Reclaiming complexity: Beneath the surface in residential child care.

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Abstract

Residential child care is an inherently distressing and multi-layered endeavour undertaken by staff who are often poorly trained and supported. In addition, the children, and the adults who care for them, can provide a convenient receptacle for the split off negative feelings of professionals, politicians and the public. The complexity and difficulty of this work is often unrecognised and a simplistic response based on a programmatic, behavioural framework, reinforced by performance-based management and an audit culture, is common. This paper argues for the usefulness of a different approach, drawing on psychoanalytic and open systems thinking, to provide a more nuanced understanding of what is happening in these volatile settings that can guide interventions which match the complexity of the work. Alongside advocating the use of key psychoanalytic and systems concepts to improve understanding, it argues for the importance of providing a containing and reflective environment for staff.

Key Words

Residential child care, psychoanalysis, open systems, containment, reflection

Introduction

This paper builds on the experiences from my career in residential child care (Furnivall, 1991). This encompassed direct practice within children's homes and therapeutic communities as well as training, consultancy and research across the UK. I have always been amazed by the transformational power of excellent residential child care in children's lives but I remain appalled by the damage created when well-meaning adults are left untrained, ill-resourced and under-supported in what is effectively the 'intensive care' of children's social work.

The concepts I examine in this paper underpin my own practice and the richness and complexity of this approach match the inherently messy, multi-layered and complicated environment of residential care. The intention is to encourage managers and practitioners to dare to look beneath the surface of behaviour and interactions and to reclaim the complexity inherent in the residential child care task. It highlights the intellectual challenge and emotional impact of the work and argues for the creation of robust mechanisms to enable workers to develop and retain a sophisticated understanding of the task and a deep and warm connection to children. Workers often face psychic and at times physical assault from children (Canham, 2004), but they are also exposed to hostile and conflicting perceptions from external sources that attack their sense of themselves as worthy people (Cooper & Lees, 2015). Existing processes such as performance-based management and the audit culture of regulatory bodies do not provide the developmental support necessary to match the emotional and cognitive difficulty of the task.

Psychodynamic ideas are often viewed with suspicion in residential child care and part of the purpose of this paper is to make the argument for recovering the lost

potential of this approach. The current fascination with neuroscience, attachment and trauma is a welcome shift towards a deeper awareness that simple, surface explanations are inadequate to frame our work with distressed children.

The paper sets out some of the key concepts underpinning the psychodynamic and open systems approach to organisations represented by the Tavistock paradigm[1], and explores their practice implications in the residential child care context. This tradition had a profound influence on the development and practice of children's therapeutic communities in the UK. In these communities there is a commitment to understanding the meaning of behaviour and the impact of the powerful group dynamics inevitably at play in such a complex emotionally charged context. In addition, there is a belief that healing and recovery occur as much in the relationship between residents as in the compensatory care from adults.

Many therapeutic communities, however, have closed or changed beyond recognition; this may reflect the difficulties of engaging with the pain of the work and also of embracing the complexity of this approach. The wider social context of the helping professions has also shifted dramatically, with the erosion of trust and the adoption of neo-liberal management practices that have led to the 'standardising and mechanising of…care' (Boxer, 2015, p.75). As a result, many organisations have adopted more behavioural and programmatic approaches, which focus on measurable outcomes and are underpinned by a deliberate adoption of 'professional' distance. These approaches defend adults against the distress of traumatised children and also insulate organisations from the negative consequences of difficult decisions. This paper argues

[1] This approach is committed to understanding what is occurring beneath the surface for individuals within organisations, as well as examining how the task and structure of organisations and the impact of their external environment interact with this, to affect the success of the enterprise.

that this colludes with the illusion that there is a simple way of supporting children to recover and flourish, frequently fails to improve the experiences of children in care and may indeed have caused additional distress in many cases. As Ruch (2011) argues such approaches 'configure practice as simple and straightforward and involve predominantly surface-level, structural responses to practice shortcomings' which fail to recognise that 'ostensibly 'simple' tasks' such as those involved in providing good basic care for traumatised children 'are complex and emotionally demanding activities' (p.4).

Children who have already experienced serious neglect and trauma deserve an approach that acknowledges that their emotional and behavioural responses have complicated, sometimes unconscious roots. They also need the professionals involved with them to recognise when dysfunctional organisational and societal processes create systems of care that impede, rather than support, their recovery. Psychodynamic and systems theories together provide the rich and complex framework to support this approach. Working in this way, however, creates major emotional and cognitive challenges and it is essential that professionals are provided with appropriate reflective support in their work with children in care.

Key concepts

The terminology associated with this framework can be alienating, though in my experience most residential workers easily recognise the actual processes and dynamics involved. For many readers, such language may be familiar but in this section of the paper I attempt to explain and illustrate five key paired concepts while minimising the use of jargon. Many of the concepts draw on the earliest developmental experiences of infancy or are built on the analytic encounter between

therapist and patient. Nevertheless, these ideas can helpfully inform the work that takes place in residential child care.

Splitting and Projection

Klein (1946) argues that the very young infant experiences powerful and conflicting impulses –love and hatred. The psychic world of the infant is developed through the struggle to manage these intense and violent impulses. Initially the infant does not recognise that the caregiver who relieves his[2] distress and makes him feel good is the same person who at times fails to respond sensitively or in a timely way, leaving him stressed and overwhelmed. Unable to cope with these feelings he projects them into those around him, usually his close caregiver. This serves the double function of expelling these frightening, aggressive feelings and also protecting against the persecutory attack he anticipates from others outside himself[3]. As the infant recognises that the split object he experiences as either wholly good or wholly bad is actually the same person, he feels anxiety about the damage he has done, a desire to repair and fear of punishment[4]. Klein (1959) suggests 'nothing that ever existed in the unconscious completely loses its influence on the personality' (p.302). She argues that these early emotional dramas are still powerfully present in the unconscious and we develop a range of individual defences to deal with them which affect our everyday functioning and which can be breached as a result of current emotional or psychological experiences.

Whether or not we accept this as an accurate representation of infant development, it provides some key understandings about emotional maturity and highlights important

[2] The use of the male pronoun reflects the original text
[3] The paranoid schizoid position
[4] The depressive position.

unconscious processes that exist for all of us. The capacity to tolerate ambivalence - loving and hating the same person; feeling joy and sadness simultaneously; being frightened and excited at the same time - is an emotional skill acquired with time and effort. It involves the abilities to regulate emotion and to trust others, abilities which usually only develop in a position of relative safety. Early negative experiences and lack of emotional containment reduce the opportunity for traumatised children to acquire these abilities. Instead they are likely to deal with complex and opposing emotions through projecting them into others and creating splits between those caring for them.

This dynamic, however, is not restricted to hurt children. We can all recognise our own susceptibility to these processes when we are stressed, tired or afraid. It is frighteningly easy to see some people as wholly negative and justify our own hostile responses to them, or to idealise others and be unable to recognise their faults. This capacity to split underpins the most damaging and dangerous dynamics that operate within human relationships, such as racism, homophobia and sectarianism. Within residential child care the level of stress and psychic assault that can occur makes practitioners vulnerable to sliding into these primitive responses, whether in relation to children or towards colleagues or managers. Kahn (2005) shows how such splitting can come to characterise whole caring organisations where insufficient attention is paid to developing processes that create resilience.

Holding and Containment

These two distinct but related concepts have much to offer residential child care. They describe fundamental development processes that emphasise the relationship between infant and caregiver rather than just the internal world of the infant. They have also

been used to understand what happens in therapeutic encounters that support recovery and growth.

Winnicott (1964) commented that 'there is no such thing as a baby, there is a baby and someone' (p.88). This reflects the importance he placed on the holding environment provided for the infant by the 'good enough' caregiver[5]. He suggests that even before birth, the mother becomes primarily preoccupied with the baby she is carrying; this acute focus on the child's needs continues in the early months of life and is the foundation for healthy development. The everyday experience of attuned physical care and psychological connection constitutes the holding environment, which enables the infant to navigate the route from total dependence towards independence. This involves moving from a state where the infant remains psychologically merged with his caregiver to one where he becomes aware of himself as separate from and different to his caregiver. This process underpins the development of the capacity for thought and creativity. He argues that this type of primary preoccupation in caregivers is most easily achieved if they are themselves receiving thoughtful, attuned support. Some failures in the holding environment are not only inevitable but necessary to support growth. The timely and sensitive repair of such failures communicates the humanity of the caregiver who provides for the infant from a position of love rather than as an unfailingly reliable machine. Where a major unrepaired rupture occurs in this holding environment, however, the movement towards independence falters or, in extreme cases, never begins, with serious effects on the emotional health of children and the adults they become.

[5] 'Good enough **mother**' in Winnicott's terminology. He argued that this was a continuation of the prenatal experience and was specific to the mother child relationship.

Bion (1962) expanded Klein's theories of infant development by exploring the impact on caregivers of the projective processes she describes. He suggests these serve a communicative function by making the caregiver feel the overwhelming emotions experienced by the infant –a process described as projective identification. Bion describes a state he calls 'reverie' in which the caregiver is able to both feel and think about these projected emotions. By accepting and processing these hostile projections without being overwhelmed, the caregiver can understand the infant's experiences. This is an active process of engagement with the infant which shapes the distressing feelings into a more manageable form that can be tolerated and thought about rather than just experienced. Bion emphasises that, alongside love and hate, there is a fundamental drive to understand and know that underpins the infant's projective mechanisms. He suggests that in the repeated, containing interaction between adult and infant, thinking and meaning are discovered. If there is a failure of containment and the caregiver is unable to accept and detoxify the projected feelings, then instead of developing an increased capacity to tolerate frustration and to think, the infant is exposed to escalating anxiety and lack of meaning.

Winnicott and Bion were skilled clinicians who transferred these developmental concepts to the therapeutic contexts of working with individuals, groups and organisations. Winnicott, for example, emphasised that it was the physical and emotional setting for analytic work along with the interpretations of the analyst that provided the holding environment for adult patients. He also described the complex process of creating a therapeutic residential environment for evacuated children whose difficulties were such that they could not be cared for in foster homes. This involved a complex web of interacting individuals and groups that together could provide the physical, social and emotional environment that mirrored the primary care

experience of healthy infancy and allow children to recover from the emotional deprivation that characterised their early experience (Winnicott & Britton, 1947).

Bion (1962) also recognised the power of therapeutic relationships, individual or group, for containing unthinkable anxieties and allowing their transformation into manageable thoughts. Most children in residential care have rarely experienced the containment of an adult accepting, surviving and metabolising their projected terror, anxiety and hostility. Not only was their infancy characterised by trauma and neglect but, as they progress through childhood, they discover that well-meaning adults have often been unable to provide this type of containment when their desperation and anxiety escalates. Every failure of containment and consequent breakdown of relationship emphasises both their own dangerousness and the hostility of the external world.

Within social care the terms ‘holding’ and ‘containment’ can have negative connotations – ‘holding’ is often applied to physical restraint while ‘containment’ is frequently perceived as meeting basic needs without support for growth or change. In contrast to this, however, Ruch (2011) has built on Bion’s concept of containment to explore how to prevent the intense anxiety, inherent in child care social work, resulting in paralysing disintegration or a retreat to sterile proceduralism. She argues for the creation of safe, reflective spaces that can offer emotional, cognitive and organisational containment to social workers at both the individual and collective level. She suggests that such holistic containment enables practitioners to continue to think in the face of their extreme anxiety about troubled children and families, as well as their own professional vulnerability.

Steckley (2010) examined the usefulness of both Winnicott's and Bion's work with specific relevance to residential child care. She emphasised that an understanding of the concepts of the holding environment and therapeutic containment can support workers in their direct interaction with children. When workers are able to survive intense and disturbing behaviour and emotions in children that might otherwise threaten to undermine their capacity to think and respond sensitively, then the children experience a compensatory experience that begins to heal their earlier deprivation and trauma. She highlights, however, that it is not only the children who need to experience such holding and containment. Canham (2004) points out that in residential care settings 'the communication is not confined to psychic states. It is not just what it feels like emotionally to be abused, one is also being kicked, spat at, hit etc. It can feel as if the abuse is really happening again (p.145)'. Faced with such powerful psychic and physical re-enactment, the workers themselves are likely to experience primitive and disturbing emotions that they need help to process within safe spaces and relationships. He suggests that in a residential setting, there should be

> … a space for the individuals working in it to think about the impact of individual children and the resident group as a whole, on them as individuals and as a group. This may only be possible with the help of someone coming from outside on a regular basis who is able to have a different perspective on the dynamic forces at play. (p74)

Transference and Countertransference

Transference - the idea that we transfer emotions and ways of relating from a person in our past to someone significant in our current life - is a concept that is generally well understood and has obvious relevance in a residential child care setting.

Countertransference is a much more difficult concept to understand and indeed, its definition is contested within the psychodynamic community. It refers to the effect on the therapist of her interaction with a client. Grayer and Sax (1986) suggest that it should be understood as 'the totality of the therapist's experience in relation to a particular client, conscious and unconscious, feelings and associations, thoughts and fantasies' (p. 298).

When countertransference was originally recognised it was perceived primarily as a problem for the therapist to overcome, as it was seen to contaminate the process of therapy. Later, however, using the Kleinian understanding of projection and projective identification, the communicative possibilities of the counter transference experience were recognised. Grayer and Sax (1986) describe important ways in which it is possible for therapists to use their own responses, particularly those that feel uncharacteristic to them, to make sense of the patient's internal world and past experiences. They describe concordant counter transference responses where the therapist finds themselves experiencing similar feelings to those of their patient. This can enhance the empathic capacity of the therapist. They also point out the more disturbing counter transference response which relates to the hidden or disavowed self of their patient. For example, a therapist may experience extreme anger rather than concern towards a helpless patient. This may reflect the patient's own disavowed anger towards their helpless parent which they could not express as a child. Even more disturbing is what they describe as complementary countertransference. This occurs when a patient successfully recreates the original relationship in the therapeutic context so that the therapist reacts as though she were the person from the patient's past.

In reflecting on the counter transference experience, it is essential that the therapist is able to recognise what she might be bringing from her own history that affects the therapeutic dynamic or makes her particularly susceptible to particular projections from the client. Because this may be happening at an unconscious level, it is normal for therapists to undergo their own training therapy as well as clinical supervision.

Although these processes are most apparent in the pure analytic situation, they can occur within any relationship or setting. Within residential child care, these complex and often unconscious dynamics are intensified because of the appalling histories of the children. Neglect, abuse and abandonment are the bedrock of their lives and consequently terror, rage and desperation ripple below the surface of their awareness. Relationships in residential care involve the actual giving and receiving of primary care which inevitably touch off unconscious echoes of previous experiences. Unlike formal psychotherapy, the contact between adults and children is not confined within physical and time boundaries but is the very business of everyday living. This leads to a complex entanglement of relationships that involve past and present, real and transferred, conscious and unconscious aspects. Unlike therapists, however, most residential workers are not supported to reflect on themselves at depth and supervision is unlikely to address these aspects of their work. The impact of this confusing and potentially toxic web of relational dynamics may be ignored and the focus remains on controlling the surface behaviour of both children and adults. The dangers implicit in this surface approach can be seen in the continual abuse scandals within residential care. Where countertransference processes are unrecognised or denied, workers are left alone to struggle with frightening and powerful negative emotions and, though obvious abuse remains relatively rare, sub-optimal care is common. In contrast, when practitioners are offered the opportunity to reflect individually and together on the

impact of the work, these countertransference experiences can provide unparalleled access to the internal worlds of children. Practitioners are also more able to deal with the difficult emotions evoked in them without needing to react in a punitive or withholding way.

Social Systems as Defence Against Anxiety and Turning a Blind Eye

Menzies' (1960) classic study of the nursing service of a large teaching hospital built on the idea postulated by Jaques (1955) that, within organisations, individuals collude unconsciously to construct shared social defences that protect them from a recurrence of unresolved primitive anxieties and that these defences form part of the basis for social cohesion within organisations. Jaques saw this process as founded solely on the psychopathologies that workers brought with them into their work places. Menzies, however, suggested that work itself can engender predictable unconscious anxieties related to the nature of the task. Nurses, for example, provide intimate care for their patients which can evoke powerful erotic responses; they also have to deal with the pain, guilt and fear of patients or their families which can arouse strong and complicated feelings mixing pity, hatred and aggression.

Menzies suggests that these emotions resonate powerfully with early developmental experiences. Part of the unconscious drive that pushes people to enter caring professions can be unresolved early experiences still present in their unconscious. By projecting these into their current work, practitioners can revisit and modify some of the anxieties evoked by the overwhelming emotions they struggled with in infancy, such as terror, rage or passionate love. Although this may create intense stress, successful management of the current experience can provide reassurance about the earlier difficulties. This, however, only works effectively if the current experience is

representative of the earlier anxiety-provoking situation rather than equated with it. In residential child care settings, workers not only face frightening and primitive emotions in others and themselves, but also physical intimidation and violence. There is, therefore, a persistent threat that the similarity between the real situation and the earlier one may undermine the symbolic nature of the current work experience so that the full force of unconscious anxieties bursts forth into consciousness.

Menzies suggested that workers strive to externalise their psychic defence mechanisms through developing real aspects of the organisational 'structure, culture and mode of functioning' (p101), such as the creation of depersonalising rituals of care in hospital, to protect them against anxiety. Over time an unconscious, collusive agreement among workers occurs about the form of these defence mechanisms, which then becomes part of the impersonal reality of the organisation that new members must adapt to or ultimately choose to leave. The relentless focus on recording and the constraining impact of risk-averse policies in residential care protect against the anxiety inherent in the work. They also, however, minimise the possibility of emotional connection and reduce the potential for experiencing joy in the work. Neither children nor staff thrive in such a context.

A particularly complicated form of social defence that operates not only within organisations but societally, is that of the perverse defence (Long, 2002). This refers to the collusive process by which a reality that challenges previously assumed certainties, or threatens the self-interest of the protagonists, is simultaneously recognised but denied. This builds on the idea of turning a blind eye propounded by Steiner (1985). He provides a new twist on the drama of Oedipus, suggesting that, far from existing in innocent ignorance of the unfolding tragedy, the main characters all, at some level, knew who Oedipus was, but it suited them to deny this knowledge until

forced to confront it because of its catastrophic consequences. Rather than daring to see and name truth, they had turned a blind eye to this inconvenient reality. This process is neither fully conscious nor fully unconscious and requires the recruitment and corruption of accomplices to preserve the unknowing state.

This resonates strongly with severely dysfunctional processes that can occur within children's homes, wider systems of care and indeed in the societal treatment of children in care and their families. A powerful recent example was the reframing of serious and widespread sexual exploitation of traumatised children in Rotherham as 'lifestyle choices' (Jay, 2014). Professionals denied the meaning of what happened because of their fear of being perceived as racist. Some of the most appalling examples of institutional abuse, such as that perpetrated by Frank Beck or the Pin-down system, were conducted in full sight but the meaning of what was happening was denied (Jones, 1995). More subtle, but affecting many more children, have been practices such as forbidding touch or allowing multiple attachment and relationship disruptions to become normal (Steckley & Smith 2011). That these had devastating effects on children's development was known, but the meaning of this was denied and this systemic abuse has continued for many years. Professionals collectively turned away from seeing the pain they were complicit in inflicting. At a societal level there has been a similar turning away from the impact of poverty and inequality on children and families and collusion with the notion of individual or family pathology as an explanatory theory for problem behaviour and low attainment (Featherstone, Gupta, Morris, & Warner, 2016). Long (2002) suggests that this perverse state of mind is most likely to emerge where instrumental rather than humanising relationships are prominent in society. She also notes that:

> Perversion begets perversion. Abusive cycles are hard to break. Corruption breeds corruption because of the complicity of the accomplices and their subsequent denial and self-deception. (p.192)

Open Systems and the Primary Task

Any organisation can be conceptualised as an open system affected by and affecting its external context. Systems need boundaries that are neither too permeable (risking being overwhelmed by the environment), nor too closed (making it impossible to engage in exchanges with the environment that enable development). Organisations, however, also exist for a purpose, a primary task that needs to be fulfilled, or ultimately they cannot survive. Organisations share a common process of importing something from the external environment, acting on it in some way, and then exporting it in its changed form back to the external environment. The input can be as different as raw materials, people or information, and obviously the conversion and export processes can be equally diverse, but the underlying process remains the same. Various factors both internal or external can affect how well this primary task is achieved.

It is easy to argue that the primary task of residential child care settings is to care for children unable to live within families. This simple statement, however, hides the complexity and diversity of need experienced by children requiring residential care. Some young people need a home for the rest of their childhood that allows them continuing contact with their family; others need a respite from temporary family relationship difficulties; some may need an intense therapeutic experience that supports their recovery from trauma; and a few need control to prevent their damaging behaviour towards themselves or others. These diverse needs require different

approaches, but children are often placed wherever a vacancy exists rather than in an environment that meets their needs. Even where the primary task is more closely defined, such as providing long or short term care, the exigencies of the wider service mean that related remits are often breached. Moreover, managers rarely control the boundary and have to accept any child requiring accommodation, even when their needs clearly cannot be met in the home and their presence may disrupt existing residents in damaging ways.

Although the concept of the primary task may seem to oversimplify the reality of a complex and multi-layered organisation, it is a helpful analytical tool and can help managers and practitioners to identify how they make choices and prioritise in their work. Without a clearly defined primary task that can provide guidance to managers and practitioners, organisational difficulties inevitably arise. In particular, an alternative primary task (anti-task) may emerge that is related to psychological anxieties within the organisation and that subverts the original remit. Some children's homes, for example, appear organised for the convenience and nurture of the staff rather than the care of children, while in others staff become so emotionally enmeshed with the children that they struggle to allow them to move on, even when it is in their best interests.

The confusion of the primary task in a particular home is exacerbated by the contradictory and unrealistic expectations imposed on the sector as a whole. When children whose earliest experiences have adversely affected every domain of their lives and who are then required to move into premature independence go on to have negative outcomes or cause problems in the community, the residential child care sector is often blamed. The concept of primary task can help define the desired and

realistic end state for children as they leave residential care and therefore what resources, skills and support may be required at the various points on their journey.

Implications for understanding and practice in residential child care settings

The emotional environment of a children's residential setting is volatile and complex. The sheer number and variety of individuals interacting with each other on a daily basis in a range of tasks, combines with painful and traumatising histories to create a space where disturbed internal worlds can be re-enacted. This simultaneously provides both the potential for transformational growth and the possibility of terrifying disintegration.

Emanuel (2002) uses the concept of triple deprivation to highlight various factors contributing to the difficulties faced by children in care. The original damage inflicted upon children can create crippling defences that make them respond to loving support in a way that alienates caring adults. This then denies them the opportunity of recovery through the experience of new healing relationships –the double deprivation. The final factor, one that is often unrecognised, occurs when the chaos and fragmentation of children and their families is projected into the whole system. This can undermine the capacity of professionals to think clearly and may result in re-enactment of the original deprivation for children through systemic neglect or trauma. This concept points usefully to the importance of examining what is happening at every systemic level - individual, group, organisation and wider society.

Individuals

Many children carry a history of appalling neglect and abuse compounded by anxiety about continuing difficulties within their birth families, such as domestic violence,

chronic mental health or addiction problems and the vulnerability of siblings still at home. Moreover, children continue to experience relational loss and disruption during their time in care, such as the adoption of siblings, the death or disappearance of significant attachment figures and the loss of special relationships with important professionals.

Many children who have experienced extreme neglect and /or devastating trauma in their earliest years defend themselves against the terrifying anxiety this can induce by processes such as splitting and projection (Briggs 2012). Within residential settings such processes can operate in different ways. Often children whose earliest caregivers were unpredictable and terrifying may struggle to integrate the 'good' and 'bad' aspects of care within a particular individual. As a result, they may unconsciously split the entire staff team or keyworker pairs so that the caring, nurturing aspect is held in one place and the controlling, withholding aspect in another. This is a common dynamic that is immediately recognisable to most practitioners. Frequently, however, workers respond as though these projections reflect reality and accuse each other of unhelpful rigidity or over permissiveness. Alternatively, they may react punitively towards the child assuming this splitting is a calculated and wilful attempt to manipulate. When adults are supported to contain and process the awfulness of being treated in this split off way and continue to provide attuned and consistent care, then, working together, they can hold these projections until the child feels safe enough to accept their caregivers as whole people with both positive and negative qualities.

Impaired attachment experiences and trauma can compromise children's development and they may find it impossible to develop a coherent self, particularly if contact with their caregivers' minds has been so frightening that they are left unable to internalise good experiences (Fonagy, Lorenzini, Campbell, & Luyten, 2014). In such

circumstances children may be unable to integrate different aspects of themselves and their sense of self may be fragmented or splintered. The residential setting provides a fertile space in which such disparate and, indeed, incompatible aspects of a child can be displayed and such displays often evoke starkly different responses in adults. These countertransference reactions in staff can provide exceptionally useful information for understanding the internal world of a child if the appropriate reflective space is available. In the absence of such spaces, they can be the basis for irreconcilable splits and tension within the staff group and may lead to the scapegoating and ejection of the child concerned.

For example, a child struggling with the recent death of his mother and loss of hope for a better relationship may evoke compassion and concern in an attuned key worker who is deeply in touch with his sadness and loss, as well as the despair that he will never now have a mother able to meet his needs. Connecting to such distress carries a burden of intense pain for the worker as well as the child – holding a young child who sobs inconsolably for his loss can feel overwhelming. Other workers may only see the charming, playful child who seems to relish the opportunities and nurture available within the home. Yet others may be presented with totally different behaviour which feels controlling and threatening and can induce real terror in workers. The same child is presenting different individuals within the team with the various parts of his fragmented and splintered self. To help such severely traumatised children recover and flourish, adults must understand them as whole people and avoid reacting to only one aspect of them. It would be just as unhelpful in this example to respond only to the charming child or the grieving, abandoned son as it would be to react punitively to the threatening, frightening youth and label him as a potential domestic abuser.

Within many residential settings there is little opportunity for these different experiences to be noticed, examined and held together. Moreover, such experiences can resonate strongly with the personal histories of many residential child care practitioners, whose motivations for entering the profession can often be complicated and may be grounded in their own experience of loss or adversity either in childhood or adulthood. Not only do workers bring their personal histories with them, they also carry the memories and echoes of other children they have worked with into their current relationships. Residential care often involves multiple losses for staff as well as children, and at times children leave in negative or unplanned ways that make it even more difficult to manage such losses. Without a protected reflective space where this countertransference information can be acknowledged and explored, there is a real risk that the intense and painful reactions evoked in adults can result in children being ejected from placements and continually bounced around the care and education systems. Equally, staff may be overwhelmed by the powerful impact of the work. They may react in ways that are destructive to themselves or others; alternatively, they may simply decide to leave the profession with the consequent further disruption of relationships for children and a sense of failure for themselves.

Within the safety of a reflective space, however, adults may recognise that their reactions to children are rooted in their own relationship histories and experiences, and learn to separate these from the communicative aspects of the children's projections. This allows adults to maintain a measured and loving response in their interactions with children. Not only can they avoid the dangers of becoming overwhelmed by the fear and anger that severely distressed children can evoke, but they are also not blinded to the children's continuing behavioural or developmental problems through compassion for, and identification with, their trauma. Despite the

fragmentation and incoherence often experienced and projected by children, the adults, within such an enabling and supportive context, remain able to reflect back acceptance of the children as whole beings as well as a belief in their capacity for development. To be able to provide such a containing context, staff need emotional and cognitive containment for themselves.

Another common dynamic within children's homes is the emergence of an individual who is perceived as 'the problem' (Obholzer & Roberts, 1994). This may be a child but equally it may be a worker. All anxiety and irritation is focused on this impossible person and the fantasy emerges that if only this person could be ejected, everything would be wonderful. Unfortunately, when the individual leaves, someone else moves into the vacated 'impossible person' space. Often the difficult individual is enacting the disowned parts of others on behalf of the group. One worker may, for example, be in perpetual conflict with managers and actively undermine the ethos of the home. Although these behaviours (and their underlying feelings) belong to this worker, they also provide a very convenient receptacle for the feelings of others who then do not have to face their own ambivalence. Workers may both respect and value their managers, but also hate them because of the demands they place on them; similarly, they may believe passionately in the ethos of the home yet be resentful of the children and want to punish them. These uncomfortable negative feelings can be split off and given to the 'impossible' colleague, who then has to carry the full weight of the staff group's negativity as well as their own. Unless there is the cognitive awareness of this process and the emotional courage to take back their own projections, this dynamic can be replayed in staff groups on countless occasions. This scapegoating process can happen in any organisation, but the extremity of the emotions involved in the

residential child care setting mean that it is played out with huge intensity and potentially catastrophic consequences for people.

Groups

Residential child care is, by its very nature, a group endeavour and within therapeutic communities for children the group is used as a fundamental arena for developing understanding and providing containment. The 'network of inter-relating groups' (Rose, 1990, p.28), whether formal or informal, provide multiple opportunities for understanding and growth but also for terror and fragmentation. Children may recruit adults and other children as protagonists in an unconscious re-enactment of their history of trauma and troubled relationships. This type of group transference can provide significant information about children's inner worlds and, over time, children can learn to recognise, accept and tolerate the difference between their negative early relationships and the nurturing care offered to them in the present. Within therapeutic communities it is the group of young people as well as the adults, who provide such corrective feedback. Not only can children be helped to let go of their own compulsion to re-enact their early trauma; they may also learn to recognise the processes by which they can be swept into the destructive re-enactments of others. Developing insight into such unconscious dynamics in the relatively protected context of a therapeutic children's community can help prevent them being trapped in mutually destructive patterns of relating with partners, employers or, indeed, their own children when they become adults.

As Rose (1990) pointed out, however, it is not only the children's unconscious difficulties that become enacted within residential settings. Unaddressed and unresolved tension or conflict that exists within the staff team or between staff and

managers can inject disturbance into the children's group. These parallel processes may result in one or more of the children enacting the tension between the adults – often in a dramatic and dangerous way which may lead to their abrupt ejection from the home. One striking example of this involved the abrupt decision of a manager of a therapeutic home to resign and leave within a few days, leaving the staff feeling totally uncontained and anxious. As the adults struggled to manage their feelings, the children became more anxious and wild as they experienced the unspoken dynamics infecting the staff group. Eventually this erupted in one child setting a serious fire the night before the adults intended to tell the group of young people about the manager's departure. The anxiety the adults experienced had been intense and unpleasant for them, but their inability to contain this resulted in one of the most vulnerable youngsters enacting it in a way that was catastrophic for his future.

Such dynamics are not solely apparent in therapeutic communities – they occur in all groups, including families, but are often not recognised. Within residential child care settings there has been an appropriately increased focus on the needs of individual children but, unfortunately, the group setting has simultaneously come to be seen as a problem to be overcome rather than an important social and therapeutic forum. If the unconscious dynamics within and between groups are unrecognised, they do not disappear; instead, the scene is set for the scapegoating of individuals and the development of delinquent subcultures among both children and staff.

Organisations

Most children's homes are sub-systems of larger organisations. The splitting and projective mechanisms that have been described within residential child care settings also get played out on this wider stage. Kahn (2005) identifies different types of splits

that are prevalent in care-giving organisations that can disrupt the essential boundaries required for effective practice. He suggests that social defences developed to protect workers against the various strains of care-giving work may lead to boundaries that are either too rigid or too loose. These splits often intensify existing organisational fault lines that might, for example, be functional or hierarchical.

In residential care, the normal tasks of parenting are held by different parts of the system: residential workers provide daily emotional and practical care as well as help children to recover from their trauma and neglect, whereas field workers and their managers undertake the procedural and decision making functions of parenting. Even in the most collaborative organisations, this is likely to create difficulties. Too frequently these separate functions become the focus for splitting and mutual projection rather than providing the different resources required to achieve the primary task. The splitting allows both sides to avoid the awful feelings evoked by the children's histories and the difficulties in helping them recover.

Kahn (2005) also draws attention to the difficulties of negotiating dependency within a caregiving organisation. Children with such difficult life experiences may have a desperate yearning to be looked after and provided with love and compensatory care to atone for the trauma they have suffered. Their distress, fear and longing is often absorbed by those who care for them, who may, in turn, pass this on to their supervisors and managers. In resilient organisations the containment provided through supervision, staff meetings and other reflective fora allows these feelings to be metabolised and returned to the children in a form that can contribute to their recovery and change. In resilient organisations the provision of such opportunities is a key leadership task (Kahn, 2005; Ward, 2014). The leader becomes an important attachment figure providing enough security for staff to fulfil their roles safely and to

remain resilient. A leader who contains the anxieties evoked in staff also offers them a model of how to work with children. Dependency is at the heart of these interactions, but it is a mature dependency that allows for growth and development.

Kahn (2005) suggests, however, that often the predominant dynamic in caregiving organisations is immature dependence. In residential child care such a dynamic may start with the overwhelming emotions of children and become transposed across all levels of the organisation. This can be expressed either through leaders and followers accepting the assumption that all authority and capacity is held by the leader and none by followers, or, alternatively, through followers denying the authority of the leader in a counter-dependent way. This counter-dependent response may be triggered when a leader fails to demonstrate the omnipotence hoped for by workers. In their disappointment and anger, workers may react aggressively or withdraw their engagement. Both forms of immature dependence avoid a key requirement for residential child care organisations, which is the negotiation of the balance between dependence and autonomy in relationships – between leaders and staff and between staff and children. Kahn suggests that to recover and become more resilient, caregiving organisations require a shift in attitude that allows leaders and followers to achieve a culture of mature dependence where the difficult work of negotiating both relatedness and autonomy takes place.

The External World

Residential child care providers are affected by the external environment in which they exist. Organisations that provide services to the most disadvantaged and difficult people in society are often in receipt of unconscious expectations and projections from the public and government. Miller (1993) suggests that the Church, for example,

is ‘to some extent…being asked to solve the insoluble, cure the incurable, make reality go away’ (p. 106). A similar argument can be made about the expectations placed on social care organisations. Not only are they expected to achieve impossible outcomes, they are often required to ‘protect and purify society from the negative and disruptive dynamics that these clients inevitably bring with them’ (Cardona, 1999, p. 250). Workers have to absorb and process these often overwhelming demands from the external context whilst simultaneously being subject to the anxieties engendered by the work and organisational dynamics.

The public perception of children in care tends to be limited to the identities of ‘victim or villain’, neither of which acknowledges children as whole people with strengths and agency as well as flaws and weaknesses. Practitioners, too, suffer these split identities – variously seen as saints for working with ‘these children’ or potential abusers and destroyers of innocent lives. This group of children and workers provide a convenient receptacle to hold some of the most disturbing, primitive and frightening emotions humans can experience. (Colton & Roberts, 2007)

Intense public anxiety about residential child care erupts quite frequently, whether as a result of the reports of historic abuse, negative outcomes, massive cost or occasionally as a result of the dangerous or self-destructive behaviour of one or more children. Unfortunately, governmental responses to such panics are usually driven by anxiety rather than thoughtful reflection. This has been described by Hoggett (2013) in his analysis of child protection work in the UK. He suggests that ‘if governments cannot contain public anxieties then they will project, enact, or embody them (p.73)’ and that as a result ‘the state and its institutions may come to embody social anxieties through its rules, systems, structures, and procedures (p73)’. He outlines how the formalisation and bureaucratisation of child protection work that this has created has

meant that ‘a virtual and electronic child has come to replace an actual child engaged in real relations with professional staff (p.77)’.

Within residential child care a similar focus on endless recording has reduced the time available for children and adults to be together (Hardy 2014). In addition, the requirement imposed by regulatory bodies to provide extensive written evidence to demonstrate compliance with national standards has meant that what comes to exist is a virtual and electronic home that may not represent the actuality of practice but enables easy grading. The various regulatory bodies in the UK have found themselves forced into implementing ever increasing governmental requirements on the residential sector, with little acknowledgement that these may undermine practice rather than support it. The negative consequences of a poor grade push organisations into prioritising easily measureable aspects of practice but divert attention from more intangible components of high quality care. This can escalate anxiety in an already volatile and complex environment. Dartington (2010) examines this process in his analysis of systems of care and emphasises that the attempt to constrain the power of relationships through policies and procedures is in itself a way of avoiding the anxiety evoked by the needs of ill, disempowered or traumatised people.

> What is spontaneous, idiosyncratic, uncertain in its outcome does not fit with an agenda of national standards. If you allow carers to have relationships of any significance with service users, things will become messy. We need the remarkable competence of ordinary people to care for others, but then we become frightened of that competence and impose control rather than, in the supportive psychological sense, containment. (Dartington, 2010 p.120)

Many of the public and governmental responses towards children in residential care are characterised by the type of perverse social defence described by Long (2002). Children are expected to become independent at a much younger age than their peers and until recently this involved the total rupture of relationships with all the adults caring for them. Politicians, professionals and the public who know what a destructive experience this would be for their own children deny the meaning of these practices for these very traumatised children. Hoggett (2010) argues that the financial and political costs of recognising this type of suffering create a 'thick skin […] between the state, its managers and policymakers on the one hand, and the many seas of social suffering characteristic of increasingly socially polarized democracies' (p. 210).

In Scotland the powerful voices of young people, in conjunction with their advocates and workers, have successfully pierced this 'thick skin'. By confronting politicians directly with the serious suffering caused by these policies and practices, they challenged the collusive denial of meaning and forced truth to be seen. This created a massive shift in policy and legislation in Scotland. Although there are implementation challenges during a period of austerity, a relational approach is now embedded in the care system, extending the rights of young people to continuing support from the adults who have cared for them up to the age of 26 (McGhee, 2017).

Conclusion

Residential child care is a complex environment awash with powerful emotions. Workers need intelligence, skill and emotional maturity to navigate the everyday challenges presented in this environment. Not only are the care settings volatile and testing, they are embedded in wider systems that often inject additional disturbance

into them. Without a theoretical approach that can shed light on the complicated dynamics created in these spaces, workers and managers are left struggling to make sense of frightening behaviour, attitudes and emotions – their own as much as that of others. This paper argues that using a systemic and psychodynamic approach can help to reclaim this complexity in a positive way and allow individuals and groups to risk looking beneath the surface of the everyday interactions that occur in residential child care. Hurt and traumatised children deserve this, practitioners and managers need it and society cannot afford the human and financial costs of continuing to turn a blind eye.

Notes on Contributor

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