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**Papers from the
Carlow College and the Masters in Therapeutic Child Care
Course Conference**

"Making All the Difference:

A Therapeutic Community Approach to Residential and Community Care"

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Why a therapeutic community approach?

[or "What did I learn from my 27 years working in a therapeutic community that I have found to be useful in other settings?"]

Introduction

Most of the material in this paper will derive from my work at the Cotswold Community. However for the past 10 years I have been responsible for the development of ISP (Integrated Services Programme). ISP's history is as impressive as any of the best known therapeutic communities. It was started by foster carers in 1987 and was the first independent foster care provider in the UK. There are now something like 300. To be the very first must have been exciting and also scary. Those original dozen or so foster carers had a vision of what they wanted to create for children which was a completely wrap around set of services meeting all the needs of the children in their care. They were way ahead of their time and in a sense were providing a different kind of therapeutic community. All the elements of a therapeutic community were to be found within ISP, they were just configured differently.

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I'm approaching this question by thinking back over my 40 years in child care and looking at the lessons I learnt, sometimes from very painful experiences, which I still use in my work today.

My career started in a brand new Probation Hostel for young offenders. I was newly married and had just graduated so I was only a couple of years older than some of the residents. It was a good first job, being involved from the very beginning of a new project. The hostel's stated aim was to re-educate these young men, to teach them good social habits eg., keeping themselves clean and tidy, getting a job and keeping it, managing their money etc. For some of the residents this was all that was needed to get them back on track. However, it became clear to me that a significant number didn't appear able to be re-educated in this way. They seemed to have deeper underlying needs that were not being met. Their difficulties were repeated time and again without the capacity to learn from experience. For example, they were continuously sacked from their jobs often because they couldn't take orders or they would explode with frustration over fairly ordinary workplace scenarios.

As I was new to social work I was sent on training courses and I count myself very lucky to have attended the Tavistock Clinic for this training where I encountered a psychodynamic approach for the first time. It was luck because I hadn't a clue where I was going and neither did my manager. This was when I began to realise that we were just skimming the surface in our work at the hostel and not getting to the root of the underlying problems in some of the young men. Their difficult and anti-social behaviour was a symptom of these underlying problems and would continue to be repeated unless this was tackled. I realised that the hostel was not set up to do this sort of work and that I needed to find a very different sort of working environment.

(1) A therapeutic community approach aims to get below the surface to the root of the problem.

In this approach there is a recognition of the emotional damage that has been done in the first few years of life if the baby's and toddler's parenting has not been good enough. This will continue throughout life unless it is addressed. Barbara Dockar-Drysdale's (Mrs D) work was based on an understanding that children who have not achieved emotional integration, and are therefore emotionally unintegrated, need to be helped in a very special and planned way if they are to recover. Imagine a fine looking house without foundations. It will crack and crumble under stress and pressure. That's what I am talking about.

So I learnt that **(2) good child care by itself doesn't rectify a child's deep-rooted primary emotional damage**. To coin Bruno Bettelheim's phrase "Love is not enough", which was the title of his famous book written in the 1950s. However, I would turn this round and say that therapy without love is not enough either. Love in

this sense meaning concern, preoccupation, attunement and emotional involvement. I will be returning to this subject.

To return to my story, what inspired me to move to the Cotswold Community was the book by David Wills, "Spare the Child". It was published as a Penguin paperback and was easily available in any bookshop. The book described the struggle to change a very traditional Approved School (junior Borstal) into a therapeutic community under the leadership of Richard Balbernie. It is still a very interesting book to read because it graphically portrays just how difficult it is to change the ethos and purpose of an institution. The resistance to change is huge and explains why so few places went through this change process.

When I went to the Cotswold Community in 1972 it was 5 years into this transformation. Although a lot had changed there were still traces of the old Approved School. For example, there were some staff members who had worked in the Approved School regime and who were not really identified with the new therapeutic community approach. They were going through the motions waiting for the day when these new fangled ideas became unstuck. Strong and determined leadership was needed to weed out these people.

(3) Therapeutic communities need to have leaders who are clear about the primary task and are knowledgeable about therapeutic work with emotionally disturbed children. Sadly during the last 10-15 years I have seen the emphasis shift to leaders primarily needing to have business skills which I think explains why so many so-called therapeutic communities are very pale imitations of the vibrant organisations that existed in the 1960s, '70s and '80s.

In these early days at the Cotswold Community I also learnt **(4) the importance of staff teams being cohesive.** If they are not the children will pick up on it very quickly. Emotionally damaged children are very attuned to splits in teams, having grown up in fractured families. Indeed they will actively try and create splits so it is vitally important that staff teams work on their cohesion, ensuring that everyone is pointing in the same direction.

Jim Collins, the famous management guru, wrote in his book "Good to Great" about the importance of getting the right people on the bus sitting in the right seats, which means not only recruiting good people but offloading those people who are anti the therapeutic task.

Therapeutic communities in particular pay attention to the dynamics of the staff team as it is realised that in planned environment therapy the quality and cohesiveness of the staff team is probably the most important part of the environment for the development of the children.

In my recent work with foster families I would say cohesion is equally important and I am particularly including the birth children ie., children who foster, when I say this. When there is a strong sense of cohesion in the foster family this makes a tremendous difference to the resilience of the family when taking on an emotionally damaged child.

My first year at the Cotswold Community was very hard and I nearly didn't survive it. I was in a team which was fragmented and although it consisted of some talented individuals who did some brilliant work with individual children this was undone by the lack of containment of the household. We were in a vicious circle being swamped by the disturbance of the children which in turn made the children feel unsafe, the level of acting out increased and we felt even more swamped. It was a disaster waiting to happen and ended with one of the children more or less burning the house down. As a team we had unconsciously slipped into believing that we were engaged in an impossible task. I came to realise this when, following the fire, I was able to spend several weeks in the other three households in the Cotswold Community and for the first time saw successful therapeutic work taking place. I realised how demoralising it had been to work in a situation where despite all my best efforts we as a team were getting nowhere.

I learnt that **(5) groups aren't automatically a force for good. They can be destructive if the balance in the group isn't right.** When you put seriously emotionally disturbed children together in a group there is considerable potential for contagion of the disturbance. Within a group living household the health of the household has to outweigh the illness for it to be a positive living experience. The majority of the health (wellness) will come from the staff team but some needs to come from within the group of children. When a group becomes established some of the children whose development is well under way become culture carriers ie., positive role models for the newer children. In therapeutic communities the children who are culture carriers identify with the therapeutic task and might, for example, say to another child, "It is important you talk to a grownup about this." Contrast this with children saying to each other, "Don't be a grass".

One of the factors behind my decision to move from a TC some 10 years ago was the increasing level of disturbance in the children referred and therefore the increased difficulty in putting positive groups together. In the main foster families don't have these difficult group dynamics and the health of the family can be a stronger influence.

Therapeutic communities have usually had **consultants to help develop the therapeutic task.** It can be difficult for the staff teams to "see the wood for the trees" amongst the bizarre, unpredictable and overwhelming behaviour of the children. **(6)**

Understanding the meaning of behaviour is a key part of the work in TCs. With children whose emotional disturbance goes back to the preverbal stage in their life it is not surprising that their feelings of distress are expressed through acting out behaviour. This is an example from a foster family. "Michael appeared not to have any idea of how to use the toilet and said that he had never used toilet paper. He was fascinated by where the water went and became obsessed with the drainage system. This was to be the first of Michael's obsessions." In my experience it takes a consultant psychotherapist, who is outside the immediate dynamic of the community, or in this case the family, to help make sense of the behaviour.

TCs should not be in the business of simply controlling behaviour but helping children gain insight into what drives them towards acting out so they can begin to work with staff in employing strategies to manage their behaviour. The aim being over a period of time for children to develop inner controls. This will also occur alongside the work to help them achieve emotional integration.

A consultant can also help a team to **(7) formulate a treatment plan for a child.** Mrs D worked with teams to assess the level of need of a child by first determining the level of unintegration. The most unintegrated children were "emotionally frozen" then there were "archipelago children" who had islands of functioning within a sea of chaos, followed by "false-self" and "caretaker self" children who had achieved the beginnings of a real self which had to be subsequently protected by developing an outer shell. Each of these syndromes of deprivation had their own treatment plans which the whole team worked on together. It is not within the scope of this paper to describe this work in any detail but it can be read about in the books written by Mrs D. The point is that different TCs probably followed different psychodynamic models but these models gave a sense of direction to their work and enabled treatment plans to be formulated. I think this is very different to the current vogue of focussing on outcomes for children. To me a treatment plan is about creating the right conditions for a child's emotional growth and once this has been achieved the outcomes will take care of themselves. To use a gardening analogy it is about creating the right conditions in the greenhouse, the quality of the soil, the amount of sunlight, the right levels of moisture and nutrients and then watching the plant grow. The focus on outcomes is a bit like a gardener holding up a picture of a flower, showing it to the seed and saying, "There you go aim for that!"

(8) A consultant can help an individual staff member to cope with and make sense of their own strong feelings that can be stirred up by the intense work with children. In psychodynamic work an understanding of the transference and counter-transference is important. We all have weak spots and children can be experts in finding them. Inevitably there are some unresolved issues from our own upbringing that can be brought to the surface through doing this work and it can be very unnerving for staff members when this happens. For example, some adults find messy eating incredibly difficult to cope with and possibly links back to their own upbringing. At the Cotswold Community it was common for staff members to

undergo personal therapy as part of their own development and a recognition that therapeutic work requires considerable self-knowledge.

(9) I think teams need the help of a consultant to withstand the testing out behaviour of the children. There is such a strong temptation to get rid of the most difficult child for the sake of the group or the sake of the sanity of the staff team. I think it was Bettelheim who said that a child's successful treatment is made up of doing the best you can each day and for a lot of the time it doesn't feel like success. The ability to keep going even through the most difficult periods is a feature of a TC approach.

One of the things that stood out for me in Mrs D's consultancy was the way she tackled the tendency to want to blame children for their anti-social behaviour. She saw this as a symptom of their underlying disturbance therefore the onus was on the adults to make sense of it by being in communication with the children, getting to know them sufficiently well to read the signs, to anticipate problems and then prevent them. When we went to a consultancy with her full of righteous indignation about the naughtiness of a child we left somewhat chastened, realising our failure to be in communication with him and the consequent loss of empathy.

Returning to my time at the Cotswold Community, having had a dire first year, which I nearly didn't survive, I went on to have 4 very good years as the manager of the household that was virtually destroyed by the fire. What changed? What changed a vicious circle into a virtuous one? Defining the tipping point between the two is incredibly difficult. Most people can describe the separate and very different dynamics of the vicious and virtuous circles but struggle to describe how you move from one to the other. One of the changes following the fire was an outpouring of goodwill within the Cotswold Community towards our household. Maybe there was an element of guilt in this as we hadn't been sufficiently helped with our difficulties prior to the fire. All I know is that it feels very different to be on the receiving end of positive attention compared to negative, critical attention.

I think the main element in creating a virtuous circle was changing from being dominated by the delinquent subculture within the group of children to creating a genuine therapeutic culture in the household within which everyone was engaged whether child or grownup. How did we do this? It is much easier said than done. This is where our consultant was so crucial. Mrs D advised that we should go back to basics and define with the children those principles by which we wished to live together in the household. This couldn't be a meaningless set of rules created by adults and handed down to children, who would in turn oppose them. These had to be principles which we all thrashed out together. Arguing over them was just as important a part of the process as reaching agreement. The discussions, arguments etc would help to clarify why certain things were felt to be important so the final

agreement was based on a good understanding of why a particular principle should be included. Anyway this is what we created at the time.

Principles By Which We Try To Live In The Households Of The Cotswold Community

- This is 'our' house and we value it.
- It is a dreadful thing for a grown up to hit a child, it is just as dreadful for a child to hit a grown up.
- It is important to be given the chance to put things right.
- There is nothing which cannot be said - in the right place, at the right time.
- It is important to listen to what other people have to say.
- When people are violent it is because they are not talking to other people.
- There must always be food if someone is hungry.
- It is important to feel clean and tidy, and cared for.
- If you feel ill, tell somebody at once.
- You cannot like other people if you do not like yourself.
- Everyone needs to be able to trust.
- It is important to be able to cry.
- The truth helps.
- If you give orders - grownups or children - these must have a reason.
- Anger must be understood, and put into words.
- It is important to accept being in the wrong.
- Sorrow must find comfort, pain must find relief, sadness must be felt.
- If there are needs these must be met somehow.
- Some people cannot be taught, but they can learn.
- Don't be afraid to ask anything.
- Some things are private.

The purpose of telling you about this episode is to illustrate another important aspect to therapeutic communities that has value in other settings, which is **(10) the need to create a sense of shared ownership for the development of the therapeutic culture**. Something important happens within the whole group (children and grownups) when discussion takes place, disagreements take place, before arriving at a consensus. This might be over what colour the crockery should be, what to do in leisure time, or the ground rules of living together.

(11) The community meeting is an important part of the therapeutic culture in TCs. This is **a place where problems within the community can be thrashed out and where the therapeutic culture can be reinforced**. At the Cotswold Community, because we were working with emotionally unintegrated children, we did not convene large group community meetings, instead we used the small household groups of up to 10 children as the basis for community meetings.

Melvyn Rose has written about the value of community meetings at Peper Harow in the 1970s and '80s. One example comes to mind where the community larder was broken into every night and initially the response was to make the larder increasingly secure. As this failed there were full and frank discussions in the daily community meeting. Initially the young people described in excited terms their delinquent exploits both within the community and before they arrived. Their description of breaking into houses usually involved stealing food and then despoiling the kitchen with excrement etc. Once the excitement subsided there was some sadness acknowledged about the need for comfort and how the stealing and spoiling process described didn't meet this need. This led to further discussions about the meaning of the larder being broken into. A solution emerged in the form of making drink and food (bread, butter, jam, electric kettle, milk, tea and coffee) available at any time of day and night by setting out a table which was continuously stocked. The larder was left alone. Melvyn made the point that it could have been tempting to interpret the behaviour to the young people but what was needed was a tangible response to an unconscious need. The 24 hour stocked table may represent symbolically the unconditional love of the mother but it would not have been helpful to make that interpretation at that time.

In the Archive section of my website www.johnwhitwell.co.uk you will find another description of the purpose of the community meeting written by David Dean based on his work at Raddery therapeutic community in the 1980s and '90s.

Community meetings can take place in any setting whether it is a classroom, a school, a youth club, a foster family, a family centre etc, etc. In the last few years I have seen foster families employ the same principles so that the children they foster can feel included in how the family operates rather than simply be expected to fit in. This has to be better for a child's emotional development which is our primary concern.

I would like to come back to Mrs D's work on the treatment of unintegrated children, work which she had started in 1948 when she established The Mulberry Bush School mainly with primary age children. She brought this understanding to the work of the Cotswold Community which was mainly working with adolescents. The main difference between these age groups was that younger children are somewhat less defended about their dependency needs, their need to regress and their need to form attachments. Adolescents are more self-conscious of these needs and hide them behind a carapace of "not giving a damn".

I still find the **(12) concept of unintegration** helpful in making sense, for example, of the terrific anger that these children experience which are more like panic rages than temper tantrums. These rages can be sparked off by the most trivial of things. But these minor frustrations may be the trigger for a volcanic eruption that has been building for some time. Unless the nature of this anger is understood it makes no sense whatsoever. It is the rage of the terrified baby who fears annihilation. Seen in this context it becomes clear that this anger is not going to be managed away by 6 sessions of anger management, which is the current fashion. This anger will only start to subside and become manageable as the needs of the whole child are met over a long period of time. Children's Homes, foster families and schools are perplexed and dismayed by children who have these panic rages and indeed it is very hard to cope with the rage in groups of children. A special environment is needed but this can be a family or school providing the staff or family members are trained and supported to make sense of the behaviour and helped to cope with it.

Another defining feature of unintegrated children, which can also make them extraordinarily difficult to live with, is their need to disrupt functioning groups. A functioning group is a threat to a child who struggles to cope in a group so it kind of makes sense to make it fall apart, to stand back and watch the rumpus. Often these disruptive children are the quiet storm centres once the storm is raging. Unintegrated children need lots of individual provision to cope in group. You have to realise that they find sharing very difficult. Once you realise this you can plan for it. For example, our school at the Cotswold Community had lots of individual cubicles for the children to work within which helped them to keep separate and focus on their own work.

There isn't the scope within this lecture to go into all the detail of the treatment environment needed for unintegrated children but let me touch on a few aspects that I have found subsequently to be useful when applied in other settings like a school or foster family.

These emotionally damaged children are desperately looking for **(13) trustworthy people to whom they can attach**. Often this need is hidden behind a defensive shell of "I don't need anybody". We have to be able to listen to the music behind the words. The crucial thing here is that we have to be trustworthy. I think it is more difficult for children, who need to make secure attachments, to do so within the context of shift system working in childrens homes. This was a factor in my decision

to leave the Cotswold Community and work for ISP, where I perceived that foster families were in a better position to provide the continuity of care that I think is a pre-condition to forming attachments.

I think TCs have been good at providing **(14) high quality physical environments** for the children in their care. The psychodynamic understanding of the importance of transitions, routines such as bedtimes and mealtimes, the fears and anxieties that unintegrated children have about food and the preparation of food, the fears and anxieties associated with toilet training, bathtimes etc has led to the symbolic importance of the physical environment being appreciated and incorporated into the design. Bruno Bettelheim devoted a whole book to this subject called "Home for the Heart", which says it all.

Unintegrated children need a flexible and facilitating environment that responds to their individual, personal needs which makes it somewhat easier to overcome the deadening institutional response that all children should be treated the same. So, for example, it was possible for James to have his bed in the form of a badger set in his room because he needed an actual safe containing space in order to overcome his nightly terrors and fears. Of course other children said they would like one of those as well but the culture supported the response that this was right for James and that in due course something would emerge that would be right for them.

(15) Transitional objects are another area where their real meaning can be lost by the desire to have the same as everyone else or the latest soft toy in the shops. If a child arrived with a battered, smelly teddy that he'd had since he was a toddler we knew we were half way home in starting to work with this child. Sadly for most children in the care system their many moves resulted in their ownership of very few objects that were emotionally and symbolically significant. We regarded it as a breakthrough in a child's therapy when he asked for a soft toy from his focal carer to help him cope with her absence. Usually the request was very specific, for example, a whale or a panda. It is amazing to see within a group of 13 and 14 year old children the unselfconscious use of transitional objects in this special setting. It is important to help the children realise that it is a special setting and that if any of them were to take their transitional object into town when shopping they would get some unsympathetic reactions.

Most emotionally damaged children have some problems regarding food and mealtimes. In a therapeutic child care setting this should be thought about very carefully. We know that unintegrated children have problems with sharing so we shouldn't be surprised that food that has to be divided up can create acute anxiety for some children and this can show itself as rage or disrupting the mealtime or both. Mrs D advised that we should try and create individual, contained portions as much as possible, for example, small individual pies rather than one big one which is divided, or fried or boiled eggs rather than scrambled. These aren't meant to be hard

and fast rules so much as guidelines when thinking your way into the shoes of a child, trying to understand the meaning of his behaviour and anxieties.

Here is an example of food issues within a foster family. “Thomas came to us with big food issues. He remembered being left for long periods without food and an occasion when he was left with a weird character (his words), in squalid conditions, who fed him rotting food that made him vomit. He had a very skinny and drawn appearance. Thomas was suspicious of any food that didn’t come out of a frozen packet or tin. We’ll never forget the look of sheer horror and disgust when he first saw us feed our baby organic meat and vegetables. Whenever we were out he would panic saying, “When will we eat?” even if we’d just had a cooked breakfast and he knew we were out for only 2 hours. We responded by putting small portions of new previously untried food on his plate, assuring him he didn’t have to eat it, but he might be missing out on something he really loved if he didn’t try. Whenever we went out we would make sure we always took a variety of snacks and drinks and always said we’d got cash if we need anything so that he could enjoy the outing feeling secure and cared for.”

(16) Food is so symbolically important because it goes right back to a baby’s first experiences and, when things go well, the establishment of trust. When things don’t go well mistrust and food seem to become linked. At the Cotswold Community we saw a very interesting example of this in a 14 year old boy, I’ll call him Paul, who arrived already addicted to smoking. He hid cigarettes and tobacco in the grounds and would wake in the night to go out and smoke. If he ran out of cigarettes he even walked 2 miles to the nearest pub to rummage through their bins (before smoking was banned). No matter how much we told him to wake the staff member who was always available through the night he didn’t, preferring the buzz of sneaking out. His focal carer looked more into his history to try and think his way into his shoes. Paul had suffered terrible neglect as a baby and toddler and had been admitted to hospital on several occasions because of his “failure to thrive”. We imagined that as a baby he could well have woken in the night hungry, crying to be fed but just left, with no response from his parents. In that pre-verbal stage there was nothing else he could do and eventually gave up. The giving up would have led to finding his own means of comfort which in adolescence had become cigarettes. This was a hypothesis and couldn’t be proven but had enough of a link to reality to be worth tentatively exploring with Paul by his focal carer. To cut a long story short, Paul didn’t dismiss the idea that he was searching for comfort in the night when he went out to smoke and that perhaps there were other ways of meeting this need. His carer suggested that perhaps a feed in the night would help. It was no good waiting for Paul to ask for it because he had already shown the desire to sneak out so it was suggested to Paul that he was woken in the night at say, 3.30am and given something to eat by the staff member who was working. Paul was amazed at this suggestion and believed it wouldn’t happen but was willing to give it a go. This lasted several weeks and made a huge difference to Paul’s therapy. Occasionally he tested

it out by having his cake and eating it by sneaking out as well as having a feed but this was very rare. He got to the point of saying when he didn't need it anymore. As well as meeting an actual need for comfort the commitment shown by the staff team helped Paul to reach another level of trust, a vital part of his emotional development.

There are many more examples that I could give but time is not on my side. What I hope to have conveyed is that therapeutic communities are special, planned environments where the very specific needs of individual children can be met. The therapeutic culture which is difficult to establish and easily destroyed encourages new children to drop their defences and to put their trust in the grownups.

Summary of main points

1. A TC approach aims to get below the surface to the root of the problem.
2. Good child care by itself doesn't rectify a child's deep-rooted primary emotional damage.
3. Therapeutic communities need to have leaders who are clear about the primary task and are knowledgeable about therapeutic work with emotionally disturbed children.
4. The importance of staff teams being cohesive.
5. Groups aren't automatically a force for good. They can be destructive if the balance in the group isn't right.
6. Consultants help develop the therapeutic task by: understanding the meaning of behaviour;
7. Helping a team to formulate a treatment plan for a child;
8. Help an individual staff member to cope with and make sense of their own strong feelings that can be stirred up by the intense work with children;
9. Helping teams to withstand the testing out behaviour of the children.
10. The need to create a sense of shared ownership for the development of the therapeutic culture.
11. The community meeting is a place where problems within the community can be thrashed out and where the therapeutic culture can be reinforced.
12. The concept of emotional unintegration helps to explain the extreme levels of disturbed behaviour.
13. Children need trustworthy people to whom they can attach.
14. TCs provide a high quality physical environment.

15. Transitional objects appear in therapeutic work.

16. Food is of great symbolic importance.

Conclusion

The therapeutic community that I worked in the 1970s, '80s and '90s could not exist today in the form that I knew it. However all the things that I have mentioned in this paper can be practiced in a variety of therapeutic child care settings.

An example of going the extra mile for children was when I heard a foster carer describe how she helped two sisters into her family. One of the symptoms of their disturbance was an inability to settle at bedtime and sleep. The carer sensed how frightened they must be and rather than admonish them she lay down on the floor between their beds and held hands with them until they fell asleep. This she did every night without fail for 2 months until they started to trust that everything was going to be alright. When she started doing this she didn't know how long she would have to go on doing it but she went ahead nevertheless. This is just as impressive as the piece of work I described with Paul. The difference being she didn't have a team to back her and it was every night.

In my view therapeutic child care requires that level of personal commitment and personal involvement, which is why I said earlier that therapy without love will not lead to the recovery of such emotionally damaged children.