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## How do we work clinically with young people and staff?

## The seven elements of our clinical approach, our clinical process, and our theoretical framework.

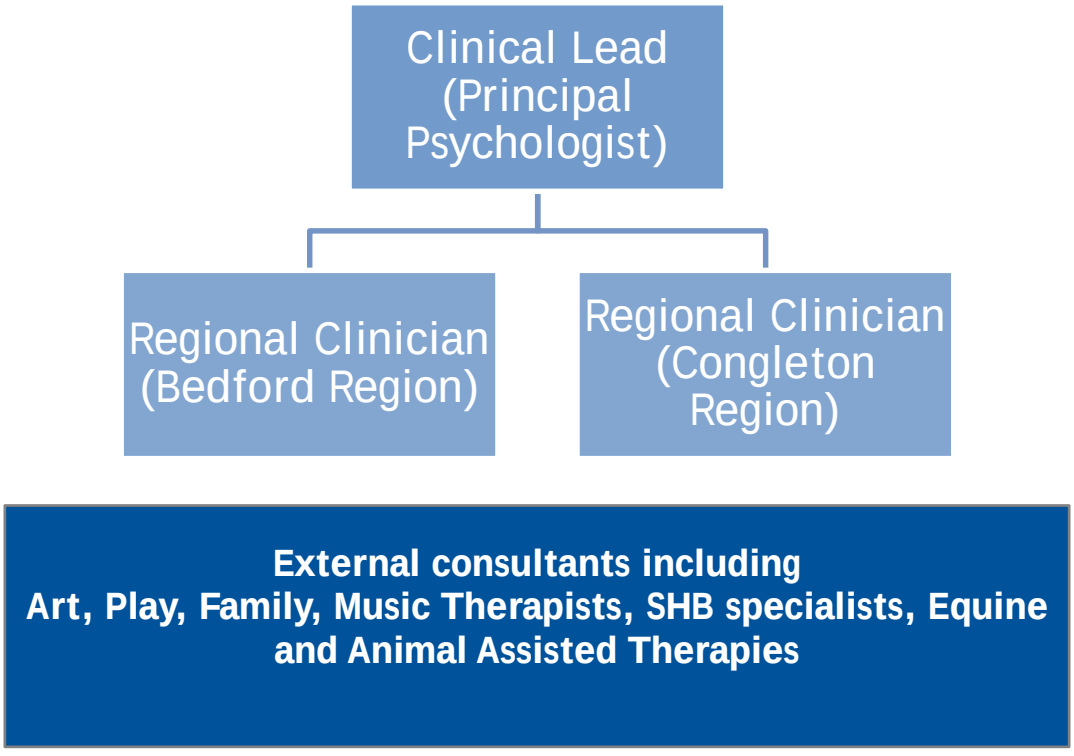
As a therapeutic service with a strong clinical team, we have the ability to ensure that all the young people in our care have the benefit of skilled psychological thinking and input into every area of their lives, even in the very few instances where a young person does not wish to take part in one to one psychotherapeutic work. The psychological aspect of what we do here at Oracle Care and Education is present throughout the service; in education, care and of course in its clinical aspects. We ensure this happens through a variety of means: from the most subtle of ways including how our underlying organisational culture manifests itself, through to the way we work directly with our young people. We ensure that we deliver therapeutic care through the following means:

1. Culture of acceptance of psychological thinking *throughout the organisation*: there is an expectation that all young people will take part in clinical work.
2. Clear clinical process that commences as soon as children enter the service, which includes thorough assessments, therapeutic plans and regular reviews of progress.
3. The nature of our direct work with young people.
4. All staff working from a clear theoretical framework.
5. Regular Clinical Consultations for every team in the homes and in both our schools.
6. In-house, theoretical training developed specifically for our staff and home managers.
7. Recruitment and induction of new staff includes an emphasis on ethical values and understanding of what it means to carry out therapeutic care.

## 1. Culture of acceptance of psychological thinking throughout the organisation and the expectation that young people will take part in clinical work.

In practice what this means is that, from the executive committee through to staff working on the ground, there is a pervading ethos in which psychological thinking and values are accepted as the norm. All staff understand that we are working within a therapeutic care environment. This is a hugely powerful influence as it promulgates a cultural *expectation* not only that our young people will be benefiting from and taking part in clinical activity, but also that staff will continually strive to enhance their psychological understanding of the children they look after. Part of this culture is enhanced by the clinicians themselves and the roles they perform in the company, so that all staff members feel they can ask clinicians' advice or support at any point, or use a conversation with them to process difficult material brought up by working with the young people in their care.

**The Clinical Team at Oracle Care consists of the following:**



Thanks to the pervading culture as mentioned above, it is an expectation that all young people will engage in therapeutic work. Clearly this does not mean that a young person is in any way compelled to do so; on the rare occasions that a child does not wish to see a therapist by themselves, we can try a group setting or family work, which can sometimes feel safer and less overwhelming for a young person. This type of work can also be highly beneficial as it works at a level where the child can address their primary experience (of being in their family as an infant and young child) and help them with their ability to relate to others and therefore form healthier relationships in the wider world. In addition we work indirectly with each young person on an on-going basis through team consultations and also through working with key workers, who may be better placed to carry out therapeutic pieces of work with the children with whom they are closely involved on a day to day basis.

An important part of this culture setting is the availability of clinicians to all staff for regular advice, ad hoc support and debriefs. Working with young people who live away from their homes can feel complicated, emotionally challenging and at times overwhelming, and it is when these sorts of feelings start to get the better of us that it is important that we reach out for support and reassurance from the right people. All staff members are aware that, should they need some extra support, they only need to approach any of the clinicians and will be listened to with compassion and interest. Our clinicians are well-placed to provide such support and all our staff not only are aware of this, but also are happy to ask the clinical team for support.

2. **Clear clinical process that commences as soon as children enter the service, which includes thorough assessments, therapeutic plans and regular reviews of progress:**

## The Oracle Therapeutic Model Process

'Clinical review request' from homes manager for suitable referrals.

Initial assessment- 12 weeks: It is a huge transition for children to move to a new home, which means they need a substantial amount of time to feel settled and safe in their new environment. Therefore we take 12 weeks to draw up our assessment and therapeutic plan for each child. However the clinical team will play an active role from admission date, and will aim to have made contact wtih the child and the team around them, as well as with social worker and former therapists by the 28 day initial LAC meeting. The assessment is completed by a qualified psychotherapist or psychologist and is overseen by the Principal Psychologist. We administer psychometric tests inlcuding Becks Youth Inventories to form a baseline picture of mental health and self concept.

As part of this process we form our therapeutic plan for each child. This will detail the sort of clinical input the teams around the child might require. It will identify what type of one to one therapy might be beneficial for the child and also whether group or family therapy might be indicated, both of which we can provide. Where the child has come to us with a YOS order or other requirement around harmful behaviour, this will be incorporated into the plan. Alongside school and care staff, clinicians help to review progress and the updating of risk assessments. The clinical team provide regular reports and progress monitoring via the LAC review process and also through our internal integrated working processes. Therapists provide termly reports for Oracle School, which detail progress and themes covered for children who are attending school and also in one to one therapy.

Therapeutic plan shared with the Home Manager and team.

Therapeutic plan shared with the LA

Therapeutic plan shared with the young person (if relevant and appropriate).

Implementation of the plan:

- Individual therapy sessions
- Family /group work set up where indicated
- Indirect work with key worker where necessary.
- Team consultations (monthly to discuss progress of the plan and placement).
- Incident reviews with the team.
- Ongoing review of child's well-being and any changes, alterations to the plan or aditional staff training required to meet need.

Interim reviews and ongoing monitoring:

LAC Review Meetings

LAC review meetings generally held every six months (sometimes more often), to monitor progress against Local Authority and our own goals for each child. All relevant and invited professionals attend; an integrated report is produced by the Registered Manager of the relevant Home with input from care, education and clinical team. Through team meetings with care and education staff, the Clinical Team have an ongoing and dynamic oversight of each child's progress, and can help staff adjust stragtegies and goals to ensure they are maintaining highest levels of care and tracking Local Authority goals for each child's stay with us.

Erasor

Aim 2

(SDQs)

Risk Assessment

Care, Clinical and Education Staff will be evidencing outcomes of children using a variety of methods.

Scoring of progress against stated goals and psychometric tests such as BECKS Youth Inventories to be repeated every six months to be presented in the LAC meeting and also form a body of evidence to show any shifts in mental health.

AIM2 and ERASOR assessments are generally refreshed annually where there has been further, siginificant, sexually harmful behaviour displayed.

We can use SDQs to obtain baseline scores for children who are not able to manage the Becks inventories.

Any relevant data gleaned from these assessments would be communicated in order for risk assessments to be up to date and fit for purpose.

Interim reports provided for LA as and when requested, by arrangement.

Final report: The final LAC meeting report will have a summary of progress throughout the child's stay, with collected psychometric and Outomes scores to provide hard data to accompany the wealth of anecdotal evidence contained in the collected reports produced throughout each child's stay.

## 3. The nature of our direct work with young people

There are many ways to work therapeutically with individuals. Here at Oracle Care we understand that it can be very difficult to speak about one's difficult experiences, particularly for our children who are usually seriously traumatised and operating from a level of severely disrupted attachments. We acknowledge that there is no 'quick fix' or 'magic wand' that is going to render our young people happy, confident youngsters just like any other who has not suffered extreme trauma, rejection, abandonment and loss.

The work required to help our children exist comfortably in the world can be a very long process that potentially can take many years. Accordingly we are able to provide this work on a long term basis, for as long as each child needs and wants the intervention. We regularly review the therapeutic work and would only bring it to an end where the child is leaving us or where the work has come to a natural end. We also know that the delicate work required to start to heal the wounds suffered by our young people cannot be rushed, and children need to be allowed to communicate their readiness to face difficult material and experiences.

Therefore we take a *non-directive* approach to clinical work with our children, whereby the work is, on the whole, child-led, rather than heavily structured by the therapist. Working in this way means that the child can build a rapport with their therapist, feel safe in the therapeutic setting and feel safe enough within themselves before bringing potentially painful and unsettling material into the room.

Models of therapy that suit this way of working include creative therapies such as play, art, music and drama, as well as person centred and psychodynamic approaches. It is often the case that children find it very hard to verbalise their difficulties; therefore creative therapies can be an excellent way for them to express their innermost thoughts, feelings, fears and desires. Having said that, where forensic approaches are indicated in the child's placement plan, we would take the appropriate, more structured approach, where required by external agencies and where we feel appropriate.

The clinical team are also aware that one to one work is not always appropriate for every child at any given moment. "*Too narrow a focus on individual therapy can lead to an expectation that children will adjust to a world for which they are not equipped. The therapy becomes a way of 'making children fit'" (Golding, K. 2006, p306).*

As already mentioned, we keep the family in mind when looking after our children. Research indicates that it is back towards family that most looked-after children will turn once they leave the care system. Therefore where at all possible, we try to engage birth or adoptive families in family work. Where we can enhance these relationships, so that families are more able to relate to one another positively, we do our utmost to bring this about.

**TERM TIME THERAPY**

Children who are seen in school will, in general, have a break during school holidays. This is completely normal procedure for any therapeutic endeavour that takes place within the school environment. It applies to all children who see their art, music or play therapist within the school environment, as is the case for the vast majority of our young people

The play/art therapists will have been speaking to their clients about these breaks long before they occur, to prepare them and to help the children think about what the break means and to help them through what can sometimes be a painful process. They will be talking to them in a way that helps the child understand that the therapist will not forget them over the break, and in fact will be thinking about them. In some cases children will choose transitional objects to hold on to until they see the therapist again. Some therapists might send a postcard to their clients during the holidays to remind them that they have not disappeared, and that they are thinking about the child. This is a powerful experience for our young clients; it gives them a deeper understanding and feelings of safety that can only be learned in this highly experiential manner.

**The benefits of term time therapy:**

It is important to note that there are several very important therapeutic, psychological benefits to the termly rhythm of work, even to the long summer break. It is very hard for our children to feel that anyone ever holds them in mind. This leads to low self esteem and a feeling of being anchorless, among other things, which is very distressing for anyone, let alone children and youngsters.

To have the experience of saying good bye for now to the person with whom they are having an intense relationship, and then to come back and see them again, with the relationship unchanged, is of huge benefit to children. It may feel sad and a bit scary at the point of saying goodbye for now, but ultimately it helps them, through the process of saying goodbye and then being reunited, understand that people *will* think about them even when they're not there, they *will* come back – ie not reject and abandon them, and they *will* remain attached to them even after a break. These things, as well as several other elements of this experience, help raise self esteem, strengthen attachments and trust in relationships and ultimately help the child feel stronger in themselves and their ability to manage the world.

## 4. All staff work from a clear theoretical framework

We understand that to be alive means fundamentally and inescapably to be in relation to each other. Our therapeutic goal, broadly, is to help our young people feel better about themselves and others, manage themselves better and ultimately

to be able to lead a more fulfilling and successful life once they leave our care and attain adulthood. We aim to help them learn to trust where trust is due and be able to engage in healthy relationships with others. We want to help our children come to terms with their situation and learn to manage themselves in the context of the social world they live in. We aim to build resilience, improve self regulation, strengthen impulse control, and help our young people feel better, less anxious and enhance their sense of agency and self efficacy. We know that all these developmental skills are learned through our relationships with others.

## Our theoretical underpinnings

It is widely accepted that, in order for staff to be able to carry out robust and consistent therapeutic care, it helps greatly if they are all working in the context of a coherent theoretical model. At Oracle Care our approach is underpinned by several important theoretical models:

- Attachment Theory
- Psychodynamic theory of unconscious communications
- Therapeutic Parenting – tailored to address the impact of early trauma
- A Family-orientated approach

At the core of what we do lie theories of attachment, whereby we think about the young people, their behaviours and communication in terms of their early attachments, what has transpired within these attachments and the impact these have had on the young people's inner working models.

We are aided in our understanding of our young people's inner worlds and how these are manifested in their relationships with others by using by psychodynamic principles of unconscious communication. By using attachment theory and also by understanding psychological strategies such as projection, transference and counter transference, we can help staff see the communications that underlie many behaviours and also help them remain resilient in the face of what can sometimes prove to be a difficult working environment.

We think about our young people in this way in the context of thinking systemically, taking into account group factors around the child in care and also, importantly, in terms of their family context.

We base our approach to therapeutic parenting on the PACE model (Hughes and Golding). We incorporate high threshold, high tolerance, low arousal approaches to challenging behaviour and we train staff to understand how trauma and difficult attachment styles can inform and propel children's behaviours. Staff at Oracle Care are trained in the differences between 'normal' and 'therapeutic' parenting techniques. We help staff understand the need for planning, predictability, consistency, compassion and separation; also how to help children understand the consequences of their behaviour in a way that can help them connect their thoughts, feelings and behaviours and thereby gain an easier relationship with themselves and others.

All staff are trained throughout their tenure in the different aspects of our theoretical framework and underpinnings.

For a full account of our theoretical framework, please see THEORETICAL FRAMEWORK at the end of this document.

## 5. Regular Clinical Consultations for every team in our Homes and Schools

At Oracle Care we provide clinically informed input to each child both directly and indirectly. Treating a child therapeutically in isolation and separately from their care givers can have a beneficial effect in many cases; however the effects of therapeutic intervention are greatly increased and ameliorated where the child's wider context can be worked with. Therefore we provide therapeutic input to our children's carers, and also to their educators, in order to bring as much clinical insight and therapeutic intervention to each child as is possible in their context of living in residential care. Furthermore, as can been seen above, direct work can represent something negative in a child's life, and it is regularly the case that an indirect, staff-focused clinical approach is in fact in the child's best interests, at least until such time as something more direct can be safely considered.

A major component of this indirect clinical input is delivered through monthly clinical meetings with individual teams in each home and in the schools. The purpose of the clinical meetings is to provide clinical input to each child's care indirectly. The clinicians help staff understand the children and think about them from a more theoretical stand point, and therefore work with them as effectively as possible. In order for this to be facilitated, it is important that the meetings are a safe space in which staff can explore their own processes and reactions to the young people/children. The meetings usually look at all children in the home (maximum three) or school. With the clinician, staff look at what has gone on with each child, think about their own material around each child and think about underlying factors and historical experiences that may be directing behaviour and experience in the here and now.

The clinicians will often make the meetings into more of a training exercise, where different topics can be discussed and each child thought about from the perspective of a theoretical training. This helps staff learn new theory, refresh existing knowledge and put their learning into practice. Trainings are kept as dynamic as possible and do not take too much of a didactic turn, as this can prove counterproductive we have found. Examples of such trainings are autism, early developmental trauma, self harm, LD, and more.

Where meetings are more training focused, staff still have the opportunity to talk about and reflect on their own experience. Where individuals are able safely to express their own difficult thoughts and feelings in the context of the group setting, this can prove extremely therapeutic for the teams and also, by default, for the young people. If staff can work through their own internal dilemmas, they can then face the children from a far stronger place, where they are able to see the child and his or her difficulties much more clearly and not get personally involved at a

pathological level. This in turn leads to healthier interactions and relationships and therefore better care.

In addition to the clinical team meetings, the regional clinicians also spend an hour a month, at a separate time, with each registered manager in the home. The purpose of this is to give each Registered Manager their own opportunity to think clinically about the children in their care, and also to give the opportunity for clinical input to be given to any relevant paperwork.

## 6. In-house, theoretical training developed specifically for our staff and home managers

In order to support our staff's theoretical understanding and to ensure they have the tools to do the best possible job that they can, we offer a range of trainings designed to teach theoretical and therapeutic underpinnings which are aimed at all levels of staff. Our Residential Childcare Practitioners (RCPs) and teaching staff where possible have exposure to trainings in topics such as: autism, self harm, therapeutic parenting, attachment theory, impact of early trauma, child development, sexual development, gender identity, active listening, understanding challenging behaviour, and therapeutic holding. Our Registered Managers undertake a rolling programme of theoretical training which includes 'normal' versus 'abnormal' sexual development, attachment theory, early brain development, impact of early trauma, differentiating between autism and the impact of trauma, parental mental ill-health, building resilience in their teams and more.

## 7. Recruitment and induction of new staff includes an emphasis on ethical values and understanding of what it means to carry out therapeutic care.

How and whom we recruit to become a member of our staff team is of great importance not only in terms of the quality of care we deliver, but also in terms of maintaining staff teams and avoiding unnecessary churn, which can be unsettling for children and staff teams alike. We have developed a robust interview process which includes in-depth enquiry into potential staff members' beliefs and ethics; their views on safeguarding and personal accountability; their own experience of being parented and how this impacts on the here and now. We try to make sure potential staff members understand the nature of the work place they would be entering and that they have the necessary resilience to do so. As part of the interview process we carry out observations of how the candidates interact with our children in a real time context. Once accepted, we then carry out a thorough induction process of all new staff which includes all the usual mandatory trainings required to operate in a care context, as well as an introduction to the therapeutic nature of our work and how this looks in practice.

# Appendix A :

# The Oracle Care and Education Ltd Theoretical Framework

## Introduction

At Oracle Care we provide therapeutic care to our young people. In practice this means that we don't just give them a home, we do our utmost to help each young person assess and come to terms with their difficulties. When a young person arrives in a residential care setting, it is usually the case that things have gone very wrong in several different home contexts, and that whatever problems that young person may have entered the care system with, they will by now have been compounded and intensified. However it is well known that the minds and systems of children and young people are open to shifts and changes, mediated by new experiences. Therefore through the giving of compassionate, boundaried, predictable and safe care and understanding, our staff help these troubled youngsters have a different experience which they can assimilate and use to change their outlook on themselves and the world around them.

There is significant evidence available which suggests that therapeutic approaches to looking after children and young people are not only beneficial to children and staff, but also a more appropriate way to bring about good outcomes. NICE guidelines on caring for children states*: "Evidence indicates that foster care and residential care are complex activities that require rehabilitative and therapeutic approaches and skills."*

## Why have a theoretical framework?

It makes sense that, in order to carry out consistent, considered and effective therapeutic care, it is important for everyone involved in the child's care to have a similar theoretical understanding of what they are doing and why. Research backs up this notion and tends to suggest that a coherent theoretical model improves practice, helps staff feel more equipped to deal with stressful situations and helps staff feel less personally attacked during incidents, thus freeing them up psychologically to better manage and contain them. Understanding the theory behind what they are doing helps staff then move their focus away from managing and containing behaviour and towards understanding it and thereby providing a different, therapeutic response. Use of psychological theory helps evolve a decreased focus on punishment and increased use of negotiation, which helps young people foster a sense of their ability to cope with and survive in the world.

A research study conducted by SCIE (Social Care Institute for Excellence) of five theoretical models utilised in children's homes in Northern Ireland found strong evidence to suggest that:

- Clearly defined therapeutic approaches enable staff to "have a better understanding of how young people's experiences affect them, consider their emotional needs and foster resilience".
- Staff reported that it had enhanced their practice, particularly relationships with young people and the consistency of their approach .
- Young people noticed staff were less stressed and the atmosphere was more relaxed at home.
- Fewer punishments and more negotiation was used.
- Staff felt more empowered and valued by the organisation, with hierarchical differences less pronounced.
- Staff felt a renewed sense of professionalism and purpose.
- Improved culture in the home and higher morale.
- Staff more able to engage in reflective practice.

## Our theoretical underpinnings

In order for staff across the organisation to deliver consistent therapeutic care, there needs to be a robust, coherent theoretical framework that everyone can understand and follow in order to deliver therapeutic care to the best of their ability. At Oracle Care, our overarching message is that through our therapeutic care, we strive to help children identify what they need from us and how we can give that to them.

*"Together we will work out what it is that you need."*

Our approach is underpinned by several important theoretical models:

1. Attachment Theory
2. Psychodynamic theories of unconscious communications
3. Therapeutic parenting – PACE
4. Family/system orientated – we work with the child's context both at home with us and also with the wider context where possible.

## 1. Attachment Theory

At the core of what we do lie theories of attachment, whereby we think about the young people, their behaviours and communications in terms of their early attachments, what has transpired within these attachments and the impact these have had on the young people's internal working models of themselves, others and the world. We help staff attune to the children they look after so that they can provide what the child actually needs from their care giver, rather than what the care giver wants to provide. The three main forms of attachment style which present in looked after children are all of the insecure type, namely: ambivalent, avoidant or disorganised.

**Ambivalent attachment style**
(can also present as dependent/or preoccupied attachment style)

Between 8 – 12% of the population are said to have an ambivalent attachment style. The main attributes include: a deep and enduring doubt as to the loveability and worthiness of the self, accompanied by a troubling preoccupation with the question of whether others will be available to give comfort and reassurance when distress should arise. People with an ambivalent attachment style often present with low self-esteem and can show a pattern of intense and entangled relationships. They are prone to separation anxiety, and together with their low self-esteem this means that when close relationships are threatened, they can become highly anxious, clingy and fretful.

This style of attaching arises when the infant/child's care giver is not consistent in their availability to provide care. This could be the case with parents who are addicted to alcohol, for example, or who are so preoccupied by their own distress or concerns that their care for the child tends to switch on and off. This leads to a child who has to constantly monitor the care-giver to check out their availability to soothe or provide nurture and care. There is never any guarantee that the child's needs will be met. This then tends to manifest itself in the child as a state of constant vigilance. Children in the class room who are ambivalently attached, for example, can find it very hard to concentrate as they are so busy watching their environment to check it is OK for them and can meet the child's needs. A child like this would probably struggle with sudden loud bangs or other shocks, as their systems are already aroused in the quest for what is essentially ensuring their survival.

It is worth noting that people with ambivalent attachment styles, through their need to be close to others in order to feel secure, can be successful social animals, highly engaging, extrovert and often attracted to the caring professions.

**Avoidant attachment style**
(defended, dismissing)

Around 15-23% of normal populations will display avoidant attachment patterns of behaviour. An avoidantly attached person finds close relationships worrying and troublesome, and will often distance themselves at times when there is a greater expectation of closeness or intimacy. When this sort of person's attachment anxiety is highly aroused, they can often pull away or even disappear, leaving the other person highly confused and distressed. They often find themselves in jobs where they can be on their own or concentrating on non human things such as IT, graphics, ideas and concepts, machines and so on.

This type of attachment style arises when the infant's care giver is unavailable, hostile, agitated or distressed a lot of the time. When the infant is emotionally aroused, rather than be able to depend on the care-giver for reassurance and soothing, he or she is met with hostility or the cold shoulder. It seems to be the infant's need itself that arouses the parent's hostile reaction. The higher the need

of the infant, the more the parent resists, or even becomes more rejecting and hostile. This leads the baby to internalise two important things: firstly, that they cannot trust anyone to meet their needs so they had better not have any, and secondly, that they themselves seem to be the thing that is making the parent hostile or rejecting. Furthermore, a care giver such as this will not only reject the infant's need for support, but will try to change the child's experience, thus ensuring that they have less of a firm hold on the validity of their own experience. The classic example would be the child with mum or dad, who takes a horrible fall, hurts themselves badly and runs to the parent who says, "Don't be silly little Roger, you're fine, for goodness sake stop crying," etc. This child can't believe in their own feelings or their own experience, because they are being told plain and simple that they are wrong! *"Overall, then, the characteristic style of parents of infants classified as avoidant is a combination of distress, rebuff, rejection and hostility mixed with control, intrusion and overstimulation."* (Howe et al, p 62).

As children, these characters learn to defend themselves against emotion. They rarely seek out emotional support and tend to be very self sufficient. Achievements and successes are far more likely to gain positive feedback from the care givers than anything with any emotional content. Positive self-regard is conditional on suppression of anger and hurt, and on displays of self-reliance and achievement. Herein lies the basis for an individual's need to achieve, workaholism, perfectionism and pursuit of material success.

**Disorganised patterns of attachment**
(controlling, unresolved)

This is a wide, troubling and in some ways quite complicated model of attaching, and is of course what we see in the young people in our care more often than not. It has been suggested that around 15% of infants in the normal population will display this pattern of attachment. This style of attaching is associated with serious childhood trauma and abuse, with children who have been parented with violence and/or sexual violence, or by parents suffering from drug addiction or profound mental health difficulties, or indeed all of the above. One of the differences between children with a disorganised pattern, as opposed to an ambivalent or avoidant pattern, is that when their need for proximity is aroused, they have no organised behavioural strategy to gain proximity, and can therefore be highly chaotic in their behaviour towards care givers. (Hence violence and acting out with adults trying to give them some kind of healthy emotional experience). The avoidant and ambivalently attached person has learned to switch off or tune out their attachment needs in order to gain proximity. This cannot be the case for the disorganised person, as their experience of trying to gain proximity has been met with violence, total indifference or worse. They are not able to learn any strategies to predictably attain proximity - emotional closeness - to a care giver. Disorganised children will present as confused, trance like, dazed, fearful or violent in the presence of their parent. This style of attachment arises when the child has been alarmed by the care giver's violent, confusing or scary behaviour. The child is scared of and/or scared for

the parent, which leads to: '*an irresolvable paradox. The parent frightens the child. Fear raises distress and anxiety, which activates attachment behaviour whose purpose is to get the child into close and safe proximity with the carer. But the carer is the source of the fear and distress. Conflict behaviour therefore results because the source of security for the infant is also the source of the fear.'* (Howe et al p 123).

The disorganised person will often present as easily 'triggered', unable to self soothe or tolerate frustration, display violent acting out behaviours and find it very hard (frightening) to form close emotional bonds. This is an important area for our work with children in our homes and is therefore an important focus of our attachment based trainings.

## 2. Psychodynamic theories of unconscious communications

We are aided in our understanding of our young people's inner worlds by psychodynamic principles of unconscious communication. By using attachment theory and also by understanding unconscious psychological strategies such as projection, transference and counter transference, we can help staff identify the communications that underly many behaviours and also help them remain resilient in the face of what can sometimes prove to be a difficult working environment.

Put simply, these are the four methods of unconscious communication we try to help staff think about when they are understanding the children's behaviour and their own responses to those children:

Projection: The process by which we attribute parts or facets of ourselves onto the other person. These qualities could be positive, negative or indifferent, however they are generally qualities that the projector is unable to acknowledge in themselves.

Transference: The process whereby we attribute facets of one person to another, and thereby believe those things to be true of the second person. For example, we might believe a partner has a certain characteristic, when in fact they are not like that and the characteristic belongs to someone from our past, for example our mother or father.

Counter transference: When we are in the process of having something transferred onto us that belongs to another person, we can have a reaction to that which is in accord with what the original person might have done. So for example, if our partner is in some way treating us as if we are emotionally withholding, we might unwittingly become quite emotionally ungenerous and even punishing.

Projective Identification: originally explained by Melanie Klein, whose life work was of course with children, this is the seemingly magical process whereby we can start to feel things that in fact belong to another person, as if they were our own. For example, where one person feels extremely angry about their experience, but is not in touch with this anger, maybe because they have been taught as a child that it is not allowed to be angry, a person in close connection with that person can

sometimes start to feel very cross and even suffused with rage without really understanding why. Children are excellent at projecting their feelings *into* carers, unwittingly of course, and this is why working with traumatised children is so incredibly difficult. Carers, particularly the more sensitive ones, will be literally continuously bombarded by these projections while working with the children, and therefore can be helped dramatically through gaining an understanding of these unconscious psychological processes.

## 3. Therapeutic Parenting

It is often heard in residential settings that parenting a child in care is not the same as parenting one's own children. Indeed, it can be said that staff should take a radically different approach. What does this mean? And what does it look like in practice?

From a general parenting perspective, research overwhelmingly supports the notion that an 'authoritative' parenting style produces the best outcomes (Steinberg, 2001). This is as opposed to an authoritarian, permissive or indifferent parenting style. Authoritative parenting strives to keep a balance between giving the child warmth and affection, with an age appropriate degree of control and permissiveness. The authoritative parent gives the child clear boundaries, but also engages the child in a discussion about potential risks and outcomes in order to help the child grow towards a position of healthy responsibility-taking for him or herself. The authoritative parent will entertain the possibility of their 16 year old attending a party on a Saturday night, but will not allow them carte blanche to be roaming the streets with unknown others until 3am.

Within the notion of an authoritative parenting approach, at Oracle Care we value the nurturing of children; we are aiming to bring an element of love and family spirit into our work. It is within this nurturing atmosphere that children and young people can find themselves and heal themselves more successfully. Alongside this nurturing approach, we have high tolerance thresholds for acting out behaviours – these are so often simply testing out if the care being offered is real and enduring, and provide a real opportunity for profound growth and psychological healing. The family-orientated approach means that we will cook with the children, make sure they access education, help with their homework, go to parents' evenings, make sure they go to leisure activities that interest them, read them bedtime stories if possible, and take a close parental interest.

When it comes to the sometimes more challenging task of therapeutic parenting as opposed to 'standard' parenting, the differences are marked. Levels of compassion and patience need to be far higher in order not to repeat former abusive responses and to help children re-learn stimuli responses. Routine is key: staff are not encouraged to take children off on trips on a sudden whim; they are taught that our children need everything in their day to be predictable, planned, structured and therefore safe. Boundaries put in place need to be firmly, calmly and consistently upheld until such time as it is the right thing to do to change them, at which point this needs to be done very slowly and carefully to reflect the child's development. Natural consequences to actions need to be embraced and worked with rather than

using punishments as a form of behavioural control. Empathic responses and reflection are key to helping the child understand themselves rather than shut down after a difficult incident.

Other important strategies include: not demanding apologies from a traumatised child; not overly praising a child, as this may in fact prove painful, confusing and conflicting for the child whose internal model of themselves is far from praiseworthy. Also, avoiding responses such as: having drawn out debriefs about behaviour, giving consequences that do not relate to the behaviour and therefore do not make logical sense; using techniques that isolate the child such as Time Out. It means responding to the child in a way that communicates with their emotional age, which is often far lower than their chronological age, and giving opportunities for the child to show sorry-ness for harm they have caused rather than exacting apologies from them.

Most of the ideas here can be found in the PACE (playfulness, acceptance, curiosity and empathy) model of therapeutic parenting, as devised by Kim Golding and Dan Hughes. This model is entrenched within Oracle Care's approach to behaviour support and how we train our staff to support children's behaviour when they start to struggle. The PACE model (Playfulness, Acceptance,Curiosity and Empathy) is particularly apposite as applied to working with children who have experienced serious and usually developmental trauma. Developmental trauma is generally understood to denote trauma that has happened in an ongoing way in an interfamilial context.

We work with staff to help them understand the impact that trauma has on children's presentation, development and attachments. For example serious trauma in early years can present in a child as nightmares, flashbacks, difficulties going to bed and problems sleeping. It can cause hyper-vigilance and an inability to self soothe. It can seriously impair emotional resilience and the ability to manage interpersonal conflict, or relationships at all. Childhood trauma affects the developing brain, and can cause cognitive deficits, total memory loss for periods of time, working memory deficits and many other problems that impede learning. Children who have experienced protracted early trauma may have very poor self esteem, poor self efficacy and poor sense of agency. However the child will not just wear these problems like a badge. As functioning humans they will try to mask them or compensate for them using often unhelpful strategies such as aggression, acting out, clinginess, oppositionality and so on.

## 4. Working with the family/system

We think out about our young people in this way in the context of thinking systemically, taking into account group factors around the child in care and also, importantly, in terms of their family context. Within the care system we work with teams around the child in order to ensure that the child is understood in the context of their current system. Having said that, we also understand that children come from families and it is usually within these family structures that things have gone wrong for the children in care. While it might be tempting to dismiss birth families as harmful or not useful to the young person, it is of course true that it is back to, or

towards these families that our young people will eventually gravitate in many cases. (Schofield and Ward, 2011). Furthermore, research tends to show that most children removed from their families remain highly concerned about their close relations, including their parents. *"Although children and young people will have mixed emotions about their parents, preoccupation with their welfare is common"* (Berridge, 1997; Schofield and Ward, 2011; Holland and Crowley, 2013). There is evidence that contact with family is an important driver to securing positive outcomes for children in residential care (Kilpatrick et al. 2008).

On the other side of this are the families, often mothers, who have had their children removed. Obviously this is never a decision taken lightly and in fact is probably more often than not , not done early enough in the child's life, however having said that, it should be remembered that it is often women who are struggling with severely adverse life conditions themselves who have their children removed. These women are not currently supported by the system to nearly a good enough degree, which leaves them struggling in their own ways to cope with the grief and shame of losing their child. In practice this means that these parents resort to their known coping methods to manage their profound distress, which leads to enduring cycles of unhealthy life styles, addiction, poverty and deprivation, and often to further, multiple births in an attempt to alleviate the intolerable distress. Recent research highlights this pattern of behaviour and suggests that the cycle will not slow down until the state steps in to support these parents better (Broadhurst and Mason, 2017).

At Oracle Care we recognise that the cause of problems is often also part of the solution, therefore we strive where we can and where it is appropriate and safe, to work with families and their children to help them heal some of the wounds and aim towards a better future together once the young person leaves care. We do this through working with contact arrangements and by closely supporting families with these events, and also through the use of family therapy wherever possible, provided by experienced family practitioners.