What do we mean by Therapeutic Foster Care?

by Dr Jane Herd

Synopsis

This article discusses the concepts of 'trauma' and 'traumatised' as terms often used to describe children in foster care who it is thought may benefit from Therapeutic Foster Care. It explores these terms within the theoretical framework of neurodevelopment, affective neuroscience and attachment. The main body of the paper looks to describe the main facets of a bio-psycho-social model of Therapeutic Foster Care, created by the author, which attends to the neurodevelopmental, psychotherapeutic, psychological, and social aspects of the difficulties the children may present and the areas which need attending to. The model is laid out in a table of 20 headers with short descriptions of what is meant by key terms and practices. The intention is to provide a theoretically informed description of Therapeutic Foster Care which can be used on a day-to-day basis in practice.

Introduction

It is widely accepted, if not well evidenced (Department of Education, 2017), that the population of children placed in foster care in the UK and Ireland have increasingly complex needs and troubled presentations. There has been much discussion about the challenges this brings to foster care provision and individual carers and the best ways to manage and support children and carers. The discourse is often around what would work best for a routinely traumatised population and whether a Therapeutic Foster Care approach and model may be useful. But we often do not unpack what is meant by trauma and traumatised, or by therapeutic caring. In this article I will attempt to answer the first question about trauma in brief and the second question about what I believe Therapeutic Foster Care to be at more length.

Trauma when talked about in this context has a specific meaning. By 'traumatised' children, I mean children who have experienced a combination of extensive or substantial periods of significantly misattuned care giving, direct abuse, neglect, and chaotic and inconsistent environments, and that this social, emotional and contextual environment has had an ongoing impact on functioning and development (Perry et al,

2007). More precisely, that such circumstances have had a direct impact on the development of brain and bodily systems often talked about in terms of neurodevelopment and attachment (Music, 2010). This trauma is believed to be hard-wired into brain neural networks and neural chemical systems and this impacts on a wide range of functioning, including emotional, relational, psychological, communication and cognition, as well as on physical health.

> *"...simply removing a child from a care giving environment of significant concern and placing them with kind and nurturing carers does not lead to a child's behaviour instantly or simply changing, as these adaptations are part of their functioning. It can therefore take considerable work and input to begin to help children adapt to their new and, for them, strange circumstances."*

Children develop adaptations to the environment in which they are raised and the basis for social and emotional functioning in particular is formed from the third trimester of pregnancy to three years. Therefore, simply removing a child from a care giving environment of significant concern and placing them with kind and nurturing carers does not lead to a child's behaviour instantly or simply changing, as these adaptations are part of their functioning and it can therefore take considerable work and input to begin to help children adapt to their new and, for them, strange circumstances (Siegel et al, 2012).

What this discourse about trauma indicates is that many children arrive at foster care homes with a range of adaptations (Woolgar et al, 2019) which can be challenging to manage in an ordinary family setting and where the usual approaches, particularly of praise and telling off, can just make things more stressful and stuck for everyone. This has led to an increasing interest in what is often termed 'Therapeutic Foster Care' as a way of working with traumatised children.

However, this term is beginning to become ubiquitous and used in lots of different ways and about widely different provision, models and approaches. Does the offer of counselling to a child once a week or consultation for carers or staff once a month make a provision therapeutic? It may indeed be very helpful and address some of the carer's and child's needs. However, I think that therapeutic foster caring goes beyond this. It is a

way of understanding both traumatised children's difficulties and the sorts of caring relationships which can help children heal. It is based on what is called a bio-psycho-social model which incorporates neurodevelopment and affective neuroscience, as well as psychotherapeutic, psychological, social and relational models, theories and practice.

The following table is an attempt to succinctly describe some of the key facets of my Therapeutic Foster Care model based on a trauma and neurodevelopmental approach. It aims to provide a kind of guidance, a framework to scaffold one's understanding and practice when using the term 'Therapeutic Foster Care'.

Orb8 Model of Therapeutic Foster Care: A Bio-Psycho-Social Model

Copyright Dr Jane Herd Orb8

1. Put behaviour into context	This includes family, community, and contextual history. What has happened to a child, from in utero to the very first months and year/s of life, will have a lasting impact on brain structure, functioning and related bodily processes. It will lay down relational, social, linguistic, bodily, sensory and cognitive patterns which will be the basis for how the world is experienced and responded to: this is their internal working model (Gerhardt, 2004). Therefore, knowing what has happened in a child's past may help to make sense of their current ways of being.
2. Learning your child (Cairns, 2002)	A foster child will have a different internal working model of the world, based on their experience of it. One of the jobs of a therapeutic carer is to work out as best they can what their child's internal working model of the world is, which may be very different from their own and those of other children their child's age. Ways of working this out can include close observation and seeing behaviour as communication.
3. Levels of development	Children who have experienced a high level of trauma in early childhood can often struggle to develop in a wide range of areas, including social, emotional, intellectual, communication, and morality and ethics. They can function at different ages in all of these areas. Getting a sense of your child's developmental age or level of functioning in a range of areas and responding to them at this developmental rather than chronological age can be very helpful and reduce everyone's frustration.

4. Behaviour as communication	Behaviour is not usefully viewed as good or bad but needs to be viewed as a communication, letting others know what a child can or cannot manage or understand, what distresses and destabilises them and what this may say about their internal working model. Wondering out loud for yourself and the child about what a behaviour might mean or be about can sometimes be helpful.
5. Windows of tolerance	These are based on a child's inner working model. A child may be substantially more or less tolerant of particular external and internal stimuli; these are often called 'triggers'. The resulting externalised or internalised responses to what is felt as intolerable can be perplexing, confusing, and distressing for the child and carers. Carers need to work out what their child can tolerate, understand, and use and what triggers them into dysregulation.
6. Dysregulation	This is a term used to describe when an individual goes from a state of relative internal calm to a state of anxiety which triggers their limbic system to go into fight, flight or freeze mode. The body pumps adrenalin and cortisol to be able to respond to a perceived threat and children in this state can suddenly become very angry and agitated and need an adult to provide a calm, comforting response to help them feel safe and gradually go back to a state of internal regulation.
7. Co-regulation	A traumatised child is very unlikely to be able to regulate their emotional and bodily states and functions as a starting point. Carers need to set the emotional tone. They need to join the child where they are with shared attention, intention, mirroring affect, tone and rhythm. Start where they are and take them closer to where you want them to be. Follow, lead, follow.
8. Sensory processing	Early experience and trauma are primarily processed and stored through bodily and sensory pathways. This means trauma can often both be triggered and calmed through sensory or bodily experiences. Regular, repetitive, and rhythmic experiences, such as walking, drumming and music, can be particularly helpful. Sensory experiences include food, which can be used as a regulatory medium through taste, texture and chewing.

9. Mind-mindedness and mentalisation (Midgley et al, 2012)	This is an extension of empathy: being able to get a sense of your own and others' emotional, social and intellectual experiencing at any moment. Traumatised children often have poor mentalisation capacities. Their mentalisationcan be patchy, and they can lose this capacity when anxious or distressed. The lack of mentalisation function can be obvious as they will not implicitly understand how they or anyone else feels, what they might be thinking and therefore how to respond appropriately.
10. Expectation failure	Traumatised children's internal working model can often be outdated and lead to repeated unhelpful responses to situations and exchanges. These patterns of behaviour are reinforced when they get the usual response, for example a telling off for an unwanted behaviour. Carers 'facilitate' expectation failure in order to help a child to move away from well-worn patterns of behaving, and instead to allow new brain pathways to be created. Expectation failure can be facilitated by relating to a child with curiosity, wondering, empathy and humour (Golding et al, 2012).
11. Shame, rupture and repair	Young children need to feel sorry for doing things that upset others. This is when they are gently told off, the relationship is ruptured by the admonishment and is repaired by making up again. When there is no repair or the response to unwanted behaviour is harsh the child will not feel guilty – that they have done a bad thing – but will feel shame: that they are a bad person. Children who feel a lot of shame can find it impossible to take responsibility for any misdemeanour (even if you see them do it!) and can be very controlling and need to feel in charge.
12. Boundaries	These are very important and useful for traumatised children. This means you need to set the environmental, emotional, and relational tone and space. Regularity and rhythm are important, as they minimise over-stimulation and dysregulation. Think 'vanilla' – keeping things plain and predictable. Make expectations clear: *"In our house, we…"*.

13. Avoid behavioural management	Standard parenting strategies such as rewards and sanctions are likely to fit into existing unhelpful patterns of managing the world and will reinforce them, not lead to change. Rewards can encourage manipulation and 'playing the game' as part of a survival mode where getting the reward is the total focus for the child. Exclusion, such as the naughty step, may increase shame and isolation and is sending a child away from you when they need to be closer, to have your assistance in co-regulation.
14. Natural and relational consequences (Elliott, 2013)	These are much better learning tools than sanctions. Parents often report using behaviour-management strategies with ever-increasing sanctions and complain that they do not work. They are quite right, they do not! Natural consequences, such as not replacing something broken for a period, or spending time repairing it, link behaviour with consequences and feel fairer and are more likely to make sense to a child. If a child has hurt someone, either bodily or their feelings, then emotional and relational consequences such as giving someone a back rub, making them a cup of tea, or writing them a kind note are all congruent and can help build empathy.
15. Ambiguous loss (Fostering Perspectives, 2009)	This is loss that is not clear. People are gone but it is not known if they are dead; they may come back in a moment or be gone forever but are psychically ever-present. This is a very common experience for foster children. This makes change, relationships, and loss very difficult to manage. Children who are looked after often have a confused or extremely patchy narrative and sense of history. A coherent narrative is important in making sense of the child's behaviour but also for them in knowing who they are, where they come from and who is important in their life. Tools such life story work, memory boxes, family trees and road maps can be helpful in making sense of the child's life for the carer and child. This narrative or story needs to continue to be captured and extended in their current life as an ongoing task.

16. Social context	This is of great importance throughout a child's childhood. They will often feel more comfortable in situations or relationships that fit with early patterns and their internal working model. This can be particularly problematic in adolescence (Morgan, 2005) when they naturally look to peer relationships rather than parental guidance for their steer as to how to behave and may feel more comfortable or familiar with chaotic or even abusive relational contexts. Contextual and environmental risks need to be considered and worked with openly, and peer group opportunities structured and planned, to try and provide safer possibilities.
17. Identity	We find our sense of self in another person's eye, in how we are related to and met. Traumatised children often have an inconsistent, or blank sense of self and identity; they do not know who they are or what they like, or identity may be fixed or unrealistic. Noticing, responding positively to the child, and placing in words the child you see can help them begin to build a stronger sense of identity.
18. Regular supervision and reflective spaces	Traumatised children and young people can get inside of us. This is actually a regular part of relating and a part of mentalising. However, traumatised children can get in on us in such a way that we end up not knowing which are their feelings and which are ours. We can end up fitting their previous patterns of relating, which they may be used to but will feel stuck and uncomfortable. Regular supervision and reflective spaces can help carers reflect on what might be going on for them, and the child, below the surface – things that you are both acting out without being consciously aware of it. Naming and recognising them can help things move on.
19. Carers' self-regulation	This requires careful attention. As well as learning the child, carers need to learn themselves – what triggers them, how they feel when regulated or dysregulated and what helps them get calm and get back to a regulated state. What goes on inside them, such as sensations, feelings, metaphors, thoughts, and behaviours, can help carers make sense of their and their child's world.

20. Self-care is really important	Parenting is hard and therapeutic parenting is really hard. There will be an emotional impact; it is important to map what this is and have strategies for self-care. This is rarely quick work. You may get some quick wins and sudden breakthroughs but mostly it is a question of plodding away, day after day. It is worth reviewing where things are at on a regular basis as subtle and slow progress can often be missed.

I hope this model communicates something of the complexity of therapeutic care (Hughes, 2006). It could be a matter of frustration for carers that it does not offer a straightforward way to describe what to do and simple strategies to manage behaviour better that will make unwanted behaviours somehow just go away. Instead, it offers a way of understanding the underpinnings of a child's externalised distress and looks at carers' relational responses which, over often extended time periods, will reduce the triggers and drivers of such distress within the security of a trusting relationship.

The strategies that are inherent to a therapeutic model of caring are relational and emotional ones and it is a way of being and understanding which then translates into a certain kind of doing. This is not necessarily a natural thing, though some carers may find this way of working suits them and their parenting style better than others. This is something that needs to be taught and can be learnt over an extensive period. It requires ongoing support from professional others who can teach and communicate a theoretical model – that helps make sense of children's presentations; suggest a process of responding and interacting; and offer a regular, programmed level of support to help carers manage the emotional load that such work carries.

About the author

Dr Jane Herd is a consultant social worker with 35 years' experience in children's services in social care, health, education and in the third sector as a clinical practitioner, director and senior lecturer. She has a professional doctorate from the Tavistock and Portman NHS Foundation Trust in respect of the internal working model and social context of hard-to-reach adolescents and is currently pursuing a PhD at the University of Birmingham on the intersection of therapeutic practice, reflection and spirituality. She is currently founder and CEO of Orb8, a social enterprise providing transformative

teaching, learning, consultation and developmental opportunities for anyone working with traumatised children and young people.

Bibliography

Bomber, L. (2007) *Inside I'm Hurting: Practical strategies for supporting children with attachment difficulties in schools.* London: Worth Publishing Limited.

Cairns, K. (2002) *Attachment, Trauma and Resilience: Therapeutic caring for children.* London: British Association for Adoption and Fostering (BAAF).

Elliott, A. (2013) *Why Can't My Child Behave? Empathic parenting strategies that work for adoptive and foster families.* London: Jessica Kingsley.

Fostering Perspectives (2009) 'Ambiguous Loss Can Haunt Foster and Adopted Children' *Adoptalk* 14(1). North American Council on Adoptable Children.

Gerhardt, S. (2004) *Why Love Matters: How affection shapes a baby's brain.* Hove: Brunner-Routledge.

Golding, K., Hughes D. (2012) *Creating Loving Attachments: Parenting with PACE to nurture confidence and security in troubled children.* London: Jessica Kingsley.

Hughes, D. (2006) *Building the Bonds of Attachment: awakening love in deeply troubled children*. New York: Rowman and Littlefield.

Midgley N. and Vrouva I. (eds) (2012) *Minding the Child: Mentalization-Based interventions with children, young people and their families.* Hove: Routledge.

Morgan, N. (2005) *Blame My Brain: The amazing teenage brain revealed.* London: Walker Books.

Music, G. (2010) *Nurturing Natures: Attachment and children's emotional, social, cultural and brain development.* Hove: Psychology Press.

Perry, B. and Szalavitz, M. (2007) *The Boy Who Was Raised as a Dog – and Other Stories from a Psychiatrist's Notebook*. New York: Basic Books.

Siegel, D. and Payne Bryson, T. (2012) *The whole-brain child: 12 proven strategies to nurture your child's developing mind.* London: Constable and Robinson.

United Kingdom. Department of Education (2017) *The fostering system in England: Evidence Review.* King's College London and Quest Research and Evaluation Ltd.

Woolgar, M. and Simmonds, J. (2019) 'The diverse neurobiological processes and legacies of early adversity: implications for practice'. (Editorial). *Adoption and Fostering,* 43(3), pp 241-255.