

# Why am I in care? A model for communicating with children about entry to care that promotes psychological safety and adjustment

*Adoption & Fostering*

2016, Vol. 40(1) 49–59

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DOI: 10.1177/0308575915626379

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## Abstract

When children are removed from their parents' care, the adults often become involved in processes that are highly attentive to the past and future care of the child. While the present physical and educational needs are attended to in the new placement, there are often dilemmas about how to help the child adjust psychologically to their new situation. In particular, children often struggle with why they have been admitted to care and what the future holds for them. The authors discuss the challenges of communicating with children about these issues and then outline the model they have found to be helpful.

## Keywords

Communicating with children, care, psychological adjustment, Northern Ireland

## Introduction

Many children entering care experience considerable uncertainty as they struggle with questions about why they had to leave their birth family, whose fault it was and whether or not they will be returning home. There are also likely to be questions about their current

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placement, the complex legal process surrounding entry to care and the amount of time required to arrive at a definitive decision about the future.

How can we, the caregiver network (parent, statutory social worker, carer and other key players), respond to these questions in ways that help children adjust psychologically to their newfound circumstances? Often, there are dilemmas about what information, if any, should be shared with children about their current family situation. When is it best to share this? Who should do it? What if birth parents disagree?

Over the past number of years we, the authors, have frequently encountered such questions. We are members of a Therapeutic Team for Looked After and Adopted Children in Northern Health and Social Care Trust (Northern Ireland). This is a small Trust-wide team led by a clinical psychologist and includes clinical psychology and social work staff. We provide a therapeutic service to a population of nearly 700 looked after children and 300 others adopted from care. We work with children, their caregivers, parents and the social care professionals involved to improve placement stability. This is achieved through consultation with the caregiving network in the first instance and/or providing direct therapeutic support to children and/or their caregivers.

Efforts to navigate our way through these issues and to guide others in their conversations with children have led us to develop a collaborative model for communicating with children about their care journey and for supporting their psychological adjustment to it. Over time, this model has been fine-tuned by experience and feedback from parents, carers and care staff about its use and value.

In this article we outline some of the dilemmas of communicating with children about care and our views on this. We then discuss the process for identifying what to communicate, who should lead this and how information-sharing can be part of a process of conversing with children in a therapeutic way. While the article focuses on adjusting to entry to care, we have also used this model to communicate with children at other points in the care journey, such as when the court has decided on future care, helping children to move placements (planned and unplanned), when changes have occurred in the birth family and following placement disruption. There is also the potential to adapt the model for use pre-care when family support is required to safeguard children.

Consequently, the model should be considered as an aid for communicating with children and promoting continued dialogue about difficult issues; it should not be used as a one-off event (Brodzinsky, 2011). We do not regard it as the only way for communicating with children and emphasise that it should be held lightly as individual circumstances require individual consideration.

### **To share, or not to share, the truth**

In our clinical work we have heard children explain that they are in care because of their behaviour or Attention Deficit Hyperactivity Disorder (ADHD) or 'there is something wrong with me'. Others have attributed it to their 'mum working hard at the moment', 'moving house', 'being sick' or being 'busy having another baby'. In all cases, the children perceive themselves as being to blame for their circumstances – either because there is something personally wrong with them or because they have come to believe that there is something fundamentally wrong with a child making demands on a parent.

Children cannot tolerate ambiguity and rush to fill gaps in their understanding of events with their own myths. Sadly, the myths they create on entry to care often compound feelings

of self-blame and shame. These can have a powerful negative influence on the child's emerging relationships: with themselves (self-worth); with people they love and, indeed, the relational template for being in loving relationships; and with normal life events.

For the child, having a clear understanding of why they are in care is an important step towards orienting and adjusting psychologically to the new set of circumstances. It helps the child redefine their relationships with self, parents and siblings now that they are living apart from them.

This understanding is also important for promoting placement stability. How can a child be free to join another family and accept their rules, routines and rituals if they do not understand what was wrong with, or not working in, their birth family? How can they be free to experience a sense of belonging in the new family, even temporarily, if they are preoccupied with why they cannot live in their previous home?

### **Being truthful is not easy**

Sharing information with a child is a complex task and requires careful consideration of the following questions:

- Regarding the age and stage of the child, how do I translate the information in an age-appropriate way?
- What was the child aware of in the family home and what is it appropriate to share?
- Is now the right time to share the information? Will the child experience distress on hearing it and/or feel overwhelmed? Will this result in placement strain?
- Is it right that the child may experience more emotional pain by having to talk about these issues? How do I contain my own emotions about this while talking with the child? Will sharing information result in deterioration in the child's or parent's mental health?
- How will this be interpreted within the court context?
- Will information-sharing 'let the genie out of the bottle' and result in the child seeking information about lots of issues that for one reason or another cannot be answered at this point in time?
- Will discussing these issues add strain to the relationship between child and parent? Will it increase strain on what may be an already challenging relationship between the parent/caregiver and the agency?
- What if a parent does not consent?

Sadly, the evidence is that sharing information does not compete well with the many other tasks that require action when a child is admitted to care. Munro (2011) reports that children interviewed about their experience of the child protection process found it confusing and 'they [the children] made a plea for better information, honesty and emotional support throughout the process' (Munro, 2011: 26).

It appears that this important task can be overlooked, completed in a way that is unhelpful for the child or directed to someone who is considered to have more time or expertise, such as a life story worker or therapist. By ignoring or failing to give this task the consideration it deserves, we could be closing the door on a potent therapeutic opportunity that can promote the child's psychological adjustment, placement stability and, in some cases, improve birth family functioning.

## A therapeutic opportunity

Children enter care with many beliefs shaped by their family experiences. These concern communication with adults, emotional pain and its management, and vulnerability and its treatment. Such beliefs are often compounded by implicit or explicit messages from parents about the need to keep secrets – especially from social workers – and maintain family loyalty.

The information-sharing exercise on entry to care can be a powerful therapeutic opportunity for the child to experience something different to what they have known in their birth family: openness and transparency about painful topics instead of avoidance and denial. There is a chance for the child to have their inner life of feelings and thoughts validated and responded to in a respectful and attuned way, instead of being ignored or dismissed and ultimately considered secondary to the needs of their parents. In the words of Hardy and Laszloffy (2007: 28):

It's one thing to lose something that was important to you, but it is far worse when no one in your universe recognises that you have lost it. The failure to acknowledge another's loss is to deny that person's humanity.

Sharing information in this way is an opportunity to communicate to the child that they are not alone in their distress about the current uncertainty and loss in their lives and that we (the corporate parent) are alongside them in their journey. We can show them through an experience, rather than words, that we will listen to them and be respectful. We can demonstrate how adults can and will be 'bigger, wiser, stronger' than children and that we will support them until they eventually pass through this experience and no longer need our support (Hoffman, et al., 2006).

Depending on the child's age and stage of development, this may be the first experience of being genuinely invited into a collaborative relationship. This sends a very clear message about how we, the corporate parent, intend to communicate with them about all future matters while they are in our care.

In this light, the information-sharing task is conceptualised as more than just the delivery of information. The details to be shared are important but equally, if not more, important is the process for sharing them. Indeed, we would go so far as to argue that the way in which this task is managed by the caregiving network will become the template for how the child and that network will relate in the future.

## A model

The value we have placed on this task has meant that we have spent considerable time discussing it with parents, foster carers, statutory social workers, therapists and guardians, applying the thinking to different cases and modifying it on the basis of what has been helpful. We have developed a model for approaching the task that is conceptual and anecdotal; we do not yet have an empirical basis for promoting it.

In applying the model to entry to care, it is important to revisit the goal or purpose of what we are trying to achieve with the child, namely that it is important for children to have a clear understanding of why they are in care in order to help them adjust to their newfound circumstances.

The goal of the information-sharing task in this instance, therefore, is to aid the child to adjust to their *present* circumstances, so they are less confused in contact with kin, clear about their relationship with the social worker and more settled in their current placement.

This does not replace the need for therapeutic support with adjustment to past events such as multiple placements, abuse or trauma, but we would argue that this information-sharing task is a necessary pre-requisite to such work.

The remainder of this article outlines the components of the model:

- A. Caregiving network meetings
- B. Using narratives
- C. Constructing a narrative for the child
- D. Delivering the narrative
- E. Breaking the silence: broadcasting the narrative to important others
- F. Responding to distress
- G. Building on the narrative

### **A. Caregiving network meetings**

Children enter care with complex histories and presenting behaviour. A considerable amount of wisdom and resourcefulness is required to parent them in ways that can support them to adjust and develop and, at the same time, maintain one's own emotional health and well-being. Rarely does one person have enough reserves to do this on their own. The challenges that the children have experienced and bring with them into a new placement mean that caregivers are likely to need to reach out to others for support.

There are many ways of accessing support. One is to draw upon the 'caregiving network'. This refers to those adults involved in the care of a child and comprises the carers, statutory link workers and therapist. It may also include the birth parent(s), depending on their emotional availability and willingness to collaborate.

A caregiving network meeting is less formal than a Looked After Child (LAC) Review and does not focus on care planning. Rather there is an emphasis on how to use the everyday experiences of the child in a therapeutic way to help him or her through a particular difficulty or set of challenges. It is a collaborative process with everyone involved in the care of the child recognised as having something valuable to contribute. It can be organised by any professional but in the more complex cases is usually co-ordinated by the therapeutic worker. It is not always necessary for the caregiving network to meet physically as much can be accomplished by phone or digital communication.

This network provides an ideal forum for discussing what ought to be shared with the child and to plan how this is done in order that the possibility of success is maximised. This includes the 'what, when, where and by whom'. It provides an opportunity to draw upon the wisdom of the group in working out what themes and messages need to be included for *your child* and to consider how birth parents and carers might be supported, if necessary, during the process.

A question often arises about who should deliver the information. There are no hard and fast rules and this has to be worked through with the caregiving network. Our preference is that for children in care, social workers deliver the narrative as they will have known the child throughout the care episode. Moreover, at a later point in their lives, when the child requires more information, it will be the social worker or welfare agency to whom they will need to turn. Holding this conversation enables the child to associate social services with obtaining information, truth and a balanced approach to why they are in care.

This arrangement frees caregivers to enter into a supportive role with the child. They metaphorically position themselves alongside the child, holding his or her hand rather than leading in the walk through difficult experiences, and reducing any sense of isolation or abandonment. Carers can also adopt the role of co-investigator and can ask questions with naivety.

In some cases birth parents wish to speak to the child about entry to care but suffer the same dilemmas as professionals and carers regarding what to share. The collective wisdom of the group can empower them to begin to share information with their child in a way that is child focused and may provide words or phrases which they could not find themselves. They can be forthcoming about previously unknown details when supported by the social worker. This is a very powerful experience with the capacity to begin a process of genuine repair between the child and birth family.

### ***B. Using narratives***

Up to this point we have discussed the information-sharing task and delivering information on entry to care. In sharing information with anyone, it is important that it is done in a way that is meaningful for them. The focus, in this instance, should be on the information that we want the child to retain after the intervention.

A narrative is a useful way of sharing complex information and maintaining focus. It comprises an outline of the child's experience of being looked after in language that is appropriate to their stage of development. It is created by the adults for the child and functions like a 'scaffold' within which he or she can build, in time, a more thorough understanding of their history and present circumstances. Without this scaffold, the child finds it very hard to locate a starting point for reflecting on their care experience.

Narratives should help a child become more oriented to their present circumstances: Why do I live here? Why do I live with you and not my mummy? How long will I live here? Who makes these decisions? This orientation is the starting point for a child to adjust psychologically to separation from their birth family.

A narrative acknowledges some of what the child has experienced while living with their birth family and by doing so, gives the child permission to feel the way they do about it and to share their experiences with the new adults in their lives. It also gives the child and the caregiving network a common language they can use to communicate experiences. Often adults are unsure about whether to mention any experience of maltreatment and, if they do, what words to use. No one wants the child to experience more pain than they already have and children are unsure about what it is permissible to say and the words to use. Through a narrative, the unspoken can begin to surface. The child is no longer alone with his or her emotional pain and has adults who are sympathetic about his or her experiences and allow them to try and articulate these feelings.

Building a narrative allows the caregiving network and the child to have a congruent message, in contrast to a fragmented one where the child and others do not know who knows what and, indeed, what should be talked about with whom. Thus, along with the other benefits, it can help children build a sense of psychological safety in the here and now of their current placement. This is an important building block for adjusting to separation and loss.

### C. Constructing a narrative for the child

The social worker should outline the narrative on paper and collaborate with the caregiving network so that the content is acceptable to everyone. By committing it to paper, everyone can familiarise themselves with the message the child will receive and a copy can be kept in the social work file. The expectation is that the child will be given a copy of the narrative after the intervention, so it should be written in a way that is accessible to a young person. Hiles and colleagues (2008) illustrate how simple language can be combined with 'stick people drawings' to talk to children about their family experiences; others have used 'clip art'.

Narratives about entry to care should start with a reminder of the experiences that an infant normally has with their primary carer and why they need a consistent and caring adult. Even young children are aware of the primary care tasks that infants require, such as feeding and changing. Thereafter, themes for inclusion can be discussed within the caregiving network, who can consider the factors previously mentioned (see 'Being truthful is not easy'). Additional themes may include:

- whether there is evidence that the child has actually been neglected and/or harmed emotionally, physically or sexually, or been at risk of same;
- who is responsible for maltreatment;
- whether this was deliberate or the consequence of other factors, such as substance abuse, mental health issues or low ability;
- how much we think the child knows;
- how much the child has shared about the experience;
- whether the child is involved in care proceedings and/or being interviewed by police in relation to maltreatment;
- the most appropriate means of communication, including visual and sensory tools.

Decisions about what information to include should be guided by the key goal: to increase the child's sense of psychological safety in placement. How much detail does this child need right now in order to feel safe there? How much would make them feel unsafe?

Our inclination is to offer broad brushstrokes about the kinds of experiences that the child has had with their birth parents. According to Rees (2009: 14–15): 'The past should not overwhelm the child and the history should be kept honest but short – in perspective in terms of the child's whole life.'

Broad brushstrokes should not be so broad that they airbrush the reasons for the child's absence from home. The narrative needs enough information to acknowledge the reality of the child's present situation without submerging him or her entirely in it. There needs to be enough information to:

- acknowledge that they cannot live with their birth parent(s) right now because of the maltreatment they experienced;
- explain that the maltreatment is not what normally happens in family life and was not their fault – we (including the child) are all puzzled why it happened;
- aid understanding of the uncertainty of their current care arrangements and of the court processes;
- explain why they are living in this family now and how this will help with the plan.

Some examples of narratives can be found in the Resources section of the Psychological Pathways website ([www.psychologicalpathways.co.uk](http://www.psychologicalpathways.co.uk)).

#### *D. Delivering the narrative*

It is useful to be able to draw upon the collective wisdom of a number of people who are sensitive to the child's needs in making the decision about when to deliver the narrative. Some advocate a child-led approach and recommend that we should proceed at the child's pace. While we agree that it is important to be sensitive and attuned to the child's needs and to pace the intervention accordingly, it is important to bear in mind that the nature of maltreatment can damage children's developmental competences (Blaustein and Kinniburgh, 2012; Perry, 1995) and a more 'adult-led' approach may be needed. When children hurt themselves physically, we do not wait until they approach to give them help. In the same way, when a child is hurting emotionally, we adults can be proactive in attending to their hurts. This proactive approach is particularly important with children whose early attachment relationships have resulted in them having difficulties turning to adults when in need.

Shortly before the meeting for delivering the narrative to the child, we recommend that he or she witnesses an experience of 'normal nurturing behaviour'. There are many ways of doing this – using videos, stories or preferably having the opportunity to watch a parent with a young infant. This can be done by anyone in the caregiving network. Afterwards the child can be helped to reflect on the parenting work that was done for the vulnerable child. A meeting for delivering the narrative should then follow within a few days. The person delivering the narrative will probably benefit from rehearsing it as the delivery can be difficult because of the emotional content. The meeting itself is usually between the social worker and child, although sometimes the child likes the caregiver to be present. Advance planning should ensure that the child expects to see the social worker and is not missing out on some pleasurable activity. It should be in the child's placement rather than in a restaurant or office, so that he or she is free to share emotions or leave the room if they want to escape. The seating arrangement should be something the child is comfortable with and the room free of distractions. However, the presence of a few toys or teddy bears can help the child to settle.

It is important for the social worker to consider the emotional temperature with the caregiver beforehand to make sure the timing is right. If a child is having a particularly difficult day, consideration should be given to postponing it. The style of delivery must respect the child's feelings and also exude confidence that it is important to have this conversation:

While knowledge of what actually happened to children may be extremely painful, if delivered in a sensitive manner it will help them to cope with their past and prepare them to make the most of their present and future. (Melville, 2005: 3)

In delivering the narrative, it is important for the social worker to make time for the child and check if he or she has understood the main points of what has been said. Some children are active during the meeting and the social worker may just be talking aloud, confident that the child is actually listening.

The narrative may trigger questions from the child. This is part of the adjustment process and should be encouraged. At this point, however, the child has been given a lot of



information and any answers offered now may be lost because he or she has so much to process emotionally and intellectually. Rather, we think it more profitable to answer only those questions that clarify what has been delivered in the narrative. For dealing with all other questions see section G on 'building on the narrative'.

### *E. Breaking the silence: broadcasting the narrative to important others*

It is important that the child understands that this 'narrative' is shared among all the key adults involved in caregiving and the reasons for this. Its delivery to the child and the caregiving network constitutes an antidote to the culture of secrets and fragmentation among adults that children have usually experienced pre-care. At the end of the meeting the social worker can work out with the child who else needs to hear the narrative. The child and carer then share it with key others (if deemed agreeable). For example, some children like their teacher to know.

The social worker attends the next contact meeting between child and birth parent and ensures that the narrative is communicated again, either by him or her or the birth parent, in front of the child.

### *F. Responding to distress*

Some children find a conversation stressful and respond by shutting down emotionally or becoming highly energetic and bouncing around the room, with the result that the narrative never gets started. There are many different ways to engage the child in the process. Asking them to draw a picture of their home and the people in it, or their family, can be a helpful way of starting. Alternatively, one can use toy figurines or dolls and a dolls' house to illustrate points during the delivery.

Other children respond without any obvious emotional reaction and some appear perfectly happy. Children in care have learned ways of managing emotional pain that have kept them safe in the past and it is useful to understand that their reaction (or lack of it) in the here and now probably reflects how they always deal with situations they perceive to be threatening. Their emotional response should not be interpreted as confirming or disconfirming our hypotheses about their relationships with kin. Nor is this the time to teach them new ways of expressing emotion. Now is the time to respect that their way of reacting is good enough for right now. Now is the time for observing their reaction.

No one wants to cause children pain. Sometimes talking about the pain a child has already experienced causes him or her to re-experience it, perhaps becoming tearful or angry. Although it is tempting to change the narrative in response to the child's pain, the child's response is an appropriate reaction to the situation. By allowing them to share that pain, the message we communicate is: 'I am with you in the pain'; 'you are not alone'; 'pain is a normal response and will pass'.

The child is grieving in this circumstance and needs support to cope with the loss. We have found that the most helpful response from adults to all children's emotional communication is to adopt a position that is accepting, empathic and curious. Dan Hughes (2012) and Kim Golding (2012) have written extensively about this therapeutic stance.

### G. Building on the narrative

Part of the adjustment process is questioning. This allows us to discover information that could make sense of a traumatic incident. Even if that information is not available, the very act of questioning pulls us closer to others.

Many children who come into care have stopped asking questions of adults – some have stopped seeking anything from adults – just accepting that their experience was ‘normal’. Thus, children’s questions offer precious opportunities to share information with them but equally important, to connect with their inner life. What’s in the question? What’s behind it? How do we connect with the child behind the question?

The importance of the child’s questions should be discussed in advance at the network meeting with consideration given to how they will be respected and responded to. The social worker and carer are encouraged to make a fuss about the child’s questions during the narrative meeting, praising them for having questions, and such good questions too. But rather than stepping into answering them, the carer acts as co-investigator. Metaphorically, they stand with the child, holding the child’s hand while they ask questions that are difficult for them or hard to hear the answers to.

Some carers suggest using a special book or crafting a box in which to collect any questions the child may have (they can later spend time together decorating this). This holds the questions until the next social work visit. Whenever the child asks a question, the carer can remind them of the box and the importance of writing that question down.

The carer needs to update the social worker in advance of a visit so they can prepare answers to any questions, enabling them to deliver on their promise to address them. For those questions that cannot be answered, the social worker affirms the questions, and acknowledges that they don’t yet have an answer but will take steps to try and find out. The questions that the child asks can help determine the next steps in terms of therapeutic work. For example, if the child is demonstrating confusion about family membership or has blanks in terms of not knowing their placement history, life story work might be considered. If the child has questions about why they were abused or not protected – one might encourage them to explore this with a therapist.

There are many helpful story books with themes that may parallel those in the child’s narrative and which can be helpful in supporting the child to adjust to particular aspects of their narrative; for example, BAAF’s *Nutmeg* and *Dennis Duckling* series (Foxton, 2001–2007; Sambrooks, 2009; 2011; 2015), the *Billy Says* series (Alper, 2002) and *Murphy’s Three Homes* (Gilman, 2009). Another excellent BAAF resource is *Once Upon a Time . . . Stories and drama to use in direct work with adopted and fostered children* (Moore, 2012).

From our perspective, these resources should be used to supplement the narrative and not instead of it.

## Conclusion

This model was developed in response to repeated themes arising in our clinical work with looked after children. We have developed a training day for social workers in LAC, residential care or family placement teams so they can implement the model and be less dependent for support from the therapeutic team. We now have social workers and foster carers who are familiar with the model through training and/or the experience of being guided through it in a consultation with our service. As a result, the therapeutic team now only

becomes involved when the situation is particularly complex, for example, when there are sibling groups in care, the suicide or death of a parent or when there is conflict or disagreement within the caregiving network.

Feedback from our training events and consultations with carers, social workers, guardians and parents about the model has been very positive. Our collective experience has been that this approach is helpful for children's psychological adjustment to their new circumstances and in some cases has removed the need for other therapeutic interventions or given them a clearer role. While the model is not embedded in social work practice in a formal way within the Trust, we are encouraged by how often narrative work is now included in the plans at the initial LAC review.

## References

- Alper J (2002) *Billy Says*. Bedfordshire: Fosterplus.
- Blaustein ME and Kinniburgh KM (2012) *Treating Traumatic Stress in Children and Adolescents: How to foster resilience through attachment, self-regulation and competency*. New York: Guilford Press.
- Brodzinsky DM (2011) Children's understanding of adoption: developmental and clinical implications. *Professional Psychology: Research and Practice* 42(2): 200–207.
- Foxton J (2001–2007) *Nutmeg Gets Adopted; Nutmeg Gets Cross; Nutmeg Gets a Letter; Nutmeg Gets a Little Help; Nutmeg Gets into Trouble; Nutmeg Gets a Little Sister*. London: BAAF.
- Gilman J (2009) *Murphy's Three Homes: A story for children in foster care*. Washington, DC: Magination Press.
- Golding KS (2012) *Creating Loving Attachments: Parenting with PACE to nurture confidence and security in the troubled child*. London: Jessica Kingsley Publishers.
- Hardy KV and Laszloffy TA (2007) *Teens Who Hurt: Clinical interventions to break the cycle of adolescent violence*. London: Guilford Press.
- Hiles M, Essex S, Fox A and Luger C (2008) The 'words and pictures' storyboard: making sense for children and families. *Context*, June: 10–16.
- Hoffman K, Marvin R, Cooper G and Powell B (2006) Changing toddlers' and preschoolers' attachment classifications: the Circle of Security Intervention. *Journal of Consulting and Clinical Psychology* 74(6): 1017–1026.
- Hughes D (2012) *Parenting a Child with Emotional and Behavioural Difficulties*. London: BAAF.
- Melville L (2005) *Working with Children and Families, Vol.2: A training manual*. Manchester: The Family Protection Project/The British Council.
- Moore J (2012) *Once Upon a Time... Stories and drama to use in direct work with adopted and fostered children*. London: BAAF.
- Munro E (2011) *The Munro Review of Child Protection: Final Report. A child centred system*. London: Department for Education.
- Perry B (1995) *Principles of Clinical Work with Traumatized Children: Special considerations for parents, caretakers and teachers*. Houston, TX: Baylor College of Medicine. Available at: <http://trauma-pages.com/s/perrykid.php>.
- Rees J (2009) *Life Story Books for Adopted Children: A family friendly approach*. London: Jessica Kingsley Publishers.
- Sambrooks P (2009) *Dennis Duckling*. London: BAAF.
- Sambrooks P (2011) *Dennis and the Big Decisions*. London: BAAF.
- Sambrooks P (2015) *Dennis Lives with Grandma and Grandpa*. London: CoramBAAF.

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