The 24 / 7 approach to improving outcomes for children affected by chronic trauma and dissociation

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Introduction

> 'All truth passes through three stages. First, it is ridiculed. Second, it is violently opposed. Third, it is accepted as self-evident' (Schopenhauer, 2004, p.73).

Perceptions of childhood have changed over time. In the nineteenth century, for example, children were seen as miniature adults (Aries, 1962). Now they are seen as distinct individuals with an inner world which is very different from the adults who care for them. The same could be said of our understanding of childhood trauma. Over time, various clinicians have theorised about psychological and emotional distress observed in children, but it is only in relatively recent times that they began to attribute some of the causes to early childhood experiences of neglect and trauma. Chronic trauma relates to recurrent exposure to major stressors over time, such as child abuse. Evidence now supports that chronic trauma increases the risk of dissociative disorders (Hart, Nijenius and Steele, 2006). Researchers are now beginning to postulate that dissociation is the key concept to understanding trauma.

The idea of dissociation is misunderstood and, at times, inappropriately used. Dissociation was initially referred to as a division of the personality or consciousness (Janet, 1887) which involved divisions among 'systems of ideas and functions that constitute personality' (Janet, 1907, p.332). It has been described by Briere (1992) as a disruption in the normally occurring connection between feelings, thoughts, behaviours and memories in response to trauma, to reduce the psychological distress both during and after the traumatic event.

In 2004, a report was published by the Scottish Executive on the mental health of young people in residential care in Scotland (Meltzer, Lader, Corbin, Goodman and Ford, 2004). Among the report's findings were the following:

- 45% were assessed as having a mental disorder
- 38% had clinically significant conduct disorders
- 16% were assessed as having emotional disorders – anxiety and depression
- 10% were rated as hyperactive

Some of these mental health indicators are symptoms relating to chronic trauma and dissociative disorders (Terr, 1991; Putman, 1993). Given the high numbers of children and young people in residential care who may be affected by these issues, it is important to examine approaches to working with them.

This paper discusses a therapeutic model used with Care Visions for working with children and young people who have experienced chronic trauma and dissociative disorders. This model is based on a therapeutic milieu approach in which the relationships the child has within small therapeutic group residential homes are harnessed to improve outcomes for young people. The model emphasises the importance not only of the quality of the relationships but also the quality of the environment. A positive experience of both can improve the therapeutic outcomes for the child. In this way the Consistent, Attuned, Reframing new Experiences (C.A.R.E.) approach becomes 'the therapeutic footbridge which the child or young person can use to step onto a path of feeling, knowing and finding one's self' (Shirar, 1996, p xi).

The basic foundations of C.A.R.E.

Many of the children with whom the author has worked in residential care have experienced severe disruption in their early years of development, as well as high levels of neglect and abuse. The child's world has often been characterised by chaos, and staff need to work hard to establish a basic foundation to act as a platform for work. The creation of this basic foundation is about providing the very fabric of experience and containment that the traumatised child needs to recover and develop. One way to provide this structure is through basic care. Hence, one of the key messages about any therapeutic approach is not to forget basic needs. Seemingly small and insignificant acts, which staff may take for granted when they are used to performing them on a daily basis, can be crucial in sending a message to a child that they are safe (for example eating well, staying warm and clean, and attending to health). No child who has experienced trauma and who may use dissociation to cope with the effects of trauma is going to heal and learn to use different ways of coping without first feeling secure. Donavan and McIntyre (1990) point out that verbal reassurance is rarely enough for a child and that they first need to experience safety and environmental protection in order to *feel* safe. For children who have experienced chronic trauma, the importance of environmental interventions cannot be overemphasised and are viewed as essential (Shirar, 1996, p.146), in terms of providing the stable and safe place from which therapeutic work can be undertaken.

Traumatised and dissociative children can be hypersensitive to change due to their past experiences of unstable, disorganised and chaotic environments. Sadly, this can be replicated when they become looked after. For example, many children experience a repeated pattern of placement breakdown prior to coming into a residential unit. In order to help them cope with change, they

therefore need a stable physical environment and clear-cut daily routines and expectations (Putman, 1993). The stable environment is transmitted to the child through the consistent approach of staff to their care. Stability is also represented by the internal fabric of the unit. In psychotherapy, for example, it has been acknowledged that even the slightest changes in the therapy room can increase anxiety for the chronically traumatised client. Therefore, if the internal fabric of the house is being changed, this should fully involve the child, so that they understand fully what is happening, why it is happening and also be part of the process.

To provide a sense of safety, another crucial aim is to provide a culture of *unconditional care* and be there for the child for the long term. This means putting boundaries in place and communicating about unacceptable behaviour in a way that helps the child's understanding. Unconditional care not only provides safety but also an environment that is nurturing and able to provide comfort. It provides a potential space where it is safe to think about the trauma, experience feelings about it and create the correct 'holding environment' where healing can take place (Miller, 1993; Ward, 1998). This means that the adults responsible for the child's care have a huge responsibility to be there to care for them, *not just some of the time* but all of time. In effect, the staff become part of the therapeutic parenting team.

In this way, the milieu or *life space* in a group living environment becomes a focus for the staff to use daily events and processes as part of therapeutic work. The care staff can provide a responsive environment which manages the boundaries within which the child behaves. This will ultimately assist the child to manage and regulate their internal affect.

As we have seen, dissociation is utilised to protect the individual from overwhelming anxiety. This is illustrated in the following quote:

> Without realizing it, I fought to keep my two worlds separate. Without ever knowing why, I made sure, whenever possible, that nothing passed between the compartmentalization I had created between the day child and the night child
>
> (Van Derbur, 2004, p.26)

An alternative reframing environment should be created by staff to help the child to alter their perception of the world and of self. In this way trust in the outside world becomes the foundation for self-trust and self-care as the child or young person grows and develops. It is essential that staff strive to create a safe place in the real world so the child does not need to retreat to their inner world. The C.A.R.E. approach embodies the notion proposed by Heard and Lake (1997) about 'supportive companionable' relating within a safe environment.

The importance of understanding the child's behaviour

A child who has been abused carries around a set of habitual expectations and responses specifically designed for survival. The child has developed mechanisms and behaviours to provide themselves with a sense of safety and control in situations where they had none. Staff continually strive to make sense of the child's behaviour. This pattern is called a *trauma bond* (Herman, 1992; James, 1994).

Staff at Care Visions do not take any of the behaviour personally (for example, angry acting out). This can be particularly difficult when the child is violent, damages the carer's property and attempts to test the messages provided by the adult. By reframing the child's behaviours, one can see these as opportunities to undertake meaningful work and to question where the behaviour fits into an old pattern. In this way, staff arrive at a better understanding of why the child copes in a certain way.

By reframing, staff learn to view the behaviour as the child's way of communicating, and are then able to use this understanding to help inform formal therapeutic interventions.

If behaviour is seen as a type of communication, it may be asserted that some behaviours only occur if formal communication breaks down. This can be a challenging concept, but by looking at violence as communication, for instance, it provides an opportunity for reflective practice that staff can harness to improve inter-relational understanding and outcomes for the child.

For staff to be able to make sense of the extreme transference and chaos within the child's inner world, they must remain grounded and self-aware. In doing so, they are able to react calmly and non-punitively in the face of a child's anger and anxiety. Support structures in Care Visions such as supervision and team meetings are utilised by all staff. In such meetings, the focus is on processing and ensuring understanding of dynamics, feelings, and how best to meet the child's needs (Tomlinson, 2004).

The experience of the child in a particular interaction is important, but positive interventions also depend on how the staff member can make use of their sense of that interaction for the benefit of therapeutic work with the child. The staff member then has greater ability to become attuned to the child's subjective experience, and can make sense of those experiences. In this way, staff develop an improved ability to communicate them back to the child through the subtle nuances of behaviour like eye contact, tone of voice and other physical responses which arise throughout the day to help reframe the child's expectations and beliefs.

The skilful work based on the 'here and now' undertaken by the therapeutic residential care staff can help the child to cope with the internalised narrative of the past. The child views themselves as good or bad, smart or stupid, depending on what messages they have gained from their experiences. These are often heard in the child's dialogue; for example they may say, 'I am bad' or 'It's all my fault.' The messages that the child gains from the experience of therapeutic residential child care can slowly challenge and change the internalised messages received in the past. Staff should aim to help change the child's beliefs relating to self through natural positive reinforcement of the child's strengths and abilities.

The agency approach to assessment

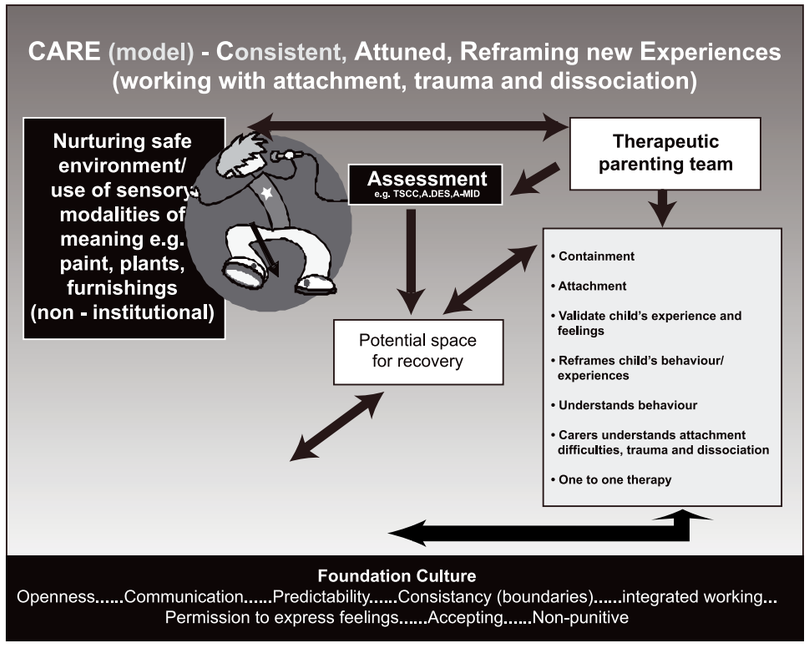
As can be seen a crucial part of the therapeutic residential care approach is the ability to understand and make sense of each young person's needs and behaviours. This is done by undertaking an assessment process which aims to construct knowledge of the young person's developmental history and current functioning.

This process is dynamic and ongoing throughout the young person's placement. This information is then used to make sense of and understand their current behaviour, and how this relates to their overall emotional and social functioning. This process takes place for all young people and within a culture of openness and informed consent from the outset. The process openly acknowledges the experiences of many of the young people who come to stay with at Care Visions and utilises appropriate assessments such as the Trauma Symptom Child Checklist, Adolescent Dissociation Scale, Adolescent Multidimensional Inventory of Dissociation and Child Dissociation Checklist.

Outcomes are also based on maintaining realistic expectations of children and understanding that children and young people within our care can regress to a younger age and will think and behave as a child much younger than their chronological age. As such, staff need to respond to the child at that level, and tailor the assessment process to account for this.

How does all this fit together (The C.A.R.E. model)

The aim of the C.A.R.E. model is to provide a Consistent, Attuned, Reframing intervention which creates new Experiences. Consistency comes from the provision of clear boundaries and consistent responses from staff. Being attuned means that staff are child centred, truly responding to the child in an individualised attuned way, and understanding the basis of the child's behaviour. Reframing means that every opportunity is harnessed to help reframe the child's past experiences in a natural, nurturing way. This in turn helps the child to understand and to benefit from new experiences. This approach not only forms the foundation for the therapeutic work but also helps the development of the child's integrated sense of self. A simple pictorial diagram of the approach is given below:



Conclusion

Richard Kluft in 1996 wrote:

> Although there are many important and compelling concerns in the dissociative disorders field, the recognition and treatment of youngsters with dissociative disorders deserves to be among its highest priorities (Kluft, 1996:12)

In this respect, I feel there are opportunities being grasped to improve outcomes relating to attachment, trauma and dissociation for children and young people within the residential environment if we:

- assure a safe and nurturing environment and milieu
- are accepting, non-threatening, non-punitive and able to maintain consistent boundaries
- train those involved in the care of the child about trauma, dissociation and attachment
- view regressive behaviour through our knowledge of the child's past experiences

- provide opportunities to reframe the child's perceptions of the world, others and self within the daily living environment.

The C.A.R.E. model bases itself on what we feel are the essential elements for the emotional wellbeing and child-centred care of children. As Hughes (1998) outlined, everything we do as practitioners can carry a message to the young person. In this way the child's daily experiences can become the very path by which they find their way through trauma and into a more hopeful future.

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