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Original Research Article

Therapeutic child care: Are we clear what we are talking about?

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Abstract:

The Hill View School provides therapeutic residential care, through its specialised therapeutic school, for primary aged children who have experienced early-life trauma. Despite children making significant progress whilst placed at the school the understanding of the term therapeutic child care is often misunderstood across both the school and the sector. This paper draws upon a case study of the Hill View School, including the experiences of children, their families, staff teams and senior managers who supported and interacted with them whilst they were placed at the school. Data analysis incorporates psychodynamic, reflective and phenomenological approaches to elucidate how misunderstandings associated with the term 'therapeutic child care' can, in part, be understood as an emotional defence against being in touch with children's traumatic early life experiences.

Introduction

This article draws on PhD research undertaken within the Hill View School (HVS), which focussed on how a therapeutic approach affected the capacity of children, who have experienced early life trauma, to understand and regulate their feelings and behaviour, whilst developing meaningful relationships. The original study explored the benefits and limitations of a therapeutic approach within the setting as well as how changes to children's behaviour were recognised by families, staff teams and the children themselves.

This paper focusses on one strand of that study, namely how the concept of therapeutic child care was understood by a sample of children, their families and the staff working with them.

The HVS, in central England, describes itself as a therapeutic, non-maintained, residential special school, with a purpose-built children's home. Up to 30



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primary¹ aged children, from across England, are placed for 38 weeks of the year at the school, though up to six of these children reside for 52 weeks in the children's home. The children are placed at the school by local authority social service and education departments, for a period of around three years.

The children placed at the HVS have all experienced adverse early-life experiences, which have often included abuse, neglect or experiencing or witnessing violence (Harriss *et al.*, 2008). Most have an Adverse Childhood Experience (ACE) score of at least five out of ten, though some are as high as seven, resulting in complex trauma, ambivalent and disorganised attachments and the breakdown of multiple previous placements, both family and educational (Onions *et al.*, 2025). The work of the HVS is to help the children build trusting relationships, make sense of their feelings and their behaviour and engage in educational and social settings (Diamond, 2009). This is achieved through a carefully structured residential therapeutic milieu (Diamond, 2009).

Therapeutic residential child care (TRC)

Within the UK, therapeutic residential child care is often reserved for the most emotionally traumatised children, within a range of residential schools and communities outside of the mainstream education provision, for whom foster care is not appropriate (Bullock, 2009; Burns & Emond, 2023). The children in TRC settings are often referred to as 'troubled and troublesome' (Bullock, 2009) or the 'most disturbed and difficult children and young people' (Ainsworth & Hansen, 2005). Their early-life experiences have typically led to them becoming 'children looked after', previously referred to as 'looked after children' (LAC), with many experiencing multiple placements before a specialised residential setting, such as the HVS, is considered (Macdonald and Millen, 2012; Stanley *et al.*, 2005; Ward, 2006; Whittaker *et al.*, 2023).

Despite the importance of understanding the role and impact of TRC, it remains an under-researched topic (Dooner and James, 2019; Kor *et al.*, 2021), with most of the available research focussing on short-term residential care outcomes (Dooner and James, 2019; Martinovich *et al.*, 2007) and a lack of clarity about what is meant by 'therapeutic child care'.

Lack of an agreed definition of 'Therapeutic'

Perhaps the most helpful definition, for the purpose of this study, is that proposed by Whittaker, La Valle and Holmes (2015):

Therapeutic Residential Care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education,

¹ UK primary school age is 5-12



socialisation, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources.

Although the term 'treatment' is often more associated with settings in the US it is also widely used within HVS, for example to describe the integrated therapeutic provision carried out by a group of multi-disciplinary staff to meet the needs of the child, referred to as a 'treatment team' (Diamond, 2009).

Despite Whittaker *et al.*'s (2015) definition, the lack of a consistent definition regularly stands out in the literature. Evidence suggests that, in the USA, the term covers a wide range of provision (Gallagher & Green, 2013), and in the UK there is similar, though less wide, diversity (Ward *et al.*, 2003), although there is a noticeable lack of information relating to these UK services (Bullock, 2009). This diversity of provision is recognised to include several variables, such as the theoretical underpinning model (Bettmann & Jaspersen, 2009; Bradley & Kinchington, 2024), the duration of the placement, and the length and type of therapy (Curtis *et al.*, 2001). Many organisations describe themselves as offering TRC, with each developing their own models of practice. Accordingly, there is an underinvestment in staff training (Bellonci & Holmes, 2021), which, in England, is too often focussed on meeting mandatory standards rather than providing a clear therapeutic underpinning to the work (Roberts & Davidson, 2023). The literature relating directly to the HVS, for example Diamond (2018), suggests the issues of investment and development of staff training have been recognised and addressed as part of the HVS's model of practice, and linked directly to the HVS's training programme. However, the literature clearly highlights that this approach is based on the HVS's own work and not widespread, unlike other countries including Scotland (Smith, Monteux & Cameron, 2021).

Methods

Research Design

To understand the HVS's model of therapeutic work a case study approach was developed. The case study approach was selected as it would allow the research to capture the complexity of a primary case, the HVS, by investigating a phenomenon in its real-world context, and this would be particularly appropriate given that the boundaries between context and phenomenon are not evident (Yin, 2014). The case study approach was also chosen because it is associated with the exploration of processes and dynamics of practice, and because it was important to this study to understand the organisational context.

Following a short pilot-study, the participants in this research were identified as a sample of four children, their parents and carers, staff working with the



children and families and members of the school management team during an 18-month fieldwork period.

Ethics

Formal ethical approval for the research was granted by the Institute of Education/University College London ethics board, as well as by the senior leadership team of the HVS, prior to undertaking the research.

Consent was considered from the perspective of all participants, being gained by having participants 'opt in' to the study to enable respect and to encourage their free choice (Alderson, 2004). Consent was clarified as lasting throughout the data collection and dissemination period, with participants reminded and shown their consent form, before commencing each interview.

The potential risks to participants were considered to include issues of embarrassment, feelings of intrusion of privacy, fear of admitting anxiety, the risk of feeling coerced into participating (Alderson & Morrow, 2014) and the impact of discussing potentially traumatic histories. To ameliorate some of these risks, formal and informal opportunities for participants to decline participation were incorporated throughout the study (Mason, 2004), and children and families were made aware that their decision to participate, or withdraw, was not linked to the children's placements, and what they said would not be fed back or impact upon their placement. This was felt to be particularly important when interviewing the parents and carers.

Each participant was made aware that they could be directly quoted in the final thesis, and subsequent papers, and that brief details of their lives may be included, under a pseudonym. Given the small sample, of four children, it was explained that children and staff may be able to identify themselves, but that details would be anonymised as much as possible to prevent external readers identifying children, families or staff members.

Having gained ethical approval, parents and carers were interviewed as couples, though one was a single woman. The foster carers were all experienced and intended to continue with a long-term placement with their foster child. All the participants described themselves as white British, which also reflects the overall ethnicity of the HVS staff team, though not the child population.

Sources of evidence and analysis

The primary case study used multiple sources of evidence: literature, in the form of archival data and document analysis, primarily case files which allowed contextual data to be gathered. Having constructed a written profile of each child, semi-structured interviews were developed for each of the children, their families and staff teams. These ranged from 30 to 90 minutes in length,



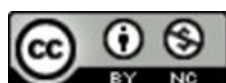
depending on interviewees, and all were recorded and transcribed. This data was further supported by ethnographic observations of each child spread over the course of the data collection period. The semi-structured interviews with children were supported through the use of imagery created and shared with the children.

Initially six children were identified based on criteria to try and ensure they reflected the range of family placements, gender, age and placement. Data from four, see table 1, were used allowing two reserve cases in case of drop-out. Although each of the four children participated in three interviews, they, unsurprisingly, often found directly answering the questions difficult; they changed the conversation, wanted to move around and, on occasion, they left. This meant the data contained fewer direct quotes from the children, but their avoidance of specific topics was, in itself, considered significant data. Two interviews were undertaken with parents/carers of each child and two focus groups with between eight and twelve staff members undertaken, again in relation to each child. Lastly, individual interviews were undertaken with three, long-standing, members of the senior leadership team, none of whom, at the time, worked directly with the children or families involved.

Participant	Family placement	Gender	Age at start of data collection	Months into placement	Number of family members involved	Number of staff members involved in study
Leo	Birth family	Male	10 years, 6 months	6	1	8
Lola	Fostered	Female	7 years, 4 months	8	2	10
Jamie	Adopted	Male	9 years, 10 months	15	2	11
Kerry	Birth family	Female	10 years, 11 months	9	2	9

Table 1: Participant placement type, gender, age, duration into placement and number of family and staff members involved in the study.

Once the data was collected, a phenomenological approach was adopted to the analysis in order to gain depth by giving emphasis to participant's descriptions of their experiences, rather than adopting a definite 'cookbook of instructions' (Keen, 1975), and allowing the study to go beyond 'experience' drawing on 'the



participants' perceptions, feelings, and lived experiences' (Guest *et al.*, 2012). However, the analysis also drew on psychosocial methods as a secondary framework, a model with strong links to psychotherapy, counselling and group relations. As such, it is a thread linking ideas such as Bowlby's attachment theory, Bion's ideas about group functioning, Winnicott's ideas of holding and containment and the psychoanalytic understanding of the unconscious (Frosh & Baraitser, 2008), all of which are described as information the HVS' therapeutic model. These models were felt to complement one another and offered a research design that would prevent or restrict my own biases (Groenewald, 2004). This approach also allowed my counter-transference (my response to the transference from others) to inform my reflexivity (Jervis, 2009), thus giving greater insight and the recognition of emotional and relational processes (Froggett & Briggs, 2012).

Discussion of Findings

Within the data, several themes were identified which helped develop insight into how the term 'therapeutic child care' was understood by children, families and staff as well as the factors which might contribute to this understanding. For the purpose of this paper attention is given to two particular themes:

- Understanding the language
- Defences against anxiety

Understanding the language

When speaking about the children's life histories, all the parents/carers gave clear examples of the significant emotional trauma their child had experienced. However, understandably, they had a limited understanding of the impact of these traumatic episodes on the children's emotional development and behaviour; consequently, the children's understanding was also limited which felt appropriate to their age. It was apparent from the family narratives that, at times, the children's violent and impulsive behaviour drew attention away from their emotional trauma and that this had been a pattern throughout previous placements.

He was always hitting people and getting into trouble, getting sent home and stuff. I told them about what he'd been through but they didn't seem to care (Leo's mother – interview 2)

The term 'therapeutic' was noticeably absent from interviews with the children and families, none of whom made any direct reference to the therapeutic nature of the HVS and who, often, appeared confused about the therapeutic nature of the HVS:

I don't think we were quite sure about what it meant, no. I didn't really know what it meant to be honest. We did some research



on the school. We were looking on the websites, we visited here, to try and get a feel of it...and the social worker told us a bit. That's before it had been decided whether the funding was available. I don't think we had a very clear understanding of what a therapeutic school was, or what that involved...When he first came to us he seemed OK but then he started to get really difficult and we didn't know why. We thought maybe we were doing something wrong... (Jamie's mother – interview 1)

Because it's quite a tricky place to describe. Yes, they kind of tell you, 'This is what we do,' but I think until she was actually there, and you could actually see what it was. Then they would have meetings, and they would explain what they've done, what they're doing. I think you can't really understand it until they're actually there. (Kerry's mother – interview 1)

For some parents, the word 'therapeutic' referred to direct provision from a specialised therapist, rather than to the 24-hour-a-day therapeutic milieu which the HVS aims to provide, and which is integral to their work (Diamond, 2009).

Well, I've been told that the therapy will come after her initial time, 12 weeks or whatever, and then they'll see what therapy, if she needs it, is there for her then. Music, drama, all these sorts of things. (Lola's foster mother – interview 1)

Leo's mother was also unsure of the therapeutic input at the HVS, but described her son's previous school:

The last school: they had a therapeutic room, where they had waterbeds, 'touchy-feely', and an open-air heated swimming pool. It was actually the best thing you'd ever seen on the grounds. It was absolutely beautiful. Leo was quite pampered. Leo was quite spoilt there, to be honest, to the extent of the foot massages and the oil rubs. (Leo's mother – interview 2)

The comments from Leo's and Lola's parents appear to suggest what was expected by the term 'therapeutic' at the HVS. Previous experiences and placements had involved a set number of sessions with an individual therapist for each of the children. These had typically been provided by external services, such as CAMHS, and were brought into schools or therapy centres.

It should be recognised that the understanding of many parents/carers, and perhaps staff, was linked to a number of factors, depending on not only their ability to understand potentially complex concepts but by their own emotional needs and experiences. For example, a family at emotional and physical breaking point, which in different ways they all described themselves as being



at, may appear as just needing a break or placement, without showing a detailed interest in the placement's underpinning model of practice.

To be fair, I don't know what I was told. He'd been at home for so long we were, like, at breaking point... I just needed somewhere that could look after him, everyone else had kicked him out... (Jamie's mother – interview 1)

Whilst it may be unsurprising that parents and carers did not have a comprehensive understanding of the therapeutic approach, this could be seen as being at odds with the school's described model of working. It should not be assumed everyone will, or should have an identical understanding, however, if parental involvement is core to the school's therapeutic approach (Diamond, 2013), it should be considered there is the potential that a limited, or confused, understanding from parents and carers may impact their ability to fully engage in the work. Whilst the data highlights a limited understanding of therapeutic child care, it is important to recognise that the data does not question the overall effectiveness of the therapeutic model.

Staff understanding differed from that of the parents, which had been expected in part due to them undertaking specific therapeutically informed training (Roberts & Davidson, 2023). Most staff seemed clearer about the therapeutic milieu on which the school is based – though the term 'therapeutic' was also noticeably absent from staff focus group interviews. However, the language used differed between the care and education staff teams, with education staff making more reference to children 'attending therapy', despite the therapeutic milieu overarching the entire day. This suggests a possible split between these two staff teams, with a potential lack of shared understanding of the HVS's therapeutic approach. This may be understood as the education team have a greater focus on 'educating' the children.

...I think we do all work in a therapeutic manner, we always support the children to attend their therapy and let them talk afterwards if they want to... (Teaching Assistant, focus group 2)

Whilst this may simply represent the difference in tasks between education and care team, it should also be considered whether this might represent an unconscious defence (Collie, 2008) against the emotional pain of working alongside the children.

Defences against anxiety

Literature specific to the HVS frequently discusses the school's therapeutic model (Dockar-Drysdale, 1968, 1973; Diamond, 2009; Onions et al., 2025). However, as highlighted, evidence of a clear understanding of the therapeutic approach was at times lacking from children, families and staff. Whilst, to some extent,



this was to be expected, an alternate way of understanding this difference is to suggest that it may not purely be due to a lack of understanding but may also be linked to the need to maintain an emotional distance, as a defence mechanism, from the children's trauma. Although the school's therapeutic model is relationship-based (Diamond, 2004; Turberville, 2018) the intensity of maintaining relationships, and remaining emotionally in touch with the children's traumatic feelings, can, for some, necessitate an unconscious drive to maintain an emotional distance (Ward & McMahon, 1998). The school uses a model of reflective practice to try and bridge this unconscious response, but this is dependent on individuals being emotionally resilient and open to reflective practice (Burns & Emond, 2023; Farrell, 2012; Price *et al.*, 2018), including being open to the idea of having defences.

The idea of defending of an unconscious emotional defence can be related to all those involved in the study, including, potentially, the organisation as a whole. For the families it was important that consideration be given to whether they may have experienced their own trauma (Cook *et al.*, 2005), either directly or through the child's trauma and how this might impact them. For example, Leo's mother spoke about how his life experiences were traumatic for him but had also led to the rest of the family being '*really distressed and impacted*' and being '*ready for him to move out*', desperate for the HVS placement, without being clear what the placement would involve. Both Kerry's and Leo's mothers recognised that the therapeutic work had been explained to them, but that they had not been able to fully think about or understood it due to being at '*breaking point*'.

They might have told me, I don't know. I hadn't slept and no-one was listening to me. I just needed some help... it felt like lots of people were saying stuff, but no-one listened to us and I don't really know what they were saying. (Kerry's mother – interview 2)

This sense of not being heard, at differing levels, was apparent for all of the families, as was the families experience of emotional exhaustion before their child's placement. This emotional exhaustion may also help understand their limited understanding of the therapeutic task. The evidence suggests them being emotionally unavailable to new information, perhaps through sheer exhaustion and frustration but perhaps also unconsciously being unable to take anything else on due to the emotional experience.

In therapy or in a therapeutic environment?

The lack of understanding of the therapeutic task was also highlighted when discussing the difference between being in 'therapy' and being in 'a therapeutic environment/milieu'. Professional documentation for each of the four children referred to prior individual therapy, provided by a qualified therapist, which had



ended, and the subsequent need for a therapeutic placement. However, there was contradictory evidence about whether the professionals understood the difference between the two.

This difference was also identified in the interviews with families/carers, particularly Leo's and Lola's, who were unsure why the children did not have individual therapy and felt they did not know what a therapeutic school was.

I thought she would have a therapist like she used to but that didn't happen for a while...I don't really know where the therapy happens, but I can see she's making progress (Lola's mother - interview 2)

Although Jamie and Kerry acknowledged that they were currently meeting with a particular therapist, none of the children could articulate what made the HVS therapeutic. Given the children's age this was not unexpected. Leo suggested that his previous placement had '*been more therapeutic 'cos they had a swimming pool I could use when I got angry*', suggesting he could recognise that an activity, swimming, was beneficial when he was angry. However, this is a more practical definition of 'therapeutic' than those considered in the literature review (Haigh, 2013; Whittaker *et al.*, 2016), further attesting to the lack of clarity surrounding the term. We need to recognise that therapeutic work involves emotional as well as the more practical aspects our work, for example being aware of feeling states (Price *et al.*, 2018) and matching body based and sensory interventions to children's needs.

The lack of reference, from many staff, to the term 'therapeutic' was felt to be significant. From the staff focus groups, it was clear that those who discussed the terms more were the senior staff, who were generally more distant from direct work with children and families.

We have quite a clear model and the treatment teams discuss and plan the therapeutic needs of the children, though it is different between the children... (Senior member of the residential side of the school – focus group 2)

This suggests that newer, or less senior, staff perhaps have less confidence in discussing the therapeutic model, or, have undertaken less therapeutic training. However, an alternative consideration might be that newer staff have less understanding of the unbearable feelings projected onto them (Reber, 1995) and that this may be understood as a potential means of protection from the anxiety and pain of the work (Bateman *et al.*, 2000).

In contrast to the data from children, families and some staff were the views of some senior staff, principally management and trustees, who stated that the school has a clear therapeutic model articulated through its training programme,



practice and written documentation. These views were supported by the analysis of documentary evidence, suggesting that it may not be that the therapeutic model is unclear, but rather that it is not always articulated by the HVS in a manner that supports understanding.

The therapeutic model of the HVS is built around the need for relationships. Diamond (2004) argued that staff should avoid overly close relationships which might become dependent and instead aim for a more measured emotional distance within these relationships. However, this concept was inconsistently understood or practised by staff. Staff in the care team, particularly keyworkers, indicated closer relationships – similar to those described by Dockar-Drysdale (1990) – than education staff and, naturally, those who did not work directly alongside the children.

My key-child finds it really hard when I'm not here and waits until I'm on shift to tell me stuff which can be difficult. It would be good if they could talk to the rest of the team but that is sort of my role I guess. (Key worker – focus group 2)

This suggests that written models of working may be articulated but not necessarily operationalised by staff working alongside the children.

One further way accounting for this understanding, while linking it to the ambiguity about the therapeutic model, is that, there perhaps exists an organisational defence against clarifying the exact nature of the work. For example, if work is too clearly defined, staff may be left holding the overwhelming anxieties of the children. Thus, the lack of clarity in the 'therapeutic model' may serve as a defensive function and help to understand the lack of understanding of the therapeutic model. Of course, these findings may be explained more basically as 'things are unclear' and 'children are anxious', but this seems rather simplistic, akin to looking only at the behaviour, and not recognising the communication behind it. It is difficult to comprehend that in an organisation with such good outcomes (Gutman *et al.*, 2018; Price *et al.*, 2018) the understanding of the model is simply unclear.

Why am I here?

A further finding from the study, which links to the lack of understanding, was the lack of comments from the children relating to the reasons for their placement. All the children believed their placement was due to their behaviour. Both Kerry and Leo stated that their placement at the HVS was to enable them to '*behave properly*' and '*stop hurting people*'. This brought to light parents', carers and several education staff members' perceptions of the children's behaviour, which, for many, overtook the children's emotional trauma. Unsurprisingly, this meant the trauma and abuse became hard to discuss with more focus on negative behaviours – a point stated by staff working directly with



Kerry, Leo and Lola. The children focussed on their negative behaviours as some professionals and families had done prior to the HVS, rather than the underlying reasons for the behaviour. Although not directly discussing childhood trauma, the ideas of Menzies Lyth (1988) can help clarify this focus as a defence against the emotional trauma and a defence from staff. Taking focus away from the early-life complex trauma may, unconsciously, 'protect children' from it, and from the potential negative perceptions which may arise if it is brought to consciousness.

Conclusions

The evidence from the study suggests that, despite, the HVS having a long history of therapeutic child care, as well as excellent outcomes, the nature of the therapeutic model is inconsistently understood by children, families and staff. Given the wide range of roles and experiences of those involved in this study, variance in understanding therapeutic child care is not a surprise. However, given the frequency of this finding, and that it was apparent from all participants, possible alternate interpretations should not be ignored. The findings suggest that this lack of understanding may happen unconsciously, acting as a defence, creating an emotional distance between staff, and families, and the children's trauma. Whilst the work is rooted in the development of relationships the closeness of these can be emotionally overwhelming leading to such defences.

The lack of understanding of the term therapeutic is unlikely to be restricted to the HVS meaning there are implications for the wider child care sector, particularly those who describe themselves as therapeutic. If professionals and providers have an inconsistent understanding of the term there is a real risk that placements may not be matched to the true needs of the children, with an over-emphasis on the behavioural rather than emotional needs of children.

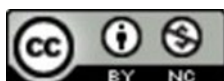
Until these issues are explored and acknowledged the national provision for children who have experienced early life trauma, sadly, risks failing to fully meet the needs of those children who have already been, too often, failed.

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About the author

Dr Dave Roberts qualified as a social worker in the late 1990's and is currently the Head of Learning and Research for The Mulberry Bush Charity, having worked in the field of residential child-care for 35 years. Dave has written and spoken nationally, and internationally, about residential child care, therapeutic work with children who have experienced early life trauma and professionalising the workforce.

