Providing Therapy to Children and Families in Foster Care: A Systemic-Relational Approach

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Foster care is a system created to protect children from an unsafe home environment yet multiple foster home placements, conflictual or nonexistent relationships between foster parents and birth parents, long, drawn out court battles, and living in an ongoing state of not knowing when or if they will be going home are just some of the challenges many children in care are expected to manage. This paper presents a guide for therapists working with families involved in foster care. Utilizing ideas from the postmodern therapies and structural family therapy, suggestions will be provided about who needs to talk to whom about what, when to have these necessary conversations, and how to talk to people in a way that mobilizes adults to take action for the children, with the goal of minimizing postplacement trauma, strengthening and repairing relational bonds, and moving children out of foster care and into permanent homes as quickly as possible.

Keywords: Foster Care; Children and Families; Postplacement Trauma; Structural Family Therapy; Postmodern Therapies; Transparency

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Johnny, age 9, was placed in foster care after reporting to a school counselor that his father’s girlfriend, who was living with the family at the time, “beat” him with a belt. In 20 months of foster care, Johnny was in his fourth foster home and had acquired multiple psychiatric diagnoses including Attention Deficit Disorder, Bi-Polar Disorder, and Oppositional Defiant Disorder plus a variety of medications to manage his increasingly challenging and aggressive behavior. Johnny expressed feeling loved by his current foster mother and sad about leaving her care to return to his father. He also stated that returning to his father’s home was his “number one wish.” Johnny’s father and foster mother disliked one another and never spoke. Mr. Edwards, Johnny’s father, was a proud, college educated man of Afro-Caribbean descent who felt humiliated by what he perceived to be the injustice of the foster care system.

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He believed his child was placed in foster care because the investigator from Child Protective Services (CPS) disliked him and his firm style of parenting. Mr. Edwards was adamantly opposed to Johnny’s medication regimen, calling Johnny’s treatment team of mental health providers a bunch of “quacks” and the agency workers “idiots,” thereby alienating the people who were prescribed the role to help him and his family. Family therapy was mandated to “convince” Mr. Edwards of Johnny’s need for on-going mental health treatment and to shift his aggressive parenting style.

The stories one hears about the reason for foster care placement are upsetting and often disturbing. The stories one hears about what happens after a child is placed in foster care can be, paradoxically, more upsetting than the ones leading to the foster care placement. Foster care is a system created to protect children from an unsafe home environment, yet multiple foster home placements, conflictual or nonexistent relationships between foster parents and birth parents, long, drawn out court battles, and the reality of living in an on-going state of not knowing when or if they will be going home are just some of the challenges many children in care are expected to manage. Currently in the United States, 408,425 children are in foster care (Adoption and Foster Care Analysis and Reporting Systems, 2010). Many of these children wind up in therapists’ offices during some point of their foster care stay, sent by well-intentioned caseworkers who are hopeful that therapy will minimize problematic behavior. The therapists, told to “fix” the problem, often have minimal information about the emotional and litigious process of foster care and the crazy-making paradoxes that are inherent to the system’s structure. Without a guide, frustration and resignation are often accompanying feelings for therapists, as symptom reduction is hard to come by and the work feels more inert than transformational.

Principles of practice from the field of family therapy have guided me during 15 years of working within and outside the foster care system as a caseworker, casework supervisor, and family therapist. Family therapy’s commitment to locating family resources and paying attention to contextual factors is perfectly suited to take on the demanding responsibility of helping families navigate the challenging emotional terrain that is foster care. Children and families involved in foster care need family therapists who are willing to engage birth parents, foster parents, and system players1 in conversations about the children, with the goal of minimizing postplacement trauma, repairing and strengthening family connections, and moving children out of foster care and into permanent homes as quickly as possible.

This article will serve as a guide to providing therapy that makes a difference to families involved in foster care. The first part of the article will orient therapists to contextual factors including the legal landscape, agency policies, and common relational dynamics that inform and impact presenting problems in the therapy. The second part of the article will articulate a therapeutic approach to providing family therapy that integrates ideas from the postmodern therapies and structural family therapy. Suggestions through case examples will be provided about who needs to talk to whom about what, when to have these necessary

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1For the purpose of this article, “system players” refers to service providers involved in the foster care case, including case workers, agency supervisors, therapists, lawyers, and judges.
conversations, and how to talk to people in a way that encourages adults to take action for the children.

THE FOSTER CARE SYSTEM

Foster care is a system created to protect children from an unsafe environment by legally removing them from their homes. The safety concerns that led to the child’s removal from the home must be addressed and reconciled before the child is allowed to return home. Monitoring foster care agencies are assigned the task of finding services for the parents that will help ameliorate the safety concerns. Once children have been remanded to foster care, agency workers, optimally in a collaborative fashion with parents, but frequently in an isolated process with co-workers, develop service plans for the birth parents that outline individual goals for children and parents with the aim of improving the overall functioning of the family and specifically decreasing the safety concerns that led to the foster care placement. Service plan goals for parents, although unique to each particular individual, typically include tasks such as completing a parenting class, attending individual therapy, completing an anger management course, attending weekly visits with children, and successfully completing a substance abuse program if needed. Children’s goals typically center on making sure that their individual medical, educational, and emotional needs are met (i.e., children will be placed in appropriate educational setting, individual therapy, and attend ongoing medical appointments). Foster parents are expected to make the children accessible for family visits and take the children to needed appointments. Caseworkers are expected to arrange services for birth parents and children. Documentation by caseworkers of the services provided and birth parents’ participation in these services is essential to building a case in court regarding the parents’ progress or lack of progress regarding the meeting of goals. Birth parents are evaluated at different time intervals by family court judges and an assessment is made as to whether enough progress has been made on the goals for the children to return home, or if ongoing or additional services are needed to acquire “parenting skills,” sobriety, etc., in order to ensure that the parents will be able to provide a home that is safe enough for the children’s return. If the goals are not met in certain time frames, the parents are at risk of having the permanency goal changed to adoption, and their parental rights terminated.

The Adoption and Safe Families Act

Historically, minimal attention was paid to how long it took for the parents to address cited safety concerns. In 1997, The Adoption and Safe Families Act (ASFA) was passed, which symbolized a philosophical shift in the world of child welfare, moving from an environment in which family reunification was prioritized in almost all circumstances to one that prioritized child safety first and permanency in an expedited timeframe (Lowry, 2004). ASFA prescribed time limits on how long children were allowed to stay in foster care, mandating that the permanency goal be changed from reunification with birth parents to adoption if a child has been in foster care 15 out of the most recent 22 months (Child Welfare League of America, 2009). The federal law was passed due to a growing consensus among child advocates that children’s best interests were not being served by

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lengthy foster care placements and the under-use of adoption as a permanency goal for children.

The ASFA has been in effect for over 10 years and there is some evidence that permanency through adoption or guardianship has improved by some degree for children in all states (Notkin, Weber, Golden, & Macomber, 2010). However, little to no significant improvement in the timeliness of family reunification has resulted from ASFA, with the average length of time a child stays in foster care averaging 25.3 months (AFCARS, 2010). Some of the reasons for the on-going delay with permanency through adoption or reunification include differences in beliefs among system players regarding what is in the best interest of children and inefficient documentation or information regarding parental progress in meeting service plan goals. Dissolving a family unit legally through a court hearing and terminating a parent’s rights is no small task. System players struggle to find a balance between protecting children from abuse and neglect and respecting the integrity of the family and the rights of parents. This balancing act, however, too frequently leads to drawn out decision-making that leaves the children in the vulnerable position of not knowing when or if they will be returning home for far too long.

Information to Gather

Often, well-intentioned therapists see their role as therapists too narrowly, putting them at risk of contributing to case stagnation and on-going foster care placement. I recently consulted on a case where the therapist expressed frustration with the lack of movement with a family she was seeing. When I asked the therapist with whom she was working, she told me the foster parents and the children. The birth mother was excluded from the family therapy because the caseworker and the children’s law guardian were worried that she would discourage the children from talking about their feelings in the therapy. After three years in placement, the permanency goal remained “Return to Parent” because the mother consistently attended visits, completed her parenting class, and was drug-free. However, the law guardian felt “uncomfortable” returning the children. In the consultation, I recommended calling the caseworker and advocating for the birth mother’s inclusion in therapy, reasoning that family therapy would be the place to encourage the mother to listen to her children’s feelings. The second intervention was to find out exactly what the law guardian meant by “uncomfortable.” The therapist was a bit embarrassed by the simplicity of the suggestions and her oversight of such seemingly logical systemic interventions.

Questions to Ask

Providing therapy to children and families involved in foster care means that one must be a true systems therapist, intervening in the larger system as fluidly as in the therapy room (Imber-Black, 1988). Gathering information about what system players think about family members is as important as finding out what family members think of each other. The following questions help the therapist orient him/herself to the foster care case and the established rules around interaction:

- How long have the children been in foster care?
- What is the permanency goal?
- How many foster homes has the child been in since the start of placement?

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• How do the birth parents and foster parents communicate to one another about the children?
• What is the current visitation plan?
• Would the agency be open to increased opportunities for parent/child interactions?
• Who is invited to the therapy?
• Is the therapy mandated?
• Why is it mandated?
• Who wants what to be achieved in the therapy?
• Do the children and/or parents want to come to therapy?
• If the goal is reunification, what are the specific goals the parent needs to achieve in order for the children to be reunified?

Within the answers to the above questions, the therapist will begin to develop an understanding of how larger system dynamics might be contributing to presenting problems. Learning how the birth parent is perceived, for example, can guide the therapist in helping the parents navigate interactions with caseworkers, lawyers, and judges, all people who hold great power in decision making regarding the outcome of the case.

In a conversation with Mr. Edwards’ caseworker, who referred him and his son for mandated family therapy, I learned that every service provider Mr. Edwards interacted with during his son’s 20-month stay in foster care had a negative view of him. The caseworker described him as “narcissistic,” the lawyer described him as “selfish and aggressive,” and the judge regularly threatened to throw him out of the courtroom for his cursing and disrespectful attitude. These descriptions didn’t surprise me, as few birth parents are able to calmly tolerate the typically humiliating experience of being in a courtroom or a service plan meeting where one’s parental failings are the topic of conversation. The information influenced my first session with Mr. Edwards. Early in the session, I asked Mr. Edwards about his experience with the system players, and listened to him describe how demoralized and furious he felt in being silenced by people in positions of power who were making decisions for his son with which he did not agree. I started to think about how, in our work together, I could facilitate different interactions between Mr. Edwards and system players where they could see his care for his son, rather than just his anger. The information also helped me to be mindful of how I positioned myself in the playing field, wanting to serve as a facilitator of different interactions rather than exacerbating the already polarized positions where Mr. Edwards was fighting against the child advocates for Johnny. From experience, I knew that advocating for opportunities for Mr. Edwards to be more involved in making decisions for and spending more time with his son would be more helpful than throwing my opinion into the mix. Discounting the experiences of other professionals one disagrees with can inadvertently contribute to case stagnation, as the adults become more focused on proving they are right rather than thinking about how to help the children move out of foster care.

**IF IT FEELS CRAZY, IT IS CRAZY: THE INHERENT PARADOXES OF FOSTER CARE**

It is not unusual for therapists to become overwhelmed with the information gathered in the beginning stages of the therapy. Feeling overwhelmed comes, in
part, from crazy making paradoxes that are an inherent part of the structure of foster care that can have the effect of burning out service providers, immobilizing parents, and burdening children. Being conscious of the paradoxes in the system can inform choice points for the therapist, increasing the possibility that interventions might help children and parents repair and develop stronger connections, move children out of foster care more quickly, and minimize post foster care placement trauma (Colapinto, 1998).

**Become a Better Parent – Go to a Parenting Class**

In the first meeting after a foster care placement, it is all too common for empathically minded caseworkers to tell distressed and angry birth parents, who are begging for information about their children and raging about the placement: “Don’t worry, your children will be well taken care of – go get yourself together.” Birth parents are encouraged to work on completing personal tasks that will purportedly decrease safety concerns. Day-to-day responsibilities and decision making for the children are taken over by caseworkers and foster parents. Moments for parents and children to connect are reduced to weekly visits at the agency. The element of urgency and anxiety is removed, and the stage is set for parenting atrophy to set in. As Jorge Colapinto states:

Foster care is practiced as though parents can become better parents without actually parenting, and children can maintain a “virtual attachment” to them in the meantime. But isolation begets disaffection, and as the ties that bind parent and child dissolve, they become attached to separate realities. (Colapinto, 1997, p. 45)

Placement should be the time for intensity and change making for the parents and children. The unintentional consequence of separation in the name of protection is that parents and children have fewer opportunities to be together to connect and family relationships are diluted (Colapinto, 1995). Caseworkers have fewer opportunities to see parents parenting and making decisions for their children’s best interest, so they have limited information to report to the courts about the progress the parents are making in “improving their parenting” skills. When a parent is mandated to a parenting class to learn how to be a better parent, the parent then needs to practice, with the actual child, not the doll, the newly acquired relationship skills. For the foster care agency workers, who must build a legal case for either a discharge to reunification or a termination of parental rights, it is vitally important for case movement and decision-making about permanency to have as much information as possible about the parent–child relationship.

When one starts to think of family connectedness as a good and necessary thing, service plan goals become less about individual tasks the parent has to complete away from the child and more about opportunities for the parent and child, in a safe setting, to be together. With this thinking, the questions guiding service plans should be: “How many activities may involve the parent? How much contact can be allowed? How much emotional upheaval can be accepted as a normal part of the process? How many decisions about the child can be left to the discretion of biological and foster parents, working together?” (Colapinto, 1997, p. 46).
Parents – Your Children Will be Returned to You When You “Improve Your Parenting” But You Have to Guess What That Means

It happens all too frequently that case workers/lawyers are judging parents on behavior changes that have not been articulated to the birth parents and explicitly described in the service plans. If the parents understand the goals and are clear about what actions they need to take in order to decrease the safety concerns, then assessing whether goals have been achieved becomes easier, therefore encouraging timely decisions about permanency.

In therapy, Mr. Edwards recounted an experience in court where he read for the first time a report written by the worker, about him, stating that he was “inappropriate” and “verbally aggressive” with Johnny during family visits at the agency. The report listed examples of Mr. Edwards reading the newspaper instead of helping Johnny with homework, and yelling at Johnny for his bad behavior in school. Mr. Edwards expressed being surprised and outraged by the report. Neither of the worker’s concerns had been brought to his attention in multiple face-to-face meetings nor were they outlined in the service plan. Mr. Edwards went on to explain his actions to the therapist, stating that he never helped his son with homework unless his son asked him for help, so there was nothing in this interaction that seemed “inappropriate” to him. Mr. Edwards explained he was a “tough” father and believed that Johnny needed to know that he was not going to be able to get away with bad behavior in school. The court hearing resulted in a 6 months’ adjournment for additional review while Johnny remained in foster care.

Children get placed in care due to specific safety concerns. Once in care, all aspects of the parents’ parenting and personality come under scrutiny. Obviously, if new safety concerns become apparent, caseworkers and therapists are obligated to address the concerns with the parents. There is a difference, however, between a safety concern and different styles of parenting. Not paying attention to one’s child when he is doing homework during a family visit as Mr. Edwards did might show poor judgment. It might show a lack of interest in the child’s homework, or it might simply show a difference in belief about parents helping children with homework. But does this behavior put the child at eminent risk? If the caseworker is concerned that it might, then the worry has to be made transparent to the parent who will then have the option of whether to change the behavior or not.

One cannot escape the subjectivity involved in decision making in foster care. An interaction between a parent and child might leave one caseworker singing the parents’ praises and another worrying that the children will be emotionally neglected if they return home. The personal beliefs of system players impact case decisions and can have major consequences for the life of a family. A guiding question all system players must ask themselves when doubts about the parent’s parenting arise: does this doubt signify a safety concern or is this a difference in a belief about parenting? With children of color disproportionately represented in foster care (58% compared with 44% of the U.S. population, AFCARS, 2010), paying attention to how culture and racism impact decision making is critical to a just practice. The beliefs and assumptions I hold about what it means to be a “good” parent are culturally constructed (Falicov, 1998; Freedman & Combs, 1996). In my white, middle class home, my liberal leaning parents valued their children’s input in decision making, favoring family discussion over authoritative rule and the
threat of corporal punishment. The parents I am working with do not have to adopt the ideas I have about how to parent to be good parents. They have to prove to the judge that they are able to provide a home free of abuse and neglect. Legal standards of child protection determine that, not a therapist’s or caseworker’s opinions.

**Children, We’re all Working Together for You, but We Won’t Talk to Each Other**

Many birth parents are less than enthusiastic about befriending foster parents, who often times symbolize the “other” who has stolen their children from them. Foster parents are frequently given minimal information about the children who will be sent to their homes, and the information that is given to them about the birth parents is often negative, increasing their anxiety and fear of interaction. These anxieties and fears are often reinforced at the first face-to-face meeting or family visits, where foster parents see angry parents who express little gratitude toward the person who is caring for their children.

Caseworkers, in an attempt to minimize conflict, step in to be the intermediary between the parents, rather than helping foster parents and birth parents find a way to talk about the children. The centralized role of the caseworker quickly becomes established. The parents are not expected to talk and are frequently discouraged from communicating directly because of a worry about disagreements that might occur. The unintended consequence is that foster parents and birth parents start to see one another as adversaries rather than as resources. In addition, children with already challenging emotional loads start monitoring to whom they say what in order to protect the feelings of the adults. Case movement slows down, as overburdened caseworkers do not have the time for the children.

Unfortunately, patterns of interaction get established that can set the scene for future presenting problems in therapy. Foster parents and birth parents get in the habit of not communicating with one another and small infractions, like a birth mother who does not like how the foster mother fixed her daughter’s hair, can become heated relational impasses, with the children stuck in the middle.

**Children, Behave**

Foster care placement is generally traumatic for children. Hearing about the story of what happened during the removal often uncovers memories of police officers, crying and screaming, and general chaos as children are removed from their homes with little information as to why they are being taken and where they are going. Having a lack of information is a theme that continues. Children are often given minimal information about what is happening in the court system, although they often overhear conversations about upcoming court dates and parents meeting with the judge. Other times children are told contradictory stories from the adults in their lives who are not talking to one another. The adults not talking to one another also leads to children feeling caught in loyalty binds – they worry about hurting the feelings of or angering their foster parents and/or birth parents, so they choose instead to silently hold their difficult thoughts and feelings, frequently resulting in increased behavioral problems (Linares, Rhodes, & Monalto, 2010). Added to the mix is the anxiety of not knowing where they are going to live in the future.

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All of these challenges can create emotional landscapes that are intolerable to children and behaviorally challenging to adults. It does not help children that few foster parents are ready to meet the emotional needs of the children in their homes, utilizing the typical reward and punishment programs that are common to foster parent trainings and so unhelpful to children who have experienced trauma and are struggling with feeling safe in their environment where nothing is for sure (Fisher, Gunnar, Dozier, Bruce, & Pears, 2006; Pearlman & Courtois, 2005; Perry, 2006). A typical threat to an “acting up” child in foster care is: “If you don’t behave, you’ll have to leave” which is akin to throwing fuel on a fire. Overwhelmed caseworkers, in an attempt to save the foster homes, send the children for evaluations that typically result in a psychiatric diagnosis and a course of medication. Normal reactions to an abnormal living situation are thus pathologized, and children, the ones the system is trying to protect, are now deemed the sick ones in the system that has been created for their protection.

THE SYSTEMIC-RELATIONAL APPROACH TO WORKING IN FOSTER CARE

The complex clinical dimensions of working with families in foster care call for utilizing the best ideas from therapy. The therapist must be able to hold a “both-and” framework that allows for shifting from one philosophical stance to another in order to meet the challenges of the systemic and relational dilemmas of the families (Goldner, Penn, Sheinberg, & Walker, 1990). In the world of family therapy, structural family therapy and the postmodern therapies (an umbrella term referring to narrative, solution-focused, and collaborative language systems) are philosophically at odds, yet utilizing ideas from both schools provides a way to stay therapeutically aligned with the family members and help them to navigate their way out of the foster care system (Dickerson, 2010).

Structural family therapists believe in using their position as a therapist to make specific changes in the family happen, while postmodern therapists listen and ask questions, believing that questions that bring forth hopes, longings, and beliefs will lead to new ways of being (Anderson, 2007; Minuchin & Fishman, 1981; White, 2000). Ideas from structural family therapy help me identify the obstacles in the family system and in the larger system of foster care that contribute to case stagnation and relational dissolution and point me in the direction of what needs to happen next for children to move out of foster care into homes. Ideas from the postmodern therapies provide a framework for staying emotionally attuned to the parents and children I am working with, paying attention to the meaning people are making of the past and current experiences. The families involved with foster care need therapists who can listen without judgment and who can provide clear information about the consequences of certain actions and inactions (Goldner, 2004). Family court is not postmodern. The knowledge of “experts,” such as judges, lawyers, and therapists, is privileged over the parents who are accused of abuse and neglect. The goals mandated by the family court judge are not up for discussion and they are not developed in a generative dialogue with the accused parties. In the therapy room, questions asked of the birth parents that highlight personal values, beliefs, and intentions all help me better understand the parents and hopefully send the message that I see them as knowledgeable collaborators in the therapeutic process. Birth parents do not need to be educated about the power imbalances that exist within the foster care
system, because they live it. In my experience, however, parents do feel relieved to have their feelings validated and they appreciate help in navigating the myriad of obstacles they will encounter in trying to reunify with their children (if this is their stated goal). In order to have their children returned home, the parents must prove to the court that their “problem saturated narrative” is not the only narrative and the therapist can help in this process (Epson & White, 1990).

The Relational Stance

Both structural and collaborative therapists hold a dogged belief in the resources, both present and underutilized, of individuals and families. Both schools of therapy value curiosity, but with different desired outcomes of what the curiosity will bring to the therapy:

The structural family therapist’s curiosity is not “free” but disciplined, organized by his commitment to change. It is the curiosity of the inventor who needs to solve a problem and asks the questions that can lead to a solution—not the curiosity of the explorer who wants to know more and asks all the questions. The structural therapist needs to know about the family’s fears, misguided helpfulness, and available resources, enough to be able to challenge existing patterns and promote new ones. (Colapinto, 1983, p. 15)

For the postmodern therapist, asking questions from a position of “not knowing,” where one is listening for what has not been said rather than what has been said, creates an attitude of curiosity where possibilities and new stories can emerge (Anderson & Goolishian, 1988; Freedman & Combs, 1996). Postmodern therapists listen, asking questions such as: “Am I understanding what it feels like to be this person in this situation, or am I beginning to fill in the gaps in her story with unwarranted assumptions? What more do I need to know in order to step into this person’s shoes?” (Freedman & Combs, 1996, p. 45).

I utilize both forms of curiosity with families at different points in the therapy. I am on the lookout for patterns of interaction that might be contributing to on-going foster care placement and I am listening to understand what the interaction means to the family members. If a missing pattern of interaction is detected, such as the example where the caseworker observed Mr. Edwards reading a newspaper rather than helping his son with homework during a family visit, a “pure” structural family therapist might make the desired interaction happen, either by nudging, questioning, or provoking Mr. Edwards to become involved with Johnny and the homework. When I see or hear of a “missing” interaction such as Mr. Edwards’ disinterest in his son’s homework I sequence the intervention differently. The postmodern curiosity encouraged me, in this example, to wonder about and then ask what Mr. Edwards thought about parents helping children with homework. The question uncovered a belief he held about his role as a parent—homework was for children to do alone, and for parents to oversee and manage. Completion of homework was not seen by the father as an opportunity to connect. The conversation about the homework led to conversations about the expectations of the system players and the consequences of not meeting the expectations (on-going foster care for Johnny); the real differences in power inherent in the system—a caseworker’s belief about what constitutes “good parenting” has more pull than a birth parent’s belief; and the power differences that existed in the
therapy room—what would we do in the therapy room if we had differences of opinions about what constituted “good parenting,” as I was the one writing the reports to the court?

Mr. Edwards and I were able to have these conversations because when I asked questions during this session, I was not trying to problem solve or diagnose. I was trying to understand his experience. My curiosity about his experience, rooted in a deep respect for difference and complexity, is key to the relational stance I work to hold throughout the therapy. The “relational stance,” as William Madsen describes it:

Is a way of being in relationship with family members, an “attitude” that permeates the therapeutic relationship, where family members’ thoughts, feelings and ideas are respected, and where a sense of “working with” the family is felt throughout the therapy. (Madsen, 2007, p. 23)

Shame, humiliation, and sadness are generally the dominant feelings operating in parents whose children have been placed in foster care, and are expressed as rage, defensiveness, and denial of any responsibility regarding the placement. Too often, caseworkers and therapists move in quickly to have parents “take responsibility” for their actions and repent. The judgmental, accusatory stance generally is a trigger for parents, whose defenses are working overtime for self-preservation. Therapeutic work becomes impossible and an impasse of wills sets in which leads to case stagnation and the polarized way of thinking that leaves children vulnerable. As I work to join with the birth parents, I am curious about their experiences and want to hear what they have to say (Anderson, 2007). When someone feels truly understood, “known,” the attunement that occurs creates a space where it is possible to try new ways of interacting (Siegel and Hartzell, 2003).

Maintaining the relational stance, where people feel I am “working with” them, not “working on” them, takes work. It is easy to slip into hopelessness and despair when parents disappoint children, repeat many of the behavioral patterns that led to the foster care placement, and hold on to beliefs about parenting that might contribute to cycles of neglect or excessive corporal punishment. When a mother comes to a family therapy session late and starts screaming at her rambunctious 5-year-old child, who has not seen her all week, I am at risk of moving into a judgmental stance. I have to remind myself that this mother is stepping into the parenting role, taking charge of managing her daughter. If worry about the mother meeting her daughter’s emotional needs takes over, I have to talk myself into a place of compassion for the mother, or I am at risk of losing my alliance with her, which is vital to helping the family. Asking myself questions such as—What is this mother feeling right now? What can I do to make her feel better understood? How can I help these two people experience a different kind of interaction?—all help me to regain my therapeutic stance.

If I am successful in establishing a working relationship with the parents, holding and maintaining the relational stance where I respect the parents’ viewpoints, even if I don’t agree with them, there might be room for the parents to understand my viewpoint, if it differs from theirs. In order for this to be authentic, I need to be transparent about my beliefs, where they come from, and I need to be open to being influenced by...
the parent in return. The hope is that differences can be acknowledged and different viewpoints can be held side by side.

**Practice Pointers**

Creating a therapeutic environment where family members feel known, understood, and validated is not enough in the world of foster care. The stakes are too high. The following ideas point therapists in the general direction of case movement and family connection.

**Parents take care of children**

An organizing idea of structural family therapy is that all families and systems need some form of hierarchy and boundaries. As discussed earlier, parents having opportunities to parent their children while their children are in foster care is the single most important idea needed in working with families in foster care, and the single most challenging idea to maintain because the system is set up to protect children from parents who abuse and neglect. Birth parents and foster parents take care of children, not well-intentioned caseworkers, lawyers, and therapists. A boundary is drawn between the family unit and the system players, and interventions are aimed at increasing the interactions between parents and children, foster parents and birth parents, not decreasing them. For the therapist, this means looking for opportunities for the parent to meet his/her children’s needs in sessions and advocating for parents to parent as much as possible outside of the sessions. When the therapist follows these guidelines, choice points become clearer in therapy sessions.

Ms. Jones was completing an 18-month residential drug treatment program and family reunification was planned within the next few months. As so frequently happens, Ms. Jones’s stress load was high. She was overwhelmed with meeting the needs of her children, the foster care agency, and the drug treatment program and had missed the last three family visits. Her children, Eli (11) and Frederick (12), were fighting with each other in the foster home. The foster mother, new to the children, told the caseworker that she couldn’t handle the fighting and needed help, or she might have to have the children removed to what would be their third foster home in 18 months. This information was relayed to me by the caseworker. Ms. Jones made it to the family therapy session and was visibly tired and overwhelmed. I guessed that the last thing she wanted to do is to talk about her past missed visits and the boys’ feelings about it. The guiding principles that parents take care of their children made choice points clear in the session. I knew that I needed to bring up the missed visits, encourage the children to express their anger and frustration to their mother, and encourage her to meet with the foster mother. Protecting Ms. Jones from the children’s reactions would be robbing her and the family of working through real family conflict (Colapinto, 1995). In addition, the children were used to having to protect their mother, and needed the experience of their mother hearing their needs and responding to them. Sequencing mattered. In the beginning of the session, Ms. Jones took the stage with her needs, complaining about how she was overwhelmed and “couldn’t take it anymore.” I acknowledged her feelings and then asked her how she managed to make it to the visit today (highlighting a positive behavior that was at odds with her general mood). She stated that she was “barely here” and rolled her eyes in exasperation. Ms. Jones said that she had the “fuck-its,” the “addicts...
national anthem.” I used the moment of levity to shift the focus to the kids, asking them if they ever got “the fuck-its.” Eli talked about having the “fuck-its” in his previous foster home, where the foster mother didn’t care about him. Ms. Jones refocused the conversation on her needs, saying: “...and that’s another thing. I have to get used to another foster mother. I am tired of this.” Holding firm to the idea that parents take care of children is harder than one imagines when a mother presents with such emotional distress. The pull is strong to ignore the needs of the children, who are sullenly sitting in their chairs, protecting their mother and the therapist from their emotions. I wanted to both validate the mother’s experience and encourage her to think about the boys: “So I know the visits have been tough to get to lately. The boys have a really hard time in the foster home when you don’t come. This past weekend they started going at it with one another. What do you think might have helped them?” Ms. Jones replied, “nothing can help being disappointed by your mother.” I turned to the boys and asked, “What would have helped you two this past weekend?” Frederick turned to his mother and said: “you could have called and told us you weren’t coming.” The parents and children now were talking to one another and Frederick went on to express his worry that the foster mother wasn’t going to be able to keep them if she didn’t get a break. Throughout the rest of the session, Ms. Jones continued to complain about all that she had to do. At the end of the session, however, she agreed to meet with the foster mother to talk about the boys fighting. She heard from the boys, with confirmation from the therapist, that the foster placement was at risk and as the parent, she needed to help.

**Transparency and Collaboration**

Transparency and collaboration in therapy are essential elements to a therapy where people are mandated, which is typically the case for all families in foster care. Transparency means that I share my beliefs, ideas, and thoughts when asked or when I have information about the process of foster care that will help the family meet its goals. Collaboration means that I ask for suggestions, ideas, thoughts, and opinions about how the therapy is going and I engage family members in solving therapeutic dilemmas whenever they arise (Sheinberg & Fraenkel, 2001).

Early in my initial session with Mr. Edwards, I posed our first therapeutic dilemma: “How is this therapy going to work, as here you are, mandated for yet another service that you don’t want, and here I am, a therapist, a white therapist, saying ‘how can I help you?’” He responded: “I guess you could say I deserve an Oscar.” Naming that he didn’t want to be in the therapy, that I was yet another service provider, a white one at that, thrown in the service-provider mix to help when he hadn’t asked for it, sent the message that I understood the challenges of this mandated relationship (Roberts, 2005). This conversation set the stage for developing a therapy that was as collaborative as possible, given the circumstances. I asked him why the foster care workers and the judge wanted him to come to family therapy, and what they expected to see change. He explained that the caseworker didn’t like the “tone” in which he talked to his son and the agency was concerned that he would not continue Johnny’s current medication regime. I asked him if he agreed with these concerns, and he told me he thought the agency workers were “idiots.” We talked about the fact that even though he didn’t agree with the agency’s goals, he wanted his son home and was willing to do what he needed to make this happen. I didn’t get caught up in
needing to convince him of the validity of the agency goals. It was enough for me that he was willing to act on behalf of his child. A follow-up question was: “Even though you don’t want to be here, is there anything that you think is important to work on, where you could say at the end of our work together, I didn’t want to come, but the therapy was helpful?” (De Jong and Berg, 2001). As typically happens in this type of collaborative dialogue, he came up with ideas he had about helping his family. He expressed his concerns about his son’s emotional well being, wondering about the impact of his mother “abandoning” him at the age of three and said talking about Johnny’s mother was “key” to understanding his son. I ended this conversation about goal setting for the therapy, naming the therapeutic reality: “So in here [therapy] we can work on what the agency wants you to work on, and we can work on what you want us to work on—we will have two different treatment plans, really.” Being transparent about the reality of the situation—that he didn’t want to come—and then asking what he might want to work on if it was just up to him, invited him to collaborate (Berg & Kelly, 2011).

This provided a platform for future conversations. After several months of working with Mr. Edwards, I had a very different view of him than virtually every other person involved in his case. I heard from the caseworker that Mr. Edwards, in his anger about the on-going delays regarding the reunification, was antagonizing Johnny’s lawyer and the judge by becoming aggressive and hostile in the courtroom. I wanted to share this information with Mr. Edwards. I was conscious of wanting to help Mr. Edwards express his rage differently, because it wasn’t helping him meet his goal of reunifying with Johnny. The ideas of transparency and collaboration informed my conversation. I asked Mr. Edwards: “How is it that I have such a different view of you than the people in the courtroom?” Mr. Edwards commented that he felt listened to in the therapy and respected as a father. I went on to wonder if there was a way for him to channel his rage without feeling silenced, so that the people in the courtroom might be able to experience him differently. I expressed my worry that the anger, although justified, wasn’t helping Johnny get home any quicker. We talked about how in the courtroom, focusing on his future hopes for his family, free of foster care, could help him accomplish his goal of getting Johnny home.

Who needs to talk to whom about what?

When information stops moving in foster care, stagnation sets in and children remain stuck in foster care. For the therapist, gathering, giving, and relaying information between and among system players is as important as encouraging moments of connection in the therapy room. At the end of every therapy session, the information generated determines who should be invited in to have conversations that will encourage emotional repair and connection (Sheinberg & True, 2008). Does the therapist need to meet with the foster parents and birth parents alone to talk about the loyalty bind the child is in? Does the therapist need to meet with the child alone to talk about a worry the child might be having that she can’t tell her parent directly? Does the therapist need to meet with the entire family unit together to talk about the upcoming court case? After every therapy session, the therapist needs to think about what information needs to be shared with system players, or what type of advocacy is needed on behalf of the children.

Johnny started fighting with peers at school as the reunification with his father became imminent. Johnny’s individual therapist believed that Johnny’s increased
aggression at school was because of his conflictual feelings about reunifying with his father. In his report to the court, the individual therapist was planning to discourage the planned overnight visits until Johnny “stabilized.” In a conversation with the individual therapist, I advocated for the overnight visits to proceed, suggesting that changes in behavior are normal for children anticipating changes in their living situations, particularly when children are caught in loyalty binds, as Johnny seemed to be. I described a series of sessions I had with the family that painted a more complex picture of Johnny’s increased aggression. In an individual session, Johnny revealed to me how he was excited about going home and how sad he was about leaving his foster mother (a normal feeling state for children in care). He felt particularly worried that he would never get to see his foster mother again because his foster mother and father “didn’t know one another” and “didn’t like one another.” Using a decision dialogue (Sheinberg & True, 2008), where the child decides what parts of the conversation should be shared in the family session, Johnny gave me permission to tell his father that he was going to miss his foster mother, something that he had never disclosed before because of his worry that his father would get angry. Johnny wanted me to share with his father his wish to have contact with his foster mother after the reunification. When meeting with Johnny’s father alone and relaying Johnny’s wish, Mr. Edwards shared his anger toward the foster mother for cutting off contact with him months earlier, refusing to talk to him directly about his son. I validated and empathized with his frustration with the impasse with the foster mother and the lack of help in resolving the conflict from the foster care agency. We discussed the ways in which he felt humiliated by the agency workers and in the courtroom by people assuming he was “uneducated” and a terrible parent who didn’t care about his son. He expressed a desire to cut out everything associated with foster care after the reunification, allowing his family time to “heal.” Fully understanding his perspective around not wanting to be reminded of the foster care system who he felt “destroyed” his family, I posed the dilemma: “So I understand that you don’t want to have anything to do with any part of the foster care system when Johnny comes home. What should we do with Johnny’s wish to keep a connection with his foster mother?” The father paused, thought about Johnny’s wish, and acknowledged that he could understand that Johnny would want to see her, as “she has been pretty good to him.” In the family session, the father told Johnny that he understood that he wanted to keep in touch with his foster mother after returning home, and he could call her and visit her whenever he wanted.

This intervention provided information on Johnny’s father’s ability to put Johnny’s needs first, something few people saw him as being able to do, because all the system players only saw an enraged father complaining about what the system had done to him. With this new information, the individual therapist agreed to take out his recommendation to delay overnight visits between Johnny and his father.

The relational stance created the therapeutic environment where Mr. Edwards could describe his feelings about the foster care experience. The structural frame encouraged me to redirect the conversation to Johnny’s experience in foster care. The guiding value of transparency led me to pose the relational dilemma to Mr. Edwards: What do we do when your wishes conflict with Johnny’s? I did not tell Mr. Edwards what he should do, and in fact because I was listening to understand, did “get” his perspective about never wanting to be reminded of the foster
care system ever again. With the new information about how Johnny was feeling, Mr. Edwards solved the dilemma by making a decision that he thought was best for his son.

CONCLUSION

This paper provides a guide to working with children and families involved in foster care, highlighting the need for therapists to move fluidly between larger system and family system interventions, and between structural ideas and postmodern ideas. Involvement with the foster care system, for both system players and family members, is emotionally challenging in every way. There are wonderful stories of family healing and repair, and there are devastating stories of parental disappointment and systemic failure. Integrating ideas from structural family therapy and the postmodern therapies have helped me to stay hopeful about the possibility for change and the ability to make a difference in the life of a family.

REFERENCES


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