

# THERAPEUTIC FOSTER CARE

Integrating Mental Health and Child Welfare  
to provide care for traumatised children

A Literature Overview



## **Acknowledgements**

A number of people have been instrumental in the creation of this literature review. In particular I would like to thank my supervisor, Laurel Downey, whose vision inspired the development of a literature review and for the countless discussions sharing her clinical wisdom and time proofreading. Thanks also to my colleagues, Georgina Swinburne, Val Barker, Kathy Lancaster and Joanie Bartolo, who all contributed in various ways, through clinical discussions, editing and constructive comments. Finally, thanks also to my partner, Shane McClung, whose support, patience and encouragement ultimately enabled me to finish this document.

**Lisa McClung  
Senior Training Officer  
Take Two Program  
Berry Street Victoria**

**January 2007**



# Table of Contents

<b>Overview</b> .....	5
<b>Key findings</b> .....	5
<b>A trauma-attachment framework</b> .....	6
<b>Mental health problems of children in care</b> .....	6
The interplay of trauma and attachment .....	6
Attachment and culture .....	6
Aboriginal child-rearing practice .....	7
Cultural variance of exploration and closeness .....	7
Access to services for children in care .....	7
Evidence-based and recommended treatment interventions .....	8
Referral and assessment process .....	8
Assessments for children entering care – Stargate model .....	9
Training the child welfare system in mental health .....	9
<b>Children in care – an Australian context</b> .....	9
<b>Therapeutic foster care</b> .....	10
Origins of TFC .....	10
Definitions of therapeutic foster care .....	10
Difference between TFC and general foster care .....	11
<b>Characteristics of TFC</b> .....	11
Enhanced services and caregiver reimbursements in TFC .....	11
Characteristics of children in TFC .....	11
Assessment and matching process .....	12
The therapeutic foster carer .....	13
Motivation for fostering .....	13
Foster carer selection and assessment .....	13
<b>Training therapeutic carers</b> .....	14
A rationale for training carers .....	14
Engaging carers in training .....	15
Effect of foster care training on children's functioning .....	15
Theoretical approaches to training carers in TFC .....	15
<b>Training models</b> .....	16
International training models: .....	16
Fostering attachments with children who are looked after and adopted: .....	16
A group for foster carers and adoptive parents (Golding, 2006) .....	16
Training program for foster carers and their supervising social workers (Allen & Vostanis, 2005) .....	16
Attachment and Biobehavioral catch-up: An intervention targeting the relationship between parent and child (Infant caregiver project, University of Delaware, 2005) ....	17
Attachment for foster care and adoption: A training programme (Beek & Schofield, BAAF, London, 2006) .....	17
Specialised training programs in Victoria .....	17
Advanced training program for TrACK carers (TrACK evaluation report, 2005) .....	17
Working with Children in Care – manual for carers (Connections, Child, Youth and Family Services – Challenging Behaviours Consultancy program, 2005) .....	17
Creative training and support for carers .....	17

<b>The child's network</b> .....	<b>18</b>
Biological parent involvement in therapeutic foster care .....	18
Barriers to involving parents in TFC .....	19
Parents' experience of TFC .....	19
The therapeutic parent and biological parent interface .....	19
Training carers in working with parents .....	20
<b>Therapeutic foster care programs</b> .....	<b>20</b>
Multidimensional treatment foster care .....	20
Oregon early intervention foster care project (OEIFC) .....	21
TrACK (Treatment and Care for Kids program) .....	22
BSV Southern Services 1:1 & Intensive HBC program .....	22
<b>Cultural applications of TFC</b> .....	<b>23</b>
<b>Effectiveness of therapeutic foster care</b> .....	<b>24</b>
TFC effectiveness and cost-efficient benefits .....	24
TFC outcome studies .....	25
Comparative studies .....	25
<b>Future directions in out of home care</b> .....	<b>25</b>
<b>A potential TFC model</b> .....	<b>26</b>
What might a therapeutic care model look like? .....	26
Therapeutic parenting .....	26
Therapeutic parenting and the care team interface .....	27
Attachment-focused dyadic or family therapy .....	27
Elements of a trauma-attachment TFC model .....	28
Towards a permanent care system .....	28
Supervision, consultation and support for the carer/foster family .....	29
Creative respite options .....	29
<b>References</b> .....	<b>31</b>
<b>Appendix 1</b> .....	<b>34</b>
Website references .....	34
<b>Appendix 2</b> .....	<b>35</b>
A framework for understanding the integration of trauma and attachment theories (from the Take Two Practice Framework) .....	35
Attachment theory .....	35
Regulation and intersubjectivity .....	36
Trauma theory .....	36
Impact on the brain and body .....	36
Neglect .....	37
Trauma affects thinking .....	37
Traumatised children in out of home care .....	38
Intervention .....	38
Contact and access with biological family .....	39
References .....	39

## Overview

The fields of mental health, child protection and child welfare have tended to develop independently of each other, relying on different theoretical orientations, different research and different practice. Irrespective of these differences, there are areas of overlap and many common areas of thinking and practice. Truly therapeutic out of home care will depend on an integration of perspectives, theory, research and practice from these fields, which have historically remained too separate. Recent initiatives such as the Take Two program have attempted to bring together leaders from these different areas of practice, who are working together to provide services for vulnerable children, families and communities. This literature review is an attempt by Take Two to further integrate these fields of endeavour to explore what has been said about therapeutic foster care.

This literature review explores areas of commonality as well as looking at the strengths and weaknesses in both the literature and practice within these fields; as it relates to therapeutic foster care. The literature review begins by exploring the difficulties commonly experienced by children in care. This is followed by an exploration of the characteristics of therapeutic foster care as well as several therapeutic foster care programs within Australia and from overseas. Exploring such programs may provide ideas for the development of future practice that will create healing therapeutic care environments to ameliorate the effects of children's experiences of trauma and attachment disruption.

Therapeutic foster care is known by a wide variety of titles. This includes "treatment foster care", "specialised foster care", "professional foster care", "foster family care", "foster family-based treatment", "multidimensional foster care", "intensive foster care", "parent-therapist program", "therapeutic families", "therapeutic home based care" and "treatment family care". In this literature review, the term therapeutic foster care is adopted (at times abbreviated to TFC) in a generic sense to encompass a variety of titles and definitions. This term is preferred in that it is a widely recognised term internationally and is also consistent with terminology commonly used by the Victorian Department of Human Services.

It is important to note the contextual changes that have occurred in the course of writing this review. Predominately, these have included the development of soon-to-be-implemented pilot programs of therapeutic care models in Victoria (DHS, 2006).

It must be said at this point that there are as many questions arising from this literature review as there are answers to our current questions which will point to many avenues of research to pursue in the future.

## Key findings

1. Therapeutic foster care has been initiated as a response to perceived inadequacies in the care system in Australia and overseas. It is important not to lose sight of inadequacies in the whole care system as TFC is piloted in Victoria. Research to date indicates that TFC is a cost-effective means of enhancing outcomes for children in care.
2. Access to appropriate services for children in out of home care is limited, including access to physical and mental health assessment and treatment.
3. Access to services is often determined by circumstance and environment, not by assessed need.
4. There is little research or other writing detailing the experience of or outcomes for Aboriginal children in out of home care, although there is an agreed knowledge that such children are over-represented and under-catered for in our system.
5. There is a lack of comprehensive research into the most effective interventions for traumatised children in care, with a corresponding lack of consensus regarding models of appropriate intervention.
6. The most promising interventions rest with programs that demonstrate:
  - Coherent theoretical frameworks with a systems oriented trauma/attachment base
  - Comprehensive assessment frameworks
  - Focus on relationship building in both collaborative professional practice and therapeutic practice
  - Include carers and biological family in program design and implementation.
7. There is a strong need in Victoria for an assessment service such as the now de-funded Stargate program.
8. There is a need for ongoing training and education for staff in all sectors on the impact of trauma and attachment disruption on children, the signs and symptoms of this impact and the most effective interventions.
9. While TFC varies greatly across existing programs, there are some commonalities.
10. The key differences between traditional foster care and TFC are the expanded role of the carers and the greater complexity of the children entering TFC. In all TFC models carers are an integral part of the care team and equal partners in treatment planning.
11. There is a range of interesting tools designed to assist the matching of children to carers in TFC.



These matching processes have been shown to enhance placement stability.

12. In TFC the carer is considered to be therapeutic in their parenting practices, so that therapy is much more than the domain of the mental health clinician.
13. Specialist frameworks and skills are needed in the assessment processes of caregivers in TFC. There is a need for practice standards in these assessment processes, not to raise the bar but to increase the knowledge of workers whose aim is to understand and support carers.
14. Common to all TFC programs is the emphasis placed on enhanced training and support for carers, to provide good outcomes.
15. There are a number of factors which increase the chances of successful training.
16. Established TFC programs in the U.S. and U.K. generally promote contact between carers and biological family, and have therapeutic services aimed to assist biological family, as this family involvement has proven to be a critical element in provided good outcomes for children. Research has shown that a carer's anxiety about a child's contact with biological family is associated with poor child adjustment.
17. Ideas for a practice model of TFC in a Victorian context might include:
  - A comprehensive assessment framework
  - A trauma-attachment model within a systemic framework
  - Therapeutic parenting
  - Strong care team/collaborative approach, providing a 'reflective space'
  - Attachment focused dyadic or family therapy
  - Therapy and case management for the biological family
  - Focus on permanency, either with biological or foster family
  - Supervision, consultation and support for carers and workers, with a focus on self care
  - Creative support and respite options, such as the 'Mirror Families' initiative

## A trauma-attachment framework

Children with trauma-attachment difficulties present a significant challenge for all who work with them, in understanding and responding to their needs. An integration of trauma and attachment theories offers a useful framework in understanding children's

difficulties, making sense of their thoughts, emotions and behaviours and guiding interventions for them. In examining therapeutic care models, an emphasis on the importance of developing secure attachments through therapeutic parenting as well as treatment which may facilitate this development deserves considerable attention. *"In attachment-focused therapies the aim is to help children use their carer as a secure base from which they can explore the unhappy and painful aspects of their past and of their present"* (Golding 2006, p. 343). For this reason, this literature review adopts a preference for therapeutic models that utilised a trauma-attachment approach which emphasised a relational approach to treatment interventions.

Throughout this document there is reference to a 'trauma and attachment framework'. It is most useful to integrate the theories developed around both trauma and attachment when trying to understand the complex worlds of children who have suffered abuse and neglect: attachment theory because it speaks of human relationship development from pre-birth throughout the human life span and trauma theory because it helps us to understand the neurobiological and social impact of abuse and neglect on the human individual (See Appendix 2.)

## Mental health problems of children in care

### The interplay of trauma and attachment

Children in care are particularly vulnerable to developing social, emotional and psychological difficulties. In entering the care system, children have often already experienced a multitude of difficulties, such as abuse and neglect, family histories of mental illness or drug and alcohol abuse, exposure to substance abuse and family violence, family dysfunction and criminality (Schneiderman et al., 1998). These experiences are often compounded by the separation that is inextricably created when a child enters care and the associated loss of family, culture, community, peers and, frequently, school environments. Such experiences of loss, trauma and disruption have a significant impact on children developing secure attachment relationships as well as their capacity to later form attachments with a new carer (Golding, 2006). A secure attachment is fundamental to a child's development and is regarded as a key protective factor while an insecure attachment is a risk factor and is often associated with children who have experienced abuse and neglect (Golding, 2006).

### Attachment and culture

In light of the over-representation of Aboriginal children in out of home care and the growing application of trauma-attachment based models of interventions with children in care, it is important to understand the interplay between attachment and culture. Attachment theory has largely evolved from

a Western, individualistic social context and therefore its application to cultures that have a more collectivist base requires caution. Yeo states that, *“Aboriginal culture is collectivist, where they are more likely to think of themselves in terms of their affiliation with other people and their community”* (2003, p. 297). In this regard, Aboriginal values, meanings of 'relatedness' and child-rearing practices differ and therefore assessing attachment of Aboriginal children, parenting practices and beliefs will also differ.

### **Aboriginal child-rearing practice**

*“In Aboriginal culture, a child may have multiple caregivers with occasional lengthy absences from their parents and develop multiple attachments”* (Yeo, 2003, p. 299). In addition, it is not unusual in Aboriginal culture for children to be *“..cared for by different women interchangeably and often will be brought up by women who are not their natural mothers”* (Ralph, 1998 as cited in Yeo, 2003, p. 297). It is imperative that these differences in child-rearing practice in relation to assessing attachment are acknowledged. For Aboriginal children whose cultural experience may be that of having multiple caregivers, it is essentially multiple carers who provide the 'secure base'. Such a perspective of attachment is in contrast to Westernised models of attachment that promote dyadic attachment principles of 'a primary carer' as the secure base. This essentially means a change in thinking from a dyadic perspective of attachment to an attachment network approach (Yeo, 2003 as cited in Tavecchio & Van Ijzendoorn).

### **Cultural variance of exploration and closeness**

Attachment literature commonly refers to concepts of exploration and closeness to assess and describe a secure or insecure attachment. In Aboriginal culture exploration and closeness are largely defined differently from Westernised cultures. Yeo provides an example of an Aboriginal community approach to illustrate that different meanings are attributed to such concepts. For example *“prior to 2 years of age, Aboriginal children are discouraged from exploring the environment by threats and by distracting them with offerings of food. This inhibits exploration and, based on this particular value system, an Aboriginal child may be assessed to be insecure and to have difficulties using their mother as a secure base to explore”* (Yeo, 2003, p. 300). Using this example it can be seen that some attachment behaviours may be assessed as being culturally appropriate or regarded as 'secure' in one culture but in another culture may be regarded as 'insecure'. For this reason, it is important to acknowledge cultural variance in concepts of exploration and closeness which are used to assess children's attachments. In summary, an understanding of the interplay between culture and attachment for Aboriginal children in out of home care is critical. This approach is supported by Yeo who states that *“any assessment of bonding and attachment of Aboriginal children must take into account the historical, cultural and spiritual contexts”* (Yeo, 2003, p. 293).

### **Access to services for children in care**

It is well documented that children in care have higher rates of social, emotional and psychological and physical health difficulties in comparison to the general population (Schneiderman et al., 1998). Such difficulties are most likely exacerbated by the absence of protective factors such as a safe and secure caregiver. For traumatised children in care, access to health care services (including a comprehensive assessment) may be one element of many necessary in the child's healing process. It is also important to acknowledge other elements, such as family and other caregivers (and the provision of therapeutic parenting) or access to culture, as healing elements in their own right for children in care.

In exploring access to health care services for children in care, the Royal Australasian College of Physicians (2006) provides several recommendations in order to achieve optimal care.

These include:

- Routine physical, developmental and mental health assessments provided for all children entering out of home care (within 30 days of placement).
- Formulation of a health plan and ongoing monitoring/review.
- Ensuring access to treatment services (including fast tracking access to therapeutic services given the transient nature of many care placements).
- Developing transferable health records.
- Improved training and support to foster carers.
- Co-ordination and enhanced communication of health care services.

Such strategies provide a useful framework to ensure that children in out of home care and their carers have access to health care services. Whilst these recommendations are welcomed, the provision of health care services for children in care to date is variable.

For example, whilst carers or workers may sometimes identify the need for children to have access to specialist therapeutic services, some specialists limit services to children who are not in a permanent placement (Minnis et al., 2001). Such practices have resulted in many children in out of home care failing to receive comprehensive psychological assessments followed by timely treatment that is often necessary to circumvent their experiences of trauma and disruptions to their attachment.

Some program initiatives have not only identified this difficulty in service provision but have consciously sought to address such issues. The Stargate program (although short lived) was one such early intervention initiative in Victoria for children in care which illustrates such a philosophy.



*“One of the major service gaps that led to the formation of the Stargate program was that children and young people entering care have not been able to access a mental health service until a stable placement had been established. There are sound therapeutic principles behind this requirement, in that theoretically one must have stability in one’s life before issues of an emotional and traumatic nature can be effectively addressed. In reality many of the children and young people entering care do not achieve a stable placement for some time, often years. The Stargate program works from the philosophy that broader system change to achieve immediate stability is crucial; however, working within the system to address the aftermath of trauma and disruption is possible, and in fact intervening at the time of disruption and change can enhance outcomes at the crucial systemic case planning stage, and working with the family at a time of crisis gives opportunities for change that might not otherwise be present further down the track”* (Stargate report, 2002, p. 46).

Other systemic difficulties such as the child's experience of transience (multiple placement change) and uncertainty (length of placements) further compound the child's reduced social, emotional and psychological wellbeing, and their access to mental health services (Clare, 2001). Studies have found that, *“Children in care do not receive appropriate quality of health care because of frequent moves and unclear arrangements”* (Arcelus et al., 1999, p. 235). Such systemic factors need to be acknowledged and their impact considered when developing comprehensive service provision models for children in care. These may include greater flexibility and continuity across service sector borders or priority transition planning and commitments between services for children in out of home care.

One study has compared the access of mental health and other services used by youth in therapeutic foster care (TFC) to that of youth in group homes (Breland-Noble et al., 2005). The findings suggest that youth in TFC were more likely to receive community-based, individualised services such as: in-home counselling, respite, seeing a medical doctor, participating in after school programs, adult mentors or therapeutic recreational services. In contrast to this, youth in group homes were more likely (than TFC youth) to receive restrictive services such as attending a detention facility, have a probation officer and to receive hospital-based mental health interventions such as to work with a psychologist, psychiatrist or therapist, visit an emergency room and attend a special school (Breland-Noble et al., 2005, p. 175). Such findings indicate that children in TFC receive and have access to different kinds of therapeutic services, with a particular lack of specialist psychological and psychiatric treatment. By identifying youth's access or lack of access to mental health services this study provides a useful base for further research into the real needs of children and youth care, and highlights the advantages and disadvantages experienced by youth in different care settings. In addition to this, further research is

required to explore the barriers and access to therapeutic services for carers themselves (with or without the children in their care) in order to gain the support, consultation and training they require as 'primary healers'.

### **Evidence-based and recommended treatment interventions**

A number of authors have explored the prevalence of social, emotional and psychological difficulties for children in out of home care (Clare, 2001; Arcelus et al., 1999; Schneiderman et al., 1998; Leslie et al., 2005a; Leslie et al., 2005b; McMillen et al., 2005; Breland-Noble et al., 2005). Despite this understanding of the psychological difficulties children in care present with, a challenge in the area of child psychiatry has been the lack of development and consensus of effective treatment for children with trauma-attachment difficulties (Rushton & Minnis, 2002). Whilst there are some promising treatment interventions that appear effective for this group, the evidence for these interventions is limited. Evidence-based treatment interventions for traumatised children in care include: Dyadic Developmental Psychotherapy (Hughes, 1997, Becker-Weidman, 2006), Theraplay (Jernberg and Booth, 2001), Neurosequential model (Perry, 2006), Attachment and Biobehavioral catch-up intervention model (Dozier, 2005) and Trauma focused cognitive behavioural therapy (Cohen, 2004). There is also evidence to suggest promise in other interventions such as Parent-Child Interaction Therapy, for biological families, and Dialectic Behavioural Therapy for older adolescents.

Treatment models for traumatised children in care which emphasise a relational approach are noted as being most effective. *“The only interventions with demonstrated effectiveness in reducing the emotional and behavioural problems of looked-after children are those delivered either in close liaison with foster carers, or directly through foster carers”* (Rushton & Minnis, 2002, p. 369). Despite this finding, a difficulty in treating children in out of home care is sometimes the absence of a consistent and committed carer. This absence of a caregiver to participate in dyadic therapy with the child may be attributed to the transience of foster care with some children experiencing multiple placements throughout their time in care with no consistent carer.

### **Referral and assessment process**

International research supports the benefits of providing comprehensive assessments for all children who enter out of home care (Leslie et al., 2005b). In Victoria, the provision of physical, developmental and mental health assessments of children in care varies. Practice principles such as the 'Looking after Children' (LAC) tool provide a systematic screening for children in care. Such practices go some way to ensure that children's health care needs are identified and the provision for treatment intervention plans to be developed.

Whilst such screening tools are useful, the process of referral and assessment for children in out of home

care is largely inconsistent. This process is further compounded by the small number of services available in comparison to the number of children who require such services. Another contributing factor appears to be a lack of understanding of the impact of trauma and attachment disruption to children in out of home care, with a corresponding lack of awareness of the needs of such children. Current practice in Victoria means that only a small number of children in the out of home care system will ever have an assessment or receive treatment from a mental health or allied service. Some authors have described systemic difficulties of workers who may minimise or fail to identify children's presenting behaviour and thereby may not refer to mental health service. *"Those who work exclusively with looked-after children may have particular difficulty in recognising problems warranting referral because they have become accustomed to working with disturbed children"* (Rushton & Minnis, 2002, p. 368).

### **Assessments for children entering care – Stargate model**

Australian findings such as those from the Stargate report (2005) echo those from international programs that children in out of home care are particularly vulnerable to developing mental health difficulties. The Stargate program illustrated the need for, and benefits of, a comprehensive assessment for children in out of home care. Stargate, an early intervention program for children and young people aged 0-17 years entering out of home care for the first time, provided a comprehensive therapeutic assessment. The findings from Stargate indicated that *"nearly two thirds of children had mental health diagnoses and required mental health referral"* (p. 3). Such findings not only indicate the high prevalence of psychological problems for children entering care for the first time, but also highlight potential benefits of screening all children who enter out of home care, providing comprehensive mental health assessments, and ensuring children in care receive access to ongoing treatment.

It is important to note that while the focus of Stargate was on assessment, service linkages ensured that such assessment formulations were well utilised to ensure that children gained access to ongoing mental health treatment. The Stargate report notes that approximately one-third of the children assessed were referred for ongoing mental health treatment, the majority of which was provided by CAMHS (Stargate report, 2002). A continuity of care policy was created for Stargate clients that required ongoing mental health treatment with the Royal Children's Hospital Mental Health Service. This agreement enabled a seamless transition from one service to another without difficulties that are typically encountered such as waiting lists. Ironically, some children assessed by Stargate were referred to mainstream mental health services for ongoing treatment, at times to the very service that may have previously denied access to such children (due to their lack of placement stability as previously mentioned).

### **Training the child welfare system in mental health**

In the absence of a therapeutic foster care system in Victoria (in which treatment is an integral part of the child's placement), children in care are dependent on the adults that care for and support them, such as their caregiver, protective worker, or foster care worker, to refer them for specialist psychological services. Literature indicates that some residential and foster care workers may not refer to mental health services due to waiting lists, the child's placement instability, and insufficient funding (Arcelus et al., 1999).

For child welfare workers to generate a referral to child and adolescent mental health services, they must first decipher when and how to do so. Unfortunately, there has been a tendency for carers and workers to focus on events and behaviours of children in care with minimal attention given to the underlying causes of difficulties (Clare, 2001). This in turn appears to generate referrals for older children and adolescents with externalising behaviours, with younger children and infants (or those with internalising presentations) often failing to warrant enough attention to be referred for specialist services. The absence of a referral for such children (those with internalising presentations and infants) often occurs despite experiencing the same traumatic sequel and attachment disruption as those with more externalising presentations/adolescents. Such practice issues of identifying and referring children to mental health services highlights the importance of child protection workers and foster carers receiving adequate training in mental health. Such training should focus on the identification of mental health problems, knowledge of how to make referrals, and navigating and understanding how the child mental health and welfare systems intersect (Arcelus et al., 1999).

In summary it is argued that specialised training within the system should include a screening tool for potential mental health referrals and assessments for all children in care (as previously mentioned). A designated therapeutic foster care service (such as is currently being developed in Victoria) will address some of these difficulties of access to mental health services for children in care.

### **Children in care – an Australian context**

In 2001-2002 there were reportedly 8,628 children in out of home care in Victoria, with 5,164 of these children residing in foster care and 924 children in residential care (DHS, 2003). Other placement categories included kinship care and permanent care. In considering a therapeutic foster care model for Victoria, it is interesting to look at where such referrals would originate and the impact this may have on existing placement types and numbers. Such factors also need to be considered in light of recent trends that

have shown a decline in foster care placements and an increase in kinship and permanent care (DHS, 2003).

It is important to note that the children represented by such figures include a large proportion of Aboriginal children and that Aboriginal children are over-represented in care (Higgins et al., 2005). Such findings are reported in the DHS Public Parenting Report that states, "Victoria has the highest rate of Indigenous children placed in out-of-home care in Australia" (DHS, 2003, p. 29). Further troubling is the low compliance rate observed in Victoria with reference to the Aboriginal child placement principle. Such findings demand that considerable attention be provided to exploring culturally appropriate and innovative therapeutic care models for Aboriginal children and their families. An excellent resource for services wanting to develop a better understanding of the needs and perspectives of Aboriginal children and their carers is provided by Higgins et al. (2005).

A notable review of children in out of home care in Victoria was conducted by DHS in 2003. The review identifies the increasing complexity of children in out of home care with 56% of current foster carers identifying children in care as becoming more difficult to care for (DHS, 2003). This complexity was attributed to:

- Children presenting with more complex needs.
- Aggressive behaviour.
- Different problems.
- System savvy.
- Sexualised behaviour.
- Drug and alcohol addictions (DHS, 2003).

Despite this increased complexity of children in care, there have been minimal changes to enhance the support and training provided to carers to assist them in responding to these increased needs.

The Public Parenting document recommended several strategies to reform out of home care in Victoria, one of which is centred on developing more responsive service models that include "increasing the availability of therapeutic foster care" and "Increase[ing] the availability of therapeutic services" (DHS, 2003, p. Xvii). Such recommendations for reform are an exciting glimpse of possible future directions in out of home care.

## Therapeutic foster care

### Origins of TFC

The emergence of therapeutic foster care has been developed and shaped by a range of factors. Pioneering international TFC programs largely established in the 1970s arose in part as a result of the failures and shortcomings of existing services to treat children in care. Murphy & Callaghan (1989, as cited in Horejsi, 1979) refer to several limitations of

traditional foster care: "(1) not providing individualised treatment, (2) failing to include birth families in treatment plans, (3) equating foster/house parents with baby-sitters and, (4) operating in a generally insensitive manner with respect to meeting a client's needs". Such criticism of traditional foster care models illustrates the significant thrust within the international child welfare sector during the 1970s to create more effective treatment models for children in care.

In addition to such attempts to respond to the limitations of traditional foster care, TFC also evolved from legislative changes and shifts in residential care philosophy. The amendments to the U.S. Social Security Act in 1961 supported such changes, in which a provision for "federal cost sharing for difficulty of care rates for challenging young persons" was created, as well as "payments to programs organized to recruit, train, and pay foster parents to provide treatment services to challenging youth" (Hudson et al., 1994b, p. 1). Such legislative changes undoubtedly provided the necessary financial resources to support the implementation of new service models at that time.

Another change during this period was a move within residential treatment services towards deinstitutionalisation. Such ideology emphasised foster homes as a preferred alternative to residential care settings for children requiring care and was additionally supported with reference to economic costs savings.

Whilst the impetus to develop TFC appears to be attributed to several contextual factors occurring internationally in the 1970s, it is interesting to hold in mind the factors responsible for its development and whether current applications of TFC have answered the traditional shortcomings it was meant to address.

### Definitions of therapeutic foster care

Definitions of therapeutic foster care vary. Stroul (1989, cited in Jivanjee, 1999b, p. 451) defines therapeutic foster care as combining the "normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant home". Such a definition encompasses a central tenet of therapeutic foster care: that treatment for children occurs in a family environment or essentially that the family themselves are seen as 'therapeutic'.

Whilst definitions and service models of therapeutic foster care may vary, there are a number of fundamental characteristics that remain essentially the same. Common characteristics of therapeutic foster care include:

- Home-based treatment for children with therapeutic carers who receive specialised training.
- Typically one or two children in the home.



- Small or low child welfare case worker caseloads, to enable them to work more intensively with each child and family.
- Higher stipend (reimbursement) than traditional foster carers.
- Professional treatment parents or caregivers who participate as members of a treatment team.
- Comprehensive assessment of the child and matching process.
- Support services for carers, including regular supervision and access to clinical consultation.
- Provision of clinical treatment for children, carers and biological families.
- Crisis intervention services.
- Educational services (some).
- Health screening and medical services as per assessment
- Co-ordination of services ensuring system linkages (care team approach).

### Difference between TFC and general foster care

A key difference between TFC and general foster care is the role of the carer. Essentially, carers in TFC are regarded as part of a professional treatment team. Some TFC organisations have attempted to define this difference stating that, *“While all treatment parents are foster parents, not all foster parents are treatment parents. Treatment parents serve both as caregivers of children with treatment needs (the fostering role) and as active agents of planned change (the treatment role)”* (FFTA, program standards, 2004, p. 19).

Others have emphasised the child and their family's access to intensive treatment as fundamental to TFC programs. *“Treatment foster family programs are distinguished from traditional foster home placements by their emphasis on planned intensive treatment of children, which it is hoped, will develop effective interpersonal, emotional, and social behaviours”* (Thomlison, 1991, p. 2).

It has also been argued that children in TFC are more traumatised and challenging in their behaviour than those in general foster care. This is reflected in the increased caregiver reimbursements, intensity of staffing and intensive treatment provided. Thomlison (1991, p. 3) writes, *“Treatment foster care children are substantially more difficult to understand and to parent. This is due to the extensive and negative child and family interactions over longer periods of time than for a child placed in traditional foster care.”* A more comprehensive and detailed description of the elements of TFC is provided below and serves to distinguish further how TFC differs from traditional foster care models.

## Characteristics of TFC

### Enhanced services and caregiver reimbursements in TFC

Typical of most therapeutic foster care programs are the higher rates of reimbursements provided to caregivers. An interesting study conducted by Chamberlain and colleagues (1992) explored the impact of providing carers with enhanced training and support services plus a small increase in their caregiver reimbursement rate on caregiver retention rate. A sample of 72 children and their carers were included in the study and placed into one of three groups. One group was given an increased caregiver payment and offered weekly group sessions as well as telephone contact with program staff members three times per week (referred to as the enhanced placement group). A second group was provided with an increase in their caregiver payment without additional support. The control group was provided with neither an enhanced training and support, nor an increase in caregiver reimbursement.

The results of the study indicated that caregiver retention rate was impacted by the level of support and increased reimbursements, with significantly less carers discontinuing (16.6%) compared to a state-wide drop out rate of 40%. Outcomes for children in the enhanced placement group were reported as significantly more successful (based on daily report measures) than children in each of the other two groups. This study suggests that carer retention is influenced by increasing caregiver reimbursements and enhancing training and support to carers (Chamberlain et al., 1992). Such findings provide a strong argument of the potential benefits to children and their carers when additional supports and resources are provided. These enhanced placement services are also consistent with a professionalisation of foster care and therapeutic foster care models.

### Characteristics of children in TFC

Whilst there is a large volume of literature that notes children in out of home care have complex needs, there appears to be a limited number of studies which have attempted to distinguish the different characteristics of children in TFC from traditional foster care. One description of the characteristics of children and youth served by TFC includes those children with *“serious emotional and behaviour problems who have experienced significant abuse or neglect and multiple out-of-home placements, including hospital or residential settings”* (Bryant, 2004).

A more detailed account of the characteristics of children and youth served by TFC has been investigated by Hudson and colleagues (1994) in a study of 321 TFC programs. Several key characteristics of children and youth in TFC included;

- The ages of children in TFC were: 8% less than 6 years old, 25% were 6-11 years old, 28% were 12 to 14 years old and 38% were 15-17 years old.

- The majority of clients were male.
- The majority of clients (51%) entered TFC from residential homes, 22% entered into TFC from parental home while only 6% entered TFC from Kith and Kin placements.
- Typical presentations for children entering TFC included 65% placed into TFC with psychiatric or emotional difficulties, 17% with criminal behaviours, and 13% with health or behavioural difficulties.

In addition to this study, other attempts have been made to further define the client group by comparing the characteristics of children in TFC and those in residential group homes. One study (Duerr-Berrick et al., 1993) surveyed all group care and specialised foster care agencies in California to explore the characteristics of children in specialised foster care and group home care according to demographic, educational, health, and behavioural characteristics. Results of the survey included:

- The majority of group homes served older children and adolescents while specialised foster care provided more services to younger children.
- African-American children were over-represented in both group homes and specialised foster homes.
- Children in both types of care exhibited problematic behaviours including history of sexual and physical abuse, acting out behaviours, aggression, sexual promiscuity and substance abuse.
- Children in specialised foster care were noted as having more medical problems than those in group care.
- Total behavioural problems scores for children in group home care were somewhat higher than those in specialised foster care.
- In terms of education, the average child in specialised foster care was in grade 6 and approximately 30 % had been held back or repeated a grade previously, while 40% of children in specialised care were enrolled in some type of specialised education class.

The above characteristics provide a useful source of data about the types of children served by TFC and, in doing so, indicate the challenging client population that this model serves.

### Assessment and matching process

Placement stability, which is noted as a positive outcome of TFC, is often attributed to effective matching processes of children and carers (Redding et al., 2000). Despite the importance of matching children and carers, Redding and colleagues note that research in this area is possibly limited due to the minimal number of foster families available/accredited

compared to the number of children needing to be placed in care.

Placement breakdowns create a major challenge for the child welfare system and are often linked to poor outcomes for children in care. Research has noted that, *"Foster parents often consider giving up an emotionally disturbed child within the first 90 days of placement"* (Baker, 1989, as cited in Redding 2000, 433). Such statistics highlight the importance of not only providing training and support to carers but the importance of matching children and their carers in the effort to reduce the possible risks associated with placement breakdowns and children's instability of care.

Despite the importance of the matching process, there appears to be little information or emphasis in the service system to guide practitioners in the matching process. In Victoria, the matching process in practice appears to be largely dictated by caregiver availability rather than suitability.

Several authors have explored the importance of assessing and matching children and their carers, with one innovative study exploring an interactional model (Street and Davies, 1999). This model explores the interaction between the child and caregiver and uses this to guide placement matches. The model is largely built on the principle that both the child and carer bring something to the establishment of a relationship and by looking at interactive patterns we may be better able to assess and match children with carers. Such a model provides a useful framework for further discussion when developing effective matching processes for children and their carers.

An ongoing difficulty that continues to be mentioned in the literature is the lack of information provided to carers. This practice appears to generate a 'culture of secrecy' in which carers are rarely informed or included in matters relating to the child despite often playing a de facto parental role. Such a practice is in contrast to the majority of TFC programs that emphasise the importance of carers being informed about the child's background. It is unknown to what extent (if any) the impact this practice has on placement stability, or whether a more comprehensive information and matching process would reduce placement breakdowns.

In summary, a comprehensive assessment of the child and the carer is seen by some programs as fundamental in the matching process for therapeutic foster care (Gregory & Phillips, 1997). Some therapeutic foster care programs place a strong emphasis on the matching process much more than traditional foster care programs. This includes not only a comprehensive assessment of the child but that of the carer's characteristics and the compatibility or fit between the two (Sinclair & Wilson, 2003). These TFC programs anticipate that by placing a stronger emphasis on the matching process, this will greatly increase the likelihood of placement success.

## The therapeutic foster carer

A key characteristic of therapeutic foster care that distinguishes it from more traditional foster care models is the role of the carer. For the majority of therapeutic foster care programs a central facet is *"using trained foster parents to provide therapeutic intervention to a child within a family setting"* (Fisher, Ellis et al., 1999, p. 162). In this regard, carer/s are considered to be an integral and active member/s of the treatment team. The therapeutic carer's role (also referred to as treatment parent) is essentially extended from traditional conceptualisations of care to implement an individualised therapeutic plan for the child. This approach is built on the premise that the daily contact carers have with the child in their care offers countless opportunities for 'therapeutic moments'. Essentially, *"therapeutic foster parents are trained to view their interaction with foster children and everyday activities as supplying opportunities for therapy"* (Murphy & Callaghan, 1989). Such frequent contact enables carers to implement a treatment strategy daily as opposed to the limits of a weekly visit to a therapist (Chamberlain & Weinrott, 1990, Sheperis et al., 2003). Essentially, it is contended that, *"Treatment foster care is based on the premise that foster parents can serve as a major provider of therapy in their daily interactions with the child, and that therapy need not be practised by the clinician alone"* (Redding et al., 2000, p. 426).

## Motivation for fostering

The foster carer's motivation to foster a child has been noted as a predictor of placement success (Redding et al., 2000). A study by Dando and Minty (1987, as cited in Redding et al., 2000) has indicated that high performance was correlated with two motives, infertility issues with a desire to parent, and identification with a child due to own past personal experiences. Such motives highlight that quality fostering is associated with caregiver motivations being based on strong personal needs (Redding et al., 2000).

Motivations to foster from a cultural perspective are also interesting to consider. An Australian review of Aboriginal and Torres Strait Islander carers found that *"Aboriginal people may be motivated to foster to help prevent another generation of children being disconnected from their people and their culture"* (Richardson et al., 2005). This finding highlights the ongoing impact of past welfare policies (stolen generation) on Aboriginal and Torres Strait Islander people and how such experiences may contribute and motivate a desire to become foster carers.

## Foster carer selection and assessment

The importance of considering the carer's personality in the assessment and recruitment process is complex and an issue that is deserving of exploration. One study has examined the relationship between the personal characteristics of carers and their effectiveness in providing therapeutic care: *"understanding the personalities of parents who choose to*

*work with these disturbed children, and identifying those personality factors that predict success may reduce the number of failed foster homes"* (Ray & Horner, 1990). Whilst the authors are not proposing psychometric testing as a determinant for carers, it raises an interesting question as to the relationship between the quality of the caregiver assessment in assessing the carer's personal characteristics and in predicting good outcomes for children in care. Further consideration is required as to the competence and skill required to conduct a specialist caregiver assessment, as well as the training provided to caregivers in implementing a therapeutic foster care model.

A comprehensive assessment of the caregiver is critical in order to understand potential relational dynamics between the carer and child, and in developing interventions for the child and their carer. International research, particularly that conducted by Dozier (2001), has found that *"the attachment classification of a foster mother has a profound effect on the attachment classification of the child"* (Becker 2006, p. 3). Despite this finding, the attachment experiences (or unresolved history of trauma) of the caregiver are not always well assessed or understood in a child welfare context. Child welfare agencies could potentially assist carers and the children in their care greatly by developing more comprehensive psychological assessment frameworks and the skills of those professionals undertaking the assessment.

Existing Victorian foster care agencies adopt a variety of criteria when assessing carers, with quality and expertise varying across both agencies and workers who undertake such assessments. Similarly, there also appears to be differences in practice between traditional foster care assessments undertaken by permanent care teams in comparison to foster care programs. Whilst such differences in practice are not well understood, it perhaps illustrates the importance of developing practice standards for caregiver assessment and training and the staff that undertake such tasks.

It is important to make the distinction that while advocating for more comprehensive caregiver assessment processes, it should not be seen as 'increasing the criteria' or 'bench mark' to become a therapeutic carer. Rather, to illustrate the importance for professionals to have a more comprehensive knowledge of 'who they are working with' and the potential vulnerabilities that children in their care may elicit. Carers come from a variety of experiences and backgrounds. In developing a therapeutic foster care program, emphasis should not be placed on finding the 'perfect' carer, but on developing a better understanding of the carer who will potentially become an integral part of the treatment team. Knowledge gained from such specialist assessments is likely to assist in both a sophisticated matching process and a better understanding of the potential support and specialist training carers require. For example, this knowledge could possibly include a possible history of trauma, unresolved family of origin difficulties and attachment difficulties.



## Training therapeutic carers

Whilst therapeutic foster care programs may differ in theoretical orientation or structure, a common philosophy is the enhanced training and support provided to therapeutic carers (or treatment parents). The emphasis on specialised training and support provided to carers is seen as critical if carers are to deliver and implement treatment plans for children in their care. Whilst the specialist training for therapeutic carers is typically facilitated by specialist mental health clinicians, the theoretical framework and training content is largely dependent on the treatment paradigm of the program. Many of the therapeutic foster care programs provide pre- and in-service training to carers who are also supported by ongoing training and regular support groups facilitated by TFC program staff. TFC programs internationally typically adopt a behavioural approach to treatment and therefore train carers in such approaches, as opposed to attachment-based-therapeutic parenting approaches that have gained favour in the Victorian context.

In Victoria, foster carers typically access standard foster care training as part of their initial assessment/recruitment process, with the process being largely determined by the agency. Whilst some agencies may provide specialist training for their carers, this appears limited and inconsistent. Recent departmental initiatives in Victoria have sought to address this, by developing a common and competency based pre-service package for foster carers based on an NSW Department of Community Services model, Shared Stories Shared Lives training program (Hayden et al., 2001). This pre-service training is then supplemented by advanced training for carers (DHS, 2006). These advanced training programs are currently in a developmental stage at the time of writing this review. Such initiatives provide an important first step in developing standard training for carers in Victoria. Further specialist training that complements existing training and support services is also essential to ensure that carers can continue to build on their skills and access specialist resources to continue in their role of caring for the complex children who present in out of home care.

Whilst the need for specialised training for carers is enormous (see an Australian review of carers views and needs about specialist training by Anne Butcher, 2002), what appears fundamental is the inclusion of opportunities for carers to explore the impact of their own family of origin experiences, relationships, and possible experiences of trauma which is highly likely to be evoked in caring for a foster child. Cole (2005a, p. 57) states that, "*Prospective caregivers may need assistance in understanding how their own childhood experiences of childhood trauma and anxious concern for the infant can make it difficult to respond to the relational needs of the infant in care. Caregivers may need coaching to develop the ability to read the signals the infant is providing and to understand and respond to the needs of the child* (Dozier &

*Albus, 2000b). Most foster parent training includes topics related to child development, loss, and attachment from the child's perspective (Child Welfare League of America, 1996). However, the training does not assist caregivers in exploring their own childhood experiences. Child welfare agencies can provide training that links the caregiver's experience with its effects on the infant."*

### A rationale for training carers

In line with the need for enhanced training for carers, several factors are deserving of mention. These are:

- The impact of increasingly complex presentations of children in care requires more intensively and highly skilled foster carers (Butcher, 2002).
- 25% of placement breakdowns result from carers feeling incapable of responding to and managing the child's behaviours, which is attributed to a lack of foster parent training (Redding et al., 2000).
- The need and importance for specialist ongoing training. Studies have shown that "three days of training within the normal structure of services is insufficient to improve the emotional and behavioural functioning of children in foster care" (Minnis & Devine, 2001, p. 53).
- Training can provide carers with a conceptual framework that assists them in understanding the young person's difficulties (Allen & Vostanis, 2005).
- Studies have shown that training carers reduces placement breakdown and increases caregiver retention rates (Bryant, 1981; Webb, 1989 as cited in Redding et al., 2000).
- In TFC programs, carers are expected to implement a treatment plan daily and while some carers will be able to do this instinctively, many will need training to develop the specialist skills and knowledge to enable them to carry out this role (Chamberlain & Weinrott, 1990).
- A key area of effective treatment for children with reactive attachment disorder is attributed to foster care training (Sheperis et al., 2003).

These aspects provide a strong rationale for the importance of providing specialist training to foster carers. Carers are often ill-equipped to manage the complexity of behaviours, histories and needs that children in care present with, and often face the risk of placement breakdowns, resulting in further disruption for the child. Training and support for therapeutic foster carers is not regarded as an optional extra or an after-thought, rather as an integral part of the therapeutic foster care treatment model. Training is considered necessary in supporting placements, achieving optimum outcomes for children in care, enabling carers to implement treatment plans and indeed as the carer's right.

## Engaging carers in training

Foster care programs typically note difficulties in engaging foster carers to attend training. Whilst some therapeutic foster care programs regard attendance at training a necessary component of a carer's ongoing accreditation and supervision, some foster care training programs have explored creative ways of engaging carers from a more 'voluntary' position. Pallett and colleagues (2002) describe a training program for carers with a central component that emphasises strategies of engaging carers to attend training. These strategies include:

- the use of focus groups,
- an initial home visit prior to training, and
- a training philosophy that values carers.

In this study the focus group was created prior to training to initially consult with carers and explore ways of minimising potential aspects that impinged on a carer's ability to attend training. Experience has shown that carers' reasons for not attending training usually relate to practical concerns such as babysitting or managing the child's other commitments such as the child's access schedule or appointments. In gaining a better understanding of the factors that impacted on carers attending training from the focus groups, further consideration was then given to assisting carers with the practical arrangements of travel and childcare to facilitate their attendance.

The pre-training approach included an initial home visit to the carer prior to training commencing. The home visit was used to;

- engage carers,
- provide information about the course,
- arouse interest and enthusiasm,
- encourage networking with other carers (to avoid isolation),
- explore the carers' previous experiences of training, and
- the carers' experiences of caring for the child, including current struggles.

The final approach to engaging carers to attend training was seen as a message embedded in the philosophy of the program. This included developing 'training assumptions' such as;

- respecting the experience carers bring to training,
- including carers in the training as active participants,
- valuing carers (this includes a written letter being sent to carers if they do not attend a session to offer support),
- placing an emphasis on fun, and

- carefully considering what food is provided during sessions (as this has been noted by carers as reflecting their feelings of self worth).

Such strategies, although not generally identified as common approaches in engaging carers to attend training in therapeutic foster care programs, offer a useful framework that could readily be implemented in developing TFC training models.

In addition to these suggestions, considerations to engaging carers in training need to also include a cultural perspective. Whilst some of the practice difficulties in engaging carers to attend training may be broadly applicable to Aboriginal carers (such as the need to organise assistance with child care), it is important to acknowledge the additional impact of culturally inappropriate training programs. From an Australian context, the majority of training provided to foster carers is not developed in a culturally appropriate framework, impacting significantly on engaging Aboriginal carers to attend training. Higgins and colleagues (2005) note that for some Aboriginal carers, the anxiety of being the only Aboriginal or Torres Strait Islander person present in the training prevents their attendance. Such issues require careful consideration in order to minimise the potential barriers for Aboriginal carers attending training and to ensure that all carers can access culturally appropriate training.

## Effect of foster care training on children's functioning

Several studies have sought to explore the impact of training foster carers in caring for traumatised children. Although such training has been shown to be valued by carers overall, studies indicate no change to psychopathology for children in their care (Minnis et al., 2001; Minnis et al., 1999; Minnis and Devine 2001; Hill-Tout, 2003; Pithouse et al., 2002). Interestingly these programs have overwhelmingly operated from a behaviour management approach and further study is required to explore the application of other treatment frameworks used in foster care training on children's psychopathology. One more promising study that explored a cognitive-behavioural approach to training carers was developed by Pallett and colleagues (2002). This study showed improvements in carer/child interaction, children's emotional symptoms, and child difficulty. However, insignificant changes were noted in the child's hyperactivity and conduct problems. This training program placed a strong emphasis on engaging carers in training and it is interesting to consider if this aspect is what contributed to its success.

## Theoretical approaches to training carers in TFC

Therapeutic foster care programs differ in their theoretical approaches with some emphasising trauma-attachment theory and others focusing on a

cognitive behavioural approach. Naturally the theoretical approach to training carers is typically consistent with that of the specific therapeutic foster care program's approach to intervention.

Whilst a number of studies have explored the application of cognitive behavioural parenting approaches to training carers (Herbert & Wookey, 2004, Pallet et al., 2002) an increasing number of authors (Hughes, 1997, Allen and Vostanis, 2005, Golding, 2004, Cairns, 2002) have documented the need for a different approach to parenting children from a trauma-attachment perspective (therapeutic parenting). Allen and Vostanis (2005) note that *"it is well recognised that traditional parenting skills may need adapting in order to meet the needs of children with attachment difficulties consistent with a history of abuse and trauma"*. Given this, the application of mainstream parenting programs which often rely on a cognitive behavioural approach require careful consideration in their application for this client group.

It is likely that a fundamental mistake in training foster caregivers to date has been the application of training generalist parenting principles to carers of children with trauma-attachment difficulties. Furthermore, a growing body of literature now exists that argues for carers to receive specialist services (trauma-attachment based parenting principles) which are different from mainstream parenting services and take into account the complexities of children in home-based care (Golding, 2004).

An interesting study by Golding and Picken (2004) compared the effects of a CBT parenting program with an attachment-based program on the foster carer's ability to understand and respond to foster children. The CBT parent-training group (group one) was based on the 'Incredible Years parent-training program' with an additional component added to the program on child abuse/neglect. The aim of this group was to promote parenting skills, building positive relationships with children, and increasing carer understanding of children's behaviours. Sessions occurred weekly for 2<sup>1</sup>/<sub>2</sub> hours for 9 consecutive weeks.

The attachment-based group (referred to as the 'Fostering attachments: an attachment theory and intervention group') focused on helping carers to develop specialised skills for children with attachment difficulties. Initially a four-week course explained attachment theory and the development of attachment patterns. This was followed by two-hour group sessions held monthly over an 18-month period where carers explored therapeutic parenting from a dyadic developmental psychotherapy perspective.

Quantitative (i.e. outcome measures) and qualitative (feedback from carers and facilitators) were used to evaluate the two groups. Results showed a significant improvement in carers' level of understanding, confidence and ability to relate to the child in the attachment group (group two) whilst in comparison only a moderate improvement was noted for the CBT

parent-training group (group one). No significant difference was noted in children's pro-social behaviours, or emotional problems for either group. Scores revealed that carers from both groups reported satisfaction with the training. Whilst the evaluation of the two groups both indicated success, the CBT parent-training group was shown to largely assist carers to develop behaviour management skills, while the trauma-attachment group was found to assist carers to develop an understanding of attachment theory and managing children with attachment difficulties, with opportunities to develop their new skills. Further research is required to explore the extent of these improvements and if particular theoretical training programs are better suited than others to training carers and improving outcomes for children in care.

## Training models

A number of specialist training programs have been developed internationally and within Victoria to assist carers in their role of caring for children with a complexity of needs. Noteworthy examples cited in the literature include:

### International training models:

#### Fostering attachments with children who are looked after and adopted:

##### A group for foster carers and adoptive parents (Golding, 2006)

This is a very comprehensive and well-developed group program for carers that is deserving of special mention. The program consists of 3 modules with each module consisting of six sessions. The modules include: attachment theory, providing a secure base for parenting the child with attachment difficulties and building relationships, and managing behaviour from an attachment perspective. The model has been heavily influenced by therapeutic parenting ideas from Dyadic Developmental Psychotherapy developed by Daniel Hughes (1997).

##### Training program for foster carers and their supervising social workers (Allen & Vostanis, 2005)

This seven-week program consists of training carers on attachment theory. It differs from other training programs in its systemic focus on engaging both carer and the social worker in joint training. The group intervention aims to assist carers and their social workers to explore the impact of abuse and trauma on the developing child. It is intended that the joint participation will both improve the degree to which foster carers feel supported and develop a team approach. Such a model serves to increase the supervising social workers' confidence in supporting/advising carers in trauma-attachment, and assist carers to feel understood by their support workers in the day-to-day challenges of caring for such children. In providing joint training, it is further anticipated that greater appreciation of the roles is developed and a sense of a team approach fostered.



**Attachment and Biobehavioral catch-up:  
An intervention targeting the relationship between  
parent and child (Infant caregiver project,  
University of Delaware, 2005)**

This intervention model consists of ten sessions that are individually conducted in the home of foster carers. Sessions focus on assisting carers to provide a nurturing relationship, a responsive interpersonal world, and a predictable environment for the child. Carers and their infants are videotaped frequently and these tapes serve as a tool for discussion about the caregiver-child dyad. The program has been evaluated (outcome measures included cortisol testing to measure stress levels) with results showing that the training intervention was effective in targeting children's regulatory capabilities (Dozier et al., in print). It is important to note that the training program was developed out of extensive research in the field of the foster carer-child dyad including the correlation between 'maternal state of mind' and infant age at placement in developing attachment security (Bates & Dozier, 2002).

**Attachment for foster care and adoption: A training  
programme (Beek & Schofield, BAAF, London, 2006)**

This training program consists of 6 training modules covering:

- Module 1 - Core concepts in attachment theory.
- Module 2 - Being available - helping children to trust.
- Module 3 - Responding sensitively - helping children to manage feelings and behaviour.
- Module 4 - Accepting the child - building self-esteem.
- Module 5 - Co-operative care giving - helping children to feel effective.
- Module 6 - Promoting family membership - helping children to belong.

These modules draw on a 'secure base' parenting model which was developed by the authors and based on the earlier research of Mary Ainsworth. The training program is accompanied by a well-developed training package that consists of a DVD, CD ROM slide show, and a comprehensive book that outlines much of the theory used within the training.

**Specialised training programs in Victoria**

**Advanced training program for TrACK carers  
(Success Works, TrACK evaluation report, 2005)**

The training in this program targets carers and staff and consists of three modules that include:

- Understanding the child's history of trauma, attachment and loss, self care.
- Exploration of the impact of trauma on the brain and development, and introduction to therapeutic fostering.
- Rebuilding children's lives, and therapeutic fostering.

This advanced training provided by the TrACK program was evaluated as part of a wider program evaluation in 2005. Qualitative results indicated positive feedback, however no standardised outcome measures were used to evaluate children pre- and post- placement.

**Working with Children in Care - manual for carers  
(Connections, Child, Youth and Family Services -  
Challenging Behaviours Consultancy program, 2005)**

Challenging Behaviours Consultancy (CBC) is a specialised program that provides in-home secondary consultation and training to foster carers and supporting agencies (Connections, 2005). The CBC manual for carers provides an overview of helpful information for carers who care for children in out of home care with emotional and behavioural problems. The manual covers topics such as child development, assisting the child entering care, promoting and encouraging attachment, working with the child's external system (or network), practical strategies in responding to the child's challenging behaviour including consequences, giving praise, providing choices and includes a section on carer self-care. It is unknown if any evaluation of this consultation and training model has occurred.

**Creative training and support for carers**

In reviewing the literature, a number of creative ideas to support and train carers were highlighted and have been provided here as the basis for further exploration:

- Online specialised and highly accessible training programs for carers (a few examples are cited at the end of this review under websites).
- Provision of a foster parent support group that meets regularly and is a requirement of ongoing carer accreditation (as well as attendance at training) (Hudson et al., 1994).
- Access for carers to professional therapeutic supervision for the entire foster family.
- A formal consultation service provided by clinicians to create a 'reflective space' for carers and the child's network together, to explore the needs of the child in care (Golding, 2004).
- Twelve-month internship for foster carers supervised by experienced foster carers (i.e. buddy system approach) (Gregory & Phillips, 1997).
- Professional development opportunities for the carer to gain recognised qualifications such as participating in certificate courses in counselling and child development (Walker et al., 2002 and Hutchinson et al., 2003) or nationally recognised qualifications such as the New Zealand Certificate in Family/Whanau and foster care (Lawrence, 2004).
- A "probation" period of 12 months for carers in which they receive intensive supervision by a clinician and ongoing training before full carer accreditation occurs (Yokley, 2002).

## The child's network

Children in care often have extensive professional networks created by the very nature of being in care. These networks may include foster carer, biological parents, child protection worker, foster care worker, clinician, cultural worker, school and professionals and other health professionals. Oppenheim (1992, ed. in Hill 1999, p. 203) states that, "*The complex web of relationships surrounding fostered children may be more helpfully conceived of as a network rather than a family system.*" Such networks require careful attention to the communication processes between members. Some authors have emphasised this by stating that communication within the network should be regarded as the "*actual currency of interaction and is vital to the system*" (Oppenheim, 1992, p. 204).

While the intention of the network that supports the child in care is to work collaboratively with clear communication processes, the realities of achieving such outcomes are highly variable. A common element of contention within the network is the potential for confusion and misunderstanding about each other's role (Stott, 2006). It is these tensions that in turn hinder individuals within the network from working together in the best interests of the child. Stott (2006, ed. by Golding et al., 2006, p. 50) writes, "*The danger in inter-agency forums is that there is a great potential to split professionals or agencies into good and bad, helpful or neglectful, rescuing or abandoning. This is a way of dealing with the heightened emotion of working with strong and opposing feelings towards the same child or birth parent or carer.*" These powerful feelings that are evoked often create difficulties for networks striving to create a space to reflect and work together. It is therefore the collaboration and reflective space created by the network that is seen as essential in achieving good outcomes for children in care.

A useful framework that describes the process of creating thinking networks for children in care is provided by Stott (2006, edited by Golding et al., 2006). Some services have even created a role of consultancy to the network. An example of this is a specialist consultation program in the U.K. that provides support to the child's whole caregiving network (Golding, 2004). Golding argues that the child's network coming together is emphasised as being important in promoting understanding and to support working relationships (Golding, 2004). This process of consultation is thought to provide the "*members of the network with time for reflection, which in itself can bring about change*" (Golding, 2004).

At times, defining and exploring the child's potential network can be problematic. Oppenheim (1992, ed. by Hill, 1999) suggests that the care team casts a wider net that is inclusive of extended family members and cultural links. In doing so, a greater resource for helping the child in care is created. At times "*networks may have to be purposefully arranged*" (Oppenheim, 1992, in Hill 1999, p. 210), in order to assist the children and their families. One potential

model that purposefully seeks to create networks to benefit the child and their family (biological or foster) is the Mirror Families Concept (Brunner, 2006) described later in this review.

One issue that appears to have received little attention in the literature to date is the notion of shared responsibility and equal partnership within the care network. In traditional foster care models the foster carers are often relegated to a 'lesser position' in their ability to make decisions, this being most evidenced by failures to invite foster carers to meetings, or neglecting to provide them with information about the child. In general, carers have often deferred to professionals within the network to assist in making decisions in relation to the child. In contrast to these practices, therapeutic care models place an emphasis on carers being an integral part of the treatment care team and 'equal partners' in treatment planning.

### Biological parent involvement in therapeutic foster care

Parents' involvement with their children in out of home care has historically been marred with difficulties. Some authors have attempted to explain this by noting the paradoxical dilemma that the child's source of 'security' is also the child's source of danger and that it is this dilemma; that impacts on the 'system's' active engagement and involvement of parents. Jivanjee (1999a, p. 330) writes that, "*Traditionally, the desire to protect children from abusive and/or neglectful parents contributed to limitations placed on their involvement when children were in foster care. [However,] Bowlby's (1969) seminal work on the importance of attachment relationships drew attention to the potential harm caused by parent-child separation when children are placed in foster care.*"

In Victoria, current practices which provide attention, support and inclusion to the biological family when children enter out of home care appear inconsistent. Carers within the Victorian care system have historically had little contact with biological families. In practice this has resulted in carers both receiving little information about the child and the biological family, and rarely being included in supporting the child's contact with parents directly. A frequently utilised approach is that of the foster carer agency typically performing a "mediating role" between carer and parent. Such models of carer and parent separation are inconsistent with therapeutic care approaches adopted internationally, which emphasise the carer's involvement with the biological family.

Many authors have explored the importance of family continuity and involvement for children in TFC (Thomlison, 1991, Jivanjee, 1999a, Jivanjee, 1999b, Sanchirico & Jablonka, 2000). Biological family involvement is noted as being a critical element in providing therapeutic support to children in care. "*Family involvement in children's treatment and care is likely to contribute to achieving the goal of long-term stable placements for children either with their families or in*

*adoptive homes*" (Jivanjee, 1999b, p. 451). Whilst such views are generally supported theoretically, practice experience appears to disregard the importance and involvement of family when case plan decisions have indicated long-term or permanent out of home care. Despite these practices, some authors stress the importance on greater family continuity regardless of the child's case plan stating that, "*Parent-child contact and parent involvement can help to ensure family continuity and stability whether the goal is family reunification, or placement for adoption or other long-term out-of-home care*" (Thomlison 1991, as cited in Jivanjee, 1999a).

### **Barriers to involving parents in TFC**

Whilst some therapeutic foster care programs have acknowledged the importance of involving biological family and even policies that encourage family involvement, there have been noted discrepancies between policy and actual practice (Jivanjee, 1999a). In a study of barriers to family involvement in therapeutic foster care, key aspects identified were: limited professional time, philosophy of the program, bureaucratic constraints, practical and emotional barriers, parents' experience, intrusive nature of child protection, therapeutic foster care providers lack of commitment to families, and lack of training provided to carers regarding the importance of family involvement (Jivanjee, 1999a).

Therapeutic care models should seek to clearly define 'how' families should be involved to ensure that further neglect does not occur. Several authors (Fisher & Chamberlain, 2000, Fisher, Ellis et al., 1999, Gregory & Phillips, 1997) describe TFC programs that have designated specialist worker roles to support and provide direct treatment intervention with biological parents. This may include: providing family therapy, providing mentoring or parent management training, facilitating group therapy for biological parents, respite service for biological parents during a 'step-down' (transition back home, with diminished clinical support) (Gregory & Phillips, 1997) and as highlighted by some programs the provision of a 24-hour crisis intervention service. Such TFC programs emphasise the importance of including parents in weekly family therapy stating that, "*Maximising the natural family's capabilities to effectively care for their child is a priority treatment goal. Weekly family therapy sessions are conducted with the goal of helping parents learn and practice effective family management strategies*" (Chamberlain & Weinrott, 1990, p. 26).

### **Parents' experience of TFC**

A key article on the experience of parents' involvement in TFC (Jivanjee, 1999b) provides a useful examination of the potential barriers and experiences of parents, and serves to direct TFC programs to developing strategies for enhancing parent involvement. Jivanjee's research provides a comprehensive description of the relationships and practices which contribute to parents' involvement. The relationship aspects are noted as: child welfare

and mental health professionals who communicated understanding of the challenges the parents faced, advocated for the parents, facilitated the parents' involvement, and took time to develop relationships with them. Parents were also said to appreciate parent-professional relationships that were honest, respectful and supportive, with parents also expressing appreciation when TFC providers shared information about their children's progress, offered support and facilitated contact with their children (Jivanjee, 1999b).

### **The therapeutic parent and biological parent interface**

Therapeutic (or treatment) foster parents have a particularly challenging role within any TFC program in defining their role as a 'therapeutic parent' (providing both care and treatment). Essentially, "*...the treatment family needs to consider itself as part of the children's larger family system and network, and not as a substitute family*". In addition to this view, the treatment parent plays a critical role in that "*the treatment family as a whole must be regarded as part of the children's support and treatment solution*" (Thomlison, 1991, p. 3).

Treatment foster carers face a demanding task in needing to differentiate their role and function as treatment family from that of the biological family. This difference is important in that conflict can quickly emerge, particularly during critical decisions over levels of contact and support provided. By seeking to clarify the nature of each parent/carers contribution to the child's development, it is anticipated that greater functioning between the two family systems can be achieved, which is noted as being essential for the child's optimal development (as cited in Thomlison, 1991).

Many TFC programs emphasise the carer's role in encouraging the child's links with their family. The interface between the carer and parent is essential to facilitate the best outcomes for children in care. Studies aiming to explore this interface have indicated that the carer's anxiety about a child's contact with biological family is associated with poor child adjustment (Gean et al., as cited in Rushton & Minnis, 2002). Whilst such anxiety is often understandable, little support appears to be directed towards training and supporting the carer in this context, and neglecting to do so most likely further contributes to the child's difficulties.

While some may argue that biological parent contact is not appropriate in some cases (perhaps in the consideration of past abuse) it is important to note that therapeutic foster carers can play a critical role in assisting children to have a different and positive experience of contact with their biological family and that "*contact can be meaningful even if contact is symbolic and less than full parenting*" (Thomlison, 1991, p. 12). It is argued that further reflection needs to occur regarding the quality of access and the potential



therapeutic benefits that may occur (including supervision of access from clinicians) as opposed to traditional approaches of focusing merely on the frequency of contact.

### **Training carers in working with parents**

Training carers to work with biological parents is seen as a central aspect in preventing barriers to family involvement (Jivanjee, 1999a). Suggested training topics for therapeutic carers include:

- the frequency and types of biological parent contact,
- communication with biological parents,
- ways of sharing information about the child's progress,
- involving biological parents in decision making,
- exploring with carers potential barriers to family involvement, and
- developing strategies that may enhance involvement (Jivanjee, 1999a).

The literature suggests a number of ways in which therapeutic foster carers may involve parents. These include welcoming biological parents into their home for access (when appropriate) and assisting parents to learn skills in parenting through role modelling and mentoring roles. It is important to note, however, that whilst a greater emphasis in TFC is placed on the carer to facilitate greater involvement with biological families, greater attention needs to be placed concurrently in providing carers with specialised training and support to enable them to do so.

An innovative example of training carers about their contact with biological families is provided by Gilchrist & Hoggan (1996). The authors devised a caregiver training program that included birth parents as co-facilitators as a way of enhancing both the carer's and the worker's sensitivity and empathy towards birth parents, and essentially to bridge the gap between carers and parents (Gilchrist & Hoggan, 1996).

The outcomes of this program suggest that whilst carers and workers felt that the information parents shared was reasonably familiar to them, the value of being reminded of the parents' pain was seen as helpful. The 'rawness of such pain' was seen to be important in assisting both carers and workers to ensure they remained sensitive towards the parents. Parents themselves described a positive experience in participating in training that included feeling accepted and as worthy contributors, developing a sense of partnership with carers and professionals, and relief in knowing that carers may also feel anxious and vulnerable (Gilchrist & Hoggan, 1996). Such training programs provide a useful example of ways that professionals can assist in reducing the barriers between carers and parents and, in doing so, ensure greater family continuity and stability for children in care.

## **Therapeutic foster care programs**

A number of therapeutic foster care programs have been established internationally with the majority based in the U.K. and U.S. Therapeutic foster care programs noted in the literature included: Multidimensional treatment foster care (Fisher & Chamberlain, 2000, Chamberlain & Weinrott, 1990, Fisher et al., 1999), People and Places (Bryant & Snodgrass, 1992), Progressive Life Center (NTU, Gregory & Phillips, 1997), and Community Alternative Placement Scheme (CAPS, Walker et al., 2002). A review of three of these international TFC programs is included in more detail below. Whilst therapeutic foster care models in an Australian context are lacking there are several promising initiatives within Victoria such as TrACK and Berry Street Victoria Southern Services 1:1 and Intensive home-based care program.

Whilst an internet search (author search, June 2006) indicated a proliferation of TFC programs (some of which are included as an appendix to this review), many of the programs identified indicate minimal attempts to assess the effectiveness of TFC to date with several programs not appearing to adhere to a uniform set of standard practice. A useful guide for developing program standards in Therapeutic Foster care is provided by the Foster Family-Based Treatment Association (FFTA). The program standards for Treatment Foster Care outlines key operational aspects of TFC, such as, program staff, worker caseloads, cultural competency, qualifications of staff, treatment parents selection and training, children, youth and families assessment, matching, contact and treatment planning (FFTA, Program standards for treatment foster care, 2004). The Standards guide also provides a standards review self-assessment instrument to assist programs in determining compliance with FFTA standards and goals for improvement. The application of such program standards ensures that complying TFC programs provide quality therapeutic care services and provides a useful framework for those beginning to develop TFC programs.

### **Multidimensional treatment foster care**

Patricia Chamberlain, a prolific writer in the area of treatment foster care, is well known as the developer of Multidimensional Treatment Foster Care (MTFC), a program for "*severely emotionally disturbed, antisocial children and adolescents who would otherwise be treated in congregate care settings*" (Fisher & Chamberlain, 2000, p. 156). MTFC youth are placed "*singly in well-trained and supported community foster homes*" (OSLCCP website). Typically, the focus of MTFC placements is short-term of 6-9 month duration. The goal is essentially home return, and for this reason "*From the beginning of placement, work with the youths' parents is emphasized to prepare the youth and the adults for post-MTFC life*" (OSLCCP website). Key aspects of the MTFC model include: close supervision, fair and

consistent limits, predictable consequences for rule breaking, supportive relationships with at least one mentoring adult, limited exposure and access to delinquent peers.

MTFC provides a multi-level intervention approach for treating children and youth in home-based care that is directed towards their family, community, and school settings (website). MTFC adopts a multifaceted treatment intervention approach that includes:

- behaviour parent training and support to MTFC parents,
- family therapy for biological parents,
- skills training for youth,
- supportive therapy for youth,
- school-based behavioural interventions, and
- psychiatric consultation.

In MTFC, the treatment team consists of:

- behaviour support specialist (works with youth on pro-social behaviour and problem solving skills),
- youth therapist (advocate/support for youth),
- family therapist (parent management training),
- consulting psychiatrist (medications/diagnoses),
- PDR (parent daily report) caller (telephone contact with carers daily and completing a behaviour checklist list/daily report on child),
- case manager/clinical team supervisor (treatment team leader/integrates activities of team), and
- MTFC parents (trained and supported to provide close supervision and implement a structured program for youth).

(Fisher & Chamberlain, 2000)

Such examples illustrate a comprehensive 'treatment team' in which the carers are central in the treatment process, play a key role in identifying 'target behaviours' and assist in formulating treatment plans. Carers are expected as well as willing to take an active role in treatment, such as in the daily data collection. Carers are trained pre-service to analyse behaviour and implement treatment plans. In contrast to Victorian practices, carers are given all the information regarding a child's history (including the child's history of trauma).

The MTFC treatment approach utilises a very structured/behavioural approach in treating children in a family environment. A greater understanding of the application of MTFC programs in practice (Transitions and Monitor aged for youth 12 to 18 years) through the use of a case example is provided by Chamberlain & Weinrott (1990).

## Oregon early intervention foster care project (OEIFC)

The majority of therapeutic foster care programs have focused developmentally on latency age children and adolescents. Fisher et al (1999) have attempted to highlight the frequently disproportionate response within the child welfare sector which focuses on older children, with younger children commonly being overlooked despite younger children often remaining in the system. They state, "A preschooler who has prolonged tantrums and is not developing prereading skills, for instance, is likely to be a lower priority to a caseworker than a 12-year-old foster child who is getting into fights at school, stealing, and displaying sexually aggressive behaviour in the foster home" (Fisher et al., 1999, p. 166).

Preschoolers are a particularly vulnerable group who often display difficulties in subtle ways that may often go undetected or untreated. Fisher et al., (1999) state that "preschool-age children in the foster care system may fail to be identified or referred to services. Despite the fact that they may be at great risk for later conduct problems and related difficulties, the behaviour of preschool-age children may be less troublesome than older children in foster care". In the context of this developmental focus on older children, the OEIFC program is an early intervention program for preschool-age children (3-5 years), largely adapted from the Multidimensional Treatment Foster Care program. Whilst much of the program philosophy is consistent with MTFC, such as employing foster parent families as the primary intervention milieu, providing higher caregiver reimbursements and a multidisciplinary team, the OEIFC program focus is much more on the child and carer/parent dyad. The parent/carer is essentially seen as the primary agent of change. This approach has built on research that has demonstrated that "interventions that strengthen the parenting of foster and biological families have been found to exert a powerful preventative effect on long-term outcomes" (Reid & Eddy, 1997 as cited in Fisher et al., 1999, p. 167). The OEIFC model identifies several risk factors for preschoolers including behaviour problems, emotional regulation and developmental delays, and uses these areas to target their interventions (Fisher et al., 1999).

OEIFC uses a multidisciplinary team who meet weekly, with an emphasis on communication and info sharing. The early intervention team consists of:

- Foster parents (paraprofessional implement intervention).
- Clinical team supervisor (leader of team, liaison with other agencies).
- Foster parent consultant (carer advocate/V, runs carer support groups).
- Early interventionist (works with child - runs therapeutic play group).
- Family therapist (works with biological families teaching parenting skills).

The program embraces a developmental focus with a behavioural intervention emphasis to treatment. Behavioural techniques with the preschooler are typically applied by foster parents, such as token systems, within a positive behaviour reinforcement philosophy. Emotional regulation difficulties are addressed by adopting the mutual regulation model that affectively explores the attunement between the caregiver/parent and the child.

An early interventionist screens all children entering the program for developmental delays, assesses specific areas of delay and develops treatment to target those areas (structured activity-based intervention approach) (Fisher et al., 1999). All children within the program participate in a weekly therapeutic play group that is facilitated by the early interventionist. The play group occurs at the same time as the foster parent support and supervision group which also meets weekly.

Whilst the program has noted positive results with preschoolers, a few children within the program have what is described as 'treatment resistance' (Fisher et al., 1999). These children share a common history of prenatal drug exposure, have experienced a number of primary caregiver losses, and are thought to struggle in 'emotionally connecting in the foster home environment' (Fisher et al., 1999). Whilst further research is required to explore the possible limitations of the program, the OEIFC model provides a good example of a developmental approach to therapeutic foster care for young children.

### **TrACK (Treatment and Care for Kids program)**

TrACK is a Victorian therapeutic foster care program delivered in partnership by Anglicare Victoria Eastern Foster Care program (Case Management) and the Australian Childhood Foundation (Therapeutic Services) and funded by the Department of Human Services.

The program employs a multidisciplinary team approach, with the following roles,

- Case Manager (provided by Anglicare with case load ratio of 1:6).
- Placements support worker (assists with transporting children to access, appointments or support in school setting).
- Foster Carer (attends specialised training, participates in the establishment of management plans, therapeutic goals and case plans, and receives a higher rate of caregiver reimbursement).
- Therapist (provides secondary consultation and training to foster carers and professionals, and provides direct therapeutic intervention).

Essential referral criteria include children needing to be under 13 years of age at the point of entry, requiring a medium to long-term placement and present with challenging behaviours and complex needs (TrACK evaluation report, 2005).

An important distinction between the TrACK program and other international therapeutic programs is the differing emphasis on involving biological families. TrACK clearly defines its target client group as children where there is "no prospect or plan for family reunion in at least the medium to long term" (TrACK evaluation report, 2005, 27).

A specialised training program for foster carers has been developed (in addition to the standard training provided) that relates specifically to trauma-attachment theory and includes 34 hours annually in the form of 3 modules (TrACK evaluation report, 2005).

The TrACK program was evaluated in 2005 with a small sample size of 7 children. Methodology included: case file audits, a questionnaire (developed by TrACK) that was delivered to carers, caseworkers and therapist regarding the child's behavioural changes; focused groups; and individual discussions with members of the therapeutic program and key stakeholders, including DHS. The evaluation did not include the use of standardised pre- and post- measures, although this was noted as a future recommendation.

The TrACK program is a promising therapeutic care initiative for Victoria, with several years experience in leading the field of Therapeutic foster care.

### **BSV Southern Services 1:1 & Intensive HBC program**

This 1:1 and Intensive HBC program is based in the southern metropolitan region of Melbourne and works with children and young people between the ages 0 and 17 years (Sauer, 2006). A structural model is utilised that draws on a network of support in caring for and responding to the young person's needs. "A structural model utilizes the hierarchy in the agency program to reflect a network of support which, depending on the need, can be called upon at any time to reinforce rules and behavioural expectations" (Sauer, 2006, p. 8).

Young people are referred to the program by DHS and are assessed at intake (which may include a psychological assessment). The specialist role of a clinician may provide direct therapeutic intervention for the child (nominated as 'primary therapy'), or crisis and secondary consultation to the case manager, carer and members of the care team (Sauer, 2006).

The model adopts a strong therapeutic community approach, recruiting predominantly from the young person's extended family or within a community non-family network (Sauer, 2006). A high proportion of carers are recruited from the South Pacific Islands region, which are regarded as culturally valuing the importance of children and adopt a community approach in caring for them. The foster carers' cultural approach to caring for children is recognised as a positive contribution to the workings of the program, "the importance of childhood as the foundation of a healthy life and society, are inclusive of them in all their daily activities and readily embrace the concept of caring for non-biological children as historically the village/family "group" shared responsibility of all child rearing" (Sauer, 2006).



The community network approach enables carers to support each other in the day to day tasks of caring for children with challenging presentations. Subsequently most carers know each other, support one another and visit each other in their homes. This extends beyond the carers to the children themselves having frequent contact with each other through social means (personal communication, Sauer, 2006). This cultural value of a shared responsibility and community approach to caring for children may offer particular relevance to developing therapeutic foster care models within the Victorian Aboriginal community, which generally parallel these cultural values.

Carers within the program are seen as holding a 'para-professional' role, this being similar to many international therapeutic foster care programs. In effect, this means that carers attend care team and case planning meetings and various treatment consultations with the child/young person (Sauer, 2006). Personal attributes of the carers that are typically sought are *"robust, resilient, tough and nurturing all at the same time"* as well as being able to commit to caring for the young person for the 'long haul' (Sauer, 2006). Key aspects sought in assessing carers are noted as having an *"uncomplicated, structured, family/child focussed lifestyle where there is a high degree of predictability from one week to the next"* with an emphasis also being placed on a supportive community and family network available to the carers (Sauer, 2006).

Aspects of the model that are consistent with standard TFC philosophy include low case management case loads of 6 clients, and higher reimbursements for carers that are commensurate with the needs of the young person. Specialised training is provided to carers (consistent with other TFC models) although this is essentially individualised, being built on the child and carer's needs rather than general training. More than one child may be placed with carers, such as siblings groups; however, this depends on an assessment. Such an approach differs slightly from some TFC programs that place a strong emphasis on limiting placements to one or two children.

Whilst the program lacks rigorous outcome measures, the success rates of the program appear promising, with minimal disruptions of breakdowns in care. Such outcomes are particularly encouraging in light of the complexity of backgrounds and a range of challenging presentations the children presented with, that included high risk adolescents with significant histories of unsuccessful out of home care placements.

## Cultural applications of TFC

In reviewing the literature, there appear to be few dedicated culturally based therapeutic foster care programs or culturally appropriate resources for carers. An interesting website that provides online courses for carers from a cultural (Native American

Indian perspective) can be found at the Alaska Center for Resource Families (ACRF) (website details are included at the end of this review). From a Victorian Aboriginal context, a useful guide for carers in understanding the importance of culture and maintaining connections for Aboriginal children in care has been published by VACCA (caring for Aboriginal and Torres Strait Islander children in out of home care booklet, 2005).

While many programs have attempted to provide non-indigenous carers with a cultural understanding and resources to assist them in caring for children, it appears that there are very few therapeutic foster care programs that have 'embedded' a cultural framework as part of their model and direct practice.

When considering potential ways of improving the health and wellbeing of Aboriginal children in care, developing a sound understanding of health is essential. Definitions such as that provided by NACHO, emphasise a holistic understanding of health and should serve as a basis for developing and examining therapeutic care models. Models that have embraced culture, identity and spirituality as being fundamental to its success are worthy of investigation. One such therapeutic foster care program, Progressive Life Center developed with African American families (Gregory & Phillips, 1997), provides an interesting approach and is worthy of further exploration. This model provides a spiritual and cultural framework in providing care using culturally competent therapeutic techniques. Such models emphasise a strong community approach and actively incorporate the biological family as part of the service. Such holistic models that incorporate the importance of continued connection with family and community may also have particular application to all children in out of home care.

The Progressive Life Center TFC program provides treatment (referred to as healing from an Ntu perspective) to children and their families in care that is delivered within a spiritual and cultural framework. A more detailed account of the Ntu treatment approach can be found in Gregory & Harper (2001). Therapy is organised around philosophy of health, life, spirituality/energy, and clinical principles of harmony, balance, interconnectedness, and authenticity. *"The priority within Ntu is the development of cultural awareness as a necessary first step to self-knowledge"* (Gregory & Phillips, 1997, p. 130).

Children and youth in the program are referred as presenting with *"serious emotional disturbance"* and are predominantly African-American. *"The common clinical pattern of these children is one of severe cultural deprivation, spiritual disconnection, lack of awareness of their own personal biography, disconnection from community and family, and an intense sense of not belonging"* (Gregory and Phillips, 1997 p. 132).

The program provides a range of clinical and educational services that include, parent training, rites of passage, weekly in home family therapy,

planned and unplanned respite, foster parent support group, training for carers (pre and ongoing), 24-hour crisis intervention, multifamily retreats, and an innovative 'step-down' program that prepares children to transition back home, with diminished clinical support.

The goal of the program is for children to return to parents or permanency in 18-24 months. An innovative matching process is supported by creating videos for children to view prior to entering care of potential foster families.

Outcome measures for the program include the Child and Adolescent Problem Checklist, administered pre-treatment and every 6 months thereafter. The program outcomes appear promising with 74% of youths noted as improving significantly emotionally, 37% improved in school and 47% stabilised in school situation, with 53% showing an improvement in behaviour.

In an Australian context, further discussion and consultation with Aboriginal services is necessary to explore therapeutic care models that are more closely aligned to culturally appropriate and community orientated practice. The over-representation of Aboriginal children in the out of home care sector (DHS, 2003) demands that considerable attention be provided to exploring appropriate therapeutic models for Aboriginal children and their families. In doing so, acknowledgment needs to be given to the impact of past welfare policies (stolen generations) and how this contributes to the current tensions within the Aboriginal community to be associated with formal out of home care services, as the agencies involved may be the same ones or reminiscent of agencies implicated in the forced removal of Aboriginal children (Higgins et al., 2005). Furthermore, Higgins et al., (2005) write *"a tension between a cultural commitment to community and an aversion to formal child welfare among Aboriginal and Torres Strait Islander peoples appears to be a fundamental issue in enhancing culturally appropriate placements for Indigenous children"*.

## Effectiveness of therapeutic foster care

### TFC effectiveness and cost-efficient benefits

Therapeutic foster care is often touted as an effective treatment model for children with challenging behaviours in out of home care. Research on the efficacy of TFC has identified that:

- The characteristics of children and youth served in TFC have similar problems to those in residential care which suggests it is a viable option for children and youth with emotional and behavioural difficulties to receive treatment and care in a family setting (Chamberlain, 2000).
- Some studies have shown that Youth in TFC have shown better adjustment and outcomes

than those children living in congregate care programs (Chamberlain, 2000).

- TFC has been shown to lead to higher rates of placement stability than regular foster care, despite serving a more challenging population of children and adolescents (Bryant, 2004).
- A high proportion of children are discharged to less restrictive settings following a placement in TFC (Fanshel, 1990 as cited in Chamberlain, 2000).
- TFC is noted as cost-efficient, placing children who would otherwise be placed in residential care at half the cost or less (Bryant, 2004).

Although the efficacy of TFC has typically been evaluated by quantitative measures (such as length of placement, number of placements, etc), recent research has called for inclusion of additional outcome measures to be explored. Redding and colleagues (2000, p. 428) note the limitations of previous quantitative research in TFC and state that, *"Although these measures are valuable in measuring placement success, they do not provide adequate information regarding child and family functioning and adjustment, nor do they provide a systematic evaluation of placement satisfaction"*. It should be noted that there is little research contributing long-term outcome data about outcomes for children in any kind of placement, whether that is traditional fostercare, therapeutic fostercare or residential care.

In an effort to better define what TFC programs look like, one study has focused their evaluation on describing the programmatic and youth characteristics served by TFC (Hudson et al., 1994). Hudson and colleagues (1994) surveyed 321 TFC programs operating across America and Canada. Data from the survey were categorised by program characteristics, such as private/public status, annual program budgets, training provided to carers, caregiver requirements/attendance at support groups and training, involvement of parents, treatment approaches, caseload sizes and client characteristics (Hudson et al., 1994). Results indicated that the majority of programs were privately operated, and most required pre- and in-service training, compulsory attendance at caregiver support groups and written treatment plans. A significant number of programs identified a preference for a behaviour modification treatment approach of 56% with only 26% choosing a systemic, contextual or ecological approach. The majority of children admitted into the programs were from residential settings and had psychiatric, behavioural or emotional problems. Approximately two-thirds of youth were aged 12-17 years and stayed, on average, a period of 13 months in TFC. Whilst it was not the intention of the survey to evaluate the 321 programs, it does provide a useful description of a number of TFC program characteristics and youth served.

## TFC outcome studies

A useful summary of treatment foster care from an efficacy and economy approach is provided by Bryant (2004) and mentions several of the more significant outcome studies that are detailed below.

Perhaps one of the most interesting studies to date is a review of 40 published outcome studies of treatment foster care, provided by Reddy and Pfeiffer (1997). The review analysed treatment outcomes according to: placement permanence, behaviour problems, discharge status, social skills, psychological adjustment, training and support to parents (therapy to biological families or therapy to treatment families), and treatment provided. Outcomes of the review indicated that the largest effects were reported in improvements in children's social skills and placement permanency. Medium effects were noted in reducing behaviour problems, post-discharge restrictiveness, and in increasing psychological adjustment (Reddy and Pfeiffer, 1997).

Similarly, a review of 11 evaluation studies from children and youth across Canada, the United Kingdom, and the United States also showed success in providing TFC to troubled youth (Hudson et al., 1994). The review noted positive changes during program transitions, most family care placements were completed as planned and favourably discharged plans (Hudson et al., 1994). Significant psychological benefits were identified in the youth served, including significant changes in self-esteem, sense of identity and sense of personal worth and general functioning. TFC programs were also described as less costly than institutional programs providing care for youth.

## Comparative studies

Several studies have claimed the efficacy of TFC in comparison to other placement options, in particular residential treatment centres. A literature review comparing outcomes of residential group care and therapeutic foster care sought to examine this assertion (Curtis et al., 2001). In comparing the literature, no differences in services provided or received were indicated. There was a difference noted in the gender and age served by each placement type, with children in residential treatment care generally older males, whereas TFC youth tended to be younger females (Curtis et al., 2001). The authors note one outcome study (Chamberlain and Reed 1998) which indicated that children and youth in TFC did better than children in residential treatment centres.

Suggestions by the authors also included that although there was no empirical evidence, residential treatment centres were seen as being most appropriate for children who need a structured program or cannot tolerate the emotional intimacy of TFC, and that practice wisdom generally suggested TFC as a preference for 'young' children who are capable of engaging with a family (Curtis et al., 2001).

Further research is required to assess the effectiveness of TFC across developmental ages. Some researchers have suggested its success with predominantly older youth (Hudson et al., 1994). In contrast, some studies that have been specifically developed for preschoolers have shown positive outcomes (Fisher et al., 2000).

Whilst TFC's reported effectiveness is promising, the methodological rigour of several TFC studies makes it difficult to draw definitive conclusions regarding its overall effectiveness (Reddy and Pfeiffer, 2004) and therefore some caution is required. Despite these limitations, TFC remains a promising option for a number of challenging children in out of home care. The development of further empirically evaluated studies of TFC programs will further assist in developing this model of care as an effective option for children in out of home care.

## Future directions in out of home care

Therapeutic foster care is noted as an integral part of many mental health and child welfare systems used internationally, particularly in the U.K. and U.S. As previously noted, such therapeutic approaches to care have often been adopted in response to the limitations of traditional models of practice and within a context of change that has evolved through a movement away from residential care facilities to a preference for family care. There have been debates regarding the effectiveness of therapeutic foster care in relation to residential treatment centres with a general position often adopted that home-based care offers a "*less restrictive and more cost effective alternative to residential treatment*" (Redding et al., 2000).

Despite a push for greater flexibility in placement and service options for children entering out of home care in Victoria, current options appear limited. A review of out of home care by DHS notes that there has been a "*... narrowing of placement options and an increasing reliance on conventional, family-based foster care*" (DHS, 2003, p. 95). Such practice fails to acknowledge that some approaches and placement options may not be appropriate for some children and youth and greater individualised treatment planning should be created. For this reason a diverse range of options for children in out of home care should be explored. The current Victorian system currently consists of traditional foster care, adolescent community placements, residential care, kinship care or permanent care. A greater diversity of models may serve to create opportunities for greater matching of individualised care needs and potentially those that are more closely aligned to culturally appropriate and community orientated practice. Comprehensive assessment and intervention planning should always assist this process.

Ainsworth & Maluccio (2003) describe two innovative models, a Family for Family model (recruitment of a foster family for a birth family) and a Circle of Friends model (designed for children and young people whose



behaviours exhaust traditional foster carers) that adopt a community approach to care, facilitate a continuing connection for the child with their birth family and community, and recognise a shared role of adults caring for children. Such models, whilst requiring further exploration as to their appropriateness, are perhaps more closely aligned with Aboriginal cultural values and may have particular application for Aboriginal communities in which caring for children is considered the responsibility of the whole community rather than a sole family as in traditional foster care models. It is important to note that evaluated therapeutic care models for Aboriginal children and their families constitute a significant gap in the out of home care research literature (Richardson et al., 2005).

Other promising approaches from a Victorian context that require further exploration include that of the Mirror Families concept. This approach serves to increase informal networks to serve as a support to children and their families. This model was essentially developed by the experiences of a foster carer and seeks to create a network of informal (non-professional) support for the family. The model originated from the identified need that families often require ongoing support after DHS had ceased involvement. The Mirror Families model consists of families referred to as A, B, and C each with a designated role of informally supporting the child. Family A (could potentially be biological family or a long-term foster care family with whom the child resides). Family B (takes on the respite role and may be another foster carer or an extended family member or even family friend). Family C (their role is a support or mentor role and may be a student, teacher, carer, friend). The A,B,C families essentially work together as a team to identify specific tasks and roles with a focus on long-term commitment to the child, no matter where they are living (Brunner, 2006). Such concepts illustrate potential opportunities within the sector to continue to explore a diversity of options for children and their families entering the out of home care system and deserve further exploration.

There has been a growing call in Australia to develop a professional foster care model. *“As the challenges faced by foster carers increase and the focus on quality foster caring intensifies, demand for the development of a more professional approach to foster care has increased”* (DHS, 2003 p. 102). Such a move towards therapeutic care in Australia requires extensive reform in the out of home care sector, paralleled by careful planning and implementation. Whilst international therapeutic care programs potentially offer a useful framework for the development of future treatment and care models in Australia, some caution is required in understanding the limitations of this system. Therapeutic foster care in the U.S. has historically been identified with social welfare reform rather than mental health services. As a result, the opportunities for interdisciplinary teamwork and specialist child psychiatric support have tended to be the exception rather than considered standard practice (Fine, 1993). Whilst there have been important advances in both

the child welfare and mental health sectors, these advances have remained predominantly separate.

## A potential TFC model

### What might a therapeutic care model look like?

Whilst the evolution of TFC in Australia to date has been limited, current changes afoot within the Victorian child welfare system provide an exciting opportunity for the development of TFC programs locally (DHS, 2006). The literature and practice of TFC programs both nationally and internationally provide a useful source of reference in developing future models of therapeutic care. Whilst TFC programs vary widely, in a trauma-attachment TFC model, *“...attunement, attachment theory, and understanding of trauma dictate how to interact with a child rather than a specific set of rules or a predetermined structure”* (Shell & Becker-Weidman, 2005, p. 141). Key elements of a trauma-attachment TFC model include:

- Theoretical base of trauma and attachment theories.
- Therapeutic parenting to facilitate secure attachment.
- Para-professional role for carers.
- Provision for attachment focused dyadic or family therapy.
- Inclusion of biological family.
- Care team approach.
- Extensive training, supervision and consultation for carers and workers.

### Therapeutic parenting

Traumatised children in care with insecure attachments require a therapeutic parenting approach that facilitates attachment. Cairns (2002, p. 70) defines therapeutic parenting as, *“parenting which aims to enable the child to move from insecure to secure attachment”*. This approach to parenting has a therapeutic purpose, which has an intentional effort to promote change in attachment patterns. In such a TFC model the focus is placed on the relationship. It is the caregiver-child relationship that is considered to be the primary agent of change rather than the child-therapist relationship (Shell & Becker-Weidman, 2005).

In such a model, specialised training would be provided to carers on trauma-attachment as well as therapeutic parenting principles (including ways to facilitate attachment). Such caregiver training approaches are in contrast to mainstream parenting strategies (which are generally cognitive behavioural based). Therapeutic parenting approaches respond to the specific needs of these children and the complex behaviours they often present with. Delany & Kunstal (1997, p. 150) state *“Special children with special needs require special parenting”*.

Several authors (Cairns 2002, Hughes 1997, Golding 2006) have identified fundamental principles involved in therapeutic parenting. Cairns (2002) describes therapeutic parenting as an environment that creates a particular 'attitude' towards the child she refers to as SAFE:

- Secure (a secure base the carer provides that promotes stability)
- Attentive (an interest, curiosity about the child)
- Friendly (a quality of love, joy, commitment)
- Empathic (ability to be empathic with children)

Similarly, Hughes (2004) describes a therapeutic parenting approach in which carers maintain an attitude of being:

- Playful
- Loving
- Accepting
- Curious
- Empathy (PLACE)

This therapeutic attitude of parenting the child with trauma-attachment difficulties described by Hughes (2004) has been further built on by Golding (2006) who has developed a 'house model of parenting'. Such an approach to parenting provides a useful resource in training foster carers on therapeutic parenting principles and could be readily adopted in the development of a potential trauma-attachment TFC model. Golding (2006, p. 213) describes this model as assisting carers "... to focus on how to provide a positive family atmosphere and how to avoid being drawn into a re-enactment of child's early experience. Carers are encouraged to control the emotional rhythm of the house. In this way they foster a secure base within which the child can learn emotional regulation skills and the ability to be reflective. Within this family atmosphere children can be helped to feel that they belong to the family and to experience mutual enjoyment with family members".

### **Therapeutic parenting and the care team interface**

Whilst therapeutic parenting is seen as a fundamental aspect in a trauma-attachment TFC model, the role of the care team is also crucial. The care team has the core responsibility of assisting the caregiver to create and maintain a therapeutic attitude. Essentially, the care team needs to be able to 'emotionally hold' the carer to enable the carer to be able to 'emotionally hold' the child. Cairns (2002, p. 71) writes,

*"Therapeutic parenting and reparenting both require the creation of a formal care team around the child. The informal social structures which will sustain child development and prevent injury for securely attached children are not adequate to meet the needs of children with unmet attachment needs. Parenting insecurely attached children is often counter-intuitive; carers have to learn how to approach children who beyond infancy are unable to*

*regulate stress and impulse, and they have to be reliably sustained in maintaining that approach. That is the task of the care team."*

In a trauma-attachment TFC model, regular meetings with all members of the care team would be considered necessary as a way of reflecting and thinking together on the therapeutic environment which is essential to promote secure attachment for the child in care. Such approaches emphasise the development of 'thinking networks' and are seen as crucial in avoiding placement breakdowns (Golding, 2006). Support for the care team, such as an external consultant, may at times also be helpful.

### **Attachment-focused dyadic or family therapy**

In a trauma-attachment TFC model, therapies that promote the development of a secure attachment relationship between the child-carer/s are emphasised. Dyadic Developmental Psychotherapy (DDP) is a treatment intervention for children with trauma-attachment difficulties based on attachment theory. In this treatment approach, the carer is an active participant in the treatment intervention. Hughes states that *"a crucial and central feature of the treatment of the poorly attached child is the active participation of the parent with whom he is expected to learn to form a secure attachment relationship"* (Hughes, 1997).

In DDP, the treatment approach is relational and focuses on the therapist-child and child-caregiver relationships. Golding (2006, p. 347) states *"Therapeutic sessions are structured to replicate the attachment sequences found in healthy parent-child interactions. Thus sequences of attunement, socialization/shame, and re-attunement are repeatedly provided for the child. The child experiences the intersubjective sharing of affect that is attunement (Stern, 1985) and learns that breaks in such intersubjective experience can be repaired following conflict and mis-attunement (Hughes, 2003)."*

Central elements in Dyadic Developmental Psychotherapy as identified by Hughes, (1997); Becker-Weidman (2006); and Golding (2006) include:

1. Therapy consists of working with the carer/s on their own and working with the child and carer/s together. Little is done with the child on their own.
2. An understanding of the carer's own attachment history. This includes the 'state of mind' of the caregiver which has been found to directly impact on the attachment classification of the child and success of the interventions (Dozier, 2002, 1999).
3. Therapists attend to their own attachment history and other issues of family of origin, to contribute to the success of interventions (Dozier, 2002, 1999)
4. Therapist and caregiver are attuned to the child's subjective experience and reflect this back to the child. In the process of maintaining an intersubjective attuned connection with the child, the therapist and caregiver help the child regulate affect and construct a coherent autobiographical narrative.

5. Therapist employs the principles of PACE and at home the caregiver uses the principles of PLACE (as previously outlined). Caregivers use attachment-facilitating interventions (therapeutic parenting). The therapy is therefore intrinsically linked to therapeutic parenting strategies.
6. The therapist adopts a directive approach that addresses the inevitable misattunements and conflicts that arise in interpersonal relationships.
7. Treatment interventions vary and may include paradoxical interventions, psychodrama, touch, information and education, engagement and leading, etc.

The principles of DDP are as follows:

- It is derived from attachment theory and research and principles for PTSD, and based on the premise that development of children is dependent upon and highly influenced by the nature of the parent-child relationship, particularly the process of the parent making sense of the child's experiences and communicating these back to the child.
- Attachment security and emotional development require appropriate ongoing reciprocal experiences between parent and child. These experiences must be affectively and cognitively matched to developmental, age-appropriate needs of the child.
- The primary context in which dyadic interchanges occur is one of real and felt safety, as without such actual and perceived safety, the child's neurological, emotional, cognitive and behavioural functioning is compromised.
- When early attachment history consists of abuse, neglect and/or multiple placements the child fails to experience interactions with caregivers necessary for normal development and often has a reduced readiness and ability to participate in such experiences.
- Treatment and parenting must be based on parenting principles that facilitate security of attachments, incorporating an attitude based on playfulness, acceptance, curiosity and empathy - PACE. Eye contact, voice tone, touch (including nurturing-holding) movement and gestures are used to communicate PACE. Strategies never involve coercion, threat, intimidation, or use of power to force submission. Opportunities are created for enjoyment and laughter, play and fun, unconditionally throughout every day.
- Decisions are made to provide success, not failure. Successes become the basis for development of age-appropriate skills, and the child's symptoms or problems are accepted and contained. The child is shown that problems simply reflect his/her history and need not be experienced as shameful.

- The child's resistance to parenting and treatment interventions is accepted and contained and is not made shameful by adults, while skills are developed with patience, accepting and celebrating 'babysteps' as well as developmental plateaus.
- Adult's emotional self-regulation abilities must serve as a model for child.
- Adults must constantly strive to have empathy for child and never forget that, given his/her history, he/she is doing the best they can, and that the child's avoidance and controlling behaviours are survival skills developed under conditions of overwhelming trauma which will decrease as safety increases.
- While behaviours need to be addressed this is not done with anger, withdrawal of love, or shame.
- Child may only be held (restrained) at home or in therapy for containment when in a dysregulated, out-of-control state, and only when less active means of containment are not successful in gaining control and only as long as child remains in that state. The therapist's primary goal is to ensure the child is safe and feels safe.
- Negative emotional responses are never provoked. The model for this type of holding is that of a parent who holds an overtired, overstimulated, or frightened preschool child and helps him/her to regulate distress through calm, comforting assurances and through the parent's accepting and confident manner.
- The child's experiences of abuse, neglect, abandonment and loss are discussed as they arise in words or behaviours, using an empathetic approach to diminish shame and resolve trauma.

## Elements of a trauma-attachment TFC model

### Towards a permanent care system

For healthy development, children require a safe, predictable and secure caregiver. For children in care, their attachment security is often compromised by a system that is frequently temporary in nature, with placement time frames dependent on a variety of external factors and sometimes unpredictable. Shell & Becker-Weidman (2005) state that, "*The child welfare system may have other goals and objectives that interfere with the normal process of forming a healthy and secure attachment. For example, the use of temporary foster placements until a "permanent" foster placement can be made may result in several moves for a child. Consequently the priorities for rules, staff, and program approaches do not always allow for the type of relationships to form between staff and child that would naturally or therapeutically promote the establishment of a healthy and secure attachment relationship*" (Shell & Becker-Weidman, 2005, p. 131).



Additionally, another attachment researcher, Dozier (2005), has expressed concerns in a 'temporary surrogate care system' for children and calls for system reforms that enhance opportunities for a caregiver to commit to a child in their care. Such caregiver commitment has been found to be essential in a child developing a secure attachment (Dozier, 2005). This unpredictability in the system can have a significant impact on a carer's ability to commit to the child.

Such issues identify the important considerations required in developing a therapeutic care model that enables carers to commit to the child in their care, providing greater opportunities for children to develop secure attachments. Whilst current legislation may impact on such efforts to promote opportunities for caregiver commitment, such issues may require consideration in the recruitment of caregivers. This essentially means recruiting carers with a view towards permanency, so that they may become the child's long-term/permanent caregiver if family preservation is unsuccessful, providing greater opportunities for caregiver commitment and the child's potential to develop secure attachment relationships. Some U.S. services adopt this philosophy and are successfully working with many children, families and carers towards permanency, either back to biological family or with the foster family, (see Casey Family Services website).

#### **Supervision, consultation and support for the carer/foster family**

Living and caring for traumatised children is a challenging task that may evoke intense emotions in the caregiver. In a trauma-attachment TFC model, 'normalising' and supporting the caregiver during these challenges as opposed to pathologising the carer is an important role. Cairns states, "*It is particularly important to recognise that living with traumatised children*

*evokes strong feelings and powerful dynamics. Every family is at risk of becoming dangerously disordered when living with such disorder. It is vital that good supervision and support are available to families providing therapeutic parenting"* (Cairns, 2002, p. ii). Regular supervision for the carer and their family is a necessary inclusion in developing an effective TFC model. In addition to the supervision and support provided to the caregiver is the support and consultation provided to the care team. Golding (2004, p. 72) describes a care team consultation model that could be readily adapted by TFC programs that "*provides a reflective space in which carers and the related network can explore the child in placement in a way that both supports the carer and provides ideas for a way forward"*.

#### **Creative respite options**

Respite is frequently provided in many foster care programs to assist the carer to 're-charge' from the stressful and demanding role of caring for the child with trauma-attachment difficulties. In a trauma-attachment TFC model such approaches may require further consideration. Whilst caregiver self-care is a critical element in caring for the child with trauma-attachment difficulties, for some children the experience of respite/being 'sent away' may be internalised as further abandonment and rejection. In contrast to such approaches, it is useful to build in structures for respite that do not impede the development of the carer-child attachment. This may include providing in-home respite where possible or assisting the carer to have time out from the home while the child remains at home with a supportive and well-known alternative carer. Furthermore, creating networks that support the foster carer and foster care family such as those employed by the Mirror families' model are promising (Brunner, 2006) and may provide a more creative alternative to traditional respite care options.



## References

- Ainsworth, F. and A. Maluccio (2003). "Towards new models of professional foster care." Adoption and Fostering 27(4): 46-50.
- Allen, J. and P. Vostanis (2005). "The impact of abuse and trauma on the developing child: An evaluation of a training programme for foster carers and supervising Social Workers." Adoption and Fostering 29(3): 68-80.
- Arcelus, J., T. Bellerby, et al. (1999). "A Mental-health Service for Young People in the care of the Local Authority." Clinical Child Psychology and Psychiatry 4(2): 233-245.
- Baker, J. (1989). "Therapeutic Foster parent: professionally or Emotionally Involved parent?" Child and Youth Services 12(1-2): 149-157.
- Bates, B.C., and Dozier, M., (2002). "The importance of maternal state of mind regarding attachment and infant age at placement to foster mothers' representations of their foster infants". Infant Mental health Journal, 23(4): 417-431.
- Becker-Weidman, A. (2006). "Treatment for Children with Trauma-Attachment Disorders: Dyadic Developmental Psychotherapy." Child and Adolescent Social Work Journal 13(2).
- Breland-Noble, A., E. Farmer, et al. (2005). "Mental health and other service use by youth in therapeutic foster care and group homes." Journal of Child & Family Studies 14(2): 167-180.
- Brunner, C. (2006). Mirror Families: 1-15.
- Bryant, B. (2004). Treatment Foster Care: A cost effective strategy for treatment of children with emotional, behavioural or medical needs. FFTA.
- Bryant, B. and R. Snodgrass (1992). "Foster Family care Applications with Special Populations, People Places Inc." Community Alternatives: International Journal of Family Care 4(2): 1-25.
- Butcher, A. (2002). Foster carer research. ACWA conference, "What works! evidence based practice in child and family services", Sydney.
- Butcher, A. (2005). "Upping the ante! The training and status of foster carers in Queensland." Children Australia 30(3): 25-30.
- Cairns, K., (2002). "Making sense. The use of theory and research to support foster care". Adoption and Fostering 26(2): 6-13
- Chamberlain, P. (2000). What Works in treatment foster care. Washington DC, Child Welfare League of America.
- Chamberlain, P., S. Moreland, et al. (1992). "Enhanced Services and Stipends for Foster Parents: Effects on Retention rates and Outcomes for Children." Child Welfare 71(5): 387-401.
- Chamberlain, P. and M. Weinrott (1990). "Specialized Foster Care: Treating Seriously Emotionally Disturbed Children." Children Today 19: 24-27.
- Chamberlain, P., and Reid, J. (1998). "Comparison of two community alternatives to incarceration for chronic juvenile offenders". Journal of Consulting and Clinical Psychology, 6(4): 624-633.
- Clare, B. (2001). "Managing the care journey: Meeting the health care needs of children in out-of-home care." Children Australia 26(1): 27-33.
- Cohen, J. (2004). "A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms." Child and Adolescent Psychiatry 43(4): 393-402.
- Connections-Challenging Behaviours Consultancy (2005). Working with children in care: Manual for carers. Melbourne, Connections.
- Curtis, P. A., G. Alexander, et al. (2001). "A Literature Review Comparing the Outcomes of residential Group Care and Therapeutic Foster Care." Child and Adolescent Social Work Journal 18(5).
- Delaney, R., and Kunstal, F.R. (1997). Troubled Transplants: Unconventional strategies for helping disturbed foster and adopted children. Wood 'N' Barnes.
- Department of Human Services Victoria (2006). "Every chance": proposed Victorian therapeutic foster care model: 1-26.
- Department of Human Services Victoria (June 2003). Public Parenting: A review of home-based care in Victoria. Melbourne, Victoria.
- Dozier, M., C. Stovall, et al. (2001). "Attachment for Infants in Foster Care: The role of caregiver state of mind." Child Development 72(5): 1467-1477.
- Dozier, M. (2005). Attachment and Biobehavioral catch-up: An intervention targeting the relationship between parent and child, unpublished training manual, Infant caregiver project, University of Delaware.
- Dozier, M. (2005). "Challenges of foster care." Attachment and Human Development 7(1): 27-30.
- Duerr-Berrick, J., M. Courtney, et al. (1993). "Specialized foster care and group home care: similarities and differences in the characteristics of children in care." Children and Youth Services Review 15: 453-473.
- Fine, P., (1993). A developmental network approach to therapeutic foster care. Washington D.C.: CWLA.
- Fisher, P. and P. Chamberlain (2000). "Multidimensional Treatment Foster Care: A program for Intensive Parenting, Family Support, and Skill Building." Journal of Emotional and Behavioral Disorders 8(3): 155-164.
- Fisher, P., H. Ellis, et al. (1999). "Early Intervention Foster Care: A model for preventing risk in young children who have been maltreated." Children's Services: Social Policy, research, and Practice 2(3): 159-182.



- Foster Family-Based Treatment Association (2004). Program Standards for Treatment foster care. Hackensack, NJ, FFTA.
- Frederico, M., A. Jackson, et al. (December 2005). Reflections on Complexity: Understanding the world of Take Two clients, First Evaluation Full Report-2004 Berry Street Victoria Take Two. Bundoora, Australia, School of Social Work and Social Policy, La Trobe University.
- Gilchrist, A. and P. Hoggan (1996). "Involving birth parents in foster care training." Adoption and Fostering 20(1).
- Golding, K. (2003). "Helping foster carers, helping children: Using attachment theory to guide practice." Adoption and Fostering 27(2): 64-73.
- Golding, K. (2004). "Providing specialist psychological support to foster carers: A consultation Model." Child and Adolescent Mental Health 9(2): 71-76.
- Golding, K. (2006). Fostering attachments with children who are looked after and adopted, unpublished training manual.
- Golding, K., H. Dent, et al., Eds. (2006). Thinking psychologically about children who are looked after and adopted. Holding it all together: creating thinking networks. England, John Wiley and Sons.
- Golding, K., and Picken, W. (2004). "Group work for foster carers caring for children with complex problems". Adoption and Fostering (28)1: 25-37.
- Gregory, S. D. P. and F. B. Phillips (1997). "'Of mind, body and spirit': Therapeutic foster care - an innovative approach to healing from an NTU perspective." Child Welfare 76(1): 127-142.
- Gregory, H. and K. Harper (2001). "The Ntu approach to Health and Healing." Journal of Black Psychology 27(3): 304-320.
- Hayden, P., L. Mulroney, et al. (2001). Shared Stories, Shared Lives: A course for new and prospective foster carers, The Centre for community welfare training as a project of the association of children's welfare agencies.
- Herbert, M. and J. Wookey (2004). Managing Children's Disruptive Behaviour: A guide for practitioners working with parents and foster parents. England, John Wiley & Sons.
- Higgins, D., L. Bromfield, et al. (2005). Enhancing out-of-home care for Aboriginal and Torres Strait Islander young people, Australian Institute of Family Studies.
- Hill-Tout, J., A. Pithouse, et al. (2003). "Training foster carers in a preventive approach to children who challenge: mixed messages from research." Adoption and Fostering 27(1): 47-56.
- Hill, M., Ed. (1999). Signposts in Fostering: Policy, practice and research issues. The importance of networks to partnership in child-centred foster care. London, BAAF.
- Hudson, J., R. Nutter, et al. (1994a). "Treatment foster care programs: A review of evaluation research and suggested directions." Social Work Research 18: 198-210.
- Hudson, J., R. Nutter, et al. (1994b). "Treatment Foster Family Care: Development and current status." Community Alternatives: International Journal of Family Care 6(2): 1-24.
- Hughes, D. A. (1997). Facilitating developmental attachment: The road to emotional recovery and behavioural change in foster and adopted children. London, Aronson.
- Hutchinson, B., J. Asquith, et al. (2003). "'Skills protect' Towards a professional foster care service." Adoption and Fostering 27(3): 8-13.
- Jernberg, A. and P. Booth (2001). Theraplay: Helping parents and children build better relationships through attachment-based play. San Francisco, Jossey-Bass.
- Jivanjee, P. (1999). "Parent perspectives on family involvement in therapeutic foster care." Journal of Child & Family Studies 8(4): 451-461.
- Jivanjee, P. (1999). "Professional and provider perspectives on family involvement in therapeutic foster care." Journal of Child and Family Studies 8(3): 329-341.
- Lawrence, G. (2004). "Caregiver training." Social Work Now (April): 25-28.
- Leslie, L., J. Gordon, et al. (2005b). "Addressing the developmental and mental health needs of young children in foster care." Developmental and Behavioral Pediatrics 26(2): 140-151.
- Leslie, L., J. Gordon, et al. (2005a). "The physical, developmental, and mental health needs of young children in child welfare by initial placement type." Developmental and Behavioral Pediatrics 26(3): 177-185.
- McMillen, C., B. Zima, et al. (2005). "Prevalence of psychiatric disorders among older youth in the foster care system." Child and Adolescent Psychiatry 44(1): 88-95.
- Minnis, H. and C. Devine (2001). "The effect of foster carer training on the emotional and behavioural functioning of looked after children." Adoption and Fostering 25(1): 44-54.
- Minnis, H., Devine, C., and Pelosi, T., (1999). "Foster carers speak about training". Adoption and Fostering 23(2): 42-47
- Minnis, H., A. J. Pelosi, et al. (2001). "Mental health and foster carer training." Archives of Disease in Childhood 84: 302-306.
- Murphy, J. W. and K. A. Callaghan (1989). "Therapeutic versus traditional foster care: Theoretical and practical distinctions." Adolescence 24(96): 891-900.
- NACCHO, National Aboriginal Community Controlled Health, <http://www.naccho.org.au/Members/About-Us.html>

- Oppenheim, L., Ed. (1992). The importance of networks to partnership in child-centred foster care. Signsposts in Fostering. Policy, practice and research issues. London, BAAF.
- Pallett, C., S. Scott, et al. (2002). "Fostering Changes: A cognitive-behavioural approach to help foster carers manage children." Adoption and Fostering 26(1): 39-48.
- Perry, B. (2006). Applying principles of neuro-development to clinical work with maltreated and traumatized children. New York, The Guilford Press.
- Pithouse, A., J. Hill-Tout, et al. (2002). "Training foster carers in challenging behaviour: a case study in disappointment?" Child and Family Social Work 7: 203-214.
- Ray, J. and W. Horner (1990). "Correlates of Effective Therapeutic Foster Parenting." Residential Treatment for children and Youth 7(4): 57-69.
- Redding, R., C. Fried, et al. (2000). "Predictors of Placement Outcomes in Treatment Foster Care: Implications for Foster Parent Selection and Service Delivery." Journal of Child & Family Studies 9(4): 425-447.
- Reddy, L. A. and S. I. Pfeiffer (1997). "Effectiveness of Treatment Foster Care with Children and Adolescents: A Review of Outcome Studies." Journal of the American Academy of Child and Adolescent Psychiatry 36(5): 581-588.
- Richardson, N., L. Bromfield, et al. (2005). The recruitment, retention, and support of Aboriginal and Torres Strait Islander Foster Carers: A literature review, Australian Institute of Family Studies.
- Rushton, A. and H. Minnis (2002). Residential and Foster Family care. Oxford, UK, Blackwell Science.
- Sanchirico, A. and K. Jablonka (2000). "Keeping Foster Children Connected to their Biological Parents: The impact of Foster Parent Training and Support." Child and Adolescent Social Work Journal 17(3): 185-203.
- Sauer, S. (2006). Berry Street Victoria Southern Services, 1:1 and Intensive Home Based Care Program Model, Berry Street Victoria.
- Schneiderman, M., M. Connors, et al. (1998). "Mental health services for children in out-of-home care." Child Welfare League of America 77(January/February): 29-40.
- Schofield, G. and Beek, M., (2006). Attachment handbook for foster care and adoption. London: BAAF.
- Shell, D. & Becker-Weidman, A. (2005). Creating capacity for attachment: Dyadic developmental psychotherapy in the treatment of trauma-attachment disorders. Wood and Barnes.
- Sheperis, C. J., E. L. Renfro-Michel, et al. (2003). "In-Home treatment of reactive attachment disorder in a therapeutic foster care system: A case example." Journal of Mental Health Counseling 25(1): 76-88.
- Sinclair, I., and Wilson, K., (2003) "Matches and Mismatches: The Contribution of Carers and Children to the Success of Foster Placements". British Journal of Social Work, 3317
- Stargate report (2002). Protected and respected: Addressing the needs of the children in out-of-home care. The Stargate early intervention program for children and young people in out-of-home care. Melbourne, Royal Children's Hospital Mental Health Service.
- Street, E. and M. Davies (1999). "Assessing and matching foster care relationships. An interactional framework." Adoption and Fostering 23(2).
- Success Works (2005). Evaluation of the Treatment and Care for Kids (TrACK) Program, Department of Human Services Eastern Metropolitan Region, Anglicare Victoria, Australian Childhood Foundation.
- Thomlison, B. (1991). "Family continuity and stability of care: Critical elements in treatment foster care programs." Community Alternatives. International Journal of Family Care 3(2): 1-18.
- Victorian Aboriginal Child care Agency, VACCA (2005). "Caring for Aboriginal and Torres Strait Islander children in out of home care". Melbourne, Victoria.
- Walker, M., M. Hill, et al. (2002). Fostering and Secure Care: An evaluation of the community alternative placement scheme (CAPS), The Glasgow Centre for the child and society - University of Glasgow.
- Walker, M., M. Hill, et al. (2002). Testing the limits of foster care: Fostering as an alternative to secure accommodation. London, BAAF.
- Yeo, S. (2003). Bonding and Attachment of Australian Aboriginal Children. Child Abuse Review 12:292-304
- Yokley, J. and S. Boettner (2002). Forensic Foster Care for young people who sexually abuse: Lessons from treatment. Dorset, Russell House publishing.

# Appendix 1

## Website references

The internet provides copious information relating to therapeutic foster care. The following list provides a small sample of useful websites for further exploration.

<http://www.cwti.org/>

Child Welfare Training Institute website. Provides training to carers and professionals and online training resources.

<http://www.oslccp.org/>

This is the home page of the Oregon Social Learning Center Community Programs, known for its Multidimensional Treatment Foster Care (MTFC) programs.

<http://ntuplc.org/>

Progressive Life Center (PLC). This organisation has developed a TFC program that adopts culturally competent therapeutic techniques and a spiritual and cultural framework referred to as NTU.

<http://www.peopleplaces.org/services.htm>

People Places program is a family-based treatment foster care program. The program adopts a behavioural intervention approach in which parent skills training is provided to treatment foster parents.

<http://www.futurefamilies.org/>

Future Families provides an intensive foster care treatment program. Treatment carers are expected to accompany children to treatment sessions twice weekly, attend regular support group meetings and specialised training.

<http://www.namasteinc.org/>

Home page of a treatment foster care program with a specific attachment-based approach to intervention.

<http://www.gccs.gla.ac.uk/pages/publications.htm>

This is the home page for the Glasgow Centre for the Child & Society (publications). Free access is provided to the evaluation of the Community Alternative Placement Scheme (CAPS) program based in Scotland. This program is also well known for the publication of their book, "Testing the Limits of Foster Care", by Moira Walker, Malcolm Hill and John Triseliotis.

<http://www.acrf.org/>

Home page of the Alaska Center for Resource Families (ACRF). Provides training, support and information to Alaska licensed foster and adoptive parents. ACRF offers a variety of educational opportunities to carers that include onsite and distance delivery training programs. ACRF also provides some interesting online courses for foster carers from a cultural (Native Indian) perspective.

<http://www.childtraumaacademy.com>

This is an excellent website that provides an online course developed by Bruce Perry for foster carers or professionals to complete on bonding and attachment in maltreated children.

<http://www.ffta.org/>

This is the website for the Foster Family-Based Treatment Association (a peak body for TFC programs in North America). The site provides articles and research in TFC, facilitates conferences, and newsletters. The FFTA has also developed standards for treatment foster care programs.

<http://www.caseyfamilyservices.org>

Casey Family Services, located in several U.S. states, is a large non-government welfare organisation devoted to foster care and adoption. They provide a range of innovative programs, including therapeutic foster care.

## Appendix 2

### A framework for understanding the integration of trauma and attachment theories (from the Take Two Practice Framework)

It is most useful to integrate the theories developed around both trauma and attachment when trying to understand the complex worlds of children who have suffered abuse and neglect; attachment theory because it speaks of human relationship development from pre-birth throughout the human life span and trauma theory because it helps us to understand the neurobiological and social impact of abuse and neglect on the human individual. It is in the early care-giving relationship that a child grows to know love, to depend on that love and to come to the conclusion that they are fundamentally good and worth loving. Without a good experience of early love, and of having someone interact with us in an attuned way when we are infants, our brains don't develop the pathways we need to understand the social world, to understand the rules of relationships and to gain strength from the pleasure of healthy touch, healthy talk and healthy play.

Attachment and trauma together give a complex understanding of development under adverse conditions. Attachment theory, though, has inherent complexities. It has been developed in a Western, individualistic social context and does not completely translate to other cultures; particularly cultures which have a collectivist base rather than an individualist base, collectivist meaning where social cohesion is valued above the needs of the individual. For example, when we attempt to assess attachment in Aboriginal or other ethnic group families we must be extremely careful not to impose Western values as we cannot assume infant/caregiver behaviours have the same meaning in cultures where there is a different idea of family and belonging to our own.

#### Attachment theory

Attachment, though, is a way to describe the fundamental early caregiving relationships that allow the development of a sense of safety and a sense of being lovable. Normal development, expressed in play and exploratory activity in children, requires the presence of a familiar attachment figure or figures, who modulate their physiological arousal by providing a balance between soothing and stimulation. The heart rate curves of mothers and infants parallel each other during interactions. This capacity of the caregiver to modulate physiological arousal reinforces the child's attachment to her, and allows a smooth alternation between activities, that increase and reduce arousal as they go back and forth between exploring the environment and returning to their caregiver.

The response of the caregiver not only protects the child from the effects of stressful situations by providing soothing where appropriate, it also enables

the child to develop the biological framework for dealing with future stress. In this process the caregiver plays the critical role. The caregiver is the leader of the child, helping the child to know their own feeling states by giving words to their experience (oh, you look tired, what a beautiful smile, you look so happy, you're really upset now), helping the child to regulate their physical bodies and to know physical boundaries by holding, touching, playing with and comforting them. Without these early experiences we grow up not recognising or understanding our emotional and physical states and consequently not able to make good decisions and judgements, not able to manage strong emotions and lacking trust in the world.

Another important resource a secure infancy gives us is the capacity to cope with stressful or traumatic events. If we have been well cared for we will have responses to stress and trauma but we will recover more quickly than those who had neglectful or harsh early parenting. When we are growing up, those of us who had a caring, attentive care-giver were more likely to be comforted when something painful or scary happened than those who did not.

An example of this is when a young child who, upon seeing the front door open wanders into the front yard, to be confronted by a large dog who rushes at the child, growling and barking. A parent or caregiver hears the noise and, if competent, rushes out, shoos away the dog, picks up the child, holding tight, speaking in a calm and soothing voice, until the child is calm again. The alternative picture is the caregiver who runs out, grabs the child by the arm, smacks her bottom and drags her inside, shouting 'what were you doing out there, I told you not to go out the front door'. Both parents have been frightened, but one acts to comfort the child while the other acts on their own raw emotions. If we don't get attuned and loving early care ourselves, we tend to act on our emotions, not being able to think or put other's needs first. And so we see some of the mechanisms of the intergenerational transmission of patterns of difficulty.

What we know about the elements of security in early relationships are:

Infants' brains develop within their relationships with those who love them. We know that from birth infants will turn their heads toward the sound of a parent's voice, and from 2 months of age babies prefer a parent's face. To encourage the growth of this relationship, parents use exaggerated facial expressions and 'baby talk' to communicate with their infant. The baby discovers who he or she is in this relationship, through three essential dimensions:

- Attunement which could be called a sense of a shared heart - "my mother gets me, she knows how I feel".
- Attention, or a sense of a shared mind - "I pay attention to you because you pay attention to me and I like that".



- And co-operation - "I like the feeling of getting your approval so I will (usually) do what you want me to".

## Regulation and intersubjectivity

Security with a parent or caregiver brings regulation, regulation of emotional and physical states. When the parent or caregiver can regulate their own emotions and reactions this is passed on to the baby, as the baby will always look to the parent to decide how to feel about something new.

The parent or caregiver's mind and heart act as a go-between for the infant, as the infant's experience is understood, modified and regulated by the parent. When the parent can quickly recover from stressful emotions, the infant learns to do this too.

This whole process is often referred to as 'intersubjectivity'. This has been defined as "*a deliberately sought sharing of experiences about events and things*" (Stern, 1985). Understanding intersubjectivity is fundamental to understanding the growth of the human infant and child, and also fundamental to understanding how to repair and heal traumatised children. Through intersubjectivity infants and children discover that they have a mind and that other people have minds as well. Between the seventh and ninth month of life, infants gradually come upon the momentous realisation that inner subjective experiences, the 'subject matter' of the mind, are potentially shareable with someone else. It works something like "what is going on in my mind may be similar enough to what is going on in your mind that we can communicate this (without words) and thereby experience intersubjectivity". For this experience to occur, there must be some shared framework of meaning and means of communication such as gesture, posture or facial expression (Stern, 1985).

It is important to understand intersubjectivity, not just to give us an understanding of the benefits of security in early childhood, and the limitations for children who did not participate in this kind of attuned relationship, but also to show the way forward, as one of the aims of therapeutic care is to recreate an opportunity for intersubjectivity as a healing mechanism for traumatised children.

## Trauma theory

One definition of trauma is when something happens that is so terrible it overwhelms our ability to cope.

*"At the moment of trauma, the victim is [made] helpless by overwhelming force... Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning"* (Herman, 1992/1997, p. 33).

Trauma occurs when an event is so frightening it causes a prolonged alarm reaction, where the body is primed and pumped with chemicals and enzymes like adrenaline and does not calm down for a long time. This creates an altered neurological state in any person, the severity of which is mediated by a

number of factors, including previous experiences of trauma and the availability of support. Children are more vulnerable to trauma than adults. Traumatic events modify an adult's original state of organisation but may be the original organising experience for the child, which creates the foundation for the child of key neurological systems. Traumatic experience in adults alters their mature and organised brain, which can create difficulties, but in infants and children it organises the developing brain (van der Kolk & McFarlane, 1996).

The media pays far more attention to the one-off traumas of natural disasters, terrorist attacks or acts of random violence than it does to child abuse, even though it is known that around 80% of human trauma occurs within the family setting. "*The most pernicious trauma is deliberately inflicted in a relationship where the traumatized individual is dependent - at worst, in a parent-child relationship*" (Allen, 1995). Trauma affects children differently at different ages, depending on temperament and existing resilience factors. Chronic childhood trauma interferes with the capacity to integrate sensory, emotional and cognitive information into a cohesive whole and sets the stage for unfocused and irrelevant responses to subsequent stress. The solutions to life used by traumatised children seem unconnected and unhelpful. Yet they are all they have. Children who have suffered chronic abuse/neglect often experience developmental delays across a broad spectrum, including cognitive, language, motor and socialisation skills (van der Kolk & McFarlane, 1996). One of the key messages that has become clearer over the past couple of decades is that trauma affects the whole person: their mind, brain, body, spirit and relationships with others.

## Impact on the brain and body

In the last couple of decades, there has been a major growth in understanding about trauma - thanks to the inventions of new ways of scanning the brain. Equipment such as the MRI and PET scans enable us to look at what is happening in the brain when it is experiencing certain emotions. Our brains are developed to help us to respond to threat. We refer to this as the flight, fight or freeze response. When we are confronted with a dangerous or potentially dangerous situation, our brain goes on alert and makes the body ready to respond. It does this by increasing the adrenaline in our system so we can be faster and stronger. When the threat is no longer there, then our brain releases other chemicals such as cortisol to reduce the adrenaline in our bodies. This helps us to relax and to quieten down. We no longer need to fight or run so our body adjusts accordingly. This is a normal, healthy reaction in all humans and many animals. "*In a dangerous situation, your adrenal glands may begin to pump ... adrenaline ...into your system. Adrenaline places your body into a state of biological alertness. Your heart rate, blood pressure, muscle tension, and blood-sugar level increase...Your pupils dilate...The blood flow to your arms and legs decreases,*

*while the flow to your head and trunk increases so that you can think and move better and more quickly. This is called the fight-or-flight reaction” (Matsakis, 1996, 26-28).*

In some situations where fighting or running is not possible, our brain may help us to freeze. In these situations our breathing may slow down and different chemicals such as endorphins are released that help us to be very still or even to go numb and therefore feel less pain. When someone is traumatised by extreme or repeated events of abuse, chemical reactions in the body and brain can be switched on as if they are never switched off. Some people who are traumatised have ongoing high levels of adrenaline in their bodies. They are wired for attack even though no attack is in sight. Some have high levels of cortisol, and are wired for numbness. This is often referred to as dissociation. “Each time a [traumatised person] has a flashback or nightmare, or is merely startled by a sudden sound or movement, his heart, lungs, muscles, blood vessels, and immune system are primed to save his life - from nothing at all” (Beaulieu, 2003, p. 53).

It is not surprising that some traumatised children have ongoing problems controlling their anger and impulses, as their bodies are flooded with adrenaline as if they are under threat, regardless of their actual situation. Alternatively, if they have been in freeze mode, their bodies may have high amounts of different chemicals called endorphins which numb the body's response to pain. This is useful when in a helpless and painful situation, but becomes counterproductive and even dangerous when that situation is over and they need to participate in activities, such as work or school. They may be described as having poor attention and concentration, as easily distracted, as not focusing on what needs to be done.

## **Neglect**

Neglect can also be conceptualised using trauma theory. Each time a young child is left cold, hungry, dirty or unattended this experience triggers a fear response, which turns to terror if it goes on for long. This fear or terror will have the same effect on the brain and body of the child as abuse. The terror is also compounded by the lack of stimulation usually seen in neglect, which slows brain growth and social development. It is compounded again by the lack of an attuned intersubjective relationship, where the child is not getting the opportunity to understand themselves and others within a loving relationship. Neglected children therefore can be seen to be compromised in many ways.

Bruce Perry's work examines children traumatised by abuse and neglect from a neurodevelopmental perspective, which allows an awareness of human brain development and functioning, and an awareness of abnormal functioning following trauma.

Essentially Perry says that the human brain is organised in a hierarchical way, with all incoming

sensory information first entering the lower parts of the brain, where no conscious thought exists. The brain uses the incoming information over time to build patterns and associations, that is how we build a picture of the world inside us to explain and interact with the world outside us. These are the neurobiological explanations of the intersubjective relationship. If patterns and associations built up in childhood are associated with threat, that person's brain will have built a picture of a threatening world inside and will respond to the world outside as if there was constant threat. This person will respond to neutral triggers as if they were threats, and the part of the brain doing the responding will be the lower part of the brain, not the higher 'thinking' part. Children who are exposed to danger and threat associated with early neglect and abuse will respond to neutral triggers and to any emotion-laden interaction as if the original threat was right there. They will have anxious, regressed, aggressive or numb responses, which we refer to as a dysregulated state. The child's thoughts, emotions and behaviours can be affected by this dysregulation. Therefore healing for traumatised children has to start from the bottom up. The child must feel safe, as a sense of safety will help the child stay in a regulated state, where they have access to the higher parts of the thinking brain, so that when a problem arises they can think and solve the problem, rather than become dysregulated, lose the capacity to think, and act on the raw emotions of fear and terror (Perry, 2006).

## **Trauma affects thinking**

One of the most difficult issues for carers and others like teachers who interact with traumatised children is the problems they have in thinking. They often seem to have very disorganised minds, they forget things, they leave their clothes where they fall, they leave their toys and other mess for others to clean up after them, they don't seem to pay attention to things others tell them, they can seem thoughtless and uncaring due to that thoughtlessness. Consider though, that some victims of childhood abuse and neglect cope by refusing to conceive of their caregiver's thoughts, thus avoiding having to think about their caregiver's wish to harm them. They close down any thoughts that come into their minds about that harm because thinking takes them down corridors of pain. It is better if they close the door than go down those corridors. Eventually they have closed so many doors in their minds that they can hardly think about anything.

This process can continue to disrupt the capacity to think about their own thoughts or the thoughts of others and this leaves them to operate on inaccurate assumptions of the thoughts and feelings of others (Fonagy, 1999).

Neglect and other maltreatment may result in children never developing these skills, and can cause children to withdraw from the mental world, due to several factors:

- The child who recognises the hatred or murderousness implied by the parent's acts of abuse is forced to see him/herself as worthless or unlovable.
- The parent may deny or distort the meaning of the abusive acts, the parent may claim beliefs or feelings at odds with their behaviour, and the child may not be able to make any sense of the parent's behaviour or their explanations of such behaviour. For example, a parent may say "I'm doing this for your own good", or "I'm doing this because I love you", or "I'm doing this because you really want me to".
- The lack of a capacity for reflection on the contents of one's own mind or the minds of others is connected with intersubjectivity, as it is learnt in the early pre-verbal caregiving relationship.

To cope with relationships we all need to be able to think about what other people might be thinking. We all 'read' people, we read their faces and gestures and we make quick, often accurate, assumptions about what they might be thinking. We do this all the time, checking out our assumptions with questions, looks and gestures. It is a large part of our communication with others, our ongoing intersubjective relationships, and if we can't do it we place ourselves at a great disadvantage. Not being able to do this leaves such people intensely vulnerable in intimate relationships.

### Traumatised children in out of home care

Trauma, neglect and a lack of early security are often played out in foster care placements. Daniel Hughes has a list of common qualities present for many abused and neglected children that make it difficult for them and their parents or caregivers to establish a positive relationship:

- They work very hard to control all situations, especially the feelings and behaviours of their caregivers.
- They relish power struggles and have a compulsion to win them.
- They feel empowered by repeatedly saying 'No!'.
- They cause emotional and, at times, physical pain to others.
- They strongly maintain a negative self-concept.
- They have a very limited ability to regulate their affect.
- They avoid reciprocal fun, engagement, and laughter.
- They avoid needing anyone or asking for help and favours.
- They avoid being praised and recognised as worthwhile.

- They avoid being loved and feeling special to someone
- They are enveloped by shame at the origin of the self (Hughes, 1997, p. 2-3).

These patterns of difficulty reflect failings in the development and integration of the basic body-self, of affect, behaviour, and cognition that occurs during the first three years of life. Each difficulty most likely reflects a combination of both a lack of affective attunement or regulation and excessive shame.

*"These children perceive caregivers as violent, cruel, rejecting, and unpredictable. Safety is increased through avoidance, silence, denial of one's own feelings and thoughts, lying, manipulation, and developing an attitude of constant vigilant control over one's environment"* (Hughes, 1997).

### Intervention

Bruce Perry's research indicates that the earlier intervention is applied, the greater chance for recovery. Children who are neglected and abused in infancy stand the greatest chance of recovery if intervention is applied in the first year of life. The older the child, and the longer they have been exposed to trauma, the more difficult it is for them to recover. However, the presence of other caring adults in the child's life will build resilience, maintain hope, and provide a different template of possibility (Perry, 2006). Recovery from trauma will not occur unless the child is safe. There is no hope for recovery from trauma if the trauma is still occurring. This means ensuring that not only is the abuse or neglect no longer occurring, but that the child is feeling safe and secure where they are living. This does not only mean no one is actually hurting them, it means that the adults in their lives acknowledge the hurt they have suffered, nurture them in appropriate ways, contain their difficult behaviours, and most importantly, keep them in their minds. To be happy, we all need to know that there is someone who cares about us and thinks about us, thinks about what we are doing, and how we are feeling. This is the basis of security. *"Trauma robs the victim of a sense of power and control; the guiding principle of recovery is to restore power and control to the survivor. The first task of recovery is to establish the survivor's safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured"* (Herman, 1992/1997, p. 159). Recovery from trauma also requires the creation of a relational network of people who are committed to and invested in the child.

Humans are fundamentally relational beings. In pre-historic and traditional communities there is no self and other. All are connected. The human brain is designed for this kind of milieu. Most of us in Western society have adapted to the changes in social life (although we could point to the high rates of anxiety, depression and other forms of physical, emotional and mental ill-health in our community). However, this relational poverty affects those children most at risk of abuse and neglect much more profoundly. The more



isolated physically and socially a family becomes, the more vulnerable a child becomes (Perry, 2006).

### Contact and access with biological family

Contact with family is vital to the well-being of children while in care, and ongoing contact has been shown to facilitate family reunification. However, in the light of trauma theory, actual and felt safety needs to be established in relation to contact and access visits with family members. Establishment of this kind of safety is often beyond the means of carers and workers. Advocacy for safety is very important. This also means that contact has to be properly supported, and carers need to understand the child's experience of contact.

Many children react badly to contact visits, returning to placement with destructive and oppositional behaviours. The reasons for this are complicated and include:

**Grief** - the child may be reminded of both the care they did receive from their natural family, and of the care they should have but did not receive. Children visiting extended family members can also be reminded of absent parents. Loss for these children is huge, loss of real people and loss of potential for love.

**Trauma** - children are sometimes reminded of traumatic incidents when they see a family member who has hurt, frightened or neglected them. Children may be afraid that the adult will hurt them again, no matter how much supervision is provided, so they have a compounded reaction, the memory of hurt is activated, in the presence of the possibility of further hurt.

**Guilt** - children often feel responsible for abuse - it is part of childhood to believe that everything that happens is somehow due to something you did or did not do - trauma is no exception, and many children feel responsible for the breakdown of the family, as they might be the one who disclosed, or who didn't keep their bruises hidden. Children in these situations are also sometimes blamed by the parent for the disclosure or for the abuse.

**Abuse** - there are many examples of abuse continuing during contact visits, sometimes physical or sexual, sometimes threats.

All of the above responses can create intense feelings, they can be confusing for children, and can easily lead to acting out behaviour, distress, rejection of the carer, or regression. This is not to say that contact should not happen, but the experience of the child must be acknowledged and understood.

### References

- Allen, Jon, G. (2003) "Mentalizing" Bulletin of the Menninger Clinic 67(2) Spring, 91-112.
- Beaulieu, D. (2003) Eye Movement Integration Therapy: The Comprehensive Clinical Guide. Crown House Publishing, Carmarthen.
- Fonagy, Peter (1999). "Transgenerational Consistencies of Attachment: A New Theory" (web version: [www.dspp.com/papers/fonagy2](http://www.dspp.com/papers/fonagy2)).
- Herman, Judith, L. & van der Kolk, Bessel, A. (1987). 'Traumatic Antecedents of Borderline Personality Disorder' Psychological Trauma. American Psychiatry Press Inc. Washington.
- Herman, J., Perry, J. van der Kolk, B., (1989) "Childhood trauma in borderline personality disorder" American Journal of Psychiatry, Vol 146 (4)
- Herman, Judith (1992/1997) Trauma and Recovery.
- Hughes, Daniel A. (1997) Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioral Change in Foster and Adopted Children Rowman & Littlefield Publishers, Inc. Lanham.
- Matsakis, Aphrodite (1996). I Can't Get Over It: A Handbook for Trauma Survivors (Second Edition) New Harbinger Publications, Inc, Oakland.
- Perry, B. (2006). Applying principles of neuro-development to clinical work with maltreated and traumatized children. The Guilford Press: New York.
- Stern, Daniel (1985). "The Interpersonal World of the Infant".
- van der Kolk, Bessel, A. (1996c). "Trauma and Memory".
- van der Kolk, Bessel A., McFarlane, Andrew & Weisaeth, Laars (Eds) Traumatic Stress: the effects of overwhelming Experience on Mind, Body and Society. The Guilford Press, New York.





