Making meaningful connections: assessing for clinical work in a child residential setting

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Abstract

Purpose – The purpose of this paper is to discuss the clinical assessment of children and the development of a multi-disciplinary team in an established residential school for children aged five to 12.

Design/methodology/approach – Using clinical examples the paper describes how assessment can identify different levels of therapeutic need, and then how the decision is made whether or not to offer milieu therapy, music therapy, dramatherapy or psychotherapy.

Findings – The paper suggests that children who have early histories of abuse and trauma have differing clinical needs.

Practical implications – The implication is that children will engage better with the therapy if the level of intervention is sensitive to their state of mind, which in turn will help them make better use of the environmental provision of the school.

Originality/value – The paper offers an original perspective on the possibilities and limitations of psychotherapeutic work with extremely vulnerable damaged children in a residential therapeutic setting, the Mulberry Bush.

Keywords Education, Psychoanalytic techniques, Children and young people, Residential

Paper type Technical paper

Introduction

[...] the object, if it is to be used, must necessarily be real in the sense of being part of shared reality, not a bundle of projections (Winnicott, 1988, p. 103).

In an initial assessment session, Ryan aged nine found it impossible to come into the room with me and prowled up and down the corridor in a terrified state. The way in which a child engages with the assessment process gives an insight into their internal world and emotional level of development. In this paper I describe the assessment of a number of children, including Ryan, and discuss how that informs their treatment pathway, which comprises milieu therapy, music therapy, dramatherapy or psychotherapy.

The Mulberry Bush School, Oxfordshire, is a residential therapeutic school for children between the ages of five and 12. The majority of children have experienced pre-verbal neglect and abuse and a central part of my clinical role has been to clarify whether a therapeutic intervention, in addition to the work of the milieu, would be of benefit. The development of a multi-disciplinary clinical team is an attempt to find a way to assess the best match, from a variety of psychotherapeutic options. Most referrers assume that children have individual child psychotherapy but this is not what usually happens. In fact about a third of children are not considered suitable for additional therapeutic work, and the milieu is the locus for their therapy.

I joined the school in 2004 and worked alongside three other part-time child psychotherapists. It gradually became evident that there was a limited group of children who seemed to benefit from psychotherapy, a larger group who managed psychotherapy to start with but then had
difficulty attending and often dropped out, and another group who were unable to access it at all. It was the middle group of children who managed to attend for a while that interested me most. Not wanting to generalise or oversimplify the description of this group, but they tended to be the more aggressive and violent children, who showed little capacity to think or reflect.

During my initial years at the school there was a proliferation of ideas, within the child mental health field, linking neuroscience, attachment theory and “looked after children”. Through these developments I began to reconsider how we worked individually with children, and gradually a model of assessment and treatment emerged which specifically considered the developmental level at which we were providing therapy. Three years ago this led to the school employing a broader range of therapies, specifically music and dramatherapy. My dawning realisation, that traditional child psychotherapy approaches were not sufficient to treat this group of children, brought with it considerable turmoil and uncertainty. Some child psychotherapy colleagues were surprised at my plan, and I appreciate that in the current financial climate, where NHS child psychotherapy posts have been threatened, that my decision may have seemed like a further attack on the profession. However, other colleagues who have worked with this group of children understood my reasoning.

Before discussing this new idea further I will introduce the residential setting, and give a brief history of psychotherapy with damaged and traumatised children. Links to theories from neuroscience and attachment will be discussed before I illustrate with clinical examples.

The Mulberry Bush School

Barbara Dockar-Drysdale founded the school in 1948 and it has a well-documented history (Reeves, 2002; Diamond, 2009). She had a long and close working relationship with Winnicott and they were influenced by each other’s ideas. It is a non-maintained not-for-profit residential special school. Located in rural Oxfordshire, the school provides a nationwide resource for children with long histories of failure and rejection within education, social and home contexts. Most have experienced complex trauma; that is, cumulative trauma that occurs within the parent-child relationship, rather than post-traumatic stress disorder which can be linked to single traumatic events (Courtois, 2008). When the main carer of the child is also the person they are most afraid of, the outcome is a disorganised attachment style, and this is the experience of most of our children (Main and Hesse, 1990). Referrals often occur when foster and adoptive placements are on the verge of breakdown, and it is not unusual for children to have been excluded from more than one school.

Four on-site residential houses surround a large grassed area with climbing pyramid, swings, etc. The houses are bright and airy, with communal play spaces, and most children have their own room. There is a manager overseeing each house and each child has a key worker. Education is also on-site and children progress depending on their emotional readiness to learn rather than in year groups. At foundation level learning is based largely on play and small nurture groups with huge efforts made to enable the classroom to feel a safe place. Anxiety is high as previous school experiences and permanent exclusions have left the children with low self-esteem and little capacity to think of themselves as learners. Most children progress through to the middle and top stages of school, and academic work is tailored to each child’s ability.

Where does the therapy happen?

The place of individual psychotherapy in residential settings for children has been at times a thorny issue, with the question being “whether the real treatment occurred in the therapy room or in the milieu” (Kornerup, 2009, p. 26; Trieschman et al., 1969/2009). Gunter (2005) writes persuasively about milieu therapy and individual therapy in Germany complementing each other by stabilising psychotic teenagers, and in the UK there are therapists who work individually in residential settings, but relatively little is written about this individual work with primary aged children (Carrick, 2009). The role of child psychotherapist can vary between not seeing children individually but providing consultation and supervision to staff groups, to a model where staff support happens alongside clinical work. One argument is that using the milieu is a more
effective way to help adolescents on their journey towards independence (Sprince, 2002), whereas primary aged children, perhaps more recently separated from parents or carers, benefit from the developmental benefits of individual therapy (Cant, 2002). In addition a long-term follow-up study of adults who received psychoanalytic treatment as children at the Anna Freud Centre, suggests that the younger the child the more likely they are to benefit from psychotherapy (Target and Fonagy, 1994/2009).

Child psychotherapy with traumatised children

There is a long history of child psychotherapists working with traumatised and “looked after children” in the community. The impact of pre-verbal trauma, neglect and abuse has devastating effects on their social, emotional and cognitive development and consequently they experience profound feelings of annihilation and disintegration (Rosenfeld and Sprince, 1963, 1965). The intensity and rawness of the therapy both for children and therapists has been carefully considered, and at times the violence and aggression with “severely deprived children” can be risky and dangerous (Boston and Szur, 1983).

The child psychotherapy profession has debated how to work with these children as they present significant challenges (Hunter, 2001; Lanyado, 2004; Hindle and Shulman, 2008). The psychoanalytic method has had to be adapted and there is general agreement across the theoretical spectrum that the work has to proceed gently and cautiously (Woods, 1982), with interpretation in the early days “tentative and infrequent” (Rosenfeld, 1979/1983, p. 60).

Commenting on technique, Fonagy (2002) writes “[…] it seems that borderline traumatised children are not substantially helped by interpretations of conflict, Oedipal or pre-Oedipal. More simple therapeutic interventions, focussing on the elaboration of the child’s current mental state […] appeared to be far more effective for these childhood problems” (p. 146).

Anna Freud always held a developmental perspective central to her ideas (Midgley, 2012), and Hurry (1998) elaborated this into the idea of “developmental therapy”. She defined this as work specifically about furthering development but not via interpretation. Hurry challenged earlier views that developmental work had to be kept theoretically separate from psychoanalysis and helpfully gave validity to work that takes account of a child’s developmental deficits and earlier pejorative views about therapeutic developmental work have given way to an acknowledgement of the importance of this type of approach. Also within this is the idea of the therapist becoming a new developmental object, different to the original parental object, and for many of our children the school itself becomes a new developmental environment.

More recently Alvarez (2012) has expanded her ideas about working with the unreachable and hardened child. In Live Company (Alvarez, 1992) she wrote about working with borderline and very damaged children and introduced the idea of two levels of interpretation. The first is at the explanatory level, for example, “I wonder if you feel this because […]” where there is the possibility of creating meaning by linking different parts of the child’s internal world. This presupposes a level of symbolic thinking and an ability to tolerate another person making comments about a child’s internal world. Alvarez called the second level the descriptive level, where feelings are recognised, named and given meaning and I tend to think about this as operating at a similar to Hurry’s developmental therapy. In her recent book The Thinking Heart she has added a third level called the “intensified vitalising level”, where there is simply an attempt to bring feelings to life. In all levels Alvarez is mindful of the impact of grammar and language on children.

Research in neuroscience, child development and attachment theory

In the past two decades there has been an explosion of ideas linking research in neuroscience, infant development and attachment theory. It has been written about extensively (Schore, 2001; Howe, 2005; Music, 2011) helping our understanding of the long-term impact of early abusive and neglectful experiences. However, the work of others in the field such as van der Kolk (2005) and Perry (2006) has been interesting to discover and has challenged my thinking.
Using modern scanning techniques Perry scanned the brains of many children affected by complex trauma, and saw that key neural systems and brain areas were affected by adverse developmental experiences. The research suggests that these key pathways develop in sequence starting from the brainstem up to the cortex, and with this in mind Perry (2009) proposed a model of specific activities to help the most important pathways develop in ways which mirror the sequential nature of normal brain development. He calls this the “Neurosequential Model of Therapeutics” (NMT), which, rather than being a particular therapeutic technique, “helps target the selection and sequence of therapeutic, enrichment, and educational activities” (p. 240). For example, Perry recommends sensorimotor and repetitive, rhythmical body-based activities, e.g. drumming, yoga and music and movement, as ways of organising early (brainstem) deficits. When there is improvement in self-regulation the work can focus on developing interpersonal relationships (limbic) using play or arts therapies; as these dyadic relational skills improve then therapeutic techniques can be more verbal and insight orientated (cortex) such as psychodynamic approaches.

The overarching aim of his model is to help children learn to self-regulate, and preliminary applications of this approach in an American residential setting similar to the Mulberry Bush have been positive (Hanson, 2011). It is notable that the early “enrichment” activities that he recommends are very similar to what a parent does intuitively with a young child, such as rocking, humming, singing, as well as all the predictable repetitive games that infants and toddlers love.

What is of interest in terms of the clinical assessment of children at the Mulberry Bush School, is that Perry suggests that talking and insight-based therapies are most effective once a child can regulate themselves, rather than being the treatment to attain self-regulation. I believe this is a challenge to therapists of all disciplines, as we hope that through our treatment children will become more integrated, less impulsive and more able to feel and think; yet Perry suggests that music, rhythm and body-based sensorimotor therapies are needed for self-regulation before insight and deeper explanatory levels are used.

Clinical assessment at the Mulberry Bush

A child psychotherapy colleague and I see all new children for an assessment. It is not just an assessment for therapy, but a chance to see what sense the child has made of the move to the school, how possible it might be to engage with anxieties and conflicts, and to get an impression of the quality of their defences. The move to the school is often another change in a long history of separations and so we tread a fine line, being careful not to re-traumatise and further expose them to the impact of previous losses. We also do the Story Stem Assessment Profile, a validated assessment tool for children aged four to nine to assess their attachment representations (Hodges and Steele, 2000). Afterwards the treatment team, household manager, key worker, teacher, therapist, family practitioner and possibly the nurse and speech therapist, meet to gather information about progress in class and house, and together we develop an initial impression of whether or not the child would benefit from individual therapy in addition to the milieu, and, if so, what that benefit might be. There are other important decisions made, such as the nature of the work with parents/carers. In the following description of assessment sessions, the names of children have been changed, and in most instances different children have been combined, in order to protect identity and confidentiality. In combining different individuals care has been taken to ensure that the examples themselves accurately represent assessment sessions.

Ryan – milieu therapy

I knew Ryan, aged nine, had arrived by the sound of loud voices and kicking on the door. Barny, a therapeutic care worker, explained that Ryan does not want to come to see me and had been agitated in class all morning. Ryan was peering around the back of Barny with staring eyes and furrowed brow. I felt my anxiety rising and the atmosphere was tense. Ryan pushed past me, flung open the door to my room saying he did not want to be here, it was boring and a waste of time. I felt intimidated and he started growling and showed me his teeth. I followed him back into
the corridor and Barny said, as Ryan had seemed worried about coming to see me he would suggested that Ryan bring something with him. With that Ryan raised a hand and threatened me with a large plastic polar bear. I flinched as he pretended to throw it at me and I felt a sinking feeling as a triumphant smirk briefly crossed his face. I took a risk and said that I have some animals he could play with, and with that he shouted “I want wild ones”. I opened my drawer of animals and placed two dinosaurs on the edge, he turned away saying he wanted to go and I immediately wondered whether my dinosaurs felt too powerful and if I had trumped his polar bear. “I don’t want to be here you fucking morons” he shouted. As his agitation was increasing I said I could see that he was very cross and hoped we could try again next week. The following week he refused to come.

We did not find out why Ryan was so frightened and angry about coming to see me, although he was highly resistant to most new things; but he is an example of a child, who we believe would benefit from the milieu rather than individual therapy. His anxiety about being in the room with me suggested that he would initially make better use of therapeutic relationships within the group setting where there is not the intensity of relating to one person, and where he could observe interactions between staff and other children. Staff had not seen much latency-aged play; climbing was his main activity. We have a weekly drum circle for all new children, plus daily class-based rhythm work, and Ryan was encouraged to take part. Drumming links in with Perry’s idea of how to organise early deficits, where repeated rhythm and repetition help establish self-regulation. We would not discount the possibility of offering something individual in time, and this would be regularly reviewed, but ideally we like to start therapy earlier rather than later in a child’s placement.

**Albany – joint individual time**

In the assessment Albany was a confused and frightened girl with fleeting attention and little capacity to play symbolically. She presented as highly anxious, mistrustful, and suspicious. I had the feeling that daily life was enough of a challenge to her, and anything in addition to this seemed to alarm her deeply. Staff found it difficult to relate to her, feeling she was “empty”. We decided not to offer individual therapy, thinking that the environment was where her treatment should occur. Two years into her placement her key worker felt it was becoming increasingly difficult to talk to her, particularly about feelings. As there were issues relating to family contact and her birth mother was pregnant, we decided that I would join Albany and her key worker Rachel for a weekly play session.

For the first three sessions Albany asked “tell me again why are you here?” It felt more than just irritation at having me involved in a playtime with Rachel; she had an elusive grasp that there was a purpose. During the first session Albany appeared to ignore me, and when I made the odd comment she jumped as if she had forgotten I was there. She and Rachel painted whilst I sat close by, and occasionally Albany would lean on me. The second week when she and Rachel were struggling to decide what to play, I made a comment that perhaps it was easier to find something for two people to do but more tricky when there were three of us. She held up a hand “stop! stop!” leaving me in no doubt that my comment had been unwelcome. However, by the end of that session I had managed to say a few things about the game and was put in the role of the frightened child who did not know anything. This was encouraging, and I could see that in the previous two years that symbolic play had developed. Week 3 Albany wanted to cook, and this allowed us to stand next to each other at the sink and have our first conversation in the presence of Rachel. The work continued weekly until Albany left the school, and towards the end the three of us were able to reflect together on what we had found out about Albany. She was able to think about how frightened she had been when she first came to the school and how much she would miss the Mulberry Bush. She was happy to be going to a school near her foster carers and felt that this indicated that they liked her.

Albany had little experience of parental adult figures thinking and helping her put her mind together, and this is what Rachel and I were doing. A worker on their own is much less able to initiate and develop ideas about feelings, whereas the presence of the third/object enables an outside perspective to be introduced in a safer unthreatening way. I saw my work with Albany as
being similar to Hurry’s idea of developmental therapy but in the presence of an/other. I became a new developmental object, different to the original, and probably, anything other than this way of engaging her would not have taken off. We provide this joint individual time for children who have traditionally not been able to access any individual therapy, for children who would find being in a room on their own with a therapist too difficult and overwhelming. Initially Albany was similar to Ryan, but over time she trusted staff which enabled us to feel she could benefit from this intervention.

Darren – music therapy

Darren, aged eight, was a lively and engaging lad who willingly attended the two assessment sessions. His play was fixated around violent accidents and emergencies, which were a mixture of make-believe and reality. Darren used real place names, but locations became muddled and before long I was quite confused. He flitted from scene to scene and I found it hard to follow his train of thought. However, within the muddle, he repeatedly engaged me in brief scenarios, which typically included children being abandoned and then looked after by nameless nurses and professionals. I found this painful to be a part of although Darren did not show any affect; instead he became distracted or needed the toilet when something raw was touched upon in the story. For example, when a baby was left at the airport, I showed concern and wondered how far the parents had gone before they realised what they had done. At this point Darren had to briefly leave the room to check whether the key worker was still waiting for him. In the second session he gave a long rambling description of a fight between himself and another boy, and wanted me to know how injured he had been, giving me great detail about how many adults had looked after him and how worried they all were.

Darren’s play suggested that he really enjoyed the company and attention of adults; however, I found his stories and themes confusing and often any attempt on my part to clarify or explore the play led to further muddle. Any gentle mention of feelings in the play seemed overwhelming and he would leave the room or change the theme completely. Staff had noticed that he seemed to be rigid and obsessive and at times very aggressive especially when enraged. I wondered whether his rigidity was an attempt to gain some internal sense of control and predictability, as his play and train of thought was so chaotic and difficult to follow. Darren was offered music therapy. It is largely a non-verbal therapy where, musically, the therapist makes contact in ways that mirror the proto-conversations of parents and infants (Trevarthan, 1977). Through the repetitive use of sound, melody and rhythm, affective communication occurs at a level which bypasses speech and transforms feelings into a language where they can be heard and experienced in a different non-verbal way. It equates to a sound version of Alvarez’s “intensified vitalising level” and fits alongside the first stage of Perry’s NMT model of attaining self-regulation.

Darren enjoyed music therapy and his attendance was good. Through the use of sound he was slowly able to communicate feelings and gradually tolerated his therapist developing this for him musically. For example, he liked her to represent different feelings by playing sad or uplifting music on the piano, and this led him to write raps about what had happened at home between his parents.

Zac – dramatherapy

In the assessment Zac, aged ten, played a game where a mother fed a baby the wrong food and the baby had to go to hospital. The doctor chastised the mother and sent her to prison. Zac told me the baby was sad and that the doctors were very worried that the baby would not live. Zac’s way of holding the baby was tender and loving and I felt moved by the way he told me the story. The baby went to live with a new family but kept thinking about the mummy in prison and the new parents did not understand how upset the baby really was. Staff said that Zac would play this game repeatedly. He could also be intense and intrusive in his relationships with staff, for example, he wrote passionate letters of longing to a teaching assistant, wanting to be breastfed by her, and later had crushes on a number of young male staff, following them around and repeatedly asking to go home with them.
In the assessment Zac was able to use play and stories to express his feelings of sorrow and loneliness about what had happened to him as a baby, but in class, his play was repetitive often with a mindless quality. He spontaneously brought in the feelings of the characters and was not overwhelmed, when in displacement, I gently explored these with him. By that I mean that I continued the story and explored its affective content via the characters rather than making links to Zac’s early life. Zac was offered dramatherapy; here the therapist and child use play and stories and generally the therapist does not relate the child’s play to the reality of their life; neither are interpretations made, although the therapist may gently elaborate a character or story line as part of the therapy process. The therapeutic potential of using dramatherapy for Zac was that the therapist was able to take up the relationship difficulties that Zac had, within the safety of Zac’s own script. This would be work at Alvarez’s descriptive level and, in the NMT model, at the relational related (limbic) level.

Dayna – psychotherapy

There was historical evidence that suggested that Dayna, aged seven, might have been sexually abused when she was four years old. In the assessment she was curious and interested about the room and the toys. She asked my opinion about her play, about me, and what I thought about her. The play focused on a baby doll that was very hungry, but no matter how much food it was given it still did not feel any better. I was able to say this to Dayna who then replied “but we have to help the baby coz if we don’t she will feel like this forever and she doesn’t like feeling like this”. I asked Dayna if she would like us to carry on meeting to see if together we could help the baby feel better and she nodded. After the assessment she asked her key worker when she was coming back to see me as she thought I could help her stop having the horrible thoughts about sex. She also told her teacher that she had not finished telling me her story.

Dayna arrived at the assessment relating to me and interested in having a dialogue. It was as if she “knew” I had a mind that she could engage, and she certainly had an expectation that I might help her. We were even able to have a brief conversation about this, which developed out of her play, and this did not alarm her. She presented as if she had experience of adults taking an interest in her and her feelings, and this did not frighten her. Dayna was seen in once-weekly psychotherapy and it was possible to work towards an explanatory way of working where Dayna could gain a deeper insight into her objects and relationships.

Discussion

Ryan is a typical example of the children for whom the milieu is the most appropriate level of intervention. With children like Ryan I am able indirectly to join the work through regular consultations with house and class teams. With Albany her ability to engage on a feelings level was infantile; when babies are distressed we recommend parent-infant psychotherapy and I now think about our work in that way, a three-person milieu approach.

In the allocation to music, drama or psychotherapy we use a number of factors from the assessment, particularly our countertransference, the child’s ability to play and whether they do so symbolically, how they relate to us, and perhaps what their understanding is of why they are at the school. It would be misleading to give the impression that it is always an easy process, especially deciding between dramatherapy and psychotherapy. However, intuitively and in most cases, each of the therapists independently come to a similar view about the assessment, and therefore which type of therapy would best suit a child. Many children arrive having had three times weekly psychotherapy in CAMHS[2] or with a request for intensive treatment, but often we find that less intensive treatment is more manageable for the children, especially at the beginning, but this is always open to review. They are in a therapeutic setting and we need to bear this in mind.

Hurry, Alvarez and Perry all approach this work by considering the child’s developmental level and ego deficits, and this is in common with our model at the school. However, Hurry and Alvarez do not suggest using different types of therapies but recommend that child
psychotherapists vary their level of interpretation, interaction and initiation of play. I think that our three types of therapy are probably doing something very similar and that we use music therapy, dramatherapy and psychotherapy like developmental therapy (Hurry, 1998) and Alvarez’s different levels of interpretation. However, one difference is that with children like Darren, we are deliberately avoiding the use of spoken language; the “intensifying” and warming up of his affects occurs via the mirroring of sound, tempo and rhythm. Words can feel like verbal assaults for some children, especially those whose primitive states of mind leave them unable to process talk about feelings; music is a powerful way of creating a bridge between the child and the scary world of affects.

When I read Perry’s NMT model and its implications for traumatised children I wondered whether music and dramatherapy would be useful additions to the clinical team and if these ideas were correct then it might explain our experience of why some children were able to use psychotherapy for an initial period of time but then dropped out. We are sensitive to the pace of work, but investigating their internal worlds in the presence of an adult, is probably not what these children had consciously signed up for (Hunter, 2001). We have to acknowledge the mistakes we have made, as mentioned above, in offering and starting individual psychotherapy, only for it to come to a premature end when the child disengages after a relatively short period of time. It could be easy to misinterpret Perry’s work and read it as if he were saying that he knows exactly which “enrichment” activities we have to do and for how long to develop or re-establish a neural pathway, but I find something compelling about his argument which intuitively fits with our child group. The connections he makes to the psyche-soma also fit with other widely held psychoanalytic views about the way the body becomes the repository and vehicle for early trauma (Glasser, 1979; Parsons, 2009).

In practice the children do not fit exactly into our neat categories, and there are overlaps in approach especially between dramatherapy and psychotherapy particularly the level at which the therapist engages in the play. One difference that is a useful way of deciding is the child’s ability to come out of the play and reflect on themselves, however, briefly, and to show an ability to make use of our gentle comments based on the therapeutic relationship. We also take account of the research there is about effectiveness and there is clinical evidence that psychotherapy with sexually abused girls reduces their post-traumatic stress symptoms so we consider it for these children (Trowell et al., 2002). We have also found that girls and boys traumatised by a significant event, e.g. witnessing the death of a parent or sibling can be helped by psychotherapy.

To function effectively all parts of the school need to communicate well. It is vital that a child’s therapy does not happen in isolation and that the treatment team around a child talks about all parts of that child’s life. It works best when there is “shared confidentiality” between staff about all aspects of the children’s treatment including their therapy (Cant, 2002). Inevitably children see therapists around the school at times outside of their therapy, at weekly assemblies, whole school meetings and simply walking around. This does impact on the work, but a child’s primary transference is generally to the school as a whole rather than to their therapist and so meeting us outside of their therapy time has a different meaning than if working in an out-patient setting. This is not to minimise a child’s transference to their therapist but to acknowledge that it is alongside their transference to the whole environment.

One question that needs to be asked is the impact on those children who do not have individual therapy. Peer rivalries around the school can be rife and this type of difference in treatment could be used as ammunition for bullying and conflict. However, some children used to say that psychotherapy was for “the babies” but since introducing music and dramatherapy this has reduced. Another issue is the impact on staff, particularly those in the houses where similar envies can occur. Staff can project all the “expertise” onto the therapists whilst others can feel as if we have a “nice time” playing with the children whilst they have to deal with relentless boundary setting and mess clearing. There is also an issue that the days can be busy for the children, with their time filled by many different therapeutic activities. On the one hand this supports the children who find unstructured group times difficult but for those children who can play, then they can resent having their time so tightly managed.
Irrespective of the type of therapy they receive, we observe that a child’s individual therapy is the catalyst, which allows them to use the adults they know and trust the most, so that by using those close relationships therapeutic changes occur. This is not to say that the therapist would not be an important person in a child’s life but we want children to find ways of trusting and using the adults available to them as they go about their daily lives in an ordinary way.

Conclusion

Children referred to the Mulberry Bush School experience overwhelming levels of distress and their behaviour communicates this loud and clear. Some children will have had over 20 family placements as well as numerous school exclusions. We need to continue to think about and develop new ways to help them, so that when they leave the school, generally after three years, they are in a better position to make use of education, their family and community. Equally important is the fact that when they leave us they are on the cusp of adolescence and so it is crucial to bring stability before the turbulence starts.

Taking account of developmental therapy, neuroscience research and child development a model of providing music therapy, dramatherapy and psychotherapy has been described, which attempts to make meaningful, therapeutic connections with traumatised children. The therapies chosen intervene at different therapeutic levels with milieu three-person work being akin to parent-child work. Clear assessment is needed in order to make the correct selection, bearing in mind that the milieu is itself a powerful environment for change. The implication is that children will engage better with the therapy if the level of intervention is sensitive to their state of mind, which in turn will help them make better use of the environmental provision of the school.

More study is needed to understand exactly how a child’s level of emotional development influences which type of therapy could be most useful and I am currently engaged in doctoral research in the area of assessment, which will contribute to this. This could have implications not only for residential work with primary aged children but also in outpatient and other settings. Research in the area of effectiveness of psychotherapy has found that the therapy relationship accounts for why clients improve or fail to improve, as much as the particular treatment method (Norcross, 2011), and so in terms of how we develop our understanding of what works for traumatised children it will be important to explore further how we decide which children are allocated to which type of treatment.

Notes

1. I trained at the BAP now the British Psychotherapy Foundation and the child training is at IPCAPA – the Independent Psychoanalytic Child and Adolescent Association.
2. CAMHS is Child and Adolescent Mental Health Service – an NHS community-based team.

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