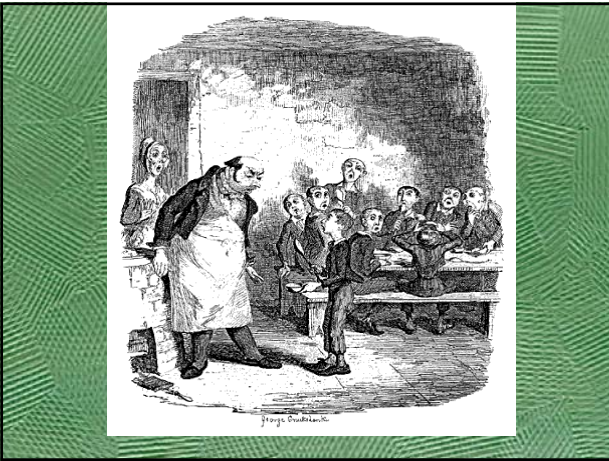


Psychotherapy with Deprived Children :

theoretical and technical issues



Definitions:

Deprivation:

Inadequate physical and or psychological care before birth, at birth, or at some later stage of childhood.

Loss of good enough parents.

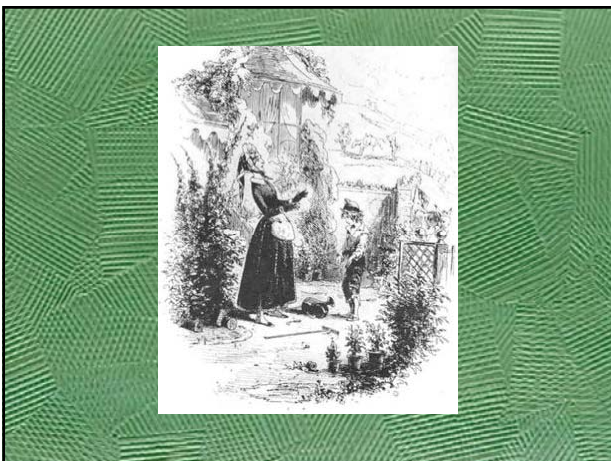
Privation:

The total lack of any good enough experiences.



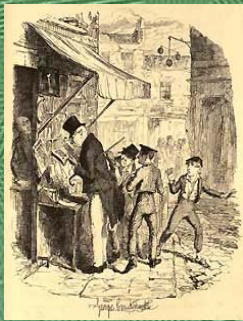
General characteristics

- Usually living in foster care
- History of loss, abuse and neglect
- Major difficulties in relating - no empathy for others
- Emotionally flat but prone to violent outbursts in response to small triggers
- Physical development may also be compromised



Theoretical models:

- General understanding that failure /breakdown in the environmental provision leads to delays, gaps in emotional development.
- Results in lack of age appropriate internal structure which in turn influences behaviour.



Freud [1915] lack of fusion between aggressive and libidinal drives results in failure to modify aggressive impulses.

Klein [1946] child dominated by persecutory anxiety, manic defenses, no toleration of depressive anxiety, no concern.

Erikson [1950] child fails to achieve 'basic trust' in self and others.

Winnicott [1962] ego development is compromised resulting in "false self" /caretaker self.

Main and Solomon [1986] disorganised attachment [D]-
no inner working model of behavioural response to attachment arousal
Kohut [1972] no internalised self object functioning - dependent on external figures for emotional stability [affect regulation]
Gergely and Watson [1996] no core capacity to regulate negative emotions
Fonagy and Target [1997] no capacity for reflective function

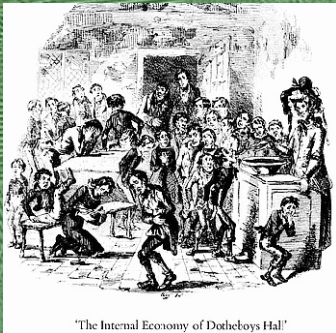
In summary- all theories point to a lack of internalised structures, patterns, RIGS, IWMS etc. which enable affect regulation and thinking about one's own and others feelings and behaviour.

Common presenting problems often threaten placement and include:

- **Hyperactivity**
- **Explosive aggression in response to minor triggers**
- **Stealing and hoarding [food]**
- **Telling lies - even when caught out**
- **Sexualised play and behaviour with peers or younger children**
- **Peer group difficulties - need to 'control' play**
- **Soiling and smearing**

Frequent diagnoses

- ADHD
- ODD
- Reactive attachment disorder
- Adjustment Disorder



'The Internal Economy of Dotheboys Hall'

Assessment Issues

- Need for long term work- therapist availability and commitment
- Support for treatment from the foster parents/caregivers is crucial -therapy often seen as an indulgence
- One stable relationship with an adult [past or present] is a positive indicator for change
- Stable placement used to be considered essential

Therapist aims to:

- Provide an opportunity for emotional growth by-
- Establishing boundaries-the frame
- Providing a secure base
- Managing regression
- Adapting to individual needs
- Containing aggression
- Handling impingements
- Recognition of affect
- Interpretation of symbolic content

Goals of treatment

- The child becomes able to benefit from other relationships with benign adults e.g. foster parents, teachers, social workers etc.
- The child develops an improved capacity to think about his own and other people's minds.
- The child is more able to modulate affect and control his behaviour.
- Greater ability to use words rather than actions when distressed.

Technical Issues

- Lack of personal boundaries
- Relentless aggression in the material
- Constant demand to exceed limits
- Deprivation experiences stirred up by the therapeutic experience
- Possible acting out at home or at school
- Management of the therapeutic relationship
- Connecting with the child's environment.

Case History

- Boy aged 7 referred Paeds
- PC of abnormal eating eg 50 weetbix
- Eating normal in hospital weight normal, health good
- Very active, no limits, some bedwetting, over-friendly.
- Change of foster placement on discharge.
- Request to 'assist with attachment to the new family'.

Developmental History

- Born to teenage mother, herself taken into care when baby age 6 mths. Lost weight on the breast.
- Fostered from age 7 mths . Some physical delay noted at that time - unable to sit.
- Vera Hayward assessment at 20 mths. Problems: slow gross motor milestones, excessive eating.
- Age 2, referral re possible juvenile arthritis, muscular dystrophy, intra cerebral pathology
-

History contd.

- 2001- referred by CYFS re excessive eating e.g. 20 weetbix and stealing food. Dietician consulted, weight normal.
- 2004- referred by foster parents re eating dog biscuits, unable to go to birthday parties, be taken out etc.
- Concern re abuse and neglect, change of foster placement, referral to CAFS.

Significant events during treatment.

- September '04 -placement breaks down - temporary care.
- June '05- permanent placement arranged.
- November '05- two additional children placed with carers.
- February '06 mother decides she cannot ever care for him.
- December '06 placement breaks down due to accusations of physical discipline.

Significant events contd.

- Jan/Feb '07 three changes due to R touching other children
- Interviewed for possible CSAH and discloses sexual contact with first foster mother. Refuses to speak to counsellor/police
Temporary care 'til June. Placed with experienced carers.
- January 2008, all going well, no sexualised behaviour reported.

Themes of therapy

- Close to his issues from the start:
- Feeding - self, dolls, therapist.
- Abandonment- babies given up by parents, killing them in turn.
- Aggression - battles in the sand ,all killed.
- Reparation - First Aid material, sometimes painful
- Winning and losing- board games.
- Self expression- music and some art.

Process of therapy

- Intense ambivalence
- Attachment
- Shutting out- shutting off
- Lack of concern for the environment
- Regression
- Transference and reality in the relationship.
- Ending

Issues for discussion

- When to finish
- Managing the therapeutic relationship
- Networking with the environment
- Keeping secrets.
- Other, is it worth it?
