

# The Taboo of Love for children in care: its emergence through the transference relationship and in the system around the child

**Angela Evans**

## **Abstract**

This paper explores the taboo of love for children in care. A taboo is a social custom setting a thing apart, prohibiting association with a person, place, or thing (Oxford English Dictionary 2012). Love can become a taboo for children in care, something that they unconsciously forbid themselves from experiencing due to fears of further loss and pain. It can also become a taboo for many adults working with traumatised young people. The author, a Child and Adolescent Psychotherapist, presents her work with individual children and with the network of adults around them. She proposes that love is not a central theme in the care system, despite its direct relevance to children who have not experienced adequate love in crucial developmental months and years. The implication of this proposition is that unloved children are at risk of remaining unloved within the care system. The application of this to professional practice is immense. The author calls for more support for professionals to perform their vital work in promoting a loving approach in the system.

## **Keywords:**

Love, care, developmental trauma, idealisation, transference, loss, fear, containment, countertransference

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## **Corresponding author:**

Angela Evans, [angela.evans100@gmail.com](mailto:angela.evans100@gmail.com)

## Introduction

This paper highlights the need for children and young people in foster care (all of whom have developmental trauma as evidenced in the Department of Education statistics 2017) to have life changing experiences to help them to recover and to find love.

Love is fundamental to human existence. Each child brought up in a 'normal' loving family has an experience from birth of being noticed and loved by parents who themselves are experiencing intense loving emotions, which are conveyed to the infant through their behaviours, their voices, their gazes and their attentiveness. The parents will also have conflicting feelings but, with resilience and with support, they generally manage these. This is how love grows, and by the time the infant approaches the end of his or her first year, s/he has an awareness of being in a loving relationship before having a verbal understanding of it.

Bowlby (1952, p.59), the founder of attachment theory, stated that:

'maternal care in infancy and early childhood is essential for mental health. This is a discovery comparable in magnitude to that of the role of vitamins in physical health.'

Sixty years after Bowlby, Rutter et al (2003-2009) followed a group of 165 Romanian orphans adopted in Britain to test to what extent good care could make up for poor early experiences in institutions. All the orphans had developmental trauma, where the trauma happens during critical early development and impacts on it (Herman 1992). One of their ground-breaking findings was that the lack of love in infancy for these orphans *had a bigger impact on development than the infants' physical neglect*.

It is clear therefore that traumatised children and young people in foster care need life changing experiences both internally, through therapeutic processes, and externally, by being cared for and supported by adults who can understand the enormous barriers these young people have against love. Internally, these

children and young people did not have an early experience of being in a good enough loving, reciprocal relationship, and more likely suffered abuse, neglect and/or trauma (Department of Education statistics 2017). This leads to an internal belief that they are in some way bad, that adults are not to be trusted and that the world is a dangerous place (Bowlby 1969). Love does not feature in this internal belief system. The external systems around them often consist of adults who inadvertently become pulled in to a toxic mix of rejection, fear and anger.

Those adults in turn need therapeutic support to recognise and process the profound and frightening emotions that can be evoked in them as carers and providers. Unless this happens, love – which is fundamental to human existence – remains unknown or hidden by rage.

## **The Team around the Child**

Many children in care with developmental trauma have, at best, a compromised experience of love. Winnicott (1971) expressed the idea that the first mirror through which the infant can verify his existence is the mother's face. We might say that this is the first experience of love that the infant has as he learns that he exists within an interpersonal relationship, and that he experiences the deepest interpersonal affection with his mother (Stern, 1977, 1985). Many of the children and young people I have worked with did not have that experience. Both parents suffered from a combination of mental illness, drug and/or alcohol abuse, and their fathers were often absent or violent.

Even if love is known, it is a concept that can be very confusing. Sexual desire and a need for power and control can be expressed in the guise of love, or even alongside love. I worked with a young man whose mentally ill and sadistic father had ritually sexually and physically abused him and his siblings every morning. After the ritual of abuse, he would hug them and read to them. The young man I worked with was in a frozen state, obsessed with computer games, unattached to his foster carers and even to his siblings. Love and filial affection for him equated with pain and terror.

The Looked After Child and Adolescent Mental Health service I worked in for fifteen years functioned together as a close, multi-disciplinary team. The task for such a team is to gradually introduce the concept of love to traumatised children and to help them to process the many confusing experiences they have had. This NHS team consisted of clinical psychologists, family therapists, specialist nurses, and child and adolescent psychotherapists, the last of which was my role. We held regular meetings and reviews with social workers, foster carers, key workers, Special Educational Needs Co-ordinators, virtual school teachers<sup>1</sup> and any other involved professionals. The most successful interventions were unequivocally those where the network around the child consisted of strong and reflective professionals who could communicate well with each other and with the child.

The part that each professional plays within the network can involve being the recipient of an enormous amount of negativity:

1. The foster carer/key worker needs to provide not just food and shelter but also availability, regularity and dependability, all of which are needed for the growth of love. This is often in the face of acute rejection from their foster child and, in some cases, verbal and physical attacks on family members.
2. The social worker is crucial in guiding and containing not just the child, who may feel angry about decisions made, but also the foster carer/key worker with the day to day challenge of negativity.
3. The teacher provides containment, encouragement, boundaries and social opportunities in schools, often in the face of angry, confronting behaviour.
4. Specialist teachers liaise with other professionals and provide extra support; they are at risk of being seen by other staff as being equated with these troublesome children, and can experience a sense of isolation in schools, making their already challenging task even more so (Evans 2013).

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<sup>1</sup> Virtual schools work for the benefit of children in care, providing a head teacher to oversee the work and teachers to visit schools with a view to directly helping the children in their education.

5. The task of the child and adolescent psychotherapist is to help the growth of love through containment, attention to detail, and working closely with social workers, foster carers, key workers and teachers with a view to modifying the impact of the trauma. The therapist absorbs the terrifying processes of transference (see next paragraph) and acting out. This therapeutic process can be invaluable and life-changing for so many children and young people, as I have experienced many times throughout my work.

Central to the psychotherapeutic process is the transference relationship, in which the client can transfer earlier, infantile relationships onto the therapist and rework them through the therapeutic relationship (Freud 1905). The client experiences vulnerability, which needs to be supported by the therapeutic boundaries of time and room, and by the regularity, predictability and availability of the therapist. It can be a slow process. I was interested to read a short article in *The Guardian Weekend* magazine (2018) where transference is discussed in the context of the writer falling in love with her therapist. She writes about the loss of her therapist together with her gratitude as the therapy came to an end, after only twelve sessions. I was struck by the emotional healthiness of the writer, how much she processed during those twelve weeks.

In contrast, for children in care the development of the transference relationship is delicate and at times may feel dangerous; even the first stirrings of love often also come with overwhelmingly negative emotions. Love is a taboo internally, not to be thought about, let alone talked about.

As well as needing a strong network, my most successful work with traumatised children has been that which was long term – lasting two or more years. Policy makers find this concept difficult because it is costly, but the processes a traumatised child must endure to begin reaching the kind of emotions expressed by the *Guardian* writer are long and complex. The child in care slowly and laboriously experiences a growth of love through this enduring therapeutic relationship, alongside adequate containment in the home and school.

Typically, this growth of love might be traced through the following therapeutic processes, which fall into three phases:

1. Love is awakened, often by the therapist becoming intensely interested in the child. Children who have lacked any sense of an interpersonal relationship, and who have no or very little experience of lighting up a parent's face, need their capacity to love aroused; they have been unloved and are not interested in it until they can begin to experience being genuinely delighted in and adored.
2. Hatred and intensely negative emotions are acted out with the therapist. Winnicott (1947) wrote about the vital importance of hate in the countertransference<sup>2</sup> when working with traumatised and ill patients. He put forward the reality of the therapist hating their patient who gives them such a difficult time week after week. I have had many patients who I have not wanted to see, as they act out cruel games with the toys, often wanting me to play the part of an abusing parent, or to be the child who is being shouted at and treated cruelly. Or they ignore me and treat me with contempt. In these circumstances, it can become extremely hard to retain one's power of thinking whilst feeling.
3. An idealisation process will often come about in the transference relationship. Alvarez (2012) speaks of idealisation as a development sooner than as a hindrance. Infants need to idealise their primary caregiver, as this gives them a sense of protection and security. The reunion of secure infants and their parents is like the reunion of long-lost lovers. Alvarez refers to seriously deprived children as not having had an opportunity to experience that delight, both to receive it and to bring about such love in another. They need to go through this idealisation process before being able to reach a normal loving relationship.

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<sup>2</sup> Countertransference is a process whereby the therapist experiences the client's feelings as if they are his or her own (Freud 1910)

Lanyado (2017, p.209) talks of attending to the first tiny green shoots of new developmental growth within a therapeutic relationship with fostered and adopted children. She states that:

'these small changes in the child can grow and expand across the developmental spectrum: emotionally in the growth of new loving and trusting relationships: in the dawning of a capacity to mourn the life that went wrong and to appreciate the life that can now be lived.'

I will bring to life these three processes of the growth of love in the following presentation of Tanya, where I focus mainly on the clinical work in the room between us, initially with the key worker, then individually, alongside meeting with the social worker and the personal tutor. This is an example of the value and essential nature of multi-disciplinary work together with clinical work in the therapy room.

## **The Taboo of Love in Traumatized Children's Inner Worlds**

The therapeutic journey with Tanya depicts how she began to make a slow and painful move towards love whilst in weekly psychoanalytic psychotherapy. It also depicts how negative emotions in adults who care for traumatized children can be mitigated against with careful and empathic therapeutic work in the system.

### **Tanya**

#### **Background**

Tanya<sup>3</sup>, of Bulgarian origin, was a thirteen-year-old girl when I first met her. She had been referred to me by a children's residential unit, which she had recently joined, because she had had numerous placement breakdowns.

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<sup>3</sup> Name anonymised and some details are a composite of several cases for confidentiality

Tanya's birth parents abused drugs and alcohol and there was domestic violence. When Tanya was ten years old, her mother left her and her younger siblings in the care of her sexually abusing step-father. Tanya eventually told a friend's parent that she had been sexually abused since the age of five. She disclosed this information because she was scared that she could no longer keep the younger siblings safe from abuse. This led to the children all being taken into care. It emerged during the four years of therapy, as she began to disclose her past abuse, that Tanya had also been physically abused by her mother and step-father. Her limbs had been broken; she and her siblings had been locked in dark cupboards and frequently starved.

Tanya's three younger siblings were adopted and Tanya was put into foster care as she was too old for adoption. In summary, at ten years old, Tanya was removed from the children she had mothered and from her step-father, some of which was a huge relief but most of which she experienced as confusing and cruel. She was suddenly alone when she went into care, although towards the end of her therapy with me, she told me she had always felt completely alone for as long as she could remember.

### **Reason for Referral**

Tanya was referred to me because she was showing increased aggression in the residential unit, and rejection of Lynn, her key worker to whom she had previously been close, albeit on her own terms. She became increasingly challenging in the school provided by the unit. The thinking in the residential unit and school was that Tanya was of an age where she was wanting to make sense of her identity, and that she had a yearning to reconnect with her birth family. Tanya had had no contact with her birth mother since she had abandoned Tanya to her abuser; her whereabouts were unknown. Tanya would often tell staff that she had seen her mother and sister while shopping, and that they had given her a big hug. Her fantasy world brought her comfort but, as she turned to it, she turned away from her other supportive adults. I agreed to assess Tanya, which involved seeing her for some individual sessions, visiting her at school and reading relevant documentation.



## **Forsaken child**

When I first met Tanya in her school I was struck by her hard smile, which looked false, with eyes that didn't match it. I thought about Winnicott's false self (1965) where a defensive self is erected, hiding the more vulnerable self. Tanya was described as a loving and affectionate girl, but her eyes told me something of her cold, hard defensiveness.

During the five individual assessment sessions, Tanya made sand trays of Jesus on a cross on a mound, surrounded by babies who were looked after by an alien. Tanya said she was a baby, but that the alien looked after her. I was struck by the projections of parts of Tanya's self into this sand world; parts that felt crucified, alone and forsaken. She was the baby being looked after by aliens (her two parents); she was the small child trying to do the alien job of looking after three smaller siblings; she was identifying with Jesus on the cross who cried out, 'My God, why hast thou forsaken me?' (New Testament).

## **Next Steps**

After the assessment I met with the network, which consisted of keyworker Lynn, social worker Mark, personal tutor Carrie and myself.<sup>4</sup> This meeting was a good opportunity for me to share my observations with the people who knew Tanya well, and for them to link these observations with what they saw and experienced in their different roles. At the end of the meeting we all had a shared picture of Tanya. Given Tanya's background of adults who had fought, broken her trust, abused her and abandoned her, we agreed that it was crucial that she experience a team around her who could work closely together therapeutically.

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<sup>4</sup> Names anonymised for confidentiality

## **Working with Tanya and Lynn – bringing about loving feelings**

It seemed important, initially, to try to work with Tanya and her keyworker Lynn together, to observe their attachment to each other and to help Lynn to manage Tanya's rejection and aggression. After the first few sessions Tanya told us both about her mother being a victim of her husband, the cruel stepfather whom Tanya referred to as 'it'. The blame was all put on him, which was understandable, but it was a convenient platform from which Tanya could deny any responsibility by her mother. This is not unusual. It is a common phenomenon for traumatised children in care to yearn for their birth parents, compelled to keep holding on to the lost, precious, first relationship, however terrifying, disappointing and confusing it may have been (Durban 2017).

In the initial sessions with Lynn and Tanya, it felt as though Tanya was not able to relate to a therapist and keyworker who wanted to relate to her and think about her together. Lynn's role was that of real-life mother, as opposed to the fantasy mother, and she was in the position of being constantly rejected by Tanya with almost everything she said in the sessions. After perseverance, with Lynn tolerating being ignored in the sessions, and Tanya attempting to divide us in the room, Lynn and I managed to hold a safe space for Tanya where we presented as a thinking couple working together with her. Tanya began to use drawing pads and pens to illustrate for us some poignant emotions towards her mother, culminating in a card she wrote for mother with a message inside saying that she knew she might not even see her again, but that she would always love her. Tanya was beginning to access some grieving for her mother and for her history. She began to accept Lynn's empathy in the sessions, although Lynn had to be careful not to get too close.

## **Processing the hatred to reach the love**

A year into the work, Tanya began to challenge me more than Lynn in the sessions. She ignored me or was verbally aggressive. On one occasion, she threatened to break the glass doors in the therapy room with a crystal, one that she had always admired and loved in therapy.

She stared through me, menacing, holding the crystal up, ready to throw hard. I held her gaze, trying to see the hurt child underneath and trying desperately to put to one side my fear and anger. She looked over at Lynn, who also held her gaze, calmly and quietly. Finally, she put it down, and swore heavily at me instead. (Session 41)

I was beginning to dread Tanya's arrival, wishing she would just go away and that I could end therapy with her; at the same time I was moved by her and awaited each session with a sense of anxious anticipation. Strong elements of hatred and love were entering our therapeutic relationship. Tanya was experiencing something of the world of a healthy infant, who can feel delight in her mother's presence alongside her rage towards her (Alvarez 2012). From the early stirrings and discoverings of being seen and noticed, Tanya was now able to express her hatred and envy of my therapy room by threatening to attack it with her 'loved' crystal. The therapy room and the crystal both represented me, possessing all the goodness, which Tanya simultaneously envied and loved (Klein 1946).

### **Reviewing the work**

When we met again as a team, Lynn reported an improved relationship with Tanya. Carrie, her personal tutor, reported that things were still difficult at school and that Tanya's academic work was not going well. Mark, the social worker, had heard from an older half-sister of Tanya's who wanted contact with her. We agreed that Tanya and I would move into individual therapy, as her relationship with Lynn had improved but there were still clearly some powerful emotions that needed to be worked through in a therapeutic relationship, and this processing would inform us when Tanya might be ready to see her half-sister.

## **Absorbing the terrifying emotions**

For the first year of this individual work, I continued to feel simultaneous dread and excitement about Tanya's arrival, as she continued to let me experience her intense polarised feelings. Every week on arrival, she stood at the door with her back to me and her arms folded, telling me she didn't 'f---ing like therapy' and that she was only there because staff made her go. My emotions ricocheted between despair, anger and confusion. These powerful countertransference responses were undoubtedly Tanya's experiences and those of her carers. She was, at times, loving and wanting to reach out to me, whilst simultaneously feeling intense despair, confusion and hatred.

Staff support was essential to keep Tanya coming to therapy through this period, and to support me in the form of regular meetings with the network. At times, I was tempted to stop the therapy, but staff encouraged me to keep it going, coming up with ideas to support it. I could have re-enacted Tanya's mother walking out on her, had it not been for the staff support, the loving holding of me in my work.

## **Reaching beyond the abuser and the abused – green shoots of love**

Rustin points to many traumatised children trying to please adults in a way that they think could be loving, with no real knowledge of love. There can be an 'identification with the aggressor, confusions about intimacy, idealisation of perversity' (Rustin 2006, p 109). Tanya's sexual abuse featured throughout this part of the treatment. There were many times when I felt that Tanya was unconsciously testing me to see how much she could trust me not to be an abusing adult.

Tanya said she would show me her latest dance. She put on her music and adopted a dance pose, looking directly at me. At an opening loud beat, she began to move her hips seductively from side to side, then fell onto the floor, raising a leg high into the

air. She jumped up and wiggled her top half, grinning at me cheekily with big eyes. I felt very protective towards her and was aware of how much she seemed to want me to adore her, like an adoring mum at her daughter's first dance show. At the same time, I felt as if I was being tested. She seemed to be trying to seduce me into looking at her body in a sexual way. I felt like I was on show instead of Tanya. She was watching my every move. (Session 53)

I believe that part of what was happening internally for Tanya as she danced for me was her 'coming alive for me', compelling me to gaze at her, and watching my every move to make sure I kept looking. Winnicott's (1971) idea of the mother's face being the mirror for the infant was powerfully in the room. Her experience was akin to that of an infant realising that she is important to her mother and that she matters. This seemed to be the first 'green shoots' of love stirring in the transference relationship. I could gaze at her with an alive interest (Alvarez 2012) without my gaze becoming that of an abuser.

At other times I felt as if I was being subjected to having pornographic material thrust on me, without my consent and beyond my control, as little Tanya would have felt. This was a powerful projection of her experience of sexual abuse. Sex and love often become confused for abused children and young people, which impacts significantly on their future relationships.

### **Working with the network – managing challenging feelings**

As my individual work progressed, the meetings with the network increased to every six weeks. If someone couldn't attend, they phoned into the meeting. At this time, I shared some psycho-education on how our brains work (Siegel YouTube video clips) and we discussed projective processes.

Carrie was still struggling with Tanya at school and I agreed to meet monthly individually with Carrie for a while. During these meetings, Carrie shared with me her feelings of 'blocked care' (Hughes and Baylin 2012) for Tanya. A sense of

exhaustion seemed to emanate from her; she was an empathic tutor but found Tanya's seductive and manipulative 'tactics' with other young people in school very challenging. As I contained these emotions for Carrie, we reached a stage where she could think about my suggestions to be more playful, accepting, curious and empathic with Tanya.<sup>5</sup> As Carrie felt more held, so she could make Tanya feel more held and loved.

### **Can I be loved for myself?**

In our final sessions, having worked for several months on the ending of therapy, Tanya finally outpoured to me her feelings around the abuse and neglect. She had found a coherent narrative.

Around the last few sessions, Tanya said to me, 'I think we should give you wings so you can be an angel. You'd make a great angel.' She seemed to be entering the beginning of an idealisation process with me as the idealised, and her as someone who could express her feelings to me with a trust that they wouldn't be rejected or denigrated, but would be received with gratitude. This idealisation felt to me like a very necessary development, that both touched me and intensified loving feelings in the therapeutic relationship.

During the last session, Tanya was unable to talk about her feelings towards me but spent most of her time making a card whilst talking to me. She thrust it into my hand ten minutes from the end. Inside, she had written, 'Thank you my lovely you for everything.' When I explored the message with her, Tanya said I had just stayed with her. I hadn't left her even though she had been 'such a bitch'. She had told me previously that her mother had left her because Tanya had been a 'bitch' child. Rustin (2006) points to possible anxieties about being such a bad child that affectionate, loving feelings cannot be elicited in the birth mother.

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<sup>5</sup> PACE approach, where P is playful, A is accepting, C is curious and E is empathic, aimed at helping adults to bond with traumatised children and young people (Dan Hughes 2011).

Winterson, a writer and speaker who was herself adopted, wrote that when you have experienced severe trauma as a child, it is 'impossible to believe that anyone loves you for yourself' (2011, p.7). Tanya had not believed that anyone could love her for herself. Her internal view was that she was a 'bitch' and drove everybody away. I think that in the card, Tanya was saying that she was perhaps just beginning to believe that she could be loved for herself, and that she had reached a sense of gratitude which is so much a part of love (Klein 1946).

At this time, Tanya's behaviour and her relationships with others were improving, both in the residential unit and at school. She was more regulated in her emotions. Successful contact was arranged between her and her half-sister. She went on to form a more lasting relationship with a young man. It was not the healthiest relationship, with elements of co-dependence, but they claimed to love each other.

## **Discussion - The Taboo of Love in the Care System**

Keys (2017, p.37) promotes the view that having a theory of loving in therapeutic relationships helps to 'ensure the highest standards of professional accountability in a culture of suspicion and surveillance'. This is sadly contrary to the reality of what happens in many care systems around vulnerable children and young people. Indeed, it is because of the culture of suspicion and surveillance that many adults working with traumatised young people feel that love, and even talking about love, is taboo. Additionally, there are powerful emotions that drive love into a taboo state. I have focused on two of them. One is loss: to protect everyone against intense loss, love is avoided as a concept and as a reality in the care system. The second is fear: this is linked to our culture of suspicion and surveillance and is powerfully projected from fearful children into the system around them.

## Loss

The complex and seemingly irreversible inner experiences of traumatised young people impact on all adults around them. When met with adults who cannot reach out to them in a 'live' way (Alvarez 1992), these young people are unlikely to form new bonds where love can grow within a trusting relationship.

Love involves risk; it comes with negative emotions as well as positive ones. Normal loving parents are familiar with the emotions of sorrow, guilt and anxiety that are experienced alongside an intense love for their child. Many children in care cannot begin to understand what love is unless their new carers take the risk of 'falling in love' with them. The paradox is that foster carers will often unconsciously, and even consciously, avoid 'falling in love', to protect themselves and their foster children against the extreme pain of taking a child into their hearts when there is a possibility of losing him or her. Foster carers who do manage to take that risk will often be met by children and young people who cannot bear to be loved, who will reject them. The children are wary of love and so are the foster carers.

Klein (1935) summarised the growth of love as happening when the developing infant becomes aware that his mother can leave him. By this, Klein meant that when we really 'fall in love' with someone we become acutely aware that we could lose them. This helps us understand why many traumatised children in care hide loving feelings behind those of hate. It is easier to hate than to experience loving someone and subsequently suffer the unbearable pain of losing them. Sadly, many children and young people in the care system experience such losses repeatedly, leading to the avoidance of loving feelings by them and their foster carers.

Boswell and Cudmore (2017, p.248) wrote about their research into children who move from foster care to adoption. They found that during the two-week transition from the foster family to the adoptive family, it was hard for the foster carers and social workers to remain fully in touch with the children's emotional state and the fact that, in addition to making a new relationship with adoptive



parents, they would also need to grieve the loss of a loved foster carer. Yet it was clear that the foster carers were experiencing a lot of pain. When interviewed, one carer said:

It doesn't give you any time to think and re-adjust. I found it difficult. Maybe I'm just – you know, there's love involved.

Foster carers and adopters appeared to manage many of these difficult feelings by subtly changing their use of language, which became more procedural and less personal. In reading this research, I was struck by how love gets forgotten as the loss around it is so painful. The children are not given an opportunity to adequately process the feelings of sorrow, guilt and anxiety that they undoubtedly experience. It seems to me that the pain of potential loss is experienced so hugely by children, carers and social workers alike, that without emotional support to process each child's move from foster care into adoption, they could not possibly manage to be in touch with the rawness of the emotions involved.

## **Fear**

During my years of working with foster carers I have seen a pre-occupation with feelings of fear. This is partly due to their over-interpretation of guidelines, which is undoubtedly driven by anxiety. For example, when I have talked about the importance of creating close and intimate times with their foster children, carers have regularly responded fearfully: they wouldn't cuddle up too close to their children because of the risk of being accused of inappropriately touching them; they couldn't speak of loving their foster children, for fear of creating a lie in case they had to move on.

Another source of fear comes from children's backgrounds. Children in care often come from such violence and terror in their birth families that professionals are understandably afraid of what they will bring with them. They are especially afraid that they will see the violence emerge in the foster child.

Fear infantilises people, stops them thinking and promotes unregulated reactions. One child I worked with who had a history of witnessing extreme domestic violence fought regularly with her younger sister. One time she lashed out at her sister with particular force when provoked, hitting her and kicking her to the ground. The carers called the police instead of pulling her off and restraining her. Their three-year relationship with the child ended abruptly, as they asked for her to be removed immediately. In that attack, she had become to them a scary, unknown child instead of the girl of whom, despite her problems, they had grown so fond. Their reaction had allowed no room for repairing what had happened.

I believe that fear is projected from traumatised children and young people into the system. When infants and young children are abused and neglected, their destructive impulses are greater than loving impulses, and they fear their destructive powers. When coming into care, they need foster carers who can 'contain' these impulses.<sup>6</sup> In a 'normal' loving family, it is hard enough, at times, to contain a screaming infant. The power of the destructive impulses of some traumatised children and young people is so great that they need an entire network of containing adults around them, containing not just the children but also each other. Winterson (2011, p.34-35) commented that: 'In therapy, the therapist acts as a container for what we daren't let out, because it is so scary, or what lets itself out every so often, and lays waste to our lives.'

It takes time to contain adults working with traumatised young people, and it takes time to contain the young people; there is no quick fix.

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<sup>6</sup> Containment here refers to the mother's capacity to act as a container for the infant's projections of anxiety about their destructive impulses, to make sense of them, to transform them and to return them to the infant in a more thought about and acceptable form. Bion (1962)

## Conclusion

In 2017, Scottish First Minister Nicola Sturgeon ordered an Independent Care Review intended to improve quality of life and outcomes for young people in care. She stated that:

"The care system must and can do better by our most vulnerable children and young people. They need to know they are loved and feel cared for - this review is not about determining if this can be achieved, but how we create a system that puts love for the children it cares for at its heart."

I have attempted in this paper to outline the complexities of human dynamics and processes that surround Nicola Sturgeon's laudable aim. To reach loving feelings, children and young people with developmental trauma need to work through hatred and love in therapy, and they need adults who care for them to help them to know and accept love by overcoming their barriers against it.

Those adults need support to recognise and process the profound and frightening emotions that can be evoked in them as carers and providers. Work with children and young people with developmental trauma takes time and resources. Close liaison and joint support between professionals is needed to even begin to reach the lifelessness, the hatred and the confusion. Yet such work is surely essential to reach feelings of love.

Winterson (2011, p.76-77) wrote aptly about the unreliability of love, 'When love is unreliable and you are a child, you assume that it is the nature of love – its quality – to be unreliable... I had no idea that love could be as reliable as the sun. The daily rising of love.' Our aim, as professionals around vulnerable children and young people in the care system, should be for them to know the reliability of love, and to believe that it is their human right to receive it. We have not yet achieved that aim, despite the many excellent workers in the field. It is my view that policy makers need to be more aware of the extremely complex and powerful work involved, so that they can support it more. If professionals in these vital roles are adequately funded and supported in their very challenging work, their endeavours can come together to provide a nurturing environment for the child at home, at school and in the community.

Rumi, a 13<sup>th</sup> century Persian poet and Sufi mystic, expressed perhaps something of the journey of children in care, and of the adult help they need, when he wrote:

Your task is not to seek for love, but merely to seek and find all the barriers within yourself that you have built against it.

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## **About the author**

Dr Angela Evans is a Child and Adolescent Psychoanalytic Psychotherapist in independent practice. She has fifteen years' experience in NHS Child and Family Mental Health Services, trained at the Tavistock Clinic in London and is a member of the Association of Child Psychotherapists. Her training followed fifteen years of professional teaching practice, which included work as a Special Educational Needs Co-ordinator (SENCo).

Dr Evans specialises in working with children and young people with developmental trauma. She consults to other professionals and offers training in schools and care organisations. She has conducted research into the impact of trauma on SENCos working with vulnerable children and young people in schools.

## **References**

Alvarez, A. (1992) *Live Company: Psychoanalytic psychotherapy with autistic, borderline, deprived and abused children*. Routledge.

Alvarez, A. (2012) *The Thinking Heart: Three Levels of psychoanalytic therapy with disturbed children*. Routledge.

Bion, W.R. (1962) *Learning from Experience*. Karnac Books Ltd.

Boswell, S. and Cudmore, L. (2017) Understanding the 'blind spot' when children move from foster care into adoption. *Journal of Child Psychotherapy*, 43(2) pp.247-248. Routledge

Bowlby, J. (1952) *Maternal Care and Mental Health: a report prepared on behalf of the World Health Organisation as a contribution to the United Nations programme for the welfare of homeless children*. World Health Organisation. Chapter 6: p.59.

Bowlby, J. (1969) *Attachment. Attachment and Loss: Volume 1. Loss*. New York: Basic Books.

Department for Education (2017) *Children looked after in England (including adoption) year ending 31 March 2017*. National Statistics, reference SFR 50/2017, 28th September 2017.

Durban, J. (2017) Home, homelessness and nowhere-ness in early infancy. *Journal of Child Psychotherapy* 43(2), pp.175-191. Routledge.

Evans, A. (2013) From exclusion to inclusion; supporting Special Educational Needs Co-ordinators to keep children in mainstream education: a qualitative psychoanalytic research project. *Journal of Child Psychotherapy* 39(3) pp.286-302. Routledge.

Freud, S. (1905) Fragment of an analysis of a case of hysteria (Dora), *Case Histories 1*, Standard Edition V11. London: Hogarth Press and Institute of Psycho-Analysis (1953)

Freud, S. (1910) *The Future Prospects of Psychoanalytic Therapy*. Standard Edition 11. London: Hogarth Press and Institute of Psycho-Analysis (1953)

Guardian Weekend magazine, Family section. 25th August 2018.

Herman, J. (1992) *Trauma and Recovery*. Basic Books.

Hughes, D.A. (2011) *Attachment-Focused Family Therapy Workbook*. W.W. Norton & Company.

Hughes, D.A. and Baylin, J (2012) *Brain-based Parenting: the neuroscience of caregiving for healthy attachment*. W.W. Norton and Company. New York; London.

Keys, S. (2017) *Where is the Love in Counselling?* *Therapy Today* Vol.28(10), pp.35-38. BACP. Think Publishing.

Klein, M. (1935) *A Contribution to the Psychogenesis of Manic-Depressive States*. The International Psycho-Analytical Library No. 103. Hogarth Press and the Institute of Psycho-Analysis.

Klein, M. (1946) *Notes on some Schizoid Mechanisms. Envy and Gratitude and Other Works 1946-1963*. Vintage Books 1997.

Lanyado, M. (2017) *Putting down roots: the significance of technical adaptations in the therapeutic process with fostered and adopted children*. *Journal of Child Psychotherapy* 43(2), pp.208-222. Routledge.

*New Testament: English Standard Version*. Harper Collins Publishers 2002.

*Oxford English Dictionary* (2012) 7th Edition. Oxford University Press.

Rumi (circa 1230) *The Works of Shams of Tabriz* quoted in *BBC World Service: learning English: Moving Words*. Retrieved from [www.bbc.co.uk](http://www.bbc.co.uk)

Rustin, M. (2006) *Where do I belong? Dilemmas for children and adolescents who have been adopted or brought up in long-term foster care*. In *Creating New Families: Therapeutic Approaches to Fostering, Adoption and Kinship Care*. Tavistock Clinic Series.

Rutter, M. Beckett, C. Castle, J. Kreppner, J. Stevens, S. and Sonuga-Burke, E. (2009) *Policy and Practice Implications from the English and Romanian Adoptees (ERA) Study: Forty-Five Key Questions*. British Association for Adoption and Fostering (BAAF).

Siegel, D. YouTube videos – *Connecting to Calm* (2012); *Flipping Your Lid* (2012); *Name it to Tame it* (2014).

Siegel, D. and Payne Bryson, T. (2011) *The Whole-Brain Child*. Random House Publishing Group.

Stern, D.N. (1977) *The First Relationship*. Cambridge: Harvard University Press.

Stern, D.N. (1985) *The Interpersonal World of the Infant*. Basic Books.

Sturgeon, N. (2017) SNP Conference Speech, Glasgow. Retrieved from <https://www.bbc.co.uk/news/uk-scotland-scotland-politics-40100493>

Trevarthen, C. and Aitken, K.J. (2001) Intersubjectivity: research, theory and clinical applications. *Journal of Child Psychology and Psychiatry* 42 (1) pp.3-48. Wiley-Blackwell.

Wikipedia – The Free Encyclopedia. [www.wikipedia.org](http://www.wikipedia.org)

Winnicott, D.W. (1947) Hate in the Countertransference. In *Through Paediatrics to Psychoanalysis Collected Papers*. Karnac Books 1975.

Winnicott, D.W. (1965) 'Ego distortion in terms of true and false self. The Maturational Process and the Facilitating Environment', pp.140–57. In *Studies in the Theory of Emotional Development*. New York: International Universities Press.

Winnicott D.W. (1971) *Playing and Reality*. Tavistock Publications Ltd.

Winterson J. (2011) *Why Be Happy When You Could Be Normal?* Jonathan Cape, London, p 7, 34-35, 76-77.