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Towards an understanding of the 'therapeutic' in foster care: an exploration of foster carers' capacities to help heal children with trauma

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Article

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Abstract

This paper explores foster carers' therapeutic capacities. This topic arises from advances in knowledge of the adverse effects of complex trauma on children's social, emotional and cognitive development. A growing expectation of fostering agencies is that their carers work within a therapeutic framework. Knowledge of foster carers' therapeutic capacities has importance, because while foster carers are the primary agents of therapeutic change for these children, the skills and processes in which they do so are not well understood. Eighteen foster carers who work within a therapeutic framework were interviewed about their perceptions of therapeutic care. Their responses were analysed using an ecological systems framework. Foundational to therapeutic care is the mesosystem, the relationship between the foster carer and the child. Key elements of this relationship are safety, trust and love. There are two other aspects to therapeutic care: the microsystem, which represents therapeutic capacities that foster carers exercise to help in the recovery of these children, and the exosystem, which includes the networks of support that foster carers require to exercise therapeutic care. This paper will present key findings relating to foster carers' therapeutic capacities. I will also consider some key implications for fostering agencies.

Introduction

Relationship as a therapeutic construct

After years of clinical work, Perry and Hambrick (2008) have found that the therapeutic experiences of a child are mediated by their relational environment. In the context of foster care, a key element of that environment is the relationship between a foster carer and child. However, a gap exists in the literature on the construct of this relationship, and what might be some therapeutic capacities of foster carers embedded in this. Rauktis, Vides De Andrade, Doucette, McDonough, and Rinehart (2005) found few empirical studies about the quality of the relationship between the treatment parent and the young person in treatment foster care (TFC), a form of specialised treatment and care operating in the USA since the 1960s and provided to vulnerable youth by trained treatment parents in their home. From 13 published articles arising from a literature search of scholarly journals from 1987, these researchers found that the quality of the foster parent–youth relationship received only tangential attention. Moreover, while research had focussed on the effectiveness of specific models of treatment foster care, there was little systematic inquiry of the treatment process in the context of a youth treatment foster parent relationship.

While Southerland, Mustillo, Farmer, Stambaugh, and Murray (2009) identified empirical evidence of a significant association between treatment outcomes of youth and their relationship with treatment providers, they found little research in the context of treatment foster care. However, in an observational study of TFC, these researchers found a significant association between the quality of the relationship between youth and treatment parent, and an improvement in youths' emotional and behavioural function. Their findings called for more research to be undertaken to 'unpack the salient components of the therapeutic relationship in these complex settings . . . ' (Southerland et al., 2009, p. 61).

In recognition that the relationship between a foster carer and child with developmental trauma is foundational to therapeutic change, a necessary starting point in exploring foster carers' therapeutic capacities is to consider key aspects of this relationship. Among those that emerge from the attachment literature are safety, trust and love. Because children with developmental trauma have lacked these relational experiences in the past, they need reimbursement of these by therapeutic helpers (Baker & White-McMahon, 2014).

These three interconnected aspects of a relationship are foundational to the exercise of foster carers' therapeutic capacities. Golding (2008) states that a feeling of safety is necessary before a traumatised child can benefit from anything else. Similarly, reparative work is only

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possible when the child experiences a pervasive sense of safety (Taylor, 2012). Apart from a physically safe caregiving environment, security – a concomitant of safety – can best be provided for a child through an available and responsive caregiver (Bowlby, 2005). Notwithstanding, forming a secure base with foster carers can be a challenging experience for a traumatised child, who has been unable to develop their attachment relationships as a secure base (Taylor, 2012).

Closely related to a secure base, and a second indicator of safety, is predictability. According to Hughes (2009), a child acquires a general sense of safety through the caregiver providing a balance of structure – for example, in routines and rituals – and flexibility that is attuned to the child's needs. Commensurate with the notion of relational reimbursement, Golding (2008, p. 141) claims that children who have experienced 'chaotic, unpredictable and unresponsive parenting will benefit from extra predictability and consistency'.

A second key aspect of the caregiver–child relationship is trust, which develops from a child having a secure base with a parent figure. A child will learn to trust through an available parent who can cope with their strong feelings (Golding, 2008). The development of trust has particular importance for a child who, when placed with a new caregiver, has a profound sense of mistrust arising from multiple placement breakdowns. A commitment of caregivers to a foster child is necessary to build and maintain his sense of trust in the relationship. Therapeutic parenting is about this commitment, which 'means loving despite his inability to love you back, offering securely and intersubjective experience through countless rejections . . . ' (Golding & Hughes, 2012, p.37).

Of importance in maintaining trust between the caregiver and child is the timely reparation of a breached relationship. To avoid feelings of shame and humiliation in a child arising from prolonged disconnection, repair and reconnection communicate to the child that the relationship is of more importance than the cause of the conflict (Siegel & Bryson, 2014). Reparation has particular importance for children who may be hypersensitive arising from their past experience (Golding, 2008; Hart, 2011), such as children in foster care. Golding (2008) claims that children who perceive their parent as being distant or preoccupied may attribute this to their self as bad, or the parent as mean. Moreover, such attributions may seem as proof to the child that they will experience further abuse or neglect, or that they will be removed from the placement. To counter such beliefs and to build trust, reparation can involve spending time talking to him 'about your emotional withdrawal . . . and offering him reassurance about your continuing availability . . . ' (Golding, 2008, p.120).

A third aspect of the caregiver–child relationship is love. Because children cannot connect with a caregiver in the absence of love, they are deprived of safety and security (Golding & Hughes, 2012). Moreover, Perry and Szalavitz (2008: 231) claim that:

> Because humans are inescapably social beings, the worst catastrophe that can befall us inevitably involve relational loss. As a result, recovery from trauma and neglect is also all about relationships – rebuilding trust . . . and reconnecting to love.

A challenge for caregivers, particularly at the commencement of a foster placement, is to provide a foster child with a sense of love in the absence of a pre-existing biological bond. Foster carers can do so through their acceptance of the foster child. Acceptance is having an understanding of the inner life of a child, such as their feelings, thoughts and beliefs without seeking to change those (Golding & Hughes, 2012). These commentators claim that what is accepted is the child's experience, which underlies behaviour, and it is by this acceptance that relationships with children are built.

A foster child's need to feel accepted by their carer has particular importance when she enters a foster home with a strong sense of mistrust arising from multiple foster placement breakdowns. However, because of the child's belief that she is not liked by the adult and will soon be sent away, acceptance of a child that leads to positive change is a slow and difficult process (Golding & Hughes, 2012). Hence, perceiving rejection from adults, she may dissociate 'from any developing feeling of closeness or trust' (Golding & Hughes, 2012, p. 97).

A second form of love, and closely related to acceptance, is in caregivers providing foster children with experiences of validation, which are often lacking in their past. As a relational reimbursement, validation can be the identification and use of a young person's individual strengths to motivate and encourage them during difficult moments (Baker & White-McMahon, 2014). Moreover, to communicate a child's importance, a caregiver can encourage micro interactions, which need not be long and be in the form of a '"hello" or a "how is your day" . . . ' (Baker & White-McMahon, 2014, p. 97). To help children feel valued, caregivers can provide them with praise and rewards (Taylor, 2012). Validation can also take the form of carers spending time with their child, which after difficult episodes helps her to feel valued and loved (Golding, 2008).

While acknowledging that this review of the foster carer–child relationship is not exhaustive, the interconnected aspects of safety, trust and love are integral to this relationship. Moreover, it is within this relationship that caregivers can exercise therapeutic capacities that can bring healing to children with developmental trauma. Mentalising provides a theoretical perspective in which caregivers can do so.

Towards a mentalising approach in caregiving

While the noun *mentalisation* is more widely used in the literature than the verb *mentalising*, the verb better captures that it is something we do, and a skill that all of us can learn (Allen, 2013). In doing so, a key implication is that caregivers do not need to be trained as psychotherapists to engage in mentalising with their foster children (Taylor, 2012). In taking the lead from Allen, this paper uses the term mentalising; however, mentalisation is also used when citing literature that uses this form.

Fonagy, Gergely, and Target (2008) describe mentalisation using the context of the capacity of parents to understand and reflect on the infant's internal experience. In this context, attachment processes are vital to the child's growth in understanding of how mental states influence interpersonal behaviour. These commentators claim that mentalisation has an imaginative quality in that it relies on a perception and interpretation of intentional mental states that underlie human behaviours, such as needs, feelings, reasons and so on. Moreover, because we cannot know with certainty others' thoughts and feelings (Fonagy, 2006), mentalisation becomes real in being authentic and sincere (Taylor, 2012).

Fonagy and Target (1997, p. 690) posit that in the caregiver behaving towards the child as a mental agent, the child is helped to create mentalising models, and over time comes to develop 'a core sense of mental selfhood'. Of importance in this process is that in exploring the sensitive caregiver's mental state, the child is enabled to mentalise through finding 'in her mind an image of himself as motivated by beliefs, feelings, and intentions . . . '

(Fonagy & Target, 1997, p. 691). From 3 to 4 years of age the child begins to differentiate another's experiences from their own (Hart, 2011); making the behaviour of others both meaningful and predictable (Fonagy & Target, 1997). These abilities enable children to respond adaptively in interpersonal situations.

The impact of childhood trauma

Terminology used to describe trauma includes *complex trauma*, which clinicians may use to define trauma arising from multiple events during childhood (Golding & Hughes, 2012). The term *attachment trauma* is used to locate trauma in the context of the child's attachment relationships and to show how these impair their capacity to attain secure attachment relationships (Allen, 2013). The term *developmental trauma* (van der Kolk, 2005) appears to best capture the adverse effects of complex trauma on a child's development. These effects may include disturbance in affect regulation, unstable attachment patterns, rapid emotional changes, aggression towards self and others and not meeting developmental competencies (van der Kolk, 2005).

Developmental trauma can also adversely affect the prefrontal cortex and sections of the temporal lobes; brain areas that house the mentalising network (Taylor, 2012). One brain function affected by developmental trauma is emotional knowing, which includes not only knowledge of our own feelings, but also 'knowing about and understanding of others' feelings, moods and impulses' (Taylor, 2012, p. 89). A second, and related brain function affected by developmental trauma, is Theory of Mind (ToM), which is an understanding that one's thoughts, feelings or beliefs might be different to those of another person, and that those mental states of the other provide 'a good predictor of behaviour' (Golding, 2008, p. 232). If these abilities are delayed or impaired through adverse experiences of early relationships, multiple difficulties in social interaction can arise (Golding & Hughes, 2012).

Pears and Fisher (2005) found that 3–5-year-old maltreated children in foster care ($n = 60$) were deficient in emotion understanding (EU) and ToM, compared to non-maltreated children ($n = 31$) of the same age group living with their biological families. In accounting for the difference in ToM between the two groups, the researchers claim that, as the majority of the maltreated foster children were neglected, it is unlikely that they would have engaged with an adult, who used 'mind-minded' language, or with one who enabled an understanding 'that people can have different points of view' (Pears & Fisher, 2005, p. 62).

The adverse effects of abuse and/or neglect related trauma on a child's ability to mentalise, such as in the form of EU and ToM, mean that caregivers have a key role in developing these capacities. In doing so, neurological recovery is possible for these children as these mentalisating areas in the brain are changeable up until a person's early twenties (Taylor 2012). Notwithstanding, there appears to be a dearth in the literature on the ways in which foster carers can help children to do so, such as in the use of a core set of therapeutic skills. These skills not only build their relationship with the foster child, but also provide a skill base to enable therapeutic interactions with foster children, which help them to heal. Some skills and processes in which foster carers do so are described later.

Methodology

This paper presents some results of a PhD dissertation in progress, which investigates the perceptions that foster carers hold on therapeutic care. In doing so, this paper draws on interview findings to address two research questions:

- What might be some therapeutic capacities that foster carers could exercise in the care of children with developmental trauma?
- What might be some implications for fostering agencies arising from foster carers' therapeutic capacities?

Semi-structured interviews lasting from 1 hour to 90 minutes were conducted with a purposive sample of 18 foster carers across Western Australia and NSW. Foster carers recruited were those who worked with non-government agencies that adopted a therapeutic framework of care. In doing so, an expectation was that this cohort of foster carers would have formed impressions of what therapeutic care meant for them. An additional criterion was that foster carers had been providing care to a child for a minimum period of 6 months. It was the researcher's view that this period was sufficient to enable foster carers to reflect on their perceptions of therapeutic care for a particular child or children. In support of this inclusion criterion, a study by Rauktis et al. (2005) found that, after being in the foster home for 6 months, youth with moderate to serious problems showed an improvement in their level of alliance with treatment foster parents.

Approval to conduct the research activity was obtained from the University of Western Australia (UWA) Ethics Committee (RA/4/1/6806). Ethical issues identified in the application to the Ethics Committee included the possibility that fostering agencies, caregivers, foster children and other household members could be identified in quotes and stories contained in the PhD dissertation, and in publications arising therefrom. To minimise this possibility, the agency within which the caregiver fostered was referred to generically as the fostering agency. Pseudonyms were also applied to caregivers, foster children, other members of the foster household and to caseworkers working in the fostering agencies. Moreover, to minimise identification of these people the researcher where possible in writing up the interview data, decontextualised summaries of stories shared by participants.

A second issue addressed in the ethics application was the possibility that participants could become emotionally unsettled or upset, such as in the recall and sharing of difficult experiences in caring for, and building a relationship with a foster child whose behaviour was much affected by abuse and/or neglect related trauma. To minimise this possibility, participants were informed that they would have full control over what they shared with the researcher, and in their decision to terminate the interview at any time they saw fit. If a participant became distressed during the interview, she or he was to be offered the opportunity to debrief with the researcher following termination of the interview. No participant was observed to have experienced undue distress during the interview, and all interviews ran their full course.

The process of recruitment of participants involved the researcher identifying fostering agencies in Western Australia and NSW that adopted a therapeutic framework of care. In doing so, the researcher drew upon prior knowledge of the therapeutic frameworks of certain fostering agencies, and consulted the websites of fostering agencies to identify relevant programmes. Where fostering programmes met the inclusion criterion, the researcher phoned the manager of the agency in order to provide a brief overview of the research activity. If the manager expressed interest in the agency participating in the research activity, a formal email was sent to them about the purpose and procedure of the

research. The manager was also requested to consider contacting foster carers who might be interested in taking part in a research interview. Attachments to this email included the participant information form, participant consent form and the UWA Human Ethics Office letter of approval to conduct the research study. All carers deciding to take part in an interview were required to sign the consent form.

Each interview was digitally recorded and transcribed to form verbatim accounts. Transcripts were summarised to form a record of the researcher's interpretation of participant responses. To establish trustworthiness of the field data, a member check (Lincoln & Guba, 1985) was conducted in which typed transcripts and summaries of interviews were sent to each participant for checking, and making any amendments necessary.

In using an ecological systems framework informed by Bronfenbrenner (1977), excerpts from the interview transcripts were coded and organised within three systems pertaining to therapeutic care in a fostering context. As foundational to therapeutic care, the mesosystem represents the relationship between foster carer and child. The microsystem builds on the meso relationship to examine some key therapeutic capacities of foster carers. The exosystem represents the key sources of a supportive community that foster carers see as necessary for therapeutic caregiving. Common themes were identified for each system. For example, in the meso relationship, these included safety, trust and love. Sub-themes were also identified to show how these themes are manifested by caregivers in their relationship with foster children. Hence, in safety, these included providing a secure base for a foster child and having a predictable and stable caregiving environment. Organisation of interview data in this way helped to form an integrated framework of therapeutic care.

This paper explores the therapeutic capacities of this cohort of foster carers. In doing so, it recognises that these capacities exist within a broader relationship between caregivers and foster children that include the aforementioned key aspects of safety, trust and love. This paper will also articulate some key implications for fostering agencies arising from these findings.

Results

The results pertain to therapeutic capacities of participants as they emerged in the research interviews with this cohort of foster carers. They include exemplars of therapeutic skills that foster carers can use and two forms of therapeutic engagement with a foster child. Because the contexts and variables relating to interview excerpts cannot be fully known by the researcher, no claim is made that these represent the optimal responses by a caregiver. They do, however, provide exemplars of skills and engagements that may contribute to the recovery of children with developmental trauma. Moreover, in the researcher's view, they importantly demonstrate authenticity on the part of participants and a desire to act in the best interests of their foster children.

Therapeutic skills

While the therapeutic skills emerging from this research activity might be considered as standard skills used in a therapy session, the excerpts that follow show how they can be applied in foster care contexts.

Listening. One carer alluded to the notion that listening provides her foster child with a secure base:

> I do think that the key points is … letting the child come to you, being there to listen and providing that knowledge to the child that you are there to listen when they're ready; so that allows them to open up. (Fiona)

For another carer, listening to a foster child assists in building a relationship with her or him:

> So if I can learn five things about you (i.e. foster child) in the first day I feel I've got a base to start a relationship … Yes, just in general conversation, but the next day I can relate to it and they'll think 'Oh, she was listening', or 'I do understand them'. (Sue)

Attentional awareness. Some carers framed attentional awareness in the context of taking time to observe the behaviour of their foster children. One carer spoke of the importance of observation when a child is first placed in a foster home:

> … you have to observe for quite a long time, because you need to get to know these kids … what they like, and what they don't like, and how they live their day. (Gemma)

Another carer spoke of her ability to cue very quickly into a child's expression, such as when he or she arrives home from school:

> I'll have a good idea how they got on, cause you know the … expressions the minute they walk in the door. You know, you do cue in on things like that … You can tell their emotions. (Maria)

Seeking clarification. Some carers referred to the importance of asking questions when interacting with their foster children. Exemplars include a caregiver allowing her foster child to talk, before responding with some questions of her own:

> 'Well, how did that feel?' and 'What do you think about that?' (Tracey)

In response to a child's sadness about his past, one carer asked him:

> … what would that be like? What would help? (Bill)

Empathic responding. Some carers commented that their response to a child is informed by having an understanding of what the child has experienced in the past, or is currently going through. The following exemplars point to this capacity:

> You know when … somebody is really upset or sad … you should say, … I'm really sorry about it; you know, it must be difficult for you' … I think it's definitely important. (Helen)

> It's being able to understand the other person's perspective, and their experience of a situation … It changes your perspective, and it changes the way you might react about a situation, or how you might approach a situation. (Leanne)

Voice prosody. Voice prosody refers to the manner we say words to a person, such as in 'modulations of tone and intensity, latencies and rhythms of vocal expression' (Hughes & Baylin, 2012, p.149). Exemplars of voice prosody emerging from the research interviews include the following:

> … like she's just getting upset, and I keep this really sort of like calm tone of voice, … now she'll kind of sometimes like see that no one else is getting upset, and that I'm staying calm. (Tessa)

> I would stay calm when she would get upset, and have like a quiet voice and whatever; she finally would come to me for comfort. (Tessa)

Reflective functioning. Reflective functioning is described as 'the capacity to understand or describe both one's own and another person's behaviour in terms of underlying mental states and intentions' (Cooper & Redfern, 2016, p. 9). The following excerpt demonstrates a carer's reflective functioning in ways that informed her parenting practices:

> So if what I'm doing's not working, I'm not going to continue to do it. So then I go back and ... look for another way to manage the behaviours that I've got ... .So I guess reflecting, and then come up with a strategy that if it happens again, or I need to go back and mend what's just happened ... (Sue)

Therapeutic interactions

Because recovery from trauma occurs in the context of the caregiver–child relationship (Golding, 2008), more needs to be known about how these changes take place at the level of interaction between a foster carer and child. The following explores two types of therapeutic interactions that fall within the mentalising processes of emotion understanding and co-construction.

Emotion understanding. EU, which refers to one knowing their own feelings and those of others, is essential to one's psychological well-being and social competency (de Rosnay et al., cited in Karstad, Wichstrom, Reinfjell, Belsky, & Berg-Nielsen, 2015). Interview excerpts describe some ways carers help their foster child to better interpret emotions of self and others. For example, a carer, Maria, helps one of her foster children to put names to emotions through the use of 'feeling' cards that show different facial expressions of a bear. Neil, the 10-year-old foster son of another carer, Alicia, has the propensity to misinterpret others' behaviour towards him as that of anger. For example, he has done so when Alicia's biological son, Brett, chooses to read a book in his own room for a short while, rather than play with Neil at this time. Alicia will often explain to Neil that Brett needs some time for his self. For this carer, these types of conversations with Neil form part of her therapeutic care role.

Caregivers can also enhance their foster children's emotional understanding through an appropriate sharing of emotions. Due to the foster children of one carer having never dealt with death, they at first could not understand why she was so upset at the recent loss of two close family members. Because for this carer children learn about emotions by example, she explained to her foster children what these feelings meant to her in this situation:

> I'm very sad, because you know nanny has passed away, and ... I won't see her again. (Lilly)

Another carer believes it is important for children to learn that foster carers also have emotions and feelings. This carer will ensure that her foster children know why she is feeling a certain way, such as giving them a reason for her being sad on a given occasion. A failure to do so may lead a foster child to think that they are somehow responsible for how their foster carer feels. Hence, when her foster children noticed that she was upset one night, she explained to them that she felt sad, because her father was sick. She comments:

> ... instead of the children feeling nervous or anxious about what's wrong ... they sort of go 'Oh okay' (Beth).

A sharing of emotions can also model 'honesty and courage via acknowledgement of our own current and future mistakes' (Taylor, 2012, p. 92). A carer described this aspect of self-disclosure when her 3-year-old foster child noticed that she was upset after the carer had just learned that she had lost her mobile phone. The carer comments:

> And I was like 'I'm feeling sad' ... and I was like ... 'it's okay, because everybody makes mistakes, and it's gonna be okay, and I can just find another phone like'. Cause I thought I better say this now, because when she loses her shoe ... it's no big deal (Tessa).

Co-construction. Golding and Hughes (2012, p. 227) describe co-construction as a process of shared meaning in which a young child is helped by a parent 'to develop a coherent autobiographical narrative about his life and experience'. The responses of participants point to co-construction as an ongoing process of caregiver–child interactions, in which a child is helped to make sense of and ascribe meaning to their experiences.

In the following excerpt, a carer described how she responded when her foster children asked her why they could not live with their parents:

> Cause your mum's really sick from taking drugs. But when she's better, then who knows what's going to happen. But right now she can't look after you. (Sarah)

The same carer will also tell her foster children that while their parents are unable to care for them, they still love them:

> And we try to make that difference for the kids ... loving you is not a question; they love you very much. They can't look after you, and that's different. (Sarah)

A foster child, Pippa, felt responsible for her birth mother no longer seeing her and questioned her foster mother on what she did wrong to bring this about. In a brief remark, the carer communicates the message to Pippa that she is not at fault:

> You're the child; she's the adult ... they should be more ... forthcoming ... (Tracey)

A carer in attending a final counselling session with her 11-year-old foster son, Derek, described how she and the counsellor helped him to question and reconstruct the perception that he was somehow responsible for coming into care. Prior to this session, the counsellor conducted some research on the events leading to Derek's entry into care and brought together much of what was said during the 2 years of counselling. In the final counselling session, Derek's foster carer and the counsellor talked to him about the responsibilities parents have towards their children. The counsellor informed Derek that the state protection authority had made multiple visits to the family home over a 6-month period to help his mother care for her children. The counsellor also mentioned that she could still be working to have Derek back, 'rather than ... undermining ... his relationship with the other carers'. The carer describes the effect of sharing this information with Derek:

> He was much more willing ... to acknowledge me as his carer, and his whole person changed; he became ... calmer. ... there's been a dramatic change in the number of ... tantrums, and ... outbursts and, and everything else ... . I think he realised that he wasn't to blame. (Gemma)

Aware of the existing bond between Derek and his birth mother, the counsellor and foster carer also spoke to Derek about his mother in a respectful manner. The carer comments:

> ... we also spoke about how his mum was very good at some things, but she just ... was unable to provide him with appropriate care, nor his brother ... we also in some ways let him let go of the notion also ... that his mother was to blame, because we also said for whatever reason mum's experience in life meant that she wasn't able to fully look after you ... (Gemma)

Discussion

While expecting foster carers to be therapists is inappropriate and unethical (Douglas, 2018), the responses of this cohort of carers support the view that, in the context of the caregiver–child relationship, foster carers are the prime agents to help these children to heal (Caw & Sebba, 2014). However, while caregivers are

expected by their fostering agencies to work within a therapeutic framework, the skills they use and how they interact with foster children are not well understood. The aforementioned therapeutic skills arising from this research activity could be conceptualised as providing some of the building blocks for caregivers to interact with foster children in ways that facilitate their healing from developmental trauma.

Among therapeutic interactions with foster children are those described earlier that facilitate emotion understanding of self and others. Alicia's routine interactions with her 10-year-old foster son, Neil, have helped him to understand that rather than just anger, people can experience different emotions. Moreover, these interactions represent a form of mentalising, which can assist these children in the processing and interpretation of new interpersonal experiences (Fonagy, 2003).

Foster carers can also facilitate a child's emotion understanding through appropriate self-disclosure. Because the literature on self-disclosure by foster carers is lacking, guidelines on appropriate self-disclosure by therapists with their client could be adapted to meet the contexts of foster care. For example, clinical lore and theory outline 'appropriate' as that which is beneficial to the client (Edwards & Murdock, 1994, p. 384). Long-standing sanctions against the personal disclosure of thoughts and emotions by therapists, such as those from psychoanalytic traditions, have since shifted to a discussion about the feelings, thoughts and impressions that might be usefully shared with clients (Bernstein, 1999).

Among the suggestions for appropriate self-disclosure by Knox and Hill (2003) include the judicious use of self-disclosure and that it be deemed helpful to the client. By parallel, in Beth's foster children noticing that she was upset one night, she explained to them that this was so because her father was sick. Apart from enhancing her foster children's awareness of her own thoughts and feelings – a mentalising process – these forms of self-disclosure alleviate for some foster children the sense that they are somehow responsible for how a foster carer feels. This was alluded to in Beth's comment, that in her foster children knowing the reason for her upset – her father was sick – relieved them of 'feeling nervous or anxious about what's wrong . . . '

An additional suggestion by Knox and Hill, and of relevance to the foster carer–child relationship, is to fit the self-disclosure in accordance with client needs and preferences. As foster children enter out-of-home care at different levels of emotional, cognitive and behavioural development, they require care adapted to their individual needs. A needs-based approach to therapeutic care, rather than a 'one size fits all' approach, was an emergent theme from the research interviews. Hence, a foster carer's self-disclosure needs to match a child's level of development, such as in the use of appropriate language terms, and voice prosody.

When used selectively, self-disclosure may convey empathy to a client, such as when certain patients have had early and repetitive experiences of being 'shut out of their parents' lives . . . ' (Goldstein, 1997, p. 48). Empathic connection to a client may be compromised when a therapist does not share information that is emotionally important for him or herself, such as grieving the loss of a loved one (Goldstein, 1997). Moreover, while the professional domain encompasses knowledge and skills, a requirement for staff in 'people work' is that 'they also bring themselves as whole persons to their work . . . ' (Petrie, 2011, p. 85). However, in doing so, Petrie claims that a balance be sought by workers in the professional domain between avoidance of their thoughts, feelings and experiences and self-disclosure that is unhelpful. The latter, for example, would include sharing information that is a burden to others, and taking 'too large a part in the conversation . . . ' (Petrie, 2011, p. 88).

The concept of mentalising provides an understanding of how appropriate caregiver self-disclosure might enable a traumatised child to better perceive their own, and others' inner world. In doing so, 'the child begins to be able to put feelings into words – the feelings are reflected cognitively . . . ' (Hart, 2011, p. 110). For example, Lilly's sharing with her foster children of her sadness at the loss of two close family members, provided them – the children had never dealt with death – an occasion to reflect on what it meant for a person to lose a loved one.

Co-construction, in which a foster child is helped to develop a coherent life narrative, occurs in the context of life story work (Cook-Cottone & Beck, 2007). A tangible outcome of this work is a life story or life book that is appropriately commenced soon after the child enters care, and which can be added to and used therapeutically to resolve 'strong emotions about past events . . . ' (Fahlberg, 2012, p. 368). However, the interview responses point to co-construction of a child's narrative being an ongoing and encompassing process in which foster children seek out a parent figure to make sense of their experience when they need to do so.

Moreover, as found in this research activity, co-construction may not always mean a foster carer having a 'sit-down' conversation with a child. Rather, co-construction may occur in a foster carer having a somewhat spontaneous and brief exchange with their foster child, and which offers the child a different perspective than the often negative and distorted one that she or he holds. For example, in response to Pippa feeling blame for her birth mother not seeking contact with her, the foster carer communicated to Pippa that she was not at fault, and shifted responsibility for requesting contact with Pippa onto her mother, as the adult.

Derek's final counselling session in the company of his foster mother, Gemma, demonstrates how foster carers might work jointly with counsellors in co-constructing with a foster child the meaning of a significant life event. In providing information to fill gaps in Derek's knowledge of the events that led to his entry into care, he was able to release feelings of shame. He became more willing to accept Gemma as his carer, and he became a calmer person, shown by the dramatic reduction in the number of tantrums.

Implications

While not exhaustive, some key implications arise for fostering agencies in facilitating the therapeutic capacities of foster carers as they emerged in this research activity. Foster carers require appropriate training that will develop therapeutic fostering skills, such as those described earlier. These skills can enhance caregivers' mentalising abilities and enable them to interact with their foster children in ways that promote their healing. Increasing the mentalising capacities of foster carers is consistent with the notion that children previously exposed to hostile and rejecting adults, require caregivers with high mentalising skills (Taylor, 2012). Moreover, development of these skills is a necessary complement to knowledge which foster carers receive in training on the neurobiology of trauma, and on theoretical concepts, such as bonding and attachment.

To better prepare foster carers for their complex roles, a training focus might include the development of therapeutic thinking, which is integral to attentional awareness, listening, empathic responding and reflective functioning. This focus is consistent with the claim by Douglas (2018, p. 336) that rather than being fearful of what the child presents, therapeutic thinking could enable foster

carers to 'be a real source of comfort and containment'. Interview examples presented earlier demonstrate the capacity of caregivers to use therapeutic thinking skills in ways that potentially benefit foster children. For example, Tracey alludes to listening in allowing her foster children to talk before she asks a question. Through observation and cueing into the child, Maria picks up on their emotions. Sue will rework in her mind what happened in an interaction with her foster child.

An additional training focus might explore how foster carers can engage in appropriate self-disclosure in ways that bring a sense of authenticity to their caring role, and build connection with their foster child. Such training could also impart knowledge on how appropriate self-disclosure might help foster children to develop their understanding of self and others as intentional beings – that is, mentalising – in a safe and supportive manner. Training forums of this type also provide an opportunity for fostering agencies to articulate the boundaries surrounding appropriate self-disclosure by foster parents in ways that are consistent with a child's well-being.

There appears a strong need for therapeutic workers at the foster agency level and foster carers to work collaboratively in ways that promote a foster child's recovery from developmental trauma. Doing so will allow foster carers to adopt approaches in their care that are consistent with those of an agency therapist, such as a psychologist. Moreover, therapists might also be open to the insights gained by foster carers through their day-to-day observation and care of foster children. An exemplar of effective collaboration is that of Gemma attending counselling with her foster son, Derek, which enabled the counsellor and her to reinforce the message that he was not to blame for coming into care.

Conclusion

While there is acknowledgment in the literature that the foster carer–child relationship is integral to emotional well-being and healing from developmental trauma, there is a lack of attention to an underlying therapeutic skill base that foster carers can use. Moreover, there is a need for more understanding about how foster carers might interact with a child in ways that contribute to their well-being and healing. Emerging from this research activity are therapeutic skills that caregivers could exercise in their interactions with foster children. This paper has also explored two, but not dissimilar, forms of foster carer–child interactions that have therapeutic implications for a traumatised foster child. Interactions that promote emotion understanding can increase a foster child's emotional literacy through understanding their own emotions and those of others. Co-construction as a process of shared meaning can assist in a foster child's ongoing sense-making of their life experience. As both of these interactional processes involve an interpretation of intentional mental states that underlie human behaviour (i.e. mentalising), they assist in the development of a child's interpersonal functioning.

However, to realise their therapeutic potential, foster carers require a community of formal and informal support around them. Integral to this support is the fostering agency, which provides the training, resources and personal support needed by foster carers. Foster carer training could include the development of a therapeutic skill base to complement knowledge and theory on attachment in fostering contexts and on the neurobiology of trauma.

Baker and White-McMahon (2014, p. 15) assert that in every interaction between a therapeutic helper and a youth, 'a new opportunity for healing and transformation becomes possible'. To realise this potential, we need to build an evidence base of therapeutic skills that foster carers can use, along with an understanding of how foster carer–child interactions might occur in ways that bring positive change to the lives of children adversely affected by developmental trauma. These aspects of the caregiver–foster child relationship emerge as a key focus for future research.

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Reference

Allen, J. G. (2013). *Mentalizing in the development and treatment of attachment trauma*. London: Karnac Books Ltd.

Baker, P. W., & **White-McMahon, M.** (2014). *The hopeful brain. NeuroRelational repair for disconnected children and youth.* Lulu Publishing Services.

Bernstein, J. (1999). The politics of self-disclosure. *Psychoanalytic Review*, *86*(4), 595–605.

Bowlby, J. (2005). *A secure base. Clinical applications of attachment theory*. New York: Routledge.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531.

Caw, J., & **Sebba, J.** (2014). *Team parenting for children in foster care. A model for integrated therapeutic care.* London: Jessica Kingsley Publishers.

Cook-Cottone, C., & **Beck, M.** (2007). A model for life-story work: Facilitating the construction of personal narrative for foster children. *Child and Adolescent Mental Health*, *12*(4), 193–195.

Cooper, A., & **Redfern, S.** (2016). *Reflective parenting. A guide to understanding what's going on in your child's mind.* New York: Routledge.

Douglas, M. (2018). Using transactional analysis to help foster parents develop therapeutic parenting skills. *Transactional Analysis Journal*, *48*(4), 335–349.

Edwards, C., & **Murdock N.** (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling & Development*, *72*(4), 384–389.

Fahlberg, V. (2012). *A child's journey through placement.* London: Jessica Kingsley Publishers.

Fonagy, P. (2003). The development of psychopathology from infancy to adulthood: The mysterious unfolding of disturbance in time. *Infant Mental Health Journal*, *24*(3), 212–239.

Fonagy, P. (2006). The mentalization-focused approach to social development. In P. Fonagy & J. G. Allen (Eds.), *Handbook of mentalization-based treatment* (pp. 53–99). West Sussex, England: John Wiley & Sons, Ltd.

Fonagy, P., Gergely, G., & **Target, M.** (2008). Psychoanalytic constructs and attachment theory and research. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment, theory, research and clinical applications* (2nd ed., pp. 783–810). New York: The Guilford Press.

Fonagy, P., & **Target, M.** (1997). Attachment and reflective function: Their role in self organization. *Development and Psychopathology*, *9*(4), 679–700.

Golding, K. S. (2008). *Nurturing attachments. Supporting children who are fostered or adopted.* London: Jessica Kingsley Publishers.

Golding, K. S., & **Hughes, D. A.** (2012). *Creating loving attachments. Parenting with PACE to nurture confidence and security in the troubled child.* London: Jessica Kingsley Publishers.

Goldstein, E. (1997). To tell or not to tell: The disclosure of events in the therapist's life to the patient. *Clinical Social Work Journal*, *25*(1), 41–58.

Hart, S. (2011). *The impact of attachment.* New York: W.W. Norton & Company, Inc.

Hughes, D. A. (2009). *Attachment-focused parenting. Effective strategies to care for children.* New York: W.W. Norton & Company.

Hughes, D. A., & **Baylin, J.** (2012). *Brain-based parenting. The neuroscience of caregiving for healthy attachments.* New York: W. Norton & Company Inc.

Karstad, S. B., Wichstrom, L., Reinfjell, T., Belsky, J., & **Berg-Nielsen, T. S.** (2015). What enhances the development of emotion understanding in young children? A longitudinal study of interpersonal predictors. *British Journal of Developmental Psychology*, *33*(3), 340–354.

Knox, S., & **Hill C. E.** (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, *59*(5), 529–539.

van der Kolk, B. A. (2005). Developmental trauma disorder. Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*(5), 401–408.

Lincoln, Y. S., & **Guba, E. G.** (1985). *Naturalistic inquiry*. Beverly Hills, California: Sage Publications.

Pears, K. C., & **Fisher, A.** (2005). Emotion understanding and theory of mind among maltreated children in foster care: Evidence of deficits. *Development and Psychopathology*, *17*(1), 47–65.

Perry, B., & **Hambrick E. P.** (2008). The neurosequential model of therapeutics. *Reclaiming Children and Youth*, *17*(3), 38–43. Retreived from www.reclaiming.com

Perry, B., & **Szalavitz, M.** (2008). *The boy who was raised as a dog. What traumatized children can teach about loss, love, and healing*. New York: Basic Books

Petrie, P. (2011). *Communication skills for working with children and young people. Introducing social pedagogy*. London: Jessica Kingsley Publishers.

Rauktis, M., Vides De Andrade, A., Doucette, A., McDonough, L., & **Rinehart, S.** (2005). Treatment foster care and relationships: Understanding the role of therapeutic alliance between youth and treatment parent. *International Journal of Child and Family Welfare*, *8*(4), 146–163.

Siegel, D. J., & **Bryson, T. P.** (2014). *No-drama discipline. The whole-brain way to calm the chaos and nurture your child's developing mind*. New York: Bantam Books.

Southerland, D. G., Mustillo, S. A., Farmer, E. M., Stambaugh, L. F., & **Murray, M.** (2009). What's the relationship got to do with it? Understanding the therapeutic relationship in therapeutic foster care. *Child and Adolescent Social Work Journal*, *26*(1), 49–63.

Taylor, C. (2012). *Empathic care for children with disorganized attachments. A model for mentalizing, attachment and trauma-informed care*. London: Jessica Kingsley Publishers.

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