

The Narrative Model for communicating with looked after children about challenging issues

Adoption & Fostering

2020, Vol. 44(2) 142–155

© The Author(s) 2020

Article reuse guidelines:

sagepub.com/journals-permissions

DOI: 10.1177/0308575920925814

journals.sagepub.com/home/aaf**William Coman**

Psychological Pathways, Northern Ireland, UK

Lynda McGill

Northern Health and Social Care Trust, Northern Ireland, UK

Michelle Rainey

Northern Health and Social Care Trust, Northern Ireland, UK

Abstract

When children are first looked after, a significant challenge for those who support them is helping the children understand the reasons why they are in care. The Narrative Model is a model for supporting social workers to structure conversations with children about their entry to care and other complex issues. This article summarises the Narrative Model and shows how it supports placement stability for children. It clarifies how it differs from life story work and how it includes birth parents in the process. It then describes how the child's response to the experience of having a narrative shared with them can aid social workers when making decisions about what the child may need next.

Keywords

Communicating with children, care, caregiver network, psychological adjustment, Northern Ireland

An explanation for being in care

In this day and age it is inconceivable to think that any adolescent would be admitted to hospital without some age-appropriate explanation that they are ill, the type of illness they

Corresponding author:

William Coman, Psychological Pathways, City East Business Centre, 68–72 Newtownards Road, Belfast BT4 1GW, Northern Ireland.

Email: William@psychologicalpathways.com

have, the treatment planned and what that involves. Indeed, how can they consent to the treatment and be a collaborative partner in their recovery without such an explanation? Good practice dictates that younger children also receive enough information with explanations given in a developmentally sensitive way.

The same logic might be applied to looked after children. They need to know why they are not living with their parent(s). Otherwise how can they:

- understand the actions of the social worker in taking them from their birth parents;
- develop a trusting and collaborative relationship with the social worker;
- be a collaborative partner with processes in social services that are designed to include their views and opinions (i.e. to engage with and contribute to reviews and share their views about potential decisions) while they live away from home;
- have open and honest conversations with their birth parent(s) that can help them better understand their pre-care experiences and/or engage meaningfully during contact;
- accept the care being offered by the caregiver;
- develop a coherent personal narrative;
- be clear and appropriate in what they share with friends, other looked after children, those at school and other adults involved in their lives?

Coram Voice¹ argue convincingly that ‘coming to an understanding about this life-changing event is the “right” of every child or young person and fundamental to their development, identity and emotional well-being’ (Bright Spots Insight, 2019: 1), yet a significant number of children do not have an adequate understanding of why they are in care.

As part of a wider online survey of looked after children’s views on their well-being, *Our Lives, Our Care*, Coram Voice asked children and young people if they had received enough information about their entry to care. In response, 3314 of those aged four to 18 years in 23 English and Welsh local authorities replied. Of these, 48% of children aged four to seven, 33% of eight- to ten-year-olds and 20% of 11- to 18-year-olds reported not having sufficient information (Briheim-Crookall, Baker and Selwyn, 2018). In a similar study of care leavers aged 18 to 25, nearly one-quarter stated that they had not received a full explanation about why they were in care (Baker, et al., 2019).

Staines and Selwyn (2020) note that placement type, duration of care experience and whether or not the child had contact with birth parents had no influence on the results. They further identify that for some children, lacking a full explanation is associated with feeling unsettled in placement and low social well-being.

The authors of this article are members of a therapeutic team for looked after and adopted children and have encountered this issue frequently in consultative and therapeutic work ever since the establishment of the team in 2011. They formed a view that children ought to be given age-appropriate information on entry to care routinely, upstream from their service, by the social worker. This would lessen the confusion for many children and, in so doing, reduce challenging behaviour and the need of some children for the service.

An obvious starting point for the team was to introduce leaflets describing the care journey. But while these are helpful for giving corporate information, they are impersonal and do not address the key issue which the children were struggling most to understand: Why am *I* (as distinct from anyone else) in care? What is wrong with me or my family?

The authors also discovered various reasons why children might feel that they did not have an adequate explanation. In some cases, adults may have given them no such

information while in others, the explanation received amounted to a partial account or a sanitised version of events that did not stand up to probing questions.

In addition, children sometimes receive contradictory messages from the adults involved in their care, reflecting the adults' own conflicting views. In these situations, the child does not know whom to believe and which explanation is truthful and so remains confused. In other cases, children are given an adequate age-appropriate explanation but they just cannot accept it; it is too emotionally painful for them.

We quickly discovered that supporting a child to have a good-enough understanding of why she or he is in care is a much more complex task than it first seems. Elsewhere, Coman and colleagues (2016) set out significant challenges that can arise for the child, the parent(s), the social worker and indeed all involved in corporate parenting in communicating about entry to care and other care related issues.

The task involves first gaining an understanding from the child about what she or he knows already. Then one needs to identify whether they wish for further information. Often the details sought are highly complex and need to be translated into language that the child can understand. The information then needs to be communicated in a way that the child can receive it and which does not overwhelm them. All this needs to be done in a timely manner and within a challenging systemic context: corporate parenting where caregiving responsibilities are shared among a number of people in addition to birth parent(s), all in the arena of court proceedings.

Acknowledging this complexity, the authors decided that it would be helpful if social workers had a model to aid them to navigate their way through the various dilemmas that can arise and so facilitate better communication with children.

An initial informal literature review revealed no models of best practice for this area. A systematic literature search of CINAHL Plus, PsycINFO and Social Care Online, the Cochrane Library and Campbell Collaboration has since been undertaken by one of the authors (McGill, 2017) as part of an MA dissertation and this confirmed our initial findings.²

While no best practice models were identified, we did come across many useful models and excellent tools for communicating with children about a range of issues. These include (but are not confined to) the following:

- fictional stories;
- autobiographical stories;
- social stories (Gray, 2015);
- workbooks that a social worker can complete with a child;
- therapeutic stories – especially the work of Golding (2014), Sunderland (2001), and more recently, Treisman (2019);
- the 'words and pictures' storyboard (Hiles, et al., 2008);
- helping children understand their parent's mental illness (Reupert, Cuff and Maybery, 2015);
- life story work (Rose, 2017).

These proved to be helpful aides in our therapeutic work with looked after children. However, the team was seeking something that could be used upstream from our service – an early intervention as distinct from one that is completed as part of a therapeutic programme. We wanted it to be something that social workers could integrate into their

work and so needed to be mindful of their role and function and their particular skill set. It was important for social workers to experience psychological safety so that they, in turn, could help the children experience this too. Consequently, the model needed to help them in the complex social context of corporate parenting.

It was important for it to feel personal for the child and for them to experience it as therapeutic, even though it took place outside a therapy setting. Also it was intended to be a process for starting dialogue, not an end in itself. Finally, it had to be completed in a timely manner (see Multiple Narratives below) but not be a tick-box exercise.

We came to a view that we needed to build a bespoke model for this task.

The Narrative Model

The Narrative Model was developed in Northern Health and Social Care Trust by workers from the aforementioned therapeutic team for looked after and adopted children (Coman, et al., 2016) to support adults to collaborate together and communicate with children about difficult issues.

The underlying theory was that if we intervened with carers in a way that brought greater congruence to the messages they were communicating to the child or children they were looking after, and supported them to do this in a developmentally sensitive way, this would, in turn, increase the likelihood of the child 'hearing' and perhaps understanding any explanations given to them. We believed the reduction in fragmentation among the caregivers would increase the child's sense of psychological safety, reduce safety-seeking behaviour and promote greater acceptance of their immediate care circumstances.

In brief, the model comprises seven components:

1. *The caregiver network* – those who have a significant role in caring for the child including the social worker, foster carers or residential workers and, where possible, the birth parent(s). The network works together to identify the priority narrative that a child needs at this time, to develop an agreed form of words and to formulate a plan for sharing them.
2. *The use of narratives* – the adults do the work of translating complex information rather than leaving it to the child to decipher; they translate the invariably complex context into words the child will easily understand. A written copy is available for the child and others.
3. *Delivery of the narrative to the child* – the caregiver network attends not only to the content of the narrative but also to the process for communicating this to the child. Members work together to plan the delivery of the narrative, attending to the roles of each person in supporting the delivery and the practicalities of doing this. Attention is also paid to the child's sensory strategies and what might help him or her from being overwhelmed.
4. *Responding to the child's emotions* – those involved in delivering the narrative are attentive to the child's emotions prompted by the narrative, are accepting of them and communicate empathy to the child.
5. *Responding to the child's questions* – they are attentive to the child's questions, validating these and promoting the child's curiosity about her or his experiences and using them to continue the conversation with one another on other occasions.

6. *Broadcasting the narrative to significant others* – this entails identifying those key people with whom the child might wish to share the narrative and helping them to do so. This is considered an antidote to the secrecy and fragmentation that often accompanies child maltreatment.
7. *Building on the narrative* – reflecting on the child's responses to the narrative can signpost other ways to support him or her to adjust psychologically.

We have described elsewhere in detail the rationale for the model and its components (Coman, et al., 2016). The components are not new; indeed, they are principles evident in many models of good practice (Leamy, et al., 2011; McGill, 2017). Where we have been creative is in bringing these principles together, making them explicit and applying them for a specific task – communicating with children about complex issues.

For various reasons, those using the model may be tempted to focus on one of its components and to exclude others, but in our experience this weakens the intervention. For example, one social worker decided to leave out the caregiver network element in order to reduce the time cost. The narrative they shared with the child was an accurate account of the circumstances that led to the child's admission to care but omitting the birth parent's views; consequently, the birth parent interpreted this as an effort by the social worker to align the child 'against' the birth parent. The resulting conflict among the caregiver network functioned to undermine the very sense of psychological safety that the social worker had wished to create for the child who ended up not accepting the narrative.

Accordingly, we believe that each and every one of the components of the model are necessary in helping the child adjust psychologically to challenging circumstances and to promote his or her engagement while in care.

Narratives

We have used the word 'narrative' quite deliberately in order to describe what it is that we deliver to a child. Hence the process for creating the narrative, delivering it to the child and responding to them is called the 'Narrative Model' (McGill, et al., 2018). Since the term 'narrative' is used in many contexts and can evoke different meanings, it may be helpful to clarify its use here.

We use the term as defined by the Oxford Dictionary (2019): 'A spoken or written account of connected events; a story'. In addition, it is important to distinguish between the child's personal narrative and 'our' narrative (the one that the caregiver network creates and offers to him or her). The latter is based on information that the network holds at a particular moment in time; it is not the child's 'story'.³ The child is the author of his or her own story and the Narrative Model is not meant to usurp that role. Rather, it is a tool for prompting communication with the child about aspects of their story and as an aide for reflection and 'meaning-making'. It serves as a temporary scaffold within which the child is supported to construct or edit their personal narrative.

Accordingly, the narrative that the caregiver network creates, the caregiver narrative, ought to be held lightly and offered tentatively to the child. It is presented as a 'best guess' concerning what has happened to them. The spirit of the approach is one of collaborative enquiry and curiosity about the child's experience.

Evidence to support the Narrative Model

Some anecdotal evidence of the usefulness of this model can be found in the following quotations selected from many positive comments people have made:

For anyone using the model for the first time it is scary, but I say embrace it. I see a confidence in my social workers at LAC reviews and I am able to endorse the plans. (Social Work Service Manager)

It helps professionals all come together with foster carers and parents; it allows children to have the same consistent information from the adults around them. The focus remains on the child and focuses the adults on what we need to share. (Guardian ad litem)

I definitely wanted my view given; we worked hard to make it an agreement between us all. It was really helpful. (Birth mother)

Amazed at how simple it can be and how effective it can be. (Supervising social worker)

If I was on my own, I don't think I would have been able to be as honest to the kids. (Birth mother)

We have written elsewhere about a survey of social workers who had used the Narrative Model (McGill, et al., 2018). Eighteen social workers responded to the survey and completed information about 48 children. Importantly, no respondents indicated any detrimental impact on the children from using the model, nor did they highlight any reduced placement stability. Indeed, the social workers reported finding it a helpful tool to aid communication with children about the 'tough stuff'; all stated that the model had benefited the children with whom they had used it. They also reported that it had had a positive impact on the child's placement.

We have delivered training on the model to over 300 social workers in a number of different teams (family support and intervention social work teams, looked after children social work teams, therapeutic teams/CAMHS [Child and Adolescent Mental Health Services], fostering, post-adoption and independent review chairs) across eight different agencies. The feedback about the training and, in particular, the usefulness of the model has been overwhelmingly positive as measured by standard training evaluation feedback forms using Likert scales.

Further research is needed to ascertain the views of birth parents and foster carers on how helpful they believe the Narrative Model has been. Research is also needed to evidence if the young people with whom the social workers have used the model demonstrate greater satisfaction with their understanding of why they are in care.

The Narrative Model and life story work

In training events, a key question that arises is the relationship between this model and life story work. Indeed, some view the Narrative Model as a method for short-cutting the latter. Such a view is in contrast to what the Narrative Model promotes and is a disservice to both methods. We have previously described the relationship between them as akin to the

relationship between a 'frame' and an entire movie (McGill, et al., 2018). The life story is composed of many, many narratives while the Narrative Model has a much narrower focus.

Indeed, the first task for the caregiver network is to identify what, out of all the information needs to be communicated to the child, would be most helpful to focus on at this particular time in order to help this child adjust to a particular challenge. It is highly specific.

Furthermore, the Narrative Model was devised as a tool for having a *structured conversation* with the child. Deviating from this purpose can lead to delays in the construction and delivery of the narrative and, most importantly, result in the child being distracted or overwhelmed by information.

Multiple narratives

A related challenge is where workers try to deliver multiple narratives in one conversation.

The following case example helps to illustrate this.

A child of six years is about to be placed for adoption and the social worker wishes to prepare her in advance of the move, using a narrative. In an ideal situation one would like the child to have experience of at least four narratives about her care journey prior to moving to the new placement, each one targeting a particular psychological challenge to which she needs help adjusting.

The first narrative, completed shortly after admission to care, is to help the child adjust to entry. It communicates to her that there are multiple viewpoints about why she is not currently living with her birth parents, that there are judicial proceedings underway which will decide her future care, that she will live with these particular foster carers until the proceedings conclude, and this is what to expect from the 'short-term' carers while living with them. It also includes the level of contact with family members.

A second narrative follows the conclusion of proceedings (for example, when a care order is granted) and the principle focus is to acknowledge that the child will not be returning to the care of her parents and to support her to adjust psychologically to this.

A third narrative (which usually follows the second one quite quickly) is to prepare the child in advance for moving from her current home – it acknowledges the process for finding a family for her and endorses the importance of securing not just any family, but one that is a good fit for her. It also recognises the feelings she may have about moving from her current placement and the uncertainty she experiences while waiting to be matched. In our experience, caregivers often value the Narrative Model especially at this stage as it not only gives them words, but also role clarity and a framework for supporting children with their emotions.

A fourth narrative includes a summary of the previous narratives and introduces the fact that a new family has been identified, describes why we (the caregiver network) think this is a good fit and outlines what we believe might support the child and family in making the transition.

A fifth and sixth narrative may follow the child being placed if she is freed for adoption and an adoption order is subsequently granted.

In the best-case scenario, the narratives are completed in a timely way and in sequence, supporting the child to adjust psychologically to 'news'. Each narrative also lays the foundations for the next one.

In the worst-case scenario, the worker is confronted with having to develop a narrative at a later point in the child's journey without any of the previous ones having been completed or heard by the child. She now has to adjust psychologically to the news that she is not returning to her birth parent(s), will not be staying with the current carer(s) with whom she has lived for some time and has been found an adoptive family to whom she will shortly be moving.

The worst-case scenario raises many questions. How to make the child ready for the new placement? How to fairly present caregivers or indeed the new adopters? How is it fair to birth parents who have the capacity to be supportive of the adoption? What will the child think in future about social workers and children's services?

'Psychological constipation' is the term one of the authors uses to describe the reaction of children in such circumstances. There are so many significant psychological issues occurring simultaneously for the child that they bind to one another and become too big for the child to process further. This can predispose them to intense emotions that are very challenging for the new carers to contain (given they do not have a historical relationship with the child) or indeed, in some cases, to reject the new carers entirely.

If these issues have not been addressed in sequence for the child before moving to the adoptive placement, they can also predispose adopters to become blocked in their ability to communicate with their children about their narratives. In our experiences to date, where this scaffolding has not been laid down in a timely, responsive way before the point of adoption it tends not to be progressed into the child's future, thus culminating in significant difficulties within the family.

Engaging the network

Another area of discussion that arises during training on this model is the caregiver network.

The African proverb 'It takes a village, a whole village, to raise a child' alludes to the fact that children flourish within a healthy community context. Bruce Perry notes (Perry and Salavitz, 2006: 260):

... what maltreated and traumatised children most need is a healthy community to buffer the pain, distress and loss caused by earlier trauma. What works to heal them is anything that increases the number and quality of a child's relationships.

When a child is first looked after, their 'community' extends and changes; they have a new 'village' that includes, but is not confined to, their birth family. It is right and proper for the social worker to seek opportunities within this extended village to strengthen a child's relationships. The professional meeting can provide an excellent chance for mining such opportunities.

However, an error that some social workers make when establishing a caregiver network is to equate this with a professional meeting. Accordingly, they invite numerous members of the new village – guardians, teachers, police, past social workers, etc. – potentially resulting in a loss of focus and duplication of other discussions.

Instead, we conceptualise the caregiver network as functioning like the village elders for the particular task of planning and delivering a narrative. Before deciding on the membership of the group, it is helpful for the social worker to have a reasonably clear sense of what, out of all the possible narratives that this child might need, the caregiver network will focus

on in the first instance. This may change in time but a sharp focus will make it easier to select the membership.

Typically, it includes the social worker, the caregiver, family placement social worker and the birth parent.

The 'health' of the caregiver network is critical to the successful implementation of this model, evident in the degree to which members can be congruent in the best interests of the child. Congruence in the caregiver network is to care what hygiene is to surgery; fragmentation, the opposite to congruence, undermines the capacity to experience psychological safety. Without due diligence the intervention will be undermined and could result in a worse outcome than if such an initiative had never started. Consequently, in deciding membership of the caregiver network, one must evaluate the degree to which members can work together.

Often the child's networks have become fractured somewhere along the way. Parents and professionals may disagree about the reasons or concerns that led the child to become looked after or why he or she is presenting a particular behaviour. As adults try to navigate their way through positions that might conflict with one another, managing the friction can become their primary focus and the child's need for psychological safety can be eclipsed.

We have found that adopting the Narrative Model with the network can assist the child's 'village' to refocus on what she or he needs, even where there is conflict. Consequently, we do not necessarily exclude a family member for this reason but only do so if the dispute is unmanageable or the parent is unable or unwilling to engage. Even then, we seek to include their views, as explained in the next section.

On a very rare occasion we have decided that a foster carer should not be part of the caregiver network. This has been largely due to their having become involved in unmanageable conflict with social work or adopting a position of intractable hostility to a birth parent whom social workers have assessed as being able, willing and ready to engage in the work. Alternatively, they may have been kinship carers and were overly aligned with a hostile parent's position. In such cases, we have tried to be creative in identifying who is best placed to support the child while the narrative is delivered.

When parents and professionals disagree

Although every family is unique, certain harmful experiences have usually led to a child becoming looked after; for example, child abuse, neglect, absence or death of a parent, the impact of alcohol or drugs and domestic violence.

In most cases, birth parents value an offer of help to find words to communicate with the child about these difficult issues. Often the parents' views do not align neatly with professionals. This has not stopped us generating a narrative that is agreeable to all parties. Our purpose is not to get agreement about all aspects of everything. Rather, we try to develop a framework within which the multiple views can be held simultaneously. This runs as follows: these are the facts (relevant for this child's narrative) we adults hold, this is what your parent (s) think about them and these are the views of the professionals. We let the child know there is disagreement and it is for this reason that the case is going before the court and the judge will decide after considering all positions. For most parents, it is enough for them to know that their views are being included.

In some cases, however, this approach has not been sufficient in and of itself to arrive at an agreed narrative. There are situations where parents are resistant to a narrative being completed and we have found it is not the facts per se that are disputed but the meaning associated

with them. For example, ‘the child was hit by their father and injured’ may be perceived by the parent as adults calling them a child abuser; or ‘when your mum took alcohol or drugs, she did not take good care of you’, may be interpreted by a parent as the adults saying to the child, ‘She was not a good mum.’ Such meanings can evoke intense feelings of shame for the parent and may, in turn, manifest as resistance, conflict and/or anger.

In our experience, investing time with birth parents and working collaboratively to find words and reduce shame has in itself reduced conflict and enabled them to engage not only in the narrative intervention but also more positively with other professionals, even when court processes are ongoing. Achieving this requires a child- and family-centered approach (Boddy, 2013) where compassion and an understanding of one another’s perspectives is integral to successful narrative progression.

We have also found that parents’ resistance to a narrative often softened when they understood that it is helpful not just for the child but also for them and their ongoing relationship with their offspring absent in care. The narrative can serve as a useful launch point in facilitated contact where the parent and child are supported to talk about what has not been good in their family. This, in turn, can improve the quality of contact for both parties.

Furthermore, assisting parents and children to talk about experiences and repair relationships before they return home, or gravitate back home when they are old enough to leave care, minimises the potential for unhealthy or unhelpful conversations at a later point, for instance, under the influence of alcohol or drugs, or when angry.

There have been cases where parents have not taken part because they have been unavailable or unable to do so due to their personal circumstances. In such cases, we adopt the usual approach to the narrative, outlining the threshold information and what professionals think about this. We include what we believe are the parents’ views and admit that this is our best guess. In exceptional cases we have had parents withdraw consent for a narrative to proceed. In those situations, we look to legal services and the courts for legal permission before progressing.

A helpful concept we use within a narrative when dealing with disagreement is that of being puzzled. For example:

We have told your mum what needs to change so that you can be looked after safely and we have tried to help her to make those changes. Mum disagrees; she thinks she has made the changes. But this keeps happening and we are really puzzled why she doesn’t make the changes. I’m guessing you are too.

While the disagreement is central for adults, it is important to remember that it constitutes only a few sentences and that the narrative is larger than this; it should not become such a big issue that it is insurmountable.

The Narrative Model as a tool for informing further therapeutic work

The Narrative Model was designed to help social workers to communicate with children about difficult issues. While the social worker needs some therapeutic skills (especially playfulness, acceptance, curiosity and empathy [PACE] as described by Hughes, 2007 and Golding and Hughes, 2012) for this work to progress, they are not expected to be a therapist per se.

The delivery of the narrative is not considered to be a ‘one-off event’ but a stimulus for social workers, carers and parents to relate to the child. Accordingly, it is never a completed task.

By attending to the child's response to the caregiver narrative, the social worker can gain insight into what is important to the child and, indeed, what she or he might be struggling with currently and need help with. This allows the social worker to adopt a more targeted approach and suggest interventions to the child that are more salient for them which, in turn, increases the chances of the child engaging with them. The child's response to the caregiver narrative, therefore, can serve as a signpost to the next intervention they require.

These points are illustrated by the following examples:

- For some children, a narrative gives them permission to disclose abuse or elements of abuse they have not previously revealed. During or after the delivery of the caregiver narrative, they may start to reveal new information about past abuse and it is now timely to commence joint protocol.
- The child may be curious about an aspect of his or her life that was omitted from the original caregiver narrative or was only mentioned in passing and now needs more detail. Examples include expanding on a parent's mental health problem, ongoing substance abuse, receiving a jail sentence or completing suicide; or a narrative about a sibling being placed with birth family or siblings needing to be placed separately. One might support such narratives with helpful literature on families where there are similar challenges. Many children experience anxiety about what to say to friends and peers in school and one might help them to have a ready-made narrative they are comfortable to share.
- In the weeks following the delivery of the narrative a child's communications may indicate that they have gaps in their knowledge about the membership of their family or placements that were important to them, suggesting that they might benefit from life story work. They may be struggling to integrate the narrative or other important aspects of their personal story and they may benefit from therapeutic life story work (Rose, 2017).
- The child's questions or comments might show that they feel they are the only one to have been maltreated in the world and they struggle with isolation and a sense of difference. Depending on the age and stage of the child, one might bring in books or stories which have themes that parallel their own personal journey; or introduce biographies of others who have lived through difficult times and come out the other side or, indeed, young people who can witness directly to them. Therapeutic stories can be helpful.
- The child may present as highly anxious or aggressive prior to, during or after the caregiver narrative. If this is their typical response to anxiety, it may indicate the need for sensory regulation skills training and/or specific anger/anxiety management or trauma-focused interventions.
- It may be that the child really struggles with being in a new family and the narrative, while a starting point, is not enough to help them accept the care and love offered to them in their home setting. Theraplay (Booth and Jernberg, 2010) is a helpful intervention for strengthening relationships between a child and their caregiver. However, as Hughes, Golding and Hudson (2019: 45) explain, a significant proportion of children who have experienced developmental trauma:

... are not able to either resolve the traumatic relational events that they have experienced or develop secure attachment relationships with the new carers. They are isolated and have limited abilities to enter into the healing and restorative conversations needed to develop new

relational stories that can enrich and support them. They are locked in a fragmented sense of self and others that is permeated with fear and shame. The developmental abilities that they need for an integrated sense of self and a coherent narrative are not in place. [It is] the intent of Dyadic Developmental Psychotherapy to facilitate the development of these core skills.

- The narrative can also be a starting point for supporting improvement in the relationship between a child and her or his birth parent(s). In some cases, they respond to the narrative with lots of questions about why their parents behaved in a particular way. In cases where the parents refuse to engage with the caregiver network but are open to engaging with the child, we might encourage the children to write down their questions for their parents and open a letterbox dialogue. This includes taking time with the child to support them with the answers they receive and helping them to process their feelings about the experience. When parents do engage with the network, we can support parents and children to enter into a dialogue about important and difficult issues until they can manage these conversations without support. Understanding the needs and experiences of the birth parents is central to the process, as is being able to support them within it. This is highly relevant as their emotional well-being will continue to have a bearing on the child's welfare within any continued contact arrangements (Memarnia, et al., 2015) and in their future relationships.
- In our experience, when children and parents are supported to discuss these challenging issues, parents begin to validate the children's experiences. For some children, this has supported a pathway of continued conversations and an acceptance of the reality of where a parent is at and the issues that challenge their caregiving role, thereby enabling a greater settling within their placement or prospective adoptive home. For others, the experience has resulted in them deciding to take a break from contact arrangements until they have processed their feelings further.

Using the Narrative Model does not guarantee that children will 'hold' the caregiver narrative about their care circumstances over time, but they usually have a written copy they can refer back to if they again become confused. Furthermore, the experience of having a social worker who has initiated and promoted ongoing dialogue and a caregiver network that has been part of that conversation ought to make it easier for the child to turn to the adults when she or he has questions.

Conclusion

Since its development, feedback on the Narrative Model has highlighted its effectiveness in navigating the complexities of talking to children about their personal care circumstances. In particular, we have found that by focusing on what information the child requires at this specific time, the caregiver network avoids overwhelming the child or causing 'psychological constipation'. Investment of time in this network has been found to be integral to this process and sensitive utilisation of the child's 'village' has enabled divergent views to be mediated. Birth parents' involvement in this process, while provoking anxiety for some social workers, has had some observable rewards: for the child, in improving contact, reducing torn loyalties or influencing future orientated relationships with them; and for the parents, in reducing their levels of shame or conflict with the agency or carers.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Notes

1. Coram Voice is a UK national charity dedicated to enabling and supporting the voices of all children and young people in care.
2. It did identify models of communicating with children about mental health (Niemelä, et al., 2010; Pihkala, Sandlund and Cederström, 2011, Solantus and Ringbom, 2002; Solantus, et al., 2009), substance abuse (North South Hidden Harm Group, 2015; Templeton, 2012) and cancer care (Ranmal, Prictor and Scott, 2008).
3. We have observed some workers calling a narrative they are offering to a child 'Your story'.

References

- Baker C, Briheim-Crookall L, Magnus L and Selwyn J (2019) *Our Lives Beyond Care: Care leavers' views on their well-being in 2018*. London: Coram Voice.
- Boddy J (2013) Understanding permanence for looked after children: a review of research for the Care Inquiry. *Briefing Paper*. University of Sussex. Available at: http://sro.sussex.ac.uk/id/eprint/44711/1/Boddy_2013_Understanding_Permanence.pdf
- Booth P and Jernberg A (2010) *Theraplay: Helping parents and children build better relationships*. New York: Wiley & Sons.
- Briheim-Crookall L, Baker C and Selwyn J (2018) *Our Lives, Our Care: Looked after children's views on their well-being in 2018*. London: Coram Voice.
- Coman W, Dickson S, McGill L and Rainey M (2016) 'Why am I in care?' A model for communicating with children about entry to care that promotes psychological adjustment and safety. *Adoption & Fostering* 40(1): 49–59.
- Golding K (2014) *Using Stories to Build Bridges with Traumatized Children: Creative ideas for therapy, life story work, direct work and parenting*. London: Jessica Kingsley Publishers.
- Golding K and Hughes D (2012) *Creating Loving Attachments: Parenting with PACE to nurture confidence and security in the troubled child*. London: Jessica Kingsley Publishers.
- Gray C (2015) *The New Social Story Book*. New Horizons.
- 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.
- Hughes D (2007) *Attachment Focused Family Therapy*. New York: WWW Norton & Co.
- Hughes DA, Golding KS and Hudson J (2019) *Healing Relational Trauma with Attachment-Focused Interventions: Dyadic Developmental Psychotherapy with children and families*. New York: WW Norton & Co.
- Leamy M, Bird V, Le Boutellier C, et al. (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry* 199(6): 445–452.
- McGill L (2017) Interventions to improve communication between children and their birth parents about the reasons they are in care – A Systematic Narrative Review (unpublished MA Thesis). Northern Ireland: University of Ulster.
- McGill L, Coman W, McWhirter J and O'Sullivan C (2018) Social workers' experiences of using the Narrative Model to talk with children about why they are in care and other sensitive issues. *Adoption & Fostering* 42(1): 49–57.
- Memarnia N, Nolte L, Norris C and Harborne A (2015) 'It felt like it was night all the time': listening to the experiences of birth mothers whose children have been taken into care or adopted. *Adoption & Fostering* 39(4): 303–317.

- Niemelä M, Väisänen L, Marshall C, et al. (2010) The experiences of mental health professionals using structured family-centred interventions to support children of cancer patients. *Cancer Nursing* 33(6): 19–27.
- North South Hidden Harm Group (2015) Opening our eyes to hidden harm: empowering frontline workers to support children and young people affected by parental problem alcohol and other drug use. Available at: www.setrust.hscni.net/pdf/Hidden_Harm_Online_version_-_DRAFT_27_Aug_2015.pdf
- Perry BD and Salavitz M (2006) *The Boy Who was Raised as a Dog and Other Stories from a Child Psychiatrist's Notebook*. New York: Basic Books.
- Pihkala H, Sandlund M and Cederström (2011) Children in Beardslee's family intervention: relieved by understanding of parental mental illness. *International Journal of Social Psychiatry* 58(6): 623–628.
- Ranmal R, Prictor M and Scott JT (2008) Interventions for improving communication with children and adolescents about their cancer. *Cochrane Database of Systematic Reviews, Issue 4*. Art. No.: CD002969.
- Reupert A, Cuff R and Maybery D (2015) Helping children understand their parent's mental illness. In: Reupert A, Maybery D, Nicholson J, et al. (eds) *Parental Psychiatric Disorder: Distressed parents and their families*. Cambridge: Cambridge University Press, pp. 201–209.
- Rose R (2017) *Innovative Therapeutic Lifestory Work: Developing trauma-informed practice for working with children, adolescents and young adults*. London: Jessica Kingsley Publishers.
- Solantus T and Ringbom A (2002) *How Can I Help My Children? A guide for parents with mental health problems*. Finland: Picascript.
- Solantus T, Toikka S, Alasutari M, et al. (2009) Safety, feasibility and family experiences of preventive interventions for children and families with parental depression. *International Journal of Mental Health Promotion* 11(4): 15–24.
- Staines J and Selwyn J (2020) 'I wish someone would explain why I am in care': the impact of children and young people's understanding of why they are in out-of-home care on their wellbeing and felt security. *Child & Family Social Work*. doi.org/10.1111/cfs.12721
- Sunderland M (2001) *Using Story Telling as a Therapeutic Tool with Children*. Milton Keynes: Speechmark.
- Templeton L (2012) Supporting families living with parental substance misuse: the M-PACT (Moving Parents and Children Together) programme. *Child & Family Social Work* 19(1): 76–88.
- Treisman K (2019) *Cleo the Crocodile Activity Book for Children Who are Afraid to Get Close: A therapeutic story with creative activities about trust, anger and relationships for children aged 5–10*. London: Jessica Kingsley Publishers.

William Coman is a Chartered Clinical Psychologist with Psychological Pathways, Northern Ireland.

Lynda McGill is Team Manager and Clinician for a therapeutic team for looked after and adopted children at Northern Health and Social Care Trust. She also works part-time with Psychological Pathways, as above.

Michelle Rainey is a Senior Practitioner Social Worker with the same Northern Health and Social Care Trust.