workers who had also received the same training. The continuum of outcomes became apparent in this study and so forms the basis for final conclusions in the following conclusions:

1. It appeared from the data that not all carers in this study had the same level of insight, sensitivity, or therapeutic understanding when providing for the

developmental needs of children with complex attachment problems. What the data demonstrated was that all were able to provide a caring environment in which the child could experience protection, safety, and security. These messages provided the child with the kind of adult care and consideration they had not previously experienced and, because of these experiences, offered an opportunity for change in terms of perception of self and other.

2. The project data reinforced the literature that suggests that children exposed to chronic neglect in the early years require high levels of consistent, predictable, patterned, and highly repetitive interactions to address the harm caused. It is clear in this project that the carers who were able to understand how chronic neglect could present in children were also those able to consciously provide the highest level of necessary, simple, consistent messages and repetitive interactions. In other words, the greater training/experience appeared to correlate with more evidence they impacted the child's ability to feel happy and safe, cope with stressors and/emotionally regulate, make friends, be more honest, sit exams, etc. These data show that some of the carers in this study use entangled behaviours (as demonstrated in multiple coding) without conscious thought; suggesting they may have internalised this understanding of early trauma. Even if some entangled behaviours developed as implicit response, it can be taught to others and should have positive effect.

This leads to three final conclusions as to the importance of this work and suggestions for foster care placement, and therapeutic support for children who have

suffered early trauma. First, these data suggest strongly that foster carers can provide the foundation upon which therapy can happen, and that this would be the necessary order: therapeutic foster care first; leading the way to traditional therapies when the child is ready. Second, therapeutic foster care required support. And finally, I conjecture that, if done properly, offering this type of training and service may allow for easier recruitment of carers for these children. The following will look into each of these ideas in more depth.

Foster caring provides an opportunity for frequent relational contact with the child, during periods of strength and vulnerability (in sickness and in health). It is the trained and supported foster carer that can provide the environment within which the child can begin to attach and develop trust. From this position of trust, the child can then begin to take the risk of showing vulnerability, can begin to learn to cope with the feeling of not being in control and of being emotionally exposed. This sets the stage for later therapy, potentially making it more effective as well, since the child will be in the correct developmental space to trust and interact with the therapist.

The first port of call, therefore, should not be direct-therapy but rather therapeutic caring. The focus of the foster carer should be on understanding and changing through the provision of experiences, the child's thoughts, feelings and perceptions of self and other, rather than simply focussing on their presenting behaviours. Given the complexity of these changes, this is not a short term fix and needs to be gauged at the child's emotional pace.

As the role of the foster carer is so important and so emotionally demanding, this project provides data that emphasises the need for regular and consistent support throughout the life of the placement to avoid disruption. This support could be provided by the social workers who already meet regularly with the foster carers, but who need to be appropriately trained and supervised by a lead therapist working from an

attachment/trauma-based approach. Frequency of visits should be a minimum of two to three weekly, dependent upon placement stability.

This level of high quality support has the potential to encourage recruitment and retention of foster carers, providing consistency within the agency and, most importantly, placement stability for the children, which is essential for their on-going development. Work has been done to establish comprehensive, multi-level, training and therapeutic support package suitable for adoption by independent fostering agencies (IFAs) and /or local authorities.

Of course, consideration needs to be given to the support system within the agency into which these carers will be placed before future research can move these ideas forward. Training Appendix B. discusses a case study supported by this new structure.

**Final Reflections**

Conducting this doctoral research and developing the therapeutic support package has been an emotional and intellectual journey. For instance, it took me a while to appreciate the philosophy that underpins my choice of research methodology. Initially I believed that my stance was a social constructionist one, but later I realised that this did not fit particularly well alongside the positivist realist orientation of the neuroscience research that informed the content of my training. Discussion at the Viva led to a realisation that my positioning might more accurately be described as critical realist. This reflects a conviction that there is an objective truth concerning complex attachment histories, but in the context of fostering access to this reality is mediated through the subjective interpretations of carers, social workers, therapists and, crucially, the researcher.

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## Appendix A: Foster Carer Participation Data

Figures below display several types of data denoting the range of carer experience for the foster carers involved in this appreciative inquiry. As the reader will see, foster carer experience with attachment training and prior experience ranged from very little previous experience or training to several members whose experience was more robust.

Figure A1: Types of Training Attended

| Name | Attended 3-day training Yes/No | Date attended Training - Month/Year | Attended PDG Yes/No | Date attended PDG - Month/Year | Direct sessions carer/psychotherapist | Fostering experience as at 2016 | Regular SSW support (fortnighly) by trained and supported SW's |
|---|---|---|---|---|---|---|---|
| C1 | Yes | 10/13 | No | | | 10 | Yes |
| C2 | Yes | 7/12 | Yes | 6/12 | | 15 | Yes |
| C3 | Yes | 10/13 | No | | | 3 | Yes |
| C4 | Yes | 7/12 | Yes | 3/12 | | 7 | Yes |
| C5 | Yes | 10/13 | Yes | | | 7 | Yes |
| C6 | Yes | 10/13 | Yes | 11/13 | | 11 | Yes |
| C7 | Yes | 5/14 | No | | Ongoing regular support | 7 | Yes |
| C8 | Yes | 10/13 | No | | | 4 | Yes |
| C9 | Yes | 10/13 | No | | | 12 | Yes |
| C10 | No | | No | | Ongoing regular support | 4 | Yes |
| C11 | Yes | 7/12 | No | | | 6 | Yes |
| C12 | Yes | 7/12 | Yes | 5/13 | | 5 | Yes |
| C13 | Yes | 10/13 | No | | | 3 | Yes |
| C14 | Yes | 10/13 | No | | | 4 | Yes |

Figure A2: Number of Participants Attending Each Type of Training

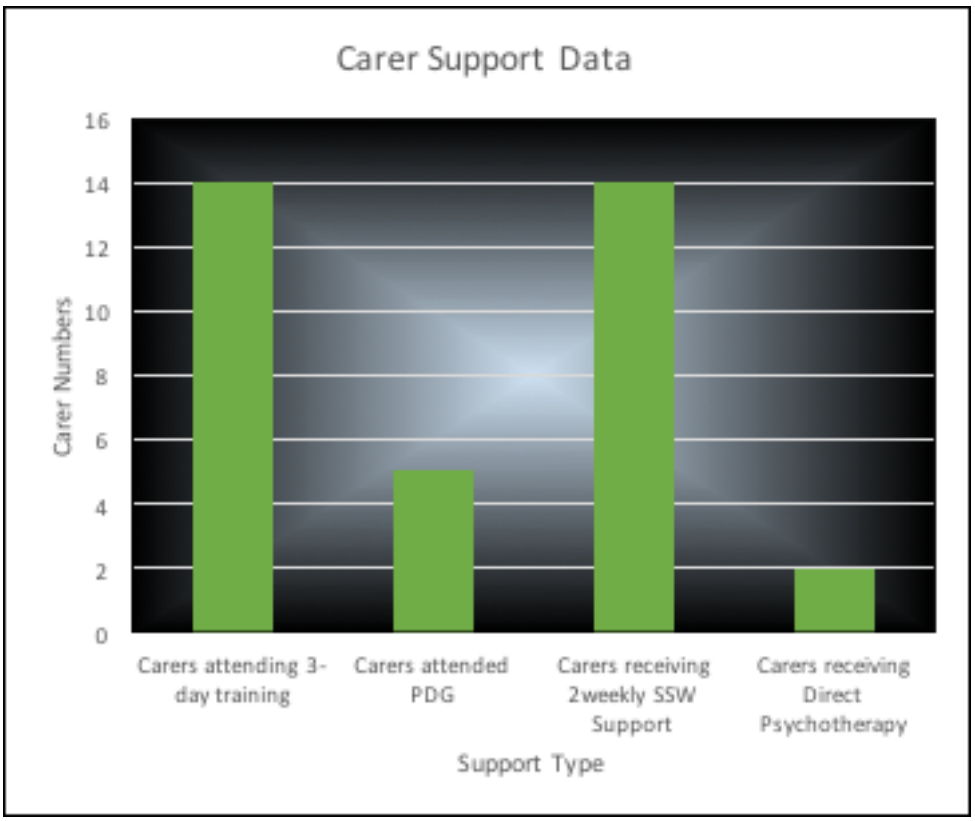
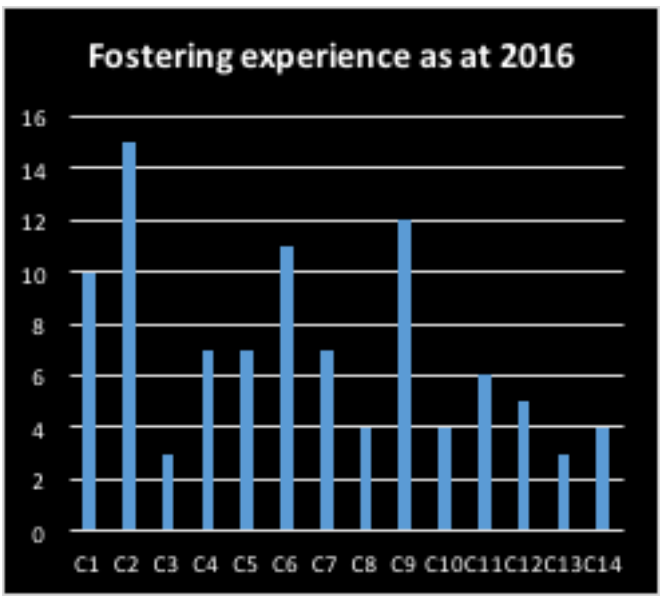



Figure A3: Participant Experience



## Appendix B: Training Package

What follows is a comprehensive outline for a complete agency training and support package, based on the literature and the research outcomes previously discussed. Included here are: a discussion of the codes that developed from the research as they are applied during this training, the training objectives, outline for discussions, after-supports, frequently asked questions and two examples in the training appendices.

As mentioned during the discussion of the analysis of the carer interviews, fourteen codes emerged for consideration at the final, training development phase of this research.

**Fourteen Themes Threaded Throughout Training**

1. Carer developing confidence with knowledge
2. Importance of language, words, and delivery
3. Showing the child they are equally important as the carers birth children
4. Explicit and repetitive caring behaviours and attitudes
5. Non-shaming at all times
6. Knowing your buttons so they don't get pressed
7. Diversion tactics and other coping mechanisms
8. Complimenting and affirming the child
9. Minimising choices to child to avoid fear of failure
10. Developing resilience and regulation to stressors
11. Recognising presenting anger could be terror or fear
12. How to respond to child testing boundaries
13. The importance of repetitive low level affirmations

14. Showing affection and the importance of touch as a positive message and means of affect regulation

From the chart in Figure B1 below, we see that explicit caring co-occurred most often with other codes, especially those focused on other, discussions of the ways and means these children need or will accept caring.

Figure B1: Training Code Co-Occurrence Chart

Code Co-Occurrence

| Codes | T1 - carer developing confidence | T2 - Importance of language, | T3 - showing the child they are | T4 - Explicit & repetitive caring | T5: Nonshaming at all times | T6: Knowing your buttons so they | T7: Diversion tactics and other | T8: Complimenting and affirming | T9: Minimising choices to child to | T10: Developing resilience & | T11: Recognising presenting anger | T12: How to respond to child | T13: The importance of repetitive | T14: Showing affection and the | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| T1 - carer developing confidence | | | | 1 | | | 2 | | | | | | | | 3 |
| T2 - Importance of language, | | | | 5 | | | | | | | | | 2 | | 7 |
| T3 - showing the child they are | | | | | | | | | | | | | | 1 | 1 |
| T4 - Explicit & repetitive caring | 1 | 5 | | | 1 | | 3 | 1 | 2 | 1 | | | 3 | 3 | 20 |
| T5: Nonshaming at all times | | | | 1 | | | | 1 | | | | | | | 2 |
| T6: Knowing your buttons so they | | | | | | | | | | | | | | | |
| T7: Diversion tactics and other | 2 | | | 3 | | | | | 1 | | 1 | | | 1 | 8 |
| T8: Complimenting and affirming | | | | 1 | 1 | | | | | | | | | | 2 |
| T9: Minimising choices to child to | | | | 2 | | | 1 | | | | | | | | 3 |
| T10: Developing resilience & | | | | 1 | | | | | | | | | | 1 | 2 |
| T11: Recognising presenting anger | | | | | | | 1 | | | | | | | | 1 |
| T12: How to respond to child | | | | | | | | | | | | | | | |
| T13: The importance of repetitive | | 2 | | 3 | | | | | | | | | | | 5 |
| T14: Showing affection and the | | | 1 | 3 | | | 1 | | | 1 | | | | | 6 |
| Totals | 3 | 7 | 1 | 20 | 2 | | 8 | 2 | 3 | 2 | 1 | | 5 | 6 | |

Each time one or more of these concepts appears in the discussion of the therapeutic support system that follows, it will be followed with [#] as an aid for the reader to see the many ways the concepts that developed through this research are interwoven through the training. This will help to highlight the way in which the

training stresses, not only the findings but also the importance of small, regular carer behaviours and how they entangle to create positive neurological and biological outcomes over time.

**Background – The Training and Support Package for the Agency**

Growing numbers of children in the UK enter the care system with significant emotional and behavioural problems and as a result, foster carers are looking after children who present with more complex difficulties and needs. Foster carers frequently report receiving insufficient or inadequate support for the challenging behaviours of the children they look after (Octoman and Mclean 2014). Challenging child behaviours and carers' lack of understanding and skill in dealing with them are the two most common reasons for placement breakdown (Hutchings and Bywater 2013). A crucial aspect of maintaining a successful and thriving placement is that carers have developed the metacognitive skills for thinking [1] about the foster child's mind (Ironside 2012). To provide placements with the best chances of thriving foster, carers need relevant and accessibly training and regular and consistent support.

The chronic nature of some children's difficulties means that the children need a 'whole system' approach (Hill-Tout *et al* 2001, p. 47). Placement stability allows the opportunity for relationship development and the potential for a healthy attachment between carer and child. The aim of the whole team approach is to equip everyone involved in supporting the foster placement with consistent, relevant and effective knowledge, and importantly the ability and confidence to deliver what is needed [1] by the child at the level at which the child can cope at that time.

Being a foster parent for children who have experienced early neglect /abuse is a complex and demanding task on many levels (Ironside 2012). This trauma-informed

approach recognises and understands the complexity of the fostering task, particularly with children who have suffered early chronic neglect and who consequently develop adaptive/survival responses that are seriously challenging to more traditional parenting styles. This approach explains that the child's way of responding has developed as a way of coping with and surviving traumatic early experiences [4]. Understanding is not enough and does not take away the difficulty of parenting appropriately on an hour-by-hour day-to-day basis. What helps is regular support from a trained and trauma-informed supervising social worker, who is skilled and able to assist the carer to reflect on and reframe the challenges in context and from an attachment-based perspective. This acts as a reminder to the carer of the importance of their therapeutic role and the consistent, predictable, patterned, and highly repetitive interactions/messages [13] needed by the child to address the neurological insults of early trauma (Gaskill and Perry 2012); insults which have impacted on the child's perception of self and other, leaving them vigilant, fearful, and easily dysregulated.

Providing for placements with such complex needs requires regular and consistent support that will not hinder the child's need to attach to their primary carer. Such support is aimed at the primary carer and guided by a lead therapist who will offer regular support to the field to avoid any miscommunication. It is important from the offset that all receive the same training; however, this should be delivered to social worker and foster carer groups separately and at a level that is useful, relevant, and appropriate to both sets of participants.

The training introduces a practical and theoretical understanding of attachment theory and connected neurobiological research. It is practice-focused and uses examples from participants to bring to life the impact of trauma on the development of several

areas of the brain, including attachment system, self- concept, emotional and behavioural regulation, and cognitive development. Strategies and responses are discussed that are often counter-intuitive but are trauma and developmentally aware, and will help the carer and child attune long enough for relationship development.

The training and support is underpinned by data evolving from this research project, which indicated nine codes identified by foster carers that correlated with six positive developmental outcomes in the children. These included cognitive, affective and behavioural changes, positive self-concept, sense of belonging, and development of trust.

**Training for Foster Carers and Social Work Professionals**

The training "Understanding attachment, regulation, and resilience" is delivered to social work professionals, foster carers, and others that offer support to the placements of looked after children. The content bridges attachment theory and neurobiological understandings with practical parenting strategies and responses that promote placement stability and relationship development.

Beginning with attachment and the social brain, participants learn how and why children attach and how the brain can be seen as social. The training clarifies that, along with secure attachment and the associated developmental stages, are three types of insecure attachment as follows:

i. *Avoidant*: these children do not look to caregivers for comfort and pay more attention to the environment than to people. They gradually become more hostile and distant with peers and teachers alike, socially isolated, less compliant with rules, and more expressive of negative emotions.

ii. *Anxious or Ambivalent*: these children alternate between seeking proximity and resisting contact. They have problems directing attention to the environment; anxiety and fear is prominent. As they grow older, the anxious child is likely to be clinging with adults, whiny, dependent and demanding, eager to please, intrusive on adult space, have excessive separation problems, feel easily rejected, and exhibit immature behaviours when craving love or affection.

iii. *Disorganised*: these children show elements of both avoidant and ambivalent kinds of attachment behaviour. They appear to lack a defensive strategy to protect them against feelings of anxiety. They can on occasions make mechanical contact, but with little feeling or emotion. The child's early traumatic experiences of being parented lead to the perception of caregivers as either frightening or frightened and, therefore, not available as a source of comfort or safety, which compounds the child's anxiety and leaves them with an irresolvable conflict of the attachment figure, also being the cause of the anxiety (Main and Solomon 1990).

Understanding that children can develop different insecure attachment styles as a direct response to parenting that did not meet their emotional and behavioural needs, allows foster carers and their support networks to respond consistently and repetitively in ways that provide positive messages of security and affirmation to the child [2,4,8,13].

A healthy attachment relationship assists the stressed child in returning to calm (homeostasis) when situations are beyond the child's developmental ability to cope; such as being fearful, hungry, tired, frustrated or disappointed for some reason. The

development of the child's ability to self-regulate grows over time through consistent, supportive, and nurturing responses from a primary carer [2,4,10,13,14].

The training content considers specifically the development of resilience in carers and children. What this means is helping carers develop resilience to the rejection that the children can sometimes present and help develop resilience and tolerance to stressors in the children [10]. These could be things that may not seem at all stressful to other adults or healthily attached children.

On completion of this training, participants will have become aware of the impact of early primary care on brain development. They will have understood reasons for behaviours associated with complex attachment problems, such as chronic neglect, and become aware of specific strategies and responses for intervention and change [4,7,11].

As part of the research, presented earlier, into best times or high points in foster carers experiences of caring for children with complex needs, nine parenting codes emerged from their accounts. As they correlated with six positive cognitive, affective, and behavioural changes in the foster children, these nine parenting codes are now a significant part of the training. In other words, the outcomes of the training from the carers' point of view, expanded by interjecting research and neurological understandings, make up the 14 themes discussed here, in the slides and case study. See Appendix A for greater explanation of these relationships.

**Objectives for the Training**

The following objectives are based on Bloom's taxonomy of learning (Bloom *et al.,*1956), which emphasises three domains: cognitive, psychomotor, and affective. Each domain is broken down into sub levels; some of which become important here in

that (as an example) foster carers cognitive retention needs to be carefully scaffolded for the training to "stick." The sub-domains for cognitive knowledge retention are: recall, comprehension, application, synthesis, and evaluation. The sub-domains for practice oriented (psychomotor) skills are: awareness, knowing first what then how, showing how, doing, and mastery.

**Objective 1: Placement stability**. Because this objective is the focus for the agency and everyone who works there, it has been broken down into the level of detail specified above.

***Theme: Carer developing confidence with knowledge.***

Children who have been neglected and maltreated can still suffer feelings of separation and loss, and these feelings are compounded when they experience multiple placement moves (Schofield and Beek 2005). Placement instability reduces the child's opportunities to develop secure attachments and may in fact exacerbate emotional and behavioural difficulties, which in turn make it more difficult for the children to establish relationships with carers and the important goal of a stable placement.

***Cognitive development required.***

1. *Recall*: It is the learning around the impact of neglect and trauma on brain development and how early chronic neglect from birth can seriously impair healthy neural connections and cause maladaptive development in several regions of the brain, including attachment, emotional regulation, behavioural regulation, and self-concept. Carers will recall that maladaptive development impacts on how the children experience the world and consequently how they think, feel, and behave. Carers will recall that behaviours are frequently the

presentation of thoughts and feelings which may be completely inappropriate, but are the child's reaction to their perception of the situation [1,11].

2. *Comprehend*: It implies that messages are both verbal and nonverbal and that the children can be hyper vigilant and hyper sensitive to messages, and that even intentionally positive messages can be received by the child with a negative slant. Carers will understand that the child is anxious/fearful much of the time and that this can present as wanting 'to do' something or keep busy all of the time, wanting to be engaged in activities rather than 'just be'. This anxiety/fear can also impact on the child's ability to be still and concentrate and/or process information; making education problematic. Carers will understand that chronic neglect /trauma that impacts on the child's perception of self and others, and those early negative experiences, will have been internalised as normal making; being cared for with kindness and safe boundaries odd, scary, and something to challenge [11,12]. Carers will comprehend that, although attachment to a safe carer is good for the child, messages from chronic neglect will have left the child untrusting, fearful of closeness and vulnerability, and resistant to genuinely attach. Carers will understand that the child's inability to trust and need to be in control are survival responses developed because of their early parenting experiences, which consistently failed to meet their attachment seeking behaviours that, if met, would have embedded messages of emotional or behavioural security. Carers will understand the importance of a healthy attachment and that the critical period in which this is usually triggered have not been met. Carers will be able to comprehend, associate, and interpret the child's fear of relationship development, the need to be in control, and fear

of vulnerability, with early rejection and living in a state of high arousal/fear and insecurity [1,11].

3. *Apply*: Carers' understanding of the flawed early experiences, which impacted on the child's development and structuring of their internal working model, illustrates the importance of applying a parenting style that is not simply good enough but positively nurturing [4] at the emotional rather than the chronological age of the child. Carers will be able to demonstrate parenting that is underpinned by kindness, calm, clarity, consistency, and tolerance [2,13] and, because they understand that these actions may be novel, alien, and even scary to the child, the carers will deliver them at a level from which the child can cope. Carers will model positive, caring language and actions with the child and others [1,4] that will illustrate a healthy norm. They will understand that by using caring and affirming words and actions sensitively [1,2,4] the child will develop a tolerance to the words and eventually a belief in the meaning/feeling behind the words. Carers will understand that by applying the approach consistently and repetitively [4] the experiences will form new and healthier connections and internal working models from which the child will view and measure the world.
4. *Synthesise*: Over time, carers will combine knowledge from training and integrate the theoretical understandings from research [1] that underpin the practical strategies and multiple carer codes explained in the training. Carers will gradually assimilate and modify their parenting approach, language, and responses into a parenting style that becomes their own [2].

5. *Evaluate*: Rather than simply identifying that the placement seems more stable, carers will be able to appraise positive outcomes in the placement by understanding what it is they are looking to evaluate in terms of developmental changes [1]. These outcomes will able to be assessed in terms of both emotional and behavioural change and can be seen as soft and hard outcomes. For example, carers can be noting that the children are happier, smile and laugh more, look and show less anxious, make and retain friendships, calling carers 'mom and dad', seeking closeness, support or protection when fearful, less busy/more relaxed, and coping better with disappointments, stressors or high arousal situations. Carers will be aware that the experiences of chronic early neglect become embedded as internal working models -a biological process stimulated by experiences; therefore, change will not be a quick fix or respond to simple behavioural conditioning of consequence or rewards.

***The psychomotor skills required.***

Placement stability offers the opportunity of relationship development between carer and child, and it is through this consistent and repetitive primary carer relationship that a healthy attachment can be promoted [4,13]. Carers will understand that attachment is a crucial developmental process by which the child seeks closeness to a primary carer for survival, and this attachment seeking drive for proximity is biologically wired into the infants' brain prior to birth. The activation of attachment behaviours depends on the infants' evaluation of a range of environmental signals which results in the subjective experience of security or insecurity. The experience of

security is the goal of the attachment system, which at this early stage is crucially a regulator of emotional experience (Fonagy 1999; Sroufe,1996).

Codes identified during research demonstrate that to achieve placement stability the following levels of practise development need to be demonstrated.

1. *Awareness*: Carers will have a clear understanding of the importance of relationships in attachment theory and how it is supported by a considerable neurobiology / neuroscience evidence base [1]. Carers will be aware of the significance of early parenting to the structuring of the brain and, consequently, to how the child perceives self and other and interacts with the world/environment. Carers will be able to connect attachment and neurobiology research with the complex tasks and knowledge required by them as foster carers [1,4]. Carers will be aware that the consistent, repetitive, and affirming messages the child now receives can form new connections, impacting positively on early negative experiences [4,13].
2. *Knows what*: Carers will be able to identify outcome measures from a healthy attachment. They will know what it looks like in terms of responses and behaviours from the child. For example, the child with a healthy attachment will, age appropriately, be able to seek support or reassurance when worried or anxious, will be able to cope with stressors such as disappointment, anxiety, tiredness, anger, and excitement, will be able to cope with failure and sanctions, will show empathy, remorse and conscience, and will be able to interact socially. Carers will also be able to identify and describe children with complex attachment problems. Carers will know that child development is experience-dependent and that for the foster child this will have been significantly with a

birth parent, and that much future development will depend on their responses as primary caregivers to the emotional and behavioural needs of the child [2,4,11,14].

3. *Knows how*: It refers to the knowledge carers needs to promote healthy attachment – what to do [1 to 14] and what not to do, such as be rejecting, cause shame, anxiety or emotional/ physical fear [5].
4. *Knows causes*: Carers will know that chronic neglect can be causal in the development of complex attachment problems, and that chronic neglect is the lack of a primary attachment figure that consistently and repetitive responds to the emotional and behavioural needs of the child. Carers will know how to respond to offset the messages of these early developmental insults, and provide new messages which stimulate the kind of nurturing relationship important for positive emotional and behavioural development. Equally important, the carer will know what not to do in order to avoid reinforcing the early messages of insecurity and worthlessness. Carers will look for opportunities to provide messages that the child is safe, cared about and of importance to them. [3,4,8,13,14]. Carers will understand that the child is unlikely to trust the positive messages because of the early negative messages delivered by the primary attachment figure that have become part of the child's internal working model and believed as real and normal. Carers, therefore, will know that the messages will have to be delivered consistently and repetitively through multiple codes [4,13] identified by foster carers during the research. The codes "It is about trust, showing child they are valued/important, honest caring for child as individual, showing kindness, consistency and repetition, inclusion in

the family, a relationship that matters, modelling 'good enough' parent, and maintaining hope" will have to be delivered by carers as part of a parenting style rather than an 'add-on' to a different parenting style. This way the carers will be consistent and the child will not be able to find a flaw in the affirmations or feel they are being made up rather than being real or genuinely meant.

5. *Availability for support*: Carers will understand that, although the child will at times need proximity and support, they may not be able to seek it for fear of being rejected, shamed, or made to feel vulnerable; all feelings they have already experienced at verbal and preverbal levels. Carers will know that they have to make themselves available to offer non-shaming support and deliver the caring at the level the child can cope with at that time [5,13].
6. *Shows how to promote attachment*: Carers will understand that children that have not formed a healthy attachment with their primary attachment figure or anyone else before coming into foster care, are likely to have developed maladaptive responses to traditional kindness or caring. Carers will show what good and nurturing relationships are by sensitively and repetitively model caring and kindness, safety and security with the child and with others for the child to observe [2,8,13,14]. Carers will look for the opportunity to show and tell the child that they are valued and important [2] and are included as a member of the family, promoting a positive sense of self and belonging. Carers will look for opportunities to respond to any attachment seeking behaviours, even if the behaviours are miscued [4]. For example, the child might struggle to say sorry to carer because of fear it might be rejected and not wishing to feel vulnerable, and instead the child may exhibit clinging behaviours such as

offering to help wash up with the carer directly after being unkind. Carers will recognise and accommodate this action as a wish to say sorry and, in doing so, allows the child to reconnect and feel safe and valued again. Showing the child acceptance when they have been unkind will promote a sense of safety and hope for the future because the carer shows she can cope with undesirable behaviours and rejections without responding with rejection or ending the placement [6,7,10]. The carer shows through consistent and repetitive affirming messages that the child is wanted, cared about, and belongs. These highly repetitive messages/experiences [4] will over time create new positive neural pathways which myelinate (seal) and form positive internal working models of self. Some that challenge previously formed negative experiences of self; those in which the sense of rejection, insecurity, and worthlessness developed.

7. *Does*: Carers will have attachment understanding at the forefront of their mind, knowing what attachment is and does, and what is needed for looking after a child. They will consciously seek not to shame, reject, or promote experiences that might trigger fear of failure or put the child in situations of stressors that they cannot yet cope with or regulate [4,5,9]. Carers will understand why traditional 'consequences and reward' systems are not helpful or effective in changing unacceptable behaviours and will instead look for ways of developing a 'relationship that matters' to the child and, in this way, encourages the development of empathy and conscience from which the child will want to please and not disappoint. In promoting attachment and relationship development, carers will accommodate the child's emotional needs and their inability to age appropriately, regulate their emotions, and instead seek to

provide the secure-base opportunities that both helps the child regulate emotions and develop the child's own affect regulating system [7,10,14], which had been impaired by abuse and neglect. Carers will seek opportunities for proximity with the child at the level the child can cope with [14]; this will mean, for example, play activities, washing up together, reading together, homework etc. which will provide the child with repetitive experiences in which they feel happy, valued, and safe in a caring relationship. Carers will understand that by providing frequent repetitive and consistent experiences of kindness and valuing the child [2,3,8,13] can begin to develop a positive sense of self and trust in the carer, their attachment figure. The carer recognises that the consistent positive experiences can be simple and short in duration; this helps the child cope with feelings they may be resistant to, excepting for many reasons associated with early neglect. Therefore, the carer may simply offer a 'high five' and acknowledgement of 'hi buddy', simple touch on shoulder and a smile as carer walks past, noticing the child exists and is important, without expecting anything [8,10,14]. In promoting successful experiences which include close proximity and/or contact, the carer understands that each positive outcome plays a part in the context of wider developments of self and other. Being part of the experiences is important in that the carer will model, throughout the experience, positive examples of coping, with; for example, winning, losing, or disappointment which the child needs to be able to see with a 'good enough' carer who is able to regulate emotions and can help the child regulate during difficulties too [4,10,14]. Each time the carer and child successfully get through an experience that may involve conflict builds on their relationship strength and

the child's developing resilience to closeness and other potential stressors [4,10].

8. *Mastery*: It is shown by carers when they have understood and internalised what attachment is and does, what early neglect is and does to the developing child as well as what and how chronic neglect presents in a child [1]. Mastery can be recognised when carers can reflect and respond to situations such as 'button pressing' by the child rather than react. This suggests their ability to understand and sense the need of the child and respond in the best way possible at that time [4,6,7,10,11]. This may be allowing the child to have the last word because the carer can see the child is unable to cope and about to become unregulated and the carer understands that this will have no benefits and may in fact be counter-productive in developing a healthy relationship with the child. Mastery is knowing how to respond most of the time, being able to avoid unhelpful battles and yet remain healthily in control rather than overtly controlling [1,12]. The carer recognises that being in control is when they can step sideways and move backwards, and allow the child to feel a level of control because they need it at that moment, and yet the carer, by allowing it to happen, knows they are in control.

**Objective #2: Sustainable biological change**. Training will equip/provide carers with relevant knowledge from research and practice (new understandings) that explain why some children are brought into care for protection from emotional and physical abuse. They will learn that as a consequence of the abuse/neglect the children evolve thoughts, feelings, and behaviours about self and the world that make them different to children that have experienced good enough parenting. Carers will

understand that the child that has experienced chronic neglect has to develop a way of surviving and that these maladaptations make receiving traditional 'good enough' parenting difficult to believe and cope with.

The experiences / messages to the child mean the child typically develop feelings of anxiety and hyper-vigilance, a sense of insecurity and unworthiness, an inability to cope with stressors or regulate emotions, a need to be in control of everything, and an inability to trust or make and retain friendships. These complex issues make caring for the child a difficult task for most carers; this is evidenced by the amount of placement breakdowns experienced by children with chronic neglect, particularly as they enter primary school years onwards.

This training prepares carers with parenting skills and practical strategies that can help address the insults of early neglect and enable the child to remain in one placement long enough to develop a consistently safe, secure, and nurturing relationship. Within this relationship, the child can learn to trust and form a healthy attachment with its benefits for cognitive, affective, and behavioural development. Over long term application, new understandings develop in how the child thinks and feels about self and others; the consequence of which is the development of new inner working models. Through this primary carer relationship, the child's view of the world can change from feeling fearful and unlovable to confident and worthy of safety, security and love. Carers can assess development in terms of growing friendship groups, less unhealthy behaviours, better affect regulation -including a maturing ability to cope with embarrassment, loss, disappointments, and other stressors.

**Using the Codes Developed from Research in the Training**

By understanding and learning the importance of these codes, foster carers are more able to provide this often counter-intuitive parenting approach, grouping the codes together rather than individually, as tends to happen when the carers are learning the parenting style. For example, carers may demonstrate kindness and inclusion in the family, giving messages that promote a sense of belonging and evidence to the child that they are valued and important. This would also imply that the carer genuinely cares about the child, modelling the kind of parenting the child has not received before - good enough parenting.

**How the Training Package Works**

For this training to be most effective in terms of time, cost, and its ability to support placements, it needs to be consistently implemented throughout the agency or the local authority. In the population used in this research, directors, managers, independent reviewing officers, members of the agency's referral team, social workers, and foster carers; all took part in the same training. The rationale behind this was to avoid potential mixed messages or conflict in approach. All could use the same language, understand the children in the same way, and recognise the difficulties and the complexities that the children bring to placement as well as their need for good support and the difficulties of providing it. In addition, the team that takes referrals of children from local authorities could have a better understanding of the importance of the matching process of a particular set of carers to a particular child.

Attendance of managers and directors at the training also offers the important message that all people guiding and managing the agency have the same aim; all value

the importance of foster carers and all recognise the complexity of the work they are being asked to do. Management support of the training also reduces the potential for conflict.

The training is delivered over 2 full days for social work professionals and 3 three quarter days for foster carers. The reason for this difference is simply that foster carers frequently have child care issues and cannot work outside of school hours and so the training fits into the time the children are at school.

Once again, the material covered during the training is the same for social work professionals and for foster carers. No matter how useful, effective, or stimulating the training is, with relevant and practical ideas, it is still likely that much will be forgotten after a very short period of time; this would be normal. Anecdotal evidence and experience suggests that information and ideas, particularly if new, novel or counter intuitive, will be forgotten unless the ideas are reiterated with examples on a regular basis.

To promote retention of new ideas, the training is reinforced on a regular basis by providing 'Practice Development & Therapeutic Support Groups' (PDTS) for foster carers and for social workers. Additionally, foster carers are supported every fortnight by their supervising social workers (SSW), who have received the same training and using the same language and ethos. This level and consistency of support is important.

**Outline and Explanation of Topics Covered During Training**

The topical outline that follows is sequentially the same for both the training of social work professionals and foster carers. As previously explained, there are timing differences; however, to avoid any confusion this outline and explanation of topics covered is the same.

***Understanding attachment, regulation, and resilience – The training outline.***

Understanding attachment

Care matters

Origins of Attachment Theory

Attachment behaviours

Developmental Tasks

i. Building a sense of security and trust
ii. Building a sense of self-confidence and independence
iii. Yourself and world around you
iv. Understanding life outside of family and exerting control
v. Making sense of yourself and your place in the world

The how and why of attachment

i. Abilities that come with healthy attachment
ii. What can get in the way

The social brain

i. Connections
ii. Parts of the brain
iii. Regulation
iv. Disrupting the development process
v. Adaptations and behaviours

Attachment

i. Secure
ii. Insecure/ anxious or ambivalent
iii. Insecure / avoidant

iv. Insecure / disorganised

Transference and the caring task

A therapeutic approach

i. Consistency and repetition

ii. Inclusion in the family

iii. It is about trust

iv. Modelling 'good enough' parenting

v. Showing child they are valued and important

vi. Honest caring for child as individual

vii. Maintaining hope

viii. Showing kindness

ix. A relationship that matters

Resilience

i. What is it?

ii. How it develops

iii. The neurological and biological components

14 Themes

i. Carer developing confidence with knowledge

ii. Importance of language, words and delivery

iii. Showing the child they are equally important as carers' birth children

iv. Explicit and repetitive caring behaviours and attitudes

v. Non shaming at all times

vi. Knowing your buttons so they don't get pressed

vii. Diversion tactics and other coping mechanisms

viii. Complimenting and affirming the child

ix. Minimising choices to child to avoid fear of failure

x. Developing resilience and regulation to stressors

xi. Recognising presenting anger could be terror or fear

xii. How to respond to child testing boundaries

xiii. The importance of repetitive low level affirmations

xiv. Showing affection and the importance of touch as a positive message and means of affect regulation

**Training for Social Workers (2 days) and Foster Carers (3 days)**

The content of the training delivered to foster carers is no different to that delivered to social workers; although foster carers will frequently ask questions that are more practice-based, focussing on parenting responses to children's behaviours. To meet the child care demands of fostering, the foster carer training is delivered over three shorter days rather than 2 full days.

The number of training participants is limited to 14 or 15 people; this is due to a recognition that not all participants will have the same confidence or ability to speak in larger groups. The training approach is dialogic; the intention being that the facilitator talks with, rather than, at participants. It is inevitable that whilst some participants are less able to speak in larger groups, others can dominate conversation; this can cause the less-confident participants to withdraw from dialogue altogether. The larger group can make it more difficult for the training facilitator to meet the needs of each individual and to encourage conversation and interaction.

The facilitator offers clarity to participants at the very outset of training on a number of issues. This is to help reduce any anxiety and to create a more comfortable and effective learning environment. Participants are offered reassurance that there will be no role play exercises; these are frequently unpopular and can create unease for many. Participants are also reassured that there will be no small group exercises; these are often considered time-consuming and can take away opportunities for everyone involved to learn from each other. Participants are assured they can ask any question that they like throughout the course; no question will be deemed 'silly' or wrong and there will be no 'shaming' of any participant on the part of the facilitator. Any subsequent incidents of ridicule or belittling by participants is addressed in a kind and affirming way by the facilitator, though this is rarely required due to ground rules being established from the outset.

Participants are also made aware at the outset of training that attachment is a subject that can prompt reflection upon one's own early experiences of having been parented and upon one's own experiences of being a parent. Another important rationale for group size limitation, therefore, is the recognition that the subject of attachment can potentially be an emotionally difficult area to consider for many. Individuals enter the social work or fostering profession for a variety of reasons and with very different experiences; some of which may be potentially abusive and the facilitator is required to be sensitive to this. Participants may also start to identify that they have not been the kind of parent they would like to have been and may start to feel uneasy about this.

It is important, therefore, that participants are made aware at the outset that this training is not about looking for fault; rather it is about looking for better ways of being

the kind of parent that can meet the needs of children with complex attachment problems. Participants also need to be aware that some parenting practices are as a consequence of experience or cultural norms. Whilst they will be reassured that they will be neither judged nor criticised, the training will still make clear that the kind of experiences our children now need are a long way from punitive, cruel, shaming, or harsh, because those kind of practices will only reinforce the child's negative internal working model and not allow for emotional development.

An 'aide memoir' exercise is employed on the last day of training for both social workers and foster carers as a way of assessing or evaluating what each participant has learned or recalled and to expand on recommended therapeutic parenting strategies. Foster carers' literacy skills are always clarified with social workers prior to the commencement of their training and the exercise is always implemented in a way that is non-shaming and non-competitive. In addition, participants are reassured that they do not need to complete the sheet of questions that is provided for this 'aide memoir' exercise; rather this is an exercise designed to help clarify what has so far been understood and what requires further development of understanding. The facilitator will always take full responsibility for participants' inability to recall any element of the training. Participants are asked not to confer or share answers and they are reassured that their completed sheets will be for their eyes only and to take home for future reference. Participants are also advised that they can leave blank what they do not know as all questions will be revisited by the facilitator in order to fill any gaps.

The questions asked in this exercise (detailed below) are all related to the training event and, when addressed for a second time with participants, serve to elicit ideas and strategies that participants want to further question, discuss, and use:

1. What do you feel is a secure base?

This can lead to a considerable discussion. Ultimately clarification is provided that a secure base is someone, ideally the primary carer, who will keep the child safe; someone to whom the child will seek closeness or proximity – the first healthy attachment figure, which sometimes can be the foster carer.

2. What is the value of a secure base?

This gives further opportunity for dialogue about what a child can get from an attachment figure. It also offers the opportunity to talk about the importance of a secondary secure base, which would ideally be an individual within the school whom the child can seek when feeling worried or anxious, and what carers can do to support such a link.

3. Name two/three things that can lead to complex attachment problems?

This provides plenty of scope to revisit the impact of neglect as discussed during the training.

4. Can you give some examples of self-soothing?

This offers the opportunity to discuss real examples of self-soothing behaviours that have often led to self-harming, and how best to respond. This is an area that is sometimes difficult for some carers and social workers to understand.

5. Can you give examples of attachment-seeking behaviour?

Participants will generally be able to identify the early attachment-seeking behaviours, such as crying, sucking, smiling, clinging, and following. This question

allows the group to consider the attachment seeking behaviours of older children with unmet needs and to view those behaviours as opportunities to respond to those unmet needs. It offers the opportunity to reframe behaviours that have otherwise been viewed as 'attention-seeking' and to help foster carers and social workers notice when a child is attachment-seeking.

6. Why might children with complex attachment problems struggle with kindness and warmth?

This is an area that is often very difficult for foster carers and social workers to understand and participants will frequently respond with the statement that this is because children have previously not experienced kindness and warmth. The question allows the facilitator to explore another possibility, which is that if a child starts to accept kindness and warmth from their carer, it might leave them with a feeling that the carer - the person they accepted the kindness and warmth from - is now in control of them. Many children who have experienced significant neglect in the early years will internalise messages from these experiences; one being that they don't want other people to be in control. This helps carers and social workers to better understand why some children might struggle with allowing other people to know that they have enjoyed an event or an affirmation, for example.

7. Why might children with complex attachment problems have difficulty managing emotions?

This allows the opportunity to revisit the neurobiological aspect of the training, reminding participants that the neglected child may not have developed the capacity to regulate their emotions because they have not previously been responded to in an appropriately nurturing way. Participants are reminded that the development of the

human brain is experience-dependent and that, if a child has not experienced an adult that has helped to regulate their emotions, then their ability to regulate these emotions for themselves, such as tiredness, irritation, anxiety, anger, happiness, or disappointment, is immature. Participants are helped to understand that part of the foster carer role is to promote development in this area and several strategies and responses are discussed that may help develop the capacity of the child to regulate their emotions and help develop their capacity to cope with both difficult and happy situations in an age-appropriate way.

**Post-Training Support Structure**

**Practice development and therapeutic support groups**. The Practice Development and Therapeutic Support Groups (PDTS) evolved from Practice Development Groups (PDG), as a direct consequence of this research, which considered the complexities of caring for children with significant emotional and behavioural issues. The research data demonstrated that nine foster carer behaviours and attitudes correlated with emotional and behavioural development of children in their care. Whilst this information is certainly helpful, it remains necessary to provide consistent, high quality, trauma-informed support to enable foster carers to continue providing for placement stability and growth; this is due to the relentless task of responding to the complex needs of their foster children.

PDTS sessions are typically 2 to 2.5 hours in duration and are facilitated by a lead therapist on a monthly basis. Each session involves the social work team, including the supervising social worker (for carer), and one set of foster carers, either a single foster carer or a couple. In order to provide knowledge from a wider context and to

promote a consistent, repetitive, and predictable approach to placement support, appropriate education, nursery, local authority, and CAMHS staff can also be invited to attend and participate in the sessions.

The format for the PDTS is to seek information from participants in order to better understand how early experiences can impact on how a child thinks, feels, and behaves. Although cases change, the process of collecting information is consistent and repetitive in approach. The dialogue around each session centres on providing a mixture of theoretical understanding and practical responses for one particular placement using the following case history information:

- Parents or primary carers' information
- Length of time with parents or primary carers / when taken into care
- Environmental circumstances to which the child was exposed
- Consideration of possible impact of this exposure on child development
- How many placement moves the child has had at this point in time
- How long the child has been in the present placement
- How the child is presenting in placement

The language and ethos of the PDTS is consistent with the training to reiterate and support learning and confidence. Pertinent points from the discussions are displayed on flip chart sheets by the lead therapist to give a visual guide/aide memoire and to allow another level of processing for individuals to come back to if clarification of any sort is needed. This mapping of the child's developmental history frequently provides insights for foster carers and others that were not previously considered or understood as a whole. By helping carers and those supporting the placement understand the nature of trauma and implicit memory, and providing carers with

accessible information, responses and activities to connect with their children, promotes the kind of relationship that can, over time, help recovery.

***Parents or primary carers' information.***

This information may be limited, but when available can indicate where a parenting style originated, and if that parenting approach was typical of the wider family such as aunts, uncles, and grandparents. This can assist in understanding whether a child has had any shelter from abusive parenting or has been able to experience 'good enough' parenting for any period of time.

***Length of time with parents or primary carers / when taken into care.***

It is understood from research, identified in the review of literature of this thesis, that the earlier the child is in a traumatic situation and the longer the duration of the trauma, the more severe the developmental consequences. Because brain development is significantly experience-dependent and early brain development is a period of rapid growth, it is important to understand the early experiences to which the child was exposed.

***Environmental circumstances to which the child was exposed.***

Drawing on information discussed at the PDTS sessions, primary parenting received by the children is frequently identified as parenting that consistently does not meet the child's emotional or behavioural needs. This is invariably due to a number of common factors such as alcohol and/or drug dependence, violence and/or inability to regulate arousal/anger, immaturity, mental health issues, and not having themselves experienced the modelling of 'good enough' parenting.

***Consideration of possible impact of this exposure on child development.***

Whatever the reason for the parenting inadequacies, the neglected child regularly experiences traumatic feelings of fear, lack of safety/security, hunger, anxiety and chaos associated with adult disinhibition and adult/child blurred boundaries. In effect the child has no secure-base who will consistently respond to the child's need for nurture, safety, security, kindness, and appropriate regulation during these stressful times, and no one to help the child feel valued and important enough to be kept emotionally and physically safe.

***How many placement moves the child has had at this point in time.***

Several placement moves can be an indicator of the complexity of the child's needs and lack of understanding around those needs in relation to previous experiences. Discussion of why the child was moved often centres on the child's behaviours rather than any meaningful consideration of the thoughts and feeling associated with those reactive behaviours. It can also become apparent that each previous foster placement has been supported in repeating the same parenting style in the hope that there will be a different outcome; instead of recognising that something different is needed to meet the needs of this particular child.

***How long the child has been in the present placement.***

This is an important context for the PDST to understand because a child that has recently been placed will still be 'information gathering' about the carers, their new home, and school environment. The child is likely to be anxious/fearful and will be learning what they have to do in order to survive. This being the case, the carers with support will be able to provide the right messages and level of delivery for the child to

begin forming a relationship that matters for positive development. For the child who has been in placement for some time, carers need to be prepared for the probability that the child will notice when they start to change their parenting style/language as a result of this therapeutic support package. The child may feel uncomfortable by the delivery of consistent and explicit messages of kindness and affirmation and may attempt to 'shame' the carers into stopping this change in parenting style. The provision of informed support will be essential in promoting resilience in carers during the difficult times.

***How the child is presenting in placement.***

The intended outcome of the PDTS is for the foster carer and supervising social worker to leave the session with relevant practical parenting strategies that are underpinned by an attachment-based/trauma-informed perspective of the presenting behaviours. In practice, the supervising social worker will help the foster carer to explain the issues or experiences they are having within the placement. For example, the carer may want to understand why the child is being controlling and defiant, cruel to grandchildren, unable to manage anger, consistently lying, unappreciative, unable to sleep, and unable to cope with a good time. The PDTS then discusses how early experiences and the implicit and explicit messages they contain can present in children, how they can impact on the lens through which the child views self and the world - their internal working model - and consequently how the child reacts to situations, including being in foster care.

In other words, the PDTS endeavours to place presenting behaviours within the context of the child's early experiences and to reframe these from an attachment-

based/trauma-informed perspective. The early messages of persistent or chronic neglect are turning on its head the responses an infant is wired to expect from a primary care-giver and can lead to maladaptive development. The neglected child may feel fearful and unsafe, may be hyper-vigilant, hyperactive and controlling and may have poor self-concept, difficulty regulating feelings (including being happy, tired, hungry, shame, disappointed), a lack of trust, and limited impulse control – in essence physical, emotional, and cognitive developmental delays that impinge on the child's ability to socialise appropriately.

The PDTS is there to remind the carers that early negative experiences can lead to thoughts and feelings about self and other and to offer practical strategies that are accessible and useable to offset these developmental insults of chronic neglect. The foster carer needs to be able to leave the PDTS with an agreed response to a particular behaviour. They need specifics to understand why a child acts and responds in the way that they do and they also need to have something practical that they can try as a parent to a child with complex attachment problems.

***Summary.***

A significant aim of the PDTS is also to recognise and model the ethos and concepts of the therapeutic parenting approach first delivered in training. The lead therapist within the group will use the language of the codes common to the training; the language of the codes that the foster carers are expected to understand and use and that would also be used during supervision between social worker and foster carer. Those involved in supporting the placement should be consistent and repetitive in their support recognising its importance in learning. The lead therapist will also be providing hope for the placement by reframing issues and problems from an attachment-

based/trauma-informed perspective and by providing accessible and useable therapeutic parenting strategies. Acceptance and kindness are codes that are modelled by the lead therapist during the PDTS. Also modelled is the recognition that those involved are not looking for faults; rather they are looking for resolutions, to appreciate and affirm what is working well in placement and noting the carers' part in this. The PDTS always models and promotes a non-shaming stance as this can help show what is needed and what is expected of foster carers and supervising social workers in placement.

**Additional Post Training Support**

The need for additional support for complex cases is recognised and noted in the literature review; consequently, there is opportunity for supervising social workers to contact the lead therapist outside of the PDTS by telephone and by email. Communication by email encourages supervising social workers to identify, reflect upon, and be clear about the concerns and provides the opportunity to use the lead therapist as a guide. This helps to embed knowledge and understanding and promotes confidence over time.

**Annual refresher training**. Supervising social workers and foster carers have separate annual one-day refresher training. This provides opportunity to review the content of the 3-day training event, consider the strategies that are working well and those that carers are having difficulty implementing, and to reframe specific problems that might be occurring within placements from an attachment-based/trauma-informed perspective. Supervising social workers tend to utilise part of this training opportunity to consider ways of supporting those foster carers who are proving resistant to this therapeutic parenting approach. Foster carers often want to understand what to do when a child stops responding to a strategy that was once working. This has to be put into its

wider context; for instance, carers may unwittingly be giving mixed messages or something within the carers' household dynamics or school dynamics may have changed. Carers also need to be helped to understand that they are caring for children that are growing and developing too and that this may require a 'tweaking' of responses.

**Training for educators involved with children in placement**. One of the additional benefits of education staff attending PDTS sessions is that schools then often request additional training for the wider staff group at their school. This is always made available because it promotes relationship-building between school and the placement, and indicates a willingness of school to consider the additional needs of traumatised children. Support to the wider school does still focus on the needs of the child discussed at the PDTS, using the same language and responses; however, it is usually also relevant to other children within the school. A significant part of the school session focuses on practical responses, in particular:

- Non-shaming responses that recognise poor self-worth and fear of failure
- Use of mantras/language identified in the research coding, which encourages a feeling of safety, value, and importance in the child
- Calm responses from adults, be they consequences or affirmations. This recognises the child's difficulty with regulating emotions and high arousal situations.

**Training in assessment and supervision of foster carers for social workers**. This one-day training event for supervising social workers aims to cover themes associated with the assessment and supervision of foster carers. It looks at practical

ways to elicit information that demonstrates carers' understanding of and ability to put into practice the therapeutic approach of the training. It introduces Bloom's taxonomy model of skills and attitudes as a format social workers can use during their fortnightly supervision sessions to assess how carers demonstrate understanding and application of knowledge from the training in their caring approach. The training also considers the assessments of new and prospective foster carers, focussing on the qualities needed to provide care for children with complex attachment issues, and offers ideas about how social workers can evidence the qualities or potential for the caring task.

**Frequently Asked Questions**

One aim of the training is to provide, in an accessible way, an evidence-based understanding of attachment and the impact of chronic neglect upon children. The intention is to equip foster carers and their support networks with the necessary tools, skills, and resilience to provide for a stable foster placement from which the child can feel safe, valued and thrive. During the training, there are frequently asked questions, which seem to indicate a reflection on participants' present skill-base and perhaps a wish to know there is a chance for the child; in essence looking for hope.

Three of the most frequently asked questions are:

**Q1**. Is there a cut-off point for change? Is there a time when it is too late?

**A1**. Whilst there are critical periods for optimum development, neurological research has identified several significant regions of the brain associated with self-concept, attachment, and processing of information that retain a level of plasticity, making them accessible to change until mid to late 20's. Given that brain development is experience-dependent and that chronically neglectful early relationships have caused the harm to the child's perception of self and other, the opportunity for change requires

a consistent, repetitive, and affirming relationship over a long period of time, providing messages that are consistent with the foster carer codes that evolved from the research.

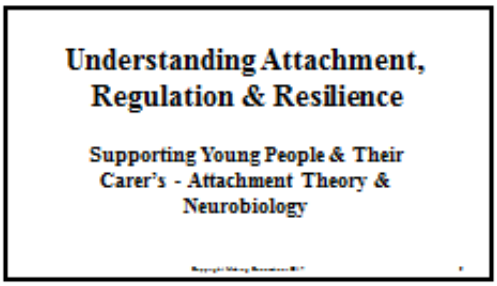
**Q2**. How long will change take?

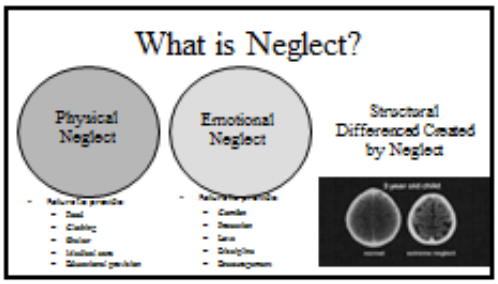
**A2**. This is difficult to answer because the change implied in the participants' question frequently relates to the child's presenting behaviour whereas the required change would be to the child's perception of self and other, and the thoughts and feelings that underpin the behaviour. This kind of change requires evaluation from a wider perspective and over a longer time-frame, and necessitates implementation of the explicit parenting messages and attitudes typified in the carer codes.

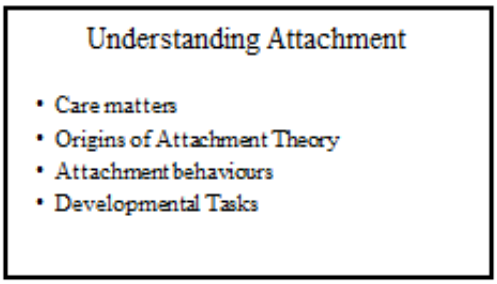
**Q3**. How do I respond to my birth children when they ask me why I am treating the fostered child differently to how they were treated?

**A3**. Ideally all the children in the household can be treated the same way, which promotes a positive message of equal importance and belonging to the fostered child. But when the birth child asks directly why the foster carer is treating a fostered child differently to how they were treated, the response can be that parents never stop learning, they must always try to do the best that they can, and they have learned that this is the right way to be. Additionally, a relationship can be drawn with the importance of learning at school and college.

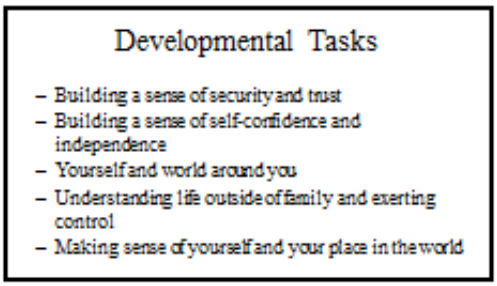
**Slides for Training**





## The How and Why of Attachment

- Abilities that come with healthy attachment
- What can get in the way

## The Positive Interaction Cycle

## The Social Brain

- Connections
- Parts of the brain
- Regulation
- Disrupting the development process
- Adaptations and behaviours

## Attachment

- Secure
- Insecure/ anxious or ambivalent
- Inscure / avoidant
- Insecure / disorganized

## Transference & the Caring Task


Section Two

## BUILDING RESILIENCE

## Overview of A Therapeutic Approach

- Consistency & repetition
- Inclusion in the family
- It's about trust
- Modelling 'good enough' parenting
- Showing child they are valued and important
- Honest caring for child as individual
- Maintaining hope
- Showing kindness
- A relationship that matters

## Consistency & Repetition


## Inclusion in the Family

## It's About Trust

## Modelling 'Good Enough' Parenting

## Showing Child They Are Valued and Important

Maintaining Hope

Showing Kindness


A Relationship that Matters

## Appendix C: Code Relationships

### Nine Codes Identified Through Research with Foster Carers

The following nine codes were frequently used by foster carers managing successful placements with children who had complex attachment issues, and were discussed at length in the results and findings of the research previously presented:

1. It is about trust
2. Carers showing the child they are valued and important
3. Caring for a child as an individual
4. Carers showing kindness
5. Consistency and repetition
6. Inclusion in the family
7. A relationship that matters
8. Modelling good enough parenting behaviour and finally
9. Maintaining hope

### Linkages Between Codes Developed in Training and the Experience of Foster Carers

Figure C1 below shows the linkages and relationship between the ways in which foster carers described their experiences and the fourteen key knowledge inputs of this multi-level package of training and support. First the linkages are diagrammed and then each is briefly discussed.

Figure C1: Relationships in Carers Perspective and the Training

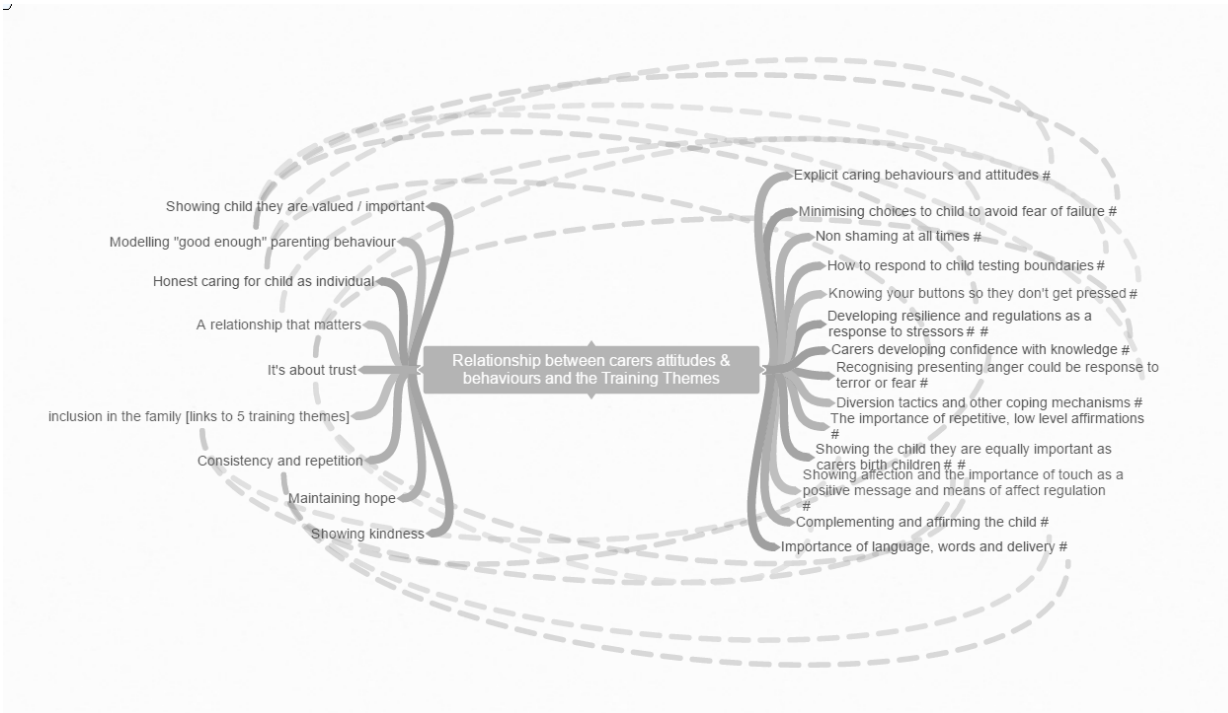



Figure C1: Relationships in Carers Perspective and Training

1. ***Carer developing confidence with knowledge*** influences all the others as it allows the carer to maintain hope through difficult situations. This theme correlates with the overall goal of the training to provide a clear practical approach, underpinned by evidenced-based research, to work with by treating carers as professionals with expectations and guidance towards the important goal of provision of a parenting style and ethos that meets the 'whole' developmental needs of children. This provision of knowledge with regular high quality support promotes confidence in carers that they can do it.
2. ***Importance of language, words and delivery*** offers carers the opportunity to select and utilise words and phrases (mantras – “it's because your important”, “it's because I care”, etc.) that challenge the child's negative sense of self and of adults as uncaring and scary. The carers use language that promote the child as valuable and other (carer) as a figure who cares and will offer safety and

protection because the child is important to them. Carers, supported by social workers and others come to recognise the importance of 'pacing' words and phrases, delivering slowly and with calm, understanding that anxiety makes processing of information more difficult for the child.

3. ***Showing the child they are equally important as birth children*** correlates with multiple other themes, including: honest caring for child as individual, inclusion in family, showing child valued/important, maintaining hope, and a relationship that matters. Sometimes showing can be more powerful than telling, especially when a child has not learned to trust (actually has learned NOT to trust). Carers look for opportunities to let child know they are part of the family, promoting a sense of belonging, family photo includes them on notice board, or fridge magnet. Carer choosing not to have respite because they do not put their birth children in respite or have a break from them (even if they need a break!).
4. ***Explicit and repetitive caring behaviours and attitudes*** correlates with other themes as well, including: showing kindness, modelling "good enough" parenting behaviour, and honest caring for child as an individual. The training identifies the needs of these children at times requires explicit, consistent, repetitive, and affirming parenting at the emotional level of the child at that time. The emotional / behavioural level of traumatised children is frequently not consistent and can change minute by minute. Understanding this and responding to the emotional need of the child at that moment helps fill the early unmet need and encourages development in self and the carer/child relationship.
5. ***Non shaming at all times*** correlates with the carer codes or themes of creating trust, maintaining hope, showing kindness, consistency and repetition, and

maintaining hope. The goal of the training would be that carers and social workers would understand that children that have such poor self- concept can be triggered into feeling shame with any slight intentional or not. Showing kindness and being consistently mindful of this predisposition avoids this harm and potential for negative responses, such as anger or harming self. This would mean avoiding sarcasm, humour centring on them, other humour - they are likely to misunderstand it, catching them out, etc. They will not cope. Their coping abilities / resilience will develop with their growing self-concept as a consequence of feeling valued and important by carers.

6. ***Knowing your buttons so they don't get pressed*** correlates with consistency and repetition, and modelling "good enough" parenting behaviour. Carers will show proficiency when they express knowing that because of early experiences, chronically neglected children can fear attachment / emotional closeness, feeling vulnerability or not being in control, helps foster carers recognise that the children develop an armoury of ways of keeping detached and in control. Carers recognise that typically children will collect information that they know will cause unease with the foster carer, and use it against them at some point - typically (perhaps counter-intuitively) when the child is feeling a some attachment or closeness to the carer which can triggers a feeling of vulnerability. Carers need to know their buttons and be able to respond calmly and without obvious anger, not acknowledging the comment or action has caused unease. This response rather than a reaction (anger or punishment) give no negative power to the comment or action which will then be reduced and then dropped. Not reacting but modelling a positive response also helps the

child see that you, the adult, remains in control (not the child) and therefore can be relied upon to keep them safe. As the adult / relationship positively develops with use of multiple codes, the reasoning behind the need for the child to press buttons stops.

7. ***Diversion tactics and other coping mechanisms*** correlates with consistency and repetition and modelling “good enough” parent. Diverting the carers attention as much as the child's attention from a 'situation' can be helpful in regulating a situation - the adult is regulating the situation. Social workers and carers come to understand that the intention is to move away emotionally and / or physically from the potential for a battle. Always with calm. It might be simply 'I'm just getting an orange juice (or piece of toast), would you like one too? (term of endearment) e.g. Lovely, mate, etc. The child might be in a position they cannot get out of and they need adult to help them out of the situation. Over time the child will know what you are doing and will realise it feels good to have the space. They see an adult model how to cope.
8. ***Complimenting and affirming the child*** correlates with consistency and repetition, showing child valued/important, showing kindness, modelling good enough parent, and maintaining hope. Proficiency is achieved when carers realise that to impact on the negative experience-dependent messages the child has received and internalised about self 'as real' they have to provide consistent, regular, repetitive, and affirming messages. Because the messages may not be believed by the child and it may cause the child to feel some conflict. The messages have to be delivered at the level the child can cope with 'repetitive low

level affirmations', minimising eye contact, and not expecting a show of appreciation in words or smiles.

9. ***Minimising choices to child to avoid fear of failure*** correlates with modelling "good enough" parent and honest caring for child as individual. Rather than relishing the opportunity of having lots of choices the child with poor self-concept fears making the wrong decision and/or cannot cope with the 'stress' of too many choices. Carers seek to offer two choices, without pressure, and accept whatever choice is taken. The child gets used to the mon-judgemental responses of the carer and coping capacity grows over time.
10. ***Developing resilience and regulation to stressors*** correlates with modelling "good enough" parent, consistency and repetition, and it is about trust. Recognising that the capacity to regulate emotions develops as a biological consequence of good enough parenting presents carers with knowledge and opportunity to be that nurturing parent. Allowing opportunities for low level stressors alone with close proximity to trusted adult in case the child shows inability to cope. The carer gradually sees growth in ability to cope with and regulate emotions such as anxiety, fear, or excitement.
11. ***Recognising presenting anger could be terror or fear*** correlates with it is about trust, modelling good enough parent, honest caring for child as individual, and showing kindness. Carers understand early chronic neglect means the child becomes hyper-vigilant and sensitised to situations that others may not see as problematic. Carers understand the child's primitive survival fight; flight or freeze system is on alert much of the time and consequently may react whenever a threat is perceived and that the reaction is likely to be high arousal/attack. As

the child develops a trusting relationship with carer over time, a feeling of safety, and being protected by carer, the child's fear response reduces and as more appropriate parenting responses are experienced through explicit modelling of safety and security the child's responses become more appropriate.

12. ***How to respond to child testing boundaries*** correlates with being a "good enough" parent, a relationship that matters, and maintaining hope. It is important for carers to understand why the child needs to test boundaries. Many neglected children come into care having never been provided with any boundaries or guidance on danger and have lived with emotional and behavioural chaos; although scary, this can be normal for them. It may be that they have been in a number of placements where the carers, with the best intentions, offer too many choices and mixed messages leading to the child feeling unsafe and trying to take control.
13. ***The importance of repetitive low level affirmations*** correlates with the carers experience of the importance of showing child they were valued/ important, consistency and repetition, and "good enough" parenting. Carers understand that to change the negative messages of neglect takes consistent, repetitive, and affirming messages over a long period of time to offset the earlier embedded developmental insults. These need to be delivered at the level the child can cope with to avoid rejection.
14. ***Showing affection and the importance of touch as a positive message and means of affect regulation*** correlates with the carers experience that it is about trust, showing kindness, showing child valued /important, a relationship that matters, and modelling "good enough" parent. Carers recognise that positive

touch is both an opportunity to make contact and promote a feeling of safety, value and importance in the child, and a means of reducing stress (cortisol) and regulating arousal in the child. It is also a way that carers can assess developing levels of trust.