MA in THERAPEUTIC CHILD CARE

# ‘Angels with dirty faces’

A reflective study of the journey of a residential care worker’s emotional and practical development, in order to aid the development of therapeutic ethos in a private care provision.

MARC STEELE
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University of Reading

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Abstract

The dissertation is a study about the changing climate in residential care and how a private residential child care unit is attempting to move towards a more therapeutic ethos.

This study suggests that the conventional care worker can benefit from an understanding of the principles that support a therapeutic approach, along with an emphasis on reflective practice to develop awareness of the self, to better comprehend sound management strategies.

It is the responsibility of all workers in an organisation to manage their anxiety, and essential when working with children with emotional and behavioral difficulties. When managing stress levels the organisation has a duty to provide adequate support to help its members understand and process their feelings in a positive way.

This study highlights the benefits and value of reflective practice where personal development informs the professional learning. The difficulty is getting workers with no therapeutic training to understand and believe in the fundamental concepts of therapeutic work, to provide better outcomes for the children and young people.

I have discovered that the need for therapeutic practice is made more apparent by the way staff seemed to want a better understanding of themselves and what the young people are trying to communicate. Staff want to feel good about their job and through therapeutic work the need can be satisfied.

Acknowledgements

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*And thanks to everyone who was on the course who experienced the journey along side me, as well as my family who put up with trials and tribulations the course presents, with special thanks to my loving and patient partner Claire Dunbar whose support and understanding I could not have done without.*

*I would also like to mention special thanks to Jeff Walker from the Cornloft arts studio in Stockbridge who mentored me post course, when I started the task of attempting to practically apply theory, and who I still work with very closely, whose insight into the children we work with is unparalleled.*

*The title of the study (Angels with dirty faces) was taken from a film with James Cagney, where an adult chooses to take an emotional leap to benefit a group of children that look to him for guidance.*

*The title also is symbolic of the children we care for and how their angelic innocence has been cut short due to some of their exposure to the realities of adult life long before they should have.*

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# Chapter one - Introduction

## Question

Would residential care workers benefit from having an understanding of therapeutic processes including personnel reflection, and would this aid them deliver a better and more objective provision of childcare? This study is a reflective account of my journey through the course in the MA Therapeutic Child Care, and how I developed the practical application of the principles to my work.

## Background and rationale

In the last eighteen years the childcare sector has undergone some very significant changes. Since the implementation of the 1989 Children Act there has been a shift in how the work has been viewed. This has had a profoundly positive effect on the levels of professionalism required to undertake work with looked after children. This also changed the way staff and managers had to access risk, resulting in the quality of the relationships changing. As in child development, every advance is only attained at the cost of giving up a previous state of being. Maher (2003:281) highlights some possible gains and losses from the change in climate and attitude to care work.

*As I read it, for most children and young people in residential care, things have improved since a generation ago. For the most damaged and difficult, with the stepping back and the resultant psychic no-go areas, things may become worse. This perhaps then, is the price? Clearer professional boundaries (good thing) have lead to greater emotional distance (bad thing). More scrutiny and regulation (good thing) has lead to more defensive practice (bad thing). A greater emphasis on care and safety and child protection (all good things) has lead to the loss of commitment to treatment and an unwillingness to take necessary risks (bad things). The emphasis on the individual (good) has lead to a loss of belief in the potential and importance of the group (bad).*

The need for residential homes in the private sector along as well as in a local authority meant both had now to think about the risk the extremely disadvantaged children posed to the group living environment. Finding suitable placements became very difficult to find for the children with greater needs. They would be moved more frequently due to the demands put on their carers.

One alternative was to exclude the children from the group living environment and locate them in one bedded units with staff in place to keep them safe. The other choice was to find a place in a therapeutic community, where there is an emphasis on the group experience. The child would have to use the group to process and work through problems together, with the staff's help, to live and thrive in a group; exclusion was an avoidance of the problem. Therapeutic work needs more involvement, emotionally and physically. But if managed and processed it can be contained and worked with in a positive way.

Although this method of working seems to be successful there were not enough communities to deal with the amount of referrals from other newly scrutinised care provisions that moved the children due to their need for more specialised care. The overflow went into the private sector or more specialised local authority homes.

I currently work in a private children's home located in Hampshire as a senior staff member attempting to apply therapeutic principles. This new role is in its embryonic stages and shall grow and develop with my understanding of psychodynamic approaches during and after the completion of the MA course. My role within the residential unit enables me to introduce new systems and ideas to provide better containment and growth for the team and client group.

We currently have capacity for four young people, and cater for children with emotional and behavioural difficulties. We have recently moved from an inner-city residence to a country house, where we endeavour to create a more beneficial provision, by selecting a more thought-about planned environment to provide a stable foundation for the work we would like to develop. The company is relatively new although has grown steadily. We are in the early stages of development, and are enthusiastic to provide the best provision of care possible with our resources.  We currently have a large foster care department, a residential unit, an independent living unit and have recently opened a school for students who have difficulty getting their needs met in mainstream education.

The residential unit has a very encouraging outlook to child care, the staff team are very involved with the children and what they need. A lot of the experience in the team has come from various local authority run child care provisions. Where the model practiced seems to be limited, the staff are competent with basic behaviour management techniques that contain the clients to a degree, but have limitations on how to effect change or understand more complex forms of communication from the children.

During my experience in the local authority homes the staff seem in constant conflict about being able to stay working in such an intense area of child care. This was possibly due to lack of understanding of the powerful feelings that the children were experiencing and projecting onto the carers. The teams seemed ill prepared to make sense of and work with the unmanageable feelings being experienced by the group, increasing the possibility of feelings getting acted out repeatedly. Without any therapeutic intervention to help the children and staff articulate and explore the triggers of behaviour, the cycle appeared to be redundant and static.

Over time 90% of referrals to private sector were children that had increasing levels of need that required a new more effective method of working. This method of care brings a new set of challenges. I proposed in my role to attempt to introduce a culture of learning through the implementation of therapeutic concepts to help the team understand some of the conscious and unconscious communications that are happening constantly in the environment where we work. The aim is to retain some level of professional objectivity, and depersonalise the work, to enable the worker to make better judgements for the child and prolong their 'shelf life' in the residential sector. I have benefited from learning this approach and will endeavour to help my colleagues understand. I am under no illusion that it will take many years to create a culture where these methods are effective and common place. This study shall hopefully show that a worker can grow and develop their practice by adopting therapeutic ideas.

## Chapter 2 - Methodology

### Introduction

The research study attempts to evaluate the impact therapeutic methods of working introduced in to a residential care provision have on the quality of care provided by the workers. The main focus is on helping the staff understand some theoretical aspects combined with helping them make sense of their feelings and how they impact on the group and visa versa.

By introducing reflective groups for the team to gain a sense of self in the personal and professional context, I hope to develop the team's ability to provide a holding environment for the children. This I hope to achieve through providing the same experience for the team, by understanding their unconscious projections and the difficult feelings evoked by the primary task, and giving it back to them in a manageable form.

Winnicott (cited in Davis and Walbridge1981) explains the common thread is the notion of the mother's attentiveness to her child's communication and her ability to bear and to think about this, holding on to all the baby's feelings without feeling overwhelmed and giving them back to her infant in a more manageable form. This enables the infant to take in more good feelings than bad ones, holding on to them and in time becoming a container in turn.

### Qualitative research

The main research method chosen for this dissertation is a reflective practice approach. This is considered to be the most appropriate form of application because it gives the opportunity to study situations, experiences and processes in some depth (Adelman 1977). This qualitative style of research will allow me, to concentrate in one particular area and look at details to

discover the various processes at work, which may remain hidden in a large-scale survey (Bell 1993). It is also a sensitive approach, which reflects value, appreciation and respect for the various differences involved. The fundamental characteristics that form a qualitative study are in the importance of context to achieve adequate understanding of events in its organic state.

Key (1991:15) lists some of the advantages and disadvantages:

Advantages

- Produces more in-depth, comprehensive information.

- Uses subjective information and participant observation to describe the context, or natural setting, of the variables under consideration, as well as the interactions of the different variables in the context. It seeks a wide understanding of the entire situation.

Disadvantages

- The very subjectivity of the inquiry leads to difficulties in establishing the reliability and validity of the approaches and information.

- It is very difficult to prevent or detect researcher induced bias.

- Its scope is limited due to the in-depth, comprehensive data gathering approaches required.

The limitations of such a study are pointed out by Padgett (1998:2) who states that, 'they imply a degree of closeness and an absence of controlled conditions that stand in contrast to the distance and a control of scientific studies'.

Although I am aware that my findings using this method affect the reliability and validity of the research, I consider my journal to be a valuable tool to achieve the best results. Ward (1998:218) suggests that contemporary professional practice requires the ability to reflect on the relationship between theory and practice '.

Using a reflective journal

When engaging in therapeutic work with children. There is a need to understand and process very complex communications. Reflective writing tends to provide an organic holding space to attain and insight into learning and informing better practice. Best (1998:155) describes the use of the journal for students as a tool "To assist them in tasks of monitoring their learning and of developing their ability to reflect, students are asked to keep a journal as a way of "making connections, unravelling difficulties and arriving at new understandings'.

During my experience on the MA I was under considerable pressure to keep up to the required learning standards. My journal served as an honest space for me to externalise and express the difficulties I was having. It appeared to act as a holding environment for me to manage feelings of anger, frustration and annihilation. This is in the same context as the holding function explained by Winnicott around the mother baby relationship where the baby's anxieties and stresses are managed and processed by the primary care giver.

The utilisation of the journal to gain a real understanding of what unbearable and difficult conscious and unconscious communications are being experienced within the group continues to prove invaluable when attempting to achieve a shift in perspective. I found at first when I viewed the use of my diary, that it was just more work I had to fit in to my already busy day. However over time I began to reap the benefits. Primarily I only used it when I felt I needed support or when

there was something I was experiencing emotionally I felt I could not communicate to someone else. However over time it grew into a tool where I put my thoughts into words and then developed them into a solution or a strategy for working with the children.

At the beginning I was having one or two entries per week, then it became an integral part of my day where I was able to externalise my feelings from the day's work and then look at it from a more objective view, enabling me to be more professional at work and at university. When attempting to write the dissertation the journal proved itself invaluable. I would start with an idea and it would grow into a chapter. Then I would critique the chapter in my journal and revisit the dissertation and make developmental changes I would not have come to if I had not used the reflective element the journal provides.

The introduction of reflective group supervision

Using the reflective meetings to process and understand what care workers are experiencing as a group proved extremely productive whilst on the MA. I was overwhelmed when engaging in academic study for most of the day, however the experiential meeting held by Teresa Howard acted as a forum to make sense of the difficult feelings alongside the day's work. Knowing how important this type of meeting was to me led me to use this medium to evidence how the team could progress and manage the change in practice and retain some objectivity from the powerful projections from the children.

Diamond (1998:201) clarifies that strong, indeed overwhelming, feelings are inevitably projected onto the adults who live and work alongside the children and these feelings will be received in different ways. The anxieties that unintegrated children produce in the adults who work with them are within the realm of the normally unknowable. They may induce fears of disintegration, loss of a

sense of self, loss of control, emptiness and deep fears of separation, loss and annihilation. Much of this material is 'transmitted' at an unconscious level and manifests itself by adults carrying `uncomfortable' feelings on behalf of the children. 'The defences employed by adults against such overpowering feelings include avoidance through emotional distancing, denial, fight/flight and pairing.

For this reason it is essential that workers have time and space to think and talk about the impact of the task on themselves. Before incorporating this element of therapeutic practice I found myself resistant to engaging the team, and wondered if I could facilitate and hold on to what the team presented. I will discus later my findings and reflections.

Vignettes

I have decided to use vignettes from practice to illustrate how the team coped with two very difficult and challenging periods being presented by the children and how the team attempted to work through and hold on to the children.

The team use practical examples in meetings to attain an understanding of where the child is and how to be pro-active in creating care plans and strategies to manage the presenting behaviours. I have chosen this method of evidencing for that reason.

## Chapter 3 - Review of Literature

The literature review will cover the main areas of an examination of the authors I deemed relevant to help me achieve my objective of trying to assist staff in grasping the essence of therapeutic work. The main focus will be based around the fundamentals of therapeutic care, with an emphasis on the holding environment, containment, group thinking as well as unconscious communication.

I have used various sources including the library at Reading and Portsmouth University, my own books and various websites including the Mulberry Bush and Planned Environment Therapy Trust to help gain an understanding of the theory needed to complete my research.

The databases used were as follows
www. psych matters.com
www.pettarchiv.org.uk
www.psychology.org
www.mulberrybushschool.com

### Holding Environment

Winnicott developed the concept of the 'holding environment', which is based on the process of emotional availability between the mother, baby and their environment. This means that the mother will require adequate holding for herself to offer the necessary holding for the child. This was later extended to the organisation of therapeutic environments, which aimed to provide such 'holding' for emotionally underdeveloped people.

The concept of holding is related to the mother's capacity of

responding and containing her child's emotional needs, most importantly in its primary years. Inadequate holding will arouse negative feelings such as 'going to pieces', 'falling for ever', 'feeling unsafe' (Winnicott 1965). During the formative months the baby is in its very early developmental stage and has not yet gained individuality, or 'unit status'. The baby is wholly dependent on the mother with no differentiation. The baby has instinctive drives for fulfillment of basic needs. These drives invoke raw, primitive emotions, which at this stage the baby has no ability to contain. Winnicott writes: 'the term 'holding' is used here to indicate not only the actual physical holding of the infant, but also the total environment provision' (Winnicott 1965:43).

Whilst the mother is in the state of her 'primary maternal preoccupation' (Winnicott) she instinctually understands the baby's needs. As long as this process continues to be 'good enough' (Winnicott) the baby will experience a facilitating environment where his/her emotional needs will evolve. This is a process, which facilitates the growth of personality where integration takes place. From this the baby achieves individuality and gains a sense of 'I am'. This foundation then leads to further emotional and intellectual growth in later life. It also leads to being able to develop appropriate trusting relationships.

There are some situations when the baby will not receive any or inadequate `holding'. This is usually when the mother is not able to provide it due to her not being 'held' or due to past experiences, which damaged her ability to 'hold'. In this case the 'primary experience' of the baby is disrupted and the child is unable to achieve integration and depending on the severity the child may remain in an `unintegrated' state. If this happens then 'their development will be 'false' or `arrested', underlined by a tremendous incapacity for relationships, by

terror and confusion and by the danger at any moment that the fragmented core which ought to be the self will give way to chaos.' (Fees 1990:94).

The concept Winnicott puts forward fits well with the young people I work with, as all of them have had the early provision of holding unmet by their primary care giver. The holding environment would appear to be useful when assisting the staff deal with the level of un-integration the children experience. This could be a useful theme to cover in team supervision, to provide an understanding and a level of objectivity when feelings of falling apart are aroused in the team.

Therapeutic Holding relationship

Ward & McMahon (1998:51-53) introduce the idea of holding in relation to the therapeutic community approach and how mutuality of holding can be used in all interaction from not only the organisation to the managers but staff to young person and child to child. They explain the elements of what a holding relationship may need in order to stay intact and develop.

(1) the provision of appropriate boundaries upon behaviour and upon the expression of emotion so that strong feelings can be expressed but do not get 'out of hand'

(2) at the same time, an element of 'giving' and tolerance in relation-ships, so that people feel genuinely cared for and, where appropriate, looked after. If this element is not consciously aimed at, there is a risk that the holding environment can merely become either a 'controlling environment' or a 'withholding environment'

(3) the appropriate containment of anxiety Bion (1962). This might mean conveying to the other person – 'worry about that problem for the moment until you can find a way or an opportunity to manage it for yourself'

(4) Working towards maximum clarity in communication, means making sure that any misunderstandings get clarified and resolved as soon as possible. People under extreme stress are highly likely to interpret things in quite distorted ways and those prone to feeling `unheld' these distortions will often come from variations on the theme of being persecuted or in other undervalued.

Containment of anxiety

Anxiety can lead to all manner of problematic situations. It can also be a useful warning to individuals of specific dangers etc, but I will, here discuss the containment of anxiety, assuming that it will be problematic if uncontained. A dictionary definition of 'contain' includes "to keep something harmful within limits and not allow it to spread" and "to control or hide a strong emotion, such as excitement or anger" (Cambridge University Press 2006). Perhaps these practical definitions aid us to understand a highly complex emotional interaction, allowing this containment of emotions to exist, but not truly describing the interaction of anxiety between two people or stating how this is actually done. Through transference (the unconscious redirection of one's own thoughts, feelings and desires onto another person), counter-transference (the feelings evoked by this transference in the worker) and projection (unconsciously putting one's own undesirable thoughts, motivations, desires, and feelings onto someone else) the worker can really feel the anxiety and other emotions of the client. Should the worker be skilled enough to recognise and contain what is occurring between them, there is the possibility of positive emotional interactions that greatly aid learning. Without having a container for his feelings, or an ability to contain himself, learned as an infant, the worker may take on the difficult feelings of the client.

Projective identification

Roycroft (1988) defines projective identification as 'the process by which a person imagines himself to be inside some object external to himself (Roycroft 1988:67). Another aspect of projective identification can be that workers 'act out' the role of the clients. 'This process can easily propel workers into an unconscious collusion with their clients unless they are able to tune into their own emotional reactions and use their counter-transference diagnostically' (Preston Shoot and Agass 1990:39). Preston Shoot and Agass place an understanding of projective identification within the worker's diagnostic counter-transference,

*'The importance of projective identification is that it attempts to describe, metaphorically, how disavowed aspects of a client's emotional state can be directly and unconsciously communicated to the worker, and how that communication can evoke responses in the worker which may provide vital counter-transference clues to the client's inner world of object relationships'*

Team reflective meetings - Reflective practice

Understanding the importance of reflectiveness to aid more effective work has proved one of the more difficult but more rewarding elements of my therapeutic development, as it means you have to look at your issues and how they impact on the group. However this can be extremely uncomfortable, and can provoke some very difficult feelings from the past that have to be acknowledged and accounted for before change is possible.

It is a continuous process from a personal perspective, by considering critical incidents within your life's experiences. As defined by Schon, (*The Reflective Practitioner'* 1983) reflective practice involves thoughtfully considering one's own experiences in applying knowledge to practice while being coached by professionals in the discipline. An unstructured approach directs understanding and learning, a self regulated process...

Group thinking

Philip Stokoe (2003:82) explains the practical application of the group thinking model. Earlier books that introduced the ideas, such as Hinshelwood's *What Happens in Groups* (1987) or Bion's *Experiences in Groups* (1961), seem to illustrate the importance of recognising the impact of the staff structures and the client group in order to enable the staff to challenge difficult behaviour, and not get put in subjective roles that the client has had a earlier unhelpful experience of. This can become very stressful and frightening unless the principle is thought about and applied as a behaviour management strategy.

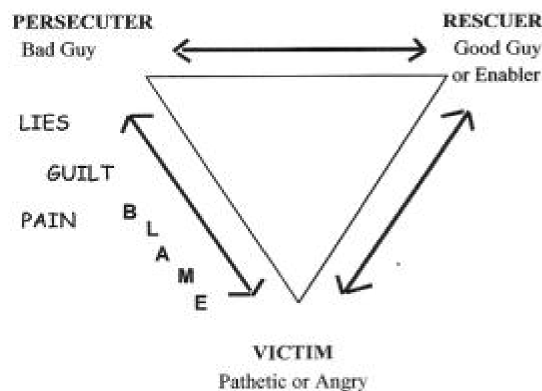
*'It is a principle that therapeutic work takes place in a relationship within a setting, the assumption being that the unconscious minds of each participant attempt to distort the relationship to fit the inner world expectation of what relationships are like. If you can arrange to neutralise this process in the direction staff to child, you can create a hypothesis that any distortion of the relationship is the result of the work of the child's inner world. The business of setting up the therapeutic system is, therefore, the business of setting up structures to reduce the effect of the staff unconscious on the staff/child relationship*

*and to maximise the chance of detecting the effect of the child's inner world on the system.'* (Stokoe 2003:83)

Unhelpful relationship dynamics

When observing the type of person who chooses to work in an environment where the emphasis is on caring for others, there is usually a common characteristic and that is the role of the rescuer.

Steve Karpman(1990) explains the characteristics of each element of the "the Drama triangle"; the roles of Persecutor, Rescuer and Victim are portrayed in psychological games. Think about a triangle. On each end are roles that we play in life. One is the persecutor, another is the victim and the last is the rescuer. If anyone in this triangle changes roles, the other two roles change as well.




PERSECUTOR - "It's All Your Fault"

- Sets strict limits unnecessarily.
- Blames
- Criticizes
- Keeps Victim oppressed
- Is mobilized by anger
- Rigid, authoritative stance

- "Critical" Parent

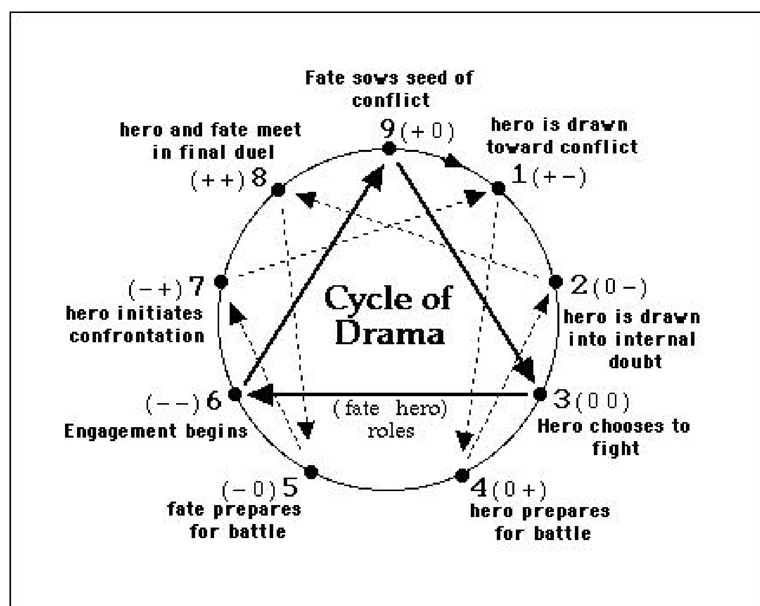
VICTIM - "Poor Me"

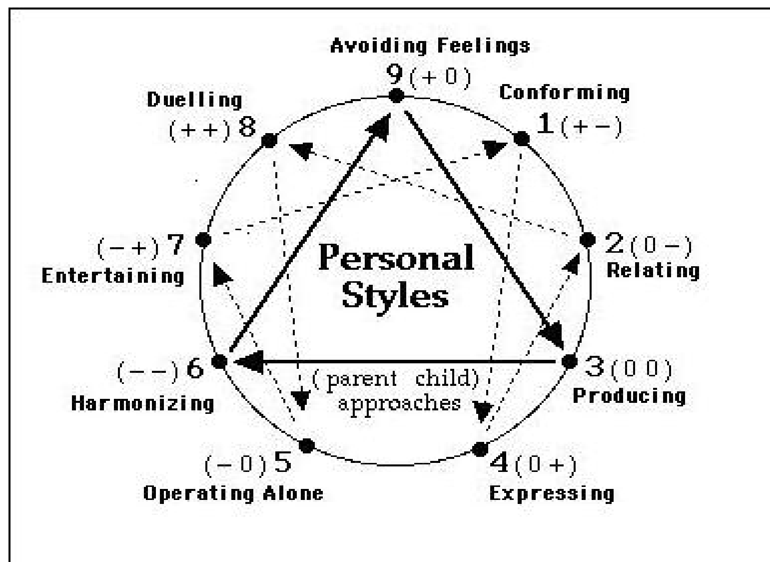
- Feels victimized, oppressed, helpless, hopeless, powerless, ashamed
- Looks for a Rescuer that will perpetuate their negative feelings.
- If stays in Victim position, will block self from making decisions, solving problems, pleasure and self-understanding.
- "Dejected" stance.

RESCUER - "Let Me Help You"

- Rescues when really doesn't want to.
- Feels guilty if doesn't rescue.
- Keeps victim dependent.
- Gives permission to fail.
- Expects to fail in rescue attempts.
- "Marshmallow" Parent

| | A Persecutor | A Rescuer | A Victim |
|---|---|---|---|
| B Persecutor | A Loses<br>B Loses | A Loses<br>B Wins | A Loses Much<br>B Wins Much |
| B Rescuer | A Wins<br>B Loses | A Wins<br>B Wins | A Loses<br>B Wins |
| B Victim | A Wins Much<br>B Loses Much | A Wins<br>B Loses | A Loses<br>B Loses |






The children in the care sector usually have had experiences of being persecuted by their parents. The child automatically goes into the role of the victim, and the staff member if not adequately trained or experienced move into the role of the rescuer. the unconscious drive to put someone else's feelings above one's self, The need to feel better by making someone else feel good is not a negative quality but if not worked through or managed well, the person can be consumed by the extreme demand put on them by the children's vast needs.

This pattern will be ingrained in the worker's psyche from their own early child hood experiences of relationships with a parent or care giver. It could be one of many reasons that keeps the worker in the job. He/she may feel that they are not managing to bear the volume of pain that they are exposed to in the work of the day, but seem to want to prolong and re-enact the patterns they are comfortable with.

Meinrath and Roberts (1982) discuss the problems that arise in a therapeutic community when the worker tries to meet all the child's needs on their own. They explain that the children often seek out staff

members who they think will meet all the needs that never got met with their birth families, and how this can lead to feelings of failure and depression and 'burn out' as the therapeutic community worker feels inadequate to carry out their job.

Staff can become very full emotionally and react by going sick or putting the blame on the organization, this can affect their ability to look after the staff emotionally while they contain the children's emotions, witch is not entirely untrue. If the staff are unaware of the difference between their feelings and the child's, they could be full of feelings of guilt or anger or the inability to be able to have any satisfaction in their job because they feel that they are not good enough.

If the staff were able to be made aware of the unconscious projections from the children they would understand that they could gauge how the children are feeling through the emotional projections, giving them an idea of what the child is experiencing. Barbara Dockar-Drysdale (1990) explains the process of self analysis as **.....** *I have sometimes said to staff at the Cotswold Community and the Mulberry Bush that I feel that workers in such places go through something a bit like an analysis - without an analyst, sessions, a couch or a fee! - But with a lot of pain. Their work and their personal lives become enriched through this experience, and they improve their emotional economy, but the gaining of insight must always be a slow and painful process.*

The staff can become so enmeshed in the child's world and what they need to do to achieve some element of emotional stability that they are unaware of the difficulties for the client to become compliant with our process. The staff should have elements of understanding of themselves and at least attempt to resolve some of their issues in order to understand how difficult it is to resolve emotional defenses and to give an idea of the time scale and understand the process of the need to be held on to through these very vulnerable periods.

Therapeutic fundamentals    The provision of primary experience

The fundamental problems that arise with the children we come into contact with is the unmet need in predominantly the first two years of life where they experienced separation from their mothers.

When describing aspects of maternal care, one of the most important elements is the mother's (or myself as holding adult for the team) ability to create a safe holding environment for the child to have total psychological dependence.

Winnicott (1965) states that a functional holding environment … '*protects from physiological insult… takes account of the infants skin sensitivity – touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling (action of gravity) and the infant's lack of knowledge of the existence of any thing other than itself*'. It includes the routine of care throughout the day and night. Also it follows the minute day-to-day changes belonging to the infant's growth and development, both physical and psychological.

Being able to understand this process of life and how it can go wrong will give the worker a framework to work from when deciding how to approach the child's care. Know that the child could be emotionally still at the point waiting for it to be facilitated well enough so emotional growth can carry on enhances practice, it also allows the worker to be more objective when presented with painful feelings or certain infantile behavior and reasoning. It can also identify some aspect of our experiences and how we interact with other people and enable us to question or maybe even answer some questions about ourselves. Being able to role model for the team and containing their anxieties should provide them with the space to learn how to facilitate this for the children.

Being a 'good enough' staff member

When developing a therapeutic approach to childcare in any community one of the obstacles that has to be worked with intensely is how the worker manages their feelings and practice when interacting with the client. Roberts (1982) explains the need for staff members to provide the Winnicottian 'good enough' experience for the child. In a therapeutic community it is possible for the staff to become hypothetically idealist when they try to be the perfect staff member and in 'loco parentis' strive to be the parent that the child had never had.

Roberts (1982:7) goes on to explain that the task of the staff member is to 'care' for the client, his colleagues and himself. There is a propensity in therapeutic communities for the staff member to care too much for the client and too little about themselves. If such a situation was able to go unmanaged it would promote undue regression in the client group and to say the least be exhausting for the staff member. This is extremely relevant as the team currently appear not to be able to care for themselves enough to maintain consistent care without getting overwhelmed.

One of the fantasies that can arise as a result of the splitting of the staff and client group is that the children are so emotionally deprived that they entice the staff member into the role of the loving parent. To provide the children with a corrective emotional experience that is loving and caring and has been denied to them previously. This is a powerfully and seductive scenario according to Roberts as it makes the staff member experience gratification of being loved and develop into fantasies of receiving the child's underlying gratitude to confirm their own self worth.

In turn when the child does not meet these expectations of the relationship the staff member becomes vulnerable to collusive caring and become tremendously disappointed when these relationships break down.

Winnicott teaches that the good enough mother is attuned to children's needs emotionally and physically. When working with children with extremely demanding needs, staff may adopt the same good enough experience that they gave to their own children. This confusion can entice the worker into a very unhelpful and unproductive dynamic were the child will exhaust the worker to the point where the worker can not meet the needs of the child and both parties are left with feelings of failure in the worker and rejection in the child. This is why it's best for staff to understand and work with the children as a group and be the "good enough team".

The good-enough mother is one whose conscious and unconscious physical and emotional attunement to her baby adapts to her baby appropriately at differing stages of infancy, thus allowing an optimal environment for the healthy establishment of a separate being, eventually capable of mature object relations. Winnicott sees the key role of the good-enough Mother as adaptation to the baby, thus giving it a sense of control, subjective omnipotence and the comfort of being connected with the mother. Furthermore, the mother can be viewed as a container for the infant's bad objects, as the child projects these into the mother. A critical ability for her is in accepting and surviving this onslaught with equanimity. This holding environment allows the infant to transition at its own rate to a more autonomous position.

It is unreal to think that one staff member can provide everything for a severely deprived and damaged client. This arouses feeling of guilt and inadequacy in the staff member and the staff group on a whole. Chessick (1979) gives some example of how to better manage this

relationship; he explains this in the context of a therapist, but the same structures could be applied to residential care relationships. To achieve ‘good enough’ holding Chessick recommends

(1) A consistent and frequent being at the service of the patient, at a time arranged to suit mutual convenience.
(2) Being reliably there, usually on time.
(3) For a contracted-for period, keeping awake and becoming professionally preoccupied with the patient and nothing else (such as telephone calls, tape recorders, etc).
(4) The expression of ‘love’ by the positive interest taken, and "hate" (as Winnicott sees it) in the strict start and finish and in the matter of fees.
(5) The sincere and dedicated attempt to get in touch with the process of the patient, to understand the material presented and where the patient is at, and to communicate this understanding by interpretation.
(6) Use of a method stressing a non-anxious approach of objective observation and scientific study.
(7) Work done in a room that is quiet and not liable to sudden, unpredictable sounds and yet not dead quiet, proper lighting of a room, not by a light staring on the face and not a variable light.
(8) Keeping out of the relationship both moral judgment as well as any uncontrollable need on the part of the therapist to introduce details of his personal life and ideas.
(9) Staying, on the whole, free, from temper tantrums, free from compulsive falling in love, and so on, and in general being neither hostile and retaliatory nor exploitative towards the patient.
(10) Maintaining a consistent, clear distinction between fact and fantasy, so that the therapist is not hurt or offended by an aggressive dream or fantasy; in general eliminating any "talion" reaction and insuring that both the therapist and the patient consistently survive their interaction.

The matching principle

Adrian Ward (1998) identifies a gap between training and practice and provides a bridge of connecting the two processes together by a method of what he calls `matching principles'. The gap is the distance between theory and practice and the dilemma of how to bring the two worlds (academic learning and workplace-based learning) closer together. His view is that all professional training should reflect a style or mode where the process of learning matches the content of learning as well.

He draws our attention to the conscious and unconscious elements in practice and training and suggests the 'reflection process' (Mattinson, 1975) through which the operation process of the matching principles can be traced.

If training is really to affect the quality of people's therapeutic practice, it needs to reach the unconscious as well as the conscious elements of this practice. A further aim of using the matching principle in this context therefore is to facilitate this connection between the experience of training and the unconscious element of process in practice.' (Ward, 1998: 80)

Conclusion

The literature I have chosen to study to write the dissertation has all been primarily based around understanding conscious and unconscious communication of feelings, and how staff could benefit from being aware of the fundamentals of psychodynamic analysis when attempting to change from one way of working to a more therapeutic treatment.

I have also covered communication through team meeting and reflective journal work as it takes more than understanding theory and applying it. There has to be an investment from the worker to share and explore in meetings how the young people impact on them and how they impact on the group as well.

## Chapter 4 - Vignette from practice - Luke

Some months ago our organisation had a referral about a child called Luke aged fifteen who had not left his bedroom for three months. He had been house bound for two years since he had left an institution for children with autism where he was heavily medicated then released when there was a deterioration in his behaviour. Since then he has been at home in a depressed state of fear and panic.

Luke had become very difficult in his family group, he was very demanding on a daily basis, especially with mum. He could not sleep at night when his mum worked nights in the hospital. He would also act out his anxiety around food by fasting. Mum had asked for support from social services due to her increasing inability to cope with Luke's demands as well as her work as a midwife, and the demands from the rest of her family.

When Luke arrived with us he was in a heightened state of panic about being separated from his mother and seemed to be presenting agoraphobic type behaviours. I tried to approach Luke's needs from a psychoanalytic approach as opposed to the medical approach he had in the past. I read Luke's case history and was shocked to discover that no professional had thought about Luke from this angle before. He had been diagnosed with eight different disorders or syndromes in the past then un-diagnosed later. The other interesting aspect of Luke's file was present in the first four years of his life. His mum and dad had separated when he was one, at this point Luke slept in his mother's bed, I assume to act as some sort of comfort to mum. When Luke was three mum met a new partner. When he moved in Luke had to sleep on his own in a separate bedroom. Once Luke was four mum got pregnant. According to his file this change in circumstance had a huge impact on Luke's behaviour.

He had been rejected by his father as was his mother, so they formed a dependent attachment to each other to fill the gap, and when this bond was severed in Luke's eyes he was desperate to get his mums attention by any means possible. He was also dealing with this new man in his mum's bed. As Luke grew he rejected all offers of a relationship with his stepfather and began to complain of various illnesses, as well as mum and step dad having two further children, witch added to Luke's problems. Luke's birth father moved to America where Luke had been to visit him twice in fourteen years, who he often talked about in a very positive way.

When Luke arrived he was able to have a considerable settling period, before we added structure. He came to live in the annex attached to the residential children's home, equipped to support a young person moving towards independence. Reflecting on that made me realise that we had recreated a situation were Luke was unconsciously placed in an environment that put him outside the main community, exactly what was happening in his family. We tried to build relationships with Luke with a lot of success. He engaged well but Luke was unable to leave the annex due to his inability to cope with the outside world, or his chaotic inner world.

We thought about what Luke's needs were and observed what would be described as classic agoraphobic behaviours that are directly linked to loss in early childhood. 86% of people studied by Bowlby (1973) had a similar experience. In Luke's case it was linked to the fear of total abandonment by his mother.  If he ever goes out she might not be there when he gets back or when he goes to sleep she may not be there when he wakes.

As a result of Luke's fear of his mother leaving he would sleep in the day when she was asleep, and stay awake at night when she was at

work. So when Luke came to us his sleep pattern was reversed. This was affecting Luke's health and it also inhibited us doing any work with him as he only had contact with the night staff. It was clear to us that Luke was able to manipulate his mother by controlling the family routine around his needs. We agreed that he would have to engage in some form of education as well as conforming to our routine, letting him know that he was not in control and in turn making him feel safer, by setting firm boundaries that his mum could never do because he always threatened to commit suicide if he never got his own way.

We slowly changed his inverted sleep pattern one hour every night until he started education when he got up in the morning at eight thirty. Luke seemed to be very unmotivated to do any cleaning or washing his clothes for hygiene purposes and our duty of care we had to take responsibility for his basic needs, as he was not ready for independence.

We observed that Luke had a tatty cloth that was chewed at the ends. I discovered this as I was helping symbolically put the order back in his life by tidying his room and washing his clothes. Knowing what this may be I asked Luke if he wanted me to wash it and he replied no way, that this was his blanket. Of course I said to him the smell is really important. He then took it and smiled and sniffed it.

Donald Winnicott writes about transitional objects. With "transition", Winnicott means an intermediate development area between the psychic and external reality. There we can find the "transitional object", which is the first element leading the child to face the external reality through the creation of symbols. I later observed Luke would go to his bed when he was feeling low with his cloth, which we later found out to be his mother's old night gown.

It appeared to me that Luke had never got over being removed from his mother's bed as a baby and has been desperately trying to re-create this dependent relationship ever since.  He seemed to be unable to move past the emotional age of a four year old, he's so scared to be alone. We had an incident lately where I was sleeping in. Luke and I had had a very good day - he is a very intelligent young man with immense insight into everything else in the world except himself. He went to bed without any problems at the arranged time. Then that night at three in the morning I heard Luke screaming from the annex where I was sleeping in. When we saw Luke he was in a state of panic in the living room wrapped in bed clothes. Going to bed and been left alone was terrifying for him. Staff stayed with Luke trying to engage him in conversation and help him through these difficult feelings; he was also complaining of hallucinogenic visions and having spasms. This type of behaviour has been present since Luke had left his last institution. We realised that this may be learned behaviour created to gain attention and express his anger and other difficult feelings. During the incident staff moved closer to Luke to calm him as I moved closer to him to comfort him he grabbed me held and on like a child and asked us not to leave. Luke sat upright on the sofa and was crying. Although I was aware that this may be learnt behaviour I knew I had to understand why he needed to do this rather than disregard it as Luke trying to manipulate the situation.

Luke was asking us to get him sectioned, and staff explored with him the positives and negatives of his last experiences. He then said that if he got worse then his father would have to come back from America and look after him, but if he got better he would never come back. Over time staff realised that Luke would discharge a lot of unwanted feelings and tension in this way, but would always start to talk about what really bothered him when he was in these highly strung states.

Luke has been trying to hold on to his mum by faking illness for so

long he has actually become ill. He has formed behaviour patterns he can not break easily. The family have not helped by facilitating the environment for this to escalate. Luke has become very skilled in getting what he wants from his mother and other professionals he has come in contact with. Everyone has failed with Luke in the past because his primary objective when he is taken to an institution is to do what he needs to get back home then revert to his old behaviours.

We as a team had to acknowledge that maybe there was a possibility that Luke may have psychiatric problems. And that it was ok to feel that we could not manage all aspects of Luke's development. That we could only do what we could in the best way we could, and when Luke is at the stage where he can take responsibility for his own actions then its up to him to move on. This was a very difficult concept for the team to take on board and process. The team were changing and realising their limitations and were beginning to get more confident in their roles and what they wanted from the job.

We also decided to have a psychiatric evaluation to determine if Luke had the primary stages of schizophrenia or something to that effect. We had a psychological assessment to find out what behavioural light could be shed on the situation, and a medical examination to find out if he had damaged any of his internal organs from fasting etc.

On assessing Luke's presenting behaviour it was apparent that this would be a challenge for me and the team and the manager of the unit. During this time we were beginning to introduce aspects of therapeutic care from my course.

Family support

As part of my new role I would have to provide Luke's family with support. I remember travelling to the family home and feeling quite anxious about having to take on such an intense piece of work. Also

being aware of how they may be feeing anxious about another new professional entering their dynamic. From reading Luke's historical documents it was clear that by this stage the family would not trust what care professionals said or did.

On arriving at the family home I met mum, who was very welcoming, she invited me in and offered tea. On first impressions mum seemed very tired. Luke was now fifteen and she had been emotionally drained with the demands that Luke's needs had put her through. Step dad was not home from work yet even though he had arranged that we would meet. As mum and I talked it was apparent that she felt very guilty and blamed herself for Luke's situation. She explained the break up with Luke's birth father, and appeared through her communication that she had ben trying to make up for this ever since.

Step dad arrived home and introduced himself. He then made a negative comment about Luke and then went for a shower and didn't get involved in the rest of the meeting. When dad left mum just hung her head and then apologised for her partner. It was apparent that the situation had taken its toll on their relationship. Mum said that she did not know what to do, and that she could not manage any more. I assured mum that we would be available to support her any time. I would be available every day until five and she could contact the residential unit for support from our team out of working hours. Mum asked me would I be able to make everything ok and all she wanted was her little boy back the way he was before. I explained we would do our best to care for Luke and her but could not promise anything. I was aware that she may have asked these questions to the other professionals that had not been successful. So making promises would not have been a good foundation to our relationship. Wanting to build a trusting relationship and obtaining and understanding of the family dynamic was my role whilst undertaking the support.

We then moved on and talked about Luke's likes and dislikes, his presenting behaviours and how she managed them. I also explained the environment that Luke was in and how we were hoping to work with him. Mum began to feel more optimistic about our model of working and how it differed from other resources that Luke has been offered in the past. She said that she was really confused Luke had been diagnosed and undiagnosed so many times that she did not know what was wrong with her little boy. I said we are not a medical provision and we primarily work with behaviour and formulate strategies from that perspective, and if we think that Luke needs any further medical assessments, we would make his social worker aware of our observations.

When the meeting finished I was on my way back to work, which was an hour ferry journey thinking how was I going to hold the family, the team and myself together through this very difficult case and introduce therapeutic work to my practice at the same time.

Journal entry –
*On my way back from Luke's family home, it seems that mum is unable to manage Luke's needs as he has grown older. She appears to be unable to put in firm boundaries as she thinks that Luke has suffered enough because of her mistakes. Through mums communications she thinks if gives she gives Luke everything he missed out on that he will be ok. Mum talked about when she was very young when she had Luke and that her parenting skills were not very developed. I'm sure she was explaining to me that now she knew how to parent she wanted to provide Luke with a 'good enough' primary experience.*

*Mum spoke about how Luke wants to make up for the lost time when he spent time in hospital due to always being unhealthy as a child. Mum explained Luke found it really difficult when she entered in to a*

*relationship with John. He was so used to having one hundred percent attention from her because she felt so guilty.*

*It would appear Luke is trying to gain his mums attention or love by re-creating how the primary relationship feels by attempting to make mum feel like she used too. This could be the first good practical example I have witnessed of how a baby internalises his or her mother's emotional state before there is any conscious memories. Luke may know that this is very demanding on his mother but appears not to be able to form any maturational development in this area.*

*Note training for team- provision of primary experience/ therapeutic holding/ projection.*

*Note to team meeting - foundation for care planning,*

- *Explain family dynamic and how Luke may re-enact his family dynamic.*
- *Recreate an environment where Luke can regress safely.*
- *Provide safe trusting relationships*
- *Firm boundaries- sense of containment*
- *Reflective work (benefit of keeping a journal).*

*If I could hold on to mum and the team then how could I get them to get to the stage where they could hold for themselves and Luke.*

*Step dad appears to be at the stage where he does not want to engage in the care provisions for Luke. Step dad appears to be very angry and unable to be in a place to deal with Luke's needs.*

*Note for team meetings - look for staff who are holding on to step dads feelings in regards to caring for Luke.*

*Maybe mum is being forced in to a situation were she has to choose between Luke and her husband. Mum communicated her difficulty in meeting Luke's needs, saying that she can't say no because he makes her feel guilty. Mum may need considerable support and containment to build trust with me and the team. I will need to give mum current updates on Luke, and provide and understanding of how Luke and her interact and attempt to provide an understanding of what might be unhelpful and suggest some possible strategies, to manage Luke and preserve her emotional and physical strength, as well as make Luke feel safe at the same time.*

<u>Team meeting - Luke – making sense and separating feelings</u>

The team meetings usually incorporate all four children as well as all the other household issues or updates. On this occasion it was felt that Luke was having such an impact on the team we would have to use all the time to explore presenting behaviours and formulate coping strategies for Luke and the team. My journal entry reads:

*Since Luke has arrived with us the meetings are becoming more difficult for the team. I noticed that certain members of the group would become ill on meeting days and not attend. This has parallels with the team when trying to manage Luke on a day today basis. Luke seems to be able to make the team feel inadequate when working with him.*

*Luke has been with us now for one month and the communication from the team appeared to be that we did not have the expertise to manage him. Some of the team did not want to admit that they were struggling while others wanted to end the placement. It was apparent that Luke was able to successfully make the team feel like his parents felt. The team were splitting of and acting out the family dynamic.*

When listening to the team's communications it was clear Luke's presence in the unit had made them feel some very unwanted feelings. Because of his age and the historical aspects of his narrative it was not a common type of referral we would usually get. Due to the level of Luke's intelligence the staff were worried that they were being manipulated, as Luke had perfected this in the relationship with his mother, by making staff take responsibility for his situation as he does his mum. Then telling them they are unable to care for him as they did not know how to do their job.

The most important revelation I observed and shared with the team was the possibility that we were experiencing the same feelings of guilt, impotency and frustration as his mother has been dealing with for years. Some appeared to be giving so much and doing all they could to make things better by placating Luke's wants the more Luke told them that they could not meet his needs. A majority of the team are trying harder to care for Luke. It was amazing to see the team acting and feeling like mum.

As the meeting went on I attempted to make sense of the communications for the staff. Some of the team responded well while others did not believe and continued to be defensive and again said we could not manage this type of referral. It appeared that some members of the team were rejecting the change in working methods and were having mixed feelings about the change from the conventional approach to childcare and found it difficult to embrace the therapeutic ideas. Combined with the fear of not being able to manage Luke, who did not fit in to what they thought their area of expertise is.

<u>Journal entry (fear and pain)</u>

I knew I had to provide a containment for the team through providing and understanding of the presenting behaviours using a mixture of

theory and coming up with working strategies to help them contain Luke.

*The element of the team that appears to feel reluctant or avoidant of the care provision for Luke may be experiencing a projected identification from step dad as well as having difficultly carrying out the primary tasks, of the new method of changing treatment. The team has parallels with Luke's avoidance with not wanting to let go of the old relationship even though he has the ability to understand that there could be a better way to have a relationship. If I could provide holding for the team by processing their feelings of fear, and making sense of the presenting behaviours from Luke, I could give it back to them by giving them options to better manage Luke's care and an understanding of why they could be feeling like this. They could feel safe and confident when working with Luke and attain some element of professional objectivity, to think clearer about the task.*

I may have made a link between my development, the team and Luke's. I think it would be best described as the same as the archipelago child. Luke has islets of ego formation as I and the team appear to have islets of therapeutic understanding.

During the process of writing my dissertation I have came to the conclusion when self belief is achieved, and one's ability to match theory with practice is accomplished, that you become a better container for other peoples' emotions. Once I embraced and understood the benefits of change even though it's long and painful I ceased to feel fear. This experience has given me the momentum to trust the process works, and feel confident that I could provide this for my work colleagues and hopefully in turn they to the children.

Considering how long it has taken me to understand internalise and adapt these therapeutic ideas to my practice, I have to find a short cut

for the staff to achieve a basis of understanding. I shall try to underpin their practice with a therapeutic framework in a manageable form, through practical analogies of definitions of projection, holding and containment as one method.

Team training was introduced at this stage – see second part of chapter.

Journal entry- analysis of team at past meetings

*In the past all meetings took the same theme and were totally focused on the children, and the staff were always lost and forgotten about on and emotional level. The agenda was always what the staff were not doing so well and could they sharpen up. The staff would also not have any ownership or control over the meeting. If they added any suggestions or ideas they would be shut down by management, by not embracing any staff ideas. This inhibiting of communication had an impact over time to the point the staff did not want to come to the meetings or engage in them when they were there. The management failed to hold and nurture the team in a safe way (Winnicott holding).*

Reflective group supervision - feeling safe to change,
Team holding

-

After two months of working with Luke we arranged for external supervision from a therapist to help us look after each other and our selves. The day before the meeting our facilitator cancelled our session. She also works individually with Luke. Maybe she was avoiding having to hold on to the team and Luke at the same time and felt too much.

My self and the unit manager considered changing the format of the meeting but decided that this would have negative impact on the team as they were looking forward to having space for them. I decided to

facilitate the unconscious work while the manager addressed other issues like rotas or pay.

The agenda was to set boundaries for the meeting. The idea of creating our own contract was welcomed and the team came up with ways of having ownership of the meeting by setting the boundaries. The feeling from the team seemed positive they discussed differences in how they felt about attendance and time keeping. They achieved containment by asking everyone to make a commitment to arriving on time and texting a message to the group if they could not make it.

They explored the fear of sharing and how they could make the space more safe and trusting by not talking about group issues outside the whole group in sub groups. Everyone also agreed not to share any information personal to the group. The team appeared confident to work out issues together.

The space did not seem to be flooded with Luke. The team also explored in an light hearted way about their understanding of how they had split and acted out one or the other parents but through being able to hold on to them, shift in perspective and think about Luke in a more professional way than mum and dad could, they felt that they were able to manage Luke much better. They also discussed how developing and understanding of themselves had helped in achieving their goals and improved their practice considerably. The group supervision now takes place every three weeks and have proved an invaluable medium of communication.

<u>Journal entry</u> – change

*Due to the team not having their views and ideas taken into consideration when constructing behaviour management strategies in meetings they felt inadequate when managing the children's behaviour*

*on the floor. Due to staff wanting to be responsible for something, they appeared to take responsibility for what they could, usually the children's feelings, thoughts and actions.*

*The introduction of team supervision has been a considerable success. The staff team have responded really positively. There was some confusion on what the meaning of the meeting was going to be. Some staff spoke out and explained that they could not talk about private supervisory issues in front of the team. I clarified that we going to discuss group issues in this forum. This is where our different moral and ethical values can be discussed and where compromises can be made so we can function better as a team.*

*I thought I would have felt an overwhelming feeling of fear to take on the task, but was able to hold the team satisfactorily due to their ability having developed to hold themselves and each other.*

<u>How we made Luke  feel safe and contained to change – Care planning</u>

We structured and planned his day with him the night before. In the morning when he was brought tea and fresh towels for the shower he had great difficulty getting in and out of bed, he would take over an hour of slowly easing out of his sleep and out of his bed or his symbolic womb that smells of his mother.  We would always plan a good breakfast and eat together, then he would play the acoustic guitar and sing for fifteen minutes before education.  This thought about approach to daily living reduced his anxiety levels. Luke's diet improved over time and he has started to go outside in small doses and needs lots of human contact. He has put people in many different roles, to enable him to get what he needs so he can survive away from his family.

In the evening after mealtime where he has some free time Luke can choose and plan his reward for each day. He usually chooses a game

or music and sometimes a favourite TV programme. Before he goes to bed we tidy and put his clothes out to wash and plan the next day with him. Bettelheim writes about the importance of letting the child know where you are sleeping if he needs you throughout the night. He seems to have formed secure and safe relationships with staff, he would still get panicky when staff are leaving at night, needing hugs and warm milk to help with the transition. He now talks about his father and his experiences of him. He would laugh and say my dad has really bad parenting skills, he would ask me not to swear and does it all the time. It was as if he was learning not to idealise his father but still love him and could hold the good and the bad in his father together.

I know from feedback from the team that Luke's progress could not have happened if we hadn't thought about the Luke's feelings and care without the input of therapeutic aspects of daily living, by continuing to hold on to him in an infantile manner to build secure attachments with staff and then slowly move him away from total dependency, and take responsibility for his own thoughts feelings and actions.

Developing team training

Food for thought - and how that affected the provision of care for Luke's difficulty at mealtimes.

At staff meeting I would be given a one hour slot to introduce new therapeutic management strategies. For example recently we discussed the symbolic provision of food. I gave a small presentation then set tasks for staff to slit up into two's and discuss their relationship with food. The generated some very vibrant discussion. The staff made some very important links with their own childhood

experiences and then had a better understanding of the children's cultural experiences of food as well. Since then the staff are more aware of mealtime and how difficult this time of day can be. They explored ideas where the child may never have sat a table to eat or not have had meat on their menu at home. Below is and example of what medium I used when attempted introduce new principles like the inner world, projection, symbolizing, attachment, e.g.

Work of the day:  Explore our own feelings in relation to food.
If everyone could get into pairs and spend around 15 minutes talking about their experiences with food and how it makes you feel. There are no right or wrong answers, this is purely an exercise in reflection. If we can understand what makes us emotional about food, then we can begin to understand the children's emotional responses and improve how we manage this very difficult time of the day for children in care.

Examples:

1. Do you enjoy eating?
2. Do you eat a wide range of food, and was this the same in childhood?
3. What foods do you not like and why?
4. Do we meet the young people's cultural needs? What do you think their eating culture consisted of?
5. What do not like about other peoples eating habits and why? I.e. gluttony or obsessive fasting (crash dieting). Do you think there is an emotional link? Or eating with people with bad table manners, how does this make you feel and why?
6. Were you breast fed, and do you thinks it has a bearing on how you relate to food now.
7. In relation the children we work and eat with, can you show empathy with the way they emotionally relate to food.

8. Or do you get angry when they reject the meal you have prepared?
9. Do you worry when they don't eat balanced diets?
10. Why do think it can be a very difficult part of the day?
11. Then ask yourself were there any similarities to you when you were a child, do you have the same problems with your own children. If not, why? If yes, why?
12. Did your parents force you to eat food you did not like, and how did this feel. Can you see parents in yourself now when trying to manage mealtimes?

If staff could take a copy of the handouts on food to read, then we can in the future explore the more sensitive therapeutic provision of food and how we can integrate this into our practice.

When introducing new staff to the fundamentals of psychodynamic thinking and change in working practice. It has been very difficult to manage and work with the anxiety around change. People in general are reluctant to accept any change without resistance. This could be based on fear of the unknown and will I be good enough to learn something new and apply that to my practice. In child care there is an element of responsibly for other people's lives and the impact you as a worker have on them. So to be changing what you already know to be a good enough way of working to something that will deliver a better provision that means a change of culture and considerably more emphasis on you to explore yourself as well as the child is very daunting to staff who have been avoiding thinking about themselves on an unconscious level. Some of the other fundamental areas of therapeutic work that the team found helpful and appeared to be able to understand on a personal level making it easier to apply to practice were:

Working with uncontained communication - Positive holds and Life space interviews

When behaviour starts to escalate staff need to remember that the child is trying to communicate something, which they may or may not understand. The child is acting out with anger because he fells scared and upset because he does not feel safe (usually linked to a time in their life when they were terrified even more so than the situation that there in now).

Staff to child communication –First of all attempt to talk with the child about how you can see by the way they are behaving that they having problems managing their feelings and that you are there to assist them in understanding what is going on for them (acting as a container for their feelings, then giving it back to them in a understanding and manageable form ((i.e. doing their thought processing for them then giving it back in a basic way, so they can process the rest)). You will also stop them from losing control if it gets too much, i.e. if they want to hurt themselves or someone else or property, and you will do this by holding on to them in a safe way until they can regain control.

Therapeutic understanding- The reason why adults have to provide this for the children we look after is because they have not had a 'good enough' level of integration in their infantile years. Birth mum or their primary care giver will probably behave in the same way as it has not been provided for them either. The child has not properly separated and formed an individual 'ego' that is able to think through and manage their own problems. They are at the 'id' stage and will project and blame everyone around them for how they feel. E.g. "if you stub you toe on a table leg you may swear but you are able to manage the pain and take responsibility yourself. If a baby does this they will cry

for their mum to make it better by physical holding( a hug and verbal reassurance"( e.g. by blaming the table saying "that silly old table" . what we are seeing it young adults doing the same they have not emotionally moved passed that stage. But the problem becomes considerably more complicated as that young man is chronologically older.

Staff to child communication - the child does not seem to respond in a positive way to your clear explanation of why you are there. This could mean that they do understand but still want you to take hold of them (a hug). They will be to upset and angry and proud to ask for this so they may engineer the situation so you will have to hold them.

<u>Holding an uncontained child</u> - During a hold always try to make the child feel as comfortable as possible. When you are communicating with the child let them know that they are making all the choices. Clearly state that you are doing this to keep them safe, and then instruct them what you do to end the hold.

1. Try to explain to us what is bothering you.
2. You seem to be very upset. (acknowledging that its ok to feel this way)
3. When you choose to stop struggling we will be able to ease of and relax.
4. After you are in a relaxed position and are able to manage you behaviour then we can talk about releasing you.

If the child is constantly saying let me go or more colourful language to that effect. Inform them that you are not going to listen to the way they are talking to you and will observe their behaviour. I.e. if they are struggling more then you it is very clear you do not want us to let go, as you not in a place to take charge of yourself. The child will probably repeat unreasonable demands. At this point you do broken record.

Staff note – probably best to think about rotating staff at this point. The person who initiated the hold will be the best person to remove from the situation.

Another strategy to use at this or any other point is talking in the third person. – I.e. talking to your work colleague on a level that the child understands.

The objective for the duration of the incident is to analyse the child's behaviour and form management strategies, but always trying to get him to a place where he can articulate his issue.

Therapeutic understanding - what we are trying to replicate is a safe containing environment were the child can express his needs and work through then with adults in a professional thought about responsive way. We are attempting to provide that important developmental communication that his mother could not provide.

How to carry out a Life space interview

1. The objective of the interaction is to clarify what has just happened, why.
2. To ask the child how could we have avoided this?
3. Or how we could have handled him better.
4. To explain the reason why we had to take hold of him.
5. To explore with the child further, his issue in a more controlled and verbal contex

## Chapter 5 - Reflective chapter

I am currently working for a private child care company who provide a service to social services in the Hampshire area. The company has a foster care department, residential home and a school for children who have been excluded from mainstream education. I have been working for the company in the residential home for the past seven years. I started my career in childcare a year and a half prior to this, working for an agency that provided support for local authority residential units in the Hampshire area. I was taken on full time by social services after four months with the agency.

I came to work in my current position through a work colleague who asked me if I would consider a move to an agency he was, I took the position due to his enthusiasm and commitment to creating a provision that put the children at the centre of the work rather than on the periphery. My experience with social services was invaluable from a practical learning point of view but the outcomes for the children seemed to be very disappointing. The approach that was adopted was more focused around containing the children until they came of age to be placed in the community on their own. It struck me that they were unequipped to survive as they had not resolved any of their issues that placed them in care in the first place. They had grown institutionalised and resented their carers, parents and the world for not giving them the help or care they needed. They would be placed in bed-sits and supported lodgings at sixteen to fend for themselves, but would find this very difficult to cope with and get involved in petty crime.

I as a worker was very inexperienced and did not understand enough about the children, but sensed that we were not doing enough and began to become disillusioned with the job, until I got approached by and old agency colleague and asked to come and try a new approach

with a company he was starting up. This was supposed to be a more involved and thought about method of working which felt a lot better. When this new agency materialised the intention seemed right, but the team of workers were not very experienced. We tried to give the children the best care we could with our experience but were not successful on many fronts.

I was now aware that what kept me interested in the job was as much to do with me meeting my needs as it was meeting the child's, it was only over time and experience that I understood the type of people that carers were, it usually consisted of people who had difficult childhoods of their own, that were exercising their own demons through the work with the children. I knew that I was one of these people and started to ask myself what was it that happened to me that made me want to stay in this field of work.

I came from a very complex family dynamic where love was mixed with violence and chaos. My father was very unintegrated from his early negative childhood experience, and needed a lot of emotional needs met from my mother. This put increased pressure on my mother as she was providing all the emotional support to the family and was not getting supported herself from my father as it should be. My self and my siblings had no space to express our emotions, and reflecting now we were put in the role of parent by looking out for our mother's emotions. As my behaviour patterns developed and became more engrained I had taken on the negative aspects of my parent's relationship. By observing my mother rescuing my father and how her behaviour developed as she was forced into the role, combined with developing the role already with my mum and her needs. This is how I came to care for other human beings more than myself. It had its positive aspects which were easily transferable to the caring profession, I found that I was very much attuned to other peoples feelings and needs on and emotional level.  I grew up to be a people

pleaser, which was very good for everyone around me, as they always had someone who was attending their needs, however left me as a person feeling very empty and unfulfilled.

I was unaware of this behaviour pattern, and when I spent some years in the caring profession, the children I was working with capitalised on this characteristic of my person by manipulating me, leaving me burnt out within three to four years exposure. I at this point was looking for a new field to work even though I knew I wanted to make a difference to the children in the care system. I could not work out how not to give everything to them, so went and studied computers at hnd level and worked nights in the children's home to fund myself through the course. I felt I had to undertake this course in an attempt to preserve some of my self from being totally consumed. On completion of the course I never pursued what I had trained for and seemed to be revitalised enough to stay in childcare.

It wasn't long before I was feeling drained again and losing interest in the work. It wasn't until I discovered a course on therapeutic childcare at the University of Reading I began to understand myself and what drove me to re-create old cycles of behaviour. The course was primarily focused on the early experiences we have as children and how that impacts on us for the rest of our lives. There was an element of the course that prompted us as therapeutic workers dealing with children with emotional trauma, to try and resolve or understand what had happened to us as children so we could become more objective and effective practitioners.

The experiential group took place at the end of the university day and was a very uncomfortable time of the day for everyone. We shared very personal narratives from our lives with each other, and through this we hoped to make links with each others' experiences to help us understand why we behaved and felt they way we do. The most

prevalent feeling I had throughout my life so far was magnified the moment I came on the course; I had an overwhelming feeling of not being good enough. I was sharing a space with some very good child care practitioners, which I was quite comfortable with but they were also very academic students.

I was never very academic and had very poor level of education up to this point that was not helped by the fact that I was very dyslexic. I had not discovered this until I handed in my first essay on course and one of the lecturers suggested that I get tested. Finding out has answered a lot of questions for me as I knew I had a fair level of intelligence, my thoughts were very complex all my life but I was unable to remember spellings or read at speed. This disability was never highlighted in my early years of schooling and I can remember being put in some very difficult situations, like reading out loud to my classmates and being very embarrassed. These experiences had a significant effect on my emotional development by engraining feelings of worthlessness and being inadequate in the presence of anything academic.

On entering the classroom again at university I knew I was going to be feeling very uncomfortable, as these old feelings had not been dealt with. The structure of the course day was a seminar approach where I had to think and process information quickly, and then talk about my thoughts within a seminar environment at master's degree level. For two years every week I put myself in this environment constantly living outside my comfort zone. Some times it was too much to deal with and I did not come. However, I knew if I could not deal with what had happened to me and stay with the pain and overcome it, how could I expect the young people I worked with to do what I could not. For me it was an important process I had to go through to understand what had to be experienced, so I could facilitate this for my clients as well as resolving some of my emotional vulnerabilities.

Writing this part of the dissertation has been very difficult and emotionally overwhelming, I can only reflect on how difficult but how necessary it feels to revisit these memories, and how different I now feel after writing them in my journal a year and half ago and how it feels now writing in the dissertation. The feelings are the same but they have reduced in intensity.

During my academic and personal life, I have always felt that I have not been good enough. The not feeling good enough links with my experiences in school, and in my life. I have come to the conclusion that I have always been apologising for everything to everyone, to the point that I don't even realise I am doing it.

This brought up feelings of guilt if I ever thought I may have upset someone or done anything wrong. This is linked to my early childhood and feeling guilty for being born. On reflection I always felt bad as a child for existing, because if I had never been born, then my mother would have been able to leave my father and not suffer so. This was probably not the whole reason why she never left but as a child this was the only deduction I made. This feeling embedded itself again in my psyche, and became apart of the person I am.

Before I began the course at Reading I had been in the caring profession for six years. I had become confident as a carer due to my ability, to always think about other peoples' feelings above my own, and my advanced people skills I had developed trying to survive as a child at school and at home. I had been given opportunities to move into management positions but over time usually failed on some level. Maybe it was the inability to confront staff about issues, due to my inability to make anyone feel bad, or my management problems in relation to my dyslexia. My early experiences had given me some very

good survival tools but were also inhibiting my career due to my insecurities.

It wasn't until the MA in Therapeutic Child Care that things changed for me. One year in to the course I had been learning new theoretical aspects of working with children, combined with my emotional development I began to overcome and manage my uncomfortable feelings and start to believe in myself. All the aspects of the job I desired started to become easier to carry out, I found that I could challenge my colleagues and not feel bad. I could voice my opinion and talk about therapeutic approaches in meetings, and feel good enough inside. I was being more responsive rather than reactive with the children, and not feeling as drained. I was able to be more objective and help my colleagues begin their journey of becoming more professional carers through my approach. For the first time in my career I was meeting the needs of the children and not my own.

Professional

When looking at what has been difficult when writing the dissertation I would have to say my difficulties started during a residential weekend in February 2006. This residential on the MA course was a dissertation workshop were we had to define what our subject of study for the dissertation was going to be. We had to split in to small groups and had a small amount of time to work on what we wanted to do, then present this to the rest of the group.  I usually had a lot more time to think about and produce all of my academic work. This process brought up all my insecurities and fears, my issues were all around self belief and being good enough. I was already suffering, and always have in any academic forum from a recently introduced myth, that graduate students were calling "impostor syndrome". This was a feeling that students get when they think they don't deserve to study at higher level education, and think that they are charlatans that are

going to get exposed at any time. I had always been able to get by, but this on the spot type of interview process made me feel very uncomfortable, my colleagues helped me through the process and in the final group of the day, I became emotionally overwhelmed for the first time in seventeen years.

I knew at this stage something was very different, and this is the area where I had to focus on and stay with the pain as long as I can and try and understand what had happened and why I responded in that way. I had always been searching for the reasons, why I was the person I was and why in my professional work, that I was only getting to a certain level and had not the confidence to go any higher.

I subconsciously probably chose the course as a way to identify these problems and somehow make amends. I knew that it was there all the way through the first year, but nothing had forced the issue up until this point in the course. Over the next eight months I had a total loss of confidence, and many times wanted to leave the course and move on to something else. Near the end of the eight months my dissertation had to be handed in, I had spent the whole summer in my study not really getting any thing down on paper. Every time I wrote I thought it wasn't good enough and deleted it. I had finished the course at the start of the summer, so I did not have the group to help me understand my feelings. I was getting paranoid about people's view of me on the course, and I thought they did not want me there either. I started to distance my self from the group by not writing any group e-mails, the only form of contact we had after leaving the course.

I was getting extremely frustrated, and spent nearly every waking moment trying to work out what was happening to me, and how could I break my life cycle. I wanted to give up, but I always thought about my mother's tenacity when dealing with my father's reign of terror. If she ever gave up, we would have been very different people today. I

also thought about my grandfather, a great friend of mine who passed away on December 2005, and how he spent four years in a prisoner of war camp in the Second World War. He endured pain that I could never imagine and overcame it. I realised that these two people had suffered so much for me just to be alive. I had adopted this family trait and could never give up. Finally in September I seemed to feel better, I was using my journal to work through and reflect on the past eight months, which turned out to be an invaluable element to this process.

I started to get recognition from my peers at work about the therapeutic elements I was introducing. I was able to take compliments, believe them and build on them. This was a catalyst for me to believe I had what it took, and I had to finish the dissertation, for me, my work with children, my mother and grandfather, and my career. From that launch pad I was able to find the core of my study for the dissertation. I would write about the journey I have started and how psychoanalytic awareness gave me the tools, to deal with the most difficult and fearful areas of my personality and in turn improve my professional work tenfold.

I think there are a considerable amount of people that get in to our line of work who have similar issues, and will succumb to the same pitfalls. If any can learn from my experience through this dissertation then they will improve themselves, and the children they work with will have a better experience in care.

<u>Becoming a helpful container</u>

My experience over the past two years has given me something I never had before. I grew up in an environment where an authoritarian approach was adopted to all of my communications with my parents. Nothing was ever explained, as it would be when using an

authoritative method of raising children. I lacked understanding of myself, my identity and a general understanding of the world. This combined with not having any place for my feelings to be explored, had an impact on my academic and emotional development.

The basis of most of my material has come from my journal for my dissertation, and has proved to be the tool that met needs of mine that were never provided in my early childhood. The journal has made me put my feelings first- a place to cultivate and develop ideas and understanding. It has acted as a container for my feelings, to enable me to move on from my past. I was always a container for other people's feelings before, but because I was meeting needs of my own by doing that it would always become unprofessional and counterproductive in my professional work, as well as draining and unfulfilling in my private life.

The journal became a safe holding environment for me to express my deepest and most complex emotions. It gave me a safe, trusting experience, where over time my most difficult, and unwanted feelings were given back to me in a manageable form, as well as some understanding of my identity, through self exploration. The realisation of finding the source of my trauma induced panic. It has inspired me to find creative ways of providing a similar safe container for the children I work with.

## Chapter six - Conclusion

### Introduction

I have undertaken this study with the optimism that a therapeutic method of working with children with emotional and behavioural problems does produce better outcomes for the staff and the clients. This study initially was chosen to identify not only if but what work could benefit both parties. During the process of constructing and researching the material for the dissertation the process has brought some interesting and helpful findings to light.

### Structure and process

When analysing what residential workers struggle with when working in this environment, it was clear that in their current and historical work places they were overwhelmed with structure. Structure is a very important and necessary element but means nothing if the process within that structure is not thought about and facilitated as well. The training on the therapeutic child-care course had an equal balance of both fundamental elements. Having access to a therapeutic process has enabled me to understand what has been missing from my work place and begin to apply these concepts to the day to day practice, by introducing team supervision, reflective individual supervision, community meetings, specialised one to one work and staff training on therapeutic intervention etc.

Each of these important additions to the structure and the difference in the quality and reviewing of the work taking place within the structures has proved invaluable. We have had to deal with a lot of

change which was difficult at the beginning, and was met with considerable resistance. But the team are now beginning to reap the benefits of staying with the pain. The theme of change has been worked with in the group supervision and the team also realised the parallels with the children we work and how difficult it must be for them to change. They understood the quality of the holding environment needed to get them to change needs to be the same for the children. Based on the difference in staffs attitude to their work and how they have taken ownership of the care for these children has been a gauge to say that worker can benefit from having an understanding of therapeutic work.

Future plans

My vision for the future would be to further develop the staff's skill level so they in the future will be able to make connections and understand in more depth themselves and what is being communicated by the children, so they can think and work more independently and give the young people and themselves the best outcomes possible.

Journal entry 24th March 2007

*When considering the huge task that writing a dissertation would be for me I avoided it under the pretence that I was still not good enough to compile something so academic.*

*During the process of writing I began to understand what to do more and the task became more manageable. Then I had a revelation that I had to let go of the past and not hold onto the fact that had dyslexia and that's the way I am. More like the fact I am overcoming the disability and the emotional aspect linked to it, if I want to move into my new role I feel that I am having to leave it behind and look to a more professional future with no links to the past.*

By overcoming my areas of insecurity to complete the course and be able to have the confidence to apply the principles to my day to day practice was only possible by the ability of the lecturers to facilitate a safe secure holding environment where we as students could understand, grow and develop as people and as professionals. Being part of such an experience was the only way to gain trust in the process that this type of work can assist people overcome great difficulty.

<u>Bibliography</u>

Alston, M & Bowles, W (1998), *Research for social workers: an introduction to methods*, Austrailia: Allen & Unwin.

Banks, S (2001), *Ethics and Values in Social Work* 2nd ed, Basingstoke: Palgrave.

Bettelheim. B (1950) *Love is Not Enough New*York : Free Press

Bowlby. J (1973) *Attachment and loss, volume 2 Separation*: Pimlico

Bradley, C. in Trowell, J. & Bower, M: Edited by (1995), *The Emotional Needs of Young Children and Their Families: Using Psychanalytic Ideas in the Community*, London: Routledge.

Campling, P & Haigh, R. (1999), Therapeutic Communities: Past, Present and Future, London: Jessica Kingsley.

Carter, J. The Meaning of Good Experience cited in Ward (2001) *Therapeutic Communities for Children and Young People*. London: Jessica Kingsley

Challender - Hardwick, A. & Woodhead, J. (1999), *Loving, Hating & Survival*, Aldershot: Ashgate.

Cairns, K. (2002), *Attachment, trauma and resilience, Therapeutic caring for children*, London: BAAF

Clough, R. (2000), *The practice of residential work*, Basingstoke: MacMillan Press.

Davis, M. & Wallbridge, D. (1981) *Boundary and Space : an introduction to the work of D.W. Winnicott.* Karnac Books.

Dockar-Drysdale, B (1994), *Therapy in Child Care*, Free: Papers on Residential Work, Vol.3, London: Longman.

Dockar-Drysdale, B. (1983) *Therapy and Consultation in Child Care*, Free Association Books.

Dockar-Drysdale, B (1990), *The Provision of Primary Experience*, Free Association Books.

Hardwick, A. & Woodhead, J. (1999), *Loving, Hating & Survival*, Aldershot: Ashgate.

Halton, W. - Obholzer, A. & Roberts, V.Z.: Edited by (1994), *The Unconscious at Work, Individual and organisational stress in the human services*, London: Routledge.

Hinshelwood, R.D. & Manning, N. (1979), *Therapeutic Communities*, *Reflections and Progress*, London: Routledge & Paul Kegan.

Hinshelwood, R.D. & Manning, N. (2001), *Thinking About Institutions*, *Milieux and Madness*, London: Jessica Kingsley.

Hinshelwood, R.D. & Skogstad, W. (2000), *Observing Organisations: Anxiety, defence and culture in health care*, London: Routledge.

Holloway, I. (1997), *Basic Concepts for Qualitative Research*, Oxford: Blackwell.

Howe, D. (1995) *Attachment Theory for Social Work Practice*, Basingstoke; Palgrave.

Hunter, M. (2001) *Psychotherapy with young people in care: Lost and found*, Hove; Brunner Routledge.

Kennard, D. & Roberts, J. (1983) *An Introduction to Therapeutic Communities*, London: Routledge & Kegan Paul.

Mattinson, J. (1975) *The Reflection Process in Casework Supervision*, London; IMS.

Mason, J. (1996) *Qualitative Researching*, London: Sage.

McMahon, L. (1995) *Developing skills in therapeutic communication in daily living with emotionally disturbed children and young people,* Journal of Social Work Practice: 9, 2, 199-244.

McMahon, L., Adams, M., & Best, D. (1998) *Intuition is Not Enough: Reflective enquiry as a method of research in therapeutic child care*, Chapter 13, Unpublished chapter.

McMahon, L & Farnfield, S (2004), *Too close in or too far out –learning to hold the role of observer: tutors introduction to a social work students reflections on her experience of learning through child observation, Journal of Social Work Practice*.

Meinrath, M. & Roberts, J.P. (1982), *On being a good enough Staff Member*, International Journal of Therapeutic Communities, 3 (1).

Menzies-Lyth, I. (1988) *Containing Anxiety in Institutions* Vol 1, London: Free Association.

Miller, E.J. (1993) *From dependency to autonomy, Studies in organisation and change*, London: Free Association.

Obholzer, A. & Roberts, V.Z.: Edited by (1994) *The Unconscious at Work, Individual and organisational stress in the human services*, London: Routledge.

Rycroft,C. (1995) *Critical dictionary of psychoanalysis, Second edition: Penguin reference*

Shohet, R. in Hardwick, A. & Woodhead, J. (1999), *Loving, Hating & Survival*, Aldershot: Ashgate.

Stokes, J. in Obholzer, A. & Roberts, V.Z.: Edited by (1994), *The Unconscious at Work, Individual and organisational stress in the human services*, London: Routledge.

Ward, A, Kasinski, K, Pooley, J, & Worthington, A (eds 2003), *Therapeutic Communities for Children and Young People*, London: Jessica Kingsley.

Ward, A & McMahon, L (1998), *Intuition is Not Enough, matching learning with practice in therapeutic childcare*, London: Routledge.

Winnicot.D.W, in Davis, M. and Wallbridge, D. *Boundary and Space: Introduction to the Work of D.W. Winnicott*, London:Karnac

Schön, D. A. (1983) *The Reflective Practitioner: How professionals think in action*. London: Temple Smith