PRACTICE REPORT

Working with the families of children in care

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Abstract

If at the start of day-care or residential care of a child or adolescent it is acknowledged that a request for help does not equal assessment and diagnostics – at least not for some time – then it follows logically that there needs to be a wide variety of parent guidance.
In this article first the attunement between requests for help and defining goals for intervention is discussed in case of a multi-problem child.
Next, the various methods of working with parents and/or remaining nuclear family in combination with intensive care or treatment of a child are discussed. Sometimes certain methods of working result logically from one another and growth is being marked. Sometimes a certain method of working is the most feasible one in a given situation and should be regarded as static.

Key words: day-care, residential treatment, multi-problem children, parent guidance, multi-theoretical framework

Introduction

If a child is in day-care or in residential care, and if there are treatment goals, working with the parents requires special sensitivity. In these settings, it is no longer the parent-child dyad that forms standards and rules, but a triad, i.e. the parents, the child and the treatment providing environment (Green & Jacobs, 1998; Hendren & Berlin, 1991; Robson, 1994). A systemic approach is necessary in order to achieve and maintain good insight into this triangular interactive network. Right from childbirth, special attunement is already needed between parents and their developing and growing child. Aspects and parts of this special sensitivity have been described by various authors, such as:

- Winnicott's maternal preoccupation covers prenatal attuning (Winnicott, 1965);
- Stern's motherhood constellation covers the more lasting psychological changes in a woman becoming a mother (Stern, 1995);
- Erikson's psychosocial tasks like sense of basic trust, sense of autonomy, sense of initiative, sense of industry, and sense of identity represent the results of intensive social attuning between child and adults during developmental consecutive phases (Erikson, 1950);
- Hartup's description of infancy and childhood as parent-regulated, the end of childhood and a big part of adolescence as co-regulated, and the last part of adolescence as self-regulated also characterizes an aspect of the attuning between parents and child (Hartup, 1988).

The author's work as a child and adolescent psychiatrist and a manager of day-care and inpatient wards form the background for this article. In the Netherlands it is not only still possible to observe disturbed children (and their families) or to offer them short-term treatment, but also to work intensively for two of three years with these children and their families, who are in need for long-term help. In long-term day-care and inpatient or residential treatment care and education, the basic elements to form parenthood, are also basic conditions to create a therapeutic environment.
Central theme of this article is: "Working with the families of children in intensive treatment cannot be specified in general mottoes. There are no general rules for parent guidance and for working with the families". It will be discussed that in most settings for intensive day-care and inpatient care the multivariate reality of the multi-problem child and his family necessitate compiled frames of reference (Rietdijk & Verheij, 1991; Verheij, 1995; Verheij & Van Doorn, 2002). Attention will be paid to the empirical fact that within a family there already can exist a variety of demands for help and that there are at least three distinctive positions as far as the matching of the help seeking system and the help giving system is concerned. This article will be concluded by a brief rubrication of eight distinctive forms of working with parents and families of children in intensive care or treatment.

A multivariate reality

"The most sick children come from the most sick families" is a famous statement in several publications. In case of a single-problem child, like a deaf, dyslectic or asthmatic child, the family is usually not considered a part of the problem, although the problem has its consequences for the family and entails the family's adaptation. In case of a multi-problem child, the interrelationship is an entirely different one. There is a good chance that the nuclear and/or the extended family, the parents and/or the siblings are part of the problems. Partial or total causality, primary adaptation and the interaction between family members and problems can explain why there is not one designated individual having problems (Morton & Frith, 1995; Pennington, 2002). The quotation may suggest a linear causality between a multi-problem child and his problematic family. This suggestion is a dangerous one. By accepting this suggestion, the perception of a multivariate reality is undermined. In reality, there are big differences between one multi-problem child and his family context and the next multi-problem child and his context. If the perception of a multivariate reality is destroyed, it is only a small step to formulate uniform guidance strategies for parents and families with multi-problem children receiving intensive care.

A short intermezzo to explain the terms multi-problem and treatment in this context. Multi-problem means that the child has a variety of problems interfering with or threatening ongoing growth, development, learning and social interaction in more than one developmental domain (physical, cognitive, emotional and social) and/or in more than one domain of daily life (as an individual, in the family, with peers and siblings, at school and in leisure activities). (Intensive) treatment needs basically good enough care and well-balanced education, but it has to be completed with influencing and initiating change (which is necessary for ongoing growth and development) by professional workers.

Back to the multivariate reality and to an implicit assumption in my reasoning: are multi-problem children in need of individual-oriented treatment combined with care for the parents and/or the family? During the previous century, especially in the sixties and seventies, family therapists argued extensively about the consequences for the acceptance of family role definitions like scapegoat, mediator, and identified patient (see for example Dallos & Draper,

2000). It is important to realise that in those days linear thinking prevailed: the family was the patient and the family needed a uniform treatment.
Because of the main theme of this article, it is necessary to focus on a framework for the individual child and his specific family context. Such a framework has to be wide, in order to appeal to an open mind and to result in differentiated made-to-measure treatment.
In the next paragraph, the consequences of accepting a multivariate reality without generalization, using mottoes or catchwords derived from (a) favourite frame(s) of reference or theory will be discussed.

Frames of reference with broad and in-depth thinking

Assessment and diagnostics of the child in his context and in the family context has to lead to insight, knowledge and subsequently to treatment planning and treatment.
In case of a single problem, assessment, diagnostics, treatment planning and treatment are often linear. In case of multiple problems, these processes are rather cyclic. To do justice to the multi-problem child, his context and the possible multivariate reality, a line of thinking with breadth as well as depth is necessary (Verheij, 1997, 1998; Knorth, Smit, 1999). Thinking broadly about the child and his family implies questions such as:

- how are the emotional bonds and the involvements between the individuals, the parents, the children, and within the family (i.e. emotionally)?
- how do they interact (i.e. socially)?
  - how do they experience, and how do they feel about their involvement and their interactions (i.e. cognitively)?
  - are they equal? Is there a feeling for differences caused by the family member's varying developmental phases?
  - are there any disabilities or physical or cognitive limitations?

Thinking in depth about the child and his family implies questions such as:

- what kind of person is he or she?
- what does his or her developmental pathway looks like?
- what kind of life events did he or she encounter?
- what is his or her resilience and vulnerability?
- what are the individual?s limitations and/or disabilities?

Thinking broadly (interpersonal thinking) and thinking in depth (intrapersonal thinking) together imply a multi-theoretical framework with supplementary theories or families of theories which need to be mutually attuned (see Verheij, 1999). Groupdynamic theories and system theories provide a grasp of the breadth. Psychodynamic, developmental and learning theories provide a grasp of the depth. In Belgium, in De Haan in 1989, at the first EUSARF-congress, we presented a lecture in which we had arranged theories within a multi-theoretical framework (Rietdijk, Verheij, 1991).

A multi-problem child and his family represent many factors in complex dynamics: a multivariate reality. Individual family members, people around the family and professional workers can all have different views on this reality. If a day care or residential facility is sensitive to these differences, the result will be a variety of ways of working together with parents and the family. In the next paragraph, this problem with help seeking behaviour and defining goals for intervention as central themes will be discussed.

Help seeking behavior and defining goals for intervention

The offering of help concentrates on three consecutive questions: 1) What is the matter?, 2) "What has to be done about it?" and 3) "How to achieve this?". Before seeking help, the family members and their context try to find some answers for themselves: their help seeking behavior. Once again, this is a generalization. A single designated way to find answers does not exist. The mother, the father, the child, the school, the general practitioner, members of the nuclear family and members of the extended family, each of them can experience the problems in a different way if they experience problems, and may give various answers to the questions. Also the family's seeking help for answers is not static, but it may be changed under the influence of new understanding and knowledge acquired during assessment, diagnostics and advisory consultations. As soon as assessment and diagnostics have started, the professional worker or the help giving system also start to look for answers to these three questions. Defining goals for intervention is the professional term for the process of answering the first two questions: "What is the matter?" and "What has to be done about it?", while this process of answering the question "How to achieve this?" is called treatment planning. Until now, this discussion has been moving away from generalizations and a single reality, and went in the direction of process thinking and a multivariate reality. This opening of the reader's mind is needed in order to understand that the multivariate reality of the problematic child and his family forces us to work in various ways with the child and his context. In the next paragraph, the three ultimate positions of help seeking behaviour as well as defining the goals for intervention will be briefly discussed.

The three ultimate positions

The attunement between the help seeking behaviour and defining goals for treatment can be considered as the vulnerable underbelly of the diagnostic and help giving practice. Ideally, treatment planning needs this attunement. In quite a few cases help seeking behaviour and goals for treatment match, but in many other cases there exist remarkable differences between "What has to be done?" (view of the staff) and "What can or may be done?" (view of the child, his family and their context). In these cases, treatment planning can be defined as an attempt to narrow the gap between the different points of view, with respect for the fact that they might be different, or "How do we reach our goals?". If there is agreement that there are problems, the interrelation of parts and the whole, child and context, contextual variables and the child, can be defined in three ultimate positions:

From the viewpoint of the help seeking system the three positions can be formulated as:

- "There is something wrong with our child (and not with us)",
- "We are unable to fulfil our parenthood and therefore...",
- "There is something wrong with us as a family and therefore...".

From the viewpoint of the help giving system the three positions can be formulated as:

- "There is a problematic child in a well functioning family",
- "Although a child is presented as identified patient, the parenthood (and not an individual child) is problematic. Of course there are consequences for the individual child", and
- "Although a child is presented as identified patient, a dysfunctional family with consequences for each of its members (and not exclusively for an individual child) is the source of the problems".

If the positions of the help seeking system and the help giving system match, treatment planning and treatment, as already mentioned, are comparatively easy. If assessment, diagnostics and several advisory consultations do not yield matching positions, then maybe this is a con-

tra-indication for giving help. But if there is a child, threatened in its growth and development, such a conclusion seems, from an ethical point of view, premature. First of all, workers need to examine if, with due regard for professional standards treatment planning is possible, taking the discrepancies into account. This brings the reader back to the central theme of this article: if the viewpoints of the parents and the therapists do not always match during intensive long-term day-care or residential treatment, then this will have consequences for parental guidance: the processes of parental guidance vary. In the last paragraph the various ways of working with the parents (and the extended family) of children in intensive care and/or treatment will be discussed.

Frames of family work

At least eight forms of working with parents and families of children in intensive care or treatment can be distinguished. These eight forms can be combined with the three goals of parent guidance, formulated by Van Loon (1989). The first goal of parent guidance is to found a working alliance, which supports the development of the treated child. Three forms of working with parents are connected to this first goal, namely reinforcing the contract, maintaining the contract, and providing information. Sometimes these phases are consecutive, sometimes only one of them is or remains possible. The second goal of parent guidance is to create the exchange of information about the child and its treatment. Two forms of working with parents meet this goal: exchanging information and child-centred parent (or process) guiding. These forms can be consecutive phases, but it is also possible that one phase by itself is the only possible way to work with the parents. The third goal of parent guidance is to stimulate changes in the family and between family and treated child, aiming for the future reintegration of the child to its family. This goal is the highest and can be reached by using one (or a combination) of the following forms of guidance or therapy: child-centred parent (or process) guiding, subsystem-centred process guiding, system-centred process guiding and family system therapy.

Conclusion

Returning to the central theme, it may be clear that the multivariate realities of multi-problem children and their families make it impossible to choose a uniform way of working with families. The degree of attunement (and sometimes its lack) between "What has to be done?" (the view of the staff) and "What can or may be done?" (the view of the parents or family) determines the possible form of working with the parents, and it also determines whether this form is static and cannot be changed in another, or whether this form seems dynamic and has potential to develop naturally into a higher form. It is clear that it is not always easy to realise full involvement of parents in the process of day treatment or residential care. Yet, it is also obvious that everything must be done to create a co-operative relationship with them.

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