

Living psychology: The 'emotional warmth' dimension of professional childcare

R.J. (Seán) Cameron & Colin Maginn

Children and young people in public care are arguably the most vulnerable group in our society and, despite considerable support and financial expenditure, the outcomes for these children have remained stubbornly poor. While the worthy intentions of government initiatives over recent years are not in question, it is clear that there is a need for a new theory-led, evidence-based model of professional care and support. This paper presents a psychological perspective which links early childhood experiences with restricted life outcomes. It argues that it is parental rejection (sometimes accompanied by abuse and neglect) which is a major mediating factor in the often-restricted life outcomes for many of these children.

The 'emotional warmth' approach to professional childcare enables a visiting applied psychologist to empower residential and foster carers to provide high quality parenting, sensitive support for post-trauma stress and a deeper understanding of the (often hidden) signature strengths of these children and young people. The inclusion of these three components in a support plan is likely to promote positive emotional, social and academic development of children in public care. The major role of the applied psychologist consultant in the emotional warmth model is discussed and appropriate outcome measures for this approach of childcare are considered.

'Foster and residential care is a complex activity.' (National Institute for Health and Clinical Excellence/Social Care Institute for Excellence, 2010, p.9)

'We believe that the greatest gains in reforming our care system are to be made in identifying and removing whatever barriers are obstructing the development of good personal relationships, and putting in place all possible means of supporting such relationships where they occur.' (House of Commons, 2009, p.27, para. 29)

THE emotional, social and academic problems of children and young people in public care have long been documented, yet as Norwich, Richards and Nash (2010) point out, there have been few published papers about educational psychologists' work with, or related to, such children. Reviewing the literature on children in residential care, Nissim (2006) concluded: *'the youngsters concerned are among some of the most disadvantaged, damaged and vulnerable members of our society, and their needs are extreme and complex'* (p.275). In a similar vein, for foster care, Guishard-Pine et al. (2007) have stated that *'many children within the foster care system are at significant risk of mental health problems because of their history of harsh treatment and neglect'* (p.79).

There has been no shortage of recommendations for helping these children and young people, a recent example having appeared in the report prepared by the House of Commons Children, Schools and Families Committee (House of Commons, 2009) which noted the potential of 'social pedagogy' as practised in Denmark and Germany, a model which was later endorsed in the joint NICE-SCIE (2010) report. However, consistently positive outcomes for a variety of interventions have so far proved to be elusive, as Cameron and Maginn (2009) have pointed out in their review of education-based interventions and their disappointingly small impact on the attainments of pupils who are in public care. While official statis-

tics, like those released for England and Wales (Department for Education, 2010), have indicated a modest increase in the number of children achieving five A*-C GCSEs at Key Stage 4 it has not been possible to attribute this improvement to any particular intervention, since similar gains have occurred in the general school population. In short, the attainments gap between children in care and those in the general population of their peers has remained the same, as Figure 1 illustrates.

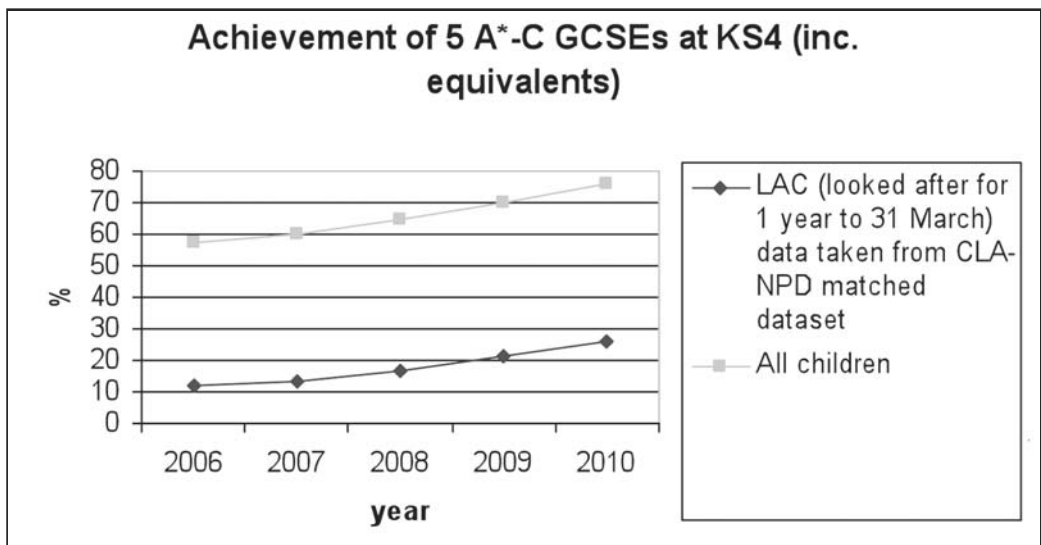
However, the high priority that has been allocated to improving GCSE results for looked-after young people appears less imperative when set against the emotional cost to the children and young people themselves (and to society at large) since far too many of these children end up with life-limiting outcomes including being homeless, jobless, friendless and deeply unhappy.

A number of applied researchers have claimed success for *specifically-targeted* approaches designed to help this vulnerable

client group. Exemplars here would include early intervention, child-focused initiatives like school-based nurture groups designed to enhance secure attachment (see Rose, 2010), parent and teacher activities to build up the resilience of these children (Dent & Cameron, 2003) or the Video Interactive Guidance initiative which enables parents to attune more closely to the needs of their child (Kennedy, Landor & Todd, 2010a, 2010b).

However, given the complexity of the problems exhibited by children and young people in public care and the dismal outcomes which they experience, a *wider intervention perspective* is clearly needed. Such an approach would have to offer children who have had negative, early life experiences, the carefully planned and specifically-targeted help which can meet their emotional needs, support them through post-trauma stress and enable them to grow and develop personally and socially, as well as academically.

Figure 1: Outcomes for children looked after by Local Authorities in England and Wales matched with data contained within the National Pupil Database.



Emotional warmth: A wider view?

Explanations as to why looked-after children fail to develop emotionally, socially and academically have often focused on what is perceived as a failing care system, poor quality care and schools which neglect to address their educational needs (see Jackson & Martin, 1998, and Jackson & McParlin, 2006). While researchers may continue to debate the merits of such explanations, their impact on policy has had major consequences, both for the young people concerned and for the allocation of scarce resources. In 2006, Alan Johnson, then Secretary of State for Education, clearly perceived the public care system as failing its children: *'it is inexcusable and shameful that the care system seems all too often to reinforce this early disadvantage'* (Department for Education and Skills, 2006, p.3). Since the publication of the Central Government paper, which echoed the views expressed above, large sums have been invested in educational initiatives (for example, 'virtual head teachers' for looked after children) in an effort to raise attainment levels in the looked-after population.

As an alternative theoretical explanation for the pain-based behaviour and poor life outcomes of looked after children, the authors of this paper have argued that it is 'rejection' in general and 'parental rejection' in particular (rather than failing care and education systems exclusively) that are the most significant contributors to the flattened life trajectories of these young people (Cameron & Maginn, 2005, 2008). The background to such a claim is discussed in the section which follows.

Parental Acceptance-Rejection Theory

While many people working in childcare have been long aware of the negative effects of psychological abuse, rejection and exclusion on individuals or group members, it is only relatively recently that satisfactory explanations of the accompanying negative outcomes have been provided:

'...rejection is not simply one misfortune among many, nor just a bit of sad drama – it strikes at the heart of what the psyche is designed for.' (Baumeister, 2005, p.732)

Parental Acceptance-Rejection Theory (PA-RT) holds that all children need a specific form of positive response – acceptance – from parents and other primary care givers (see Rohner, 2004; Rohner et al., 2004, 2005). When this need is not satisfactorily met, children worldwide and regardless of variations in culture, gender, age, ethnicity or other such defining factors, tend to behave in ways which are hostile and aggressive, dependent or defensively independent, impaired in their self-esteem and self-adequacy, emotionally unresponsive, mostly unstable and holding a negative view of the world that they live in (Rohner et al., 2004). The main features of the PA-RT are summarised in Figure 2.

A considerable body of cross-cultural research has supported the PA-RT explanation (see Rohner, 2004; Rohner et al., 2004, 2005 for a summary of three decades of investigations in this area) but the implications of this work seem to have been overlooked or ignored in UK policy making and planning for children who have experienced rejection by their parents in one form or another.

Applying PA-RT to looked after children presents a challenge to the uncritically-accepted, current view that their poor educational performance, restricted social outcomes and diminished life chances, result solely from the opportunity-restricting, emotionally-damaging or self-worth reducing effects of the care and education systems. Instead, they have their roots in the quality of the affection bond between parents and their children, and with the physical, verbal and non-verbal behaviour of parents and carers, which accompany these feelings.

For applied psychology practitioners, one important and illuminative aspect of PA-RT is the finding that parental rejection does not only consist of a specific set of overtly

Figure 2: A summary of the main components of Parental Acceptance-Rejection Theory (Rohner, 1986, 2004).

Main themes from Parent Acceptance-Rejection Theory:

- Children and young people need parental acceptance, not rejection.
- If the child or young person's need for acceptance is not met, emotional problems result.
- Such emotional problems appear to be universal, across the human race.
- Rejection can be clearly *evident* or the child can *perceive* rejection: both types of rejection can generate emotional difficulties in the child or young person.
- Many of these emotional problems result in dysfunctional and self-defeating behaviour which can persist in the long term.
- Other factors are involved in the adjustment of children, but parental acceptance-rejection has been shown to be a particularly powerful mediating factor between early experiences and later emotional development.

emotionally-damaging actions by parents, but also includes those perceptions and beliefs that are held by the child or young person. Children who experience or perceive significant rejection are likely to feel ever-increasing anger, resentment and other destructive emotions that may become intensely painful.

An evolutionary perspective offers a convincing explanation for the detrimental effects of 'parental rejection' on educational and life outcomes of looked after children. DeWall and Baumeister (2006) have argued that '*physiological processes responsible for detection and regulation of physical pain were co-opted to sense and respond to emotionally painful events, such as being rejected or excluded*' (p.3). They list studies that report decreased sensitivity to physical pain following separation from caregivers among rat pups, young mice, calves and chicks.

Physical evidence that social pain piggy-backs on those areas of the brain which react to physical pain is provided in neurological studies by Lieberman and Eisenberger (2009), who show that the brain's pain network responds in the same way to both physical pain and social rejection arguing that '*for both caregiver and infant to feel pain upon separation ensures social connection and thus offspring survival*' (p. 891). DeWall and his colleagues carried out a series of experiments to test the connection between phys-

ical pain and the pain of rejection (DeWall et al., 2010). They found that acetaminophen reduced neural responses to rejection. In short, paracetamol did lessen the pain of rejection, while a placebo did not. This neurological link between social pain and physical pain supports Bowlby's (1969) theory of attachment and the idea that survival of the species depends on the bond between infant and carer. The 'Dynamic-Maturational Model' of attachment (Crittenden & Dallos, 2009) offers an optimistic prognosis: attachments patterns are not fixed for life and children are able to respond positively to sensitive and responsive parenting, enabling them to form 'healing' attachments with committed caring adults.

Linking negative social psychological experiences, such as parental rejection, to the meta-theory of survival motivation provides the paradigm shift required to explain the different perceptions of the world together with the pain and distress experienced by children in public care and the challenges which their complex needs pose for carers and their support professionals.

One surprising gap in the PA-RT literature is the absence of specific implications for promoting parent acceptance behaviour and avoiding passive, negative or unintentional parental rejection. Rohner (2004) and

Rohner et al. (2004) do, however, offer two general principles of parenting derived from PA-RT:

- Helping parents and other caregivers to *communicate acceptance* to children.
- Helping parents and carers to find culturally-appropriate ways to *avoid behaviours that indicate parental coldness and a lack of affection*.

Emotional warmth and professional childcare

The starting point of the 'emotional warmth' model of professional childcare described in this paper is the importance of the relationship between each individual young person and their carer. A new priority becomes the empowering of residential and foster carers with the knowledge and skills to understand and respond appropriately to the emotional, behavioural and attainment difficulties that are exhibited by the children in their care. This is achieved with a two pronged approach. First, carers have immediate access to the knowledge base of psychology through regular child focused consultations with a qualified and experienced consultant psychologist. Second, in support of the on-the-spot learning which takes place in the consultation sessions, the continuing professional development of the caregivers is then supported by a programme of training in the theory underpinning the 'emotional warmth' model. This programme (which can lead to a formal qualification) covers attachment theory, authoritative parenting, adaptive emotional development, the effective employment of young people's signature strengths, involving young people in decision making and the assessment of both child and carer's progress and development.

A detailed account of the 'emotional warmth' approach to professional childcare and the psychological theory and research which underpin this approach can be found in Cameron and Maginn (2009). In brief, there are four important components:

1. *The Pillars of Parenting*. A procedure which can enable carers to meet the parenting needs of these children and young people through the eight Pillars of Parenting and the accompanying staff support activities which underpin each pillar.
2. *Adaptive emotional development*. A system which empowers carers to support children and young people in their journey through post-trauma stress using the three phases of the Cairns (2002) explanation of trauma and loss and the carer activities which accompany each phase from stabilisation, through integration and finally towards adaptation.
3. *Signature strengths*. A strategy for teaching carers how to identify children's signature (or character) strengths and helping children and young people to utilise these effectively in their everyday life.
4. *Living psychology through consultation*. A protocol which allows experienced applied psychologists to provide on-going advice and support for residential/foster carers in their everyday work through regular group consultation sessions employing the emotional warmth model.

The individual action plan for each child, which results from these group consultation sessions, lists activities which carers and consultant have discussed, agreed and intend to carry out to meet the child's parenting needs, support the child through emotional stress and build on signature strengths. Therefore, the emotional warmth approach is designed to bring about positive outcomes for these children and young people by enabling them to live more fulfilling lives and to avoid the fate of too many children in care: homeless, jobless, friendless and incarcerated. In the case of the latter outcome, it is estimated that over a quarter of the prison population have been in care (Social Exclusion Unit, 2002).

The Pillars of Parenting

Words shape the way we see the world, and no other word captures the long-term responsibilities of raising children so completely as 'parenting.' Children in care have often been disadvantaged by the terminology used. 'Looked after' implies a passive receiving of some 'looking after' behaviour by adults, while 'caring' is devoid of the commitment, engagement and attunement which comes with the 'parenting' process.

Professional residential and foster 'parenting' for particularly vulnerable children and young people demands that the skills and knowledge of parenting cannot be left to trial and error, but need to be unpacked, analysed, understood and implemented so that even in challenging circumstances, the 'professional parents' will know what they should do (and why).

Working with an applied psychology consultant, carers can select one pillar (occasionally two) which is particularly relevant to the parenting needs of the child or young person at that point in time. For each of the eight pillars, there is a menu of parenting activities, from which the group of carers can choose and discuss and agree the two or three activities which are the most appropriate for supporting the child or young person in the previously selected pillar. In the case of a children's home, all the carers would agree to carry out these selected support activities when appropriate opportunities present themselves, while foster carers would involve other family members in these activities.

As well as being based in psychology theory and research, the Pillars of Parenting are closely linked with many of the specific outcomes of the *Every Child Matters* outcomes framework (Department for Education and Skills, 2005), especially in the areas of mental and emotional health, personal and social development and developing self-confidence and successfully dealing with significant life changes and challenges.

The selection of each of the eight 'pillars' followed months of discussion with young people, carers, psychologists, managers,

parents and foster 'parents' to identify and agree what 'good parents' should do. Further development and refinement took place during pilot schemes at two London children's homes. How the Pillars of Parenting are used and selected is dependent on the needs of each individual child at any given time. The child is the focus, not the model; the model can be viewed as a set of tools to provide a transparent structure for everyone working with the child. While the eight pillars are not hierarchical, and individual pillars may sometimes overlap to some extent, their structure is designed to help caregivers, who are often unqualified or hold the minimum National Vocational Qualification Level 3 in England, Wales or Northern Ireland (Qualifications and Curriculum Authority, 2006) or its equivalent elsewhere, to make sense of the chaos in the lives of traumatised young people in their care and to agree purposeful plans for their future.

Table 1 provides a summary of the psychological background to each pillar, together with a sample of carer activities which could support each pillar, while Figure 3 contains an extract from the action plan for 'Rena' whose behaviour can often be thoughtless, random and (unintentionally) dangerous for children and carers alike.

Adaptive emotional development

A simplified and carer-friendly description of a child's emotional journey through developmental trauma stress has been provided by Cairns (2002) and her work has been extended in the 'emotional warmth' model to include the type of support and management required by traumatised children and young people during the period when they are attempting to make sense of, or find ways of living with, the traumatic events which have occurred in their lives. (See Table 2 for an overview of the three phases of the Cairns model and some examples from the list of carer activities which can support children and young people through each of these phases.)

Table 1: A summary of the Pillars of Parenting and some of the staff behaviours and tasks which support these. © Seán Cameron & Colin Maginn (2008)

<p>Primary care and protection</p> <ul style="list-style-type: none"> ● Sensitivity to a child's basic needs shows the child that we care and that they are important. ● Education is included here because in our complex world knowledge and skills are essential to survival. 	<p>Making close relationships</p> <ul style="list-style-type: none"> ● Secure attachment appears to act as a buffer against risks and to operate as a protective mechanism. 	<p>Positive self-perception</p> <ul style="list-style-type: none"> ● To allow the child to develop a positive self-image. ● Positive and negative statements have a powerful impact on the self-perceptions. 	<p>Emotional competence</p> <ul style="list-style-type: none"> ● This ability underpins the successful development of relationships outside the family and may moderate susceptibility to and propensity for later mental health problems.
<p>Why? See Maslow (1971) for his universally known pyramid of human needs.</p>	<p>Why? See Ziegenhain (2004) for a summary of the considerable volume of the research on attachment.</p>	<p>Why? For more details, see the research paper by Burnett (1999) or the book by Emler (2001).</p>	<p>Why? A useful overview of this important, high-level skill area has been provided by Saarni (1999).</p>
<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Tuning into a child's fears and offering a reassuring word or hug. ● Being aware of potential risks and dangers, yet allowing the child to take modest risks. 	<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Encouraging the child to explore new things/ opportunities. ● Engaging in play activities with the child. ● Tuning into the child's perspective of the world. 	<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Celebrating the child's developmental advances. ● Recognising and rewarding good behaviour. ● Recognising and valuing new skills as these are acquired. 	<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Maintaining your adult role during any conflicts with the child. ● Explaining why you want the child to do something. ● Teaching the language of emotion.

<p>Self-management skills</p> <ul style="list-style-type: none"> ● Self-management is the insulation, which prevents inappropriate behaviour when enticing or compelling outside factors try to intrude. 	<p>Resilience</p> <ul style="list-style-type: none"> ● Resilient individuals seem to be able to understand what has happened to them in life (insight), develop understanding of others (empathy) and experience a quality of life that is often denied to others who have suffered negative life experiences (achievement). 	<p>A sense of belonging</p> <ul style="list-style-type: none"> ● Research and theory in relationships have established human beings as 'fundamentally, extensively social' and highlighted the need to belong. 	<p>Personal and social responsibility</p> <ul style="list-style-type: none"> ● Essentially personal and social responsibility means being able to co-ordinate one's own perspective with the help of others and developing personal views of fairness and reciprocity.
<p>Why? See Lewis and Frydenberg (2002) on the topic of personal problem solving methods used by children and young people and Zimmerman (1998) for a description of the link between self-management and academic attainment.</p>	<p>Why? See Dent and Cameron (2003) or Newman and Blackburn (2002) for a summary of the research on resilience and its implications for 'parenting' of looked after children.</p>	<p>Why? For details of the link between rejection and aggression, anti-social behaviour and poor self-regulation, see the review article by Baumeister (2005).</p>	<p>Why? Personal social responsibility involves being able to solve problems in a peaceful way, understanding valuing and defending differences in people, acting on both rights and responsibilities, developing a sense of idealism, and making a positive contribution to family group or community (see Carpendale & Lewis, 2006).</p>
<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Guiding and setting limits for behaviour. ● Employing positive psychological control strategies. ● Revising rules and expectations as the child or young person grows up. 	<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Ensuring stability and continuity in care. ● Promoting friendships with pupils doing well at school. ● Encouraging of high levels of intrinsic motivation and an internal locus of control. 	<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Providing 'good beginnings' at in the foster or children's home. ● Personalising bedroom accommodation. 	<p>Examples of support required from care staff</p> <ul style="list-style-type: none"> ● Modelling considerate behaviour to other staff members, as well as children. ● Encouraging children to 'assume positive intent'. ● Helping children to recognise 'stranger danger' from helpful adult behaviour.

Figure 3: Case example. Meeting 'Renae's' parenting needs through the Pillars of Parenting.

The pillar which was chosen as a priority for Renae at this point was Pillar No 8: *Developing personal and social responsibility*. Selected support for 13-year-old Renae would involve the residential carers in the following:

- Encouraging Renae to 'assume positive intent' for the behaviour of her carers, their friends and the other children in this home (rather than negative intentions).
- Discussing the importance of different types of relationships (e.g. work, leisure, sexual, etc.) and how to make relationships with peers that will last.
- Helping Renae to think about her future aspirations.
- Teaching Renae the concept of 'building up social capital' – for example, doing something for a friend or a member of the foster family, helping someone in need, or 'showing willing': all these without expecting immediate reward.

It is worth noting here that the selected pillar of parenting and the accompanying support activities chosen by carers are likely to change over time as Renae's needs evolve and her resilience and emotional adjustment increase (or decrease).

Table 2: A summary of the Cairns model of trauma and loss, together with some good practice suggestions at each phase. (Adapted from Cairns, 2002.)

Stabilisation Providing a safe and predictable physical and psychological environment.	Integration Aiding a child or young person in the processing of the trauma, i.e. putting the past in its place.	Adaptation Enabling the re-establishment of social connectedness, personal efficacy and the rediscovering of the joy of living.
<i>Some examples of good practice suggested by carers</i>		
<ul style="list-style-type: none"> ● Protecting the child from teasing, bullying and intimidation. ● Establishing a clear and predictable pattern of daily events for the child. 	<ul style="list-style-type: none"> ● Stressing the normality of feelings associated with previous traumatic events. ● Helping the child to manage post-trauma feelings of shame, guilt and anger. 	<ul style="list-style-type: none"> ● Helping the child to recognise and accept the changes which have occurred. ● Supporting the child's own efforts to adapt to the changed circumstances.

Of course, some highly resilient children and young people may learn to cope with adversity in their individual ways, but most children in care are likely to require sensitive support from carers to begin the emotionally demanding task of modifying the impact of rejection, neglect and abuse. The Cairns overview of post-trauma stress is particularly useful since it can help residential and foster carers to view a child's often-disruptive behaviour within a bigger picture.

The model highlights the need to establish a safe and stable environment where the child is able to talk about and learn more about the circumstances surrounding trauma (*stabilisation*), to deal with the often-conflicting feelings which accompany such information, to process, control and manage any resulting psychological or physiological reactions (*integration*) and, finally, to support the child in re-establishing social connectedness, developing personal efficacy, achieving a satisfactory level of emotional adjustment to the negative events which have been experienced and developing a more optimistic view of the future (*adaptation*).

The emotional warmth approach provides carers and consultants with a menu of post-trauma stress activities from which carers can determine the specific phase that the child or young person is passing through, and then choose and discuss the two or three activities which will provide the most appropriate support for the child or

young person moving through their current emotional phase. In Box 1 there is an extract from an action plan drawn up for 13-year-old 'Renaë' who as well as exhibiting self-defeating behaviour (Table 2) also has periods when she becomes subdued, withdrawn and anxious.

Again, it is worth noting here that the phase of the Cairns model, together with the accompanying staff support activities, are likely to change over time as Renaë's needs evolve and her adaptive development grows. Empowering carers to make a commitment and encouraging them to form healthy relationships with the young people in their care has an important role to play in the 'healing' process. As Perry (2008) noted:

'Most of the therapeutic experiences do not take place in 'Therapy' but in naturally occurring healthy relationships. The most effective treatments to help child trauma victims is anything that increases the quality and number of relationships in the child's life.'
(p.80)

While the Cairns model offers a useful framework to enable caregivers to make sense of the young person's journey through trauma and loss, part of the consultant psychologist's role is to bring a wider and deeper understanding of the trauma process and to use clinical skills to pick up on any atypical trajectories in the young person's response to traumatic events.

Box 1: Case example. Supporting 'Renaë' through post-trauma stress with the adaptive emotional development component of the 'emotional warmth' model.

The residential carers felt that Renaë's adaptive emotional development needs currently lay between the *Stabilisation* and *Integration* phases of Cairns's model. Key activities for all carers were discussed and agreed as follows:

- Reassuring Renaë that all the carers in her children's home were friendly, kind and good at listening to children's worries as well as their happy stories.
- Establishing a closer relationship between Renaë and all the carers, but especially her key worker.
- Trying to understand the source of Renaë's current unhappy and withdrawn behaviour.

Signature strengths

Seligman (2002) believes that each person possesses several signature strengths. These are strengths of character that a person self-consciously owns, celebrates and, if possible, incorporates into daily contexts, such as school, work, relaxation activities, relationships and hobbies. Focusing on the signature or character strengths of children and young people can generate increased motivation and energy for everyone involved. In particular, it can shift carers' perceptions of a young person from 'problems' to 'possibilities'.

A list of signature strengths (which might include a love of learning, a sense of fairness, the ability to use humour in everyday life and enthusiasm) can be found in Seligman (2002) or Linley (2010), but some of the less obvious ones, which may apply particularly to children in public care, include the following:

- *Curiosity and interest in the world.* Curious children want to learn more about themselves, the world they live in and the larger world beyond.
- *Practical thinking.* This strength often involves the examination of problems from a number of different angles, thinking things through and coming up with pragmatic solutions.
- *Courage.* Included here are both moral courage (for example, challenging unfairness) and psychological courage (asking for help with one's own fears and anxieties).
- *Discretion.* An important strength which avoids someone saying things impetuously that might be regretted later on.
- *Gratitude.* This involves being aware of the good things in life that have happened and not taking them for granted.
- *A sense of purpose.* Developing ambitious, but achievable, aspirations for the future and working steadily towards these.

After the signature strengths of a child or young person have been identified and personalised, Seligman's advice is to consider how and in what contexts these

strengths can be employed in everyday life. In the case of a looked after child, the uncovering and utilisation tasks could be carried out most effectively in a discussion between a carer, a teacher and the child or young person, and then shared with other carers, teaching colleagues or family members. These significant adults in the life of a child in care would then use this information to provide opportunities (or would look out for appropriate windows of opportunity) which allow the child or young person to employ signature strengths and to realise how powerful or successful these character strengths are (see Table 4).

Living psychology through consultation

Central to the implementation of the 'emotional warmth' model is the everyday contribution of those residential or foster carers who are working directly with children and young people. Monitoring and support for their work, together with training and professional development, all therefore become prerequisites for high-quality care. Responding to a child whose behaviour can be perceived as deliberately vindictive and hurtful, and who may frequently reject or exploit acts of kindness, affection and positive intent, demands considerable conviction as well as informed carer management skills.

On the positive growth and development side, tackling the challenges of providing emotionally warm caring in their encounters with difficult and rejecting children, of assisting them to move through the post-trauma stress process and of enabling them to utilise their signature or character strengths effectively, all demand that residential and foster carers require a combination of personal skills, experience and informed professional expertise. While these direct contact carers have amassed detailed knowledge about the children in their care, it is an 'indirect contact' or consultant psychologist who is able to draw upon the knowledge base of psychology, and who can provide carers with the much needed insight

Table 4: Case example: Building on 'Renae's' signature strengths to promote personal and inter-personal competence.

Renae has two big signature strengths – *humour* (there are times when she is unhappy when she becomes withdrawn and non-communicative, but she is also able to make people laugh) and *creativity* (she can sketch, enjoys street dance and is good at gymnastics).

Possible activities which carers agreed would allow Renae to use these strengths more effectively were as follows:

- Build in a few 'sketch sessions' with Anwar (a social work student on placement in the home) who likes to draw cartoons.
- After supper on Friday, staff member would introduce 'Renae's stand-up comedy time' and invite her to start off a series of jokes told by the children and staff.
- Provide opportunities for Renae to display some of her finished drawings publicly.
- Investigating the possibility of helping Renae to join and settle into a local dance club or a gymnastics class.

into children's complex problems, offer evidence-based interventions and promote discussion of the sophisticated strategies required to help children and young people to deal with problems resulting from rejection, neglect and abuse.

In their review of consultation effectiveness, Sheridan et al. (1996) argued that 'well-constructed models (of consultation), articulated from sound theoretical bases may be superior to those without clear conceptual frameworks' (p.349). In this regard, the specific tasks of the applied psychologist in a residential or foster care group consultation session are set out in Table 5.

The total time involved in a group consultation session focusing on one child or young person is approximately one-and-a-half hours. At the end of the consultation session, the psychologist consultant produces notes of each session. These contain a clear description of the agreed management strategy for self-defeating behaviour, the activities agreed by staff for supporting the chosen pillar of parenting, the agreed strategy for supporting the adaptive emotional development of the child and a list of activities which will enable the child or young person to utilise signature strengths more effectively in everyday life. These notes are distributed to all the residential or foster carers who have taken part and,

in the case of the children's home, selected sections and actions from the consultation notes are then transferred into the care plan for the particular child or young person. By way of illustration, through this process 'Renae's' parenting needs (Figure 3), support for post-trauma stress (Box 1) and personal/social development (Table 4) are all addressed. In short, this is an integrated approach to supporting 'Renae' in *all* major areas of her development.

Consultation support for carers represents a different approach to the more traditional therapy for children because the former focuses on the empowerment of carers to support the child or young person. The goal of group consultation is to enable the carers themselves to provide support for and management of problems in the context in which the child or young person is having difficulties (see Dent & Golding, 2006 for a discussion of this issue). Residential and foster carers are ideally placed to carry out such context-based work since opportunities to provide 'therapeutic experiences' through the sensitive management of those moments when a child is seeking reassurance, information, insight or emotional comfort, occur frequently and naturally during everyday encounters.

Table 5: Protocol for a group consultation session involving an applied psychologist and residential team or foster carers' group.

1. Discussion of big and modest successes achieved by staff since the last consultation session.
2. Update on agreed actions and outcomes for child or young person discussed at previous group consultation session.
3. Discussion of the behaviour management problems of today's child or young person, as follows:
 - A pen portrait of the child or young person by the foster carer or key worker.
 - A thumbnail outline of the child's self-defeating behaviour(s).
 - Discussion of the Antecedent (A), (Background) (B), Consequences (C) and (Communication*) (+C) factors surrounding the problem.
 - Consideration of how to change the key A, B and C factors and how to teach functional +C skills (see Cameron and Maginn, 2009 for an account of the ABC+C approach to behaviour management).
 - Agreed action strategies for management and support.
 - A plan for implementing, monitoring and evaluating the agreed action by carers.
 - A written and shared summary of agreed action, provided by the psychologist consultant.
4. Discussion and identification of the child's current parenting needs (using the Pillars of Parenting list and selecting from the staff support activities menu).
5. Identification and discussion of the child's post-trauma emotional needs (using the Adaptive Emotional Development model and selecting from the menu of staff support activities).
6. Discussion of child's assets and talents and consideration of the learning opportunities that have arisen from these.
7. Meta-analysis of the session. Discussion of the process of the consultation process and consideration of its usefulness and possible areas for improvement.

** The Communication factor in point 3 relates to the question, 'What is the child trying to communicate through behaviour?' Possible messages here might include: revenge, or a need to escape from an uncomfortable situation, or immediate attention, or other reasons. (See Dreikurs et al., 1982, for details of this important factor in understanding and managing self-defeating behaviour.)*

Measuring changes in vulnerable children

Using the 'emotional warmth' model, applied psychologists can inform (and sometimes challenge) carers by drawing on information from psychology theory and research to improve child care practice: they can also enable carers to make changes to existing practice by evaluating the outcomes of their efforts for the children and young people in their care.

Of course, there are 'hard data' indicators of change and these can include: any improvement (or drop) in school attainment levels, an increase (or decrease) in the number of incidents of unwanted, anti-social

and self-defeating behaviour, a reduction (or a rise) in overt self-harming behaviour and absconding, or a reduction or increase in the reported frequency of intrusive thoughts, sleep patterns or night terrors. Records of such gross behaviour changes are important. However, on their own these data cannot inform carers why these events are occurring and, equally important, what they are doing to help or hinder the child's adaptive emotional development and resilience.

There are many possible ways of attempting to measure pre- and post-intervention changes in a child's life, including external global measures such as improve-

ment in school attainment, changes in behaviour or increases in cognitive ability/IQ. The problem with general measures like these is that the answer to why the intervention led to the changes which occurred can often only be speculated upon. While such gross measures are important, they tend to oversimplify or ignore the complexity of the problems of children and young people who have been rejected, neglected and abused.

Two methods of measurement are being employed to record the way in which looked after children and young people are responding to the 'emotional warmth' approach:

Standardised measures

The Trauma Symptom Checklist for Children (Briere, 1996) has been chosen to record changes which have occurred in children's post-trauma stress levels, including anxiety, stress, depression and dissociation, anger and sexual concerns. This information is particularly important, especially since the 'emotional warmth' approach is designed to reduce the level of developmental trauma and to promote adaptive emotional development. However, as well as measuring pathological aspects of development, the Resiliency Scales for Children and Adolescents (Prince-Embury, 2006) have also been selected to provide information on the strength characteristics which are associated with more successful personal and social development, especially sense of mastery, sense of relatedness and level of emotional reactivity.

The visiting consultant psychologist can discuss these findings and their implications for child care and management during the residential or foster carers' group consultation session and is able to keep an ongoing record of changes which occur in the different factors being measured. Eventually, it is hoped that the results from a larger number of children can be collated, analysed and published, not only to evaluate the results from the 'emotional warmth' approach, but also to provide much-needed

information about the emotional development of children and young people who have (or have not) recovered from the effects of negative early life experiences.

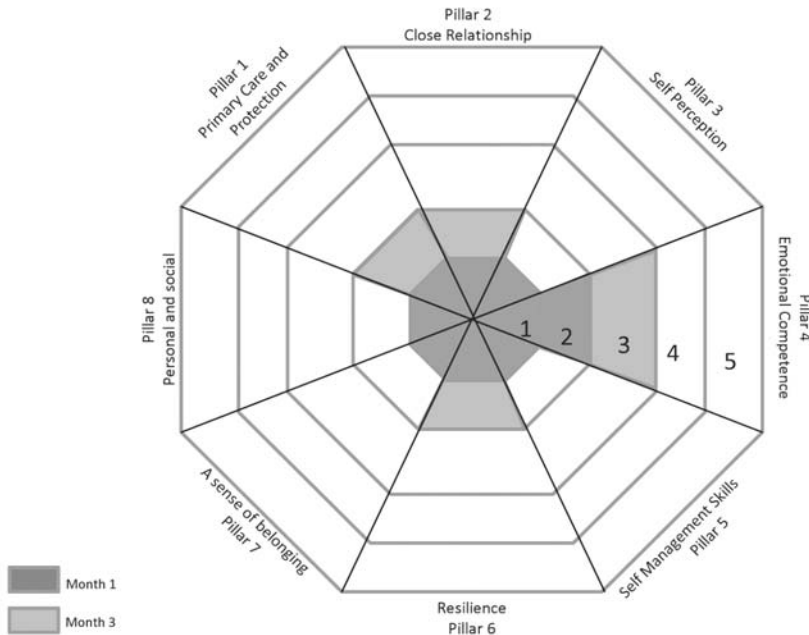
Bespoke measures

Meaningful outcome measures for children should not only provide feedback to carers on the results of their efforts, but should also permit external validation of the success of any care model. While many social care commissioners might be satisfied with information on the number of reported or recorded serious incidents, more sensitive measures are required to plot the process of change in children over a longer period. For this reason, the 'cobweb diagram' was created both to measure and illustrate the child's or young person's response to positive parenting and post-trauma stress support (see Figure 4).

The cobweb recording procedure allows carers to assess the progress of a child or young person on a five-point scale on each of the eight Pillars of Parenting. As an example, the criteria for measuring progress and development on Pillar 4 (emotional competence) have been set out in Box 2. These criteria were generated by a panel of 10 experienced applied psychology consultants and piloted with carers in a number of children's homes before the final version of the five point scales for each of the eight pillars was finally completed. These carer ratings can then be plotted on the cobweb diagram which allows progress to be measured and noted over time. Different colours can be used to provide a visual display of improvements or deterioration over a longer period of time (as shown in Figure 4).

In the example shown in Figure 4, the baseline measurements for 'Rena' show that she is rated at Level 1 (the lowest level of development) in all the pillars, apart from emotional competence where she is rated at level 2. Three months later, 'Rena' has moved up to Level 2 in primary care and protection, close relationships and resilience. In the case of emotional competence, she has moved up to Level 3.

Figure 4: The cobweb record chart of a child's progress and development over a three-month period.



Source: Cameron, R.J. And Maginn, C. (2009). *Achieving positive outcomes for children in care* London: Sage ©

Box 2: The criteria used to evaluate progress and development on Pillar 4 (emotional competence).

The emotional competence hierarchy

Level 5: Child is able to understand and accept own feelings and the feelings of others and to respond appropriately to both.

Level 4: Child can understand, control and manage a range of own emotions.

Level 3: Child has knowledge of a range of emotions and is beginning to match appropriate emotions to context.

Level 2: Child too often misinterprets the emotions of others as well as own emotional responses.

Level 1: Child is unable to understand or control own emotions or has inexplicable changes of mood or blames others for own moods.

A similar five-point cobweb scale is used to obtain essential information on a child's progress through the different stages of adaptive emotional development and to identify emotional progress, failure to make progress or regression. It has been noted by one of the referees of this paper that the progress of a young person on the parenting pillars is likely to be reflected on measures of that young person's journey towards adaptive emotional development on Cairns's model. Such parallel links are most likely to be seen with Pillar 1 (care and protection) and the *Stabilisation* phase, Pillars 4 (emotional competence), 5 (self-management) and 6 (resilience) and the *Integration* phase and Pillars 2 (close relationships), 3 (self-perception), 7 (a sense of belonging) and 8 (personal and social responsibility) and the *Adaptation* phase.

Some reflections for applied psychologists

For children or young people who have not received adequate parenting and upbringing and who also may have experienced violence, abuse and rejection, their progress towards mental health and well-being can often be a long, slow process which needs to be supported by a sophisticated form of professional childcare. Achieving a transparent connection between the psychology knowledge and practice base and the problems faced by children and their carers requires clinical, educational or developmental psychology practitioners to utilise sophisticated consultation processes and an in-depth knowledge of the discipline, so that they can provide carers with a deeper understanding of problematic situations, offer research-based, creative and effective ways of managing these problems and promote proactive approaches to minimise the occurrence and impact of such problems in the first place.

Moore (2005) has argued for a continuing, self-critical and reflective stance that examines applied psychology practice within the context of the complexities and changes

of contemporary society. According to Fraser and Greenhalgh (2001) this requires the recognition that as well as *competence* in professional practice, an additional dynamic for professional development has emerged – *capability* – the latter being a characteristic which enables a practitioner to adapt to constant change. It can be argued that the emotional warmth approach to professional child care meets both the competence and the capability criteria because:

- It focuses on the psychological needs of children (as opposed to concentrating solely on the management of their problem behaviour).
- There is a rationale, based in applied psychology and research, for the main components of this approach – meeting parenting needs, support for adaptive emotional development and the utilisation of the child's signature or character strengths.
- The 'good practice' menu for the Pillars of Parenting, the Adaptive Emotional Development and the Signature Strengths components are 'owned' by the direct contact care staff: the role of the applied psychology consultant is to help carers to make informed best-practice choices.
- The approach clarifies the complementary but distinct roles of carers and consultants.
- This approach represents an evolving rather than a static perspective of good practice in childcare. As new evidence-based research emerges, childcare can be more finely adjusted to the needs of looked after children

Based on findings from their survey of practices and issues relating to children in care in five local authority educational psychology services in the south-west of England, Norwich et al. (2010) drew some practical conclusions, including the need to develop specialist roles for educational psychologists in supporting staff working with children in care and the sharing of good practice through working groups. However, their

major recommendation was that 'educational psychology services need to clarify the distinctiveness of the kinds of contributions that EPs can make compared with other services, while welcoming opportunities to develop joint work with other services and professionals' (p.388). The role of the applied psychologist (clinical, educational or developmental) which is outlined in this paper highlights such a distinctive contribution, since it not only relies on the consultation skills of an applied psychologist, but it offers access to the knowledge base of psychology research and theory.

The argument being put forward in this paper is that emotionally warm caring can not only enhance the well-being of children and young people in care but can also lead to vastly improved life opportunities (see Linley & Joseph, 2002). The emotional warmth approach to professional childcare provides carers with the skills, knowledge and support needed to meet the complex psychological needs of these children and young people. It also offers applied psychologists the personal and professional satisfaction of using psychology as a powerful force for positive change in the lives of children who have been rejected, neglected and abused.

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Address for correspondence

Dr R.J. (Sean) Cameron

Co-Director DEdPsy Programme,
University College London,
Research Department of Clinical,
Educational and Health Psychology,
26 Bedford Way,
London, WC1H 0AP.
Email: r.cameron@ucl.ac.uk

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