Core principles and therapeutic objectives for therapy with adoptive and permanent foster families

Angie Hart and Barry Luckock provide an organising framework for integrated practice decision-making in specialist therapy with adoptive and permanent foster families. The framework is located in current available insights from theory and evidence from empirical research, personal therapeutic practice and family life. The authors formulate an initial case example and use it to illustrate their approach throughout as it demonstrates the distinctiveness of adoptive and permanent foster family life. The paper then outlines a set of core principles and objectives in relation to which therapy for these families should be planned.

Introduction
The first anniversary of the start to family life together in 17 Beechwood Place has come around but nobody is celebrating. Alec (10), Darren (9) and Billy (6) have been parked in front of Game Boys in different rooms. But even divide and rule hasn’t given Jessica much of a break. Darren still can’t sit still for more than two minutes, so he’s in and out of different rooms asking what seem to Jessica like nonsense questions. Of course he’s terrified, but nobody’s realised that. At the last parents’ evening his teacher explained to the children’s foster parents, Jessica and Elaine, that he does that at school too. And even though it’s a special school and they’ve got extra support for him in class, it drives them all mad.

While Darren’s buzzing around, Alec keeps coming back into the kitchen. He’s just as anxious as Darren, but shows it in a different way. Alec isn’t conscious of why he’s coming into the kitchen all the time, but Jessica understands that he’s deeply worried that she’s not going to be there. And she knows he comes back more or less every three minutes because she checks on the clock to time precisely how much peace she gets.

Six-year-old Billy is sitting in a corner staring into space. In fact, he’s quite numb and not very aware of what’s going on around him. Jessica’s just thankful that he’s quiet. But he’s still on her mind. Billy’s teacher called Jessica in after school today to tell her that although he’s good at art, Billy’s still not coping with anything else. Billy hadn’t told her that he’s avoided by the other children and he wets himself at school at least once a week. His teacher mentioned something about him being on School Action Plus now. Jessica’s not exactly sure what that is but she knows it’s to do with getting support.

Even though Billy’s getting some extra help, Jessica knows he seems very odd and that he is not happy. And he’s really too tired to go to school some days. Nightmares keep him awake. He keeps having them about what his birth father, Joe, did to Darren, Alec and his three other brothers. These other brothers are in long-term foster care too, but all in different families. Jessica thinks she knows what he’s going through because she hates thinking about all that, and she’s tried to make Billy forget about Joe by giving him a big mug of cocoa when he goes to bed, and one again when he wakes up in the middle of the night. During the daytime it’s as if the nightmares never happened. Jessica doesn’t mention them and Billy never remembers what happened in the night.

Jessica recalls that one of their social workers (her name escapes her) was quite enthusiastic about two places that could help. Crams was one name that vaguely sprang to mind – somebody had mentioned that they could help think about whether the boys should see their birth mum again some time, face to face. The social worker had put all the kids down on a list and something had once come in the post, although Jessica couldn’t recall what it was and where they’d put it – buried in the kids’ massive pile probably. Neither Jessica nor Elaine ever followed
up the leads. Jessica was sick of different
do-gooders coming round for a cup of tea
and then leaving without a trace (if you
don’t count the piles of paperwork which
appear regularly through the letterbox). It
felt like they thought it was her fault that
her kids were all mad.

As she clears up the chaos from dinner,
Jessica struggles to keep her eyes open
and she’s crying. She cries so much these
days, and she feels so isolated as a parent
or is it a carer? She’s never quite sure.
But she laughs when she thinks of the last
review meeting. One of the children’s
latest social workers – they’d seen five
new faces in two years – suggested that
since the law had now changed, they might
want seriously to consider adoption. This
was because it’s been agreed by social
services that this is a permanent place-
ment anyway. They could still get some
money, so she said. But Jessica’s focus is
elsewhere. She’s trying to remember what
it was that made her want to go for perm-
anent fostering in the first place. The
family life she’s got isn’t right for her, but
she’s not even quite sure what kind of
family life she does want. And Jessica feels
very sad that Elaine is working late again.
Even though all the children are feel-
ing in very bad shape, tonight is looking
up for Jessica at least. Her friend Diana
will be round soon. Like most of her old
friends, Jessica hasn’t seen Diana for a
couple of years. But Jessica’s worried
that Diana won’t bear to stay more than a
few minutes. The house is a tip, and
Jessica’s got no energy to clear it up.
Darren will seem charming and will go
on about how much he loves his family,
but then he’ll climb all over Diana and
will ask if she’ll be his new mum. Billy
will act likes he’s not there, but will sud-
denly get all upset if someone tells a joke
and then he’ll wet himself. And it will be
embarrassing when Diana can’t under-
stand what he’s saying because he’s so
speech delayed. Even though he’s ten,
Alec will want to sit on Jessica’s lap the
whole time, interrupt their conversation
and refuse to go to play in his room. All
these thoughts make Jessica cry even
louder.

Many practitioners, foster or adoptive
parents reading this article would
recognise the circumstances and difficul-
ties of the Leach, Smallwood and Jones
household. However, each of the charac-
ters is fictitious. For ethical reasons we
have deliberately made them up. Their
experiences are synthesised from those of
very real people we know through our
research, practice and personal experi-
ences.

Of course, appropriate permanence
planning, and the communication of that
to the children, is of central importance in
helping Alec, Darren and Billy to feel
more secure about their current lives and
their future. At the moment none of the
children have properly taken in what is
happening and none demonstrate any
understanding of how long they are act-
ually staying with Jessica and Elaine. We
recognise this to be central. Alongside
appropriate permanence planning, self-
help and/or routine support from social
services should provide adequate support
for many families. This is because some
families will be put off by the perceived
stigma, practical difficulties and quest-
ionable value associated with accessing
therapeutic support.

Professionals administering tests to
determine thresholds of mental health
need may think they should be the ones
distinguishing those who receive specialist
therapeutic support services from
those who do not. However, we know that
many adoptive or foster parents request
specialist therapeutic help because they
think family members need it. We know
too that, of those who request specialist
help, many think it is too long in coming
and, overall, there still seems little agree-
ment as to precisely which families and
children will benefit from it. This is as
much to do with the political economy of
therapy and the way in which its purpose
is perceived, as it is to do with the symp-
toms and behaviours of adopted and
permanently fostered children. Some
agencies, particularly in the US, see
specialist therapeutic support as a funda-
mental part of health promotion for most
adoptive and foster families while in
some areas of the UK, mental health
assessments are routinely included in
looked after children (LAC) assessments.
However, elsewhere medical diagnostic criteria are routinely used to gatekeep access to child and adolescent mental health services (CAMHS) and the precise criteria for referral remain contested. Arguably, this is because many of the mental health difficulties of fostered and adopted children are attachment related, which do not always fit standard diagnostic categories.

Even acknowledging the complexities here, for the family in our case study this debate appears somewhat academic. Given the range and intensity of presenting difficulties, for this particular family to survive, let alone thrive, specialist therapeutic support will probably be needed. However, there is little common ground for deciding precisely what kind of therapeutic help might be useful.

We know an increasing amount about what makes parenting support interventions successful in general (Moran et al., 2004) and in respect of treatment foster care (Chamberlain, 2004). Nevertheless, there is no empirical evidence on the transfer and adaptation of these models of support to adoption and permanent foster care (but see Rushton and Monck, in progress). This means that there are many different ways for practitioners to understand what is happening at 17 Beechwood Place and to conceptualise how some form of therapeutic input might best help. Family therapy, multi-systemic work, psychiatry, clinical psychology, psychoanalytic, cognitive behavioural and various attachment therapies can all claim a piece of the action.

In the light of current knowledge, as we have explained at greater length elsewhere, our own approach is to settle on integration (Hart and Luckock, 2004). Rather than evangelising about one therapeutic method, for therapists to be really effective they need to develop specific skills in fostering and adoption competence. These are the skills of using the best methods to help parents and children manage and accommodate the distinctiveness of adoptive or permanent foster family life (Luckock and Hart, 2005).

Therapists may work directly with family members or consult other people working with children and parents (Golding et al., 2006). Consultation work has a central place in work with foster and adoptive families. Here we focus on direct work with family members, but suggest that our ideas can be drawn on to inform both consultation processes and the broad therapeutic orientation of social work with permanent foster and adoptive families.

Permanent fostering and adoption have enough in common to enable us broadly to formulate core principles and therapeutic objectives to cover both. Still, we are careful not to conflate adoptive family life with life in a permanent foster family (Schofield, 2002). Adoptive family life can be very fragile. However, as Jessica’s narrative in our case study demonstrates, members of foster families, even permanent ones, may feel a particularly enhanced sense of fragility and ambiguity about their family form and identity as family members. Conducted with sensitivity, their compulsory six-monthly LAC reviews may well support family formation but, as Brian Cairns shows in his moving account of his own family life, they can just as easily undermine it (Cairns, 2004). Whether Jessica, Elaine and the children are actually on family life’s journey together is, a year down the line, still not clear.

This article demonstrates the implications of the distinctiveness of adoptive and permanent foster family life for therapy. Yet we acknowledge that some of the frustration and disappointment experienced by adoptive and foster families are related to broader failings of CAMHS. Lengthy waiting lists, rigid adherence to either medical, child psychotherapeutic or family therapy models of practice, and a lack of service co-ordination are specific criticisms (Adoption UK, 2003; Howe, 2003; Hart et al., 2005). Complex family and community contexts often confound traditional therapeutic methods and organisational contexts are not always set up to deal effectively with them.

One of us has developed Resilient Therapy, a new methodological approach to engagement with disadvantaged children that addresses the technical, emotional, political and practical diffi-
cultures of this work. Resilient Therapy draws on Masten’s notion of resilience as ‘ordinary magic’ and systematically applies the resilience evidence base to therapeutic practice. Therapeutic engagement with fostered or adopted children can certainly be understood within this broad methodological framework (Hart, in press, 2005; Hart et al, in press, 2007). However, the distinctiveness of permanent foster and adoptive family life means that it also merits its own specific focus. We also consider it right for local statutory services to take a lead in providing appropriate services. Despite regional variations in provision, we remain committed to a vision whereby local statutory services develop fostering and adoption competence so that families have access to co-ordinated, integrated services on their doorstep.

Elsewhere we have argued for practitioners to take a sociological ‘family practices’ approach to understanding and intervening in these contexts (Hart and Luckock, 2004). This complements rather than replaces the most prominent ways of understanding adoptive and foster family life: attachment or lifecycle theory. The family practices perspective demonstrates how children and parents are not simply subjects of an ‘attachment relationship’. Nor are they reducible to being represented at some stage or other on an illustration of a blueprint adoptive family lifecycle. They are active participants co-constructing their lives, albeit within particular constraints and more or less consciously (Rustin, 1999). An adoptive and permanent fostering family practices lens gives us an insight into the detailed nuances of daily life. It shows precisely how family is practised in the moment, in a stream of expectations, encounters and events. This lens helps us appreciate what a practical matter family life is and, for many adoptive and foster families, just how much hard work each family member has to do just to get through the day.

There are three further dimensions of adoptive and permanent foster family life that the family practices perspective brings home to us. Each is concerned with ambiguity. Firstly, by paying close attention to the practices of daily life, we can see that children like Alec, Darren and Billy are making their way in life in a distinctive family context, which is both similar and different from that of normative families. So although the residents of 17 Beechwood Place comprise a household, how each of them experiences and relates to the concept of ‘family’ is likely to be far more complex than it will be for their neighbours at number 18. In addition, each individual child and adult will have their own family narrative, or competing narratives in mind (Rustin, 1999; Thomas et al, 1999; Dance and Rushton, 2005). By inviting her friend Diana round, Jessica is trying to practise routine family life, but her experience shows us just how hard this is. She is feeling too tired and vulnerable about her family at the moment for Diana’s visit to succeed.

Secondly, the adoptive family practice perspective helps us appreciate the ambiguous relationship that adoptive families have with professionals and professional systems. They are initially set up with the lead taken by professionals, and as family life evolves they continue to be practised, to a greater or lesser extent, both through and in relation to individual professionals and professional systems. This can have a significant impact on family members’ capacity to access formal sources of help and support. As our case study shows, Jessica is not feeling particularly respectful of professional intervention right now.

Third is the fact that substitute family life is carried out in the context of a wider kinship network where, in the case of foster care at least, legal responsibility for parenting is separated from day-to-day responsibility for caring; even in adoption, birth parents and foster carers are, if not physically present, often held in mind by children and by their adoptive parents.

The interacting tensions of ‘professionalised’ family life, effects of children’s legacies and the need for a sense of family and community belonging are made explicit through the ‘thick description’ provided by the family practices lens (Hart and Luckock, 2005). It helps us understand why planning therapeutic intervention for the people living in num-
ber 17 Beechwood Place is so difficult. Thus, this article provides an organising framework for decision-making in relation to therapy for adopted and permanently fostered children. It does so by emphasising the core principles and objectives we consider to be foundational in therapeutic decision-making.

**Defining core principles for practice**

By core principles, we mean the very basic ideas about the structures and processes of therapeutic engagement with foster and adoptive families that we feel individual therapists and their agencies should commit to. Successive studies of CAMHS demonstrate that for clients across the board, core skills matter above all else (Farnfield and Kaszap, 1998; Laws, 1998; Hart et al., 2005). Here the basic values of person-centred therapy – listening, empathy, friendliness and acceptance – are underlined as fundamentally important to clients, whether adult or children. All these are certainly crucial for permanent foster and adoptive families. However, taking a family practices approach enables us to understand the implications of the distinctiveness of adoptive and permanent foster family life in relation to core principles.

**Offering prompt attention**

Efforts have been made to reduce CAMHS waiting lists across England. However, this remains a problem (Kirsch, 2005). Jessica and Elaine have not yet reached a stage where they feel able to ask for help but if they were to, the level of crisis in their family would suggest a need for them to receive prompt attention. They are certainly not alone. In most foster or adoptive families crisis times will come. Practice and research evidence suggests that swift and careful specialist attention can make the difference between placement breakdown or not (Fisher and Chamberlain, 2000; Walker et al., 2002).

**Avoiding 'assessment paralysis’**

In complex families, resources are often channelled into assessment and the refinement of diagnoses by specialist CAMHS practitioners. A family’s presentation may encourage an excessively convoluted response. In the mixed economy of care, clearly many different providers could be of potential use to families like that of Jessica and Elaine. Yet assessments of need and services for such a complex family could result in service fragmentation and a delay in actually working with the family towards change. This would serve further to alienate Jessica and Elaine, who are already sceptical, hypervigilant even, about professional involvement. Also it is likely that their children will have already been the subjects of many previous assessments. As we know the kind of support that can help such families, the case can be made for practitioners with a fostering and adoption imagination to have a light assessment touch, a view that is generally supported by adoptive parents and permanent foster carers (Hart and Luckock, 2004).

**Continuity of agency and therapist**

We know enough about fostering and adoption to be fairly confident that this family’s problems will not disappear overnight. Indeed, they may need assistance at crisis points over many years. Research is beginning now to explicitly link high staff turnover in social work with poor permanency outcomes (Flower et al., 2005). Services that can offer continuity of practitioner approach over time and flexible re-referral when difficulties re-emerge are then particularly valuable. Foster carers and adoptive parents are chosen for their exceptional parenting capacities. Yet in fostering and adoption the adults who bring their children to therapy find their parenting under the spotlight of the very authorities they had to persuade to let them try. This distinctiveness of permanent foster or adoptive family life can make establishing a therapeutic alliance uniquely difficult, hence once one is established it is important to keep it.

A further argument in favour of continuity is that it seems helpful, in the midst of so much uncertainty and change, for the service system to model emotional containment and continuity of professional perspectives. However, continuity of agency and practitioner is not a prized
feature of the mixed economy of care in the UK. Services often have ‘project’ status, and funding must be continually sought if they are to survive for more than a few years.

Making therapy fit family and community life

This is a key theme of recent policy documents and reflects the general aspiration within public sector services to achieve more client-centred ways of working (Department of Health, 2000, 2003; Departments for Education and Skills and Health, 2004). Making therapy fit the family is particularly important in adoption or fostering because the constellation and intensity of difficulties experienced can make achieving the very basics in daily life extremely challenging for parents, carers and children. The inability of some practitioners to recognise the potentially colossal impact of children’s legacies of abuse and neglect on family life is well documented (Howe, 2003). As a result, foster carers and adoptive parents coping with exceptionally complex children have felt unjustly labelled as poor parents by therapists lacking competence in adoption or fostering. Jessica’s experience of what Kate Cairns calls ‘secondary trauma’ illustrates this (Cairns, 2002). The vulnerability of family members can mean that if they do get to therapy, children and parents can easily find the experience unhelpful and vote with their feet. Given Jessica’s frame of mind, there is a real danger that this will happen if her family were to present in the consulting room. Ensuring that service users are entitled to change therapists if they are not comfortable with the approach taken in the initial session, and that they are aware of this right, is a key practice point.

Focusing on routine family life helps us to see that sometimes what may seem like little things actually matter more than anything else. Specific examples of client-centred therapy include after-school or weekend appointments, home visits, taking a family rather than individual child approach to planning therapy and ensuring that children with attachment difficulties do not travel to therapy in a succession of taxis driven by different drivers. Helping parents, carers and children to understand the therapeutic logic behind the jargon is also crucial. Attention to these issues increases the chance of therapy actually being therapeutic.

Core aim and objectives of therapy with permanently fostered and adopted children

As suggested earlier, our therapeutic practice with permanently fostered and adopted children avoids a solely symptoms-reduction or diagnosis-orientated approach. However, regarding the former, certainly specific micro-therapeutic techniques can be drawn on in the moment, for example to help calm anxieties or reduce behavioural difficulties. Each of the children we discussed in our case study would benefit from such help and we have included behavioural management as one of our key objectives. Regarding the latter diagnoses, it is worth remembering that they can be of strategic use to families eligible to apply for benefits such as Disability Living Allowance. Elsewhere, one of us has emphasised the therapeutic effect of working within a health inequalities framework to help clients establish what we call ‘material basics’ (Hart et al, in press, 2007); this way of working is as necessary in fostering and adoption as in other contexts. Also, providing a label for a child’s presentation can sometimes calm everybody down. Of course the reasons for certain specific difficulties may lie at least partially beyond legacies of abuse and neglect. Genetic inheritance of learning difficulties is an obvious example for the children in our case study and some of Billy’s troubling behaviour may yet be explained through a diagnosis of autism. Elaine and Jessica may feel more empathic towards him and be provided with better ways of coping if they are made aware of this. Adoption or fostering specialists with their eyes fixed on legacies of abuse and neglect can easily miss such subtleties.

These caveats aside, using the best methods to manage and accommodate the distinctiveness of adoptive or permanent
foster family life is the broad aim of therapy with adopted or permanently fostered children. The following core objectives are designed to achieve it.

Explicitly promoting resilient family practices and narratives

As with normative families, adoptive or permanent foster family lives are constructed through the daily practices of their members and wider supporters. Nevertheless, the demands imposed by legacies of abuse and neglect, as well as the lack of shared genetics and life history, can impede the production of coherent and resilient family narratives and practices. Uncertainty about what relationship children may have to birth parents or former foster carers can also work against developing an assertive approach to the issue of family identity (Rustin, 1999).

Adoptive or foster family members presenting for therapy can seem so overwhelmed and exhausted from simply getting through the day that there is little opportunity for developing a sense of family fun or positive shared experience. Focusing on children’s legacies (and even on those of parents) can be particularly depressing for everybody. Because of this, any therapeutic strategy should include the explicit objectives of enhancing the good that exists between family members and promoting a sense of positive family belonging. Here, a focus on resilience is important. In the context of such fragility and depression, small gains can easily become wiped out by perceived failures. A resilient approach encourages a climate of experimentation. It models the potential for helping people build themselves back up when they feel knocked down. It may seem as if the good family life is lost to Jessica, Elaine and the children before they ever had one. However, with the right help, they may yet get through a few meals around a table together and, in the future, they might even end up enjoying them.

Many proposals have been made about refining attachment classifications for the benefit of research and practice (O’Connor and Zeanah, 2003; American Academy of Child and Adult Psychiatry, 2005). However, debate still continues about how precisely to classify the various attachment styles indicated by the different behaviours of Alec, Darren and Billy. In the meantime, it is clear that for these boys at least, fear and insecurity about achieving a good family life are at the heart of the matter. They have no faith in the capacity of adults to care for them properly in a place called home. Family practices are disordered largely because the boys predict abandonment and abuse even in the face of persistent love and care. Facilitating occasions where they put down their Game Boys and find something more family-oriented to do instead will be difficult. However, it will be fundamental to achieving a sense of permanence and belonging for the children (and adults).

Jessica and Elaine may later regret that on this particular day they did not set up a ritual to mark an important day for their family – the day they came together under the same roof. Alternatively, with such ambivalence in the air, a celebration may be a step too far. However, as a general rule, acknowledging such anniversaries provides a helpful locus for marking family life together and reinforcing belonging. Of course there are more routine ways to do this. Getting the children to join Jessica in doing the washing up and clearing up the house every day may be a little too ambitious just yet. However, there are many incremental steps that can be taken, and seemingly mundane household activities can be one productive focus for building a mutually respectful and inclusive family life together.

All this talk, feeling and thinking about family life and relationships between family members are fundamental in determining what happens in the moment (ie what ‘gets practised’). The challenge to develop a ‘family narrative’ needs to be taken up by Jessica, Elaine and the children if they are to settle together. Developing sustainable narratives of family belonging where there are no shared histories and no shared blood to thicken emotional ties is particularly difficult. Therapists can help families to do this and we know that work of this nature goes
on in the statutory, voluntary and private sector. Yet discussion in practice texts and journals of family belonging on how therapy can help achieve it is still thin on the ground. The advice literature in fostering and adoption remains focused largely on parent–child dyadic relationships. Undertaking joint artwork in a therapeutic context has received some attention. Pavao for example provides ideas about designing family sculptures and family shields (Pavao, 1998).

Opening family communication
Things work best in adoption and fostering when confusion and ambivalence about the past and future of family life can be spoken about increasingly openly (Howe et al., 2002). Developmentally appropriate open communication lays the foundation for acceptable adoptive or foster family ‘stories’ to be jointly scripted by children and parents. Accommodating past experiences in the new family story is necessary if children and their new carers or parents are to be enabled to take charge of their family destiny together. Clearing the way for this process of communication should be a key objective of therapy. It often remains marginal as an aim because so much attention is given to assessment, solving behavioural problems and maximising child development outcomes and because practitioners and parents are often conflicted and confused about how best to tell (or to listen) to what are often very difficult stories.

Establishing a family (hi)story everyone knows and can feel a part of is a very important goal to be supported. This is a process not an event. Elsewhere we indicate some key techniques that can be used (Hobday et al., 2002; Hart and Luckock, 2004) and Connecting with Kids through Stories (Lacher et al., 2005) is a user-friendly guide that advises how to help children and young people develop appropriate personal narratives within the context of close attachment relationships. Narrative approaches also have to take account of what is happening to the children in practice, and may sometimes help to change the status quo. Whether or not the children are having any form of contact with their birth parents and former foster carers is central here. Narrative work should help clarify what is most appropriate and the precise form it should take.

Some important work may have to take place with children individually at various points. Billy, for example, is processing his father’s sexual abuse quite differently to the other boys. This relates partly to his age and partly to his very different experience of what actually occurred at the time. Tensions such as these must be considered and accommodated if a new shared family script is to be effectively written (Keefer and Schooler, 2000).

Enhancing emotion regulation and reflective functioning
Practitioners should work hard to help get family life off the ground through explicitly promoting resilient family narratives and practices, and emphasising open communication. However, in the long run their efforts will be thwarted if children like Alec, Darren and Billy fail to develop a sense of self in relation to others. This is because they are likely continually to sabotage Elaine and Jessica’s attempts to put family-belonging strategies into place. They will not have the capacity to think or to care about why they are doing so, how their behaviour affects others and how they might change it.

Although they will face rebuffs, especially from Darren, it is imperative that Elaine and Jessica are helped to improve each of the children’s emotion regulation and reflective functioning. Soothing anxieties and calming impulsive behaviour to allow Alec, Darren and Billy a safe enough space for thinking about themselves in relation to others and building secure fresh attachments are the main tasks here. As others have demonstrated (Dozier et al., 2001), for many children basic containing and sensitive caregiving are the central means of achieving this. Although giving Billy mugs of cocoa is a mistake (the sugar and caffeine are likely to keep him awake rather than soothe him), this is what Jessica is trying to do when she goes to Billy in the night to help him survive his
bad dreams. Jessica should be advised to replace the cocoa with milk and encouraged to continue with soothing him. A transitional object for Billy in the form of a photograph of Jessica and Elaine under his pillow may also prove useful. Massage and music therapy can also help soothe very anxious children and their therapeutic benefits are respected by many working in fostering and adoption (Archer and Burnell, 2003; Hirst, 2005).

Adoption and permanent foster care have a habit of stirring up uncomfortable and unresolved feelings about family and childhood for everyone involved. Troubling issues of attachment and identification are being played out. Any adult would find helping children to regulate their emotions and function reflectively a very challenging task (Ironside, 2004). Those with unresolved feelings and thoughts about their own childhood, family and adult relationships will need particular support in facing these issues. This will help them get in touch and cope with childhood experience and thereby make themselves fully available as a secure parental base (Fonagy et al., 2002; Dozier, 2003; Hughes, 2003; Steele et al., 2003). Since the impact of parental attachment styles has been shown to be influential in the development of those of their adoptive or foster children, this is crucial. Of importance too are the impact on the capacity of parents to care for children as a result of unresolved infertility issues and disappointment in the placed children who often do not measure up, for example at school.

Given that foster and adoptive parents like Jessica and Elaine have often felt criticised by professionals, the general trend among therapists with a reputation for adoption and fostering competence has been to tread very softly in providing even the most gentle of challenge to them. To our knowledge none of the textbooks on fostering and adoption available to date have seriously addressed this issue. Certainly, for any professional working with Jessica and Elaine the initial key tasks will be to give them some practical coping strategies and to engage them in a positive therapeutic alliance. There will be a clear need to work towards them experiencing external intervention as helpful. Once this is established, they should be more open to exploring child–parent inter-subjectivity. In the work of one of us, we have found that if foster carers and adoptive parents can be helped to perceive this work as akin to the development of self-knowledge gained by therapists during training, defensiveness can be reduced. Methods that promote parents as co-therapists can be helpful (Hart and Thomas, 2000). A further strategy to achieve reduced defensiveness favoured by some commentators is for experienced adopters or foster carers to be trained as therapists (Dozier et al., 2002), so using their parent or carer status to ally themselves with the client. Touching on their own personal difficulties is a key technique.

If Jessica and Elaine can access some competent advice on emotion regulation and reflective functioning in abused and neglected children, and sort out any unresolved issues they themselves might have, Billy and the others may yet settle into a more trusting relationship with them. However, the neurological damage may be such that to regulate their emotions and function reflectively, some children need more than this. Medication may certainly help in the short term and psychiatric input at this stage can be very helpful. Alongside, or instead of this, explicit and intensive corrective emotional experiences beyond that provided by sensitive and containing daily caregiving may be needed. We do not yet know exactly which children or family contexts are most likely to need more intensive support (McCarthy, 2004). Nor do we really know why children within the same family, with similar experiences, sometimes end up with quite different attachment-disordered behaviour. Darren and Alec’s presentations illustrate this point.

The next stage suggested by those working with foster and adoptive families is for parents and carers to be coached into providing children who do not respond to ordinarily sensitive parenting with an exaggerated form of sensitive parenting (Hughes, 2003). However, it may be that Alec, for example, settles to
family life in response to this kind of exaggerated parenting while Billy does not. Jessica and Elaine then may require even more intensive therapeutic support with Billy. One way of achieving this would involve two or three weeks of therapy using specific techniques designed to maximise a child’s capacity for engagement in corrective emotional experiences. Arguments for these bespoke methods come from attachment therapists who advise more or less active methods (Howe and Fearnley, 1999; Minnis and Keck, 2003). These emphasise the difficult task of altering the neurological functioning of children who have experienced abuse and neglect and, as a result, struggle to attune emotionally to even the most skilled, sensitive and containing parents. Adoptive and foster families who are struggling to stay together can certainly find some of these specific approaches helpful (Archer and Burnell, 2003; Huntington et al., 2004). However, it is important to remember that these active methods incorporate a whole range of therapies that are more or less structured, directive, intensive and intrusive. At their most extreme, they involve the forceable ‘therapeutic’ holding of children by parents or therapists against the children’s expressed wishes. On ethical grounds alone, these methods should not be recommended. It has still not yet been established in research terms whether other intensive methods are appropriate for children or for the longer-term success of family life (eg Archer and Burnell, 2003). Particular concerns have been raised over the risk of retraumatising children who have been physically or sexually abused through such therapeutic approaches and considerable caution is advised (O’Connor and Zeanah, 2003; Department for Education and Skills, 2004). Arguably, the debate about attachment therapy suffers from some quite different therapies being grouped together under the emotive concept of ‘holding therapy’ (Steele, 2003; American Academy of Child and Adult Psychiatry, 2005). Nonetheless, it is not possible for us to recommend the use of the more intensive and intrusive interventions as a viable therapeutic strategy. The demand for these, however, demonstrates just how desperate people are.

**Enhancing behaviour management skills**

Evidence suggests that most children who display behavioural difficulties can be helped when their own parents or carers improve their behavioural management skills (Scott, 2002). We know from research studies that adopters and foster carers want this kind of support but do not always get it (Schofield et al., 2000).

As we have seen in the case study, disturbed child behaviour and emotion, both internalised and externalised, need to be managed effectively if family life is to become more settled and enjoyable. Given the often difficult, inexplicable and severe behaviours of many adopted or fostered children, strategies and skills must be learned and tried out with the guidance of skilled practitioners, including experienced adoptive parents or foster carers. Again in relation to our case study, there is much work to be done here. For example, Jessica would feel more confident about having her friend Diana round if she had some specific strategies to cope with Alec’s excessive clinginess, Darren’s promiscuity and Billy’s incontinence. At the moment she is simply overwhelmed and bewildered. A number of popular and clinical texts suggest specific parenting techniques for use in adoption and fostering (van Gulden and Bartels-Rab, 1995; Archer, 1999a, 1999b; Keck and Kupecky, 2002). Agencies are increasingly finding that these techniques can usefully be learned through psycho-educative support group approaches (Hart and Luckock, 2004, p 128). However, sound empirical evidence on the effectiveness of these methods in adoption and permanent foster care is still awaited.

In the absence of group support, some simple advice could make all the difference for Jessica and Elaine. They might, for example, be helped to see that everyone would find it easier if Jessica had a friend round when Elaine was there too, or if Jessica’s reunion with her friend took place outside the family home. Broaching this discussion would also enable Elaine’s persistent absences to be addressed. Furthermore, Jessica could have been
advised to contact Diana before she comes round to suggest some explicit strategies to manage the children’s behaviour. Darren’s promiscuity might be dealt with by Diana telling him kindly that Jessica is his mother and that it is to her that he should demonstrate his principal affections. She could then lead him gently back to Jessica whenever he approached her. Taking an adoptive and foster family practices perspective can lead to empathic understanding on the part of the therapist about just how much hard work goes into behavioural management and planning for families to get through simple daily activities that others take for granted.

Facilitating social participation
Working with the above objectives in settling Alec, Darren and Billy at home should have a knock-on effect beyond the family front door, but more explicit strategies will be needed to facilitate their wider social participation. This is because adoption or fostering affects the way children and parents/carers alike find their niche in the wider social context of family and community life. Children can feel victimised or simply isolated in their difference in their social relationships beyond the home. This is not just related to their adoption or fostering status per se. Adoption, in particular, often brings the most socially excluded children together with privileged adults, and other differences, for example those of race and sexuality, can also play a part. Although differences in racial identity are not a feature of our case study, others are. For example, Jessica and Elaine are university educated and inhabit a social world of middle-class professionals. They are also active in their local gay and lesbian community and have their own experiences of social exclusion to contend with. While this new world brings the children many advantages, it also presents them with challenges. Such cultural dimensions are powerful vehicles for their narratives and practices of family and community life. Alec attends a school for children with moderate learning difficulties and all but one of his classmates are from working-class or very socially excluded backgrounds. None of them have three mothers quite like his, but four are in foster care. Finding out what everybody makes of Jessica and Elaine selling the raffle tickets at Alec’s school play would be one way of exploring the impact of these kinds of dynamics.

Discussions such as this will help clarify each time whether it is differences in culture, adoption/fostering per se, troublesome behaviour and/or learning difficulties that accentuate the children’s difficulties with social participation in a way that is most problematic (Thomas et al, 1999; Engels et al, 2002). Parents with children who are so obviously different have to find ways of securing their place in the larger community of local parenting. In both cases, therapeutic support can help in the development of effective social strategies. It can be especially useful when it actively involves other people from the various social worlds in question, such as school (Twemlow et al, 2002). Some CAMHS therapists, particularly those with a systemic background, embrace the challenge for therapeutic engagement in schools and there is strong policy backing here too, as the National Service Framework exhorts CAMHS to increase their involvement in children’s lives beyond the consulting room (Departments for Education and Skills and Health, 2004). However, the particular circumstances of adoption and fostering demand specifically attuned therapeutic responses in relation to wider social participation.

Conclusion
This article set out and elaborated on what we see as optimum core principles and objectives of specialist therapy with adopted and fostered children for whom permanency is the plan. We hope that social workers and other practitioners might also draw on these ideas to inform their work with families, including their decisions about referring children for specialist therapy. By using a fictional case study to illustrate the family practices approach, we drew attention to the distinctiveness of adoptive and foster family life. Core principles we emphasised were: offering prompt attention;
avoiding assessment paralysis; and achieving continuity of practitioner and agency. Making therapy fit conveniently with adoptive or foster family life was also highlighted. This can only be achieved by appreciating its distinctiveness.

When it comes to defining core objectives, we stressed the aim of helping parents and children manage and accommodate the distinctiveness of adoptive or foster family life. Five objectives were outlined in order to achieve this: explicitly promoting resilient family practices and narratives; enhancing emotion regulation and reflective functioning; enhancing behaviour management skills; opening family communication; and facilitating social participation.

The enhancement of emotion regulation and reflective functioning together with improving behavioural management skills are familiar aims of therapeutic practice as outlined in research and practice texts. Explicitly articulating the other three objectives as part of an integrated therapeutic approach to settling children presents a fresh approach to conceptualising therapeutic practice.

At the heart of our approach is the challenge for therapists to attune to adoptive and foster family practices. Only then will children like Alec, Darren and Billy be helped to sustain relational narratives of family belonging classifiable as something more hopeful than a symptom of Reactive Attachment Disorder.

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