

УДК 347.64:616.89-008.454:616-053.2

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## **Working with vulnerable children: therapeutic observation and Watch Me Play!**

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SOVREMENNAYA PEDIATRIYA.2018.2(90):14-25; doi 10.15574/SP.2018.90.14

Infants and young children who are taken into the care of the state are likely to have experienced multiple adversities with potential ongoing effects that may compromise their future life chances. Foster placements in early childhood provide unique opportunities to mitigate the sequelae of maltreatment: the pre-school years are a critical time frame for early intervention to prevent emerging mental health disorders from becoming persistent. However, the care given to some infants and young children in foster placements, as the result of a range of complex factors, may be under-involved, developmentally inappropriate or lacking in emotional warmth, thereby compounding the impact of early trauma.

This talk describes and illustrates two linked approaches that aim to support, validate and deepen the foster carer-child relationship in order to mitigate the impact of early trauma and improve placement quality for children and their carers: therapeutic observation, based on the psychoanalytic model of infant observation, and a briefer intervention, Watch Me Play! Both are flexible and responsive ways of supporting infants and young children during legal proceedings or during a move from one placement to another. Watch Me Play! has also been found useful with children and their adoptive parents, and for birth parents who have experienced difficulties in their parenting. Links are made to contemporary neuroscience and child development research and to Freud's discussion of attention as 'observing thought', and a form of psychic energy.

**Key words:** vulnerable children, Foster placements, therapeutic observation, psychoanalytic model, psychological trauma.

### **Работа с детьми из приемных семей: терапевтическое наблюдение и «Смотрите, как я играю!»**

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Дети раннего возраста, находящиеся на попечении государства, часто подвергаются жестокому обращению, последствия которого могут негативно отразиться на них в будущем. Воспитание в приемной семье дает уникальные возможности для смягчения последствий перенесенного жестокого обращения: дошкольные годы представляют собой критические временные рамки для раннего вмешательства, когда можно предотвратить формирование новых психических расстройств, которые могут принять персистирующий характер. Однако в некоторых приемных семьях дети, по ряду причин, могут не получать достаточно внимания и душевного тепла, что может усугубить последствия ранее перенесенной травмы.

В этом сообщении описываются и иллюстрируются два взаимосвязанных подхода, целью которых является поддержка, укрепление и углубление взаимопонимания между опекунами и детьми, а также устранение последствий ранее перенесенной травмы у детей и улучшение качества совместного пребывания в приемных семьях: терапевтический подход, основанный на психоаналитической модели наблюдения за детьми, и подход быстрого вмешательства под названием «Смотрите, как я играю!» (Watch Me Play!). Оба метода являются гибкими и эффективными, особенно при поддержке детей раннего возраста во время судебных разбирательств или во время смены приемных родителей. Метод «Смотрите, как я играю!» также был признан полезным для детей и их приемных родителей, особенно для родителей, которые испытывают трудности в воспитании приемных детей. В статье автор ссылается на современные исследования в области нейробиологии и детского развития, а также на учение о психоанализе Фрейда и формы психической энергии.

**Ключевые слова:** дети, лишенные родительской опеки, приемная семья, терапевтическое наблюдение, психоаналитическая модель, психологическая травма.

### **Робота з дітьми з прийомних сімей: терапевтичне спостереження та «Дивіться, як я граюся!»**

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Діти раннього віку, що знаходяться під опікою держави, часто зазнають жорстокого поводження, наслідки якого можуть негативно позначитися на них у майбутньому. Виховання у прийомній сім'ї дає унікальні можливості для пом'якшення наслідків жорстокого поводження: дошкільні роки є критичними віковими рамками для раннього втручання, коли можна попередити формування нових психічних розладів, що можуть набути персистуючого перебігу. Однак у деяких прийомних сім'ях діти, з ряду причин, можуть не отримувати достатньо уваги і щирого співчуття, що може поглибити наслідки перенесеної травми.

У даному повідомленні описано та проілюстровано два взаємопов'язані підходи, метою яких є підтримка, зміцнення та поглиблення взаєморозуміння між піклувальниками і дітьми, а також усунення наслідків перенесеної травми у дітей та покращення якості сумісного перебування у прийомних сім'ях: терапевтичний підхід, заснований на психоаналітичній моделі спостереження за дітьми, та підхід швидкого втручання під назвою «Дивіться, як я граюся!» (Watch Me Play!). Обидва методи є гнучкими та ефективними, особливо у підтримці дітей раннього віку під час судових розглядів або під час заміни прийомних батьків. Метод «Дивіться, як я граюся!» також було визнано корисним для дітей та їхніх прийомних батьків, особливо для батьків, що зазнають труднощів у вихованні прийомних дітей. У статті автор посилається на сучасні дослідження у галузі нейробиології і дитячого розвитку, а також на вчення про психоаналіз Фрейда і форми психічної енергії.

**Ключові слова:** діти, позбавлені батьківської опіки, прийомна сім'я, терапевтичне спостереження, психоаналітична модель, психологічна травма.

In this talk I want to discuss how clinical approaches using psychoanalytic observation can contribute to therapeutic support for a particularly vulnerable group of children, those who cannot be looked after in their birth families. The work setting for the examples I will give is a mental health service for children in care, but the ways of working we

have developed can also be applied in other contexts where there may be concerns about development and relationships, or following adoption.

This painting by William Hogarth from 1746 (c. The Foundling Museum, London) may help us to think about the experiences of infants and young children in care today: it shows a young



child, the infant Moses in the bible story, facing a move into a new family. He is being presented to the Egyptian princess who became his adoptive mother. The painting is still on display in the room for which it was painted in London's Foundling Hospital, the first home for orphans to be established in England (McClure, 1981) [19].

Hogarth was one of the first supporters of the Foundling Hospital, and he and his wife acted as foster carers for babies before they were moved to the hospital as young children. He seems to have brought all of this experience to bear in the way he has shown the child Moses, pale and hesitant, clinging to his mother's robe, and facing a great divide into a new and different world, one that he must cross alone. For me, this highlights a central aim of therapeutic work with children who are in temporary foster placements: to provide companionship and support continuity in order to help the child to be less alone with their experience.

### **Continuity**

Winnicott defined continuity, the feeling of 'going-on being', as the core of a sense of identity, essential to psychological health. He also describes repeated disruptions to 'going-on-being' as leading to fragmentation and the 'active production of chaos in defence against ... unthinkable ... anxiety' (Winnicott, 1965:61) [36]. The continuity of a relationship with a reliable adult can be a lifeline for children whose primary attachments have been disrupted. Receiving responsive nurture from reliable caregivers allows children over time to internalise experiences of adults as helpful and attentive, laying the foundations for the internal continuity that sustains the self when there are breaches in external continuity. Developing a degree of internal continuity is essential for making relationships and learning;

without these capacities, the quality of life for children and their life chances are severely compromised. What happens, and what can help, for children who have neither external nor internal continuity, who experience placement changes and changes of social worker as they progress through the care system, is the subject of this talk.

### **The 'free psychical energy' of attention**

Attention has a particular role to play in the development of internal continuity. Little discussed in its own right – we hear much more about attention deficit – attention is a topic to which Freud returned many times in his theoretical writings. In his first publication, the *Project for a Scientific Psychology* (1895), he describes attention as 'a free psychical energy', and draws a distinction between 'ordinary thought', directed towards finding a satisfying object, and 'observing thought', directed towards the internal world. 'Observing thought' relies on attention and asks 'What does this mean? What does this lead to?'

In later writings, Freud highlights two different aspects of attention, the active and the passive. On the one hand, he describes attention as actively 'meeting the sense-impressions half-way, instead of awaiting their appearance' (1911). But he also describes a stance of free-floating or evenly-suspended attention, passively receiving rather than selecting from the material, which he recommends to psychoanalysts as allowing more direct contact with the patient's instinctual life (1912; 1923) [7,11]. These ideas about attention as energy, about 'observing thought' that looks for meaning, and the duality of active and passive aspects of attention are particularly relevant to clinical work based on psychoanalytic infant observation.

### **The work context**

I work as a child and adolescent psychotherapist in a psychological health screening and assessment service for children in care. The task of the service is to assess psychological need and offer brief intervention for all children and young people entering the care of the commissioning local authority. When we are notified that a child has entered care, we send screening questionnaires to their foster carer. A child whose questionnaire score is in the clinical range, or any child about whom concerns are expressed, is followed up in consultations with their social worker and foster carer: we explore the sequence of events that led to the child coming into care and reflect on how this may have shaped the child's expectations of adults, their relationships and their therapeutic

needs. We work closely with health, social care and education professionals to facilitate a containing network around the child and foster carer. A consistent focus on the child's development and communications is used to inform discussions about care planning, placement needs and transitions.

One of the strengths of this system is that it does not rely on referral; this is particularly significant for infants and young children, who are rarely referred to mental health services and are often expected to recover spontaneously from unimaginable traumatic experiences. In the service, over time, we see or hear about many children who remain in care and find security in loving foster families, but also about a smaller group of children whose needs are not met, who fall through the net and move ineluctably towards the 'brick mother' of the criminal justice system and prison.

#### **Adversities for children in care**

Many children who reach thresholds for entering care have experienced abuse and neglect, for months or years, and may have had to turn to unpredictable, hostile or dangerous caregivers for their most basic care. These experiences are associated with significantly increased risks of mental health difficulty in infancy or later childhood. Neurological studies report that patterns of brain activity in children exposed to family violence are similar to those of soldiers exposed to combat (McCrorry et al, 2011) [18]. «Toxic stress» has been proposed as a mechanism underlying severe and enduring emotional and self-regulation difficulties that affect many children who have experienced maltreatment (Center for the Developing Child website). «Complex trauma» is another conceptualisation of pervasive difficulties that may compromise all aspects of development without reaching diagnostic thresholds, meaning that criteria for mainstream mental health services are not met (DeJong, 2012) [5].

Another aspect of the adversity faced by maltreated infants and young children is denial. When a child's suffering is denied, it is not witnessed, and cannot be addressed or mitigated, leaving the child alone with their trauma. Under-recognition of infant mental health difficulties was highlighted in the first systematic studies of childhood trauma in the 1940s and has continued despite the influential work of Bowlby and the Robertsons in the UK during the 1960s, and the subsequent wealth of studies from attachment research, child development and neurobiology (Robertson and Robertson, 1989; Gerhardt, 2004)

[23,15]. It seems that a different language is found in every decade to block out awareness of suffering and harm to the most vulnerable children in our society: a recent study of adoption breakdown found 'a prevailing view that infants do not have needs, other than basic physical ones' (Selwyn et al., 2014) [26].

Children who suffer maltreatment at the hands of their parents endure the trauma of a breach in their parenting and 'the breaking of the continuity of the line of ... existence' that Winnicott defines as the essence of trauma (1986, 22) [37]. A further aspect of adversity for children who enter the care of the state is the inevitable disruption or severance of their primary caregiving relationships. For some children, this happens repeatedly, both before and after entering care. The care system in the UK has four main placement pathways for young children, each bringing risks of disrupted caregiving and prolonged uncertainty. Re-unification with the birth family and care by members of the extended family are the preferred options where these are judged to be safe for the child, but they are also associated with the risk of receiving care that does not fully meet the child's needs, and of re-entering care later in childhood. Failed family re-unification and breakdown of kinship placements are more common than adoption breakdown. Maltreated children who return to their parents have been found to be more likely to experience further abuse or neglect and to have poorer psychosocial outcomes than those who remained in foster care or were adopted (Biehal, 2007; Sinclair, 2005; Ward et al., 2006) [2,27,34]. Adoption and long-term foster care may provide greater stability, but both are associated with lengthy legal proceedings, resulting in prolonged uncertainty during the formative period of infancy when the need to bond with a stable and nurturing caregiver is paramount.

While many children thrive and show impressive signs of recovery from their first days in foster care, for a number of children, the traumas of maltreatment and family dysfunction may be compounded by receiving uninvolved, emotionally detached foster care. This type of adversity increases the likelihood of developing a mental health difficulty and of adoption breakdown in later childhood. Abrupt, unplanned transitions are another risk factor following entry into care for later mental health difficulty and placement instability (Hillen and Gafson, 2011; Selwyn et al., 2014) [12,26].

The range and the severity of the adversities facing children before and after entering care form

the rationale for developing interventions with the specific aim of understanding and mitigating difficulties and distress for infants and young children in temporary foster care.

### **Therapeutic observation**

Therapeutic observation is an intervention model that applies the principles of psychoanalytic observation in training to a clinical context (Houzel, 2008; Rustin, 2014) [14?,24]. It offers a home-based, non-intrusive approach with minimal disruption to family life and has been applied with infants at risk of autistic spectrum disorder and young children at psychosocial risk (Rhode, 2007; Rustin, 2014; Houzel, 1999) [22,24,13]. In hospital settings, observation-based approaches have been used with premature babies since the 1970s (Negri, 1994; McFadyen, 1994) [21,20] and there are published accounts of the applications of psychoanalytic infant observation in a range of institutional settings including orphanages and children's homes (Urwin and Sternberg, 2012) [31].

In this model, the clinician, who has previous training in infant observation, visits the family home for an hour at a regular time each week. The observer's stance is one of aiming to provide a friendly, receptive presence, attentive to each family member who is present while maintaining a focus on the infant, and responding to rather than initiating interactions. A close and detailed focus is kept on the movements, expressions and vocalisations of the infant and the emotional atmosphere of his or her interactions with others during the hour of the visit. During the visits, the therapeutic observer draws on repeated close observations to promote connection between the infant and the caregiver at moments when a signal from one or the other might otherwise go unnoticed.

Detailed notes are written after the visit and discussed in supervision, with particular attention to the fine detail of interactions and the observer's feeling responses. Regular supervision from an experienced clinician is essential to this way of working; it involves a close exploration of the infant's communications and development, together with a focus on the emotional experience of what it is like to be with the infant in the home. Supervision also provides a companionship that is particularly important in a way of working that brings greater closeness to the emotional experiences of babies and young children in transition, which at times may be profoundly harrowing or bleak. In this way, the observational model sepa-

rates out the dual aspects of attention identified by Freud: the regular visit and the circumscribed role of the observer create the conditions in which as much information as possible can be received. The active aspect of attention, the observing thought that asks 'What does this mean?' comes into play later, in the discussion in supervision and the ongoing processing and reflection in the clinician's mind that it facilitates.

I had the valuable opportunity to carry out research looking at how this model of therapeutic observation might be applied with an infant in foster care (Wakelyn, 2011, 2012) [32,33]. When I discussed the project with social workers, it was welcomed. There was a general idea that it would be helpful to understand more about the experiences of babies in care. Relatively little has been written in the research literature about the youngest children in care and social workers were aware of a lack of practice guidance. Ethical permission was obtained and I was able to observe a baby boy, 'Rahan', for ten months during his time in foster care until he was moved to his adoptive family.

In the account that follows, all names and identifying details have been changed to protect confidentiality. The foster family and social workers let me know when I fed back to them after the project ended that they are pleased that findings from the research are being disseminated.

### **'Rahan'**

Rahan was born to a teenage mother who gave up her baby to be adopted. The young mother's pregnancy was overshadowed by fears of violence from her boyfriend as well as from her family and their religious community. He was brought up in the same foster family, from the day of his birth until he was adopted at the age of thirteen months. He had a different experience of foster care from that of most infants in care. He is likely to have been exposed to prenatal stress due to his mother's fears and her frequent moves, and he experienced the loss of his mother on the day of his birth, but he was not exposed to maltreatment or to any change of caregiver during his first year of life. This meant that my research provided an unusual opportunity to examine a temporary caregiving relationship in the absence of other compounding factors.

The weekly observation visits began when Rahan was three months old. My overriding impressions in the first weeks were of disarray and disconnection. A lack of communication between the foster mother and social workers at times seemed to resurface in the interaction between a very caring foster mother and the three-month old

baby. I learned that no one had been present to mediate the coming together of the foster carer and the baby she was to care for. Rahan was passed to Nadira at the door of the hospital ward after she had shown her identification. There were very bleak moments during the observational visits when Rahan seemed psychologically unheld, when I found it shocking to see how very pale and remote he could become in moments when I felt repelled by something that was ugly, that I felt I should not be seeing. In these early stages, the task that occupied both me and my supervisor seemed to be to absorb, take in and process powerful experiences of fragmentation, of 'no link'.

### Joining up

Gradually, experiences of connecting came more to the fore. The routine of the weekly visits became established and Nadira helped me to join up in my mind the Rahan of today with the Rahan of the previous week. Here are some notes from a visit when Rahan was four and a half months old: as he became more mobile, his upper and lower body were drawn into the linking of his left and right sides:

*Rahan lies on his back, draws up his knees, and takes hold of one foot in each hand. He drops the left foot, almost cries, and then again holds a foot in each hand. He repeats this movement several times. He murmurs and makes some repetitive humming sounds ... His stare moves from my face to my feet and back to my face again. When I then move my feet, he watches with a fascinated expression, and then as if in answer, moves his own feet.*

*When Nadira goes, she carries on talking to Rahan from the other room. He mouths the corner of the toy she gave him and looks steadily ahead. When she comes back, I say something about how he watches her when she is there and when she leaves, he is listening to her voice. She tells me she only just remembered to play peek-a-boo with him, as she did with all her own children when they were babies. She says she had forgotten about it. She says it helps them to be able to wait.*

While he dropped and picked up his left foot, and alternated this with picking up both feet, Rahan provided himself with a background continuity with the humming sounds that bring together the lips and the front and back of the mouth. As he became more linked up with himself, he was then able to link up with me and become curious, making full, active eye contact.

It took time to assimilate the reality of being a foster parent. It seemed that now Nadira was more able to treat Rahan like one of her own chil-

dren. The significance of the game of peekaboo, as she recognised, is that it allows experiences of separation to be repeated, experimented with and explored, and to some degree mastered, allowing a degree of control and agency to the infant: all the multiple and mysterious ways in which play, as Freud (1920) [10] observed with his young grandson, allows the ego to come to terms with and encompass previously indigestible aspects of reality.

Nadira was not alone as a foster carer, I think, in finding playfulness in relation to the comings and goings of ordinary family life, a step too far as regarded the infant for whom she was providing heartfelt but temporary care – an infant who, as so often, the foster family did not know if they would ever see again after he was taken to his adoptive family.

After a long period of limbo, when time felt suspended and it seemed that development was on hold, an adoptive family was identified for Rahan. This is a time when, with the approaching reality of a long-awaited move, emotional contact may be lost with the child's experience and, in particular, the significance of the relationship with foster carers may be effaced (Lanyado, 2003) [16]. A momentum can set in to move fast, close down thinking and cut off connections with the past. Recognising a child's previous attachments and relationships can then be perceived as a hindrance, rather than as strengths to build on. Even the current foster carer may be left out of the planning for this momentous transition for the child, and considerations about future contact with the carer can be dismissed as irrelevant or unhelpful. My task as the therapeutic observer included advocating for Rahan's emotional needs at this time and the central role that Nadira was able to play during the move to his new family.

The following excerpt is from my second to last observation visit:

*Rahan looks towards me with a distant expression. Nadira tells me he is «very day-dreamy» at the moment. She asks him if he is looking at the leaves blowing in the wind. He goes up and down the alleyway with the boys from next door as they kick the ball for him and he follows it. Rahan half-closes his eyes as the wind ruffles his hair; he puts his hands over his ears, and rubs his tummy. He says, 'Hoarrhhh', making a sound like the wind.*

*Nadira says to me, «All that time we were expecting it, and now I am thinking: it is happening now». Thinking about what the move will be like*

*for Rahan, Nadira reflects that, later on, Rahan will think about his birth mother and father, but that will be when he is older. Right now, she is like the mother: for him, at the moment, it is about her and the adoptive mother.*

*She takes him into her lap. He nestles and moulds into her body. She feeds him strawberries; he glows with delight and looks intently into her face, and she kisses him.*

*Later, Rahan plays a slow game of peek-a-boo with me. It feels serious and enquiring. He brings the duck toy to me, watching me carefully, and gives it to me and takes it back many times. Then he throws it down on the floor, picks it up and holds it close, embracing it in both arms before burrowing his face into it.*

During this time of high tension and anxiety, I was encouraged to see how child and foster mother now seemed able to move in and out of contact, as if Nadira were practicing in her mind to let Rahan go, and allowing him to practice leaving her. I came to feel that my role as a therapeutic observer was in part to be a companion on the journey, someone who could to some degree enter into, understand and, perhaps, contain something of the emotional experience of the foster mother and the baby. The focus on providing as much attention as possible during the visits and searching for meaning later, in supervision, seemed to help to regulate some of the pain of being emotionally in contact with a child who was soon to go and a close relationship that was being severed.

I visited Nadira several times after Rahan left. I felt relieved to hear about a close relationship that gradually developed between the adoptive and foster families. It seemed that the observation may have provided an additional layer of containment and helped her to remain emotionally available to Rahan during the transitional period both before and after he was moved. However, the adoptive family chose not to meet me and this meant that I was not able to ask them about continuing to observe Rahan in his new home.

### **'Trauma-driven' and 'developmental' organisation**

In the analysis of the observation notes, using grounded theory methodology (Strauss & Corbin, 1990) [28], I extracted themes that were prominent throughout the observations and related to different types of organisation. It seemed that, at times of transition and high anxiety, organisation was more likely to be driven by the dynamics of trauma - dissociation, fragmentation, panic and de-personalisation. Vicious circles of dysfunction-

al interaction are generated by the escalating impact of undigested psychic pain in this type of organisation. The result is loss of contact with the emotional reality of the infant. Particular aspects of trauma-driven organisation were identified: 'tornado', 'machine', and 'limbo', each more prominent during different periods in the life of the temporary foster placement.

The research also highlighted a different type of organisation, which I call 'developmental'. In developmental functioning, the child's experiences and states of mind occupy a central place in the adults' thoughts, preoccupations and feelings. This more integrated type of organisation shapes conditions in which emotional contact with painful realities — for the child, the foster carer and perhaps too for the adoptive parents — can be sustained.

Another finding from the observation project was the crucial role of play in mitigating the impact of experiences of discontinuity, rupture and provisionality during the infant's time in temporary foster care (Alvarez & Phillips, 1998) [1]. The research also showed that the observational approach was welcomed by social workers and the foster carers, while also highlighting moments when the integrating function that the observer comes to represent may be powerfully resisted. This became particularly apparent in a therapeutic observation which I supervised, with an infant whose start to life was severely compromised and whose first months were overshadowed by tragedy.

### **'Aisha'**

Therapeutic observation was used to provide a closer acquaintance with Aisha, an infant whose early development was causing concern, to promote the nurturing bond between foster carer and child, and to inform care planning and preparation for a transition to a permanent family. The therapeutic observer, my colleague Martina Weilandt, is an experienced clinical social worker and mental health practitioner trained in psychoanalytic infant observation.

Aisha's mother suffered from mental health and substance abuse difficulties. Born four weeks premature after her mother had taken a high dose of heroin, Aisha received specialist care but inevitably she was looked after by a rotation of changing nurses in the neo-natal unit. Her withdrawal from foetal exposure to heroin required treatment with morphine. Her father wanted to look after her but was unable to because of his own difficulties with substance abuse. On dis-

charge from the neo-natal unit, Aisha was first placed in a foster family where there were already two young children. This placement broke down after six weeks, when the carer found the demands of all the children more than she could manage. Aged two and a half months, Aisha was moved to the care of Sharon, an experienced foster carer for babies. Sharon had no other children in her care and had the support of her back-up foster carer.

Aisha's social worker requested a consultation with the mental health service after the statutory health assessment highlighted a significant developmental delay. This sensitive social worker was also worried by Aisha's withdrawn states, which alternated with shrill, inconsolable crying. She gave a vivid description of Aisha as: 'a tiny baby with rigid muscle tone, tense and screaming in a high-pitched tone that would go on and on until she would suddenly stop.' An open-ended observational intervention was agreed, with fortnightly visits to the foster placement and regular meetings with the professional network. The complexity of Aisha's needs and her situation meant that the intervention went on to last for two years.

In her first visit, Martina's impressions of Aisha were of an infant who seemed very far away:

*Aisha seemed rather pale and stiff ... when Sharon left the room, Aisha did not look at me. I felt very uncomfortable with the situation of being alone with her. The silence and aloneness after a time seemed too long and I moved to sit nearer, and talked to her quietly. Aisha stretched up her left arm until it was rigid, making her hand into a fist. She remained in this tense position until Sharon returned.*

In the second visit, Martina was again left alone with Aisha for a few minutes. This time, Aisha made a very gentle, tentative movement towards the observer:

*Aisha stared at me with blank eyes for what felt a very long time. Then she slowly moved her arm and placed her hand on my wrist. I was taken aback by Aisha's deliberate movement and by the lightness of her touch, like a feather, as if I had to hold my breath in not to blow her away. Aisha looked into my face, her eyes brighter. I stayed very still and talked quietly to Aisha until Sharon returned.*

Martina learned that making contact with Aisha had to be achieved slowly and gradually: too much movement or sound could make her instantly withdraw; but, once established, the contact between Martina and the three month-old baby felt very intense.

Over time, Martina noticed a similar pattern in her interactions with Sharon. Many of her visits

were cancelled or postponed; sometimes, Martina waited several minutes after ringing at the door, leaving her wondering if the visit had been forgotten or was unwelcome. But once she had been let in, Martina was warmly welcomed and left in no doubt that she was expected. We puzzled over this. It was as if a layer encircled the foster-carer and baby couple, requiring a particular persistence from Martina in order to get through and make contact.

Martina had been visiting for two months when Sharon received the shocking news that Aisha's mother had died, from causes that remained unknown. During her next visit, there was a profound sense of contact between Martina and Aisha:

*Aisha sat in front of me, looking at me seriously. She took hold of my hand and held it. I spoke gently in a quiet voice. As Aisha continued to look into my eyes, I responded by stroking her hand. Every now and then Aisha made a big sigh with her shoulders and chest moving. There were long periods when both of us were silent... I felt a deep sense of connectedness with her.*

The impact of Aisha's mother's death seemed to be devastating, fragmenting the cohesion of the previously well-established professional network. It now seemed as if Sharon were in a vacuum: her calls and emails to professionals went unanswered. Once again, Martina's experience with the network was that re-establishing communication was difficult and time-consuming, but once contact was made, it was valued, and further meetings were welcomed. Martina's role in addition to convening the meetings, was to validate Sharon's observations of Aisha's development, share her own observations and to advocate for Aisha's psychological needs to be kept at the centre of the planning for her future care.

As the working group of professionals once more began to cohere, Martina noticed a new arrangement of furniture in the living room. Sofas and armchairs were now arranged in a circle in the middle of the room, a small table forming a movable doorway into the enclosed and cushioned space within. This seemed both to represent a womb-like space and a protective buffer for Aisha against an external world felt to be harsh and dangerous – and against a future that will bring Aisha a cruel knowledge of her mother's death.

Just as Martina had needed to persist in reaching out in order to cross the boundary between outside and inside and to establish the regular routine of the visits, so too getting inside the circle of couches took an effort- in this case, a physical one; but once inside, the feeling was one of «now you

*were in, now we could actually just be*». The protective zone of the circle of couches seemed to both symbolise and concretely provide a place of reprieve from feelings of shock and grief, where Aisha could be kept safe and the impact of her bereavement could be gradually processed and, some of the time, set aside.

Over the next six months, plans for Aisha's future took shape. Her father's parents, who were living in another country, came forward to adopt her. Remaining within her birth family seemed to offer potential for hope, alongside anxiety about whether her needs could be met by her grandparents. There was prolonged uncertainty as assessments continued, while the potential move to another country threatened an absolute severance of the close bond Aisha had formed with Sharon. Martina describes Sharon's task during this transitional period as 'living in a stuck transition and managing the complexity of caring for a child with an uncertain future, balancing the need to provide a loving home and allowing a close bond to develop, whilst at the same time knowing that she will move on'.

#### ***'You have seen it'***

The therapeutic observer's role models a stance of keeping going forward and reaching out, while in supervision there is time and space for recognising and processing unbearable feelings. This seemed to be reflected in Sharon's capacity to go on reaching out, despite the less than clear signals that she received from Aisha. Aisha accepted comfort from Sharon rather reluctantly, but gradually she began to turn to her more. This important development helped Sharon to feel that Aisha would be able to make her needs known and find comfort from her future caregivers.

Sharon's determination to remain hopeful for Aisha and to promote her development by providing her with age-appropriate toys and stimulation came to the fore when despair threatened to overwhelm. She was keen to meet and help the grandparents and to get to know them, so that she would know who Aisha was with, but also so that there would be time for Aisha to get to know them while still having the background security of her familiar presence. The contribution of the observational intervention to an integrated transition was acknowledged by Sharon and by Aisha's social workers. The continuing availability of the professional network to take account of and validate her relationship with Sharon and to encourage Aisha's grandparents to make a connection with Sharon may have owed something to the ongoing persistence of the therapeutic observer and the

continuity modelled and symbolised by the observer's role. It was now Sharon who advocated for Martina's continuing involvement in the professional network, insisting that she was integral to the planning and should be there when the grandparents first came to see Aisha.

*«You have been coming to visit us for such a long time. You have seen it. You are important in Aisha's life».*

Martina was able to advise about Aisha's likely emotional needs in her new home. She could describe from repeated experience how quickly Aisha could be overwhelmed by too many new experiences or new adults too soon. Her traits of premature self-sufficiency meant that she did not seek help easily and might be experienced as self-reliant, when in fact she needed more attuned care and individual attention than a typically-developing child.

Aisha's grandparents had been talking on the phone with Sharon for several months before their first visit. After a three-week introductory period when they visited every day, learned her routines and gradually spent more time with her alone, Aisha was taken to her new home. The family gathered around and we heard that one of her younger uncles became an active helper to her grandparents. Her grandparents maintained contact with Sharon, talking with her on Skype, seeking her advice and sending photos. They asked Martina to send a letter that they could use to help find psychological support from services in their country.

As in the previous observation with Rahan, here too the observer's role involved an extra effort to 'get in' and to 'stay connected', particularly as the time for the move away from the foster home approached. These repeated efforts bring us back to Freud's idea of attention as a form of energy: the undivided attention given to Aisha seemed to awake a profound response in her that helped to sustain the motivation and energy that Martina needed to go on reaching out. We thought about how Aisha may have internalised the experience of being fully attended to, hoping that this might help to sustain her through the move to a new family in another country and the developmental challenges of childhood and adolescence.

#### **Play and recovery**

Observational interventions have informed our work with foster carers and social workers, particularly in relation to how play can promote attunement in foster placements and help to prepare for transitions. Children who are referred for mental health assessment or treatment are frequently described as unable to play. The play



of traumatised children can have a mind-numbing quality: the endless crashing of toy cars, random throwing of toys, breaking off a game just when the other person is joining in, can have a joyless quality that is hard to stay with. Caregivers may feel paralysed by something concrete and driven in play in which something is re-enacted, over and over again, rather than being explored and processed, leaving child and carer feeling ever more isolated from each other. At the same time, play can have a crucial function in mediating and mitigating the additional stresses that each stage of development brings for children living in temporary relationships, as I saw when Nadira played peekaboo with Rahan.

### **Watch me play!**

One day, five year-old Angus asked me to 'Shut the door and watch me play!'. The experience that he was instinctively expecting is part of typical development in many cultures, but can be inhibited by the anxieties and uncertainties surrounding young children in care. The developmental value of child-led play is fundamental in early years education, but often less well understood in social care contexts. The approach we have developed for brief interventions and trainings with foster carers and social workers is focussed on child-led play together with undivided attention from the caregiver for short but regular periods of time. We combine this focus with sharing key points from child developmental research that are particularly relevant to foster caring.

The core principle of the developmental guidance is that a secure attachment with a primary caregiver is the foundation on which a child's future relationships will be based. We also discuss how exploratory play comes before formal learning, and how it may involve making a mess, getting things 'wrong' or doing things differently. In our work together with foster carers and social workers we aim to convey that thinking about the meaning of children's communications helps them

to develop a sense of self, and to learn. We also give advice about toys, television and screens (Lerner and Barr, 2014) [17]. The living presence of the foster carer can be effaced for a child who is surrounded by televisions, computers and automated toys: instead of the responsive intimacy that healthy development depends on, the child may experience a cacophony of recorded voices, electronic music and the over-stimulation of randomly flashing lights. The child's signals and cues cannot be noticed or responded to, and this may lead to both carer and child withdrawing from each other and a situation where good physical care is being provided but the child remains in an emotional void.

### ***'Do I matter to her?'***

Nina was five months old when her foster carer, Jane, expressed concerns about her shrill, persistent crying and sudden mood changes. Born addicted to heroin, she had spent her first two weeks of life in a special care baby unit. When I visited the foster home, Nina next to Jane on a sofa in a bright living room, near a large television and surrounded by battery-operated toys. A radio in the nearby kitchen vied with the loud voices of the television programme. I saw again and again that Nina glanced briefly in Jane's direction after a particularly loud noise, and then dropped her gaze when Jane was looking elsewhere. As this went on, Nina's face became paler and her arms and legs seemed to stiffen.

It seemed that Jane may have lost confidence that her presence and attention were important for Nina. We were able to spend some time thinking together about what might help Nina to regulate her high levels of arousal. Turning the television off and putting away the mechanical toys created a quieter environment in which Jane could hold Nina in her arms, talk quietly or sing to her, and notice and get to know her rapid, fleeting facial expressions. This helped Jane to see when Nina was ready for play and when she needed to rest. It also helped Nina to send clearer signals and cues to the caregiver whose attention was now on her.

Encouraging Jane to provide Nina with undivided attention for regular periods during the week increased Jane's confidence in attuning and interacting with her foster baby. Repeatedly experiencing familiar responses in the transitional space provided by play created a 'rhythm of safety' for Nina (Tustin, 1986) [30]. Increasingly pleasurable interactions now began to be described as she

**What is Watch Me Play?**  
**Child-led play**  
 +  
**Undivided attention**  
 +  
**Developmental guidance**

began to seek Jane's attention, her long gazes giving way to slow smiles as Jane talked to her and waited for her response. Jane reported to her social worker that she felt she was getting to know her foster baby in a different way: she began to recognise the likely stressors for Nina and felt more able to anticipate her changes of mood and to soothe her when she was upset. The long periods of inconsolable crying lessened. This brief intervention brought home to me how hard it must have been for a first time foster carer to feel that she could be close to and important for the traumatised infant in her care.

Foster carers looking after toddlers may find difficulty in allowing the kind of free play that provides opportunities for children to express themselves. For Shalona, a shy, pretty three year-old who spoke in a whisper and avoided any physical comfort from her thoughtful foster carer, Kella, a shift was seen after two Watch Me Play! sessions with telephone support in between the sessions. My colleague noticed that as soon as Shalona started to play, Kella asked questions and made suggestions about what she could do next. It seemed that Kella very much wanted to find a way of giving something to Shalona, and in doing so, unwittingly, became intrusive. When Kella was able to take a step back, she began to see how Shalona was able to play more freely. A new side of Shalona began to emerge: she could now show the toy animals fighting, shout when she was winning at Snap, and ask to be held on Kella's lap when she was upset. Kella felt that Shalona had come alive, and had become a three year-old child instead of

a 'mini-adult'. The focus on play and undivided attention for a short period of time helped child and carer to find each other and Kella began to enjoy looking after Shalona more, even when she became less compliant and more challenging.

Child-led play is integral to interventions for children who may have developmental or attachment difficulties (Alvarez and Phillips, 1998; Bratton et al., 2006; Sunderland, 2007) [1,3,29]. Studies of children recovering from malnourishment report reduced mortality and increased speed of recovery in children who received intensive feeding and psychosocial support, using the principles of focusing complete attention on the child and promoting play, compared to children who received intensive feeding only (WHO, 2006) [35]. A focus on psychological well-being was needed in addition to feeding to generate the life-giving emotional connectedness between children and their caregivers.

Many factors may underlie situations that can arise in which foster carers become distant from the children they are looking after. There may have been repeated, unprocessed losses. Foster carers may feel unvalued and unimportant in a climate that militates against validating the parenting they provide.

I met Noemi, aged 2 and a half, and her foster carer Linda, following concerns that the care being provided in the foster home was 'functional'. Noemi, a sturdy toddler with a sombre facial expression, glanced at the dolls' house in the playroom without turning to Linda. I sat on the floor of the playroom with a small selection of toys and invited Noemi to play. Slowly she picked up one animal after another. In a loud voice, Linda began to tell Noemi the names of the animals and told her to repeat them. Noemi turned away and stared into space. Linda told me this was Noemi acting like a sulky teenager. I encouraged Linda to sit on the floor and just watch what Noemi chose to do and then we could talk about what we had each

### How to do «Watch Me Play!»

- Plan a regular time when you can give your child your undivided attention for 20 minutes
- Turn off TV, computers and phone
- Put out simple toys that let your child use their imagination
- Sit on or near the floor and tell your child how long you have got
- Watch your child play and show interest by describing what they do
- Let your child take the lead
- Join in the play if your child asks you to
- Notice how it feels to be with your child playing
- Help your child prepare to finish
- Keep your child's drawings in a folder or a drawer
- If watching your child play feels difficult, talk with a colleague, a family member or friend, your health visitor, social worker, or GP

### How could WMP help me and my child?

- You and your child could enjoy being together in a different way
- Your child could develop more confidence, communicate more clearly and concentrate for longer
- You could get more confident about understanding your child's signals
- You could get a clearer idea of your child's interests, skills, and any worries

seen. When Linda sat down near her, Noemi took some cushions and a blanket and played at going to bed. Linda began to talk in a quieter voice, describing to Noemi what she was doing. In the next two sessions, Noemi repeated this game with increasing delight, and began to play peekaboo with Linda, hiding behind the blanket.

In the third session, Noemi lifted her arms to be held by Linda. I saw her relax into her lap, her rigid muscle tone softened and I felt a deep relief. Noemi's sombre expression lifted more often into a smile and she vocalised more freely. Linda told me: 'the house feels lighter'. I did not have the scope to explore the underlying causes of the alienation that seemed to have come about between Linda and Noemi, or the opportunity to follow up this intervention, but it seemed that the transitional space of play and the experience of mutual delight that it afforded had allowed something to become freed up and created more warmth and attunement between carer and child.

Watching a child play, describing the play, and providing undivided attention for short periods of time can do no harm. Trainings in clinical observation and child development may be helpful and reflective supervision is always important in work with children who have experienced trauma and disrupted care. It is likely to be helpful to observe alongside a clinician or to discuss what is seen in the child's play with another interested adult, but the Watch Me Play! approach is not a brand. It is a flexible approach that can provide a helpful first stage before further more intensive treatment such as video-interactive approaches, parent-infant psychotherapy or individual child psychotherapy, if they are needed, and available.

Where possible we offer around six sessions with foster carers and children together, often with telephone support to the carer between sessions, but the approach is flexible enough to be used in briefer interventions of just one or two sessions with telephone follow-up. It has also been possible to follow a child from foster placement to foster placement and to the adoptive

### **Roles of the clinician in Watch Me Play!**

#### **Modelling the approach with carer and child**

#### **Showing interest in the child's play and the carer's observations**

#### **Noticing if it is difficult to provide undivided attention, a quiet environment, the right toys, or to let the child take the lead**

#### **Feeding back sensitively to child and carer**

#### **Making a time to discuss and share observations with the carer**

#### **Reflecting together on feelings in the play and how it feels to be with the child**

#### **Encouraging the carer to make a regular time for WMP**

#### **Feeding back into care planning and advocating for the child's psychological needs**

#### **Access supervision**

home, providing an extra layer of continuity for the child, with the same approach being used by each caregiver.

### **Conclusion**

Making sense of observations and feelings — Freud's 'observing thought' — seems to create a potential space in which something new can develop. Bringing professionals together with a focus on making connections with the child's experiences reflects the gathering and binding function that Freud ascribes to the life instinct. This approach can be particularly helpful in situations where it is difficult to maintain a focus on the child or to feel hopeful for the child.

Observational work with young children in temporary foster care can be both rewarding and harrowing, bringing closer contact with realities in the lives of infants and young children whose families of origin have broken down, always painfully. Working together, focusing on meaning and seeking out life-seeking energy through the power of attention helps to make it possible for painful experiences to become known and provides a frame in which vulnerable children can be seen and heard.

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Статья поступила в редакцию 13.10.2017 г.

# ВНИМАНИЕ!

## Изменения в оформлении списка литературы

Согласно Приказу МОН Украины № 40 от 12.01.2017 г. «Об утверждении требований к оформлению диссертаций» вносятся изменения в оформление списка литературы в журнале. Теперь оформление осуществляется в соответствии со стилем APA (American Psychological Association style), используемым в диссертационных работах.

## Примеры оформления литературных источников

### Журнальная публикация

Автор АА, Автор ВВ, Автор СС. (2005). Название статьи. Название журнала. 10(2); 3: 49-53.

### Книга

Автор АА, Автор ВВ, Автор СС. (2006). Название книги. Город: Издательство: 256.

### Глава в книге

Автор АА, Автор ВВ, Автор СС. (2006). Название раздела (главы). В кн. Автор книги. Название книги. Под ред. Фамилия СС. Город: Издательство: 256.

### Интернет-ресурс

Автор АА, Автор ВВ, Автор СС. (2006). Название статьи. Название журнала/книги (если есть). URL-адрес публикации.

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