

WORKING WITH THE ELEPHANT IN THE ROOM:

FAMILY FUTURES SYSTEMIC APPROACH TO HELPING CHILDREN WHO HAVE EXPERIENCED TRAUMA IN EARLY CHILDHOOD

Alan Burnell and Jay Vaughan

Introduction

The purpose of this article is to outline the model of a systemic multi-disciplinary approach to working with fostered and adopted children based upon a trauma and attachment theory developed at Family Futures. Family Futures has been in existence since 1998. Family Futures is now an Adoption Support Agency.

What do we do?

Family Futures offers an integrated multi-disciplinary assessment and therapy programme for children who have experienced trauma in infancy and are exhibiting attachment difficulties, impaired executive functioning and challenging behaviour. Although we are an Adoption Support Agency half of the children we work with are fostered. Our process of engagement with children and their parents begins with a free consultation, where parents and professionals can learn more about our work in order to make an informed decision about a referral.

If agencies wish to proceed, a phase one child assessment would be completed by a multi-disciplinary team. In the light of that assessment, an agency may wish to refer the child and their family to a phase two integrated family assessment. This would be followed by a third phase: the intensive therapy programme which generally runs for a minimum of three years.

Why do we do it?

There is now a large body of research and theoretical evidence of the profound long term impact that repeated early trauma has on a child's development. The impact of pre-birth and post-birth toxic environments, birth trauma and illness, neglect, physical and sexual abuse and multiple separations, singularly or in combination cause impairment to a child's psychological, neurological and physiological development. Such complex problems require a complex and holistic approach, which Family Futures has pioneered and developed.

Does it work?

An evaluation of the first 5 years of Family Futures showed that 94% of the families referred to Family Futures for the treatment programme stayed together, compared to a national comparison of only 60%. We are proud of this particularly since the children we work with at Family Futures are all in the high risk category.

Family Futures Systemic Approach

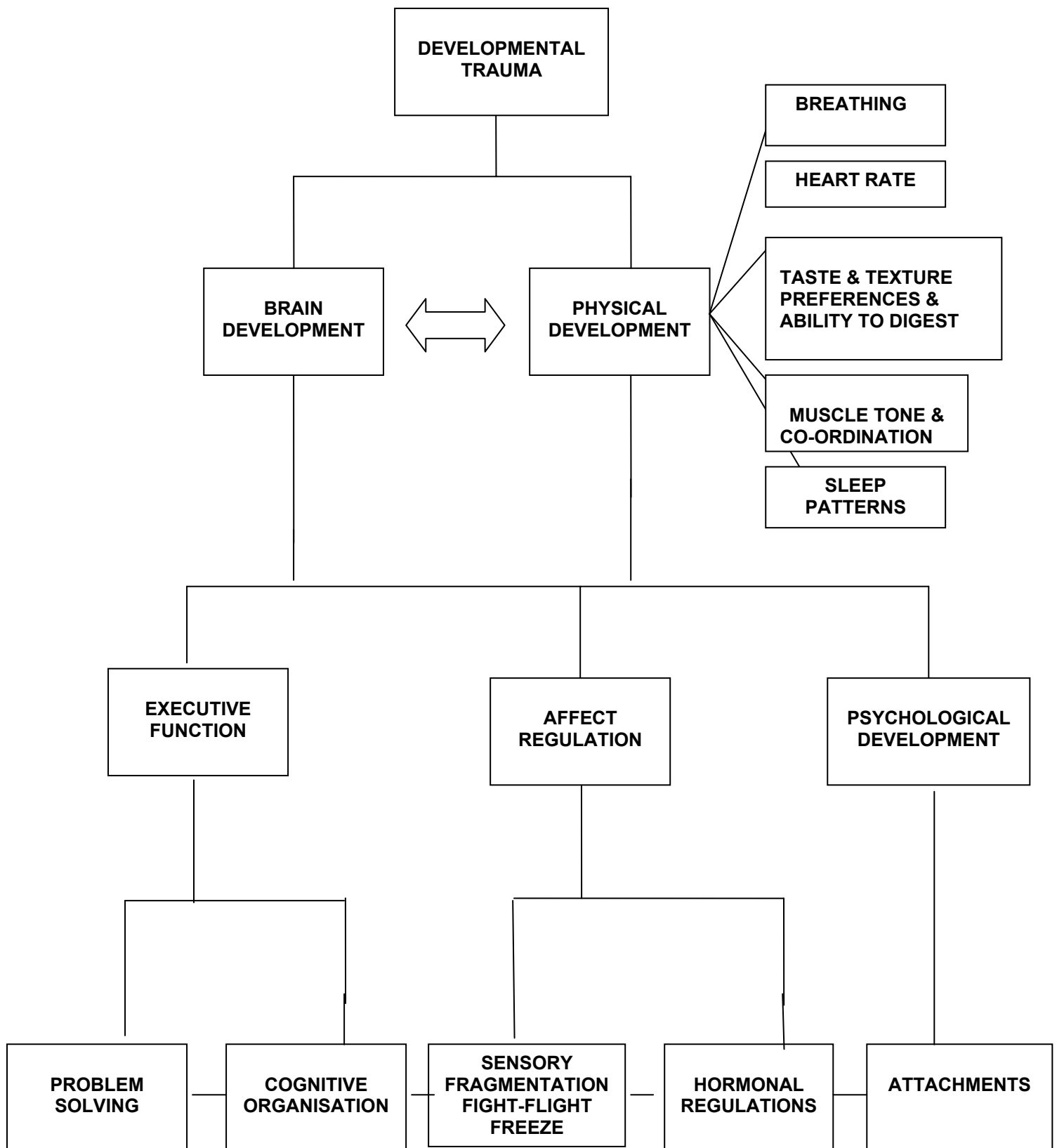
How did this approach evolve?

Traditionally adoption for babies was seen as a solution and not a problem. Since the 1970's adoption has also been seen as solution for older children and sibling groups. The models of intervention devised for helping baby adoptions through difficult periods in middle childhood and adolescence were based on the belief that children adopted as babies suffered from 'genealogical bewilderment' and "identity issues" (Triseliotis 1997). In the 1980's David Brodzinsky introduced the idea of 'adaptive grieving' (Brodzinsky 1987) to explain some of the problematic behaviour and preoccupations which adopted children exhibited during middle childhood. There was an assumption that this would also be a way of understanding the older placed child or sibling group.

The team at Family Futures in the 1990's (while they were working at the Post Adoption Centre) began to see families struggling with very challenging behaviour in young children as well as teenagers. Characteristically parents complained of their children stealing, lying, being oppositional and aggressive. What this group of children had in common was that they were typical of the contemporary adopted child who had been later placed for adoption, not as a baby, and possibly with other siblings from the biological family. Our original formulation regarding the difficulties that these children were experiencing as they developed through childhood was that they had attachment difficulties and could be diagnosed possibly as suffering from Reactive Attachment Disorder as defined in DSM4. A further common characteristic of these children, however was that they had all experienced repeated and sustained trauma in the first years of their development as well as in the womb. Since the implementation of the Children Act 1989 the threshold criteria set for removing children were significantly raised resulting in children remaining in abusive situations for longer and then often experiencing repeated but failed attempts at rehabilitation, thus adding multiple caretaking to the litany of traumatic experiences they had suffered. It was apparent to us therefore that such children, when they came to be adopted, would have severe attachment difficulties. We therefore looked to attachment theory and attachment based therapies as a solution. However it increasingly became apparent that it was hard to change attachment patterns in children without addressing the unresolved nature of the children's early traumatic experiences.

Recent developments in neuro-science, both theory and research, have enhanced our understanding of the impact of early trauma on infant and child development. In the light of this Family Futures has, in the last five years, shifted its therapeutic approach from attachment based psychological interventions to a multi-disciplinary therapeutic programme that addresses the developmental impact that early trauma has on all aspects of a child's neurological, physiological and psychological development. This is illustrated in the diagram on the following page.

TRAUMA TREE



A recent article by Bessel Van Der Kolk in an American Psychiatric Journal (Van der Kolk 2005), validates our views. Van Der Kolk and a group of American Psychiatrists are now making the case that in DSM5 a diagnosis of Developmental Trauma Disorder should be included. The article makes among other points the point that the model of simple Post Traumatic Stress Disorder or even Complex Post Traumatic Stress Disorder does not describe the impact that repeated and sustained early childhood trauma has upon children. The symptomology is very different and requires a different diagnostic category and therefore treatment.

Van Der Kolk stresses that these early experiences:

- engender intense feelings of rage, betrayal, fear, resignation and shame
- mean that traumatised children tend to re-enact their traumas behaviourally either as perpetrators or victims or by frozen avoidance
- lead to physiological dysregulation which can in turn lead to multiple somatic problems
- that the trauma permeates all their relationships with care givers, siblings and peers.)

“All of these problems are expressed in dysfunctioning in multiple areas of functioning: educational, familial, peer-related, legal and work-related.” Bessel Van Der Kolk in an American Psychiatric Journal, (Psychiatric Annals, May 2005).

At Family Futures we believe that a diagnostic classification of Developmental Trauma Disorder would be very helpful because it underlines the fact that early traumatic experiences require more than psychotherapy for children to begin the repair process; instead children need a whole range of interventions to redress the developmental impairment in all domains that is the legacy of early trauma. It is for this reason that Family Futures, for the past five years, has developed a systemic multi-disciplinary approach to our work with children who have experienced sustained early trauma. Our psychotherapy programme is family focused and typically lasts three years. During the course of the programme the child, with the assistance of their parents, will move through three phases of treatment. The first phase will focus on unresolved early trauma, the second phase on developing secure attachments, while the third phase will focus on helping the child to develop a positive sense of identity. Of course these phases are not approached in a linear way, the phases ebb and flow depending on the child's particular stage in the work. Alongside the psychotherapy is a parent mentoring programme which includes support and strategies for the parents. Embedded in our trauma therapy phase of the programme are the principles for treatment identified by Van Der Kolk (Van Der Kolk 2005):

1. safety and competence
2. addressing trauma re-enactments
3. integration and mastery

Our recognition that fostered and adopted children today are likely, because of their early history, to have some degree of Developmental Trauma Disorder led us to realise that we needed to work with the 'elephant in the room' - Trauma, in all its manifestations, neurological, physiological and psychological. In order to do this we began to develop a systemic model that looked at the impact of trauma on:

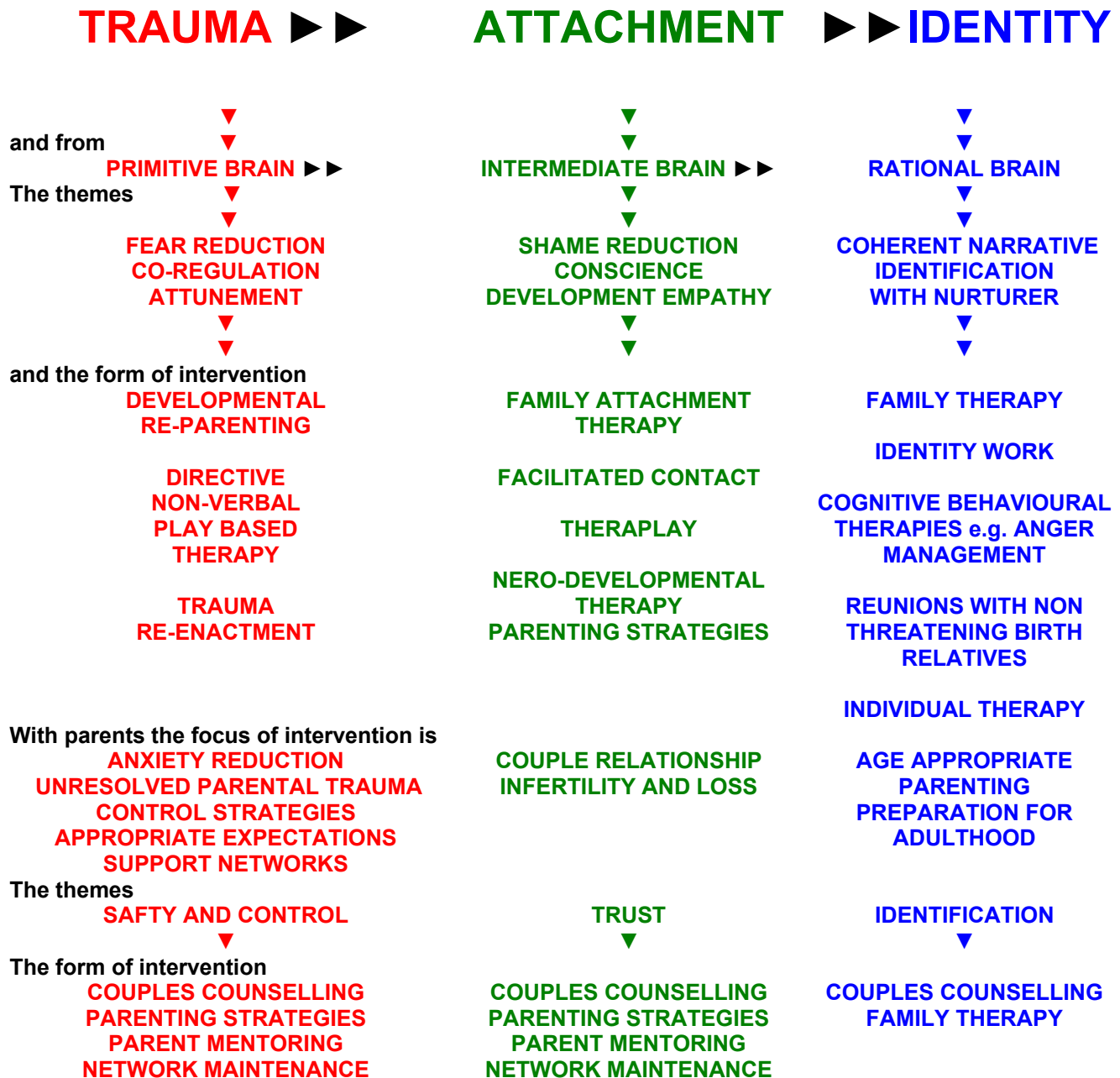
- the child's development and their relationships with parents and carers.
- the impact of caring for a traumatised child has upon the host family and the support and strategies they need to achieve developmental repair.

The model we realised needed to be systemic in terms of our intervention and impact, in order to address the complexity and the interaction between all the elements. Further our service needed to be systemic in terms of a co-ordinated, multi-disciplinary response in order to meet the developmental needs of the child and the host family's system for support. This needs to encompass extended family networks and environmental systems, particularly schools. In general terms this systemic therapeutic approach has a focus which shifts over time through trauma resolution to attachment enhancement to positive identity formation. This focus reflects the structure of the brain and the 'bottom up and inside out' process of brain development. (See diagram below)

THE STRUCTURE AND PROCESS OF FAMILY FUTURES THERAPEUTIC WORK WITH CHILDREN & PARENTS

The nature of the Intensive Attachment Programme reflects
the structure of the brain in the following way: -

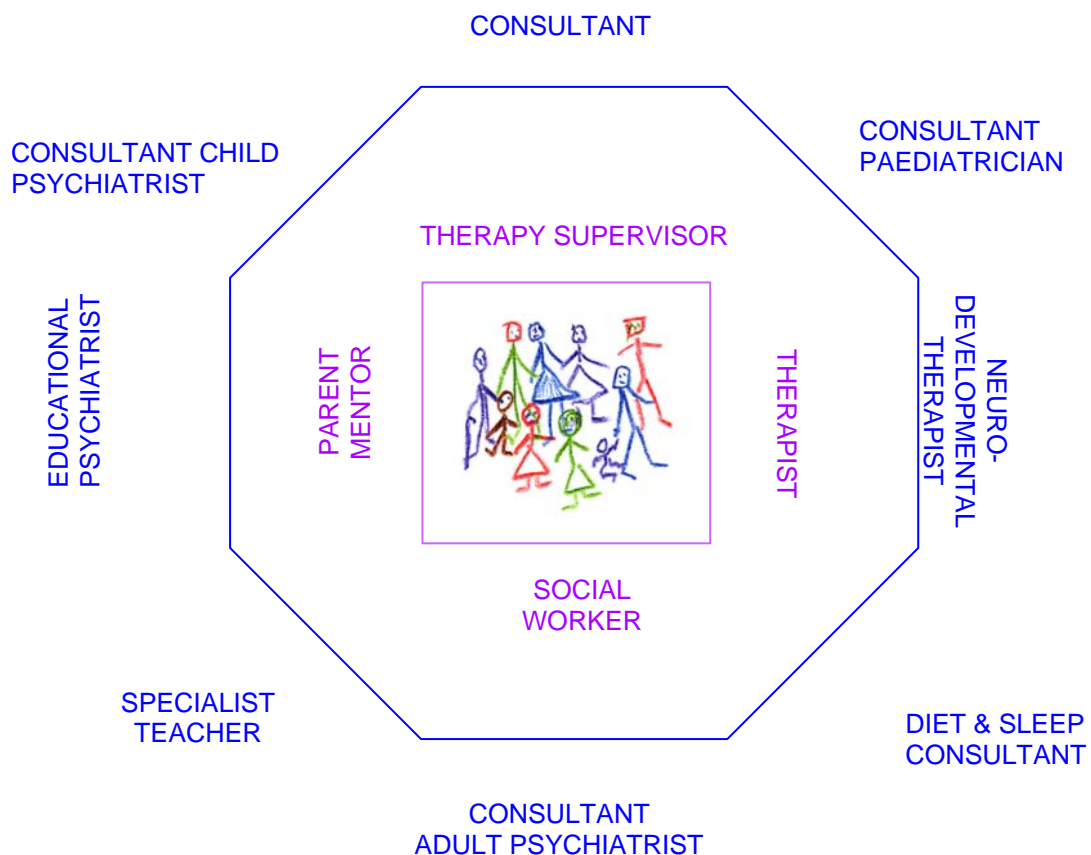
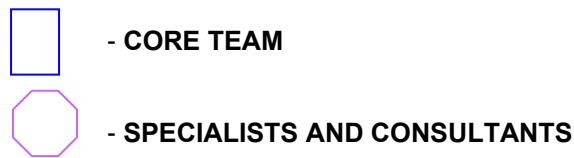
The focus of therapeutic interventions shifts over time from



Our attachment focused therapy has been informed by the Dyadic therapeutic approach of Daniel Hughes (Daniel Hughes 2002) and the attachment enhancing therapy of Theraplay (Jernberg & Booth 2001).

In order carry out this systemic therapy approach we have a team comprising child therapists, social workers and parent mentors we employ the following consultant specialists:

FAMILY FUTURES MODEL FOR A SYSTEMIC THERAPUTIC TEAM



A Truly Systemic Approach

This multi treatment approach is systemic in every sense of the word. It addresses the systemic damage done to the child system by the early trauma experienced. It also addresses in a systemic way the need for a coherent and integrated treatment programme whereby all the areas of development affected by the child's early experiences are treated physically, psychologically, interpersonally and at the social network level. A good example of this is in the area of the child's educational needs. Over the past five years Family Futures have worked with over 300 children and their families, most of whom have experienced some difficulty at school with learning. As a result of our close collaboration with our Educational Psychologist, Dr Richard Lansdown, we have pioneered the assessment of traumatised children for Executive Functioning difficulties. Of the 70 children who have been tested to date all had at least one of the eight domains measure by the test in the clinically worrying range. The majority of the 70 children had more than four of the eight domains in the clinically worrying range. Until we started to test the children at Family Futures Executive Functioning testing and strategy programmes had been developed for children with acquired brain damage, as a result of an accident or injury. The programmes had been set up to help the child learn to function and problem solve, both at home and at school, using a systematic programme of strategies and environmental interventions. As a result of our work we now believe that repeated trauma in infancy is a form of acquired brain damage because the neurological pathways that should have developed during infancy have either failed to develop, have become damaged or inappropriate pathways have been established in response to high levels of prolonged stress. In our model the educational psychologist, specialist teacher, parents, parent mentors, class room teacher and peers all work together to provide a therapeutic environment to enable the child's executive functioning difficulties to be compensated for and repaired. This is systemic therapy at its best.

Without a systemic perspective on complex multi treatment programmes the efficacy of any of the component elements would be greatly diminished; the treatment package must be orchestrated and perceived as a whole. For this reason it is crucial to the child and their family that the assessment is multi-faceted and systemic.

Case Study

(This case is representative of cases that are typical of the ones referred to Family Futures)

Tara, aged 11 years came for a Phase One Multi-disciplinary Assessment at Family Futures along with her adoptive parents. She had been placed with her adoptive family at the age of 7 years after experiencing neglect in her birth family for the first three years of her life and then languishing in foster care for the next four years. The adoptive placement had struggled from the moment Tara was placed in the family as she did not seem able to really engage with the parents although they experienced her as very demanding. The situation

had reached a crisis point by the time Tara was 11 years old, four years into placement. The adoptive parents no longer felt that they could keep Tara in their family. Tara and her adoptive parents were referred by the local authority to the Local Child Adolescent Mental Health Centre who had a two year waiting list. A referral was then made to Family Futures.

From the local authority's point of view Tara was not a difficult child and they were perplexed as to why the family was in such difficulties. The social worker's experience of Tara was that she was pleasant and engaging. The school reported that Tara was managing well in school and her teachers were confident of her ability to make the transition to secondary school. They did say that she struggled at times to pay attention but this seemed a minimal problem. Tara herself said she was happy with her life in her adoptive family. And yet something was deeply wrong somewhere.

Tara was in danger of being returned, aged 11 years old, to the care system. Everyone feared that, if this happened, Tara's age and the failed adoption would mean that she would remain in foster care until moving to the leaving care team at 18 years old. Inevitably all the professionals began to scrutinise the adoptive parents' ability to really love Tara and questions were asked about their attachment histories and what they may have hidden during the original assessment to be adoptive parents. What else could it be? The parents in turn picked up the flavour of this suspicion and became angry and oppositional when the local authority visited them. The suspicions about the parents became heightened and a negative spiral ensued. Tara continued to smile and say she was happy.

The background paper work requested from the authority for the Family Futures assessment was truly confusing. It was apparent that the adoptive parents were under suspicion but of what it was not clear. The discrepancy between the parents' perception of Tara, the school's perception of Tara and the Local Authority's perception of Tara was marked. None of it seemed to make much sense. The paper work from the local authority that had originally been given to the adoptive parents stated that Tara had, in many ways, a good experience in her birth family and that the neglect although pervasive had not been extreme.

What was unclear was why she had been taken into care aged three years old. More detailed notes provided by the local authority about Tara's history in her birth family provided some of the answers as drugs, alcohol and schedule one offenders were referred to throughout. Foster carers reported wetting and soiling until she had been placed for adoption and one foster carer reported an incident when Tara had tried to have oral sex with her son. This seemed to account for the number of moves Tara had had in foster care and the decision to place her as a single child with an adoptive family and yet there was no mention of this in the paper work given to the parents. The story of Tara began to become clearer along with the reasons for the current difficulties in the adoptive family.

At the Family Futures assessment Tara was a quiet smiling girl who was keen to please. She was large for her age with well developed breasts. She also smelt strongly of urine but neither she nor her adoptive parents seemed aware of this. Tara struggled to think much during the assessment about why she might be at Family Futures or why she had been adopted. Often Tara did not seem able to really understand what was being asked although, at first, she appeared to. It was only when further questions were asked did it become clear she did not understand.

Tara wanted to play and what she liked playing most was being a baby. Tara giggled with delight at peek a boo games. She squealed for more and gurgled deep in her throat. Hide and seek was a wonder to her and she wanted to play it over and over. In her desperation to hide she flung herself dangerously around the room crashing into the furniture. She had no awareness that the noise she made gave away her hiding place. Singing nursery rhymes and reading baby books grabbed her attention. Tara sat sucking her thumb breathing heavily whilst she simultaneously sucked up all the goodies she was offered in the therapy session and asked for more. She was demanding of attention and had to have the complete undivided attention of the therapist for every second. The only thing that disrupted Tara's fixation on the therapist was when noises happened outside the room and she flinched looking anxious. Once reassured she snuggled close and looked adoringly at the therapist whom she had only just met asking for more, more, more. At the end of the session she looked in wonder at this relative stranger with huge brown eyes ringed by long lashes and held out her arms to be cuddled muttering, "I love you".

How does one feed that back to the adoptive parents who already feel their relationship with their child is tenuous? Tara's presentation as a baby desperate for love in a big girl's body did make sense. Here was a girl who was developmentally delayed, had learning difficulties, a urinary tract infection, early puberty, executive functioning problems and was indiscriminately affectionate. How Tara presented during the assessment was likely to engender the empathy of the social worker as it was truly appealing. It was also likely to appeal to teachers as she worked hard to be liked and tried to appear as if she understood.

However Tara would not be as appealing with smell and large body. Baby ways would not encourage friends of her own age. It would not be appealing to family friends who would after a time find her increasingly unattractive and irritating however hard they tried for the sake of the adoptive parents. And finally and more importantly it would not make any sense to the adoptive parents who believed they had an eleven year old girl who had lived with them for four years and should be behaving age appropriately. They would understandably expect an eleven year old girl to be able to wash herself and not wet her knickers. Periods which had started early for Tara were a nightmare for the parents as she was unable to manage this at all. They would expect that, by this time they would be more important to Tara than her 'new found' therapist 'mummy'.

Tara was a young girl with huge needs and in order to begin to understand her and help her adoptive parents understand a Phase Two Integrated family assessment was necessary. This included a parent preparation and education programme as well as some further work with the parents and Tara.

Alongside this there were the following consultations with Family Futures:

Paediatrician: This was clearly necessary in view of the likelihood that Tara had been sexually abused and the fact that, like so many children in the care system, she had never had a full paediatric assessment. The strong odour and smell of urine from Tara could also indicate a urinary tract infection at the very least. Tara was also reported by her parents to be very constipated. In part they felt that this was due to her diet but also she seemed fearful of going to the toilet and sometimes bled. Whilst this is possibly connected to sexual abuse it may also have had a physical cause and this needed to be ruled out.

Paediatric Occupational Therapist: Tara clearly had some co-ordination problems and difficulty in self-regulation which were apparent during the assessment. It was therefore concluded that a more in-depth assessment of her physical development would be helpful alongside a sensory integration programme to help with her developmental delays.

Child and Adolescent Psychiatrist: Tara also seemed a rather desperate and traumatised child who was hypervigilant. It was important for her to see a psychiatrist to rule in perhaps Developmental Trauma Disorder and rule out other mental health problems. One of the adoptive parents' concerns was whether Tara was at risk of developing schizophrenia as they perceived her behaviour at times to be so bizarre. An assessment would help, perhaps, to reassure them.

Family based psychotherapy was also recommended to address unresolved trauma and attachment difficulties.

Adult Psychiatrist: The adoptive parents both presented as depressed and rather hopeless about their situation. They did not think they could continue to live with Tara but they also could not think how they could say goodbye to her as they knew the guilt that they would feel. The adoptive mother in particular seemed to be in need of anti-depressants as she was not eating or sleeping well.

Nutritionalist: The adoptive parents had reported that Tara was very faddy with food and had a very limited diet eating little more than sugar sandwiches. They understood that this was what she had been fed on in her birth family. The parents were concerned that Tara had grown a great deal but she had little protein or vitamins in her diet. Tara was also very constipated.

Educational Psychologist: Tara's development and understanding seemed delayed and despite the school's optimism about her transfer to secondary school, an assessment was clearly indicated. Tara's

ability to make sense of the world and what she understood needed to be considered if her problems at home and at school were to be addressed and for the most effective therapy programme for Tara to be devised.

Specialist Teacher: Tara appeared to have a huge number of executive functioning difficulties and once these had been clarified by the educational psychologist's assessment the specialist teacher could devise a programme to help Tara with these both at school and at home. School liaison prior to the secondary transfer would also be essential as well as finding ways of helping Tara make some appropriate peer relationships.

Taken together these assessments formed a clear picture of Tara as a child who was suffering from Developmental Trauma Syndrome and unresolved early trauma that had led to her having insecure attachments, developmental delay, learning difficulties, neuro-developmental and nutritional problems. The parents as a consequence of parenting her were depressed, without a support network and without hope.

Conclusions

Tara, like so many children that come to Family Futures, is typical of children who are in the Looked After Care System today. She is a complicated mixture of needs. Her adoptive parents are like many who have adopted or fostered children in recent years. They are confused by a child that in no way matches the child that they wanted or even the one that they thought they were getting. What is brought along to these first assessment days is a lot of good will and hope that someone, somewhere, can try to make some sense out of what often feels like nonsense not just to the professionals and the parents but sadly to the child who struggles to engage with a world that they do not see as we do. With this approach it is possible to move beyond the cliché of a partnership with parents and carers, to a genuinely collaborative approach where carers, parents and therapists can work together in a systemic way. We believe strongly that parents are part of the solution and not the problem.

For Tara things improved following the assessment as her parents began to see her through different eyes. They said that they felt understood by the team at their assessment at Family Futures and they in turn felt that they were now able to understand their daughter better. This is perhaps the most essential part of the process. By truly understanding the parents' struggle and refocusing their eyes on their child's struggle, change can begin to happen. But this is very much the beginning. The parents needed ongoing and intensive support to maintain the momentum; Tara needed ongoing and intensive help to begin to reframe her early traumas. Six monthly sessions of therapy or cognitive behavioural therapy was not the answer; a longer term intensive approach was required.

Tara and her parents had a long journey of therapy to embark upon. They worked hard and cried a great deal during this journey; they learnt to find new

ways of relating as well as times to laugh together. Tara was able to find ways to tell her parents that she loved them and wanted to be a part of their family. Her parents were able to find new ways of parenting Tara that took into account her difficulties and discovered, to their joy, a different person - a vulnerable and lost little girl who felt terrified at needing them so much. Tara's parents also took the huge step of engaging with Tara's traumatic history and all the distress she had experienced. It was in many ways this joint revisiting of Tara's traumatic past that brought them together as a family and began the healing process. Once this foundation had been laid the family were able to move on to work on how to be a family together.

We believe that for the large number of children in the Looked After Care System, who have experienced prolonged trauma in infancy, this systemic approach to trauma treatment is a way forward, one which we hope that other agencies will be persuaded to adopt.

Children who are fostered and adopted are some of the most vulnerable children in our society and should be entitled to a therapeutic approach that offers a truly integrated multi-disciplinary way of helping them and their families. It is these children who will be the parents of the future; without sufficient input into these children now we are only serving to perpetuate the problems facing our society. These children may well, without help, populate our prisons and psychiatric hospitals and the children of these children could therefore be the fostered and adopted children of the future.

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For further details about Family Futures you can visit our web site www.familyfutures.com or if you would like to discuss points raised in the article please contact us at contact@familyfutures.co.uk

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Alan Burnell is one of the Co-Directors of Family Futures. Being adopted as a baby has had a profound impact on his personal and professional life. Following his degree and social work training he was privileged to work with some very inspired practitioners, who led him to believe that it is always possible to improve services for each generation of children. His commitment to adoptive families stems from his own adoptive parents, who embodied the spirit of adoption at its best, and from the adoptive families with whom he has worked with over the past few years.

Jay Vaughan is one of the Co-Directors of Family Futures, and grew up in a theatrical family, with her own family dramas along the way. Training as a Dramatherapist provided her with the opportunity to re-script some of her personal dramas and express the inspiration that the theatre had given her. Fifteen years of working with children who have been traumatised has formed the backdrop to her belief in the need for integrated services for children and families, like those at Family Futures.