The Mulberry Bush School and UK therapeutic community practice for children and young people

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Abstract

Purpose – The purpose of this paper is to inform readers and researchers about the use of a “lived experience” of therapeutic community work as an effective intervention for severely emotionally troubled children.

Design/methodology/approach – An explanation of the main developmental influences and how the Mulberry Bush School is continuing to incorporate new theories and approaches.

Findings – How the Mulberry Bush as a specialist therapeutic residential provision can bring about excellent outcomes for severely emotionally troubled children.

Research limitations/implications – The paper explores the work and legacy of the school’s founder Barbara Dockar-Drysdale and of her collaboration with Donald Winnicott to create a lived experience of community as an agent of therapeutic change. The paper also provides descriptions and a case study of the current multi-disciplinary work of the school, including how neuroscientific research is influencing the evolution of the therapeutic task with traumatised children.

Practical implications – The paper shows how a highly evolved model of integrated provision can support excellent outcomes for traumatised children and young people.

Originality/value – To broaden and deepen knowledge about the use of therapeutic community principles in the treatment of severely emotionally troubled children and young people.

Keywords Residential, TC history, Therapeutic communities, Children and young people, Groups, TC practice

Paper type Conceptual paper

Introduction

The conference identifies a critical social issue: “how do we achieve psychological wellbeing for severely emotionally troubled children and young people”. It poses the questions “what environmental conditions are required for our clients live safely with themselves, and others, in families, schools and their community”. And “how do we enable children and young people to make and sustain healthy individual and social relationships”.

Our experience at the Mulberry Bush School tells us that the answer to that question is to enable young people to internalise “a lived experience”, of caring and empathic relationships within a nurturing and containing environment. This is the role of therapeutic community work.

In the UK in the current context of economic austerity, the costs associated with therapeutic care undermine this important and valuable resource. But there is a risk that those who commission placements will focus on anxieties about the immediate cost, to the detriment of the long-term value.
For those children who are placed in specialist services such as the Mulberry Bush School, where we provide emotional holding as a “24 h curriculum” for children with severe attachment disorders. In our view such provision is vital in providing the conditions where children can begin to start to grow emotionally. In this paper the history and therapeutic community approach of the Mulberry Bush School will be described. Central to this approach is the provision of safe individual and group therapeutic relationships within structured and purposeful living routines, which over time children can explore and internalise. Following this description of the model of practice, a case study illustrates aspects of this provision. The paper ends with a discussion on how new advances in neuroscience are influencing and supporting this work.

The therapeutic milieu of the Mulberry Bush School

The “Mulberry Bush Approach” is our model of specialist therapeutic residential care, treatment and education for children who have experienced early year’s trauma. Our therapeutic culture has evolved over 65 years since the founding of the School in 1948. The sum of this 65-year expertise could be described as: “the provision of primary experience within a containing, nurturing and safe residential environment”. For the continuation of the task, we are required to maintain such a structured environment, and to maintain and develop a “clinical sensibility” which enables staff to be remain preoccupied with the daily experience of routines, behaviours, thoughts, feelings, projections and relationships that exist between individual children and adults, their groups and teams, and with each other across the community. The therapeutic task supports children to grow emotionally so they can negotiate and make use of individual and social relationships. Essentially psychotherapeutic work is a hermeneutic discipline: it concerns the creation of meaning through interpretation.

Our work is underpinned by a synthesis of the following disciplines:

1. child psychoanalytic psychotherapy, as defined by Donald Winnicott (including Dockar-Drysdale’s own distinct application of this work) and Melanie Klein;
2. attachment theory, as defined by John Bowlby and Mary Ainsworth;
3. ongoing neuroscientific research, and its relationship to attachment theory as defined by researchers and practitioners such as Bruce Perry MD, and Bessel Van Der Kolk, including research into “complex trauma”; and
4. the concepts of Therapeutic Community, Planned Environment or Milieu Therapy, with three distinct features:
   - group care for its account of the overall context and mode of practice;
   - psychodynamic thinking as an underpinning theory, with the concept of the “holding environment” as a specific model of practice; and
   - systems thinking as a way of holding the component parts together (Ward, 2003).

Currently, our provision for children consists of three defined task areas:

1. **Group living**: in which the residential therapy is delivered as a lived experience by a dedicated staff team who live and work “close in” with the children in order to develop individual relationships, and to help them achieve a way of living together as a social group. This work is contained within robust and nurturing domestic routines, planned over each 24 h period.

2. **Education**: to provide and meet the child’s entitlement to an age and stage appropriate educational experience. Access to the National Curriculum is delivered within a nurturing environment which pays equal attention to the child’s social emotional needs. The curriculum is organised and delivered in practical and fun ways through which the children are most likely to learn. The education area is organised in three developmental stages; foundation stage, middle stage and top class. Children move up and through these levels as they become more able and independent learners.
3. **The Therapies and Networks Team:** which aims to maintain and support close communication and partnership working between the parents and carers of the children placed at the school, and the referring network. In this way it serves the core residential task. The team “holds the child and family in mind”, and can provide outreach therapeutic support and interventions to parents and carers. Our therapists provide mainly group and some individual therapy to the children. Our consultant and principal psychotherapist also consult to care teams, and run case discussion clinics and internal case conferences. The drama and music therapist provide individual and group therapeutic sessions. Psychotherapy supports the core task by enabling children to make a fuller and more meaningful use of the total residential experience.

These component parts of the therapeutic milieu, work together to provide an integrated and holistic environment that is organised to maximise the emotional growth of each child. The sum of the “emergent properties” of each department on the child is difficult to quantify. However, our observations of the emotional development of each child suggests that when we achieve good outcomes, the “wholesomeness” of this integrated approach has been internalised by the child.

We are currently engaged in a seven-year longitudinal qualitative evaluation of the work of the school. This is measuring social/emotional and educational outcomes for children in relation to 11 key elements identified by staff as representing the core work of the school. As well as enabling us to evidence good outcomes, it is highlighting areas of our service that require improvement. These improvements are implemented annually via our school development plan. The project has worked from a model of active practitioner-based research, thus enriching our heritage of self-generated learning and reflective practice. The completed project will provide further hypotheses about the effectiveness of the “hermeneutic” approach.

**Key historical developments of the therapeutic task.**

*Therapy in child care: the foundation of therapeutic work at the school*

In the early days of the Mulberry Bush, Barbara Dockar-Drysdale and her young family shared the original farmhouse with a group of deprived children who had been placed in Oxfordshire during Second World War as part of the national evacuation campaign. Via monthly clinical consultations with Donald Winnicott, and later a Freudian psychoanalytic training, Dockar-Drysdale provided the children with one to one therapeutic sessions. Her husband Stephen, recently returned after war service, supported the enterprise by providing robust boundary setting – a “live” authority for the group. We can imagine how this familial experience offered deprived children an experience of “Oedipal” parental roles. In 1948 their work achieved School status, as a hybrid “special school and child guidance clinic”, and from thereon they were able to employ a few staff, and the school began to grow.

Out of this experience Dockar-Drysdale (1990) developed the residential treatment methodology that she later named “the provision of primary experience”. She conceptualised this work in a series of papers which were later published in her books *Therapy in Child Care* (Dockar-Drysdale, 1968) and *Consultation in Child Care* (Dockar-Drysdale, 1973).

Robin Reeves, a former Principal of the school, and consultant child psychotherapist writes:

Dockar-Drysdale’s primary experience seems to be an amalgam of the Winnicott concepts of “primary home experiences” and “primary maternal preoccupation”. The term encapsulates what Dockar-Drysdale came to see as the essential element in therapy for children who had missed out on that early maternal provision [...] her view of primary provision could be summed up by saying that it was a matter of the caring adult having to feel and act like a mother with her new born baby, and with the same preoccupation and sense of vulnerability. This is what the “frozen child” required as an absolute condition of change (Reeves, 2002).

Within this concept of “the provision of primary experience” Dockar-Drysdale carried out her most renowned work, defining different syndromes of deprivation, and formulating treatment approaches to these syndromes. Maurice Bridgeland (1971):

Dockar-Drysdale has done her most important work in seeking to explain the nature and needs of the “frozen” or psychopathic child. The emotionally deprived child is seen as “pre-neurotic” since
the child has to exist as an individual before neurotic defences can form. The extent to which there has been traumatic interruption of the “primary experience” decides the form of the disturbance. A child separated at this primitive stage is therefore, in a perpetual state of defence against the hostile “outer world” into which he has been jettisoned inadequately prepared.

The early therapeutic milieu was managed by the staff who provided “close in” lived experiences of containing and nurturing routines, along with robust behaviour management, through which the “authentic” and chaotic child emerged. Attachment to (then “dependency on”) an adult was supported, and in the case of the “frozen child” a localised regression to the “point of failure” was therapeutically managed. Often a regular and reliable symbolic adaptation, termed a “special thing”, was introduced within the relationship. This allowed the child an experience of primary adaptation to need, and an experience of the “rhythm” of close bonding and “nursing” with a primary carer:

[… it was this familial or social factor Dockar-Drysdale particularly attended to. It led her in due course to a greater appreciation of the therapeutic potential of “ordinary devoted carers” within a setting such as the Mulberry Bush. She seized on the fact that, even without specific training and qualification as therapists, carers could become the critical focus of a child’s regression to dependency, provided that the requisite therapeutic support systems were in place (Reeves, 2002). Most often this symbolic adaptation would take the form of the child’s “focal therapist” providing a food chosen by the child, such as a boiled egg or a rusk with warm milk. The child’s choice of food often had a significant primary connotation. As the use of the “special thing” became embedded in the work, staff began to use this as a way of meeting the needs of the child. They found that the provision improved the child’s sense of security, reduced delinquency (stealing as self-provision to “fill up”), and the localised and protected time seemed to help children cope with their feelings of envy and jealousy when having to share the adult with other children in the group care setting.

This “attachment” model of meeting need, with special attention to symbolic communication, still underpins our work today. In Dockar-Drysdale’s view, for chaotic “unintegrated” children the traditional “psychoanalytic hour” was not enough, they required a total environment in which therapeutic interactions could take place within the routines of child care, she did not place the primacy of therapy as being outside of daily child care routines, hence the development of the concept and methods now known as “therapeutic child care”.

Planned Environment or Milieu Therapy: using groups and the environment as a therapeutic medium

Between 1996 and 2001 due to a successful fundraising campaign the site was redeveloped, and the children moved to inhabit the four newly built households and education area. This achieved the strategy planned by staff and trustees to develop a new therapeutic model of group living within a purposely planned environment, to improve and broaden the therapeutic experience for children. This new experience of therapeutic group living and the planned environment, led to a creative re-appraisal and exploration of the theory and practice of group based and milieu therapies.

Over the last decade, this conscious process of physically separating out and differentiating spaces for group living and educational learning, has also led to a greater professionalisation and demarcation between the two as integrated but separate tasks.

Dockar-Drysdale developed her work in an era when group psychotherapy and the concept of the therapeutic community were still recent innovations. She had met the psychiatrist Marjorie Franklin and David Wills who had both been involved in the “Q” camp experiments of 1936-1940, in which staff and young offenders built a small community and lived together as a prototype “therapeutic community”. Franklin (1945) had written and published her manuscript “the use and misuse of planned environment therapy”. Similarly, in the USA across the 1940s and 1950s, Fritz Redl and David Wineman (1950) defined their version of residential treatment calling it “Milieu Therapy”. Their work was defined and published in Children Who Hate. The terms planned environment (UK) and Milieu Therapy (USA) are used interchangeably in the following section.
The concept of planned environment therapy has a strong psychoanalytic legacy, reaching back to 1928, when Marjorie Franklin set up a “psychological and psychotherapeutic discussion group” at her consulting rooms in Harley Street. Meetings of this group included the psychoanalysts Dr Kate Friedlander, Dr Melitta Schmideberg (Melanie Klein’s daughter) and Dr Adrian Stephen. The “Q” camps planning committee also included Dr Denis Carroll (Portland Institute for the scientific study of delinquency) who later worked as an army psychiatrist at the Northfield military hospital, where the concept of the therapeutic community was developed.

By 1963 Franklin had set up a planned environment therapy discussion group, which led in 1966 to the formation of the Planned Environment Therapy Trust to promote “the serious clinical study of the use of the environment as a means of correcting asocial and other related character deficiencies”. Franklin claimed that “planned environment therapy has long reached the stage of a serious branch of psychotherapy” and psychotherapist Arthur Barron described it as “the only method that provides a viable method and approach to the residential care and treatment of the maladjusted” (Bridgeland, 1971).

The concept of Planned Environmental Therapy; using the totality of the environment including the diversity of relationships, and everyday activity in service to the recovery of the child, helped develop the concept of the school as an integrated and holistic therapeutic environment.

As our therapists Caryn Onions and Jennifer Browner write:

Milieu therapy offers children an environment that aims to understand and make sense of their inner muddle, turmoil and pain. It allows children opportunity day-in and day-out to explore their inner world and its impact on their current lives and relationships. But if this were all it did, it would be likely to overwhelm children in a swamp of transference from which they could have no respite. Milieu therapy has other jobs too: it seeks to manage children’s feelings on their behalf, to set clear limits and boundaries, to leave room for cooling off times, where the focus is not on feelings, and for building up an alternative internal world based on ordinary experiences and healthier relationships. Milieu therapy, in a different way from individual therapy, tries to “localise” the transference so that there are times in the day when children can just begin to live their lives (Onions and Browner, 2012).

For chaotic and deeply mistrustful children, the planned environment offers opportunities for a variety of relationships, and structured experiences which, over time, can be internalised by the child. At the Bush, our model of group living is created by staff enacting a “conscious use of self". For children who have previously found the intimacy of family, and class groups intolerable, the Mulberry Bush milieu is often the first time that they can begin to internalise the nurturing and healing effects of the group. Children live in a group but more importantly as a group. They play and do their school work between different groups. This combined patterning across the community creates and builds a day to day experience of “the other” which requires children to challenge their self-reliant and mistrustful view of the world, and start thinking about the “social and emotional” through co-operation and understanding others individual and group needs. As a “society in miniature” it provides the condition where disaffected children can develop a sense of the value of the group and community through the experience of a range of group mediums. These include daily household meetings, group living therapeutic groups, class “circle time”, the weekly “drumming circle” and psychotherapeutic music and drama groups. In this way, groups and the milieu in which they are set are containing for the children because each interaction can be observed, managed and talked about. Such a sense of purpose is built into the everyday routines and activities.

Our experience at the Mulberry Bush School is one of providing a responsive service for these most emotionally unintegrated and fragmented of young people. The following is an anonymised case study of one girl who came to the Mulberry Bush for specialist treatment.

Lucy’s story. At the age of three Lucy was taken into care by social services. She had been discovered living in a house which was being used as a base for trading in drugs and sexual relations. As a result of living in this environment Lucy had experienced severe emotional neglect as well as physical and sexual abuse. Lucy’s behaviour had become so disturbed that she was found to be eating off the floor with several dogs which were also inhabiting the house.
Prior to admission to the Mulberry Bush School Lucy, was placed with foster parents. In week 1 at the foster home her behaviour included wetting, smearing, self-harming, aggression, insomnia, inappropriate affection to strangers, extreme controlling behaviour and cruelty to animals. Her insomnia resulted in one or other of her foster parents having to stay awake all night with her. Attempts at schooling failed as her behaviours were so aggressive and uncontrollable, she was therefore also severely underachieving. As an early intervention to help her make sense of her chaotic life, Lucy started play therapy sessions with the local Child and Adolescent Mental Health Service team. Her therapist described her as being in complete emotional turmoil. During the sessions she was described as being highly aroused, tense and exhibiting signs of physical and sexual abuse she had experienced, she showed no understanding of keeping herself safe. Her therapist commented “she brings chaos and destruction into everything she does”.

Lucy was referred to the Mulberry Bush School at the age of seven, and was placed in one of our four care and treatment households living in a group with other children of primary age. A dedicated staff team lived alongside the children creating a reliable daily routine. The structure of this routine included close supervision and support through all aspects of the day: mealtimes, playtimes, bedtimes, transitions to school, etc. The staff managed and resolved the frequent behavioural breakdowns, arguments, rivalries and the general anti-social behaviour of the group of children. With time Lucy responded to this re-education in relationships and started to understand that she could be helped to engage with normal and respectful social living. Through this daily routine the care staff gave Lucy opportunities to help her think and talk about her confused, betrayed and angry feelings. She started to find alternative ways of interacting, and little by little, started to come to terms with the injustices in her life.

In the education area Lucy joined our foundation stage where she was helped to enjoy learning again. Alongside an introduction to the National Curriculum the children are encouraged to play with pre-school equipment, listen to stories, sing, dress up and work and play co-operatively. After a year Lucy moved to the second tier class where expectations of behaviour, application and learning are higher. She was still a noisy child, readily distracted and easily led into others misbehaviour but she made good progress and was able to move to the top class a year before she left the school. During this last year she successfully made a half day visit to a local mainstream primary school, supported by staff from the Mulberry Bush.

During this treatment process at the school, periods at home with her foster parents were still difficult with Lucy exhibiting her previous testing and challenging behaviours. However, the school placement offered some respite for her exhausted foster carers who were able to recharge their batteries during term time. With time the foster carers also noticed an improvement in her behaviour, Lucy was becoming more articulate about her needs and started to display more loving and affectionate feelings. The carers began looking forward to a time when she could come and live with them full time, and attend a local school with teaching assistance. After three years Lucy was able to make this transition and return home to her foster parents. She is currently doing well and the placement remains stable. She is successfully placed at a local school for children with moderate learning difficulties and despite being quite demanding, is no longer unfosterable nor unacceptably disruptive in school or other social situations.

Residential care as emotional holding. If Lucy had not received an early therapeutic intervention, the chances of recovery and a good outcome from such early trauma would have been reduced, and her anti-social behaviour would have accelerated with the onset of puberty and adolescence.

At the Mulberry Bush we consciously use all aspects of the community: one to one relationships, group work and the social fabric of the community itself to develop a way of helping children to live and learn together. Our approach ensures that children have their individual needs met, but also that they are able to live and learn through the process of being together in their household and class groups. Our belief is that being part of a group is essential for children. It is only through a positive internalised experience of living together, that we are able to prepare the children to return to live in families and attend mainstream schools.
The neuroscientific agenda: advances in the understanding of trauma and abuse on a child's developing brain

So how does neuroscience also play its part in our understanding of the impact of trauma on children?

In recent years there have been huge advances in our understanding of the effects of trauma, neglect and abuse on a child's developing brain. These findings have helped confirm what staff in residential settings have been experiencing with such children. Research has shown that the brain of the newborn baby actually grows in response to nurture, love and positive touch and carries on like this well into the second year of life. Chemicals such as the hormone oxytocin are released during these positive interactions promoting loving feelings, reducing the impact of stress and boosting the immune system.

However, the brains of infants like Lucy who experience severe neglect, and physical and sexual abuse can have areas which simply do not develop healthy brain connections. When early experiences are traumatic, different chemicals are released which create unhelpful nerve pathways as well as increasing blood pressure, heart rate and stress levels. It is likely that from early on, perhaps pre-verbally, Lucy became habituated to this agitated stressed way of being and that this contributed to her insomnia, hyper vigilance and unprovoked outbursts.

In the same way we know that environmental risk factors associated with childhood trauma can lead to a lack of attachment and poor outcomes for children. Environmental risk factors that diminish resilience in the personality include: family breakdown, parental drug addiction, major losses such as bereavement, neglect, sexual and physical abuse and domestic violence. These factors often become co-morbid and compound to decrease the chances of the child's successful adaptation to his or her home, school and community environment:

[...] the child exposed to chaotic or threatening caregiving develops a sensitized stress-response system that affects arousal, emotional regulation, behavioural reactivity, and even cardiovascular regulation. These children are at risk for stress-induced neuropsychiatric problems in later life (Perry and Pollard, 1998).

Over 65 years the evolution of the school as a therapeutic environment has required an openness to new theories and ideas. Recent advances in neuroscientific research tell us that just as traumatic experiences freeze and dysregulate children's emotions, over time the experience and delivery of empathic caring relationships can work to ameliorate and modify these psychopathological states.

This understanding supports and complements our intuitive and psychodynamic understanding of building close relationships. Through the provision of empathic and nurturing experiences "reflected" by adults and "mirrored" by the child, we can help children understand that meaningful relationships and social living is possible. It deepens our understanding of how children can internalise adults as caring role models.

For children such as Lucy a fundamental lack of a sense of security and attachment with a primary carer causes them to experience the world as hostile, dangerous and persecutory. A lack of secure attachment undermines the child's ability to construct self in relation to the primary carer. Rather than developing a coherent personality, their sense of self is fragile and fragmented.

This traumatised state of mind has been referred to as "unthinkable anxiety" and consequently children defend themselves against these unprocessed feelings of anxiety, betrayal, despair and mistrust through chaotic, aggressive and sexualised behaviours. In extreme cases where the attachment experience has been so disrupted, and the child's "internal working model" (Bowlby, 1969) becomes "disorganised", they can act in violent and aggressive ways, apparently showing little concern or empathy for others.

In response to these adverse experiences, children adopt behaviours which appear to be designed to keep adults away. At the school we regard these behaviours as misdirected communications for a need for security and attachment. In this sense one aspect of our task is to understand behaviour as communication. Such "traumatic" behaviours influence those adults...
who work closest with them. For these workers these “unthinkable” feelings often reflect the original intensity of feeling in the child.

Working closely with disturbed children is anxiety provoking. Chaos and aggression are never far from the surface. The effective management of anxiety is a therefore a critical and key concept in providing a safe and nurturing environment. How this anxiety is acknowledged and contained is critical for successful work with emotionally damaged children.

**The role of staff support and training**

As I explored in Lucy’s story, engaging with the process of the lived experience of daily routines in residential life allows staff and children to develop close relationships. The weave of conscious and unconscious interactions can be felt, observed, thought about and talked about. It is within this “close in” experience, that children start to internalise nurturing and empathic interactions; the building blocks of good experience; leading to them developing a better understanding of their feelings and sense of self.

In their work with Lucy, through regular supervision and consultation and facilitated “reflective spaces”, care workers and teachers were supported to talk about their emotional experience of working with Lucy in order to understand the despairing and desperate feelings that Lucy was “transmitting” or projecting into them. This understanding allowed staff to feel emotionally freer, and more able to respond in insightful and empathic ways towards Lucy. In the absence of such reflective spaces, the risk is that the team might simply mirror and react to such processes by becoming punitive, or rejecting of the child’s behaviour, rather than understanding it as a form of communication.

The aim of our training including our foundation degree in “therapeutic work with children and young people” is to explore this match between experience, theory and practice. Workers are encouraged to bring their own experiences into the themed seminars, and by doing so import elements of the process of their practice into the process of training. When there is a sufficient match within the training session, opportunities are created for deeper reflection, allowing care workers a better understand of how they interact as transmitters and receivers of these conscious and unconscious elements.

In conclusion, I would like to share some key outcomes of our work.

On entry to the school:

- 100 per cent of children have conduct disorders.
- 96 per cent of children have attachment disorders.
- 62 per cent have difficulties reading.
- 65 per cent have difficulties writing.
- 58 per cent have difficulties with maths.

As a result of placement at the school:

- 91.4 per cent of parents, carers and referring professionals have told us that as a result of a placement at the Mulberry Bush School, their child is more able to build healthy and mutually trusting relationships.
- 93 per cent of children who on entering the school were unable to be placed long term with a family were able to do so by the time they left.
- Overall progress in academic progress is good or outstanding in all subjects.
- 100 per cent of children are able to be placed in a suitable school on departure, being able to learn and be taught.

I wanted to finish by saying that the Mulberry Bush Approach – our model of practice for the care, treatment and education of traumatised children continues to evolve from the synthesis of a number of theory bases, traditions and legacies. I believe it continues to evidence that well
managed relationship based residential care really can contribute to the psychological wellbeing of our society’s most emotionally troubled children.

References


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