Supporting interaction in the context of residential child care

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Introduction

This article reflects on the use of one type of therapy, called Theraplay, in building attachments in residential child care in one agency in Finland. The purpose is to examine the role of this therapy in helping to heal relationships in the residential centre before the child moves on to a foster home. Nikinharjun kuntayhtymä is a joint municipal authority in Hyvinkää in Southern Finland. Nikinharju Child Care Centre has two units for short-term placements and assessment. Other services provided by the centre include family work, both within and outwith the centre, therapy services like Theraplay, music therapy and family therapy, supported living services for adolescents and a crisis residential service. The philosophy of the centre is based on attachment theory (Bowlby, 1988) but different approaches including psychodynamic and short-term therapeutic approaches are also available depending on the situation of the child.

Assessment at Nikinharju

When a child or adolescent is placed in the children's home, the process of assessment begins. There are three levels of assessment. The first level is an everyday living assessment which is carried out in the unit. This is when everyday activities such as eating, sleeping and taking care of hygiene are evaluated. Other areas which are taken into consideration are assessment of emotional and social behavior and the target is to obtain a picture of how the child copes with being in a new environment.

If there are particular concerns or if the authorities request more precise information, the second level of assessment is completed. This includes an individual assessment of the child by means of music therapy and, if possible, an assessment of parent-child interaction. At this point the staff use different methods such as the Marshak Interaction Method (Lender and Lindaman, 2007), the *Working Model of the Child interview* (Zeanah et al., 1993), the FAST (Family Assessment Test) and the CARE-Index (Crittenden, 2008) to assess interaction or the capability to reflect. The key workers in the centre are trained to use these methods as clinicians but it is important to stress that the methods are only one part of the whole assessment.

The third level of the assessment includes an extended observation at the home of the family, if possible. This includes longer-term work with the family and monitoring of their everyday life.

After the assessment period, a decision is made as to whether the child will return home or the authorities will seek a new foster care place. At this point the goals for rehabilitation are also identified and the need for therapy is discussed.

The importance of using attachment-promoting therapies

Research has demonstrated that insecure attachment is closely related to later psychopathology (Goldberg, 2000; Howe, 2005). Also, it has been shown that attachment patterns can transmit from one generation to the next. In the context of child care we may be familiar with the phenomenon of the cycle of attachment disruption which can follow on from family tragedies and we will also know about situations where the parent and the grandparent of the child were abused. Therefore, it is highly important to pay attention to the attachment status of the child as early as possible. In many cases the attachment bond between the child and his or her biological parent is weak or disrupted; sometimes it does not exist at all. This is often evident in the behaviour of the child. It is possible that the child cannot be selective in social relations. He or she can be clingy, withdrawn or may not wish to receive nurturing at all (see for example Zeanah & Boris 2005). Attachment is a major protective factor in situations of danger.

In which conditions is the use of attachment-promoting therapies considered? The younger the child, the greater is the pressure to start the rehabilitation. At the starting point, the therapy is both preventive and remedial because the child can have developmental delays or disturbances in the social, interactional or emotional areas. In addition, the length of the placement in the children's home is crucial. Unfortunately this aspect is often very difficult to foresee and for this reason the beginning of the therapy can be delayed for months. It is also possible that the situation will change quickly for the child. The therapy may have begun but then the plans change and the child moves away from the centre sooner than planned. These are the facts which are present in residential child care and there is little we can do to control this. Despite this level of placement unpredictability, we as authorities have a responsibility to make the situation as secure as possible for the child.

The framework of the model

The framework of this therapy model is based on Theraplay (Jernberg & Booth, 2010). Theraplay is a structured therapy method which focuses on the interaction of the child and his or her primary care-giver, which in most cases is the parent. The core of Theraplay is built around the natural, healthy interaction which should develop between the child and the parents. The key aspects which are stressed in Theraplay are: an attitude of positivity and joy (by which you convey to the child that he or she is capable, competent and skilful in doing many things), physical intimacy (by which you stress that you want to take care of the child and that he or she is worth your attention), being personal (ensuring that the child feels unique and special) and interactivity (conveying that we can enjoy being and doing together). The foundations of Theraplay work are structure, engagement, nurture and challenge. In addition, above all, is playfulness which is part of every activity in Theraplay. The media for this are different kind of attachment-based plays.

There are some special features in Theraplay which should be mentioned. First of all the sessions are focussed on 'here-and-now' experiences. We do not bring stories or histories to Theraplay, or any toys or equipment which distracts the child from the 'here-and-now' relationship with her or his caregiver. Each session is guided by a plan which is drawn up by the therapist. While it is true that the therapist will follow this plan, he or she is attuning very sensitively to the reactions of the child and the caregiver. By offering this type of guidance, the therapist retains control of the progress of the session, allowing the child to interact freely and without any constraints of responsibility. Theraplay is tuned in many ways to pre-verbal levels of development because it is important to remember that adolescents who have had disrupted attachments may still be functioning in some ways at this early developmental level. Pre-verbal methods include multi-sensory and amodal ways of being in contact, including touch, gaze and voice. Overall, however, the most important aspect of the interaction is to have fun and enjoy being together.

In this therapy, music and singing is much used. The meaning of singing seems to be more vital, the younger the child is. It is an activity that is beyond just words. Singing is one of the earliest and most common ways of being in interaction all over the world. The notable aspect of singing is its capacity to create emotional connection (Rock et al., 1999; Juslin & Sloboda, 2001; Milligan et al., 2003) as research shows that comforting a baby by singing is

experienced by the infant very differently from comforting with words. Singing can be calming (Shenfield et al., 2003) but also stimulating. With the help of songs an adult can prolong those moments of being in contact and at the same time regulate the emotional state of the child (Trehub & Trainor, 1998). Also, songs are connected to structure. Songs proceed in the same way no matter who is singing and this is especially important when there are several care-givers, as you may find in a children's home (Tuomi, 2004). The songs are predictable, which increases the feeling on being safe. In addition, the songs are transferable. They can be transferred to a new relationship and the new care-giver (for example, a foster parent) can sing the same songs another care-giver had used in the same situation (for example when settling the child for sleep).

The structure of the therapy

The meetings start while the child is living at the children's home. The participants of the process are the child, the residential child care practitioner (whom we call the primary nurse in Finland) and the therapist. This phase of therapy lasts as long as the child lives at the children's home. For example, a typical length of stay from 6 to 12 months will encompass 10-20 meetings. The meetings in the centre take place once a week, with each session lasting 20-30 minutes depending on the age of the child and how he or she manages in the situation. Meetings are usually in the therapy room but in case of the younger child the meetings take place at the home unit.

An important part of the whole process is the meetings between adults. There are around 3-5 meetings with the primary care-giver alone. During these meetings, it is possible to observe the videos taken on the sessions, point out different issues, discuss the everyday life of the child and assess the effects of therapy. In this way, different feelings, counter-transferences and images can be evaluated together. The therapist takes a rather directive role in the sessions, giving structured advice on interactions.

When a new foster placement is found, the setting and structure of the therapy changes. The new foster carer participates in the therapy as soon as possible, gradually taking a greater part as an active participant. Usually, one foster carer takes part in the therapy but in many cases the other foster carer (if applicable) can observe the session from the next room with the help of a video connection. At this point the meetings between adults continue and become more frequent. All the information available will be transferred to the new foster parents and they are given time and space to ask questions. This part of the therapy is accomplished when the child is still living in the centre. Usually there are 2-4 meetings during this period.

The third phase of the process includes sessions with the child, the new primary care-givers and the therapist. The length of this part of the process depends on many things (for example, geographical matters, the needs of the child and family, the motivation of the family and financial aspects). Usually there are about 2-4 meetings during this phase of the therapy and in many cases the child is already living at his or her new home. Therefore these sessions can take place both in the centre and at the new foster home.

When working with young children, the therapy meetings are purely about the therapeutic activity. With older children and adolescents, discussion plays an important role. Hughes (1997; 2007) has developed an application of psychotherapy called Dyadic Developmental Psychotherapy (DDP), where the primary care-giver is with the child in the therapy sessions. The DDP meetings are in two parts. First there is a meeting with the care-giver after which the child joins the session. Active parts can include the session with the help of which the engagement and joy of being together is found. Usually, there is also time for basic care and nurture (for example, feeding). Vivid discussion and speech with rich nuances plays an important role. These meetings are longer, lasting usually 75-120 minutes. It has been shown that attachment-based work becomes more effective and the environment for a foster or adopted child becomes safer when the child and therapist can, together with the primary care-giver, create a new biography which is more solid and persistent (Becker-Weidman & Shell, 2005). Therapeutic interventions such as Theraplay and DDP provide vehicles to create such new biographies.

The importance of involving the primary care-giver

Therapists traditionally work only with 'the client' (in this case, the child), and the possible attachment disorders are treated in patient-therapist relationship. In dyadic or family centered attachment-based therapy settings, the treatment is focused directly on the primary relationship of the child. In a residential setting, this primary relationship is between the child and the residential child care practioner. From the viewpoint of attachment this is relevant for several reasons. Therapy process offers a chance to change the child's problematic ways of interacting (i.e. their 'working models' in attachment theory) and help them to get some relief with the help of a remedial experience. Focus is on the new relationship and the aim is to help them to get a better start together. The transferability of the therapy effects seems to be greater when the care-giver is with the child during the therapy. The playing, songs and above all, the attitude toward each other transfer to everyday life. When the care-giver takes part to the therapy process, the important points of transitions from therapy to

the unit and vice versa are supported strongly. In addition, support between therapy sessions is available. This is important as it strengthens Winnicot's idea of continuity which he calls 'going on being'. The work individually with the primary care-giver is important and their significant role in the process cannot be emphasised too strongly. The target is to 'give birth' psychologically to the child in the care-giver's mind. This helps the new care giver to provide emotional regulation and containment for the child.

There are some additional factors that should be taken into consideration when working in the context of residential care and professional care-givers. One of them is commitment. One cannot start this kind of work until the commitment of the primary nurse is sure. The commitment of the whole team and the centre is also required to able to work efficiently. Experiences so far have shown that there will be much discussion about this (for example, the allocation of shifts and vacations to ensure that the child is best supported, and also how to take other children and staff into account). It is also very important that the primary nurse and the whole team have enough knowledge about the therapy and its background. This knowledge has to be both in terms of theory and at the experiential level as this can strengthen the commitment significantly.

Experiences and discussion

The model has been used in Nikinharjun kuntayhtymä for several years. The model has developed little by little and it is still developing and changing. It also has to be pointed out that every process is different and the model is applied with every child and every primary care-giver differently. However, some aspects seem to remain. The primary nurses claim that during the therapy, the dyadic time with the child increases, not only in therapy but also in the unit as the child develops the tendency to seek dyadic moments outside therapy times. During the process both the child and the adult have found it more satisfactory to be together than before, and the interplay offers both child and carer more joy. In addition, the songs and play activities transfer into the everyday life of the dyad, and make it richer and more joyful. The most important factor seems to be that the attachment bond between the child and the adult becomes special and strong. The dyad becomes something which is hard to break. After over 20 years of working as a primary nurse in the centre, one member of staff who participated in a therapy process stated that 'the attachment bond to this child is stronger than before with any other child during my years here.'

The development of such close attachments with professional carers can create some challenges. The new attachment bond often means that the child becomes socially selective, wishing only to relate to their primary nurse. It should, however, be remembered that this is actually a sign of healthy behavior. Nonetheless, other members of staff are not so close and this may cause jealousy both with other children and adults. From the child's viewpoint, the availability

of their primary nurse can be problematic because there are certain shifts and vacation times when the primary nurse is not there. The younger the child, the more difficult this disruption appears to him or her. Long absences of the primary nurse have been commented upon in the behaviour of the child, which often takes the form of regression. On these occasions the commitment and understanding of other staff becomes invaluable.

The crucial question is: if the child is moving away from the centre, then why build an attachment bond between the child and the adult when they are going to be separated anyway? The ethical viewpoints seem to be clear. Staying in a residential child care centre must always be rehabilitative and help the child to develop – the time at the children's home cannot only be about maintaining the status quo or waiting for the right placement. It must also be remedial. It has been shown that despite the child's apparent difficulties and seemingly regressive behaviour which occur when the primary nurse is not available or when the child moves to the foster home, the child seems to be much more able to 'bounce back' and develop positive interactions based on their good experiences of being together with the primary nurse. The key point is that these are important moments and precious development opportunities which should not be wasted by doing nothing.

In the future, it seems that the priority in Finland is to move away from providing residential care while moving toward more family-based care. This is especially the case with small children. The challenge in future could therefore be to transfer the kind of rehabilitation possible in the residential centre into foster homes. In any case, the need for rehabilitation of the attachment bond is obvious and the role of therapies such as Theraplay should always be considered, given the severe developmental delays in many children who are taken into the care of the authorities.

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